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

1. Executive Summary Montana can position a competitive Rural Health Transformation (RHT) application by pairing the State's high rural share (46.6% of residents in 2020) with a portfolio of proven virtual care, data exchange, cybersecurity, and workforce supports drawn from the Rural Health Transformation Collaborative (the Collaborative). These capabilities map directly to CMS' objectives, scoring framework, and spending limits for CMS-RHT-26-001, including multi-year funding, equal baseline plus workload-based allotments, technical factor points, and explicit caps (e.g., provider payments ≤15% and capital/infrastructure ≤20%). (ncsl.org)

Near-term, three offerings create outsized value for Montana's critical access and frontier settings: 24/7 virtual specialty support (tele-ER/ICU/pharmacy) to stabilize local care; continuous remote physiologic monitoring with exception-based clinical workflows; and statewide cyber hardening that reduces operational risk for small facilities. These services are available via Collaborative members (e.g., Avel eCare's virtual hospital model; BioIntelliSense's FDA-cleared BioButton with clinical dashboards; and Microsoft's rural hospital cybersecurity program, which by mid-2025 reported more than 700 participating rural hospitals nationally). (aha.org)

Data and interoperability are anchors. eClinicalWorks was designated a TEFCA Qualified Health Information Network (QHIN) in January 2025, enabling Montana participants to exchange clinical data nationally under TEFCA while leveraging analytics to close care gaps and support value-based arrangements. The Collaborative's system integrator partners (Accenture, KPMG, PwC, AVIA) can support planning, onboarding, and compliance reporting aligned to CMS' evaluation and continuation criteria. (sequoiaproject.org)

All implementation concepts presented are conditional on State priorities, procurement, contracting, and integration with existing Montana programs (e.g., Passport to Health PCCM), and are designed to respect CMS spending limits, 2 CFR/HHS GPS requirements, and the RHT NOFO's initiative-level scoring. (dphhs.mt.gov)

1.1 One-Page Printable Summary

- Opportunity: CMS-RHT-26-001 funds through FY26–FY30; one State awardee per state; application due Nov 5, 2025; LOI optional by Sep 30, 2025; earliest start Dec 31, 2025. Funding = 50% baseline + 50% workload (points). Technical factors can include conditional points in Year 1, with enactment deadlines through 2027/2028. (files.simpler.grants.gov)
- Montana context (selected 2024–2025 indicators):
  - Rural share: 46.6% (2020). CAHs: 50. RHCs: 62. FQHC awardees: 13 serving 128,296 patients (2024). Medicaid delivery: PCCM (Passport to Health). Telehealth: Medicaid coverage including audio-only; private payer coverage parity without explicit payment parity. Overdose mortality (age-adjusted): 19.4 per 100,000 in 2022; 17.1 in 2023 (provisional). (ncsl.org)
- Highest-leverage Collaborative capabilities for MT:
  - 24/7 remote specialty support (tele-ER/ICU/hospitalist/pharmacy) to keep care local.
  - Remote patient monitoring with exception management for chronic/acute pathways.
  - Statewide cybersecurity uplift for small hospitals and clinics; national program traction >700 rural hospitals (2025). (aha.org)
  - TEFCA-enabled data exchange via designated QHIN (eClinicalWorks) with analytics and gap closure workflows. (sequoiaproject.org)
- Guardrails (NOFO): Provider payments ≤15%; Capital/Infrastructure ≤20% (Category J); EMR replacement ≤5% if a HITECH-certified system existed as of 9/1/2025; "Rural Tech Catalyst" initiatives ≤10% or $20M; administrative ≤10%. Follow 2 CFR Parts 200/300 and HHS GPS; 2 CFR 200.216 restrictions apply. (files.simpler.grants.gov)

