ALABAMA
RURAL HEALTH TRANSFORMATION

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Rural Health Transformation Program

PROGRAM MANUAL

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SECTION I: PROGRAM BACKGROUND

1. Introduction

This Program Manual provides an overview of the Alabama Rural Health Transformation Program (ARHTP) and is intended to serve as a practical user guide for state agencies, applicants, subrecipients, healthcare delivery partners, community partners, and the public. It describes the program lifecycle, governance structure, eligible activities, implementation expectations, funding management, performance measurement, reporting, and sustainability approach. The Program Manual is a working document that is subject to change over the course of the five-year ARHTP.

1.1 Purpose of the Manual

The manual is designed to translate the State Project Narrative (Narrative) into operational guidance. It summarizes the CMS-approved State Project Narrative and provides a consistent framework for program administration, funding opportunity development, applicant expectations, subrecipient monitoring, performance reporting, and continuous improvement.

1.2 Executive Summary

- ARHTP is intended to serve as a catalyst for transformational change across Alabama's rural healthcare delivery system. The program targets improvements to healthcare access, healthcare quality, and health outcomes for more than 1.6 million Alabama citizens living in the State's 58 rural and partially rural counties. The program is guided by three core principles: transformation, sustainability, and accountability.
- ARHTP represents a significant and historic initiative supported by the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS). This effort is funded by a $50 billion Congressional appropriation to address healthcare concerns in rural communities across the nation for future generations.
- ARHTP funding is established annually as part of a federal financial assistance award from CMS. Program investments are organized around the Narrative's core priorities, such as state policy reforms, innovative startup healthcare initiatives, expansion of proven models, and retooling of rural healthcare service delivery. Strategic priorities include strengthening provider networks, expanding telehealth and tele-consulting capacity, modernizing health IT and cybersecurity, improving maternal and behavioral health access, expanding rural workforce pipelines, and creating sustainable regional care models.
- The program targets key populations, including rural low-income families, older adults, expectant mothers and infants, chronic disease patients, veterans, individuals with behavioral health needs, and residents of medically underserved areas. ARHTP is designed not only to stabilize essential services, but to redesign rural healthcare delivery around modern community needs and long-term sustainability.

2. National Rural Health Context

Rural communities across the nation face persistent barriers to primary care, specialty care, emergency response, maternal health, behavioral health, technology modernization, transportation, and workforce recruitment. The federal Rural Health Transformation Program (RHTP) was established to support state-led transformation efforts that address these gaps through innovation, technology modernization, strategic partnerships, healthcare infrastructure development, and workforce investment.

3. National RHTP Legislation and Strategy

Fundamentally, each ARHTP initiative is designed to comply with applicable Congressional legislation and align with one or more of the following CMS strategic goals: Make Rural America Healthy Again, Sustainable Access, Workforce Development, Innovative Care, and Technology Innovation.

3.1 Legislative Authority and Funding Structure

The federal RHTP was authorized by the One Big Beautiful Bill Act, Section 71401 of Public Law 119-21. Funding is provided over a five-year period, FY2026 through FY2030. CMS distributes RHTP funds to approved states in two equal parts: a baseline amount shared equally among all approved states ($100 million per state in FFY2026) and a Workload amount allocated by formula based on rural population, the share and condition of rural health facilities, and qualitative program factors. State funding levels are subject to annual CMS approval, budget revisions, and applicable funding opportunity or award documents.

3.2 CMS Strategic Goals

CMS established five strategic goals for the Rural Health Transformation Program. Alabama's RHTP initiatives and strategies were developed to advance these goals based on the State's rural healthcare needs. The following summarizes how the ARHTP addresses each CMS strategic goal:

- Goal 1 - Make Rural America Healthy Again: expand preventive, prenatal, behavioral health, and chronic disease care services closer to patients' homes.
- Goal 2 - Sustainable Access: support regional networks, shared services, Emergency Medical Services (EMS) reforms, and financially sustainable access points.
- Goal 3 - Workforce Development: develop rural training pipelines, recruitment strategies, retention incentives, and top-of-license practice models.
- Goal 4 - Innovative Care: implement flexible telehealth, EMS tele-consults, mobile care, integrated behavioral health, and regionalized care models.
- Goal 5 - Technology Innovation: scale telehealth, Electronic Health Record (EHR)integration, and Health Information Exchange (HIE) participation; improve cybersecurity and remote monitoring capacities; and implement data-driven quality improvements.

SECTION II: ALABAMA RURAL HEALTH NEEDS AND TARGET POPULATION

4. Alabama Rural Health Landscape

Alabama's rural healthcare system faces persistent challenges related to access, workforce availability, health outcomes, emergency transportation, and financial stability. Approximately 32 percent of Alabama's population lives in rural counties. These communities experience higher rates of chronic disease, higher uninsured and underinsured rates, lower healthcare accessibility, limited specialty care, and reduced access to maternity and emergency services.

4.1 Criteria for Identifying Rural Areas

For ARHTP, Alabama identifies rural areas using census tracts defined as rural by the Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy. HRSA classifies 58 of Alabama's 67 counties as rural or partially rural, representing approximately 1,613,122 residents. Because source datasets may rely on different definitions of rural, some statistics in the State Project Narrative reflect statewide, county-level, or program-specific source definitions. Data in this section is drawn from multiple sources (including Alabama Medicaid/HRSA, ADPH, and USDA Economic Research Service); reporting years vary by source.

4.2 Data Overview

Category	Aligned Alabama Data Point
Rural population	1,613,122 people, or approximately 32 percent of Alabama residents, live in rural areas.
Rural counties	58 of 67 counties are classified as rural or partially rural.
Income and poverty	Rural Alabama has lower per-capita income and higher poverty than urban Alabama. In 2023, rural per-capita income was $45,725 compared to $56,594 in urban Alabama; rural poverty was 19.1 percent compared to 14.8 percent in urban Alabama.
Education and labor force	Rural Alabama has lower rates of bachelor's degree attainment and lower labor force participation than urban areas.
Infant mortality	Alabama's 2023 infant mortality rate was 7.64 deaths per 1,000 live births, above the national rate of 5.61.
Life expectancy	Alabama's 2021 life expectancy was 72.0 years, below the national rate of 76.4; several rural counties remain below 70.0 years.
Chronic disease	Alabama has elevated rates of diabetes, heart disease, high blood pressure, obesity, and cancer relative to national benchmarks.
Maternal access	Only 12 rural counties have L&D units; in rural areas, 89.9 percent of women living in rural areas live more than 30 minutes from a birthing hospital.

