title: Rural Health Transformation Grant Guide — California version: 1.0 date: 2025-10-14 audience: State health agencies, Medicaid, rural providers, collaboratives

1. Executive Summary

California can use the Rural Health Transformation (RHT) Program cooperative agreement to stabilize and modernize rural care delivery while advancing CalAIM priorities. Under CMS-RHT-26-001, applications are due November 5, 2025; awards are expected by December 31, 2025, with funding distributed across five budget periods (FY26–FY30) and each period's funds spendable through the end of the following fiscal year [1]. (files.simpler.grants.gov)

The Rural Health Transformation Collaborative (the Collaborative) offers a configurable portfolio of technology, clinical, payment, and governance supports that can be contracted by California to meet RHT requirements. Offerings include statewide tele-specialty and virtual hospital/EMS support (Avel eCare), continuous remote physiologic monitoring (BioIntelliSense), consumer-facing engagement/triage and analytics (Humetrix, Pangaea Data), cybersecurity and cloud data platforms (Microsoft), retail pharmacy-enabled access and adherence (Walgreens, CVS), integration advisory and program management (Accenture, KPMG, PwC, AVIA), and rural provider High Value Networks (Cibolo Health) [2].

California's rural profile—about 2.3 million rural residents (5.8% of population) spread across vast geography, with six counties entirely rural—requires solutions that expand access points, connect providers, and protect thinly staffed facilities [3][4]. (ppic.org) The Collaborative's capabilities align with RHT eligible uses (e.g., prevention/chronic disease, provider payments within caps, workforce, IT/cybersecurity, behavioral health, innovative payment models, capital/infrastructure, partnerships) and with the technical scoring factors that drive workload funding over time [1][2]. (files.simpler.grants.gov)

This guide presents California-specific design options that are explicitly conditional on State policy and procurement, map to RHT scoring and compliance, and leverage existing Medi-Cal initiatives (e.g., CalAIM ECM/Community Supports) and CPUC broadband investments to mitigate rural inequities [5][6][7]. (dhcs.ca.gov)

One-page printable summary (for distribution)

- Opportunity snapshot
  - Applicant: States only; CA eligible. DC/territories ineligible [1]. (files.simpler.grants.gov)
  - Due: Nov 5, 2025 (11:59 p.m. ET). Earliest start: Dec 31, 2025 [1][8]. (files.simpler.grants.gov)
  - Funding: ~$50B FY26–FY30; half baseline/equal split, half workload via points (rural/population + technical) [1]. (files.simpler.grants.gov)
  - Key caps: provider payments ≤15%; capital/infrastructure (Cat. J) ≤20%; EMR replacement ≤5% (if HITECH-certified EMR in place 9/1/2025); "rural tech catalyst" ≤ lesser of 10% or $20M/period; admin (incl. indirects) ≤10% [1]. (files.simpler.grants.gov)
- California context (illustrative metrics)
  - Rural residents: 2.3M (5.8%) in 2020; six fully rural counties (Alpine, Mariposa, Modoc, Plumas, Sierra, Trinity) [3]. (ppic.org)
  - HRSA health centers: 171 awardees served 5.79M patients in 2024 [9]. (data.hrsa.gov)
  - CalAIM: 1115/1915(b) approvals through 12/31/2026; amendments advancing asset limits, justice-involved in-reach, MCP model change [10][11]. (dhcs.ca.gov)
  - Telehealth: DHCS all-plan policy (APL 23-007) and FAQ allow audio-only with conditions; video choice phase-in ≥2024 [12]. (dhcs.ca.gov)
  - Maternal mortality: CA ~9.5/100,000 (2023), among lowest U.S. rates [13]. (commonwealthfund.org)
  - Opioids: ~8,000 opioid-related overdose deaths (2023) statewide; CDPH surveillance active [14]. (cdph.ca.gov)
- Highest-leverage Collaborative supports (subject to procurement and integration)
  - Tele-ER/ICU/EMS backup; tele-OB and stroke AI; RPM for chronic and post-acute; analytics to close care gaps; pharmacy-enabled access/adherence; cyber-hardening and cloud interoperability; rural HVN governance [2].
- Compliance anchors
  - Adhere to 2 CFR 200/300 and HHS GPS; 2 CFR 200.216 telecom restrictions; 45 CFR 156.400 prohibition; SF-424 Box 19c "No" (EO 12372 not applicable) [1]. (files.simpler.grants.gov)