2. Eligibility and RFP Fit 2.1 What CMS-RHT-26-001 requires

- Eligibility: Only the 50 U.S. States; DC and territories ineligible. Governor may designate a lead agency; AOR must sign. Single official application; latest timely submission counts. (files.simpler.grants.gov)
- Timeline and forms: LOI (optional) due Sep 30, 2025 (email); Application due Nov 5, 2025; info webinars Sep 19 & 25, 2025. Required forms: SF-424, SF-424A, SF-LLL, Project/Performance Site. Check No on SF-424 Item 19c (EO 12372). Page limits: Project Narrative ≤60 pages; Budget Narrative ≤20; attachments per NOFO. (files.simpler.grants.gov)
- Funding mechanics: Five budget periods; each year's funds may be spent through end of following fiscal year. 50% baseline + 50% workload based on points (Table 3 weights). Rural facility/population factors set once (Q4 2025); technical factors recalculated annually; conditional points for policy actions must be enacted by 12/31/2027 (by 12/31/2028 for B.2 and B.4) or points/funds may be recovered. (files.simpler.grants.gov)
- Spending limits & prohibitions: Provider payments ≤15%; Category J (capital & infrastructure) ≤20%; EMR replacement ≤5% under specified condition; "Rural Tech Catalyst" ≤ the lesser of 10% or $20M; follow 2 CFR/HHS GPS; 2 CFR 200.216 telecom restrictions. (files.simpler.grants.gov)

2.2 Requirement-to-Capability Mapping (illustrative)

- Use of funds categories (A–K): Collaborative solutions cover prevention/chronic (A), provider payments workflow support (B), consumer-facing tech (C), training/TA (D), workforce (E), IT/cyber (F), right-sizing services (G), behavioral health (H), innovative care/value-based models (I), minor renovations/equipment (J), partnerships (K). Evidence: partner capabilities and case descriptions.
- Initiative scoring (strategy, workplan, outcomes, impact, sustainability): Consulting SIs can structure milestones, KPIs, and evaluation plans consistent with NOFO's initiative matrix. (files.simpler.grants.gov)

Table 1. CMS requirement → Collaborative capability → Evidence

- Rural access and specialty backup → Avel eCare tele-hospitalist, ICU, ER, pharmacy coverage for CAHs/RHCs → Collaborative appendix and profiles.
- Consumer screening & chronic disease management → Higi/Topcon kiosks + BioIntelliSense RPM + virtual visits → Collaborative description.
- Cybersecurity uplift for small sites → Microsoft rural program; training + discounted security suite → Microsoft/AHA update (2025). (aha.org)
- Interoperability, analytics & reporting → eClinicalWorks QHIN designation; SI-led dashboards → Sequoia Project (2025). (sequoiaproject.org)
- Workforce skilling & burnout reduction → Ambient documentation and tele-mentoring → Collaborative description.

3. Montana Context Snapshot

- Population and rurality: Montana's population was 1,137,233 (2024). Rural share was 46.6% in 2020, among the highest nationally. (census.gov)
- Rural facility mix:
  - Critical Access Hospitals (CAHs): 50. (dphhs.mt.gov)
  - Rural Health Clinics (RHCs): 62 (as of July 2025). (ruralhealthinfo.org)
  - FQHCs: 13 reporting awardees; 128,296 patients served (2024 UDS). (data.hrsa.gov)
- Medicaid delivery: Montana operates a Primary Care Case Management model (Passport to Health) rather than comprehensive MCOs for most enrollees (2025). (dphhs.mt.gov)
- Telehealth policy (2025): Medicaid reimburses live video, store-and-forward, RPM, and audio-only where clinically appropriate; private payer coverage parity in law without explicit payment parity. (cchpca.org)
- Maternal/behavioral health: MT maintains a Maternal Mortality Review Committee (MMRC) and published 2020 data and recommendations; overdose mortality was 19.4 per 100,000 (2022) and 17.1 (2023 provisional). (dphhs.mt.gov)
- Behavioral health/substance use: CDC notes modest 2023 national declines; Montana's rate remained elevated relative to national averages, underscoring need for prevention, MOUD access, and crisis tele-behavioral models. (cdc.gov)
- Licensure compacts & scope:
  - IMLC (physicians): Member; Montana serves as State of Principal License. (boards.bsd.dli.mt.gov)
  - NLC (nurses): Member since 2015. (boards.bsd.dli.mt.gov)
  - PSYPACT (psychology): Effective Oct 1, 2025. (boards.bsd.dli.mt.gov)
  - EMS Compact (REPLICA): Montana is not listed among member states as of 2025. (emscompact.gov)
- Certificate of Need: Montana continues a CON program focused on specified changes in long-term care beds/capital; see MCA 50-5-301 and DPHHS CON guidance. (law.justia.com)