Category	Aligned Alabama Data Point
EMS response	EMS response time averages are longer in rural counties and may reach 30 minutes in some rural areas.
Workforce shortages	Alabama ranked 45th in the nation for primary care providers per 100,000 people and last for mental health providers per 100,000 people in 2024.
Rural hospital risk	As of August 2025, 60 percent of Alabama's rural hospitals were at risk of closing and 48 percent were at immediate risk.

4.3 Target Populations and Geographic Areas

ARHTP will target and prioritize hospitals, providers, communities, and persons in Alabama's 58 rural and partially rural counties, where health disparities, provider shortages, and economic hardship are most severe. Priority populations include rural low-income families, older adults, expectant mothers and infants, chronic disease patients, veterans, youth with behavioral health needs, uninsured and underinsured residents, and medically underserved communities.

4.4 Cause Identification

Alabama's rural healthcare system faces pressures associated with low patient volumes, high fixed costs, transportation limitations, workforce shortages, reimbursement challenges, uninsured and underinsured populations, uncompensated care, and limited access to specialty, behavioral health, maternal, and emergency services. These pressures can contribute to service reductions, facility restructuring, and other changes that affect local access to care and the financial and operational stability of rural healthcare providers and weaken rural economies where hospitals often serve as major employers.

5. Structure of the Alabama RHTP Plan

The ARHTP was developed through a coordinated statewide process led by the Governor's Office in partnership with the Alabama Department of Economic and Community Affairs (ADECA), CMS, the Alabama Department of Public Health (ADPH), Alabama Medicaid Agency, the Alabama State Health Planning and Development Agency, and other state and community stakeholders. The planning process included targeted engagement with healthcare executives, rural hospitals, providers, advocacy organizations, education stakeholders, community organizations, tribal interests, and other implementation partners (subrecipients, contractors, and academic or technical-assistance partners). The State designed ARHTP as a set of initiatives that will solicit innovative solutions through competitive or otherwise approved funding processes. This approach allows the State to evaluate proposals against defined program parameters, sustainability expectations, compliance requirements, and performance metrics rather than preselecting all awardees in the narrative.

5.1 Needs Assessment Methodology

- ARHTP is grounded in a data-informed approach that integrates analysis of health outcomes, workforce capacity, and healthcare infrastructure with input from stakeholders across the

state. This combined approach has highlighted critical disparities in access to care, provider availability, and service distribution across Alabama's rural communities.

- Feedback from healthcare providers, community organizations, and state partners consistently points to shared challenges, including limited access to essential services, shortages in clinical and behavioral health providers, high prevalence of chronic disease, maternal health concerns, and ongoing financial pressures on rural healthcare facilities. These insights align with statewide data trends and reinforce the need for targeted intervention.
- Further assessment has identified key gaps in service delivery, particularly in behavioral health and maternal care, as well as continued barriers related to geographic isolation and transportation. These findings have informed program priorities focused on expanding access to critical services, strengthening the healthcare workforce, improving coordination across providers, and modernizing infrastructure to support long-term sustainability.

5.2 ARHTP Initiative Overview

ARHTP implements Alabama's approved rural health transformation strategy through a portfolio of eleven initiatives designed to address identified rural healthcare needs and advance the CMS strategic goals described in Section 3.2. The following is a brief overview of each initiative:

- **Collaborative EHR, IT, and Cybersecurity**: modernize healthcare IT structure by establishing regional hubs for IT and cybersecurity support and assist with EHR integration for rural hospitals and clinics.
- **Rural Health**: expand access to specialty and emergent care through a network of telehealth hubs linking EMS, first responders, hospitals, and other healthcare facilities to regional referral centers.
- **Maternal and Fetal Health**: use digital tools to connect rural facilities with maternal-fetal medicine specialists, provide access to telerobotic ultrasound, address shortages of obstetric services, and reduce maternal and infant morbidity; the initiative will also include expansion of a pilot program to provide emergency L&D carts to rural hospitals.
- **Rural Workforce**: invest in coordinated training and recruitment pipelines for healthcare professionals; leverage remote learning and clinical partnerships to grow the local healthcare workforce; and provide incentives for providers to practice in rural areas and expand Graduate Medical Education (GME) programs.
- **Cancer Digital Regionalization**: target cancers for prevention and early detection through cross-sector partnerships and improved access to screening services in rural areas.
- **Simulation Training**: improve quality of care in rural healthcare facilities by enhancing workforce through broader access to simulation training.
- **Statewide EMS Trauma and Stroke**: expand existing services for trauma and stroke statewide and expand statewide hospital-referral services to include additional patient conditions for which ambulances can be routed to the most appropriate available facilities.
- **EMS Treat-in-place**: Expand capacity of EMS providers to treat patients on-site and be reimbursed for services.

- **Mental Health**: Expand mental health access in rural Alabama through school-based tele-mental health models and CMHC-to-CCBHC conversion.
- **Community Medicine**: provide preventative screenings, navigate connections to appropriate healthcare, address food access and choice issues, promote healthy lifestyle choices, and disseminate health education materials.
- **Rural Health Practice**: Establish or expand networked rural health clinics throughout Alabama and offer facilities opportunities to partner with K-12 institutions to establish dental and health clinics and provide primary care services to students, parents, teachers, staff, and their families.

