Strengthening Health Care and Mitigating Medicaid Cuts: Funding Strategies for the Rural Health Transformation Program (RHTP)

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Welcome and Introductions

Michael Paddock:

Hello everyone, and thanks for joining us for Strengthening Health Care and Mitigating Medicaid Cuts: Funding Strategies for the Rural Health Transformation Program. I'm Michael Paddock, CEO of Grants Office, and I want to welcome everyone to today's session. We've got a great session for you today, talking about the Rural Health Transformation Program, or RHTP. Many of you have heard of it, I'm sure, and are aware of it, and we're going to be diving into it. Before we get too far into it, I want to very much thank our sponsor, Ingram Micro, for sponsoring today's session and making it possible for us to bring you this information.

Also, I've got a few housekeeping items for you. First of all, as many of you know, this session is being recorded, and the replay will be available for you tomorrow, so keep an eye out for that. Ashley will be putting a number of helpful notes in the chat, including how to access the replay and other materials. You can ask questions at any time using the chat interface at the bottom right-hand corner of your screen. If you don't see it, look for the chat down there. If you don't see that, click on the three dots, and you should be able to pull up the chat interface that way. If you have any audio issues, you can go to the audio-video menu at the top of your screen to find alternative ways to connect to the audio portion of today's session. Okay, I think that about covers it.

So let's jump right in. We've got a great session, as I mentioned, for you today. We're joined by Mike Clark, Rural Health Technology Strategist at Ingram Micro; Emily Nolan, Senior Program Manager at Ingram Micro; Chris LaPage, our trusted Chief Services Officer here at Grants Office; and, of course, me. My picture's not usually on these, but we got new headshots, so I guess we're adding them on. Happy to have this great panel with us today, and we're going to be learning a lot over the next 60 minutes.

So today we're going to be talking about, as I mentioned, the RHTP program: exploring fundable technology for rural providers; looking specifically into the RHTP program to understand it, to get a

better sense of what it is and how the funds are being distributed; and then, along those lines, looking at how states are distributing that funding — being a pass-through program, the state involvement is very important to how RHTP is being administered; thoughts on building a competitive application; and engaging with the Ingram Micro grants support program — resources that you can access to help you navigate the RHTP program, at no cost to you, to help you better leverage the funding that's available. And then we'll get to Q&A with the time that remains. All your questions, again — send them through the chat, and we'll get to as many as we can over the course of the next hour, to the top of the hour. Great, so we're going to start with Mike Clark talking with us about exploring fundable technology for rural providers. Mike?

Exploring Fundable Technology for Rural Providers

Who Is Ingram Micro?

Mike Clark:

Great. It's always usually either Mike or Michael, so thank you for the intro and kicking it over. Good afternoon. It's a pleasure to be here. This is my first time working with Grants Office, LLC. I wanted to start, before I talk about Mike Clark, just to level set: there are probably some of you — and I am bad at making an assumption — about who Ingram Micro is. We've been around 50 years or so. We're a technology — I see the reference here — services provider; for a lot of you out there, that's a distributor. What do we do? Well, we represent and expand, starting with infrastructure and technology companies — traditionally, think IBM, HP, Cisco, Oracle, those types of companies. Obviously, 10, 12 years ago, hyperscalers came into play, and so then you add in companies such as, starting with, AWS, Microsoft Azure, and GCP. So that's what we do.

So you think about, again, for any solution, you have to have 101 infrastructure. That's what we provide — the 101, whether or not that's hardware, middleware, security, and software, but software only to a certain level. So again, that's what Ingram Micro does. We're a global company representing the top technology and software companies out there.

As far as Mike Clark: if you look, I've been around doing this. For some of you that have been around, I'll throw myself under the bus — I was in Atlanta before McKesson became McKesson in the space, representing and supporting HBOC. So it became very clear, coming from the technology side — and I'm not an engineer — that we needed to understand the health care vertical. We know the challenges and the opportunity of where technology meets medicine. So for 25 years we've been attending and exhibiting at HIMSS, at RSNA, attending CHIME, now with ViVE and HLTH, to keep up with both sides of the aisle — again, the technologies, and my goodness, there are a plethora of them, and again, the challenges and opportunities from the clinical side. And what's in the middle of all that that really makes

this work? It's independent software vendors, or ISVs — software solution providers. That's what you're looking for.

And this — year one of this incredible program — thank goodness for the funding that's coming down from the federal government to the states, to the departments, and eventually to you all. Everything that we have is in place. And again, I understand you're buyers. I mean, I look at the tracker multiple times on a daily basis, and I really applaud that every state, all 50, have a different definition of, hey, what does rural health mean? In my beloved Florida, it's got to be a lot different than New Mexico, going up to Montana, down to California. So we know that there are no silver bullets here as far as coming up with solutions, but I did want to represent three of our — again, software solution providers today that I'm pretty sure are either on your checklist today or soon will be.

ClearDATA: Cloud Security and Compliance

You can't start off talking about anything in healthcare, whether or not it's rural or down the street, without security and compliance. And especially when we're getting funding from multiple services, from multiple locations, there are going to be audits. So let me talk a little bit about ClearDATA. Again, 100% health care, 100% US; they're based in Austin, Texas. You can read the notes on the left. They've been doing this for 15 years. Their target audience has traditionally been providers, physician practices, major insurance companies, the Blues — so to extend their security and compliance offering out to address the space we're talking about today, rural health, it's just a natural for them. So again, they are not a startup. They're healthcare only.