2. Eligibility and RFP Fit

2.1 What the NOFO requires (selected extracts; see Section 12 for full citations)

- Applicant/authority: Only the 50 States; Governor-designated lead agency; AOR signature; single official application per State; latest on-time submission counts [1] (Step 1, Eligibility; Step 3, Application). (files.simpler.grants.gov)
- Key dates: Optional LOI Sep 30, 2025; application Nov 5, 2025; awards/earliest start Dec 31, 2025 [1]

(Step 1 — Key dates). (files.simpler.grants.gov)
- Funding structure: Five budget periods (FY26–FY30); spend by end of following fiscal year; 50% baseline equal split and 50% workload via points [1] (Funding details; Workload). (files.simpler.grants.gov)
- Scoring: Table 3 weights (rural facility/population 50%; technical 50%); technical score recalculated each period; conditional points for policy commitments with hard deadlines (12/31/2027; 12/31/2028 for B.2 and B.4) [1] (Table 3; Step 3; Appendix Table 4). (files.simpler.grants.gov)
- Allowable uses & limits: At least three categories; caps noted above; construction as direct cost prohibited; telecom/video surveillance restrictions per 2 CFR 200.216; admin ≤10% of allotment [1] (Funding policies & limitations; Indirect/Admin). (files.simpler.grants.gov)
- Forms & format: Project narrative ≤60 pages; budget narrative ≤20; Governor's letter ≤4; SF-424/SF-424A/Project Site/SF-LLL; SF-424 Item 19c "No" (EO 12372 inapplicable) [1] (Application checklist; SF-424 instructions). (files.simpler.grants.gov)

2.2 Requirement-to-Collaborative capability map (examples)

- Requirement: Prevention & chronic disease (Use A). Capability: RPM with continuous biometrics (BioIntelliSense) and community screening/triage (Humetrix, retail kiosks) with analytics for risk identification (Pangaea Data). Evidence: Collaborative members' solution briefs and deployment descriptions [2].
- Requirement: Remote care/telehealth (Use F). Capability: Tele-ER/ICU/hospitalist/EMS support (Avel eCare), statewide tele-behavioral and specialty access via national networks (Teladoc, retail partners). Evidence: Collaborative roster and solution descriptions [2].
- Requirement: Cybersecurity & data interoperability (Use F). Capability: Azure-based security and data platform; interoperability (TEFCA/QHIN via participating EHR vendors), privacy governance. Evidence: Collaborative overview [2].
- Requirement: Workforce recruitment/retention (Use E). Capability: Ambient clinical documentation; tele-mentoring; retail pharmacy workforce models; CHW enablement; training via SI partners. Evidence: Collaborative workforce sections [2].
- Requirement: Partnerships/governance (Use K). Capability: Cibolo Health-facilitated rural High Value Networks (HVNs) for shared services, value-based arrangements, and transparent fund stewardship. Evidence: Collaborative governance section [2].

3. California Context Snapshot

3.1 Rural demographics and geography

- Rural residents totaled ~2.3 million (5.8%) in 2020; six fully rural counties include Alpine, Mariposa, Modoc, Plumas, Sierra, Trinity [3]. (ppic.org)
- Every county except San Francisco has rural residents; large rural pockets in the Sierra, North State, and parts of the Central Valley [3]. (ppic.org)

3.2 Facilities and delivery system

- HRSA Health Centers: 171 awardees served 5.79M patients in 2024, with continued growth since 2020 [9]. (data.hrsa.gov)
- Critical Access Hospitals (CAHs): California participates in HRSA/CMS Flex/CAH program; CAHs are certified under 42 CFR 485 Subpart F; the exact count should be confirmed using CMS QCOR/State sources at application time [15][16]. (cms.gov)
- Rural Health Clinics (RHCs): State counts vary over time; use CMS QCOR and CDPH/HCAI facility data for the application's baseline inventory [16][17]. (qcor.cms.gov)

3.3 Workforce and HPSA indicators

- HRSA UDS 2024 shows high Medicaid reliance among health center patients; HRSA's HPSA lists are updated regularly (Nov 2024 FR notice) and should be used to quantify current CA primary care/dental/mental HPSA counts in the application's "needs" section [9][18]. (data.hrsa.gov)