SECTION III: GOALS, STRATEGIES, STAKEHOLDERS, AND GOVERNANCE

6. Program Vision, Goals, and Strategies

- The State Project Narrative identifies seven strategic elements that guide ARHTP implementation: Improving Access, Improving Outcomes, Technology Use, Partnerships, Workforce, Data-Driven Solutions, and Financial Solvency Strategies. The specific ARHTP initiatives are briefly summarized above and described in further detail in Section IV.
- ARHTP is guided by the principles of transformation, sustainability, and accountability. Transformation will be advanced through targeted investments, new technologies and methods, and state policy changes. Sustainability will be supported through efficient and effective initiatives and strategies designed to strengthen the long-term viability of rural healthcare delivery. Accountability will be supported through performance measures, outcome metrics, monitoring, reporting, and evaluation.
- The table below summarizes the strategies associated with each strategic element. The strategies are intended to describe the overarching ARHTP framework and are not an exhaustive list of activities that may be undertaken through individual ARHTP initiatives.

Strategic Element	ARHTP Strategies
Improving Access	Expand access through telehealth and remote patient monitoring; regional specialty networks; digital maternal and fetal health services; cancer screening and referral networks; CMHC-to-CCBHC conversion and integrated behavioral health; and EMS diversion, routing, and treat-in-place models.
Improving Outcomes	Support evidence-based chronic disease management and prevention, care coordination, maternal and fetal health improvement, cancer screening and early detection, behavioral health integration, and other outcomes-driven approaches.

Strategic Element	ARHTP Strategies
Technology Use	Establish regional IT and cybersecurity hubs; support EHR integration, interoperability, and secure health information exchange; deploy telehealth and other digital care technologies; and evaluate emerging technologies and sustainable shared-service models.
Partnerships	Create and strengthen local and regional networks among rural hospitals, clinics, FQHCs, EMS providers, behavioral health providers, academic partners, and regional hubs to support information sharing, joint training, group purchasing, and coordinated service delivery.
Workforce	Build rural healthcare training pipelines; expand GME and other healthcare workforce capacity; support specialty-based simulation training; extend specialty reach through telehealth; and sustain workforce pipelines through partnerships with ASHS and community colleges.
Data-Driven Solutions	Use data and technology to support the delivery of high-quality healthcare services as close to rural patients' homes as possible.
Financial Solvency Strategies	Use connected EHRs and data to monitor quality, utilization, and outcomes; pursue payment and delivery reforms that support regionalization, telehealth, treat-in-place reimbursement, and shared-service cost recovery; and support mobile, network, group purchasing, and shared-service models intended to improve long-term financial sustainability.

7. Program Stakeholders

ARHTP implementation may involve coordination with a broad range of governmental, healthcare, education, community, and other stakeholders, as appropriate to individual initiatives and program needs. Stakeholders include, but are not limited to, the following:

- State leadership and relevant State agencies.
- Healthcare delivery partners: rural hospitals, Critical Access Hospitals, Rural Emergency Hospitals, FQHCs, Rural Health Clinics (RHCs), EMS providers, Community Mental Health Centers (CMHCs), CCBHCs, Indian Health Service (IHS)/Tribal facilities, skilled nursing facilities, dentists and dental providers, and regional referral centers.
- Community partners: community-based organizations, faith-based organizations, local leaders, K-12 schools, community colleges, universities, workforce development partners, advocacy organizations, and non-profit healthcare organizations.
- Federal partners: CMS, HHS, U.S. Department of Agriculture (USDA) as applicable, HRSA technical assistance resources, and other federal partners supporting RHTP implementation and alignment.

Identification as a stakeholder does not, by itself, establish eligibility for funding or a formal partnership with ARHTP. Eligibility and participation requirements will be defined through applicable funding opportunities, awards, agreements, and other program guidance.

8. Program Governance Structure

ADECA will serve as the lead agency for ARHTP. ADECA's Director will act as the Authorized Organizational Representative (AOR), with authority to execute award documents and official submissions to CMS. ARHTP will be housed in ADECA's Federal Initiatives and Recreation (FIR) Division, and the FIR Division Chief will serve as Project Director. The Project Director will be supported by planning and economic development specialists, administrative staff, and consultants, as needed for program administration and implementation.

8.1 State Oversight

The State, through ADECA, will maintain primary responsibility for program administration, fiscal management, legal compliance, subrecipient monitoring, reporting, and alignment with federal and state objectives. Enabling legislation and any necessary administrative rules will be developed to provide ADECA with necessary authority and guidance to administer ARHTP effectively.

8.2 Advisory Group and Policy Coordination

- The Governor established the ARHTP Advisory Group by Executive Order No. 741 on December 18, 2025, to support policy coordination, stakeholder engagement, and implementation of ARHTP. The Advisory Group serves in an advisory capacity and may provide recommendations regarding policy, program implementation, stakeholder needs, and other matters affecting ARHTP.
- The Advisory Group does not have independent authority to bind ADECA, obligate ARHTP funds, make award decisions, or approve changes to the program. Final authority for ARHTP administration remains with ADECA in accordance with applicable federal requirements. The ADECA Director, serving as the AOR, retains authority to execute award documents and official submissions to CMS.
- The composition, responsibilities, and activities of the Advisory Group will be governed by the Executive Order and any subsequent amendments.

8.3 Funding Opportunity and Recipient Selection Framework

ARHTP funds may be distributed through subrecipient awards, direct awards, interagency agreements, procurements, contracts, or other funding mechanisms authorized under applicable federal and State requirements. Applicable funding processes, including any Notices of Funding Opportunity (NOFO's), will establish requirements appropriate to the specific initiative and funding mechanism, which may include eligibility, organizational and programmatic capacity, responsiveness to identified rural healthcare needs, sustainability, alignment with ARHTP priorities, compliance readiness, and the ability to meet applicable performance measurement and reporting requirements.

8.4 Reporting Structure

- ADECA will establish financial, programmatic, performance, and other reporting requirements for subrecipients and contractors, as applicable to the specific award or contractual relationship. Reporting requirements, including required content, reporting frequency, due dates, format, and submission method, may be specified in the applicable NOFO, award agreement, contract, program guidance, or other written instructions issued by ADECA. Reports and supporting documentation will be submitted through the electronic system or other submission method designated by ADECA.
- Required information may include financial reports, expenditure and payment documentation, programmatic progress reports, performance metrics, milestone updates, sustainability information, and other supporting documentation necessary to process payment or reimbursement requests, monitor program performance and compliance, support State program administration, and satisfy applicable CMS reporting and evaluation requirements.
- Unless otherwise specified by ADECA, subrecipients and contractors will submit required information to ADECA, and ADECA will be responsible for applicable State-level reporting and submissions to CMS.

