# Rural Health Transformation Grant Guide — Colorado

**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

Colorado can leverage the Rural Health Transformation (RHT) Program to stabilize rural facilities, extend high-value primary and specialty care statewide, and modernize digital infrastructure while aligning with Medicaid delivery reforms underway in the Accountable Care Collaborative (ACC) Phase III. The Collaborative's members can support Colorado with virtual specialty and emergency coverage for rural hospitals and clinics; continuous monitoring for chronic and post-acute care; and secure cloud, interoperability, and cybersecurity services—subject to State procurement, contracting, and integration decisions.

The RHT NOFO makes up to $50B available FY26–FY30 via cooperative agreements to States only, with 50% distributed equally and 50% awarded by a points-based workload formula recalculated each budget period (technical factors) and fixed once for rural facility/population factors (Q4 2025). Applications are due November 5, 2025; awards by December 31, 2025. (files.simpler.grants.gov)

Fit with Colorado's landscape is strong. ACC Phase III launched July 1, 2025, with Regional Accountable Entities (RAEs) responsible for behavioral health capitation, primary care networks, and care coordination—platforms that can align with RHT initiatives and reporting. (hcpf.colorado.gov)

Highest-leverage offerings for early statewide impact include: 24/7 tele-ER/ICU/hospitalist support for rural facilities; remote physiologic monitoring and exception-based care management; HIPAA/FHIR-conformant data platforms with cybersecurity hardening and analytics; and formation of rural provider High Value Networks (HVNs) to coordinate shared services and value-based models—each to be tailored to Colorado's priorities and subject to contracting and integration.

One-page printable summary (for distribution)

- Eligibility and timeline: States only; LOI Sep 30, 2025; app due Nov 5, 2025; awards Dec 31, 2025. 50% baseline equal; 50% workload via rural factors + technical factors. Admin cap ≤10%. Key use-of-funds caps: Provider payments ≤15%; Capital (Cat. J) ≤20%; EMR replacement ≤5%; "Rural Tech Catalyst Fund" ≤ the lesser of 10% or $20M/budget period. (files.simpler.grants.gov)
- What Colorado can prioritize with the Collaborative (examples, subject to State decisions):
    - Tele-specialty, tele-ER/ICU, and behavioral crisis support to keep care local.
    - Remote monitoring for chronic disease and post-discharge care.
    - Secure cloud, data exchange, analytics, and cybersecurity uplift.
    - Rural provider HVNs for shared services and value-based arrangements.
- Colorado context to anchor initiatives:
    - ACC Phase III RAEs and two physical-health capitation plans launched July 1, 2025. (hcpf.colorado.gov)
    - Health centers served 648,045 patients in 2024 (HRSA UDS), supporting preventive and primary care access. (data.hrsa.gov)
    - State receiving $826.5M in BEAD; proposed mix includes fiber and low-earth-orbit satellite deployments, relevant to telehealth access. (oit.colorado.gov)

# 2. Eligibility and RFP Fit

## 2.1 NOFO snapshot (selected requirements)

- Eligible applicants: Only the 50 States; DC and territories ineligible. Governor designates the lead agency; one official application per State; latest on-time submission counts. (files.simpler.grants.gov)
- Key dates: Webinars Sep 19 and 25, 2025; optional LOI Sep 30, 2025; application due Nov 5, 2025; expected awards Dec 31, 2025 (earliest start Dec 31, 2025). (files.simpler.grants.gov)
- Funds distribution: ~$50B FY26–FY30; each year's funds spendable through end of the following fiscal year. 50% baseline equal split; 50% workload by points. Workload recalculated each period for technical factors; rural facility/population factors fixed using Q4 2025 data. (files.simpler.grants.gov)
- Scoring weights: Table 3 assigns 50% to rural facility/population and 50% to technical factors with specified weights (e.g., A.1 rural population 10%; F.1 remote care services 3.75%). (files.simpler.grants.gov)

