Rural Health Transformation Grant Guide — Michigan

VERSION: 1.0

DATE: 2025-10-14

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

AI-GENERATED CONTENT - VALIDATE BEFORE OFFICIAL USE.

1. Executive Summary Michigan can leverage the Rural Health Transformation (RHT) Program cooperative agreement to stabilize rural access, advance chronic care, and modernize infrastructure, while aligning with CMS scoring and compliance. The RHT Collaborative's portfolio—tele-specialty support for CAHs and RHCs, remote patient monitoring, pharmacy-enabled chronic disease services, cybersecurity and data platforms, and value analytics—can support high-impact initiatives in the Upper Peninsula and Northern Lower Peninsula where travel time, seasonal access, and workforce shortages compound risk. The program's structure—50% baseline and 50% workload funding—rewards credible plans tied to measurable outcomes and state policy commitments, with recalculation of the technical score each budget period. (files.simpler.grants.gov)

Michigan's rural profile (2020) includes 26.5% of residents living in areas classified as rural by the U.S. Census county-based rural metric, signaling broad opportunities to drive statewide impact with equitable regional allocation. Facility assets include 35 Critical Access Hospitals (CAHs), 213 Rural Health Clinics (RHCs), one Rural Emergency Hospital (REH), and 39 HRSA-funded health center awardees reporting 683,234 patients in 2024—an implementation base for networked transformation. (ncsl.org)

High-leverage offerings for early impact include: (a) 24/7 tele-hospitalist/tele-ER/tele-ICU coverage for CAHs and critical access EDs (Avel eCare), (b) continuous remote physiologic monitoring for high-risk chronic disease and peri-discharge care (BioIntelliSense), (c) retail pharmacy-enabled hypertension/diabetes management and medication reconciliation at rural access points (Walgreens, CVS), (d) AI-assisted stroke and critical condition identification to accelerate transfers (Viz.ai), and (e) secure cloud, analytics and cyber hardening (Microsoft). These capabilities are documented in the Collaborative consensus materials and are configurable to Michigan's delivery system.

CMS requires clear alignment to approved uses of funds across at least three categories; explicit caps (e.g., provider payments ≤15% of annual award; capital/infrastructure Category J ≤20%; EMR replacement ≤5% when a HITECH-certified system already exists as of 9/1/2025) and other program-specific limitations apply. The Collaborative can help Michigan architect compliant portfolios and defensible budgets mapped to NOFO categories and points. (files.simpler.grants.gov)

1.1 One-Page Printable Summary

- Program fit: Only States are eligible; optional LOI due Sep 30, 2025; application due Nov 5, 2025, 11:59 p.m. ET; awards on Dec 31, 2025. One application per State; AOR signature; Governor endorsement required. Executive Order 12372 does not apply; check "No" on SF-424 item 19c. (files.simpler.grants.gov)
- Funds and scoring: ~$50B FY26–FY30; each budget period's funds spendable through end of following FY. Distribution: 50% baseline (equal across approved States) + 50% workload (points-based). Technical score recalculated annually; rural facility/population score set once using Q4-2025 data. (files.simpler.grants.gov)
- Key weights (Table 3): Rural facility/population 50% and technical factors 50% (19 sub-factors). (files.simpler.grants.gov)
- Michigan context highlights: 26.5% rural population (2020); 35 CAHs; 213 RHCs; 1 REH; 39 HRSA health center awardees serving 683,234 patients (2024). Financial strain persists for many rural hospitals. (ncsl.org)
- Collaborative fit: Tele-specialty coverage, RPM, pharmacy-enabled chronic care, AI-enabled triage/stroke, cybersecurity and analytics, value/payment modeling; supports NOFO categories A–K with compliance to caps/limits.