I think most importantly, if you're looking at it from your side of the desk as a buyer, they're a managed service provider, or MSP. We know that there are workforce challenges, whether you're addressing the clinical side or the technology space, so, to hear about the software companies — if needed, they're a full-blown MSP. I just want to make that point. So let's talk about ClearDATA, and you can read along. You have to be, and they check the boxes, but it's good to document: they're already there with HIPAA and HITRUST. They address everything on compliance around protected health information, or PHI, and DICOM. You can see all the monitoring, again, for the audits that are going to come up.

I'll leave you with this about ClearDATA also, and applaud them, because let's face it: any funding that comes, whether it's federal, state, or local grants, wherever it may be, it's not forever. And one of the things, if you look down at the bottom, is their new AI cost optimization. That is, their monitoring — keeping secure all the workloads, the data, all the backup, and everything else — they're looking at the same time and producing reports on cost optimization, because eventually that cost is going to be solely on your plate. Hopefully there will be additional grants, but in the meantime, that's one of the other pluses from ClearDATA. So again, the summary from them: they are a security and compliance MSP. I'll stop there.

GlobalMed: Virtual Care and Telehealth

GlobalMed. You look over — again, US-based, in Scottsdale, Arizona. It says 20 years; they're actually coming up on 24 years of doing telehealth, so they are very well positioned to address rural health here in the US. If you look at a couple of highlights, they already have customers and clients in 60 countries. They started with the military and health care. So think about it: their first clients were working with the DoD, the VA, the Army, all the different service organizations, so they have resources everywhere on the globe. Already they know telehealth on a global basis. So to come back and address our needs today as far as rural health, they're already there. Again, I said that they're based in Scottsdale; again, health care, military — that's all they represent.

If you look at their number one application, eNcounter® — I don't have to get in those weeds — it's video-based, so they've really worked with, think about, extending the health care, without the workforce and the actual experts, all the way out into that engagement. So that secure video gives the opportunity for a clinician to be five hours, or maybe a couple of time zones, away, but to actually be there going through the experience with the patient.

Because of their military background, they definitely doubled down on behavioral and cognitive analysis and risk, so that's very special to them. They're also more involved in devices. If you look at ECG — and I think they've got a couple of other cameras, because they also have a little module that they can send out. They worked with the Salvation Army last year, and I don't know if they're doing it this year, with the Texas State Fair. They actually have their module there, so if something comes up, for whatever reason, they can bring the patient, or whatever's going on, into that little unit and, again, connect with a specialist no matter where that specialist is. For compliance, when you look at where they've already checked the boxes with the Defense Health Agency, or DHA, and HIPAA — FedRAMP may not come into play, but they've already been doing this for multiple years. And one more time, with the access to devices and the clinical device out there, that allows them to connect with any specialist. So GlobalMed, if I can just recap: been doing this a long time, US-based, but it addresses everything with telehealth and virtual health as far as the rural health initiative.

Prevounce: Remote Patient Monitoring

And then lastly, we go over to a company, Prevounce. This has always been an easy one for me. I've known them for quite a while. They're based out of Indianapolis — very small, very boutique — but when you hear Prevounce, all you have to think of is RPM, remote patient monitoring. And again, going back to the tracker: telehealth, security compliance, RPM — either they're at the top of your list today or they soon will be, in the next year or so. So again, that's all Prevounce does. Quite frankly, before RHTP came out, they had been servicing rural health and Federally Qualified Health Center, or FQHC,

clinics for quite a few years. They've got wins, case studies, and everything that goes along with it. They're one platform; they're all on AWS.

Depending on your workforce capabilities of supporting an application such as RPM, you can either buy the software and devices on a singular basis or, again, you may just want to say, take this over for six months, as a full-blown MSP offering. One of the unique things about them — they really know rural health — is all their devices. If you look at the blood pressure and glucose and everything, it's also based on cellular. Their CRO uses an example of one of his clients: they live up in the mountains somewhere in California, and they don't even have Wi-Fi. But once a week they drive down to 7-Eleven, they connect — and this device can hold up to 50 recordings — they connect, they upload everything, so all the recordings, all the billing back to Medicare and Medicaid, can happen.

So again, they've been very well versed. They're the youngest of the three software companies; they're coming up on nine years, but again, healthcare only, US-based. So again, that's Prevounce as an MSP. But one of the things I can definitely say — and you may want to take a note — they are a moneymaker for the clinics, and they will show you financially, no matter which model you engage with, how they will make money for the clinics, for the physicians, and everything. They've been doing this before RHTP, again, working with Medicare and Medicaid. So those are the three software companies that Ingram is proud to support. One of the takeaways, if you've got questions at the end — again, I'm just at the high level, trying to hopefully do a little bit more than tease you — but when you want to talk to any of these three, we will set you up directly with them and get down into the weeds as far as the engagement. So, Michael, thank you so much. I'm going to turn this over to Chris and continue the presentations.

Understanding the Rural Health Transformation Program

The Context: Reconciliation and Medicaid Cuts

Chris LaPage:

Thank you so much, Mike, for that important overview. Technology investments are a critical objective of the Rural Health Transformation Program. We'll actually be returning to that topic of fundable technologies in a bit, but first we're going to dive into the program itself. Understanding its key objectives and structure will be a critical first step to make sure everyone in the audience is able to properly justify spending those Rural Health Transformation Program dollars on technology initiatives. It would be malpractice to dive into this program without addressing the context in which it was passed. This was part of the reconciliation bill known as the One Big Beautiful Bill Act, which passed in July of 2025 — reconciliation just meaning it was a party-line vote and a certain process they used in Congress to make it happen.

