



RURAL HEALTH TRANSFORMATION PROGRAM | COLORADO

From Roadmap to Reality

Translating Colorado's Rural Futures into RHTP applications

A timely playbook for rural Colorado rural health care leaders developing competitive applications for Colorado's 2026 Rural Health Transformation Program RFA.

June 2026

Why this matters now

On June 15, Colorado opens the most consequential rural healthcare funding cycle in a generation – and gives applicants **45 days** to land it. The state's \$200 million Year 1 RHTP allocation will subgrant roughly \$160 million through eight RFA funding lanes opening June 15 and closing July 31. Awards are for **5-year projects only**; flexibility on funding shape is minimal; the supply of strong ideas will exceed the supply of dollars. **This is a one-shot window.**

The Colorado Rural Futures project already told us what matters: the Farley Health Policy Center at CU Anschutz spent two years synthesizing the operational priorities of Colorado rural hospital CEOs into 38 specific recommendations. **Rural Futures is the blueprint. RHTP is the funding.** The work that remains is translating between them – fast – into competitive applications that get submitted by July 31.

This playbook is built to make that translation easier and provides the following:

- An outline of key Colorado RHTP priorities
- A set of tangible and actionable 5-year project ideas aligned with both RHTP and Rural Futures that will move the needle in Colorado's rural communities
- A clear 45-day workplan to get your organization from concept to completed RHTP proposal before July 31

For Colorado rural hospitals and consortia pursuing RHTP, cliexa will provide pre-built application components – narrative templates, 5-year budget skeletons, evaluation frameworks, Year 5 transition plans – and a 45-day application calendar with named cliexa support at each step. If you have an idea and you're worried about the timeline, this is the fastest path we know to a credible submission.

We hope this resource is helpful to you. We are happy to help support your RHTP planning in any way you need, **but please don't miss this opportunity.** Reach out to us with whatever you have – a challenge, an idea, a partner list, or none of the above – and we will get back to you within 24 hours.



Katherine Mulready, Chief Strategy Officer, cliexa

Named external partner on the **Rural Futures Report 2026**; former Senior Vice President and Chief Strategy Officer, **Colorado Hospital Association**; former Senior Health Policy Advisor, Office of **Colorado Governor John Hickenlooper**.

RHTP in 60 seconds

The federal Rural Health Transformation Program is a 5-year, \$50 billion investment authorized to address rural health system viability, access, and quality. Colorado's first-year allocation is \$200 million, with the Department of Health Care Policy and Financing (HCPF) administering distribution. Approximately \$160 million of the Year 1 allocation will flow through 8 competitive subgrant buckets to providers, consortia, and partnerships across the state's 52 rural and frontier counties and 2 tribal nations. The balance covers state-level administrative infrastructure, the Rural Health Transformation Advisory Committee that launched in April 2026, and direct-investment activities reserved for state agencies.

Colorado's 8 RFA subgrant buckets

Funding lane	Year 1 allocation
Telehealth Participation, including Remote Patient Monitoring	\$44.0M
Whole Person Health & Alternative Care Models	\$40.0M
Establish Incentive Payments (APM / value-based care infrastructure)	\$39.2M
Strengthen Rural Workforce	\$23.4M
Chronic Disease Risk Factors	\$4.8M
EMS Transport Coordination	\$4.4M
Mini-grants to Hospitals	\$4.1M
Advisory Board & Outreach	\$0.4M
Total subgrant pool	\$160.3M

CMS's five strategic goals for the program – sustainability, technology, workforce, access, and consumer experience – overlay the state's four permissible uses (prevention and chronic disease, fostering collaboration, appropriate care availability, innovative care models). Applications must demonstrate alignment to both state and federal layers.

Key dates are now confirmed: the RFA opens June 15, 2026, with all applications due on or around July 31, 2026. Awards are for five-year projects only; applicants must demonstrate alignment to both CMS strategic goals and Colorado's permissible-use framework.