8.5 Decision-Making Framework

Program decisions will be guided by applicable federal and state requirements, established program priorities, eligibility requirements, compliance requirements, objective evaluation criteria where applicable, program priorities, sustainability considerations, duplication review, and available performance data. Award decisions will be made using published criteria and documented evaluation processes.

9. Legislative and Regulatory Alignment

The State will pursue legislative and regulatory actions to support telehealth parity and cross-facility credentialing; EMS treat-in-place reimbursement; CCBHC certification and funding alignment; data sharing and regional hub participation; cybersecurity standards; workforce development; rural facility solvency; and other policies aligned with RHTP technical factors and ARHTP sustainability goals.

SECTION IV: ALABAMA PROGRAM INITIATIVES

10.Program Initiatives

The initiative summaries below are based on the approved State Project Narrative. Funding levels and implementation timing are subject to CMS approval, State budget revisions, and other approved program modifications. References to participating entities are intended to describe the types of entities involved in or contemplated by an initiative and do not establish eligibility for funding. Eligibility and award requirements will be established through applicable NOFO's and award documents. Program metrics may be revised based on CMS direction or approved program modifications.

10.1 Collaborative EHR, IT, and Cybersecurity Initiative

- Establish regional IT provider-based hubs to assist rural facilities with IT infrastructure, cybersecurity operations, EHR integration, ALOHR/HIE connectivity, regulatory compliance, shared services, and incident response and recovery support.
- Participating entities may include rural hospitals, clinics, FQHCs, behavioral health providers, and regional referral centers, working collaboratively through shared services, aligned technology platforms, and coordinated data exchange.

Category	Information
Main strategic goals	Sustainable Access; Technology Innovation
Estimated funding	$125M over 5 years

Proposed Uses of Funds

- Establish regional IT and cybersecurity hubs.
- Procure and deploy updated IT and cybersecurity platforms.
- Procure, upgrade, or deploy EHR platforms and connect providers to ALOHR/HIE.
- Support shared services, monitoring, response, compliance assessments, and cost savings.

Program Metrics

- Number of regional hubs established and serving as IT provider-based hubs to local providers.
- Number of rural providers connected to regional hubs via IT and security operations.
- Number of rural providers connected to regional hubs via EHR.
- Number of EHR upgraded to connect with ALOHR HIE.
- Number of new provider connections to ALOHR HIE.
- Number of cybersecurity alerts triaged/worked by IT-provider-based hubs.

10.2 Rural Health Initiative

- Deploy telehealth and tele-consult services, regional hubs, EMS and provider connectivity, remote patient monitoring, specialty and emergent care access, transportation support, and a Rural Health Network pilot program based on shared services.
- Participating entities may include EMS agencies, rural hospitals, primary care providers, and regional referral centers working together through coordinated networks, telehealth platforms, and shared service delivery models.

Category	Information
Main strategic goals	Make Rural America Healthy Again; Workforce Development; Sustainable Access; Innovative Care; Technology Innovation
Estimated funding	$275M over 5 years

Proposed Uses of Funds

- Create regional hubs for telehealth and tele-consult specialty support.
- Fund local facilities to integrate with regional hubs.
- Support equipment upgrades and minor building renovations or alterations.
- Create or expand non-emergency transportation services.
- Pilot a Rural Health Network shared-services model program.

Program Metrics

- Number of regional hubs created.
- Number of endpoints deployed.
- Number of new telehealth consultations provided by funding recipients.
- Number of non-emergency transportation services created or expanded.
- Number of rural providers joining the Rural Health Network pilot.
- Number of shared services created in Rural Health Network.
- Number of shared services created in the Rural Health Network.

10.3 Maternal and Fetal Health

- Address rural maternal and fetal health gaps by connecting rural healthcare providers and facilities with regional maternal-fetal medicine resources through digital maternity care platforms, telerobotic ultrasound, and coordinated referral support. Regional referral hubs will provide rural providers with access to maternal-fetal medicine expertise and specialty services that may not be available locally. The initiative will also support emergency labor and delivery (L&D) carts at facilities without L&D units to provide stabilization until patients can be transferred to an appropriate hospital setting.
- Participating entities may include rural hospitals, obstetrician providers, regional specialty centers, and public health entities collaborating through coordinated care pathways and digital platforms to improve maternal and fetal health outcomes.

Category	Information
Main strategic goals	Make Rural America Healthy Again; Sustainable Access; Innovative Care; Technology Innovation
Estimated funding	$24M over 5 years

Proposed Uses of Funds

- Establish maternal and fetal health regional referral hubs.
- Connect rural facilities to regional referral hubs.
- Acquire and install telerobotic ultrasound devices.
- Deploy emergency L&D carts to facilities without L&D units.
- Support equipment upgrades and minor renovations or alterations.

Program Metrics

- Number of regional hubs created.
- Number of new local providers connected with regional providers to receive services funded by initiative.
- Number of new telehealth consultations provided by funding recipients.
- Number of telerobotic ultrasound procedures performed.
- Number of emergency labor and delivery carts acquired.

10.4 Rural Workforce

- Increase the number and quality of healthcare professionals in rural Alabama through education, training, recruitment, and retention strategies, including the Alabama School of Healthcare Sciences (ASHS), remote training, K-12 and community college pipelines, GME programs, certified nurse midwife and nursing programs, workforce incentives, and education support tied to rural service commitments.
- Participating entities may include academic institutions, healthcare providers, workforce development agencies, and training organizations working together to expand and sustain the rural healthcare workforce.

Category	Information
Main strategic goals	Make Rural America Healthy Again; Workforce Development
Estimated funding	$309.75M over 5 years

Proposed Uses of Funds

- Fund ASHS curriculum and equipment.
- Develop and implement remote Emergency Medical Technicians (EMT) and paramedic training.
- Create healthcare workforce pipeline partnerships.
- Establish or expand rural GME programs.
- Create or expand certified nurse midwife (CNM), licensed practical nurse (LPN), registered nurse (RN), dental, and other rural healthcare training programs.
- Provide incentives and education support tied to five-year rural service commitments.