In that package, there was $1 trillion in Medicaid cuts that are projected to happen over the next decade. Depending on who you ask — you see a quote here from the Kaiser Family Foundation, formerly Kaiser Family Foundation, now KFF — rural communities face an estimated $137 billion drop in Medicaid spending over the next ten years. Depending on who you ask, that could be $150 billion, $160 billion, depending on the study. But the point of the matter is, those rural facilities, who already operate on negative margins, at losses, are in a very difficult place when it comes to this. So in order to get that passed, they had to get the members of their own party in order in the Senate to make it happen. This was a last investment addition to that funding program, to that bill, to make it pass Congress and be signed into law.

So think about that $50 billion at the macro level: what it's intended to support, and how it's intended to help rural healthcare facilities set themselves up to withstand and mitigate those coming cuts. That's an important point, as I mentioned, because they do operate at losses. So if given carte blanche, these folks would definitely be inclined to spend the money on basic operating expenses to keep things running. Giving the program this particular type of purpose and this particular context is why the funding is going to be spent on technology advancement and forward-looking types of initiatives versus routine expenditures. So again, I hope that context is helpful, because it can help guide your thinking and approach as you look to capitalize on this funding.

RHTP at a Glance

At the 10,000-foot view, the numbers are pretty simple. It's $50 billion over the next five years that are going out — again, the next five fiscal years, through federal fiscal year 2030, which ends September 30, 2030. And so that's $10 billion per year going to the states, with an average state award right around $200 million, and that's considering the smallest award, to New Jersey at $147 million, to the largest, in terms of Texas, at $281 million. So we've got those top-line numbers. Let's get into the program itself.

Five Federal Strategic Priorities

Something you'll hear — and Mike actually alluded to this — is going to be a recurring theme: this isn't one program, it's 50 different programs. Every state had to apply for this funding in November of 2025. They were approved for that funding for the five years, and as part of that application process, they had to create a state plan. That plan had to map to these five federal goals — strategic priorities, objectives, however you want to phrase it. So these are the five goals of the program.

Make Rural America Healthy Again, with emphasis on increasing access to care, whether that be convenience and proximity for in-person visits or expansion of virtual care. This particular portion of the program also highlights the importance of preventative health and addressing underlying root issues — best summed up as: don't treat the symptom, treat the problem. Everyone understands the value of

prevention. You treat people before they're seriously sick, and you improve health outcomes and avoid the cost of emergency department visits and hospitalizations down the road. While that's great in theory, in practice these initiatives can be tough to fund, because the benefits — reduced costs, improved outcomes — may take years or even decades to realize. So that timeline does not mesh well with the one- to three-year project periods we see with most funding programs. But it does fit nicely here, and is expressly allowed with this particular program, given the objective is long-term sustainability. And if you can improve the healthcare and reduce the cost at the same time for this patient population, you're going to be able to better withstand those Medicaid cuts.

Sustainable access. This particular goal of the program is to restructure rural health operations so they can independently survive and thrive after the program's five-year funding window closes. You must have a plan for when the funding stops flowing in 2030. That's a critical thing we're going to return to as well. You're seeing projects funded here that set up shared operations and consortiums — rural facilities sharing administrative operations, technology, and even clinical staff to reduce overhead. You're seeing the development of integrated networks where primary care, specialized medicine, and emergency services are fluid and coordinated across regions. Funding can even be used to optimize the revenue cycle, which is a pretty particular use case you don't see with most grant funds. So you can upgrade your health IT, streamline data infrastructure, et cetera.

Workforce development, another critical piece here. This one is about overcoming those health professional workforce shortages that plague rural areas. So you're seeing folks fund some straightforward projects here: establishing bonus programs with five-year service commitments, or perks like housing assistance and childcare to recruit and retain those needed healthcare professionals in rural areas. But this objective also seeks to create creative projects that ensure there's a pipeline of talent, in partnerships with institutions of higher education — so upskilling and expanding the scope of current health professionals, which may include policy considerations at the state level around how folks are licensed and what their roles are. We're also seeing a ton of activity under this goal to establish formal Medicaid reimbursement pathways for community-based health workers, care navigators, doulas, and other types of professionals, like peer support specialists.

Innovative care. This particular goal aims to shift care to lower-cost settings — so into community-based clinics versus emergency departments and hospitals and institutional settings; implementing value-based payment models that reward providers for improving quality of care and reducing costs; expanding integrated care models like chronic care management, remote patient monitoring, and behavioral health integration. Again, remote patient monitoring — and I know Mike touched on this — is when you essentially have stuff in the home, wearables and other sensors, that are tracking information for folks with chronic diseases and other conditions and transmitting that information back

to the provider, so they can get ahead of stuff that could be much more of a concern down the line. And then, of course, technology innovation is a called-out, specific, explicit goal of this program.

So in this particular objective, we're seeing the expansion of virtual care, whether that's telehealth hub models or remote patient monitoring, but it's also about the entire IT apparatus in an organization: improving interoperability, enabling health information exchange, strengthening cybersecurity, leveraging AI and other technologies in staff workflow, whether you're reducing manual charting or automating documentation. All of those things are what you're seeing on the ground in terms of folks leveraging this program in year one. And I just want to note that technology isn't just a standalone overarching objective; it's woven into the fabric of the other objectives. So virtual care is being deployed as part of the other four objectives. Virtual learning is a key piece of the workforce development objective. Remote patient monitoring is being funded under innovative care and Make Rural America Healthy Again initiatives. So again, that is a through line there, and I think something for everyone to consider and to note as they're applying for this funding and trying to capitalize on it.