From Rural Futures to RHTP: Crosswalk & Actionable RHTP Projects

Colorado’s Rural Futures report is structured around five focus areas, each elaborated with multi-recommendation depth. Unfortunately, the RHTP RFA buckets do not map neatly onto those focus areas. The crosswalk below shows where each focus area is best funded and where secondary funding lanes overlap. The largest RFA funding pools – Telehealth, Whole Person Health, APM – collectively address Rural Futures’ focus areas 1, 2, and 3, and the Workforce bucket, while not the largest in dollar terms, is the only meaningful pathway for focus areas 4 and 5.

It is a useful starting point for any team beginning an RHTP proposal: "Has the applicant grounded this project in the rural priorities Colorado has already documented?"

Rural Futures Focus Area	Primary RFA Bucket	Secondary Buckets
1. Expand and protect access to clinical services	Telehealth/RPM (\$44.0M); Whole Person Health (\$40.0M)	EMS Transport (\$4.4M)
2. Ensure adequate reimbursement	APM / Incentive Payments (\$39.2M)	Mini-grants (\$4.1M)
3. Enhance access to capital	APM / Incentive Payments (\$39.2M); Mini-grants (\$4.1M)	Limited federal pathway; pair with state and philanthropic capital
4. Support executive teams and hospital governing boards	Workforce (\$23.4M)	Mini-grants (\$4.1M); Advisory (\$0.4M)
5. Strengthen the clinical workforce	Workforce (\$23.4M)	Telehealth/RPM (\$44.0M) for tele-supported staffing models

To advance your organization’s RHTP priorities further faster, the section below highlights several actionable project ideas that fit within an RFA funding lane and align with Rural Futures recommendations. **Every featured project is grounded in work cliexa has done in real-world settings, adapted to Colorado’s rural providers.**

Note on Eligibility

RHTP restricts direct applicants to CMS-designated rural provider types (CAHs, RHCs, FQHCs, REHs, CMHCs). Consortium organizations can participate as named conveners, shared-services partners, or subrecipients, but the formal applicant must be the eligible member hospital(s). The structure we propose: one or more anchor CAHs as the named applicant(s), consortium body as named convener, cliexa as named technical partner, with an explicit invitation in the application for additional Colorado rural CAHs to join over the 5-year arc.

Whole Person Health & Alternative Care Models – \$40.0M

Funds care delivery models that integrate physical, behavioral, oral, and social health – and **the data infrastructure that makes integration possible**. Rural Futures returns repeatedly to the question of how rural hospitals deliver behavioral health, maternal care, and post-acute coordination in environments where the next nearest facility is forty-five minutes away.

Featured Projects

Real-time clinical data exchange across rural CAHs and tertiary partners – the consortium flagship. This is the project we recommend most rural Colorado CAHs pursue as a **coordinated consortium application** anchored in Whole Person Health – and which could be further leveraged by a statewide CIN data backbone, as detailed in the next subsection. Builds the FHIR-based bidirectional clinical data layer that makes regional partnerships among rural hospitals and with urban referral partners real: referral routing and tracking, clinical context flow, return-of-care documentation, and quality-controlled handback across the rural-to-urban boundary.

Sample 5-year arc. Year 1: 3–5 anchor CAHs deploy FHIR exchange with named tertiary partner; baseline data and governance live. **Year 2:** anchor cohort grows to 8–12 CAHs; clinical workflow integration mature across original anchors. **Year 3:** 15–20 CAHs participating; quality-controlled outcomes data reported to HCPF. **Year 4:** consortium operating cost transitions from federal grant to multi-hospital cost-sharing model. **Year 5:** open architecture available statewide; post-grant operating model in place and operational without federal funds.

Specialty referrals and care coordination across providers. For communities without full-time, full-scope specialty services (e.g., maternal care), leveraging partners across communities is essential to patient care. Coordinated referrals, transfers, RPM, post-acute follow-up, and clinical handback are the operational core of any credible whole-person response, and RHTP expressly supports data infrastructure to facilitate these handoffs.

SDOH data exchange across rural hospital, FQHC, and public health. Rural Futures explicitly calls out partnerships between rural hospitals and FQHCs, public health agencies, and human services. The infrastructure to share SDOH data – housing, transportation, food access, behavioral health risk – across these institutional silos is what makes "whole person health" operational rather than aspirational.

