Rural Health Transformation Grant Guide — Hawaii

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary

Hawaii can use the CMS Rural Health Transformation (RHT) Program cooperative agreement (CMS-RHT-26-001) to stabilize rural access on the Neighbor Islands, modernize clinical and data infrastructure, and advance value-based models aligned with Med-QUEST's 1115 renewal through 2029. CMS will allocate $50B across FY26–FY30, with awards to approved states; half is baseline and half is workload-based, with applications due November 5, 2025 and awards by December 31, 2025. (cms.gov)

The Rural Health Transformation (RHT) Collaborative can support Hawaii with a pre-vetted catalogue of secure cloud/data platforms, tele-hospitalist/ICU/ER services, remote monitoring, pharmacy-enabled chronic care, and program management that map to RHT uses of funds (prevention/chronic disease, technology, workforce, innovative care) and the program's strategic goals. Offerings include: Avel eCare virtual hospital services (hospitalist, critical care, ER, EMS), BioIntelliSense continuous RPM, Microsoft secure cloud and cybersecurity (including deployments in >700 rural hospitals), eClinicalWorks/PRISMA interoperability, Viz.ai stroke and workflow AI, Humetrix consumer apps/analytics, and governance through provider-owned High Value Networks (HVNs) facilitated by Cibolo Health. These capabilities are described in the Collaborative consensus document.

Hawaii's rural profile—four counties across multiple islands—includes nine Critical Access Hospitals (CAHs), a statewide FQHC safety-net serving ~154,000 patients in 2024, and multiple Rural Health Clinics (RHCs). Med-QUEST operates a mandatory managed care model under an 1115 demonstration renewed through December 31, 2029, including new health-related social needs (HRSN) features. These characteristics pair well with Collaborative solutions: Neighbor-Island virtual hospital coverage, pharmacy-anchored hypertension/diabetes programs, data fabric linking claims/EHR/EMS, and HVNs to align rural providers with value-based purchasing. (health.hawaii.gov)

Near-term, Hawaii can prioritize three integrated initiatives: (1) a Neighbor-Island Virtual Hospital Network (tele-hospitalist/ICU/ER and EMS consults), (2) a Pharmacy-enabled Cardiometabolic Control program with RPM and multilingual consumer engagement, and (3) a Rural Provider HVN with a shared analytics platform. Each is feasible within RHT's allowable uses and timelines, subject to contracting, interoperability, and Medicaid alignment. (cms.gov)

One-page printable summary (for distribution)

- Program: CMS Rural Health Transformation (cooperative agreement). Total $50B FY26–FY30; one application per state; due Nov 5, 2025; awards by Dec 31, 2025. Uses of funds span prevention/chronic disease, workforce, tech/cyber, innovative care, payment supports. (cms.gov)
- Hawaii context (selected 2024–2025 facts): 9 CAHs statewide (Hawaii DOH OPCRH); 13 FQHC awardees, 154,086 patients (HRSA UDS 2024); QUEST Integration 1115 renewed through 12/31/2029 (CMS approval). (health.hawaii.gov)
- Collaborative fit (illustrative):
    - Access/quality: Avel eCare tele-hospitalist/ICU/ER/EMS; Viz.ai stroke triage; Teladoc behavioral/medical virtual care.
    - Data & cyber: Microsoft secure cloud/data/AI, cyber support for rural hospitals; eClinicalWorks interoperability (PRISMA).
    - Prevention/RPM: BioIntelliSense continuous monitoring; Humetrix multilingual triage/PHR/analytics; pharmacy partners (CVS/Walgreens) for BP/diabetes.
    - Governance: Cibolo Health-enabled provider HVNs for accountability and value alignment.
- Priority options for Hawaii (subject to procurement and integration):
    1. Neighbor-Island Virtual Hospital Network (tele-ICU/ER/hospitalist, EMS consults).
    2. Pharmacy-enabled Cardiometabolic Control (hypertension/diabetes) with RPM and consumer tools.
    3. Rural Provider HVN with shared analytics/data fabric for value-based models.
- Dependencies: CMS RHT NOFO terms, Medicaid SPA/contracting alignment, data-sharing agreements, tribal/community engagement, licensure/compact status.