How the Money Flows

All right, so we've got the goals and objectives. Now let's get into how the funding flows. There is a base amount associated with this funding: every state gets $100 million each year through this program. No ifs, ands, or buts about it. That's their funds. That'll be their funds long term. That's not anything that's recoverable or that can be taken away from them. Then, that $100 million, essentially, like I said, is 50% of the funding. So you have that $5 billion of the $10 billion over five years that's falling out, and again, that comes out to about $100 million per year for those providers. 25% of the formula is based on rural need. A lot of folks just think that means population, but it's a couple of other things as well: population; facilities, particularly how many facilities are needed across a wide geographic region and population density; and also hospital finances. Those states with the hospitals in the worst financial shape are going to be the ones that are going to be most impacted by these Medicaid cuts.

And then finally, there's a third piece here, the technical score, which is 25% of the formula. This is the main reason the state allocations will fluctuate from year to year. These are based on essentially commitments and milestones that folks included in their state plan that must be met, and if they're not, then they can get some of that stuff taken back or taken away, or funds recovered at a later date. So again, 75% of this funding is going to be based on that baseline and the rural need. Those funds are really untouchable. But there is 25% of these funds that are based on those milestones that folks had to meet.

When I say policy commitments, we're thinking about things like state frameworks to promote those value-based care agreements and payments we talked about. There may be folks who are looking for the USDA to do a Supplemental Nutrition Assistance Program food waiver, so they can do food-as-

medicine types of projects that focus on food as a nutritional source and the management of chronic diseases, and things of that nature. There could be policies around what to do with patients who are eligible for both Medicare — health insurance for the elderly and retired and disabled — and Medicaid, which is based on entitlement and being low-income individuals and families, and how to best use that dual eligibility and pay for services most efficiently. It could be reporting stuff, in terms of things like the Transformed Medicaid Statistical Information System that folks have to report into. It could be healthcare professional licensing policies that need to be updated. And again, if they miss those windows — and a lot of those windows actually pop into place starting at the end of 2027 and into 2028 — that's where they could get some of those funds recovered or pulled back.

Year 1 Awards by State

So let's get into these awards. That's the formula; let's get into the actual awards here. This map breaks down the funding ranges by state. As we mentioned, Texas got the biggest award and New Jersey the smallest. There are plenty of expected outcomes, I think, when you look at the award sizes here: seeing the heaviest-populated states, like Texas and California, in the darkest shade, $225 million or more in funding — that's anticipated; seeing some of the very urban-centric New England and Mid-Atlantic states in the lightest shade, $147 to $174 million — that also makes sense.

But then you see some states that really bring the formula we just discussed into focus, and I'll call out Montana and their $233.5 million award, the fourth largest in the country. So first off, you have the 50% base funding, which naturally favors less populated states; everyone gets an equal amount. But where Montana really did well was the 25% of the formula focused on rural need — again, not just rural population. They looked at facility count and hospital finances. And in terms of finances, Montana noted in their application that they will be hit exceptionally hard by the pending Medicaid cuts, estimated to be $5 to $6 billion in their state alone for their facilities. And then their large geographic size requires a number of sites — I think they have 85 critical access hospitals, rural health clinics, and federally qualified health clinics across the state. So they successfully made the case that the impending cuts would essentially create a systemic collapse in their healthcare infrastructure. That kind of brings the formula into focus, and why you see how these awards are made and maybe why they were made.

Eligibility: States Apply to CMS, Providers Apply to Their State

So states will remain eligible for these distributions over the next four years, but we'll discuss later that their award size will vary based on that technical score piece. So states got their awards. What does that mean for you as a potential pass-through recipient of these funds? Eligibility, and how to access the funds — this is the number one question we get here at Grants Office. Only states could apply to the Centers for Medicare & Medicaid Services, or CMS, last November. Providers and community organizations access funds as subrecipients or contractors through their state's process. Each state

decides who's eligible for what, and how. So the most important document for you isn't even the Notice of Funding Opportunity, or NOFO. It's your state's approved plan and its requests for applications, or RFAs.

A note on that one-lead-agency item you see there: it is one lead agency per state, but I just wanted to make a note, because that may involve a state agency, such as the state health and human services department, handing over a huge chunk of dollars to their state department of education or workforce development to achieve some of the objectives under that portion of the program. So it is one lead agency, but other state agencies certainly can participate, and do, as subrecipients or pass-throughs as well. The legislation also made it clear that the states should not be subject to a full application process each year of the program, so there is an annual continuation where they submit reports, submit their year two, year three plan, et cetera. But they are guaranteed, like I said — this allocation and this approval last for the entire period.

A note on these rural providers you see listed: some designations are federal — federally qualified health clinics, critical access hospitals, rural health clinics. Others are subject to state definitions. What's a behavioral health clinic? What's an emergency medical services, or EMS, provider? So it's not just the type of entity; some states are using their own different definition. It's also, what's the definition of rural in their state plan? While many are using the Centers for Medicare & Medicaid Services or Health Resources and Services Administration definition of rural, states like Mississippi are using their own. They put that in their plan, and it was approved. So in Mississippi, you're rural if one of three things is true: you're a county with fewer than 50,000 residents, a county with fewer than 500 people per square mile, or a municipality with fewer than 15,000 residents. So what it means to be rural under this program even changes state to state.

And for community partners, which are a key piece of this — because again, they want folks to work together to deliver this care — I just wanted to make a note here for the audience today. We know this program's aimed at rural providers. However, it's not just for rural providers. I think many urban-based providers, institutions of higher education, and other entities believe this program's not worth their attention based on the name alone. But major urban healthcare systems are participating, in many cases expanding their specialists and services out to rural areas via technology. Academic medical centers and institutions of higher education are playing a key role as pass-through intermediaries, technical assistance providers, and directly addressing the workforce development objectives of the program as well.

And some providers, like EMS and skilled nursing facilities, tend to be concentrated in urban areas despite the fact that they serve the surrounding rural communities. These are all things being considered in the plans that the states submitted before spending their money. So if you're here today

representing those types of entities, you're doing your organization a great service by exploring this program and your ability to participate.