Program Metrics

- Number of new students accepted to rural remote training programs.
- Number of programs established at existing rural providers to offer remote training for EMS.
- Number of programs established at existing rural providers to offer remote training for LPN/RN.
- Number of programs established to provide specialized GME in rural areas.
- Number of new rural-based GME residency positions created.
- Number of students entering certified nurse midwife training programs created or expanded through this initiative.

10.5 Cancer Digital Regionalization Initiative

- Expand cancer screening and early detection access through a digital regionalization model based on proven community partnership approaches, regional referral hubs, mobile screening, and community activation teams.
- Participating entities may include healthcare providers, public health agencies, community organizations, and regional hubs collaborating to improve access to cancer screening, strengthen regional coordination of screening services, and build community partnerships.

Category	Information
Main strategic goals	Make Rural America Healthy Again
Estimated funding	$25M over 5 years

Proposed Uses of Funds

- Expand cancer detection capabilities.
- Establish regional referral hubs and connect facilities to hubs.
- Fund mobile screening units in coordination with local providers.
- Use community activation teams for outreach, education, and social mobilization.

Program Metrics

- Number of regional hubs created.
- Number of local providers connected with regional providers to receive services.
- Number of rural counties served by newly established screening programs.
- Number of patients screened using mobile services.

10.6 Simulation Training Initiative

- Improve quality of care by expanding simulation-based training in specialties needed in rural facilities, including proven simulation-training programs already operating in Alabama.
- Participating entities may include hospitals, training organizations, and academic institutions working together to deliver specialized, hands-on training across rural healthcare settings.

Category	Information
Main strategic goals	Make Rural America Healthy Again; Sustainable Access; Workforce Development
Estimated funding	$15.5M over 5 years

Proposed Uses of Funds

- Expand or replicate simulation-based training programs.
- Create new or expand existing specialty simulation-based training programs.

Program Metrics

- Number of simulation programs established or expanded to deliver specialty-specific training.
- Number of simulation training sessions conducted.
- Number of providers trained under newly established programs.
- Number of rural counties served by newly established programs.

10.7 Statewide EMS Trauma and Stroke Initiative

- Expand statewide EMS diversion and routing systems, building on existing infrastructure where appropriate, route trauma, stroke, STEMI, psychiatric distress, L&D, respiratory distress, and other patients to appropriate facilities.
- Participating entities may include EMS providers, hospitals, and statewide coordination centers working together through integrated dispatch and routing systems.

Category	Information
Main strategic goals	Make Rural America Healthy Again; Sustainable Access; Innovative Care; Technology Innovation
Estimated funding	$20M over 5 years

Proposed Uses of Funds

- Expand trauma and stroke response capabilities to reach additional geographic regions.
- Expand statewide hospital referral services to include additional patient conditions.

Program Metrics

- Number of hospitals participating in diversion systems for additional proposed services.
- Number of EMS/ambulance services participating in diversion systems.
- Number of additional services included in diversion systems.
- Number of EMS calls routed through the new diversion system.

10.8 EMS Treat-in-Place Initiative

- Pilot treat-in-place models that allow EMS providers to treat low-acuity patients on-site with appropriate telehealth support and reimbursement, reducing avoidable transports, emergency department crowding, and EMS turnaround time.
- Participating entities may include EMS providers, hospitals, and telehealth support systems working together to implement treatment protocols and virtual consultation capabilities and to provide a revenue source for EMS providers.

Category	Information
Main strategic goals	Make Rural America Healthy Again; Sustainable Access; Innovative Care; Technology Innovation
Estimated funding	$25M over 5 years

Proposed Uses of Funds

- Establish a treat-in-place pilot program.
- Fund protocol development, telehealth equipment, software, connectivity, training, and other implementation needs.

Program Metrics

- Number of patients treated in place through treat-in-place program.
- Number of telehealth consultations conducted as part of treat-in-place encounters.
- Number of EMS providers offering treat-in-place services.
- Number of ambulances newly equipped with telehealth capabilities.

10.9 Mental Health Initiative

- Expand rural mental health access through school-based tele-mental health and CMHC-to-CCBHC conversion support to provide coordinated, comprehensive behavioral health care regardless of ability to pay.
- Participating entities may include schools, behavioral health providers, community organizations, and healthcare systems working together to expand access to school-based tele-mental health and coordinated behavioral health services, including primary care screening and monitoring through the CCBHC model.

Category	Information
Main strategic goals	Make Rural America Healthy Again; Sustainable Access; Innovative Care; Technology Innovation
Estimated funding	$45.75M over 5 years

Proposed Uses of Funds

- Support school-based tele-mental health planning, development, and implementation.
- Support CMHC planning, development, and conversion to CCBHC status.

Program Metrics

- Number of CMHCs converted to CCBHC status.
- Number of patients receiving primary care screening and monitoring from CMHCs converted to CCBHCs.
- Number of patients receiving mental health services with the CCBHC as the primary provider.
- Number of patients receiving substance use disorder treatment services with the CCBHC as the primary provider.
- Number of clinics established in schools.

10.10 Community Medicine Initiative

- Improve rural health outcomes and chronic disease prevention by expending access to preventive health screenings, health education and health literacy, nutrition-related services, food access resources, and community-based and mobile service delivery.

- Participating entities may include community organizations, healthcare providers, and local leaders working together to expand access to preventive health screenings, health and nutrition education, food access resources, and community-based and mobile services.

Category	Information
Main strategic goals	Make Rural America Healthy Again; Innovative Care
Estimated funding	$5M over 4 years (begins program Year 2 / 2027; no Year 1 funding)

Proposed Uses of Funds

- Procure mobile wellness screening equipment.
- Procure equipment for mobile grocery units, food pantries, and food banks; RHTP funds will not be used to purchase food.
- Provide or expand locations for mobile screening and mobile grocery services.

Program Metrics

- Number of mobile wellness units procured.
- Number of mobile grocery/market units procured.
- Number of wellness visits provided through newly created mobile events.
- Number of mobile grocery visits provided through newly created mobile events.