- Application contents and page limits: Project summary (1p); Project narrative (≤60 pages, 12-pt, double-spaced main text); Budget narrative (≤20 pages, single-spaced); Attachments include Governor's endorsement (≤4 pages), business assessment (≤12 pages), program duplication assessment (≤5 pages), and others. Required forms: SF-424, SF-424A, SF-LLL, Project/Performance Site Location(s). (files.simpler.grants.gov)
- Compliance checkpoints: Check "No" on SF-424 Item 19c (Executive Order 12372 not applicable). Cybersecurity plan required if project accesses HHS systems and handles HHS PII/PHI. Annual NCC apps due ~60 days before each period end; standard HHS grants rules (2 CFR Part 200/Part 300 and HHS GPS) apply. (files.simpler.grants.gov)
- Funding policies and limits (program-specific + 2 CFR): Administrative expenses ≤10% of the amount allotted per budget period; provider payments ≤15%; capital & infrastructure (Cat. J) ≤20%; EMR replacement ≤5% if a HITECH-certified EMR was already in place as of 9/1/2025; "Rural Tech Catalyst Fund"-like initiatives ≤ the lesser of 10% or $20M/budget period; prohibition on certain cosmetic/experimental services (45 CFR 156.400); restrictions on covered telecom/video surveillance (2 CFR 200.216); no construction/expansion as direct costs; no supplanting; no lobbying with Federal funds. Noncompliance can trigger funding recovery and loss of points (policy commitments must be enacted by 12/31/2027, or by 12/31/2028 for factors B.2 and B.4). (files.simpler.grants.gov)

### 2.2 Requirement-to-capability mapping (illustrative)

- Examples below show how Collaborative capabilities can support, not dictate, Colorado's choices. All activities remain subject to State priorities, procurement, contracting, and integration.

Requirement → Collaborative capability → Evidence

- 24/7 specialty coverage to sustain local access (Use-of-funds A, H, I) → Tele-ER/ICU/hospitalist and behavioral crisis support for rural facilities → Avel eCare model and experience with rural settings.
- Chronic disease prevention/management at scale (A, C, F, H) → Remote patient monitoring with clinical exception dashboards; retail/community screenings; multilingual triage tools → BioIntelliSense BioButton system; Higi/Topcon/Humetrix; population analytics.
- Data interoperability and cybersecurity (F) → HIPAA/FHIR-based cloud data platform; TEFCA-aligned exchange; security hardening and monitoring → Microsoft cloud, analytics, cybersecurity programs deployed with rural hospitals.
- Value-based models and payment integrity (I, E.1) → Design and analytics for APMs; claims modernization, prior authorization and quality gap analytics → Accenture/KPMG/PwC analytics; Pangaea Data for closing care gaps.
- Strategic partnerships and governance (K) → Provider-owned High Value Networks to pool shared services and align incentives → Cibolo Health HVN model.

## 3. Colorado Context Snapshot

This section highlights verifiable 2024–2025 facts that can anchor State-selected initiatives; precise values will guide final targeting and evaluation.

- Medicaid delivery: ACC Phase III launched July 1, 2025. RAEs coordinate primary care networks, administer capitated behavioral health, and support care coordination; two physical-health MCOs operate in specified areas. These functions can align with RHT reporting, incentive design, and network development. (hcpf.colorado.gov)
- Health center access: HRSA Uniform Data System reports 648,045 patients served by Colorado health centers in 2024 (10% ages 65+, 70.11% racial/ethnic minority), underscoring the central role of FQHCs for rural and underserved populations. (data.hrsa.gov)
- Critical Access Hospitals: Colorado's CAH presence is documented by HRSA's Flex Monitoring Team; the CAH Locations list was updated July 11, 2025. (flexmonitoring.org)
- Workforce shortages: Colorado includes multiple Primary Care, Dental, and Mental Health HPSA designations; HRSA dashboards reflect updates through October 2025 (state-level counts can be pulled directly for the application narrative and targeting). (data.hrsa.gov)
- Broadband and telehealth enabler: Colorado is receiving $826.5M in BEAD funding (Office of Information Technology, Sept. 13, 2024). In Sept. 2025, the State published proposed BEAD awards indicating a fiber and low-Earth-orbit satellite mix—relevant to remote care reliability in frontier areas. (oit.colorado.gov)
- State broadband goal: Connect 99% of households to high-speed broadband by end of 2027 (Colorado Broadband