Establish Incentive Payments – \$39.2M

This bucket's scope is broader than the label suggests: **it covers the revenue cycle, claims, and payer-management infrastructure that makes value-based contracting financially viable for rural hospitals.** Rural Futures devotes extensive analysis to the financial fragility of rural CAHs, noting operating margins ranging from -44% to 32% with a median below zero.¹ You cannot transition to APMs if your revenue cycle is broken; this bucket funds fixing that as a precondition.

Featured Projects

Denial prevention and management infrastructure. Rural hospitals lose disproportionate revenue to preventable denials. This project funds pre-submission claims reasoning, denial pattern analysis, and structured appeal workflows – the infrastructure that converts denial pain into recoverable revenue. The financial sustainability argument for any value-based care transition starts here.

Sample 5-year arc. Year 1: deployment at anchor sites; baseline denial-rate measurement; staff training. **Year 2:** pre-submission claims reasoning operational; appeal workflow optimization. **Year 3:** pattern analysis at scale; payer-specific denial intelligence; shared learnings across CAHs. **Year 4:** operating cost transitions to revenue-share or per-recovery model. **Year 5:** sustainability via revenue recovery exceeding operating cost; expansion to additional CAHs.

Statewide rural Community Information Network (CIN) data backbone. Colorado's SB23-298 collective negotiation authority gave rural hospitals a legal mechanism for joint payer engagement (with some limitations). This project funds the shared data backbone that makes joint engagement operationally feasible: pooled claims data, comparative performance metrics, and shared denial intelligence across CIN members – the empirical foundation for the collective payer scorecard work recommended by Rural Futures.

Sample 5-year arc. Year 1: governance entity organized, 3-5 anchor CAHs onboarded, claims data infrastructure deployed. **Year 2:** pooled claims dataset stable across cohort; preliminary comparative performance reports and shared denial intelligence; payer scorecard methodology finalized. **Year 3:** cohort expands to 8-12 CAHs; scorecard published to a defined audience. **Year 4:** 15-20 CAHs participating; documented contract improvements; transition from grant funding to member subscription model. **Year 5:** open architecture for any Colorado rural CAH that joins, with backbone operating as self-sustaining shared services entity; statewide rural payer performance scorecard published annually.

Prior authorization landscape navigation platform. UnitedHealthcare's April 2026 announcement exempting most prior auth requirements for approximately 1,500 rural hospitals (including all CAHs) reshapes the operational landscape immediately. This project funds the infrastructure to navigate the transition: verifying patient eligibility against new exemption rules, redirecting freed PA capacity to higher-value revenue cycle work, preparing for which payers follow UHC's lead, and maintaining compliant PA workflows for the still-unwaived portion of the payer mix.

¹ [Colorado Rural Futures Report](#), 2026.

Telehealth Participation, including RPM – \$44.0M

The largest single RFA bucket. Funds tele-delivery, remote patient monitoring, and the supporting **connectivity, devices, and clinical workflow infrastructure** rural hospitals need to extend service lines beyond their walls. Rural Futures' CEO survey named technology adoption – specifically the use of advanced clinical platforms – as a primary mechanism for keeping rural facilities clinically relevant in the era of consolidation.

Featured Projects

Rural chronic disease registry with integrated RPM. A statewide or regional registry – built once, shared across participating CAHs – that ingests RPM device data, clinical encounter data, and SDOH signals into a unified patient view used by primary care, care management, and population health teams. Solves the persistent gap between RPM hardware purchases and the clinical workflows that make those purchases pay back.

Sample 5-year arc. Year 1: registry deployed at anchor sites; RPM device integration and baseline patient cohort. **Year 2:** clinical workflow integration mature; expanded device support and SDOH signal capture. **Year 3:** cross-CAH data pooling for population insights; outcome measurement at scale. **Year 4:** registry operating cost transitions to shared infrastructure model across participating CAHs. **Year 5:** open architecture for any Colorado rural CAH; sustainable without federal funds.