Table 2. Montana metrics → year → source → Collaborative capability alignment

- Rural population 46.6% → 2020 → U.S. Census via NCSL → Prioritize virtual access nodes and RPM statewide. (ncsl.org)
- CAHs 50 → 2025 → DPHHS Flex Program → Tele-ER/ICU; cyber uplift; TEFCA connectivity. (dphhs.mt.gov)
- RHCs 62 → 2025 → RHIhub → Tele-primary care, pharmacy-enabled chronic care. (ruralhealthinfo.org)
- FQHC awardees 13; 128,296 patients → 2024 → HRSA UDS → Chronic disease management at scale; gap closure. (data.hrsa.gov)
- Medicaid delivery = PCCM (Passport) → 2025 → DPHHS → Value-based incentives layered via SPA; analytics. (dphhs.mt.gov)
- Overdose deaths 19.4 (2022); 17.1 (2023) → CDC NCHS → Tele-behavioral + MOUD access, risk analytics. (cdc.gov)

Assumptions and Open Questions (for validation)

- Broadband metric: use of Census household broadband subscription rate can be added upon latest QuickFacts field confirmation; this guide avoids a point estimate to prevent misstatement during federal

site outage. (census.gov)
- CCBHC list (as of 9/1/2025) and Medicaid DSH hospital counts: available to the State; include in Project Narrative per NOFO instructions. (files.simpler.grants.gov)
- Final selection of policy actions for technical factors (e.g., SNAP waivers, nutrition CME) requires State legal review before claiming conditional points. (files.simpler.grants.gov)

4. Strategy Aligned to RFP 4.1 Model overview (conditional)

- Hub-and-node virtual care: A statewide tele-hospital hub supports CAHs/RHCs with ER/ICU/hospitalist/pharmacy coverage and tele-specialty clinics, while community nodes (FQHCs, RHCs, pharmacies) deploy screening, RPM, and care management.
- Consumer-first prevention: Retail and community kiosks plus multilingual mobile engagement and triage direct residents into care pathways; RPM with exception-based workflows reduces avoidable ED use/readmissions.
- Secure, interoperable data fabric: TEFCA-enabled exchange (eClinicalWorks QHIN), analytics and registries to monitor outcomes and payment integrity across Medicaid and all-payer datasets. (sequoiaproject.org)
- Cyber resilience: Targeted assessments, identity hardening, email security, and privileged access controls prioritized for small rural facilities. (blogs.microsoft.com)

4.2 Alignment to Table 3 technical factors (examples)

- C.1 Rural provider strategic partnerships: State-facilitated High Value Networks (HVNs) for independent rural providers; Collaborative convening and PMO support.
- F.1 Remote care services / F.2 Data infrastructure / F.3 Consumer-facing tech: Tele-ER/ICU; RPM; TEFCA data exchange; multilingual triage. (sequoiaproject.org)
- D.2 Licensure compacts: Leverage IMLC/NLC/PSYPACT to widen clinician supply, subject to contracting. (boards.bsd.dli.mt.gov)
- C.2 EMS: Where Montana is not in REPLICA, tele-EMS consults and community paramedicine can substitute while policy options are explored. (emscompact.gov)

4.3 Equity strategy (rural and Tribal)

- Expand access points in frontier counties and Tribal communities via retail sites, mobile clinics, and tele-specialty schedules agreed with Tribal/IHS partners; ensure culturally appropriate engagement and language access.
- Use analytics to track disparities and route resources; combine FQHC data (UDS) with claims and HIE feeds under TEFCA governance. (data.hrsa.gov)

5. Program Design Options (Montana-tuned; all subject to State selections) Option A: Chronic Disease Access & Control (Primary Care + Pharmacy)

- Target: Adults with hypertension/diabetes in high-rural counties; FQHC/RHC panels.
- Problem: High rural chronic burden and travel barriers; opportunity to use pharmacists and RPM. (data.hrsa.gov)
- Components: Risk screening (kiosks, mobile), pharmacist-enabled management, RPM with escalation, tele-endocrinology/cardiology consults.
- Payment logic: PMPM care management + outcome incentives (BP/HbA1c control); comply with provider-payment cap (≤15%). (files.simpler.grants.gov)
- Policy enablers: Scope-of-practice optimization; telehealth coverage parity already in place for Medicaid (payment parity varies). (cchpca.org)
- Pros/risks: Rapid reach via pharmacies and FQHCs; manage device logistics and data triage load.

