Rural Health Transformation Grant Guide — Texas

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AUDIENCE: State health agencies, Medicaid, rural providers, collaboratives

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Texas can leverage the Rural Health Transformation (RHT) Program cooperative agreement to stabilize rural access, modernize care, and build durable delivery and data infrastructure across FY26–FY30. The federal NOFO (CMS-RHT-26-001) provides up to $50B nationwide with awards to States only, one application per State, optional LOI due September 30, 2025, application due November 5, 2025, and an expected award/earliest start of December 31, 2025. The NOFO requests a program plan, initiative portfolio, metrics, and budgeting using an illustrative $200M/year planning figure, with hard caps (e.g., admin ≤10%, provider payments ≤15%, capital/infrastructure ≤20%, EMR replacement ≤5%, limits on "Rural Tech Catalyst" ≤10% or $20M) and standard 2 CFR restrictions. CMS will weight workload funding 50% on technical factors and 50% on rural facility/population factors; scoring weights and evidence expectations are detailed in Table 3 and the Appendix. (files.simpler.grants.gov)

The Rural Health Transformation Collaborative (the Collaborative) can support Texas, subject to State procurement and integration, as a multi-sector implementation partner spanning secure cloud/data platforms (HIPAA/FHIR), telehealth and virtual hospital services, remote patient monitoring, AI-enabled clinical workflows, retail health access points, workforce training, and program management/economic modeling. The portfolio includes Microsoft (cybersecurity and cloud platforms); Avel eCare (virtual hospital, ER/ICU support); BioIntelliSense (FDA-cleared continuous monitoring); Humetrix (consumer triage/analytics); Viz.ai (AI stroke/workflow tools); large retail health partners; and integrators (Accenture, KPMG, PwC, AVIA). These capabilities are positioned to align with every RHT use-of-funds category and scoring factor, including data infrastructure and statewide interoperability, rural strategic partnerships, workforce, and tech-enabled chronic disease management.

For Texas context, 16% of Texans lived in Census-defined rural areas in 2020 (largest rural population by headcount), with pronounced regional variation across the 12 economic regions. Texas also has the most Critical Access Hospitals (CAHs) nationally, with recent counts ranging from 88 (Nov 2023, Definitive Healthcare) to 91 noted by the Texas Hospital Association in 2025, underscoring both scale and volatility in facility status. These realities, alongside documented rural hospital closures and service line reductions, suggest the need to pair financial stabilization with scalable virtual care and data capabilities to keep care local when safe and move it virtually when necessary. (comptroller.texas.gov)

The approach below is enabling and conditional. It maps CMS requirements to specific capabilities, offers Texas-tuned program design options, and identifies checkpoints, risks, and dependencies (e.g., alignment with the Texas 1115 waiver, managed care operations, and State rules on telehealth/RPM). It is designed to help Texas maximize RHT technical points (including conditional State policy factors) and measured outcomes while staying within NOFO caps and timelines. (files.simpler.grants.gov)

One-page printable summary

- Opportunity: CMS-RHT-26-001; LOI 9/30/2025; application 11/5/2025 11:59 p.m. ET; earliest start 12/31/2025; one State application; States only. Funding available FY26–FY30; annual funds usable into the following fiscal year. (files.simpler.grants.gov)
- Funds and caps (per budget period): admin ≤10%; provider payments ≤15%; capital/infrastructure (Cat. J) ≤20%; EMR replacement ≤5% (if a HITECH-certified EMR existed as of 9/1/2025); "Rural Tech Catalyst" ≤ the lesser of 10% or $20M; no construction; 2 CFR 200.216 telecom restrictions; prohibited uses include certain procedures defined at 45 CFR 156.400. (files.simpler.grants.gov)
- Scoring and distribution: 50% baseline; 50% workload based on technical and rural factors (weights in Table 3). Technical "State policy" commitments earn conditional points in Year 1 but must be enacted by 12/31/2027 (B.2/B.4 by 12/31/2028) or points are zeroed and related funds recovered. (files.simpler.grants.gov)
- Texas fit highlights (2020–2025): 16% rural population (Texas Comptroller, 2023); Texas leads states in CAHs (88–91, 2023–2025 sources); widespread hospital financial distress risks; Texas Medicaid operates statewide managed care under a long-running 1115 demonstration (expires 9/30/2030). (comptroller.texas.gov)
- Collaborative roles (subject to contracting): secure cloud/data; tele-ER/ICU; AI-supported triage/clinical workflows; continuous monitoring; retail/pharmacy integration; workforce training; governance/PMO; economic modeling.