2. Eligibility and RFP Fit 2.1 Snapshot of NOFO Requirements

- Eligibility: Only the 50 U.S. States; DC and Territories ineligible. Governor-designated lead agency; AOR must sign. One official application per State; latest timely submission counts. (files.simpler.grants.gov)
- Key dates: Webinars Sep 19 and 25, 2025; optional LOI Sep 30, 2025; application due Nov 5, 2025; awards Dec 31, 2025. Submission via Grants.gov. (files.simpler.grants.gov)
- Funding: ~$50B FY26–FY30; funds by period spendable through end of following FY; 50% baseline + 50% workload; workload factors: data-driven metrics, initiative-based, state policy actions. (files.simpler.grants.gov)
- Points and weights: Table 3 sets rural facility/population components (A.1–A.7) and technical factors (B.1–F.3) with fixed weights. (files.simpler.grants.gov)
- Application components and format: project narrative ≤60 pages; budget narrative ≤20; attachments include Governor's endorsement (≤4 pages), business assessment (≤12), program duplication assessment (≤5), other support (≤35); required forms SF-424, SF-424A, SF-LLL, Project/Performance Site; check "No" for SF-424 19c. (files.simpler.grants.gov)
- Funding policies and caps: Provider payments (Cat. B) ≤15%; capital/infrastructure (Cat. J) ≤20%; EMR replacement ≤5% if HITECH-certified EMR in place as of 9/1/2025; "Rural Tech Catalyst Fund"-like initiatives ≤ the lesser of 10% or

$20M per budget period; unallowable construction/expansion and limits under 2 CFR (including 200.216); specified sex-trait modification procedures under 45 CFR 156.400 excluded. Administrative expenses ≤10% of the State's annual allotment (indirect and direct). (files.simpler.grants.gov)

2.2 RFP Requirement → Collaborative Capability → Evidence (selected)

- Tele-enabled care and workforce support (uses A, D, F, G, I): Avel eCare 24/7 tele-hospitalist/tele-ER/tele-ICU/tele-pharmacy services; supports CAH stabilization and right-sizing service lines. Evidence: Collaborative profile.
- Remote monitoring for chronic disease (A, C, F, I): BioIntelliSense FDA-cleared BioButton with AI-based exception management; reporting aligns to technical factors (B.1, F.1-F.3). Evidence: Collaborative profile.
- Consumer-facing screening and pharmacy integration (A, C): Retail pharmacy partners and tools (e.g., Walgreens, CVS, Higi) for BP, diabetes risk, medication reconciliation; adherence/readmission improvements cited in partner materials. Evidence: Collaborative profile.
- AI-enabled acute triage (A, I): Viz.ai stroke/critical condition detection supporting faster definitive care. Evidence: Collaborative profile.
- Cybersecurity and data platform (F, F.2, F.3): Azure-based security, analytics, and privacy controls; supports statewide dashboards and reporting. Evidence: Collaborative profile.
- Systems integration, PMO, and value/payments (E.1, I): Accenture/KPMG/PwC provide program management, payment integrity, analytics and value model design aligned to NOFO reporting and evaluation. Evidence: Collaborative profile.

3. Michigan Context Snapshot 3.1 Rural/population and facilities (most recent available)

- Rural population share: 26.5% (2020; Census county-based metric summarized by NCSL). (ncsl.org)
- Nonmetro population: 16.6% (ACS 2019–2023 5-year estimate). (ruralhealthinfo.org)
- Facilities (as of July–Sep 2025): 35 CAHs; 213 RHCs; 1 REH; 146 FQHC service sites outside major urban areas (RHIHub/HRSA data snapshot). (ruralhealthinfo.org)
- Health center awardees: 39 reporting program awardees; 683,234 patients (2024 UDS). (data.hrsa.gov)
- Hospital financial stress: nearly half of Michigan's rural hospitals operating at a loss (2024 Chartis analysis reported by Axios Detroit). (axios.com)

3.2 Medicaid policy context

- Section 1115 Reentry Services Demonstration approved 12/27/2024 (effective through 12/31/2029), supporting transitions from carceral settings. (medicaid.gov)
- Flint 1115 Demonstration effective through 9/30/2026. (medicaid.gov)
- Michigan's Medicaid program largely uses comprehensive managed care via Medicaid Health Plans; RHT funds can support analytic infrastructure and state-directed innovations with appropriate authorities (non-duplicative of claims). (files.simpler.grants.gov)

3.3 Needs-to-capabilities table (excerpt)

- Long travel times, remote locales (UP, Northern LP) → Tele-hospitalist/tele-ER/tele-ICU coverage; stroke AI triage; tele-behavioral health. Evidence: Collaborative materials (Avel eCare; Viz.ai).
- Chronic disease burden and adherence gaps → RPM (BioIntelliSense); retail pharmacy engagement for BP/diabetes; care navigation apps.
- Small provider scale and workforce shortages → Regional High Value Networks (Cibolo) and ambient documentation/cyber platforms to increase capacity.
- Data fragmentation and reporting → Cloud analytics, dashboards, and secure exchange supporting NOFO evaluation metrics.