Option B: Statewide Tele-ER/ICU/Hospitalist Network for CAHs

- Target: 50 CAHs; frontier counties. (dphhs.mt.gov)
- Components: 24/7 ED/ICU backup, tele-pharmacy, transfer coordination; stroke detection/activation tools; TEFCA data exchange.
- Payment logic: Shared-services contracts; capital within Category J limits. (files.simpler.grants.gov)
- Pros/risks: Keeps care local; staffing acceptance, credentialing, and broadband are dependencies.

Option C: Behavioral Health Integration & Overdose Response

- Target: Rural counties with elevated overdose mortality. (cdc.gov)
- Components: Tele-psychiatry, crisis consults, MOUD linkage, risk alerts via analytics; community outreach through retail/CHW channels.
- Payment logic: PMPM + pay-for-performance (engagement, ED revisits); use Category H/I.
- Pros/risks: Addresses priority need; requires network MOUs and training.

Option D: Community Paramedicine and Tele-EMS (non-compact)

- Target: Remote EMS districts; frequent 911 callers, post-discharge patients.
- Components: Tele-medical direction; scheduled in-home checks; referral to primary/behavioral care; integrate with CAHs.
- Policy: Consider SPA for mobile integrated health; explore REPLICA membership impacts; maintain NOFO caps. (emscompact.gov)

6. Governance and Collaborative Roles

- Structure (text diagram):
  - Governor-designated Lead Agency (prime recipient)
    - RHT Program PMO (State) — planning, reporting to CMS
      - High Value Networks (independent rural provider consortia)
        - Delivery partners: CAHs, RHCs, FQHCs, retail sites, EMS/IHS/Tribal
        - Technology/data: QHIN/EHR, cyber, RPM, analytics
        - Systems integrators: program design, dashboards, evaluation
  - CMS: substantial involvement; monthly contacts, data/report approvals. (files.simpler.grants.gov)
- RACI (selected)
  - Lead Agency: strategy, compliance, continuation apps — Accountable.
  - Medicaid agency: payment policy (SPA/State Plan notices), data use — Responsible.
  - Hospital Association/SORH: CAH alignment — Consulted.
  - HVNs (Cibolo-enabled): shared services, fund stewardship — Responsible.
  - SI partners: PMO tooling, workplan tracking, economic modeling — Responsible.
  - QHIN/EHR partner: TEFCA onboarding, data quality — Responsible. (sequoiaproject.org)

7. Payment and Funding

- Compliance with NOFO caps: Admin ≤10%; provider payments ≤15%; capital/infrastructure ≤20%; EMR replacement cap 5%; Tech Catalyst ≤10% or $20M; telecom ban per 2 CFR 200.216. (files.simpler.grants.gov)
- Medicaid alignment options:
  - Care management PMPM and quality withholds under State Plan; SPA drafting and actuarial modeling supported by SI partners (conditional).
  - Primary care and tele-behavioral enhancements within PCCM (Passport). (dphhs.mt.gov)

Table 3. Illustrative budget lines (ROM), source, timing, Collaborative deliverables (all conditional; amounts for planning only)

- Tele-ER/ICU shared services — Category G/I; Y1 start-up; SI-supported vendor management — virtual coverage schedules, protocols.
- RPM kits and clinical monitoring — Category A/C/F; staged by county — device logistics, dashboards, training.
- Cybersecurity uplift — Category F; rapid assessments then remediation backlog; avoid disallowed purchases — assessments, identity/email controls, staff training. (blogs.microsoft.com)
- Data & evaluation stack — TEFCA onboarding, measures & dashboards — QHIN participation; KPI reporting to CMS. (sequoiaproject.org)

8. Data, Measurement, and Evaluation

- Core measures: access (tele-ER response times), quality (stroke door-to-needle for transfers; BP/HbA1c control), utilization (ED visits, readmissions), financial (CAH margin proxies), workforce (vacancy/retention), technology (cyber incidents, MFA adoption), program implementation (initiative milestones). (files.simpler.grants.gov)
- Sources: TEFCA exchange (clinical docs), Medicaid claims/encounters, UDS, CAH operational data, EMS run data, social/SDOH where available; integrated under a QHIN/EHR-anchored architecture with privacy/security per 2 CFR/HHS GPS. (sequoiaproject.org)
- Evaluation: SI partners co-develop a learning agenda; quarterly dashboards; annual continuation application evidence packages.