3.4 Medicaid policy alignment

- CalAIM approvals: CMS approved CA's Section 1115/1915(b) through 12/31/2026; amendments include asset limit changes (6/29/2022), justice-involved in-reach, and MCP model transitions [10][11]. (dhcs.ca.gov)
- ECM/Community Supports utilization continues to grow (hundreds of thousands served by late 2024), offering a platform for RHT-funded care coordination and social supports [5]. (content.govdelivery.com)
- Telehealth: DHCS policy recognizes audio-only (with conditions), requires patient choice of video modality phase-in, and parity for medically appropriate modalities in managed care [12]. (dhcs.ca.gov)

3.5 Broadband, maternal and behavioral health context

- Broadband: CPUC has surpassed $1B in grants (2024) for Last Mile projects and continues awards into 2025, expanding connectivity in rural counties [6][7]. (cpuc.ca.gov)
- Maternal mortality: California approximated 9.5 deaths/100,000 (2023), among the lowest statewide rates nationally; nationally 22.3/100,000 in 2022 [13][19]. (commonwealthfund.org)
- Overdose: ~8,000 opioid-related deaths in 2023; CDPH maintains an Overdose Surveillance Dashboard for localized targeting [14]. (cdph.ca.gov)

3.6 Context table (illustrative; to be finalized in the Project Narrative)

- Metric: Rural population share (2020); Value: 5.8%; Source/year: PPIC using 2020 Census (2024); Collaborative capability: tele-access points, RPM, retail pharmacy triage to expand coverage. [3][2] (ppic.org)
- Metric: HRSA health center patients (2024); Value: 5.79M; Source: HRSA UDS; Capability: chronic disease/RPM + analytics to close care gaps, retail adherence support. [9][2] (data.hrsa.gov)
- Metric: CPUC last-mile awards (2024–2025); Value: ≥$1B cumulative; Source: CPUC press; Capability: telehealth/video expansion, remote diagnostics, cybersecurity. [6][7][20] (cpuc.ca.gov)
- Metric: Maternal mortality (2023); Value: ~9.5/100,000; Source: Commonwealth Fund (2025); Capability: tele-OB, remote BP/glucose monitoring, postpartum behavioral health. [13][2] (commonwealthfund.org)
- Metric: Opioid-related deaths (2023); Value: ~8,000; Source: CDPH; Capability: surveillance-to-intervention analytics, pharmacy naloxone, virtual MAT. [14][2] (cdph.ca.gov)

Assumptions and Open Questions (for California's internal planning)

- CAH and RHC counts will be finalized from CMS QCOR/CDPH/HCAI at application time; this guide references authoritative sources but does not fix a number herein. Owner: HCAI/CalSORH. [15][16][17] (cms.gov)
- The certified CCBHC listing as of Sep 1, 2025 must be compiled for the narrative (NOFO Step 3; Table 4). Owner: DHCS/CDPH with SAMHSA cross-check. [1] (files.simpler.grants.gov)
- The most recent Medicaid DSH hospital count (SPRY) must be included. Owner: DHCS. [1] (files.simpler.grants.gov)

4. Strategy Aligned to RFP

4.1 Model overview (conditional; subject to contracting and integration)

- Core aim: Right-size rural access by combining regional tele-hospital/EMS support, advanced RPM for chronic and post-acute care, pharmacy-enabled primary/behavioral access, and value-based financing across rural clusters. This approach aligns to RHT uses A, C, D, E, F, G, H, I, J, K and to technical scoring dimensions (B–F) [1][2]. (files.simpler.grants.gov)

4.2 Alignment to Table 3 technical factors (selected)

- Rural provider strategic partnerships (C.1): Form provider-owned HVNs (Cibolo) to coordinate service lines, negotiate value-based arrangements, and track impact [2].
- EMS (C.2): Tele-EMS and clinical command center (Avel eCare) to support rural 911/transfer patterns and reduce avoidable transports [2].
- Certificate of Need (C.3): California does not have a broad CON program; the policy context should be documented per NOFO Table 4 for scoring [1]. (files.simpler.grants.gov)
- Remote care services & data infrastructure (F.1–F.3): Cloud/Azure-based health data platform, PRISMA-like interoperability, AI gap-closure, consumer digital triage/tools [2].
- Workforce recruitment (D.1) and licensure/scope (D.2–D.3): Pharmacy-enabled chronic disease protocols, ambient clinical documentation, tele-mentoring; track retention per NOFO outcomes [2].

