

NOTICE OF FUNDING OPPORTUNITY

Initiative 10: Rural GME Enhancement Curriculum Enhancement Grant Program

Opportunity Detail	Draft Information
Issuing Entity	Indiana Department of Health (IDOH)
Program Administrator	Indiana Rural Health Association (IRHA)
Anticipated Number of Awards	Fifteen (15), subject to final IDOH approval and available funding
Maximum Award	\$150,000 per approved residency program
NOFO Release	October 16, 2026
Application Deadline	November 16, 2026, at 5:00 p.m. Eastern Time
Project Period	From the effective date of the fully executed subrecipient agreement through July 31, 2027
Submission Method	Electronic submission via: https://redcap.link/curriculumenhancementapp

1. Funding Opportunity Summary

On December 29, 2025, Indiana was awarded nearly \$207 million for the first year of a five-year federal Rural Health Transformation Program (RHTP) to address health outcomes in rural communities. Initiative 10 includes coordinated activities intended to expand rural training capacity, strengthen the physician workforce pipeline, and support recruitment and retention in rural and underserved communities.

Through this Notice of Funding Opportunity (NOFO), IDOH seeks applications for Curriculum Enhancement Grants that support eligible Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs in developing new or substantially expanding existing curricular components that provide:

- At least eight (8) weeks of rural training experiences; and
- At least eight (8) weeks of addiction medicine training.

The purpose of this grant is to create sustainable, competency-aligned training experiences that expand rural clinical exposure, strengthen addiction medicine preparedness, and support Indiana's long-term rural physician workforce pipeline.

Federal Funding Acknowledgment

This program is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$206,927,896.80, with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CMS/HHS or the U.S. Government.

2. Program Goals and Objectives

The Curriculum Enhancement Grant Program is intended to:

- Develop or substantially expand structured rural and addiction medicine curricular components aligned with identified workforce needs;
- Increase meaningful resident exposure to rural practice settings;
- Strengthen resident competencies in prevention, identification, treatment, referral, recovery support, and other evidence-based elements of addiction medicine, as appropriate to the residency specialty;
- Increase the number and quality of sustainable rural rotation opportunities;
- Support faculty and preceptor readiness for rural and addiction medicine education;
- Build durable partnerships among sponsoring institutions, residency programs, rural clinical sites, community organizations, and addiction treatment providers;
- Create curriculum, operational workflows, evaluation systems, and sustainability plans that are ready for implementation; and
- Support long-term recruitment and retention of physicians in rural and underserved Indiana communities.

3. Funding Availability and Award Structure

Element	Requirement
Anticipated awards	Fifteen (15) awards, subject to final IDOH approval, application quality, and available funding.
Award amount	Up to \$150,000 per approved residency program. IDOH may approve a lower amount based on budget reasonableness, available funding, or negotiated scope.
Cost sharing or match	No match is required unless IDOH states otherwise in a written NOFO amendment.
Period of performance	Effective date of the fully executed subrecipient agreement through July 31, 2027.
Pre-award costs	Not allowable. Costs incurred before the effective date of the fully executed agreement will not be reimbursed.
Payment method	Reimbursement-based. Payment is subject to the fully executed agreement, required documentation, approval, available funding, and authorization.
Unused Award Balance	The approved award amount represents the maximum amount available for reimbursement. Funds not requested for reimbursement by the applicable reimbursement deadline may be reallocated or otherwise administered at the discretion of IDOH.
Future funding	An award under this NOFO does not guarantee continuation or renewal funding.

4. Eligible Applicants

Eligible applicants are existing ACGME-accredited residency programs seeking to develop new or substantially expand existing rural training and addiction medicine curriculum components. The residency program will be considered the applicant for purposes of this NoFO. The applicant must identify the entity legally authorized to execute the subrecipient agreement and receive reimbursement on behalf of the residency program.

4.1 Minimum Eligibility Requirements

At the time of application and throughout the award period, the applicant must:

- Be an existing ACGME-accredited residency program that will develop and implement the proposed curriculum;
- Maintain an eligible ACGME accreditation status throughout the award period;
- Be located in Indiana or demonstrate that the proposed project will primarily support Indiana residents, Indiana training sites, and Indiana rural workforce needs;
- Propose both an eight-week rural training component and an eight-week addiction medicine training component;
- Provide evidence of support from the residency program's Sponsoring Institution;
- Demonstrate sufficient faculty, administrative, fiscal, and operational capacity to complete the proposed project;
- Identify the entity authorized to execute the subrecipient agreement and receive reimbursement on behalf of the residency program;
- Agree to all applicable program, reporting, monitoring, record-retention, and federal funding requirements; and

- Submit a complete application by the published deadline.