2. Eligibility and RFP Fit

- Snapshot of RHT NOFO (CMS-RHT-26-001)
    - Eligibility: Only the 50 U.S. states; one application per state; Governor-designated lead agency; submission via Grants.gov. (cms.gov)
    - Funding structure: $50B, FY26–FY30; 50% equal baseline; 50% allocated by points; awards by 12/31/2025.

(cms.gov)
    - Application timing: NOFO posted mid-September; applications close early November (Nov 5, 2025); CMS applicant webinars in late September. (cms.gov)
    - Program uses of funds: prevention/chronic disease, provider payments (as specified), consumer tech, TA/training for advanced technologies, workforce recruitment/retention (≥5-year rural service), IT/cyber, right-sizing service lines, behavioral health/SUD, innovative/value-based care. (cms.gov)
    - Cooperative agreement: substantial CMS involvement; ongoing reporting and continuation applications per CMS grants policy. (cms.gov)
- Requirement-to-Capability Map (examples)
    - Requirement: At least three uses of funds across prevention, technology, workforce, innovative care. Evidence: CMS overview page. Collaborative capability: Prevention/RPM (BioIntelliSense; pharmacy partners), tele-care (Avel eCare, Teladoc), analytics/cloud/cyber (Microsoft), consumer apps (Humetrix). (cms.gov)
    - Requirement: Data/interoperability and measurable outcomes. Evidence: CMS overview/FAQ. Collaborative capability: eClinicalWorks/PRISMA data aggregation, Humetrix analytics, Microsoft cloud analytics framework, Viz.ai care-pathway AI. (cms.gov)
    - Requirement: Stakeholder engagement; naming subrecipients in Budget Narrative when known. Evidence: CMS FAQ. Collaborative capability: HVN governance (Cibolo), facilitation by Accenture/KPMG/PwC and NACHC networks. (cms.gov)

Compliance checkpoints (non-exhaustive): Grants.gov 11:59 p.m. ET submission proof; AOR signature; SAM/UEI active; Governor's endorsement letter; page limits; one official submission; monthly CMS engagement typical for cooperative agreements per CMS grants guidance. (cms.gov)

Assumptions and Open Questions

- The NOFO PDF on Grants.gov is posted but requires portal access; this guide cites CMS public pages and FAQ for core terms and timing. Please confirm section-level NOFO citations (e.g., scoring table details, any categorical caps) in the final submission package. (cms.gov)

3. Hawaii Context Snapshot

Selected metrics and implications (latest available):

- Rural share of population: Approximately 13.9% of Hawaii residents lived in rural areas in 2020 per Census-based state compilation. Implication: A small but distributed rural population across Neighbor Islands elevates the role of tele-enabled networks. (ncsl.org)
- CAHs: Nine hospitals currently qualify as CAHs (Hale Hoʻola Hāmākua; Kahuku; Kaʻū; Kauaʻi Veterans Memorial; Kohala; Kula; Lānaʻi Community Hospital; Molokaʻi General; Samuel Mahelona). Implication: Tele-hospitalist/ICU and RPM can stabilize local care. (health.hawaii.gov)
- FQHCs: 13 HRSA Health Center Program awardees (154,086 patients in 2024); one LAL (4,960 patients). Implication: FQHCs can anchor community-level prevention, screenings, and remote monitoring. (data.hrsa.gov)
- RHCs: Hawaii DOH lists multiple RHCs across Oʻahu and Hawaiʻi Island (e.g., Castle Health Clinic of Lāʻie; East Hawaiʻi Health sites; Five Mountains). Implication: RHCs can extend RPM and pharmacist-supported protocols to rural sites. (health.hawaii.gov)
- HPSA indicators: As of March 31, 2025, a compiled summary based on HRSA quarterly data reports 33 primary care HPSA designations in Hawaii, serving ~520,000 people, with an estimated need for 87 additional primary care clinicians. Implication: Workforce and licensure portability are critical. (Confirm counts with HRSA dashboard.) (commentary.healthguideusa.org)
- Medicaid (Med-QUEST): 1115 QUEST Integration demonstration renewal effective January 8, 2025 through December 31, 2029; model remains mandatory managed care and adds HRSN elements. Implication: RHT initiatives can align with MCO contracts and HRSN payments. (medicaid.gov)
- Licensure compacts (technical scoring relevance):
    - Interstate Medical Licensure Compact: Enacted; compact licensing available as of January 1, 2025 (Act 163; Hawaii Medical Board implementation). (cca.hawaii.gov)
    - Nurse Licensure Compact: Not a member as of 2025 (NCSBN). (ncsbn.org)
    - PSYPACT/Counseling/PT compacts: Hawaii not a member as of 2025. (psypact.gov)