2. Eligibility and RFP Fit

2.1 Snapshot of NOFO requirements

- Applicant and timing: Only States; one application per State; LOI (optional) due Sep 30, 2025; application due Nov 5, 2025; awards/earliest start Dec 31, 2025. Submit via Grants.gov. SF-424 Item 19c "No" (EO 12372 not applicable). Maintain SAM/UEI. (files.simpler.grants.gov)
- Funding approach: 5 budget periods FY26–FY30; equal baseline + workload points; funds from a given period spendable into the next fiscal year. CMS provides a hypothetical $200M/year planning figure for budget tables; actual awards may be larger or smaller. (files.simpler.grants.gov)
- Scoring: Rural facility/population (A) and Technical factors (B–F) with fixed weights (Table 3). Technical "State policy actions" may earn conditional points in Year 1 but must be enacted by 12/31/2027 (12/31/2028 for B.2 Health & lifestyle and B.4 Nutrition CME) or points/funds are recouped. (files.simpler.grants.gov)
- Use-of-funds: Must address ≥3 categories; categories include prevention/chronic disease, limited provider payments, consumer-facing tech, training/TA, workforce, IT/cyber, right-sizing services, behavioral health/OUD/SUD, innovative care/value-based models, minor capital/infrastructure, partnerships. (files.simpler.grants.gov)
- Key caps and limitations: admin ≤10%; provider payments ≤15%; Cat. J capital/infrastructure ≤20%; EMR replacement ≤5% (if HITECH-certified EMR in place 9/1/2025); "Rural Tech Catalyst" ≤ lesser of 10% or $20M; telecom restrictions 2 CFR 200.216; prohibition re specified sex-trait modification procedures at 45 CFR 156.400. (files.simpler.grants.gov)

2.2 Compliance mapping: requirement → Collaborative capability → evidence

- State-only applicant; one application; SF-424 Box 19c No; SAM/UEI; Grants.gov. → Program management, grants compliance, and risk review support by integrators; dashboarding and subrecipient monitoring templates. → NOFO Steps 2–6; 2 CFR 200/300; risk review 2 CFR 200.206. (files.simpler.grants.gov)
- Address ≥3 use-of-funds categories. → Prevention/Chronic (RPM/telehealth/retail screening); Technology (secure cloud, HIE, AI); Workforce (training, tele-mentoring). → Avel eCare virtual hospital; BioIntelliSense BioButton; Microsoft cloud/cyber; retail health activations; training programs.
- Show data infrastructure and interoperability. → Azure-based data platform; analytics; integration to HIE/TEFCA-aligned exchange; population analytics (Humetrix). → Collaborative materials; TEFCA alignment noted under data infrastructure examples.
- State policy factors and conditional timing. → Policy advisory/workplan support; evidence templates to document enactment by 12/31/2027 (12/31/2028 for B.2/B.4). → NOFO Table 3, Appendix timelines. (files.simpler.grants.gov)
- Budget structure and caps. → PMO tools to track by category/cap; budget scenarioing to $200M/year template; supplier T&Cs to flow-down federal restrictions. → NOFO budget narrative guidance. (files.simpler.grants.gov)

3. Texas Context Snapshot

3.1 Population and rurality

- In 2020, 16% of Texans lived in Census-defined rural areas (vs 20% nationally), with large regional variation across Texas's 12 economic regions. (comptroller.texas.gov)
- Frontier and remote areas in Texas (very low density, long travel times) increase EMS transport time and complicate service coverage, which relate to A.5 frontier and C.2 EMS scoring dimensions. (files.simpler.grants.gov)

3.2 Facility mix (illustrative 2022–2025 signals)

- Texas has the most CAHs in the U.S.; counts reported include 88 (Nov 2023, Definitive Healthcare) and 91 (Texas Hospital Association, 2025). (definitivehc.com)
- 2022 snapshot for rural facilities (Comptroller, using HRSA sources): 83 CAHs, 310 RHCs, 167 FQHC sites; regional access remains uneven. (comptroller.texas.gov)
- Collaborative fit: Avel eCare virtual hospital and tele-ER/ICU can support CAHs and PPS rural hospitals; BioIntelliSense extends monitoring to home; retail partners add access points.

