

# Rural Health Transformation Grant Guide — California

**VERSION:** 1.0

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

**AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.**

# 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](https://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](https://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](https://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](https://dhcs.ca.gov))

One-page printable summary (for distribution)

- Opportunity snapshot
  - Applicant: States only; CA eligible. DC/territories ineligible [1]. ([files.simpler.grants.gov](https://files.simpler.grants.gov))
  - Due: Nov 5, 2025 (11:59 p.m. ET). Earliest start: Dec 31, 2025 [1][8]. ([files.simpler.grants.gov](https://files.simpler.grants.gov))
  - Funding: ~\$50B FY26–FY30; half baseline/equal split, half workload via points (rural/population + technical) [1]. ([files.simpler.grants.gov](https://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](https://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](https://ppic.org))
  - HRSA health centers: 171 awardees served 5.79M patients in 2024 [9]. ([data.hrsa.gov](https://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](https://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](https://dhcs.ca.gov))
  - Maternal mortality: CA ~9.5/100,000 (2023), among lowest U.S. rates [13]. ([commonwealthfund.org](https://commonwealthfund.org))
  - Opioids: ~8,000 opioid-related overdose deaths (2023) statewide; CDPH surveillance active [14]. ([cdph.ca.gov](https://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](https://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](https://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](https://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](https://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](https://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](https://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](https://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 (HVN) 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](https://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](https://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](https://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](https://www.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](https://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](https://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](https://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](https://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](https://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](https://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](https://commonwealthfund.org))
- Overdose: ~8,000 opioid-related deaths in 2023; CDPH maintains an Overdose Surveillance Dashboard for localized targeting [14]. ([cdph.ca.gov](https://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](https://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](https://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](https://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](https://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](https://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](https://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](https://files.simpler.grants.gov))
- The most recent Medicaid DSH hospital count (SPRY) must be included. Owner: DHCS. [1] ([files.simpler.grants.gov](https://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](https://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](https://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](https://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, TECA exchange participation, and privacy consent tooling [1][2]. ([files.simpler.grants.gov](https://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](https://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](https://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](https://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](https://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](https://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](https://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; TECCA 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](https://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](https://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](https://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](https://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](https://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](https://files.simpler.grants.gov))
- Workstream: Data/cyber platform; ROM: \$20–35M/year; Source: Use F; Deliverables: State dashboards, TECCA exchange, cyber hardening [1][2]. ([files.simpler.grants.gov](https://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](https://files.simpler.grants.gov))
- Admin/PMO: ≤10% of allotment; Source: Admin cap [1]. ([files.simpler.grants.gov](https://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](https://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](https://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/CaISORH	CAH/RHC/FQHC baselines



Workstream	Start	End	Owner	Outputs
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]

## 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](https://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](https://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](https://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](https://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](https://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; TECCA 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](https://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](https://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](https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf))

## 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](https://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](https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf))

## 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](https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf))

## 11.5 Budget narrative (abbrev.)

“Budgets observe caps for provider payments ( $\leq 15\%$ ), capital/infrastructure ( $\leq 20\%$ ), EMR replacement ( $\leq 5\%$  under conditions), rural tech catalyst ( $\leq$  the lesser of 10% or \$20M), and administrative expenses ( $\leq 10\%$  of the allotment). The narrative separates direct and subawarded funds and maps each line to initiatives and outcomes.” [1] ([files.simpler.grants.gov](https://files.simpler.grants.gov/.../cms-rht-26-001_final.pdf))

## 12. References

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## 13. AI Generation Notice

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