9. Implementation Plan Gantt-style table (12–24 months; conditional on State procurement)

Workstream | Start | End | Owner | Outputs

- PMO setup, governance charters | Jan 2026 | Mar 2026 | Lead Agency + SI | PMO charter; RACI; meeting cadence.
- TEFCA onboarding/QHIN participation | Feb 2026 | Jul 2026 | QHIN/EHR + State HIE | Connection test, data use terms, initial KPIs. (sequoiaproject.org)

- Tele-ER/ICU network contracting | Feb 2026 | Jun 2026 | Lead + Avel eCare | Coverage schedule; credentialing; protocols.
- RPM cohort 1 deployment | Apr 2026 | Sep 2026 | FQHC/RHC + BioIntelliSense | 1,000 enrolled; exception workflows; training.
- Cyber assessments + remediation sprint | Mar 2026 | Dec 2026 | Microsoft + CAHs | Assessments; MFA/identity baselines; training. (blogs.microsoft.com)
- Evaluation & dashboards | Apr 2026 | Ongoing | SI + State analytics | Quarterly KPI pack; CMS reporting.

Procurement/legal gating items: standard State IT/security, data use agreements, business associate agreements, subrecipient monitoring protocol per 2 CFR. (files.simpler.grants.gov)

10. Risk Register (selected)

- Broadband constraints in frontier areas → Mitigation: offline-tolerant RPM, asynchronous uploads, scheduling tele-specialty from clinic sites; Owner: PMO/tech vendors.
- Cyber incident at rural facility → Mitigation: assessments, MFA, email security, playbooks; Owner: facility CIO + Microsoft partner. (blogs.microsoft.com)
- Clinician adoption/credentialing delays → Mitigation: early medical staff services engagement, compact use (IMLC/NLC/PSYPACT), streamlined privileging. (boards.bsd.dli.mt.gov)
- Data-sharing hesitation → Mitigation: TEFCA governance; patient privacy messaging; Owner: QHIN/EHR + State. (sequoiaproject.org)
- Budget caps breach risk → Mitigation: cap tracking; independent QA prior to submission; Owner: PMO finance. (files.simpler.grants.gov)
- Vendor capacity constraints → Mitigation: phased cohorts, multiple partners; Owner: SI.
- Evaluation burden → Mitigation: automated dashboards aligned to NOFO metrics; Owner: SI. (files.simpler.grants.gov)
- Community trust → Mitigation: partner with FQHCs, Tribal/IHS, pharmacies; transparent reporting; Owner: HVNs.
- Policy action slippage (conditional points) → Mitigation: legislative workplan and checkpoints; Owner: Lead Agency. (files.simpler.grants.gov)
- Supply chain/device loss for RPM → Mitigation: logistics partner, device tracking; Owner: BioIntelliSense + facilities.

11. Draft RFP Response Language (Montana-tailored; paste-ready) 11.1 Rural health needs and target population (excerpt) “Montana’s rural share is 46.6% (2020), with 50 CAHs and 62 RHCs operating across large frontier areas. Thirteen HRSA-funded health center awardees served 128,296 patients in 2024. Our target geographies prioritize frontier counties with CAHs and counties where overdose mortality remained ≥17 per 100,000 (2023 provisional).” (ncsl.org)

11.2 Goals and strategies (excerpt) “Our RHT Plan deploys virtual specialty support for CAHs, chronic-disease management with RPM, and a TEFCA-enabled data backbone to improve access, quality, and sustainability, while aligning with Medicaid PCCM operations. We will track outcomes and adjust under an evaluation plan consistent with CMS’ initiative scoring criteria.” (files.simpler.grants.gov)

11.3 Proposed initiatives & use of funds (excerpt) “Initiative 1 (Tele-ER/ICU): Category F/G/I; outcomes: transfer-related safety and avoidable transfers. Initiative 2 (Chronic Disease + Pharmacy): Category A/C/E/F; outcomes: BP/HbA1c control, ED diversion. Initiative 3 (Cyber Uplift): Category F; outcomes: MFA rates, phishing resilience. All initiatives comply with provider-payment, capital, EMR replacement, and admin caps.” (files.simpler.grants.gov)

11.4 Implementation plan & timeline (excerpt) “We will stand up a PMO in Q1, execute TEFCA onboarding by mid-year, and launch CAH tele-ER/ICU and RPM cohorts with quarterly dashboard reviews; continuation requests will include metric updates per NOFO.” (files.simpler.grants.gov)

11.5 Stakeholder engagement (excerpt) “Engagement is anchored in HVNs, FQHCs, CAHs, EMS, Tribal/IHS partners, and retail health. Letters of support are included; governance charters detail decision rights and escalation paths.”