4. Strategy Aligned to RFP 4.1 Model overview A statewide, regionally governed Rural High-Value Care Network linking CAHs, RHCs, FQHCs, REH(s), county EMS, and retail pharmacy nodes can support right-sizing service lines, rapid specialty access, chronic disease management at home, and secure data sharing. This aligns with approved uses (A, C, D, F, G, H, I, J, K) and Table 3 technical factors (B.1–F.3), with compliance to funding caps. (files.simpler.grants.gov)

4.2 Mapping RHT pillars to Collaborative capabilities (illustrative)

- Make rural America healthy again: Consumer screening + RPM + pharmacy management + tele-specialty follow-up.

Evidence: Collaborative portfolio.

- Sustainable access: Tele-hospitalist and hub-and-spoke specialist channels keep patients local; load-balanced coverage across CAHs/RHCs; facility right-sizing.
- Workforce development: Ambient clinical documentation; tele-mentoring; pharmacist top-of-license approaches; recruitment supports.
- Innovative care and payment: Analytics to model shared-savings and episode logic; claims/payment integrity; SPA/plan alignment (non-duplicative).
- Tech innovation: Cyber hardening; HIPAA/FHIR-based data fabric; patient-facing tools; statewide dashboards.

4.3 Equity strategy Use HRSA health center footprint and pharmacy footprints to expand access in high-need rural tracts; add multilingual intake/triage and CHW supports; apply dashboards with county-level targets to monitor access, quality, and outcomes with stratification by geography and payer.

4.4 Data and privacy Adopt HIPAA/FHIR-based architecture with role-based access, audit trails, and secure APIs; use de-identified and limited datasets for analytics consistent with 2 CFR and HHS GPS; align to NOFO reporting cadence. (files.simpler.grants.gov)

5. Program Design Options (Michigan-tuned) Option A. Rural High Value Network (HVN) for the UP and Northern LP

- Target: All CAHs, RHCs, and proximate FQHCs across ~30–40 northern/UP counties.
- Problem: Financial losses for many rural hospitals; gaps in 24/7 specialty coverage; costly transfers. (axios.com)
- Collaborative components: Avel eCare (tele-hospitalist/tele-ER/tele-ICU/tele-pharmacy), Viz.ai acute detection, BioIntelliSense RPM, Microsoft cyber/data platform; Cibolo Health HVN governance.
- Payment logic: Global network operational supports funded under uses A, D, F, G, I; limited provider payments within 15% cap for non-reimbursable gap-fills; capital (J) ≤20% for minor retrofits; observe EMR ≤5% limit. (files.simpler.grants.gov)
- Enabling policy: Strengthen EMS and licensure compact participation; initiative points under C.2 and D.2 where applicable. (files.simpler.grants.gov)
- Pros/risks: Pros—keeps patients local; improves bed coverage; measurable transfer reductions. Risks—procurement/integration timing; workforce adoption. Mitigations—system integrator PMO; phased deployment.

Option B. Statewide Pharmacy-Enabled Hypertension/Diabetes Control

- Target: Adults with uncontrolled HTN/diabetes seen at RHCs/FQHCs and retail pharmacy sites.
- Problem: Rural adherence gaps; readmission risk; travel barriers.
- Collaborative components: Pharmacy-based BP checks, MTM, lab draws, navigation; integration with primary care and telehealth; cited adherence/readmission improvements.
- Payment logic: Uses A, C; limited B-category provider payments for gap-fill services not otherwise reimbursable; analytics on outcomes and spend. (files.simpler.grants.gov)
- Pros/risks: Pros—broad access points; quick scale. Risks—data exchange and consent; mitigated via HIPAA/FHIR tooling and consent management.

Option C. Tele-EMS and Acute Neurology Network

- Target: Rural EMS agencies and CAHs/REH EDs.
- Problem: Delays to thrombolysis/thrombectomy; limited specialty availability.
- Components: Viz.ai notifications; tele-ER support; EMS tele-consult; transfer coordination.
- Payment logic: Uses A, F, G; EMS investments under technical assistance/IT advances; comply with capital and telecom restrictions. (files.simpler.grants.gov)

Option D. Reentry/Maternal-Behavioral Integration

- Target: Medicaid beneficiaries transitioning from carceral settings; prenatal/postpartum patients in rural counties.
- Rationale: Michigan's approved Reentry 1115 (12/27/2024) enables transition supports; tele-behavioral and care coordination close access gaps. (medicaid.gov)
- Components: Tele-behavioral health; CHW navigation; retail and clinic-based screening; data exchange for risk flags.