- Certificate of Need (CON): Hawaii maintains a CON program administered by SHPDA under HRS Chapter 323D. Implication: Facility/service-line changes may require CON review; RHT capital/renovation items should be coordinated with SHPDA timelines. (health.hawaii.gov)

Metrics-to-capability table (illustrative)

- Metric (year) and gap → Collaborative capability
    - 9 CAHs (2025): local inpatient capacity fragile → Avel eCare tele-hospitalist/ICU/ER; Viz.ai stroke workflows; BioIntelliSense RPM for step-down/home transitions. (health.hawaii.gov)
    - 13 FQHC awardees; 154k patients (2024) → FQHC-anchored prevention/RPM programs, multilingual intake and engagement (Humetrix), pharmacist integration. (data.hrsa.gov)
    - Primary care HPSA need (2025) → Licensure portability leverage (IMLC), tele-mentoring, ambient documentation tools, and recruitment supports. (commentary.healthguideusa.org)

4. Strategy Aligned to RFP

Proposed model for Hawaii

- A statewide "Rural Connected Care Grid" that links CAHs, PPS hospitals, FQHCs, RHCs, EMS, and retail pharmacies via:
    - Virtual hospital services (tele-hospitalist/ICU/ER and specialty e-consults) to keep patients local where clinically appropriate.
    - Community cardiometabolic prevention with pharmacy teams, RPM wearables, and multilingual digital front doors; escalations to tele-clinicians as needed.
    - A shared, secure data stack (cloud, interoperability, analytics, cybersecurity) that aggregates claims/EHR/device/EMS feeds for population insights and reporting.
    - Provider-owned HVN governance to steward funds, align incentives, and scale best practices across islands.

RHT pillars and scoring considerations (evidence/examples)

- Prevention/chronic disease: Pharmacy point-of-care checks, kiosk/retail screenings, RPM, and tele-follow-up map to RHT use categories; partners cite hypertension/diabetes adherence improvements in deployed programs.
- Sustainable access/innovative care: Avel eCare's virtual hospital model across rural settings; HVNs to coordinate shared investments and value-based arrangements.
- Tech innovation/cyber/data: Microsoft rural cyber program and secure cloud/AI; eClinicalWorks PRISMA for data aggregation; Viz.ai condition-specific AI.
- Workforce: Tele-mentoring and AI documentation reduce burden; IMLC status supports physician recruitment; pharmacy workforce development partnerships. (cca.hawaii.gov)

Equity for rural and Native Hawaiian communities

- Combine local governance (HVNs), FQHC leadership, and multilingual, culturally attuned consumer tech; strengthen access on Moloka'i, Lāna'i, and rural Hawai'i Island via mobile/retail touchpoints and tele-specialty access.

Data and privacy

- Use HIPAA-aligned cloud, role-based access, TEFCA/QHIN connectivity (where available), and audit trails; incorporate cyber hardening for CAHs.