Office). (broadband.colorado.gov)

- ACC alignment resources: RAE deliverables and performance oversight processes exist and can be extended to RHT reporting. (hcpf.colorado.gov)

Table 1. Illustrative Colorado metrics to target and monitor

- Metric (year) → Source → Matching Collaborative capability
- 648,045 health center patients (2024) → HRSA UDS → Community-linked RPM, tele-consults, and patient engagement to reduce avoidable ED and readmissions. (data.hrsa.gov)
- ACC Phase III go-live (2025) → HCPF → Align RHT incentives and dashboards with RAE performance, care coordination, and network adequacy. (hcpf.colorado.gov)
- BEAD award size $826.5M (2024) and proposed technology mix (2025) → OIT/CBO → Prioritize remote-care workflows and device connectivity in BEAD-funded areas. (oit.colorado.gov)
- Active CAH network (2025 update) → Flex Monitoring Team → Tele-ER/ICU support, pharmacy/antimicrobial stewardship, and transfer-avoidance pathways. (flexmonitoring.org)
- State HPSA designations (data as of Oct 2025) → HRSA dashboards → RHT workforce initiatives (scholarships/loan-linked rural service, virtual supervision, compacts). (data.hrsa.gov)

Assumptions and Open Questions (to be finalized by the State in the application)

- Precise counts of Colorado CAHs, RHCs, and DSH hospitals; list of certified CCBHCs as of Sep 1, 2025; and county-level HPSA counts will be extracted from authoritative sources (HRSA, HCPF, CDHS/SAMHSA) during final narrative assembly. The NOFO requires including the CCBHC list and DSH hospital counts in the application. (files.simpler.grants.gov)

## 4. Strategy Aligned to RFP

- Purpose-aligned model: Build a Rural Access and Continuity "backbone" that strengthens primary care, keeps patients local through tele-specialty/tele-ER and remote monitoring, and modernizes cybersecurity, data exchange, and analytics—implemented through RAEs and provider HVNs, and evaluated against NOFO technical factors.
- Uses of funds alignment (selected):
    - A (Prevention/chronic disease): Consumer screenings + RPM + pharmacist-enabled management; multilingual triage and engagement.
    - F (IT/cybersecurity): HIPAA/FHIR cloud platform, security hardening, identity and access management; data pipelines for statewide dashboards.
    - H (Behavioral health): 24/7 tele-behavioral, crisis consults, and virtual co-management pathways.
    - I (Innovative care): Value-based arrangements/ shared services via HVNs; analytics for attribution, quality, and payment integrity.
- Equity strategy: Target frontier and high-ruggedness areas per HRSA's 2025 rural definition updates; leverage RAEs and FQHCs for outreach; deploy multilingual apps; and include Tribal partners in BEAD-enabled telehealth corridors—subject to Tribal consultation. (hrsa.gov)
- Data/privacy: Use HIPAA/FHIR-conformant cloud, identity governance, and audit tooling; when applicable, TEFCA-aligned exchange and Blue Button data for patient-authorized views; adhere to 2 CFR Part 200/300 and HHS GPS. (files.simpler.grants.gov)

## 5. Program Design Options (Colorado-tuned; State may select and phase)

Option A: Rural High Value Networks (HVNs) + Tele-Specialty Spine

- Target: CAHs and rural clinics across Eastern Plains, San Luis Valley, Western Slope.
- Problem: Staffing constraints and transfer leakage increase cost and reduce access.
- Services: Avel virtual hospital services (tele-ER/ICU/hospitalist), centralized e-pharmacy; HVN shared services (coding, quality, cybersecurity, analytics); referral pathways with RAEs.
- Payment logic: Global/shared-savings pilots for HVN members; RAE-aligned incentives (E.1).

- Pros/risks: High impact on avoidable transfers; risk—facility change management; mitigation via on-site and virtual training.