3.3 Workforce and HPSA indicators

- HRSA HPSA data (as of 2025) show sizable primary care, mental health, and dental shortages across Texas; HRSA's methodology and maps guide prioritization. (data.hrsa.gov)
- Collaborative fit: tele-mentoring; ambient documentation; pharmacist-led chronic care support; workforce pipeline programs with NACHC/retail partners.

3.4 Medicaid coverage, managed care, 1115 alignment

- Texas Medicaid is operated primarily through managed care (e.g., STAR, STAR+PLUS, STAR Kids, STAR Health) under the Texas Healthcare Transformation 1115 demonstration, approved through September 30, 2030. Directed payment programs and MCO operations are central levers for rural alignment. (medicaid.gov)
- In 2025, Texas amended State Plan TX-24-0003 to expand home telemonitoring (RPM) by adding FQHCs/RHCs and clarifying requirements—an enabler for chronic disease initiatives and Cat. F funding. (medicaid.gov)

3.5 Broadband and telehealth prerequisites

- Texas BEAD challenge map (April 2025) documents remaining unserved/underserved Broadband Serviceable Locations; county-level analyses indicate persistent rural gaps that affect telehealth/RPM adoption. (register.broadband.texas.gov)

3.6 Maternal and behavioral health/SUD

- Texas maternal health disparities remain a concern per DSHS/MMMRC materials; the 2024 biennial reporting emphasizes preventability and the need for access/continuity. (dshs.texas.gov)
- CDC provisional data showed national overdose declines in 2024; State and local data point to evolving fentanyl trends; targeted virtual behavioral health and naloxone-supported strategies remain warranted in rural Texas. (espanol.foodsafety.gov)

3.7 Rural hospital stability

- Reporting in 2025 cites 14 rural hospital closures in the past decade, ~156 rural hospitals remaining, with >50% at risk and significant service reductions—indicating the need for financial, workforce, and tech support under RHT. (keranews.org)

3.8 Metric-to-capability table (examples)

- 2020 rural population share: 16% (Texas). Capability: virtual care + retail access nodes. (comptroller.texas.gov)
- CAH count leading US (88–91, 2023–2025). Capability: Avel eCare tele-ICU/ER; RPM for step-down/home. (definitivehc.com)
- RPM SPA (effective 9/1/2024). Capability: FQHC/RHC RPM billing (G0511) for chronic disease. (medicaid.gov)
- HPSA presence statewide. Capability: tele-mentoring; AI scribes; pharmacist-led care. (data.hrsa.gov)

4. Strategy Aligned to RFP

4.1 Model

- A statewide "Rural High-Value Network" (HVN) approach, convened by a Texas-designated umbrella entity, to connect CAHs, PPS rural hospitals, RHCs, FQHCs, EMS, and retail access points into accountable networks. The Collaborative can support governance models, shared services (tele-ICU/ER/hospitalist, pharmacy), shared analytics, and value-based contracts (subject to payer agreements).
- Data backbone: Azure-based data and analytics with role-based sharing; AI-assisted triage/clinician tooling; privacy/security controls; alignment with TEFCA-style exchange and statewide HIE(s).

- Rural pathways: keep care local when clinically appropriate (virtual backup); refer regionally via warm handoffs and shared records when necessary; expand chronic disease programs via RPM and pharmacist-enabled primary care.