4.3 Equity strategy (rural and Tribal)

- Target HPSA and AI/AN communities; leverage DHCS authority to pursue traditional healers/natural helpers (CalAIM equity-oriented amendments in development) and coordinate with IHS/Tribal providers; deploy multilingual patient apps and voice triage [10][2]. (dhcs.ca.gov)

4.4 Data use and privacy

- Apply 2 CFR 200/300, HHS GPS, 2 CFR 200.315 for IP, and data protections noted in NOFO; build a State data platform with role-based access, TEFCA exchange participation, and privacy consent tooling [1][2]. (files.simpler.grants.gov)

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

Option A. Rural Critical Care and Transfer Optimization

- Target: Rural hospitals/REHs and EMS agencies with high out-transfers.
- Problem: Intermittent specialty coverage; stroke/OB/time-sensitive care; staffing gaps; long transport times. California news reports highlight emergent risks when rural ED capacity closes [21][22]. (sfgate.com)
- Collaborative services: Tele-ER/ICU/hospitalist, telestroke/AI (Viz.ai), tele-OB; EMS tele-consult; cloud platform; cybersecurity; performance dashboards [2].
- Payment logic: Global-budget pilots or shared-savings with payers; avoid provider payments >15% cap; use Cat. F (IT) and J (minor renovations/equipment ≤20% cap) [1]. (files.simpler.grants.gov)
- Policy enablers: Interfacility transfer protocols; pharmacy scope; EMS telemedicine standing orders (documented under Table 4).
- Risks: Clinician adoption; network reliability; mitigate with training, broadband grants, and tele-mentoring [6][7]. (cpuc.ca.gov)

Option B. Rural Chronic Disease and Maternal Continuum (Primary Care + Pharmacy + RPM)

- Target: FQHCs/RHCs in rural HPSAs; perinatal and cardio-metabolic risk.
- Problem: High chronic disease burden; maternal risks persist; gaps in postpartum coverage and remote monitoring [9][13]. (data.hrsa.gov)
- Services: RPM (BioIntelliSense), pharmacy BP/diabetes management and adherence, remote prenatal/postpartum monitoring, behavioral telehealth; retail health referral pipelines [2].
- Payment logic: ECM/Community Supports integration for eligible members; performance incentives via Medicaid MCPs; RHT Use A/C/D/E/F.
- Risks: Device logistics; digital equity; mitigations include device hubs at FQHCs/retail sites and patient navigation [2].

Option C. Behavioral Health and SUD Access Acceleration

- Target: Counties with high opioid overdose; schools and justice-involved populations (CalAIM in-reach) [10][14]. (dhcs.ca.gov)
- Services: Virtual psychiatry, SUD tele-treatment, naloxone/pharmacy engagement, analytics for risk stratification; community triage tools [2].
- Payment logic: Use RHT uses H/I; align with DHCS telehealth and parity in MCPs [12]. (dhcs.ca.gov)

Option D. Rural Data and Cyber Modernization (State-Level)

- Target: State PMO + rural facilities/HIEs.
- Problem: Fragmented data; cyber risk; reporting burden under NOFO.
- Services: Azure-based data lakehouse; TEFCA exchange connectivity; security hardening; dashboards for RHT metrics; grants compliance support [2].
- Payment logic: Use IT/cyber (Use F) and Cat. J equipment where applicable ≤20% cap [1]. (files.simpler.grants.gov)

Primary recommendation: Options A+B as the backbone (acute stabilization + community chronic/maternal model) with D as the enabling layer; C deployed where overdose/mh indicators are highest. All are conditional on State procurement, legal review, and stakeholder alignment.

6. Governance and Collaborative Roles

6.1 Partnership structure (illustrative)

- State (Lead Agency designated by Governor): Recipient, overall accountability, policy and compliance, PMO.
- DHCS: Medicaid alignment (ECM/CS, MCP levers), SPA/waiver liaison.
- HCAI/CalSORH: Rural/CAH/SHIP/FLEX alignment, facility inventory, CAH readiness.
- Hospital Association/County coalitions: Acute care and EMS integration.
- FQHC/PCA: Primary care network alignment and training.
- HIE(s)/State data office: Data exchange; dashboards.
- Collaborative members: Implementation partners across virtual care, RPM, pharmacy access, analytics, cybersecurity, and SI.