Option B: Remote Care for Cardio-metabolic Disease

- Target: Medicaid, duals, and uninsured patients with hypertension/diabetes.
- Services: RPM (BioIntelliSense), pharmacy-enabled coaching, retail screenings (Higi/Topcon), multilingual triage (Humetrix), and RAE care coordination.
- Payment logic: Blended PMPM + performance incentives; ≤15% provider-payment cap observed. (files.simpler.grants.gov)

Option C: Behavioral Health Access Expansion

- Target: Rural communities with MH/SUD HPSA designations.
- Services: 24/7 tele-behavioral consults; virtual crisis co-response and 988 integration; medication safety/WhatMeds alerts; RAE network coordination.

Option D: Cyber-secure Interoperability and Analytics

- Target: Rural facilities lacking modern data exchange/security.
- Services: Cloud foundation, identity/access, interoperability, statewide dashboards; align with BEAD buildouts for connectivity. (oit.colorado.gov)

## 6. Governance and Collaborative Roles

- Structure: State lead agency (Governor-designated) holds the cooperative agreement; HCPF/Medicaid integrates with RAEs; statewide Program Management Office (PMO) coordinates procurements, data, and evaluation; HVNs provide provider-owned governance for shared services; Collaborative partners support defined scopes subject to contracts. (files.simpler.grants.gov)

RACI (illustrative)

- Responsible: PMO (tracking, dashboards), RAEs (care coordination), HVNs (shared services), vendor partners (solution delivery).
- Accountable: State lead agency designated by Governor; HCPF for Medicaid-aligned levers.
- Consulted: Hospital association, FQHCs/PCA, BHA/IHCP, EMS, Tribal/IHS, payers, broadband office.
- Informed: Legislature, consumer groups, local public health.

## 7. Payment and Funding

- Pathways consistent with NOFO caps:
    - Direct provider payments across initiatives capped at 15% of annual award. (files.simpler.grants.gov)
    - Capital/infrastructure (Cat. J) ≤20%; EMR replacement ≤5% (if HITECH-certified EMR in place as of 9/1/2025). (files.simpler.grants.gov)
- Medicaid alignment opportunities (subject to State legal review): align RHT quality/outcomes with ACC Phase III measures; SPA updates for remote care services (F.1) and pharmacist services (scope dependent); contract-based incentives through RAEs. (hcpf.colorado.gov)

Table 2. Illustrative cost categories and deliverables (subject to award amount and caps)

- Tele-specialty network: clinician coverage, tele-ICU tech, training → service-line stabilization metrics.
- RPM kits/services: devices, logistics, monitoring → reduced readmissions/ED use.
- Cloud/interoperability/cyber: subscriptions, implementation, security ops → uptime, incident rate, data-sharing metrics.
- Program management/evaluation: PMO staffing, analytics, reporting → NCC and FFR deliverables, technical score progress. (files.simpler.grants.gov)

## 8. Data, Measurement, and Evaluation

- Core measures: access (time-to-specialist via telehealth), utilization (avoidable transfers), quality (chronic control rates), financial (total cost trends), workforce (vacancy/turnover), technology (uptime, cyber incidents), implementation milestones (per NOFO Table 2). (files.simpler.grants.gov)
- Data sources/integration: Medicaid/RAE claims and encounter, EHR feeds, HRSA UDS where applicable, device telemetry, HIE/TEFCA gateways, patient-reported data; privacy and security per HHS rules. (files.simpler.grants.gov)
- Reporting cadence: Progress, FFR/FFATA/SAM/PMS/audit, NCC ~60 days before each period end; cybersecurity plan if handling HHS PII/PHI and accessing HHS systems. (files.simpler.grants.gov)

## 9. Implementation Plan (12–24 months; subject to State procurement)

Gantt-style table (illustrative)

- Workstream | Start | End | Owner | Outputs
- Program mobilization & governance | Jan 2026 | Mar 2026 | State PMO | Charter, RACI, stakeholder plan.
- Tele-specialty onboarding (Wave 1 CAHs) | Feb 2026 | Sep 2026 | HVN + vendor | 24/7 coverage live; transfer metrics baseline.
- RPM cohort launch (diabetes/HTN) | Apr 2026 | Dec 2026 | FQHCs/RAEs + vendor | 1,000 enrollees; adherence dashboards.
- Cloud/cyber platform build | Jan 2026 | Aug 2026 | State IT + vendor | Data lake, identity, logging; cyber controls.
- Behavioral tele-consults & virtual crisis | May 2026 | Nov 2026 | RAEs + vendor | Response SLAs; diversion metrics.
- Evaluation baseline & dashboards | Jan 2026 | Jun 2026 | PMO + advisors | Table 2 scoring alignment; NCC pack. (files.simpler.grants.gov)