4.2 Scoring alignment (selected)

- A.1–A.7 rural factors: Texas's large rural headcount and geography align with A.1/A.6; HVN and DSH support align with A.7 evidence requirements. (files.simpler.grants.gov)
- B–F technical factors: population health/RPM (B.1/F.1/F.2/F.3), EMS linkages (C.2), statewide partnerships (C.1), workforce recruitment/compacts/scope (D.1–D.3), Medicaid incentives/value-based (E.1/E.2), and policy actions (e.g., nutrition CME) timed to conditional deadlines. (files.simpler.grants.gov)

4.3 Equity (rural and Tribal)

- Use HRSA HPSA and maternal health indicators to prioritize subawards; deploy multilingual consumer tools; involve Tribal/IHS partners and local CBOs. (data.hrsa.gov)

5. Program Design Options (Texas-tuned; not prescriptive)

Option A. Rural Primary Care + RPM Accelerator (Recommended primary)

- Target: Rural adults with cardiometabolic conditions (hypertension, diabetes, heart failure), COPD/asthma, and post-acute recovery.
- Problem: High chronic burden, long travel times, limited specialist access; telehealth eligible but uneven broadband. 2025 SPA enables FQHC/RHC RPM. (medicaid.gov)
- Collaborative services: BioIntelliSense continuous monitoring + dashboards; Avel eCare virtual consults; Humetrix triage/navigation; pharmacist-enabled chronic care at retail sites; data platform and analytics.
- Payment logic: MCO RPM reimbursement per SPA; care-management PMPMs or directed payment add-ons consistent with 1115 authority; targeted pay-for-improvement. (medicaid.gov)
- Enablers: RPM workflow in EHR; device logistics; digital inclusion referrals via BEAD partners. (register.broadband.texas.gov)
- Pros/risks: + Rapid measurable outcomes; − device adherence/coverage variability. Mitigation: home navigators; claims/EHR data monitoring.

Option B. Rural Hospital Virtual Safety Net + Financial Stabilization

- Target: CAHs and PPS rural hospitals with coverage gaps (ED, ICU, nights/weekends).
- Services: Avel eCare tele-ER/ICU/pharmacy; Viz.ai stroke and condition-specific AI; workforce training; cyber hardening.
- Payment: Value-based hospital support through directed payments; shared-savings pilots with MCOs; budget neutrality via avoided transfers/readmissions. (medicaid.gov)
- Pros/risks: + Keeps care local; − staffing acceptance/culture. Mitigation: tele-mentoring; change management.

Option C. EMS-to-Home Care Transitions and Community Paramedicine

- Target: High ED utilizers and remote communities with long transports.
- Services: Tele-triage and post-ED virtual follow-up; remote monitoring; paramedicine protocols integrated with primary care and behavioral health.
- Payment: MCO care management; supplemental EMS arrangements; avoidable-utilization incentives.

Option D. Maternal & Behavioral Integration in Rural Hubs

- Target: Pregnant/postpartum individuals and co-occurring behavioral health needs.
- Services: Tele-OB consults; hypertension and glucose RPM; virtual psychiatry and therapy; retail site BP/diabetes screenings.
- Payment: MCO maternity case rates + RPM; targeted incentives tied to prenatal/postpartum visit completion; alignment with State maternal health priorities. (dshs.texas.gov)

6. Governance and Collaborative Roles

6.1 Structure (text diagram)

- Governor-designated lead agency (likely HHSC) — program authority, CMS award; oversight of PMO/data/shared services.
- State Health/DSHS — population health priorities, maternal/behavioral programs.
- Medicaid (HHSC Medicaid/CHIP) — MCO alignment, 1115/SPA coordination, directed payments.
- HVN (Cibolo-enabled) — member-owned network governance; shared services; subrecipient reporting.
- Providers (CAHs, RHCs, FQHCs) — implementation; quality; workforce.
- Integrators (Accenture/KPMG/PwC/AVIA) — PMO, analytics, compliance, procurement support.
- Tech/virtual care partners — platform, RPM, tele-ER/ICU, AI; support/SLA.

6.2 RACI (selected)

- CMS reporting (lead: State PMO; support: integrators; data: platform team).
- HVN formation (lead: State + Cibolo; support: hospital association; legal counsel).
- Tele-ICU/ER deployment (lead: facilities; support: Avel eCare; oversight: HVN).
- RPM scaling (lead: FQHC/RHC + facilities; support: BioIntelliSense; MCOs for reimbursement).
- Retail activation (lead: retail partners; coordination: HVN; data: platform).