5. Program Design Options (Hawaii-tuned)

Option A. Neighbor-Island Virtual Hospital Network (primary)

- Target: CAHs and small hospitals on Kaua'i, Maui/Lāna'i/Moloka'i, Hawai'i Island.
- Problem statement: After-hours coverage and specialty access gaps elevate transfers and costs.
- Services: Tele-hospitalist, tele-ICU, tele-ER, pharmacy, specialty e-consult; RPM for step-down and CHF/COPD; Viz.ai stroke activation.
- Payment logic: RHT funds for service start-up, training, IT/cyber; Medicaid MCO care management add-ons; explore shared savings in HVN contracts (subject to actuarial analysis).
- Enablers: IMLC for physician sourcing; DOH EMS integration; SHPDA CON coordination for material service changes. (cca.hawaii.gov)
- Partners/IT: Avel eCare; Microsoft cloud/cyber; eClinicalWorks data exchange.

- Pros/risks: Rapid coverage expansion/transfer avoidance vs. staffing buy-in, on-call workflows; mitigate with staged roll-in and HVN governance.

Option B. Pharmacy-Enabled Cardiometabolic Control Network

- Target: Adults with uncontrolled HTN/DM in rural ZIPs.
- Services: Pharmacy BP/glucose workflows, kiosk screenings, RPM wearables, multilingual intake/PHR, virtual visits, medication reconciliation; link to FQHCs and PCPs.
- Payment logic: RHT prevention/consumer tech; Medicaid care management incentives; value-based pharmacy pilots with MCOs (adherence/outcomes).
- Pros/risks: Community reach and adherence gains vs. data-sharing and scope alignment; mitigate through MOUs and privacy/consent tooling.

Option C. Rural Provider High Value Network (HVN) + Shared Analytics

- Target: CAHs, RHCs, FQHCs, independent practices.
- Services: Governance, pooled procurement, population analytics (Humetrix), care-gap AI (Pangaea), cyber hardening; value strategy with payers.
- Payment logic: RHT data/IT/workforce funds; Medicaid alignment via MCO contract amendments and, as needed, SPA support.

Option D. Maternal/Behavioral Integration (backup)

- Target: Rural OB access gaps and behavioral health needs.
- Services: Tele-OB consults, RPM for high-risk pregnancies, tele-behavioral health, crisis support (988 coordination), community health worker linkages.
- Payment logic: RHT behavioral and innovative care uses; Medicaid HRSN pilots (per 1115).

6. Governance and Collaborative Roles

Partner diagram (roles)

- State lead agency (Governor-designated): overall accountability; CMS liaison.
- Med-QUEST (Medicaid): MCO alignment, SPA/contract updates (as needed).
- SHPDA/SHP: CON coordination, state health services plan linkages. (health.hawaii.gov)
- Provider HVN (Cibolo Health-enabled): rural provider governance, funds stewardship, transparency, and reporting.
- Collaborative members:
    - Clinical/virtual: Avel eCare; Teladoc.
    - Data/cyber: Microsoft; eClinicalWorks; Viz.ai; Humetrix; Pangaea Data.
    - Pharmacy/retail: CVS Health; Walgreens; Walmart (subject to local availability).
    - Integrators: Accenture, KPMG, PwC (program management, analytics, compliance).
    - FQHCs and hospital associations; universities for workforce.

RACI (summary)

- Strategy & NOFO submission: State lead (R), Medicaid (A/C), Collaborative integrator (C), HVN (I).
- Clinical networks: HVN (A/R), Avel eCare (R), hospitals/FQHCs (R), State/Medicaid (C).
- Data/cyber stack: Microsoft/eClinicalWorks (R), State CIO/lead (A), providers (C), integrator (R/C).
- Reporting/evaluation: State (A), integrator (R), HVN/providers (R), CMS (I).