4.2 Multiple Applications and Residency Programs

- A residency program may submit no more than one application under this NoFO.
- One application may support multiple residency programs or specialties.
- Each application must describe a distinct project serving the applying residency program.
- The maximum award is \$150,000 per approved residency program.
- If collaborative applications are permitted, one eligible residency program must be designated as the lead applicant. The application must also identify the entity legally authorized to execute the subrecipient agreement, receive reimbursement, and assume fiscal responsibility for the award.

4.3 Specialty Priorities

Applications involving the following specialty areas may receive priority consistent with Initiative 10: primary care, emergency medicine, family medicine, internal medicine, pediatrics, obstetrics and gynecology, general surgery, and psychiatry. The scoring rubric will state whether and how specialty priority affects scoring. No applicant will receive duplicative points for overlapping specialty classifications.

4.4 Rural Definition and Site Eligibility

For purposes of this NOFO, a proposed rural training site will be considered rural if the site's physical service address is identified as rural by the Health Resources and Services Administration's Rural Health Grants Eligibility Analyzer. Applicants must use the [HRSA Rural Health Grants Eligibility Analyzer](#) to determine the rural eligibility of each proposed training site. The Analyzer permits users to enter a physical address or search by state and county to check rural eligibility status.

Applicants must include documentation of the Analyzer result for each proposed rural training site as part of the application. Documentation must clearly identify the physical service address evaluated, the eligibility result, and the date the eligibility search was completed. A screenshot or saved copy of the Analyzer result is acceptable.

A mailing address, administrative office, post office box, or organizational headquarters may not be used in place of the physical address at which the proposed rural training activities will occur. If a training experience will take place at multiple locations, the applicant must provide an Analyzer result for each physical training site proposed as rural.

A Health Professional Shortage Area designation, Medically Underserved Area or Population designation, rural-serving status, Critical Access Hospital designation, or other workforce or facility designation does not independently establish rural eligibility under this NOFO unless expressly approved by IDOH.

IDOH retains final authority to determine whether a proposed training site meets the rural eligibility requirements of this program. In limited circumstances, IDOH may approve a site that is not identified as rural by the HRSA Rural Health Grants Eligibility Analyzer when IDOH determines that the site is eligible or appropriate under the Rural Health Transformation Program, applicable funding requirements, or other controlling program guidance. Any such determination will be documented by IDOH and does not create eligibility or precedent for any other applicant or training site.

4.5 Eligible Curriculum Development

Applicants may propose:

- Creation of new rural and addiction medicine curricular components; or
- Substantial expansion of existing curricular components when the project creates a distinct, measurable enhancement and results in the required eight weeks of rural training and eight weeks of addiction medicine training.

A substantial expansion may include increasing duration, adding new rural sites, developing a new addiction medicine sequence, converting limited elective content into a structured curriculum, expanding resident access, adding competency mapping and formal evaluation, or adding faculty and preceptor development. Grant funds may not be used merely to continue, maintain, or replace existing institutional funding without documented enhancement.

5. Curriculum Requirements

5.1 Eight-Week Rural Training Component

The proposed curriculum must provide at least eight weeks of substantive rural training. The application must explain:

- Whether participation is required, selective, or elective;
- Which residents or cohorts will participate;
- Whether the experience is block-based, longitudinal, or a combination;
- How one week is calculated, including expected clinical, didactic, community, and independent-learning hours;
- The rural site or sites at which training will occur;
- The rural competencies, learning objectives, supervision model, and evaluation approach; and
- How the training will be sustained after grant funding ends.

5.2 Eight-Week Addiction Medicine Component

The proposed curriculum must provide at least eight weeks of substantive addiction medicine training appropriate to the residency specialty. The application must describe the clinical, didactic, community-based, simulation, telehealth, and other instructional methods to be used, together with learning objectives, competencies, faculty qualifications, supervision, and evaluation.

Telehealth may supplement the curriculum but may not serve as the sole method for a required clinical rotation. At least sixty percent (60%) of the proposed addiction medicine training experience must consist of in-person clinical, patient-facing, or community-based experiential learning activities. The remaining portion may include didactic instruction, simulation, telehealth-supported learning, case review, project-based activities, or other educational approaches that support the approved curriculum objectives.