7. Payment and Funding

7.1 RHT caps and guardrails

- Admin ≤10%; provider payments ≤15%; Cat. J ≤20%; EMR replacement ≤5% (if HITECH EMR in place); Rural Tech Catalyst limit ≤ the lesser of 10% or $20M; no construction; 2 CFR 200.216 telecom restriction. (files.simpler.grants.gov)

7.2 Medicaid alignment

- Use 1115 authority to align directed payments/value-based incentives supporting rural stabilization and virtual care; align RPM coverage with TX-24-0003 SPA (FQHC/RHC). (medicaid.gov)

7.3 Rough order of magnitude (illustrative, per NOFO $200M planning figure)

- People/PMO/TA: 7–10% (stay ≤10% admin). Deliverables: PMO, dashboards, subrecipient monitoring. (files.simpler.grants.gov)
- Clinical virtual services and RPM: 25–35%. Deliverables: tele-ER/ICU, hospitalist backup, RPM kits, staffing/training.
- Data/cyber infrastructure: 20–25%. Deliverables: Azure tenancy, HIE integrations, security uplift.
- Community/retail activation: 10–15%. Deliverables: screening kiosks, pharmacy-based chronic care pathways.
- Workforce development: 10–15%. Deliverables: tele-mentoring, digital navigator programs, pharmacist training.
- Capital & minor renovations (Cat. J): ≤20%. Deliverables: telehealth rooms, network upgrades; track against cap. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Measures: access (tele-visit volume, time-to-specialist); quality/outcomes (HbA1c, BP control, readmissions, ED revisits); maternal (prenatal/postpartum visit rates); behavioral (engagement, PHQ-9); financial (localizations, transfers avoided); tech (cyber incidents, uptime); implementation (site activations). (files.simpler.grants.gov)

- Data sources: Medicaid claims/encounters; HIE; EHR; EMS; RPM device streams; retail events; social referrals; HRSA/HPSA overlays. Platform: secure Azure environment with governed access and audit trails.
- Evaluation: internal learning health system plus participation in CMS/third-party evaluations; maintain data dictionaries and codebooks to expedite external review. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; conditional on procurement)

Gantt-style view (illustrative dates from award)

- Workstream; Start; End; Owner; Outputs
- Program mobilization; Month 0; Month 2; State PMO + integrator; PMO charter, risk plan, reporting calendar.
- Data/cyber baseline; Month 1; Month 6; Platform team; Tenant build, HIE integration plan, SOC processes.
- Tele-ER/ICU pilots; Month 2; Month 9; Facilities + Avel; 24/7 coverage, protocols, KPI baseline.
- RPM wave 1 (FQHC/RHC); Month 3; Month 12; FQHC/RHC + BioIntelliSense; 2,500 enrollees, device logistics, monthly outcomes.
- Retail screening hubs; Month 3; Month 10; Retail partners; 100 sites, referral loops to PCP/RPM.
- Workforce/tele-mentoring; Month 2; Month 24; Avel/NACHC; curricula, mentor rosters, CME tracking.
- Value-based contracts; Month 4; Month 12; Medicaid/MCOs; directed payment design, metrics, PAAs. (medicaid.gov)
- Scale waves; Month 12; Month 24; HVN; expansion to additional hospitals/clinics; KPI gains.

Procurement/legal: master services agreements; BAAs; data use agreements; ensure flow-down of federal terms and compliance with 2 CFR 200/300 and HHS GPS. (files.simpler.grants.gov)

10. Risk Register (selected)

- Rural hospital financial distress persists (owner: State/HVN). Mitigation: directed payments; virtual coverage; frequent monitoring. (keranews.org)
- Broadband gaps limit tele-RPM (owner: platform team). Mitigation: BEAD coordination; offline-tolerant kits; cellular options. (register.broadband.texas.gov)
- Workforce burnout/turnover (owner: facilities). Mitigation: ambient documentation; tele-mentoring; local pipeline with pharmacists/CHWs.
- Cyber threats (owner: platform/State CIO). Mitigation: Azure controls; incident response; training.
- Policy commitments miss deadlines (owner: State). Mitigation: legislative calendar integration; milestones; contingency scoring plan. (files.simpler.grants.gov)
- Cap overages (owner: PMO). Mitigation: monthly cap tracking; reprogramming guardrails. (files.simpler.grants.gov)
- Data-sharing barriers (owner: HVN). Mitigation: standardized DUAs; role-based access; TEFCA participation.
- Vendor onboarding delays (owner: procurement). Mitigation: pre-negotiated terms; cooperative contracts; phased SOWs.
- Community adoption (owner: providers/retail). Mitigation: multilingual tools; CHW engagement; local campaigns.
- Compliance findings (owner: PMO). Mitigation: internal controls; subrecipient monitoring; audit readiness. (files.simpler.grants.gov)