Mobile RPM and home-visiting infrastructure for frontier counties. Equipping community-based and home-visiting teams with RPM devices, mobile data capture, and bidirectional clinical decision support – extending primary care, behavioral health, and chronic disease management to populations that physically cannot or will not come to a clinic. Designed for the geographic and connectivity realities of the San Luis Valley, Northwest Colorado, and the Eastern Plains counties where the nearest tertiary facility is hours away.

Strengthen Rural Workforce – \$23.4M

The Workforce bucket is the only meaningful RHTP funding pathway for Rural Futures focus areas 4 and 5 – supporting executive teams and strengthening the clinical workforce. Colorado's workforce permissible use embeds a five-year rural service commitment structure in the funding terms; applications need to demonstrate not just hiring but retention infrastructure.

Featured Projects

Workforce recruitment and 5-year retention tracking infrastructure. A platform that tracks rural commitment fulfillment, manages tuition support and loan repayment terms, and surfaces early signals of attrition risk for the rural service commitments built into RHTP's workforce provisions. Pairs with state-level workforce data systems and regional consortia.

Joint workforce credentialing, scheduling, and retention platform. Shared credentialing across multiple CAHs reduces administrative cost; shared scheduling allows clinicians to work across facilities without duplicative onboarding; retention analytics across the consortium surface patterns no single facility can see. The structural fit for the rural service commitment built into the workforce bucket.

Chronic Disease Risk Factors – \$4.8M

Funds projects that identify, stratify, and intervene on chronic disease risk in rural populations – typically through workflow-integrated tools at the point of primary care or care management. Pairs naturally with the Telehealth/RPM bucket; the registry plus CDS plus monitoring stack is a coherent technology architecture for chronic disease management.

Featured Project

EHR-integrated clinical decision support for chronic disease management. Brings predictive risk stratification and protocol-driven intervention recommendations into the primary care workflow at the point of clinical decision-making, not after the encounter. Rural Futures emphasizes that chronic disease management is where most preventable acute utilization is generated.

EMS Transport Coordination – \$4.4M

A small but operationally specific bucket. Funds the coordination infrastructure for inter-facility transport and pre-hospital care. Rural Futures explicitly recommends exploring urban-rural transfer agreements; this bucket is where that infrastructure gets built.

Featured Project

Regional rural-urban referral and transfer coordination infrastructure. Inbound referral routing from rural to specialty and tertiary partners; outbound transfer agreements with quality-controlled return-to-origin; bidirectional clinical documentation flow; tracking of referral leakage, denial-of-acceptance, and turnaround times. Broader than transfer agreements alone – addresses the referral leak that costs rural facilities both clinical continuity and revenue.

Mini-grants to Hospitals – \$4.1M

A flexible, lower-dollar bucket designed for smaller, definable projects. Particularly useful for assessments, pilots, and planning-phase work that feeds into larger applications in other buckets. Mini-grants are often the right starting point for hospitals that are not yet ready to anchor a \$5M+ application.

Featured Projects

Shared compliance and regulatory burden management platform. Rural Futures' CEO survey named regulation and legislation among the most pressing operational issues facing rural hospitals. This project funds shared regulatory tracking, compliance documentation, and policy response infrastructure across collaborative members – reducing the duplicative compliance work that disproportionately burdens small CAHs.

Shared cybersecurity SOC for collaborative members. Pools cyber operations spending across multiple CAHs that individually cannot afford a 24/7 SOC. Pairs with the readiness package above as a sustainability path for ongoing cyber posture after initial assessment.

Other Supported Ideas

The featured project above are the projects most rural Colorado facilities will likely pursue under tight application timelines. Additional ideas remain valid, but may require more facility-specific scoping to define a 5-year shape. Each can be developed into a competitive application with cliexa support in Weeks 1–2 of the application window.

Telehealth / RPM: Cross-CAH RPM data pooling for population insights; tele-pharmacy and tele-radiology infrastructure for facilities without 24/7 on-site coverage; behavioral health crisis telehealth bridging gaps to tertiary inpatient capacity; urban-rural specialty telehealth networks for cardiology, neurology, maternal-fetal medicine.