11.6 Metrics & evaluation (excerpt) “We will report access, quality, utilization, financial, workforce, technology, and implementation metrics, leveraging TEFCA flows and UDS/claims/HIE data. A learning agenda will guide adjustments; we will cooperate with CMS and third-party evaluations.” (sequoiaproject.org)

11.7 Program duplication assessment (excerpt) “The State’s SOPs prevent duplication; we will not use RHT funds to pay for services otherwise reimbursable unless gap-filling/transformative, and we will adhere to 2 CFR/HHS GPS limitations.” (files.simpler.grants.gov)

12. References

1. Rural Health Transformation Program (CMS-RHT-26-001) NOFO, Centers for Medicare & Medicaid Services (CMS). https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf (accessed 2025-10-14). (files.simpler.grants.gov)
2. Table 3 scoring weights and workload formula, CMS-RHT-26-001, pp. 50–52. (accessed 2025-10-14). (files.simpler.grants.gov)
3. Funding caps and limitations (provider ≤15%, capital ≤20%, EMR ≤5%, Tech Catalyst ≤10% or $20M; admin ≤10%; 2 CFR 200.216), CMS-RHT-26-001, pp. 17–21. (accessed 2025-10-14). (files.simpler.grants.gov)
4. Rural Health Transformation Collaborative, R1 (10-11-25), capabilities and member profiles. (internal).
5. U.S. Census/NCSL Rural Population by State (2020). https://www.ncsl.org/... (accessed 2025-10-14). (ncsl.org)
6. DPHHS Rural Hospital Flexibility Program (CAHs in MT). https://dphhs.mt.gov/.../ruralhospitalflexibility (accessed 2025-10-14). (dphhs.mt.gov)
7. RHIhub Montana state profile (RHCs, CAHs, FQHC sites outside urban areas). https://www.ruralhealthinfo.org/states/montana (accessed 2025-10-14). (ruralhealthinfo.org)
8. HRSA UDS State Report — Montana (2024). https://data.hrsa.gov/... (accessed 2025-10-14). (data.hrsa.gov)
9. Montana Medicaid — Passport to Health (PCCM) (2025). https://dphhs.mt.gov/MontanaHealthcarePrograms/Passport (accessed 2025-10-14). (dphhs.mt.gov)
10. CCHP Montana telehealth policy summary (updated June 4, 2025). https://www.cchpca.org/montana/ (accessed 2025-10-14). (cchpca.org)
11. CDC NCHS State Health Stats — Montana (2025 update). https://www.cdc.gov/nchs/state-stats/states/mt.html (accessed 2025-10-14). (cdc.gov)
12. Montana Board of Medical Examiners — IMLC participation. https://boards.bsd.dli.mt.gov/medical-examiners/... (accessed 2025-10-14). (boards.bsd.dli.mt.gov)
13. Montana Board of Nursing — NLC membership. https://boards.bsd.dli.mt.gov/nursing/ (accessed 2025-10-14). (boards.bsd.dli.mt.gov)
14. Montana Board of Psychologists — PSYPACT (effective Oct 1, 2025). https://boards.bsd.dli.mt.gov/psychologists/PSYPACT (accessed 2025-10-14). (boards.bsd.dli.mt.gov)
15. EMS Compact (REPLICA) member list. https://www.emscompact.gov/ (accessed 2025-10-14). (emscompact.gov)
16. Montana Certificate of Need — DPHHS and MCA 50-5-301. https://dphhs.mt.gov/.../CertificateofNeed ; https://law.justia.com/.../section-50-5-301/ (accessed 2025-10-14). (dphhs.mt.gov)
17. Sequoia Project — eClinicalWorks designated QHIN (Jan 16, 2025). https://sequoiaproject.org/... (accessed 2025-10-14). (sequoiaproject.org)
18. Microsoft rural hospital cybersecurity program adoption (AHA Market Scan, July 15, 2025). https://www.aha.org/... (accessed 2025-10-14). (aha.org)

13. AI Generation Notice This guide was generated by the gpt-5 model on 2025-10-14. It is provided for planning purposes and does not constitute legal, clinical, or financial advice. Before use in any official submission, independently validate all facts, figures, and citations with primary sources, and consult appropriate counsel and program officials.