11. Draft RFP Response Language (boilerplate; tailor to Texas; subject to contracting)

Program purpose and fit “Texas proposes to improve rural access, outcomes, and sustainability by deploying a statewide Rural High-Value Network that connects rural hospitals, clinics, EMS, and retail access points through secure data infrastructure, tele-enabled clinical services, and value-based incentives. The plan addresses at least three use-of-funds categories (A, D, F) in Year 1, with additional categories added as projects mature. The State will use CMS’s hypothetical $200M/year planning figure to structure budgets (final awards may differ) and will maintain administrative costs at or below 10%.” (files.simpler.grants.gov)

Scoring and policy commitments “Texas aligns initiatives to Table 3 factors. For State policy action factors, the State will pursue commitments that are feasible within legislative cycles; for any commitments credited conditionally in Year 1, Texas will target enactment by December 31, 2027 (December 31, 2028 for B.2/B.4), understanding CMS will recover points-related funds if enactment deadlines are missed.” (files.simpler.grants.gov)

Data and evaluation “Texas will implement a secure data platform with governed access, integrate Medicaid claims/HIE/EHR/EMS and RPM streams, and report required NOFO measures and CMS-defined evaluations. The State will cooperate with third-party evaluations and maintain role-based access, audit logs, and PHI safeguards.” (files.simpler.grants.gov)

Budget and caps “Texas will adhere to NOFO caps (provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement ≤5%; ‘Rural Tech Catalyst’ ≤10% or $20M; admin ≤10%). Texas will not fund prohibited activities (including 2 CFR 200.216 covered telecom and 45 CFR 156.400-defined procedures).” (files.simpler.grants.gov)

Collaborative support (conditional) “Subject to State procurement, Texas may engage the Rural Health Transformation Collaborative for secure cloud/data services, virtual hospital/telehealth, RPM, AI-enhanced workflows, retail care integration, workforce development, and PMO/economic modeling—mapped to each initiative’s outputs, milestones, and measures.”

12. References

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16. Rural Health Transformation Collaborative. R1. 10-11-25 (uploaded internal consensus document). Accessed Oct 14, 2025. [Internal source.]

13. Assumptions and Open Questions

- Lead agency: This guide assumes HHSC will be designated by the Governor as the applicant/lead; confirmation

pending. (NOFO allows Governor designation.) (files.simpler.grants.gov)

- CCBHC inventory and Medicaid DSH hospital count: NOFO requires a CCBHC site list (as of 9/1/2025) and count of hospitals receiving Medicaid DSH for the most recent SPRY. Texas should validate and insert the latest counts from State/SAMHSA/Medicaid sources. (files.simpler.grants.gov)
- MCO contracting and directed payments: designs will depend on HHSC/MCO negotiations and CMS approval pathways under the 1115. (medicaid.gov)
- Broadband phasing: site-level readiness will be sequenced based on BEAD-informed unserved/underserved locations (April 2025 challenge results). (register.broadband.texas.gov)

Submission checklist (for internal quality control; mirrors NOFO)

- SF-424; SF-424A; SF-LLL; Project/Performance Site form completed; SF-424 Item 19c: No (EO 12372 not applicable). (files.simpler.grants.gov)
- Project narrative ≤60 pages; budget narrative ≤20 pages; attachments (Governor's letter ≤4 pages; indirect cost agreement if used; business assessment ≤12; program duplication assessment ≤5; other support ≤35). (files.simpler.grants.gov)
- LOI (optional) emailed to MAHARural@cms.hhs.gov by 9/30/2025; application submitted by 11/5/2025 11:59 p.m. ET. (files.simpler.grants.gov)

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