7. Payment and Funding

Funding pathways consistent with CMS guidance

- Blend baseline and workload-based RHT funds across use categories (prevention, tech/cyber, workforce, innovative care) with explicit budget tie-backs to initiatives and outcomes; adhere to CMS cooperative agreement terms and reporting. (cms.gov)
- Medicaid alignment: Use actuarial modeling and MCO contract levers (care management fees, quality incentives, prospective payments in HVNs) to sustain programs beyond FY31; pursue SPA adjustments if needed. (medicaid.gov)

Illustrative budget table (ROM; subject to NOFO caps/terms)

- Category | Example deliverables | Timing
    - Virtual hospital services setup | Tele-ICU/ER, credentialing, SOPs, 24/7 coverage pilots | Months 3–12
    - Data/cyber platform | Cloud tenancy, HIE connectors, dashboards, cyber hardening for CAHs | Months 1–12
    - RPM & consumer tech | Devices, logistics, multilingual apps, training | Months 4–18
    - HVN & PMO | Governance, subrecipient oversight, evaluation | Months 1–24

Note: Confirm any categorical caps (e.g., provider payments, capital/IT, administrative costs) directly in CMS-RHT-26-001 during budget finalization. (cms.gov)

8. Data, Measurement, and Evaluation

Core measures and cadence

- Access: tele-response times, transfer rates, time-to-stroke activation (Viz.ai), specialist consult turnaround.
- Quality/outcomes: BP control, A1c control, 30-day readmissions (med rec programs), ED revisits, ICU days avoided.
- Financial: total cost-of-care trends, preventable transfers avoided, LOS changes, avoided travel costs.
- Workforce: retention, vacancy times, tele-mentoring participation, AI documentation time saved.
- Program: milestone adherence, subrecipient spend, CMS quarterly/annual reporting.

Data sources and integrations

- Claims (Medicaid/MCOs), EHR (eClinicalWorks and others), device/RPM (BioIntelliSense), EMS logs, retail/pharmacy events, community screenings; privacy and consent management embedded into consumer apps and data platform.

Evaluation approach

- Rapid-cycle measurement with shared dashboards; independent evaluation readiness; alignment with CMS cooperative agreement reporting (FFR, progress, outcomes). (cms.gov)

9. Implementation Plan

12–24 month Gantt-style view (illustrative; dates are relative to award)

- Workstream | Start | End | Owner | Outputs
    - Program mobilization & PMO | M1 | M3 | State/Integrator | PMO charter, subrecipient templates
    - Data/cyber platform | M1 | M9 | Microsoft/eClinicalWorks | Cloud tenancy, connectors, dashboards
    - Virtual hospital pilots (2 CAHs) | M4 | M12 | HVN/Avel eCare | 24/7 coverage, SOPs, KPIs
    - RPM & pharmacy HTN/DM | M4 | M18 | FQHCs/Pharmacies | Enrolled cohort, adherence KPIs
    - HVN formation | M1 | M6 | HVN/Cibolo | Governance documents, value strategy
    - Medicaid alignment | M2 | M12 | Med-QUEST | MCO contract change orders/SPAs (if any)
    - Evaluation set-up | M2 | M6 | State/Integrator | Logic model, data dictionary, baseline report
    - Scale-up (additional sites) | M13 | M24 | HVN/providers | Island expansion, KPI tracking

Key gating decisions

- Data-sharing agreements; credentialing and privileging; MCO contracting; CON determinations (if applicable); security/A&A. (health.hawaii.gov)

Procurement/legal accelerators

- Use existing statewide vehicles where possible; align to CMS/HHS terms; flow-down to subrecipients; ensure cyber clauses and BAAs.