Whole Person Health: Cross-CAH unified patient record for shared service lines; multi-hospital lab, imaging, and pharmacy data integration; referral pattern analysis to right-size regional service lines.

Establish Incentive Payments: Payer performance scorecard implementation; Medicare Advantage claims intelligence and appeal infrastructure; VBC readiness assessment and APM pilot; revenue cycle and cost reporting technical assistance hub; multi-hospital quality improvement with shared benchmarking.

Workforce: Ancillary professions training pipeline tied to regional employers; housing, childcare, and transportation barrier reduction; executive coaching and governance support for rural hospital boards.

Chronic Disease, EMS, and Mini-grants: Shared chronic disease risk stratification; community-based prevention programs with outcomes tracking; pre-hospital data integration for community paramedicine; rural EMS workforce extension models; joint EHR procurement and shared-instance cooperative; EHR optimization sprints for facilities not in a position to replace existing systems.

Note on Crucial Cross-Cutting Priorities: Sustainability, Security, Due Diligence

Long-term sustainability. RHTP runs FY26-30 and the dollars do not renew automatically. Anything stood up with this money must have a credible plan for Year 6 when federal funding is gone. Our partnership structures are rural-calibrated, multi-year stable, and open-architecture – switching cost is never used as a sustainability lever in reverse.

Cyber. Every project description in this playbook assumes a credible cybersecurity and privacy posture. A chronic disease registry that hasn't been hardened is a breach waiting to happen. The right question for any RHTP-funded project isn't "did we fund cybersecurity" but "is the cyber posture credible enough that the State of Colorado would still be comfortable with it in Year 3?" That posture is part of the work.

Due diligence. Under 45-day pressure, full vendor evaluations are a luxury you likely don't have time for. We've assembled a 30-minute due-diligence shortcut in Appendix A we recommend for every technology partner you consider – including cliexa.

How cliexa can help

What RHTP partnerships look like

cliexa engages with rural hospitals and consortia pursuing RHTP funding at three tiers, each calibrated to where the relationship is and what the moment requires. **In the current 45-day window, consortium-led engagement is the highest-leverage tier** – and the one we recommend – but we can support any of the following:

- **At the lightest tier – application support:** cliexa serves as a named technical partner in a subgrantee's application: contributing technical scope language, pricing structure for in-kind and matching budget lines, and rural-calibrated terms if the application is awarded. This is appropriate when the hospital or consortium is leading the application, has its own clinical and operational anchor, and needs a credible technology partner reference. **Our ask:** accurate scoping and funding capabilities.
- **At the middle tier – named pilot partner:** cliexa is the technology anchor in the application: the specific platform being deployed, with defined clinical workflows, integration scope, and outcome measures named in the proposal. This is the right structure when a clinical and operational case has been built around our platform specifically, and when the success of the funded project depends on the technology being delivered as scoped. **Our ask:** joint scoping of deployment and outcome measures.
- **At the highest tier – full deployment:** cliexa is the operating technology layer for a multi-facility consortium, with shared governance, shared pricing, and shared sustainability infrastructure across members. This is the structure that produces the most leverage per grant dollar because fixed deployment costs are amortized across multiple hospitals. **Our ask:** multi-year commitment that lets us bring multi-facility, rural-calibrated partnership structures that single-facility deployments cannot sustain.

Our partnership and pricing posture across all three tiers is rural-calibrated, multi-year stable, and built around shared infrastructure economics.

Our turnkey approach: what cliexa hands over

If you commit to working with us on an RHTP application, within **5 business days** you receive:

- 5-year project narrative template, filled for your selected RFA bucket
- 5-year budget skeleton with line items, year-over-year escalation, and in-kind vs. cash split
- Signed Letter of Support from cliexa naming our role and scope
- Evaluation framework: outcome measures, milestone schedule, quarterly reporting cadence
- Year 5 transition plan template customized to your facility
- Single point of contact: Katherine Mulready, with 24-hour response during the 45-day window
- Dedicated working sessions Monday and Thursday afternoons through July 31

The 45-day path: June 15 through July 31

Below is the application cadence we recommend for any RFA bucket. The first two weeks – before July 1 – are about discovery, capabilities discussion, and committing to a bucket and partner set. Weeks 3 through 6 are about writing and submitting. For each phase, cliexa names what we hand over so you and your team know where the load lifts.