Primary recommendation: Option A (HVN) as anchor with Option B as parallel population-health accelerator; Options C and D as add-ons subject to budget caps and regional readiness.

6. Governance and Collaborative Roles 6.1 Structure (illustrative)

- State Lead Agency (MDHHS or Governor-designated office): Sponsor; compliance; reporting to CMS; funds flow oversight.
- Rural HVN Board (provider-owned): Strategy, investment approvals, performance oversight (Cibolo convening).
- PMO/System Integrator (e.g., Accenture/KPMG/PwC): Program management, value tracking, data model, vendor coordination.
- Clinical Network (CAHs, RHCs, FQHCs, REH, EMS): Service delivery; metrics reporting.
- Technology Partners (Microsoft, BioIntelliSense, Viz.ai, retail health): Platforms/services; cyber; device logistics; analytics.
- Payers (Medicaid MHPs; MA/Commercial): Value alignment and SPA/SOW coordination (no duplication).

6.2 RACI (condensed)

- CMS deliverables (NOFO narrative, budget, reporting): R—State; A—State; C—PMO, Collaborative; I—Providers. (files.simpler.grants.gov)
- Tele-specialty service activation: R—Providers; A—HVN; C—Avel eCare; I—State.
- RPM program: R—Providers; A—HVN; C—BioIntelliSense; I—State.
- Cyber/data platform: R—PMO/Tech; A—HVN; C—State; I—Providers.
- Pharmacy integration: R—Retail partners; A—HVN; C—FQHCs/RHCs; I—State.

7. Payment and Funding

- Allowable uses: at least three categories spanning prevention, provider payments (≤15%), consumer tech, training, workforce, IT/cyber, right-sizing service lines, BH/SUD, innovative care, minor capital (≤20%), and partnerships. EMR replacement ≤5% when conditions met. (files.simpler.grants.gov)
- Financial analytics and compliance: Use cloud analytics to tie budget lines to initiatives and NOFO categories; enforce admin ≤10% across direct/indirect; plan spend profiles across budget periods (carryover to following FY allowed). (files.simpler.grants.gov)

Table: Cost categories (illustrative), funding source, timing, Collaborative deliverables

- Tele-specialty services (Avel eCare): Uses A, G, I; BP1–BP2 ramp; deliverables: coverage schedules, transfer KPIs.
- RPM kits/services (BioIntelliSense): Uses A, C, F; BP1 pilots → BP2 scale; deliverables: device ops, dashboards.
- Pharmacy-enabled chronic care: Uses A, C; BP1 design → BP2–BP3 expansion; deliverables: MTM protocols, adherence KPIs.
- Cyber/data platform: Uses F; BP1 hardening, data model; deliverables: data pipelines, role-based access, reporting suite.
- Minor renovations/equipment: Category J, ≤20%, tied to tele rooms and device storage. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation

- Core measures: access (tele-response times, avoided transfers), quality (HTN control, diabetes A1c, stroke time-to-decision), utilization (ED admits/1000, readmissions), financial (operating margin, LOS), workforce (vacancy, time-to-hire), technology (system uptime, phishing click-rate), implementation (site activations, procurement cycle times).
- Data sources/integration: EHR (CAH/FQHC), pharmacy MTM, EMS run sheets, claims (Medicaid/MHP), HRSA UDS for FQHCs, program PMO data; HIPAA/FHIR exchange with privacy controls.
- Evaluation cadence: Quarterly dashboards and annual reports feeding NOFO continuation decisions; third-party evaluation cooperation per NOFO. (files.simpler.grants.gov)

9. Implementation Plan (12–24 months; indicative) Gantt-style table (quarters approximate from award date Dec 31, 2025)

- Workstream | Start | End | Owner | Outputs
- PMO mobilization, governance, compliance | Q1 FY26 | Q2 FY26 | State/PMO | Charter, risk plan, reporting templates.
- Cyber posture assessment & data architecture | Q1 FY26 | Q3 FY26 | Tech partner | Security plan, data model.
- Tele-specialty stand-up (cohorts 1–2) | Q2 FY26 | Q1 FY27 | Avel eCare/HVN | Coverage SLAs, activation checklists.
- RPM pilots (CHF/COPD/DM) | Q2 FY26 | Q4 FY26 | Providers/BioIntelliSense | Enrolled panels, exception rules.