5.3 Overlap Between Rural and Addiction Training

Rural and addiction medicine training may occur concurrently when the applicant demonstrates that the experience independently satisfies the objectives, competencies, documentation, supervision, and evaluation requirements of both components. An overlapping week may count toward both eight-week requirements only when both elements are substantive and clearly documented. Applicants may also propose separate rural and addiction medicine experiences.

5.4 Location of Addiction Medicine Training

The rural training component must occur at an approved rural site. Addiction medicine training may occur at rural, underserved, or other appropriately qualified training sites when the applicant demonstrates that the experience supports the program's learning objectives and Indiana workforce needs. While addiction medicine training is not required to occur in a rural setting, applications that integrate addiction medicine within rural clinical environments and demonstrate how the experience addresses rural workforce and treatment needs may receive additional consideration during scoring.

5.5 Required Curriculum Products

Applicants should propose the curriculum components, educational materials, training plans, evaluation

methods, implementation resources, and sustainability activities necessary to support successful implementation of the proposed rural and addiction medicine training experiences.

6. Required Scope of Work

6.1 Curriculum Planning and Development

- Conduct a documented gap analysis of the current curriculum;
- Develop measurable learning objectives, syllabi, schedules, and competency frameworks;
- Map curricular components to applicable ACGME requirements and institutional academic expectations;
- Integrate content addressing rural health needs, access barriers, health outcomes, community context, and workforce challenges;
- Incorporate addiction medicine content consistent with evidence-based practice and the residency specialty; and
- Obtain required internal academic and institutional review or approval.

6.2 Rural Training Integration

- Identify and assess rural training partners and proposed rotation locations;
- Define rotation structure, scheduling, supervision, preceptor expectations, and resident support;
- Develop affiliation agreements and teaching-site documentation;
- Establish resident travel, housing, safety, communication, and escalation plans as applicable; and
- Align rotation planning with a credible long-term sustainability strategy.

6.3 Faculty and Preceptor Development

- Identify or recruit qualified faculty and preceptors;
- Provide orientation, faculty development, and preceptor preparation;
- Establish ongoing communication, evaluation, recognition, and support systems; and
- Document participation and completion of funded development activities.

6.4 Operational Readiness

- Establish staffing roles and decision authority;
- Develop learner onboarding, scheduling, documentation, supervision, and evaluation processes as necessary for implementation.
- Confirm faculty, preceptor, and training-site readiness.
- Finalize curriculum materials and implementation resources.
- Meet the Minimum Implementation Readiness Standard described in Section 7.

6.5 Technical Assistance

The Rural Graduate Medical Education (GME) Technical Assistance Center (TAC), administered by the Indiana Rural Health Association (IRHA), is available to support awardees throughout the project period. Awardees are encouraged to utilize TAC resources and technical assistance services to strengthen curriculum development, rural rotation planning, partnership development, faculty and preceptor preparation, sustainability planning, and implementation readiness.

Upon request, IRHA may conduct site assessments, review draft products, connect awardees with subject-matter experts, facilitate peer learning opportunities, and provide nonbinding recommendations and technical assistance.

Participation in TAC activities is voluntary.

IRHA technical assistance and site assessments do not constitute legal advice, accreditation determinations, compliance findings, corrective-action decisions, or funding determinations. Information may be shared with IDOH as needed for program administration, reporting, technical assistance, or grant oversight, consistent with the subrecipient agreement and applicable law.

7. Minimum Implementation-Readiness Standard

By July 31, 2027, awardees must demonstrate that the rural and addiction medicine curriculum components are fully developed and ready for implementation. At a minimum, awardees must document:

- Completed curriculum materials;
- Identified training sites and partners;
- Faculty and preceptor readiness;
- Evaluation methods; and
- Sustainability planning.

8. Project Timeline and Key Dates

Milestone	Date or Requirement
NOFO released	October 16, 2026
Applicant webinar or information session	12pm October 21, 2026: https://zoom.us/webinar/register/WN_rG1oLQKpT_eyJ7WHR18qJw
Deadline for written questions	October 30, 2026
Responses or FAQ posted	November 6, 2026
Application deadline	November 16, 2026, at 5:00 p.m. Eastern Time
Anticipated notice of selection	December 11, 2026
Anticipated agreement execution	January 8, 2027
Project start	Effective date of fully executed subrecipient agreement
Work begins	Within 30 calendar days after agreement effective date
Reporting Periods	Quarterly Report #1: Covers activities conducted from January 8, 2027 through March 31, 2027 and is due April 15, 2027. Quarterly Report #2: Covers activities conducted from April 1, 2027 through June 30, 2027 and is due July 15, 2027. Final Report: Covers all project activities from January 8, 2027 through July 31, 2027 and is due August 5, 2027.
All activities and expenditures complete	July 31, 2027

No-cost extensions are not anticipated because of federal award-period restrictions. Any exception must be expressly authorized in writing and may require IDOH or federal approval. Applicants should not assume an extension will be available.