6.2 RACI (selected)

- Strategy: State/DHCS Responsible; Collaborative Consulted; Payers Consulted.
- PMO & reporting: State Responsible; SI partner Accountable (subject to contract); providers Consulted; CMS Informed [2].
- Tele-specialty/EMS: Providers Responsible; Avel eCare Accountable (contracted); State/DHCS Consulted [2].
- RPM: Providers Responsible; BioIntelliSense Accountable (contracted); DHCS Consulted [2].

- Pharmacy/retail integration: Retail partners Accountable (contracted); FQHCs Responsible; State/DHCS Consulted [2].
- Data/cyber platform: State Accountable; Microsoft/SI Responsible (contracted); providers Consulted [2].

7. Payment and Funding

7.1 RHT mechanics to observe

- Baseline vs. workload funding; workload tied to rural factors and technical performance; technical scores recalculated each period based on reporting [1]. (files.simpler.grants.gov)
- Caps: provider payments ≤15%; Category J (capital/infrastructure) ≤20%; EMR replacement ≤5% (if HITECH EMR in place by 9/1/2025); rural tech catalyst ≤ min(10%, $20M); admin ≤10% of allotment [1]. (files.simpler.grants.gov)

7.2 Medicaid alignment (illustrative)

- Use ECM/Community Supports and MCP contracts to sustain remote monitoring, pharmacy care management, and tele-behavioral services; prepare actuarial exhibits and quality withholds with SI support; all subject to DHCS/CMS approval [5][12]. (content.govdelivery.com)

7.3 Cost and deliverables table (illustrative; amounts contingent on award)

- Workstream: Tele-ER/ICU/EMS; ROM: $40–60M/year; Source: RHT Use F/J; Deliverables: 24/7 coverage, transfer KPIs, stroke/OB pathways [1][2]. (files.simpler.grants.gov)
- Workstream: Community RPM & pharmacy integration; ROM: $30–50M/year; Source: Uses A/C/D/E/F; Deliverables: enrolled cohorts, adherence metrics, HbA1c/BP outcomes [1][2]. (files.simpler.grants.gov)
- Workstream: Data/cyber platform; ROM: $20–35M/year; Source: Use F; Deliverables: State dashboards, TEFCA exchange, cyber hardening [1][2]. (files.simpler.grants.gov)
- Workstream: Behavioral/SUD access; ROM: $15–25M/year; Source: Uses H/I; Deliverables: virtual BH capacity, naloxone distribution, retention in care [1][2]. (files.simpler.grants.gov)
- Admin/PMO: ≤10% of allotment; Source: Admin cap [1]. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

8.1 Core measures (examples)

- Access: ED transfer rate, tele-response times, time-to-stroke intervention, OB referral intervals.
- Quality/outcomes: 30-day readmissions, avoidable ED visits, maternal postpartum follow-up, hypertension control, HbA1c.
- Financial: Net cost per beneficiary trend, ECM/CS utilization; avoided transports.
- Workforce/technology: Vacancy/turnover, provider time saved via ambient documentation; cyber incidents.

8.2 Data sources and integration

- Claims (Medi-Cal MCPs), EHR/HIE feeds, EMS CAD data, HRSA UDS rollups, CDPH/OD dashboards; integrated via secure State platform; comply with NOFO reporting cadence [1][2]. (files.simpler.grants.gov)

8.3 Evaluation approach

- Internal dashboards plus CMS/third-party cooperation; initiative-based scoring matrix (0–100) used to project and track impact across strategy, workplan/monitoring, outcomes, projected impact, sustainability [1]. (files.simpler.grants.gov)

9. Implementation Plan

9.1 12–24 month Gantt (illustrative; subject to procurement and legal review)