Phase	You bring	cliexa brings	Outcome
Weeks 1–2 (June 15 – June 30) Discovery, capabilities, and commit	Facility context, current technology stack, candidate project ideas (or none), partner relationships (or none).	Capabilities briefing tailored to your facility, the Rural Futures-to-RHTP crosswalk applied to your operational priorities, the project idea menu with 5-year arcs, and a recommended bucket and partner structure.	Commit to RFA bucket, project frame, and partner structure. Anchor partners aligned. Application track defined.
Weeks 3–4 (July 1 – July 14) Narrative and evaluation draft	Facility-specific data, internal sign-offs in progress, partner letters of support being collected.	5-year project narrative template filled for your bucket, 5-year budget skeleton with line items and year-over-year escalation, evaluation framework template, and draft cliexa Letter of Support.	Draft application narrative ready for internal review.
Week 5 (July 15 – July 21) Internal review and LOS collection	Feedback on draft, board and leadership review, finalized partner LOSs.	Revisions per feedback, signed cliexa LOS, application QA against the RFA's published scoring criteria.	Application ready for final executive review.
Week 6 (July 22 – July 31) Final and submit	Executive sign-off, final submission package.	Final QA pass, day-of-submission availability for any technical clarification questions.	Application submitted by July 31.

Start a conversation with us

If any of the project ideas in this playbook are worth pursuing for your facility or your consortium, the right next step is a conversation – quickly. The most useful version of that conversation starts with three things: which RFA bucket you are most interested in, who in your organization owns the application, and whether you are operating alone, with named partners, or considering a consortium frame.

Contact: Katherine Mulready, Chief Strategy Officer - kmulready@cliexa.com

Bring whatever documentation you already have – facility context, problem worth solving, application draft, partner list, or none of the above.

Response commitment: 24-hour response during the 45-day window (June 15 – July 31). **If we're not the right partner for your challenge, we'll say so.** Dedicated working sessions available Monday and Thursday afternoons through July 31 for any hospital, consortium, or partner actively scoping an application. And

Appendix A: RHTP Technology Partner Due Diligence

Under 45-day pressure, full vendor evaluations are luxury time. The rubric below is structured as a **30-minute due-diligence shortcut** – six questions you can ask any RHTP technology partner (including cliexa) in a single meeting to qualify or disqualify them. Run every vendor through it, ours included.

Criterion	What "good" looks like	How cliexa stacks up
Real-world performance and evidence	Multi-site deployments comparable to yours, with documented outcomes and willing references. Skepticism of vendors whose rural work is single-site demos.	Multi-site rural Colorado partners; ACC partnership; Mayo Clinic Platform qualification.
Operational discipline	Implementation timelines that respect your actual staffing. No four-week go-live promises that assume staffing you don't have.	Scopes built around CAH operating staffing baseline, not consulting fantasy.
Rural-aware design	Functions in low-bandwidth, intermittent-connectivity, low-IT-staff environments. Offline-tolerant where appropriate.	EMR-agnostic and cloud-agnostic architecture; offline-tolerant clinical workflows.
Decision transparency	When the system recommends, your clinician sees the rule that triggered it. No black boxes.	Markdown-defined rules with explicit citation of the triggering rule on every flag; explainability built into architecture.
Compliance posture	HIPAA, HITRUST, SOC 2 – certifications, dates, and scope on the table. Not "working toward it."	HITRUST-certified; SOC 2 Type II audited; HIPAA-compliant by architecture.
Governance and accountability	Clear ownership, defined human-in-the-loop checkpoints, named owner when something goes wrong.	Skills-based governance with mandatory human-in-the-loop checkpoints; named clinical and technical owners.