Permissible Uses of Funds

So let's discuss the allowable expenses. I believe there are eleven areas listed in the federal guidance that we distilled into these six categories. It's very easy to draw the lines from the five overarching program objectives we discussed to these six categories of allowable expenditures: prevention and chronic disease management; technology and data infrastructure; workforce development; behavioral health; innovative care and payment models; and right-sizing these rural systems so they're financially sustainable. Again, all of these themes are general categories, and anything you position, whether it be technology or other resources and investments, as part of your project or your submission and your proposal are all potentially fundable through this program, as long as they're meeting these categories, et cetera.

But your state plan and their specific guidance documents will determine what is being prioritized and whether it's allowable. So don't assume that because these are all eligible expenses under the federal guidance that you can work them into any RHTP application. On the contrary, each program will have its own set of restrictions and a list of allowable expenses, so you have to monitor that on a case-by-case basis.

What We Saw in Year 1

Now you have some background on the program overall. Let's discuss what we've seen in year one. First, every state was funded, and quickly. Award notices went out December 29, I believe, 2025. Second, the rollout was uneven. States like Rhode Island released 99% of their allocation by late February. Other states didn't post opportunities until late spring or summer. Many are rushing to obligate, or promise, their funds by the upcoming October 30 deadline, which is the end of year one. Third, states use very different mechanisms: competitive grants, regional hubs, direct awards, contracts. We'll get back to this in a little bit, but as of September, only 20 states had executed agreements, while others were still posting or reviewing funding opportunities.

I'll just restate that another way, because I think it shows just how hectic year one has been: as of early September, seven weeks before funds have to be obligated and promised, 30 states were still in a position where they had not executed any agreements. The good news is we now have the year one template and know what's coming next year, and we can discuss those lessons learned in a bit. And fourth, as we've mentioned, technology runs through almost every plan, and it makes sense. Remember why this program was put into the legislation: the five federal strategic goals, where technology was specifically listed but also permeated the other four objectives and the permissible uses of funds.

The Year 1 Clock

So, speaking of what we saw in year one: year one is almost done. Notices of award, as I mentioned, went out last December. Folks had to revise their budgets to get those back to CMS by late January. The states were in a position where they could start drawing down funds by early February in most cases. We get to August: they have to do their annual reporting from year one and also submit their year two plan and request, and that all happened by the end of August. So we have that budget period one ending at the end of this month. We have budget period two starting on October 31. So that's just about two weeks away here. After that, any unobligated year one money can't be committed to new work. Subrecipients typically have until September 30, 2027, to spend those year one dollars. Anything unspent will be redistributed to other states by CMS. So again, that's a deadline set federally. Most states will probably make that deadline sooner, because they have to wrap things up on their end, reporting-wise, et cetera. So if you're a subrecipient, keep those spend deadlines in mind, and we'll talk about that when it comes to applying for the funds here in a second.

How Much Year 1 Money Is Left to Obligate?

So how much is left to obligate? Unfortunately, there's no national tally, but state reports do tell a story. You see here North Carolina said nearly 80% of their funding was committed by the end of July. Oklahoma's July quarterly report showed $85 million obligated, $70 million in contracting, and $68 million still pending procurement, out of their $223 million award. Alaska had only awarded $35 million of its $272 million by mid-August, and Texas just announced its first $51 million worth of awards on September 28. So the bottom line here is to expect a burst of awards and contracts through the end of October, and then year two opportunities right behind it.

What to Expect in Year 2

So what to expect in year two. CMS is expected to announce budget period two amounts right as year one closes, right around October 31. That baseline stays the same, as we discussed. But again, those can shift to some degree. I think we expect most year two funding to be pretty close to year one, because the policy commitments and some of those milestones don't come into effect until later in the overall program timeline — again, end of 2027. And CMS will call back funds if some of those policy commitments are not met. That's all detailed in the contracts each state signed with the federal government as part of that cooperative agreement. So for applicants, that means new state rounds likely in winter and spring of 2027, with year two dollars spendable through September 20, 2028, typically, is what you're looking at there.

50 Front Doors: Following State Paths to RHTP Funding

Same Federal Rules, 50 Very Different Front Doors

All right. In order to maximize your potential to capitalize on RHTP funding, knowing the federal guidelines and processes is not enough. It's critical to know your state process, and this is something Mike touched on as well. I'd like to think of it as one program with 50 front doors — and really, it's 50-plus front doors, and I'll get to that in a second. So on that note, when you actually look at this: same rules, as I mentioned, 50 different implementations. When we look at that, states are using four main mechanisms. Open competitive grant processes, where they're putting out requests for applications, notices of funding opportunities — you're seeing that across the board in many states; there are examples we'll go through in Texas and Wisconsin here in a bit, and other places. You're seeing them use regional hub models, where they're subgranting large portions of their funds to intermediaries who will then be subgranting those out to providers and partners as part of long-term projects.

Direct awards, where they're identifying the recipients and sending them notices that they're eligible for the funding — it may include an application process, but not an open competitive process at all. And then, of course, you have contracts that the state may be putting out for administration or technology. The state may be looking to do something statewide — getting folks to buy into a health information exchange that's statewide, something on that end — so they may actually be doing some level of things at the state level where they're providing services and other things down to those local folks, versus necessarily dollars. So your first job is to figure out which front door your state is using for the initiative that fits your project, because again, states aren't just using one door. They're using many doors. Some states, we've seen two dozen opportunities fall out in year one under this program; other states, we've seen just a handful. So it really does vary state to state.