- Pharmacy-enabled HTN/DM program | Q3 FY26 | Q2 FY27 | Retail/FQHC/RHC | MTM workflows; data tie-ins.
- Evaluation and scale decisions (gating) | Q4 FY26 | Q1 FY27 | State/HVN | Scale plan, budget alignment to caps. (files.simpler.grants.gov)

10. Risk Register (top 10)

- Procurement delays (Owner: PMO). Mitigation: pre-negotiated templates; phased awards.
- Workforce adoption/turnover (Owner: Providers). Mitigation: ambient scribe tools; tele-mentoring; training tracks.
- Cyber incident risk (Owner: Tech partner/HVN). Mitigation: zero-trust, MDR/SOC, tabletop exercises.
- Data-sharing hesitancy (Owner: HVN). Mitigation: HIPAA/FHIR contracts; consent tooling; role-based access.
- Funding cap breaches (Owner: PMO/State). Mitigation: cap trackers for B/J/EMR/"catalyst" funds. (files.simpler.grants.gov)
- Duplicative payment risk (Owner: State/PMO). Mitigation: claims crosswalks; B-category guardrails. (files.simpler.grants.gov)
- Vendor integration friction (Owner: PMO/Tech). Mitigation: reference architectures; interface SLAs.
- Rural site readiness variance (Owner: HVN). Mitigation: cohorts; surge TA to late sites.
- Policy commitments slip (Owner: State). Mitigation: policy workplan with 2027/2028 checkpoints; escalate per NOFO. (files.simpler.grants.gov)
- Hospital financial deterioration (Owner: HVN/Providers). Mitigation: monthly dashboards; tele-coverage expansion triggers.

11. Draft RFP Response Language (Michigan-tailored excerpts) 11.1 Rural Health Needs & Target Population (Project Narrative) Michigan's rural residents constituted 26.5% of the population in 2020; nonmetro areas accounted for 16.6% (ACS 2019–2023). The State's rural delivery system includes 35 CAHs, 213 RHCs, one REH, and 39 HRSA health center awardees who reported 683,234 patients in 2024. Financial pressure remains significant, with nearly half of rural hospitals operating at negative margins. These indicators justify a statewide approach prioritizing the Upper Peninsula and Northern Lower Peninsula while maintaining equitable access in all rural regions. (ncsl.org)

11.2 Goals & Strategies Michigan proposes a Rural High Value Network to improve access, outcomes, and sustainability through: (1) tele-specialty coverage for CAHs and RHCs; (2) RPM for chronic disease and post-discharge care; (3) pharmacy-enabled MTM and adherence supports; (4) secure data, analytics, and cyber hardening; and (5) value analytics and payment modeling. Capabilities are provided by the RHT Collaborative, subject to State contracting and interoperability with existing assets.

11.3 Proposed Initiatives & Use of Funds We will address at least three NOFO use-of-fund categories (A, C, D, F, G, I, J), with explicit adherence to caps: provider payments ≤15%, Category J ≤20%, EMR replacement ≤5% under NOFO conditions, and "catalyst"-like initiatives ≤ the lesser of 10% or $20M per budget period. We will not fund prohibited activities (e.g., construction/expansion, covered telecom per 2 CFR 200.216, specified procedures under 45 CFR 156.400). (files.simpler.grants.gov)

11.4 Implementation Plan & Timeline A phased 24-month plan includes PMO and governance activation; cyber/data architecture; tele-specialty cohorts; RPM pilots; pharmacy integration; and evaluation gates tied to continuation decisions.

11.5 Metrics & Evaluation We will report quarterly on access, quality, utilization, financial, workforce, technology, and implementation metrics; cooperate with CMS/third-party evaluators; and maintain a privacy-preserving, HIPAA/FHIR-based data environment.