9. Allowable and Unallowable Costs

All costs must be necessary, reasonable, allocable to the approved project, adequately documented, incurred within the period of performance, and permitted by the subrecipient agreement and applicable federal and State requirements. Inclusion of a cost in an application does not make the cost allowable. Written approval of the final budget is required before costs are incurred.

9.1 Potentially Allowable Costs

- Curriculum design, instructional development, competency mapping, and evaluation development;
- Faculty development and preceptor preparation;
- Direct administrative personnel costs specifically attributable to the approved project and supported by time-and-effort documentation;
- Rural rotation and addiction medicine partnership development;
- Necessary travel consistent with the applicable written travel policy and approved budget;
- EMR learner-access fees, simulation resources, virtual learning platforms, and other approved technology;
- Curriculum licensing or modular content acquisition when the license term and continued-use plan are reasonable;
- Supplies and minor equipment consistent with the approved budget and applicable capitalization rules;
- Accessibility services required to make grant-funded curriculum and technology usable; and
- Other direct curriculum-development expenses expressly approved in writing.

9.2 Costs Requiring Specific Prior Written Approval

- Consultant and subject-matter expert services, including the proposed scope of work, qualifications, procurement method, rate or fee, and total anticipated cost, require prior written approval from IDOH before a contract is executed or costs are incurred. Approval of the grant award or project budget does not constitute approval of a consultant engagement unless the consultant and engagement are expressly approved in writing;
- Equipment purchases exceeding \$5,000 per unit, bundled technology solutions, or items requiring capitalization under the applicant's accounting policies require prior written approval;
- Out-of-state travel, conference registration, or specialized training;
- Licenses extending beyond the award period;
- Faculty protected time, preceptor compensation, or other clinician compensation;
- Minor alterations, if permitted under the final program rules; and
- Any budget revision identified by IDOH as requiring prior approval.

9.3 Unallowable Costs

- Pre-award costs or costs incurred after the period of performance;
- New construction, building expansion, significant renovation, or capital improvements;
- Costs that supplant existing State, local, tribal, institutional, or private funding;
- Clinical services that are billable to insurance or duplicate another payment source;
- Resident recruitment or retention bonuses, learner salaries, or general resident salary support;
- Clinical revenue backfill or lost clinical revenue;
- General marketing unrelated to approved curriculum recruitment or dissemination;
- Accreditation fees;
- Meals except when expressly approved and allowable under applicable federal requirements;
- Goods or services not allocable to the approved project;
- Lobbying and other prohibited advocacy costs;

- Covered telecommunications or video-surveillance equipment prohibited by federal requirements;
- Fines, penalties, entertainment, alcohol, and other expressly prohibited costs; and
- Indirect costs, if IDOH confirms the proposed program-specific prohibition before release.

9.4 Budget Revisions

Budget revisions require prior written approval in accordance with the subrecipient agreement. Awardees must not incur costs under a revised budget until written approval is received. Certain revisions may require additional IDOH or federal approval. The agreement will specify allowable movement among categories, required documentation, and approval authority.

10. Application Requirements

Applications must contain all items below in the order listed. IDOH may reject applications that are late, incomplete, ineligible, unsigned, or materially nonresponsive.

Table 1. Required Application Components

Section	Required Content
1. Application cover sheet	Residency program applicant name; sponsoring institution; ACGME program number and accreditation status; specialty; program director; primary project contact; entity legally authorized to execute the subrecipient agreement and receive reimbursement; authorized organizational representative; fiscal contact; address; and requested amount.
2. Executive summary	Concise description of need, proposed enhancement, residents served, sites, requested funding, and anticipated outcomes.
3. Eligibility documentation	Residency program accreditation documentation; identification of and support from the sponsoring institution; documentation for the entity legally authorized to execute the subrecipient agreement and receive reimbursement; and rural-site documentation.
4. Current-state assessment	Description of the current training environment, existing rural and/or addiction medicine curriculum (if applicable), identified gaps or opportunities, existing partnerships, available capacity, and the rationale for the proposed project.
5. Project narrative	Proposed rural component, addiction component, overlap if any, resident participation model, educational methods, competencies, supervision, and evaluation.
6. Rural-site and partnership plan	Description of proposed rural training sites, key partners, preceptor availability, and plans for implementation of the rural training experience.
7. Faculty and staffing plan	Roles, qualifications, level of effort, recruitment needs, faculty development, and governance.
8. Work plan	Activities, milestones, responsible parties, deliverables, dependencies, risks, and dates through July 31, 2027.
9. Evaluation plan	Plan for evaluating project activities, implementation progress, and anticipated outcomes.
10. Sustainability plan	Post-grant staffing, financing, sites, curriculum ownership and maintenance, institutional commitment, and anticipated learner participation.
11. Budget and justification	Detailed project budget and budget narrative describing how requested funds will support the proposed project.