Workstream	Start	End	Owner	Outputs
PMO setup, governance charters	2026-01	2026-03	State PMO/SI	Charter, RACI, reporting calendar
Facility inventory & readiness	2026-01	2026-06	HCAI/CalSORH	CAH/RHC/FQHC baselines
Data platform + cyber baseline	2026-02	2026-12	State+Microsoft/SI	Data lakehouse, security controls
Tele-ER/ICU/EMS pilots (3 regions)	2026-04	2027-03	Providers+Avel	24/7 coverage; transfer metrics
RPM & pharmacy integration (10 counties)	2026-04	2027-06	FQHCs+Retail	Enrolled cohorts; adherence metrics
Behavioral/SUD expansion	2026-06	2027-06	County BH+Tele-BH	Access KPIs; retention
Reporting for Year-2 technical score	2026-10	2026-11	PMO	Annual report; score update
Policy commitments (Table 4 items)	2026-01	2027-12	State (DHCS/Leg.)	Enactments to secure full points [1]	(files.simpler.grants.gov)

9.2 Gating decisions

- Contract awards; data-sharing agreements; cyber ATO; MCP alignment; policy enactments by 12/31/2027 (12/31/2028 for B.2/B.4) to avoid point/fund recovery [1]. (files.simpler.grants.gov)

10. Risk Register (selected)

- Broadband gaps delay video telehealth. Mitigation: Prioritize audio-capable workflows; leverage CPUC last-mile projects; device/data subsidies via partners. Owner: PMO/CPUC [6][7][12]. (cpuc.ca.gov)
- Provider payments exceed 15% cap. Mitigation: Use RPM/licensing/IT categories; rule-of-thumb guardrails in budgeting. Owner: PMO/Budget [1]. (files.simpler.grants.gov)
- Capital spending >20% Cat. J. Mitigation: Use IT and services first; right-size renovations; track cumulative investments. Owner: PMO [1]. (files.simpler.grants.gov)
- Policy commitments not enacted by deadlines. Mitigation: Policy workplan with checkpoints; contingency to remove conditional points before CMS recovery [1]. Owner: State/DHCS. (files.simpler.grants.gov)
- Cyber incident. Mitigation: Azure security baseline, continuous monitoring, incident response runbooks; tabletop exercises. Owner: State CISO+Microsoft [2].
- Workforce burnout undermines uptake. Mitigation: Ambient documentation; tele-mentoring; recruitment pipeline via pharmacy programs. Owner: Providers [2].
- Data fragmentation impairs reporting. Mitigation: Standardized interfaces; TEFCA connectivity; data stewardship office. Owner: State/SI [2].
- Retail integration misaligned with FQHC workflows. Mitigation: Shared care plans; data-sharing; pilot MOUs with PCAs. Owner: FQHCs/Retail [2].
- Community resistance to service changes. Mitigation: Listening sessions (CalSORH/HCAI), transparent metrics; local governance seats. Owner: State/Providers [5]. (hcai.ca.gov)
- Overdose surge in specific counties. Mitigation: Rapid analytics; mobile units; PHE protocols; tele-MAT. Owner: County BH/CDPH+Partners [14]. (cdph.ca.gov)

11. Draft RFP Response Language (California-tailored; paste-ready; conditional)

11.1 Project summary paragraph “California proposes to improve rural access, outcomes, and system sustainability by deploying a coordinated set of virtual specialty supports, community-based chronic and maternal health management, behavioral health access, and a secure statewide data/cyber platform. The State will contract for tele-hospital and EMS backup, continuous remote monitoring, pharmacy-enabled chronic disease management, and analytics-driven gap closure. Activities are aligned to at least three permissible uses and comply with funding limitations and administrative caps. Implementation will proceed under a Governor-designated lead agency with a multi-stakeholder governance structure, a State PMO, and strong reporting consistent with CMS-RHT-26-001.” [1][2] (files.simpler.grants.gov)

11.2 Rural needs & target population (abbrev.) “California’s rural population (approx. 2.3M; 5.8% in 2020) resides across large frontier/sparsely populated regions; six counties are entirely rural. HRSA health centers served 5.79M patients in 2024, reflecting a large safety-net footprint intersecting rural areas. Overdose deaths remain significant (~8,000 opioid-related deaths in 2023). California’s maternal mortality rate (~9.5/100,000 in 2023) is comparatively low but masks disparities in rural and AI/AN communities.” [3][9][14][13] (ppic.org)

11.3 RHT plan goals & strategies (abbrev.) “Goals include reductions in avoidable transfers and readmissions; improved hypertension/HbA1c control; expanded postpartum follow-up; reduced opioid fatalities; improved workforce stability. Strategies: (1) tele-acute stabilizing services; (2) RPM-enabled primary/maternal pathways; (3) behavioral health/SUD virtual access; (4) State data/cyber platform; (5) rural provider HVN governance. Timelines and policy commitments (per Table 4) will be tracked to meet the 12/31/2027 (and 12/31/2028 for B.2/B.4) deadlines.” [1][2] (files.simpler.grants.gov)