State Spotlight: North Carolina and Kansas

I wanted to get into spotlighting some states here, and some examples that I think will help bring this home. North Carolina is a good example of a hub model. It selected five North Carolina ROOTS hub leads covering six regions and all 100 North Carolina counties. That structure helped it commit nearly 80% of its $213 million by July. So investments include $10 million to 39 EMS agencies for opioid treatment; a $20-million-a-year fund for provider technology modernization; a shared consortium — a shared care coordination platform, I should say — where folks are buying into a platform and all coming together to share information; and a telehealth program for young adults with first-episode psychosis. So you see everything run the gamut here in terms of this funding, and if you tie it back to some of those strategic priorities we discussed, you can see where they line up on that front.

Kansas is actually another example of the regional hub model. They're using a University of Kansas Health System collaborative care agency as a main intermediary to pass through funding. I think a lot of states who went with this model picked it because it allows them to easily meet that year one obligation deadline, as things were moving so fast this year. The issue with the obligation deadline is that it only applies to the first primary recipient that the state awards the money to. Everything that subrecipient subawards out, or contracts with, et cetera, is considered spend, and that's where you have the deadline of September 30, 2027, for year one. So states were in a position where they could just pass bulk dollars to an intermediary and then meet that October 30 obligation deadline this year, and not have to think about it.

So again, there are other great pros to this model — there's that element of it, but also the folks in the region, the providers, the health systems that know that area, they're the ones who know best what to do in that area and how to meet the needs of their area. So a lot of good reasons folks picked that model, but certainly, I think, efficiency of distribution — getting the funds out, getting them obligated — was the primary consideration for those states.

State Spotlight: Texas

Here's a spotlight on Texas. So again, as I mentioned, your state isn't just using one door. Texas — the largest award, at $281 million for year one; they're going to get probably $1.4 billion or so over five years — organized its plan into six initiatives. Some funds flow out as direct awards to rural hospitals, and in fact, it just made its first awards, $51 million, as I mentioned, to 68 rural hospital districts in late September. Other programs you see here — consumer health technology, AI-enabled telehealth — are all competitive RFPs. So same state, many different ways in. Once you find the front door, you have to locate the right room inside as well.

Other State Routes

A few more contrasts we see here. Wisconsin ran a workforce-focused grant, the Workforce Innovation Grant: Healthcare Employment Access and Rural Transformation, also known as WIG:HEART. This is a great example, as I mentioned, where even though there's only one lead agency, other state agencies may be involved. This is a situation where the Wisconsin Department of Health Services passed through a large chunk of funding to its Department of Workforce Development to distribute those funds and to meet the goals of that workforce development objective, or strategic priority, we discussed. You see Alaska here went with many small direct awards. They identified their facilities and just sent the money out to them. So far, again, they've only distributed a small portion of the funds they have available to them. And as we've already discussed, Rhode Island was able to obligate very quickly with their funds — everything released within two months. So the point here: read your state's plan. It tells you the path and where to find the pass-through funding.

Three Layers of Alignment

I wanted to revisit this permissible uses slide and the strategic priorities we discussed earlier, remembering these are federal guidelines. State plans differ dramatically in what they were emphasizing in terms of the five federal strategic goals. Likewise, states will vary extensively from each other, and oftentimes within a single state, in terms of what they're emphasizing as allowable expenses to meet their state-specific plan. So there are three layers here: making sure you're in line with the federal objectives; making sure you're aligned to your state's overall plan and what they're emphasizing; and then the third level is your own organization.

Healthcare facilities can use this program for a variety of purposes. The biggest fight usually happens at the organization level. I work with a lot of folks that are responsible for the IT and technology apparatus at the organization, and some of their biggest complaints are that their institution is prioritizing other things over their technology upgrades. My advice is always the same: remain an advocate, but stay patient. Many rural providers are emphasizing workforce development and retention and medical equipment capital upgrades in year one — things like MRIs, CT scans, lab equipment. And the reason for that is pretty simple. Imaging and labs are two of the rare service lines that are profitable for rural providers, so these service lines subsidize the other departments that are typically operating at a loss. It only makes sense for rural providers and state plans to emphasize these types of investments in the first year of the program. But again, there's plenty of opportunity out there for technology projects across many of the programs that are being implemented at the state level.

Where Technology Fits in State RHTP Plans

So again, where does technology fit in these state plans? I think we've made that pretty clear. As we've seen with the overall priorities and permissible uses of funds, technology is the through line. Four areas show up again and again. Virtual care, as we talked about — telehealth and some of those things; I'll tie that back to Mike's discussion around GlobalMed. You have data and interoperability, cybersecurity and IT infrastructure, all those types of initiatives — and I think Mike did a great job of explaining things like ClearDATA and the solutions available there. And then AI and automation tools as well; I think Mike got into Prevounce there as well. So Mike gave us some great background on those technologies and how the Ingram Micro partner ecosystem spans all those areas.

The main reason this program was established was to help those rural providers invest in technology and help sustain those Medicaid cuts. So I just wanted to make that clear. These RHTP awards, essentially, and the program that is set up, rewards measurable outcomes and sustainability, and inasmuch as technology drives that process, the story is usually connected to patient access, workforce relief, and cost. And just one last note on that: this is a great analysis we saw of state-approved plans, their year one plans. These are some of the top ten themes that account for mentions across them. Five

of these top ten themes specifically involve technological components: data infrastructure, telehealth, capital expenses and infrastructure, remote patient monitoring, et cetera. And of course, as we know, there are other areas here, like behavioral health and workforce development, et cetera, where technology will play a key role as well. So stay patient. As you can see here, every state is prioritizing technology. It's a matter of when and where, not if.