10.11 Rural Health Practice Initiative

- Establish or expand networked rural clinics that integrate physical health, behavioral health, preventive care, chronic disease management, telehealth, remote patient monitoring, dental services, and school-based health partnerships.
- Participating entities may include clinics, hospitals, educational institutions, and community organizations working together to deliver integrated, networked care in rural communities.

Category	Information
Main strategic goals	Make Rural America Healthy Again; Sustainable Access; Workforce Development; Innovative Care
Estimated funding	$30M over 5 years

Proposed Uses of Funds

- Establish or upgrade existing clinics to offer networked services in rural areas.
- Expand workforce recruitment and training.
- Develop and implement a shared services model among clinics.
- Acquire telehealth and remote patient monitoring equipment.
- Establish dental and healthcare clinics in rural educational facilities.

Program Metrics

- Number of clinics established or upgraded.
- Number of patients served through established or upgraded clinics.
- Number of medical trainees placed in established or upgraded clinics.
- Number of telehealth consultations conducted through networked clinics funded by the initiative.

SECTION V: FUNDING, FINANCIAL MANAGEMENT, AND IMPLEMENTATION

11. Funding Overview

The federal RHTP provides funding to approved states over five fiscal years, FY2026 through FY2030. Annual funding levels are subject to CMS approval, federal program requirements, and approved State budget revisions. Funding will support implementation of approved initiatives designed to strengthen rural healthcare systems, expand access to care, improve outcomes, modernize technology, and support sustainable rural healthcare delivery.

11.1 Implementation Plan and Timeline

ARHTP will be implemented through a phased, multi-year approach across Stage 0 through Stage 5. The State Project Narrative includes initiative-specific timelines with major activities in FY2026 through FY2030 and transition to sustainability and outcome evaluation by the end of the program period. Each ARHTP initiative will be implemented according to the applicable CMS-approved workplan, initiative-specific implementation schedule, NOFO, and award agreement. Timelines, milestones, and implementation activities may vary by initiative and may be revised in accordance with CMS and/or ADECA requirements.

11.2 Budget Categories

In addition to any other program requirements, budgets must include sufficient detail to demonstrate that proposed costs are allowable, necessary, reasonable, allocable, and consistent with federal and state requirements. Budget categories may include personnel, fringe benefits, travel, equipment, supplies, consultant/subrecipient/contractual, other direct costs, and indirect costs in accordance with the award agreement.

12. Allowable Uses of Funds

Allowable uses vary by initiative and funding mechanism. The list below summarizes general permissible categories and is not exhaustive. Specific allowable and unallowable costs will be defined by applicable CMS guidance, funding opportunities, approved budgets, award agreements, and ADECA program guidance. Per Section 71401 of Public Law 119-21, states must use funds for three or more approved uses of funds. The categories below summarize general permissible uses and are not intended to be an exhaustive list of costs allowable under every ARHTP initiative. Initiative-specific allowable and unallowable costs will be governed by applicable CMS guidance, NOFOs, award agreements, approved budgets, and ADECA program guidance.

- Prevention and chronic disease management.
- Provider payments for healthcare items or services where allowable.

- Consumer-facing technology solutions.
- Training and technical assistance for technology-enabled care delivery.
- IT advances, cybersecurity, hardware, software, and efficiency improvements.
- Right-sizing care delivery systems and service lines.
- Behavioral health and substance use disorder treatment access.
- Recruitment and retention of clinical workforce talent with rural service commitments.
- Innovative care models, value-based care arrangements, and alternative payment models where appropriate.
- Other sustainable access activities approved by CMS or otherwise authorized.
- Additional uses as designed to promote sustainable access to high-quality rural health care services, as determined by the Administrator.

13. Financial Accountability

13.1 Subrecipients and Contractors

ADECA will classify entities as subrecipients or contractors based on the nature of the relationship and the role the entity plays in carrying out program objectives. Subrecipients and contractors must comply with applicable federal statutes, regulations, CMS guidance, state requirements, and award conditions. Monitoring will include risk assessment, review of financial and programmatic reports, regular communication, desk reviews, site visits as appropriate, audit review, and corrective action when needed. Subrecipient monitoring will be conducted in accordance with CMS program guidance, Cooperative Agreement RHTCMS332060, and federal regulations, including 2 CFR Part 200 (Uniform Guidance). ADECA classifies entities as subrecipients or contractors using the criteria in 2 CFR 200.331. All entities receiving funds—recipients, subrecipients, and contractors—must comply with applicable federal, state, and local requirements, including state procurement law. Monitoring requirements applicable to a particular award, including the frequency, scope, and documentation of monitoring activities, will be identified in the applicable award agreement or other written guidance issued by ADECA.

13.2 Fiscal Controls

- The State will maintain fiscal management and internal control systems to ensure ARHTP funds are used only for authorized purposes. Controls will include expenditure tracking; supporting documentation; approval processes; segregation of duties; monitoring for fraud, waste, and abuse; and reconciliation to approved budgets and performance periods.
- Fiscal controls will be maintained in accordance with 2 CFR Part 200.302 (Financial Management) and 2 CFR Part 200.303 (Internal Controls), as well as any additional CMS and State requirements. These controls will be integrated into program operations to ensure consistent financial oversight and alignment with ARHTP performance and compliance objectives.

13.3 Duplication Assessment

ADECA will conduct duplication assessments consistent with its duplication policy to ensure RHTP funds do not duplicate state, local, or federally funded programs and activities. Applicants may be required to

disclose related funding sources, existing services, and planned coordination strategies to prevent duplication.

13.4 Audit Requirements

Recipients and subrecipients must comply with audit requirements outlined in 2 CFR 200, Subpart F (Audit Requirements). Reports on these audits must be submitted to the Federal Audit Clearinghouse (FAC) either within 30 days after receipt or nine months after the end of the fiscal year, whichever is earlier. The audit reports and a completed data collection form (SF-SAC) must be submitted electronically to FAC. FAC operates on behalf of the Office of Management and Budget (OMB). The State is responsible for ensuring audit readiness, addressing findings, and implementing corrective actions as necessary to maintain compliance and program integrity.