Section	Required Content
12. Letters and assurances	Institutional leadership letter; partner letters or conditional commitments; authorized signature; conflict, disclosure, and federal assurances as required.

10.1 Formatting and Submission

- Applications must be submitted through the designated REDCap application portal: <https://redcap.link/curriculumenhancementapp>
- Applicants will be required to complete designated application fields within REDCap and upload all required application materials as PDF attachments.
- The narrative application, budget, budget narrative, letters of support, and other required attachments should be combined into a single PDF whenever practicable.
- Applications must be submitted no later than **November 16, 2026, at 5:00 PM Eastern Time**.
- Applicants are responsible for ensuring successful submission through the REDCap portal prior to the submission deadline.
- Confirmation of submission will be generated by REDCap and should be retained by the applicant for their records.
- Applications submitted after the deadline will not be reviewed unless authorized by IDOH due to extraordinary circumstances.
- After the submission deadline, applicants may not modify submitted applications unless clarification is requested by IRHA or IDOH.
- Questions regarding this funding opportunity must be submitted by **October 30, 2026, at 5:00 PM Eastern Time**.
- Responses to submitted questions and any Frequently Asked Questions (FAQ) document will be posted on **November 6, 2026**.
- Only written amendments, FAQs, or other written communications issued by IDOH or IRHA may be relied upon as official interpretations of this NOFO.

11. Application Review and Selection

11.1 Review Process

1. Administrative review for timeliness and completeness;
2. Eligibility review against the published requirements;
3. Independent or panel scoring using the IDOH-approved rubric;
4. Budget and risk review;
5. Clarification, interview, or negotiation when authorized;
6. IRHA recommendation of awardees and award amounts to IDOH; and
7. Final award decision by IDOH.

11.2 Proposed Scoring Framework

Applications will be evaluated using an IDOH-approved review framework. Evaluation factors may include, but are not limited to:

1. Alignment with the goals and objectives of the Rural Health Transformation Program and Initiative 10;
2. Demonstrated rural workforce need and potential project impact;
3. Quality and feasibility of the proposed rural training component;
4. Quality and feasibility of the proposed addiction medicine training component;
5. Organizational, faculty, preceptor, and partnership capacity;

6. Implementation readiness and ability to meet project timelines;
7. Sustainability of proposed curricular enhancements beyond the grant period;
8. Evaluation and outcomes measurement approach; and
9. Budget reasonableness and alignment with project objectives.

Applications will be reviewed using an IDOH-approved review framework. IDOH and IRHA reserve the right to request clarification of application materials and to verify information provided by applicants. Final funding recommendations will be subject to review and approval by IDOH. Final funding recommendations will be subject to review and approval by IDOH.

12. Award Administration

Selection for funding does not constitute a binding award. Final funding is contingent upon IDOH approval and execution of a subrecipient agreement.

IRHA will administer grant activities consistent with IDOH requirements and provide technical assistance to awardees.

Awardees must comply with all reporting, monitoring, documentation, and fiscal requirements established by IDOH and IRHA.

IDOH retains final authority for award approval, compliance oversight, payment authorization, corrective action determinations, and recoupment actions.

13. Publications

Awardees must use the required CMS/HHS acknowledgment and comply with any advance-review requirements for publications, presentations, websites, recruitment materials, videos, press releases, and other public-facing products developed with grant support. IRHA and IDOH will provide the required acknowledgment, calculation method, and submission process. Awardees must not publicly release covered materials until all required reviews are complete.

14. Applicant Questions and Technical Assistance

Written questions must be submitted to <https://redcap.link/curriculumenhancementTA> by October 30, 2026, at 5:00 p.m. Eastern Time. Responses will be published in an official FAQ by November 6, 2026. Only written amendments, FAQs, or other written communications issued by IDOH or IRHA constitute official interpretations of this NOFO.