Procurement/legal (to enable timely onboarding): Grants.gov submission, SF-424 NO on 19c; subaward T&Cs with Federal flow-down; BAAs/DPAs; verification of 2 CFR 200.216 telecom restrictions; adherence to NOFO caps. (files.simpler.grants.gov)

## 10. Risk Register (selected)

- Connectivity gaps delay remote care adoption; mitigate by sequencing deployments in BEAD-funded corridors; owner: PMO + CBO liaison. (oit.colorado.gov)
- Workforce burnout limits uptake; mitigate via tele-mentoring and ambient documentation tools; owner: RAEs + providers.
- Cyber incidents; mitigate via cloud security controls, monitoring, playbooks; owner: State IT + partners.
- Policy commitments slip beyond NOFO deadlines (12/31/2027 or 12/31/2028 for B.2/B.4); mitigate with legislative calendar and contingency designs; owner: State lead. (files.simpler.grants.gov)
- Overuse of provider payments beyond 15% cap; mitigate with budget gating; owner: PMO finance. (files.simpler.grants.gov)
- Capital spend exceeds 20% cap; mitigate by phasing and categorization; owner: PMO finance. (files.simpler.grants.gov)
- EMR replacement spend approaches 5% cap; mitigate via targeted upgrades; owner: CIO council. (files.simpler.grants.gov)
- Duplication with existing programs; mitigate via program duplication assessment SOP; owner: PMO compliance. (files.simpler.grants.gov)
- Data-sharing/legal delays; mitigate via template BAAs and RAE agreements; owner: legal/RAEs. (hcpf.colorado.gov)
- Non-compliance with HHS reporting; mitigate via calendars, automated extracts; owner: PMO. (files.simpler.grants.gov)

## 11. Draft RFP Response Language (Colorado-ready boilerplate; to tailor)

- Rural Health Needs & Target Population (excerpt) “Colorado’s rural communities face access and workforce constraints that contribute to avoidable transfers and delayed specialty care. Under ACC Phase III, RAEs coordinate primary and behavioral networks statewide. This plan proposes targeted initiatives—subject to contracting and integration—to deploy tele-specialty coverage for CAHs and rural clinics, remote monitoring for high-risk cardio-metabolic patients, and a secure, HIPAA/FHIR-based data platform with cybersecurity controls to support RHT reporting and evaluation.” (hcpf.colorado.gov)
- Goals & Strategies (excerpt) “Colorado will align program-level objectives with RHT technical factors, including F.1 remote care services, F.2 data infrastructure, C.1 strategic partnerships, and E.1 payment incentives, and will document baselines/targets through FY31.” (files.simpler.grants.gov)
- Use of Funds and Caps (excerpt) “Spending will adhere to NOFO limits, including administrative ≤10%, provider payments ≤15%, capital (Cat. J) ≤20%, EMR replacement ≤5% with prior HITECH-certified systems as of 9/1/2025, and any rural tech catalyst-type activities ≤ the lesser of 10% or $20M per budget period.” (files.simpler.grants.gov)
- Implementation & Reporting (excerpt) “Colorado commits to standard HHS post-award reporting (progress, FFR, FFATA, SAM/PMS/audit) and to submitting annual NCC applications ~60 days before each budget period end. A cybersecurity plan will be completed if the project accesses HHS systems and handles HHS PII/PHI.” (files.simpler.grants.gov)

## 12. References


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## 13. AI Generation Notice

This guide was generated by the gpt-5 model on 2025-10-14. It includes content synthesized from the CMS RHT NOFO, Colorado state sources, HRSA data, and the Rural Health Transformation Collaborative's internal consensus document. All facts, figures, and citations must be independently validated by the State before use in any official submission.