13.5 Funding/Financial Management

- In accordance with federal requirements under 42 U.S.C. 1397ee(h)(1)(B), RHTP funding is subject to redistribution if funds remain unexpended or unobligated. Unexpended funds are defined as those that are not fully spent by the State within the applicable timeframe for each budget period, including funds that have been set aside but not yet disbursed for approved activities, subawards, or contractual obligations. Unobligated funds refer to funding that has not been awarded by CMS within a given budget period.
- When such funds become available, CMS will redistribute them in the next feasible fiscal year using the same allocation methodology established for the program. Any funds that remain unexpended or unobligated as of October 1, 2032, will be returned to the U.S. Department of the Treasury.

13.6 Public Communications and Federal Funding Acknowledgment

When issuing statements, press releases, publications, requests for proposals, bid solicitations, or other documents describing a project or program funded in whole or in part with ARHTP funds, including toolkits, resource guides, websites, and presentations, subrecipients must clearly state the percentage and dollar amount of the total costs of the project or program financed with federal funds and the percentage and dollar amount financed by non-governmental sources. Each such statement must also include the acknowledgment of federal assistance prescribed by the Cooperative Agreement. Until one year after project completion, and unless ADECA advises otherwise in writing, subrecipients must obtain ADECA's prior written consent before releasing a document subject to this requirement to the public. Approval is not required for internal presentations, informational discussions, class lectures, or informal meetings and conversations with community leaders. The requirement as it applies to a particular subrecipient is set out in the applicable subaward agreement. Example acknowledgement language is provided below.

If the project is not funded with other non-governmental sources:

> This [project/publication/program/website, etc.] [is/was] supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $XX with 100 percent funded

by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

If the project is funded with other nongovernmental sources:

> This [project/publication/program/website, etc.] [is/was] supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $XX with XX percentage funded by CMS/HHS and $XX amount and XX percentage funded by non-government source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

14. Performance Measurement Framework

ARHTP will use program-level and initiative-level metrics to monitor effectiveness, demonstrate progress, support accountability, and inform course correction. Each metric should include a defined data source, geography, reporting frequency, baseline where available, target or expected direction, and documentation requirements. Metrics will support annual CMS reporting and, where applicable, public dashboards. Metrics and related requirements may be revised based on CMS direction, approved State program modifications, or program needs. ADECA will communicate required data sources and documentation standards to recipients through award documents or other written guidance.

15. Reporting Requirements

- Subrecipients must submit timely reports required by ADECA. Reporting will include financial status, expenditures by approved category, progress against workplan milestones, performance data, implementation challenges, sustainability updates, and any data necessary for evaluation. The State Project Narrative anticipates quarterly subrecipient reporting and CMS quarterly and annual reporting obligations, including GrantSolutions submissions, Federal Financial Reports, Federal Funding Accountability and Transparency Act (FFATA), SAM.gov responsibility/qualification records, Payment Management System (PMS) documentation, audit reporting, workplan updates, and certifications related to debarment and suspension.
- To remain eligible to continue to receive funding in subsequent budget periods, awardees must adhere to key program requirements, including the submission of quarterly and annual reports.
- Annual reports from ADECA to CMS are due 60 days before the end of the budget period. The first annual report is due August 30, 2026, covering a 7-month period; all subsequent annual reports will cover a 12-month reporting period.
- ADECA's quarterly reporting to CMS will begin in August 2026. ADECA's reporting periods are as follows: August 1 to October 30, October 31 to January 30, January 31 to April 30, and May 1 to July 31. ADECA's first quarterly report to CMS is due November 29, 2026.
- Additional CMS reporting requirements:
- Progress reports.

- Federal Financial Report (FFR).
- Federal Funding Accountability and Transparency Act (FFATA).
- SAM.gov Responsibility/Qualification records.
- PMS.
- Audit reporting (Federal Audit Clearinghouse).
- Workplan updates
- Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification.
- The State is required to comply with established reporting requirements, including timely submission of accurate financial and programmatic reports that demonstrate progress toward performance goals and proper use of funds. These reports must be supported by reliable data and sufficient documentation to meet federal transparency and accountability standards. Subrecipients are required to cooperate with ADECA as reasonably requested in order to enable compliance with CMS reporting requirements.
- The Final Report for all RHTP projects is due by February 27, 2031, which will include a comprehensive overview of all activities completed during the entire RHTP (FY26-31).
- The State will require all subrecipients to comply with applicable reporting requirements and participate in monthly in-person reporting meetings with ADECA. During these meetings, subrecipients will provide updates on program implementation, expenditures, performance, milestones, compliance matters, and any issues affecting project progress, as required by ADECA. ADECA may require supporting documentation or additional written information in connection with the monthly reporting meeting.
- RHTP funding is subject to federal transparency requirements under FFATA and implementing regulations at 2 CFR Part 170, which require public disclosure of federal spending.

16. Continuous Quality Improvement

- ADECA will use performance data, stakeholder feedback, monitoring results, and evaluation findings to support continuous improvement. Initiatives may be refined based on implementation experience, performance against metrics, duplication review, sustainability planning, and emerging rural health needs.
- The State will establish a formal corrective action process to address performance gaps, compliance issues, or implementation challenges identified through monitoring and evaluation activities. When deficiencies are identified, the State will work with subrecipients to develop and implement corrective action plans with defined timelines, measurable milestones, and ongoing oversight. Progress will be tracked to ensure resolution and sustained compliance with program requirements.

SECTION VI: COMMUNICATIONS, STAKEHOLDER ENGAGEMENT, AND SUSTAINABILITY

17. Stakeholder Engagement Strategy

- The ARHTP plan reflects a comprehensive and deliberate stakeholder engagement process that meets statutory requirements under Public Law 119-21, §71401(h)(2)(A), while fostering durable partnerships across rural communities. The State's approach emphasizes broad-based participation, alignment with federal guidance, and ongoing stakeholder consultation.
- The Governor's Office solicited input from more than 40 stakeholders, including hospital and healthcare executives, health officers, Indian tribe officials, and advocates for children, seniors, and people with disabilities. ARHTP will continue stakeholder engagement through advisory structures, targeted outreach, regional coordination, public-facing information, technical assistance, and communication with healthcare and community partners.
- Recognizing the importance of sustained engagement, Alabama has committed to maintaining ongoing stakeholder involvement throughout program implementation. ADECA, as the lead administering agency, will continue to collaborate with stakeholders through formal advisory structures and program governance mechanisms. Additionally, the Governor established the ARHTP Advisory Group by Executive Order No. 741 (December 18, 2025) to serve as the State's formal mechanism for continued stakeholder engagement and policy development.