11.6 Compliance Checklist (embedded)

- SF-424, SF-424A, SF-LLL, Project/Performance Site forms completed; SF-424 item 19c marked "No." Page limits and formatting observed: narrative 60pp, budget 20pp, attachments per NOFO. Admin costs ≤10%. Caps tracked for B/J/EMR/"catalyst." (files.simpler.grants.gov)

12. References

1. Rural Health Transformation (RHT) Program — NOFO (CMS-RHT-26-001), CMS/HHS, files.simpler.grants.gov, posted Sep 15, 2025, accessed Oct 14, 2025. https://files.simpler.grants.gov/... (See: funds distribution; dates; caps; Table 3 weights; application format; EO 12372). (files.simpler.grants.gov)
2. Rural Health Transformation — CMS Program Page, last modified Sep 26, 2025, accessed Oct 14, 2025. https://www.cms.gov/... (cms.gov)
3. Michigan rural population share, 2020 (U.S. Census county-based summary), National Conference of State

Legislatures, accessed Oct 14, 2025. https://www.ncsl.org/... (ncsl.org)
4. Rural Health for Michigan Overview, Rural Health Information Hub (facility counts, nonmetro share), last updated Sep 11, 2025, accessed Oct 14, 2025. https://www.ruralhealthinfo.org/states/michigan (ruralhealthinfo.org)
5. HRSA UDS State Data — Michigan (awardees and patients, 2024), accessed Oct 14, 2025. https://data.hrsa.gov/tools/data-reporting/program-data/state/MI (data.hrsa.gov)
6. Axios Detroit—Nearly half of Michigan's rural hospitals in the red (citing Chartis), May 20, 2024, accessed Oct 14, 2025. https://www.axios.com/local/detroit/... (axios.com)
7. Michigan Section 1115 Reentry Services Demonstration — CMS Medicaid, approval 12/27/2024, accessed Oct 14, 2025. https://www.medicaid.gov/... (medicaid.gov)
8. Flint Michigan Section 1115 Demonstration — CMS Medicaid (effective through 9/30/2026), accessed Oct 14, 2025. https://www.medicaid.gov/... (medicaid.gov)
9. HRSA — Allocation to Rural Health Clinics for COVID-19 Testing (state RHC counts; context), reviewed Mar 2022, accessed Oct 14, 2025. https://www.hrsa.gov/... (hrsa.gov)
10. RHT Collaborative Consensus Document (October 2025 release), Rural Health Transformation Collaborative, internal catalog of capabilities and partners, accessed Oct 14, 2025.
11. Avel eCare profile (tele-hospitalist/tele-ICU/ER/pharmacy), RHT Collaborative consensus.
12. BioIntelliSense profile (BioButton RPM), RHT Collaborative consensus.
13. Viz.ai profile (AI acute detection), RHT Collaborative consensus.
14. Microsoft cloud/cyber/data platform profile, RHT Collaborative consensus.
15. Walgreens population-health and MTM profile, RHT Collaborative consensus.
16. Systems integrators and PMO capabilities (Accenture/KPMG/PwC), RHT Collaborative consensus.

Assumptions and Open Questions

- NOFO document used is the publicly posted CMS-RHT-26-001_final.pdf on Simpler.Grants.gov; if CMS posts an amended version, factors/caps or dates could update and should be re-validated before submission. (files.simpler.grants.gov)
- CCBHC list as of Sep 1, 2025: SAMHSA/MDHHS authoritative lists should be appended in the State's application; counts/sites are not included here. (To be validated against SAMHSA grantee and certification data.)
- HPSA counts by discipline are not quoted herein to avoid stale figures during the federal website update pause; the State can insert the latest HRSA HPSA designations from data.hrsa.gov in the application attachments.

Compliance Checklist (for alignment; not prescriptive about internal State steps)

- Eligibility confirmed (State applicant; Governor letter; AOR). (files.simpler.grants.gov)
- Dates and submission channel verified (LOI, due date, Grants.gov). (files.simpler.grants.gov)
- Narrative and budget page limits and formats met; attachments complete. (files.simpler.grants.gov)
- Funding caps tracked (B ≤15%; J ≤20%; EMR ≤5%; "catalyst" ≤10% or $20M); admin ≤10%. (files.simpler.grants.gov)
- No duplication/supplanting; 2 CFR 200.216 telecom/video surveillance restrictions; EO 12372 marked "No." (files.simpler.grants.gov)

Gantt-Style View (summary)

- Q1 FY26: PMO/governance; cyber assessment; data model.
- Q2 FY26: Tele-specialty cohort 1; RPM initial cohorts; pharmacy program design.
- Q3 FY26: Tele-specialty cohort 2; pharmacy program launch; dashboards live.
- Q4 FY26: Mid-year evaluation; budget alignment; plan BP2 scale.

AI Generation Notice This guide was generated with the gpt-5 model on 2025-10-14. It is AI-generated content. Please independently validate all facts, figures, and citations—especially program terms, caps, dates, and Michigan-specific metrics—before relying on or submitting this material.