Building a Competitive RHTP Application

Four Moves to Align with Your State's Plan

And finally, I just wanted to round out the presentation and turn our attention to applying to these opportunities. We've talked about year one and what we saw, and what we expect in year two, and we want you to be able to capitalize on these funds in year two and beyond. I think it's important we cover some critical tips. If you've been listening to the themes we keep reiterating here, these strategies and tips to build a competitive application will seem obvious, but I think it's critical we synthesize all the information we presented today into key guidelines and takeaways on that front.

So we talked a lot about alignment. Here are four concrete moves you can make to align with your state priorities. Read the plan and the RFA — and don't limit yourself to just their original plan. Many states are starting to post their year two plans that they submitted in late August to CMS. Map your project to a specific state initiative and a CMS goal, and use the state's own language that they're using in their RFAs. Pick outcomes the state itself has to report to CMS. I can't tell you how critical that is. As a state is looking at folks to fund, folks that are already using and reflecting the outcomes they have to report back to CMS — that's going to make it easy on them. That's going to be a key piece. And again, show a credible plan for life after 2030, remembering the whole goal of the program is long-term sustainability.

What Reviewers Expect to See

And as you put these applications in, you must always keep the reviewers top of mind. You can never assume they will fill in gaps. Remember these key application components. On the proposal side: everybody applying is rural or serves rural areas. What is unique about your geographic region, your population? Is there a mountain range that cuts you off from care? What's going on with your specific population? Is it sicker than most because of a certain reason, or something that's going on environmentally in the area? Use your local statistics, your local geography, to make your case, because again, everyone who's competing for these funds is serving rural areas. Pay attention to that spend date. Work plans that show activity past the spend date for each year will automatically be tossed, especially when state officials are moving quickly to obligate and distribute these funds. It's an easy way to narrow

down your workload when it comes to reviewing applications. Budget justification and caps — we'll get into that in a second. So that's the proposal side.

The other side is the readiness side. The mantra of year one has been shovel-ready, since states had to move so quickly. That's not going to change. Shovel-ready is not limited to the project design. As I mentioned, it's also the readiness side: it refers to being ready to receive the funds and to spend them by the deadline. These include things like your SAM.gov registration; financial capacity and audit history, and dealing with those single audit-type thresholds that come into play; making sure your procurement policies are set up to reflect that; vendor quotes, approvals, data agreements. States are moving fast. Readiness really is the difference.

Know the Funding Caps and Disqualifiers

Know the guardrails. I mentioned funding caps and disqualifiers. These are the funding caps they have at the state level, in terms of how they can spend their allocation. So no more than 15% of their funds can go to provider payments. No more than 20% of the funding can go to capital and infrastructure — and they're really talking about renovation, construction, not equipment in that sense. No more than 5% for replacing certified electronic health records, or EHRs. No more than 10% for administration. So those are the federal rules. States can often set, and do set, tighter limits. In some cases, states make it clear that the caps are on a program-by-program basis — they make it very clear within the program what you're capped at — but in many cases they do not, or it's not clear how it applies to a specific grant opportunity.

I'll use Kansas as an example, with their year two transformative capital and investment program that allows providers to get up to $3 million for capital equipment projects. It notes in the solicitation that renovation counts toward the state's 20% cap across all its funding. However, it gives no guidelines on how that will be applied on an award-by-award basis. So the general rule of thumb is to keep your capital renovation costs to no more than 20% of the individual award. So if the program offers $3 million per applicant, try to keep those renovations that you're proposing below $600,000 — again, checking that that specific RFA actually allows for it at all. That can vary program to program.

Common Pitfalls

I did want to round this out with some common pitfalls we see with folks. Projects that don't match the state plan or the specific RFA — again, I can't highlight this enough. When funders reject you, or reject your project, they typically aren't saying you have a bad project. They're saying the things you requested, or the project you proposed, are not a fit for the program. So just keep that in mind. Folks who are trying to supplant funds — stuff they're already spending money on; they're trying to save

money or redirect it to other things because they can get these dollars to cover something they are already doing — is a no-no in grants in general, and certainly with this program.

Bad timing-wise: I can't tell you the number of folks I've reviewed applications for where we have that year one spend deadline of September 30, 2027, and I see them proposing stuff in October, November, December of 2027, and even 2028. Those are things that automatically disqualify you. Cash flow considerations — budgets that ignore those caps we discussed. And then, of course, the big thing across all grant projects we see: no metrics, or thin or vague metrics that really don't do much in the way of putting numbers, or not aligned to the metrics that the state and CMS are looking to track in this case.

Tips to Sharpen Your Proposal

Okay, and then finally, we'll run through these tips pretty quickly here, because it's really just a summation of everything we've already mentioned. But as you're looking to get these applications in next year, these are the steps we're looking at. Get in early. Your states are typically doing listening sessions. If they're using those regional hub models, those hubs are often meeting; they're open to the public; they're inviting attendees. Pre-application webinars are a big point on many of these as well. Use the state's own words when you're putting together those proposals. Make sure you have partnerships where it makes sense, and make sure that you're explaining them and working them into your proposals as needed. Lead with those outcomes we discussed. Be shovel-ready, and again, show that post-2030 sustainability.

Your Next Six Months

And finally, directly for our next six months: now's the time to act, right? Responding to those remaining year one opportunities. October 30, that deadline in terms of end of year one — we're going to see those year two awards follow. November and December, we're going to see states adjust their plans and then start to release the new RFAs. And then 2027 — whether it's late fall of this year or winter and spring of next year — is when we'll really start to see opportunities trickling out, but that could vary. Kansas, as I mentioned, has released a couple of year two opportunities, so states are all at different points.