18. Sustainability Framework

- By FY2030, Alabama expects ARHTP-supported initiatives to transition toward sustainability. Sustainability will be achieved through startup investments that enable self-supporting operations, policy changes that enhance financial viability, shared services and group purchasing, telehealth and treat-in-place reimbursement, regional networks, efficient service delivery, revenue diversification, and state or private funding where appropriate for ongoing transformation.
- Strategic investments in coordinated systems of care, workforce development, and technology infrastructure are designed to improve access, enhance care quality, and strengthen the financial and operational viability of rural healthcare providers. ARHTP advances sustainability through shared-service models, regional collaboration, and payment and delivery reforms that support efficient and scalable care delivery systems.
- The State's approach to workforce sustainability focuses on building and maintaining a robust pipeline of healthcare professionals through expanded training programs, partnerships with academic institutions, and targeted recruitment and retention strategies. These efforts are intended to ensure that providers are equipped to meet the evolving healthcare needs of rural communities and to support long-term workforce stability.
- Similarly, the program's technology sustainability strategy prioritizes the development of integrated digital health infrastructure, including expanded telehealth services, interoperable electronic health record systems, and strengthened cybersecurity capabilities. These

investments are supported by shared-service models and reimbursement mechanisms to ensure continued operation and long-term viability.

- In addition, ARHTP promotes regional system sustainability through the development of coordinated networks of care that facilitate collaboration among hospitals, clinics, emergency services, and community-based providers. These networks are designed to improve efficiency, reduce fragmentation, and support sustainable healthcare delivery across Alabama's rural regions.
- Collectively, these strategies establish a comprehensive and sustainable framework to improve healthcare access, quality, and outcomes for rural populations across Alabama.

19. Future State of Rural Healthcare in Alabama

- The future state of rural healthcare in Alabama is a coordinated, technology-enabled, financially sustainable, and community-responsive system that delivers high-quality care as close to home as possible. ARHTP will support regionalized care networks, stronger emergency response, digital maternal and specialty care, integrated behavioral health, modern IT and cybersecurity, robust workforce pipelines, mobile and preventive services, and data-driven accountability.
- The overarching objective of ARHTP is to ensure that, by FY2030 and beyond, rural Alabamians have consistent and reliable access to high-quality healthcare services, including both in-person and telehealth modalities. These efforts are expected to improve health outcomes, strengthen healthcare system sustainability, and enhance the resilience of rural providers across the state.
- This transformation is intended to create a lasting program legacy by establishing a sustainable, coordinated, and integrated rural healthcare delivery system that continues to generate value and improved outcomes for Alabama's rural communities over time.

APPENDIX A - GLOSSARY OF TERMS AND ACRONYMS

Acronym	Definition
ADECA	Alabama Department of Economic and Community Affairs
ADPH	Alabama Department of Public Health
ALOHR	Alabama One Health Record, Alabama's Health Information Exchange
ARHTP	Alabama Rural Health Transformation Program
ASHS	Alabama School of Healthcare Sciences
CCBHC	Certified Community Behavioral Health Clinic
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services

Acronym	Definition
EHR	Electronic Health Record
EMS	Emergency Medical Services
FIR Division	Federal Initiatives and Recreation Division of ADECA
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HIE	Health Information Exchange
HRSA	Health Resources and Services Administration
L&D	Labor and Delivery
NOFO	Notice of Funding Opportunity
RHTP	Rural Health Transformation Program
AOR	Authorized Organizational Representative
BREMSS	Birmingham Regional Emergency Medical Services System
CFR	Code of Federal Regulations
CNM	Certified Nurse Midwife
EMT	Emergency Medical Technician
FAC	Federal Audit Clearinghouse
FFATA	Federal Funding Accountability and Transparency Act
FFR	Federal Financial Report
FFY	Federal Fiscal Year
FY	Fiscal Year
HHS	U.S. Department of Health and Human Services
IHS	Indian Health Service
IT	Information Technology
LPN	Licensed Practical Nurse
OB	Obstetrics / Obstetrician
OMB	Office of Management and Budget
PMS	Payment Management System
REH	Rural Emergency Hospital
RHC	Rural Health Clinic
RN	Registered Nurse
SAM.gov	System for Award Management (the federal entity registration and exclusions system)
SF-SAC	Single Audit Report (Form SF-SAC)

Acronym	Definition
STEMI	ST-Elevation Myocardial Infarction
USDA	U.S. Department of Agriculture
Subrecipient	An entity that receives a subaward to carry out part of the ARHTP program and is accountable for program outcomes and compliance (see 2 CFR 200.331).
Contractor	An entity that provides goods or services within a competitive marketplace and is not responsible for programmatic decision-making (see 2 CFR 200.331).
Subrecipient award	A subaward of ARHTP funds to an entity that will carry out part of the program as a subrecipient (see 2 CFR 200.331).
Direct award	Funding provided to an entity without a competitive NOFO, where authorized.
Regional referral hub	A designated provider that delivers specialty support and coordination services to smaller rural facilities within a region.
Community activation team	A local partnership-based team that provides outreach, education, and social mobilization for program services.
Baseline amount	The portion of RHTP funds distributed equally among all approved states.
Workload amount	The portion of RHTP funds distributed by CMS formula based on rural need and program factors.
State Project Narrative	Alabama's CMS-approved application and plan for the Rural Health Transformation Program; the source document this manual operationalizes.
Rural workforce	The healthcare professionals - physicians, nurses, allied health, behavioral health, and support staff - who deliver care in Alabama's rural communities.
Regional specialty center	A facility that concentrates on specialized clinical services (for example, cancer or maternal-fetal care) to serve patients across a rural region.