11.4 Implementation & evaluation (abbrev.) “Implementation follows a phased plan with early pilots in high-need rural regions, scaling statewide by Year 2. The State will submit required reports and cooperate with CMS/third-party evaluations. Initiative-based scoring matrices (0–100) and data-driven metrics will be used to project and measure impact.” [1] (files.simpler.grants.gov)

11.5 Budget narrative (abbrev.) “Budgets observe caps for provider payments (≤15%), capital/infrastructure (≤20%), EMR replacement (≤5% under conditions), rural tech catalyst (≤ the lesser of 10% or $20M), and administrative expenses (≤10% of the allotment). The narrative separates direct and subawarded funds and maps each line to initiatives and outcomes.” [1] (files.simpler.grants.gov)

12. References

[1] Rural Health Transformation Program — Notice of Funding Opportunity (CMS-RHT-26-001), CMS, accessed Oct 14, 2025. https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf (See: Key dates, Funding details, Eligibility, Funding policies/limits, Table 3, Table 4). (files.simpler.grants.gov)

[2] Rural Health Transformation Collaborative. R1. 10-11-25 (consensus deck), RHT Collaborative, accessed Oct 14, 2025. (Capabilities, members, governance, and roles).

[3] Rural California (Fact Sheet), Public Policy Institute of California, Mar 2024. https://www.ppic.org/publication/rural-california/ (Rural share; fully rural counties). (ppic.org)

[4] Rural Population by State (2020), National Conference of State Legislatures, accessed Oct 14, 2025. https://www.ncsl.org/... (CA 5.8%). (ncsl.org)

[5] DHCS Stakeholder Update: ECM/Community Supports Quarterly Reports (Oct–Dec 2024), California DHCS, July 3, 2025. https://content.govdelivery.com/... (content.govdelivery.com)

[6] CPUC Reaches Milestone $1 Billion in Broadband Grants, Dec 19, 2024. https://www.cpuc.ca.gov/... (cpuc.ca.gov)

[7] CPUC Awards/Invests in Last-Mile and CASF Grants (2024–2025 press releases), California Public Utilities Commission. https://www.cpuc.ca.gov/... (examples on Sep 12, 2024; Oct 17, 2024; Feb 20, 2025). (cpuc.ca.gov)

[8] CMS Current Grants: CMS-RHT-26-001 (Posted), CMS, Sept 16, 2025. https://www.cms.gov/... (view on Grants.gov). (cms.gov)

[9] California Health Center Program UDS Data, HRSA, 2024. https://data.hrsa.gov/tools/data-reporting/program-data/state/CA (data.hrsa.gov)

[10] CalAIM Waiver Materials (1115/1915(b) approvals, through 12/31/2026; amendments), California DHCS. https://www.dhcs.ca.gov/Pages/IHP-CalAIM.aspx (dhcs.ca.gov)

[11] CalAIM 1115 Amendments (asset limits; CMS approval 6/29/2022), California DHCS. https://www.dhcs.ca.gov/provgovpart/Pages/1115-Amendments.aspx (dhcs.ca.gov)

[12] DHCS Telehealth FAQ / Telehealth policy (APL 23-007 references), California DHCS, accessed Oct 14, 2025. https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx (dhcs.ca.gov)

[13] Maternal & Child Mortality: How Do U.S. States Compare Internationally?, Commonwealth Fund, Oct 2025. https://www.commonwealthfund.org/... (CA ~9.5/100,000 in 2023). (commonwealthfund.org)

[14] Overdose Data & Information, California Department of Public Health, 2025 (noting ~8,000 opioid-related deaths in 2023). https://www.cdph.ca.gov/... (cdph.ca.gov)

[15] Critical Access Hospitals overview, CMS (Conditions of Participation; program definition), last modified Dec 30, 2024. https://www.cms.gov/.../critical-access-hospitals (cms.gov)

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[17] HCAI Datasets — Licensed Healthcare Facility Listing (CDPH feed), updated Oct 1, 2025. https://hcai.ca.gov/data-and-reports/datasets/ (hcai.ca.gov)

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13. AI Generation Notice

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