10. Risk Register (selected)

- Data-sharing delays → Pre-negotiated DSA/BAA templates; integrator facilitation. Owner: State/Integrator.
- Cyber incidents at rural sites → Harden CAHs via Microsoft offerings; continuous monitoring. Owner: Providers/State.
- Workforce acceptance of tele-models → Tele-mentoring, on-site training, AI to reduce documentation burden. Owner: HVN.
- Device logistics (RPM) on islands → Shipping, inventory, device support playbooks. Owner: Providers.
- Licensure/privilege constraints → Leverage IMLC; track NLC/PSYPACT status; contingency staffing. Owner: State. (cca.hawaii.gov)

- CON timelines affecting service changes → Early SHPDA engagement, phased deployments. Owner: State/SHPDA. (health.hawaii.gov)
- Medicaid sustainability → Early payer engagement; scenario modeling; tie incentives to outcomes. Owner: Med-QUEST. (medicaid.gov)
- Community trust and cultural fit → FQHC/Native Hawaiian organization leadership; multilingual tools. Owner: HVN/FQHCs.
- Vendor integration risk → SI playbooks, reference architectures, milestone-based payments. Owner: Integrator.
- Reporting burden → Centralized data stack; automated KPI pipelines. Owner: State/Integrator.

11. Draft RFP Response Language (Hawaii-tailored; paste-ready, subject to state edits)

Project summary (abstract) "The State of Hawaii proposes a Rural Connected Care Grid to strengthen sustainable access, improve outcomes, and modernize rural health delivery across the Neighbor Islands. The strategy expands tele-hospitalist/ICU/ER capabilities at CAHs, deploys a pharmacy-enabled cardiometabolic control program with remote monitoring and multilingual engagement, and establishes a rural provider High Value Network (HVN) with a shared analytics and cybersecurity platform. The plan aligns with CMS RHT strategic goals, uses of funds, and Med-QUEST's 1115 demonstration through 2029. Implementation will be conducted under a cooperative agreement with CMS using a measurable outcomes framework and robust subrecipient oversight." (cms.gov)

Rural health needs & target population (excerpt) "Hawaii's rural residents (13.9% in 2020) are concentrated on Kaua'i, Maui/Lāna'i/Moloka'i, and Hawai'i Island. The state operates 9 CAHs and a robust FQHC network (13 awardees; 154,086 patients in 2024). Primary care HPSA designations cover substantial populations with an estimated shortage of 87 clinicians. These conditions justify priority investments in virtual hospital services, RPM-supported chronic disease control, and workforce supports." (ncsl.org)

Rural Health Transformation plan: goals & strategies (excerpt) "We will reduce avoidable transfers and shorten time-to-treatment using tele-hospitalist/ICU/ER and AI-enabled stroke activation; improve BP/A1c control through pharmacy-enabled care and continuous monitoring; protect critical infrastructure via cloud/cyber modernization; and align rural providers through an HVN with payer-linked incentives. Data and dashboards will track county-level access, quality, financial, and workforce indicators."

Proposed initiatives & use of funds (excerpt) "Neighbor-Island Virtual Hospital Network (Avel eCare; Viz.ai); Cardiometabolic Control (CVS/Walgreens; BioIntelliSense; Humetrix); HVN + Shared Analytics (Cibolo; Microsoft; eClinicalWorks). Each initiative specifies counties (FIPS), partners, use-of-funds categories, baselines/targets (≥4 measures per initiative, with ≥1 county/community metric), and estimated funding."

Stakeholder engagement (excerpt) "Engagement includes hospital associations, FQHCs, RHCs, EMS, payers, retail pharmacies, community and Native Hawaiian organizations, and universities. Subrecipients and procurement approaches are identified in the Budget Narrative, and letters of support are appended." (cms.gov)

Metrics & evaluation (excerpt) "Access (tele-response times, transfers), quality (BP/A1c, readmissions), cost (total cost-of-care, avoided transfers), workforce (retention). Data will be integrated via secure cloud, HIE connectors, and device feeds; results reported per CMS schedule."

12. References

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20. Internal (uploaded): Rural Health Transformation Collaborative. R1. 10-11-25.pdf (capabilities, members, and case examples).

AI Generation Notice

This guide was generated with the gpt-5 model on 2025-10-14. It uses both internal collaborative materials and public sources. All facts, figures, and citations should be independently validated against the official CMS NOFO (CMS-RHT-26-001) and current Hawaii statutes, contracts, and data systems before use in any submission or decision.