I'll just leave you with one final tip: look through the year one awards and projects that were funded. A big theme in year two will be avoiding duplication and tying into year one funding initiatives. So there could be an organization like you, operating in a different part of your state, that is doing an innovative project that you were proposing in year two for your region. Tapping into the awardee for technical assistance, even potential collaboration — like a letter that documents cooperation and need — eliminates any thought that the efforts are being duplicated and will strengthen your case for funding.

And with that, I will turn it over to Emily for a brief word on Ingram Micro's program, and then we can move into Q&A.

Engaging with the Ingram Micro Grant Support Program

Emily Nolan:

Great, thanks so much. Good afternoon, everyone. My name is Emily Nolan, and I'm the Senior Program Manager for the grants program at Ingram Micro. Ingram Micro's grants program helps our partners and their customers with grant funding through the Rural Health Transformation Program. We provide free grant writing services, including identifying funding opportunities, grant writing, proposal review, as well as assistance with reporting on any grants awarded. Thanks so much for joining us today. Michael, I'll pass it back to you.

Michael Paddock:

Great, thanks very much, Emily. We have a slide on that too, pretty much covering the things that Emily just referenced, so I encourage you to reach out. Emily, if there's a contact that you'd like them to reach out to if they want to take advantage of these services, you can always throw that into the chat as well while we go through Q&A here.

Q&A Session

Audience Questions

Q1: Can we access funds if we are not in a HRSA-defined rural area?

Michael Paddock:

Okay, so thanks. We had a couple of questions that have come in. The first one is for Chris. Chris, are we able to access funds if we are not in a HRSA-defined rural area?

Chris LaPage:

That's a great question. I think most folks who deal with the federal government, particularly CMS or the Health Resources and Services Administration, HRSA, are used to that HRSA rural eligibility analyzer, and whether you're in a rural county or you're in a rural tract of a more urban county is a very important consideration. Yes, many states are adopting that and using that model, but it really is specific to your state. I used an example today in Mississippi, but there are many other states that are in the same situation, where they have their own state rules around that and what it means to be rural, and so in Mississippi it's a completely different situation. So yeah, you definitely want to get to your state plan

and see what they included there. Did they adopt the federal definition? Did they use their own? There's certainly a chance.

But just outside of that, I want to recall my point that if you're in an urban-based area, or not in a HRSA-defined rural area, but you are going to be serving those residents — if you're going to be connecting in, making your providers available to folks in rural areas — there's plenty of opportunity to partner and take advantage of these funds regardless of where you operate in the state.

Q2: With Medicaid cuts coming, should we see RHTP as a lifeline, or plan around other funding too?

Michael Paddock:

Okay, great. And another one here: with Medicaid cuts coming, should we see RHTP as a lifeline, or plan around other funding too?

Chris LaPage:

Another great question, and yes. As we talked about, $150 billion or so in projected cuts to these rural areas from Medicaid — this program is probably only covering 35 or so percent of that amount that's going to impact that area. So it's not a lifeline; it's meant to set you up to mitigate those cuts. It should be used in concert with other strategies to go after funding, and particularly grant funding, because outside of RHTP there's always been a strong federal presence in terms of funding for rural health care. And that's not just from the Health Resources and Services Administration, which has a suite of programs for rural health network development and other services, and distance telehealth — like a telehealth grant program that you can do in rural areas — but other agencies like the USDA, the Department of Agriculture, that has the Distance Learning and Telemedicine program. There's ample opportunity across the federal space, the state space, and foundations for you to get funding for these projects.

So for folks to really survive, they have to capitalize 100% on this program, but they're going to have to find alternative sources moving forward too. So yes, outside grantseeking, other types of agency funding outside RHTP, will be critical to your long-term success.

Q3: Are there grant opportunities we can apply for now?

Michael Paddock:

Great. And then we had one that just came in: Are there available grant opportunities that we can apply for now? I live in Missouri, and we're definitely considered a rural area.

Chris LaPage:

Oh yeah, like I said, absolutely. I think rural health care, and the implications of what that entails in terms of disparities of care, time to travel to appointments, makes it very fundable. So even if there's not an open federal grant right now in terms of rural health, or if there's not an open RHTP grant program, there may be a foundation in your area that will support you that's accepting applications now. Even if the programs aren't open right now, you should be preparing and setting yourself up to hit the ground running when they do open, and we know what's coming back around — it's very cyclical — so it's something we can certainly get ahead of, and that you should be getting ahead of, for sure.

Q4: How does Ingram Micro actually make these technologies available?

Michael Paddock:

Great. And then a quick question for Mike Clark. You've talked a lot about technology. Can you give us some examples of how Ingram Micro actually makes those technologies available?

Mike Clark:

Again, Ingram Micro wants to represent both on-prem and cloud — so again, the best of the best. I already referenced IBM, HP, Dell EMC, Cisco, for some of those applications and requirements that just need that on-prem data center hardware type of offering, all the way up to, hey, I need it tomorrow, I need it to be up in the hyperscalers, I need it to be secure and compliant, whether or not it's AWS, Microsoft Azure, GCP. And again, more importantly, what's the software that's going to make the deliverable to this audience, out to all the rural customers? So that's how Ingram Micro is right in the middle, as a distributor, tying all that together.

Closing

Michael Paddock:

Okay, great. Thanks. So that's all the questions we have. I want to thank everyone for participating today. Thanks to our presenters — Chris LaPage, Emily Nolan, and Mike Clark — for sharing your knowledge and insights with us. Ashley Schultz has been stalwart at adding lots of great context in the chat and resources that are available to you as well. And thanks to all of you for your participation. Big thanks to Ingram Micro for sponsoring today's session as well. I hope you found this a valuable use of your time, and we'll look forward to seeing you again on a future webcast. Have a great day, everybody.

— End of Transcript —

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