California Rural Health Transformation Program: Rural Health Policy Council Charter

1. Overview and Purpose

1.1 Purpose Statement

1.1.1 California Rural Health Transformation Program background and history

The Rural Health Transformation Program (RHTP) is a federal initiative designed to strengthen health care in rural communities by helping states improve rural health access, quality, and outcomes through health system transformation. The federal RHTP is authorized by 42 U.S.C. section 1397ee(h) to establish the program and authorize allotments to states with approved rural health transformation plans.

California's approach is the California Rural Health Transformation (CalRHT) Program, led by the Department of Health Care Access and Information (HCAI). Through the RHTP, California has been awarded $233.6 million for Federal Fiscal Year 2026 to support rural and frontier communities across the state, with 100 percent of funding provided by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS).

HCAI, guided by input from rural health leaders and feedback gathered through broad partner engagement, will use the CalRHT Program to inform long-term investments, partnerships, and policy initiatives that support sustainable and resilient rural health systems.

1.1.2 What the Council is established to do

The Rural Health Policy Council (RHPC or Council) is created by HCAI to convene a broad group of partner representatives of California's rural health providers, including rural physicians, clinicians, health plans, clinics, hospitals, consumer advocates, Tribal leaders, and state departments.

The Council will be a public forum for rural health partners to discuss and advise HCAI on CalRHT Program implementation and general issues affecting health in rural communities. The Council will consider and discuss policy questions from the CalRHT team; propose ideas for CalRHT consideration; provide subject matter expertise; help

communicate CalRHT program information to their communities; and share program performance feedback from rural California communities.

CalRHT's approach is built around three interrelated initiatives:

- Transformative Care Model (TCM): The Rural Health TCM Initiative expands access, strengthens the rural workforce, evaluates payment structures, and deploys integrated telehealth solutions to deliver evidence-based care closer to home.
- Workforce Development: The Rural Health Workforce Development Initiative will drive lasting rural transformation by building a sustainable, locally rooted health workforce. The program will include investments in connecting students to pathway programs, developing early exposure to health careers for K-12 students, and to create connections for high school students to healthcare careers.
- Technology & Tools: The Rural Health Technology & Tools Initiative will equip rural health providers with the technical capacity necessary to strengthen clinical care and improve efficiency. This initiative will advance California's rural health care providers' ability to deliver high quality primary, maternity, and specialty care and support the TCM and Workforce Development initiatives by modernizing technology systems and infrastructure.

Collectively, these initiatives help promote a resilient rural health system where primary, maternal, and other health services are provided close to home. The Council will support this work by providing statewide input, coordination, and performance feedback throughout CalRHT implementation. Beyond the CalRHT Program, HCAI may elect to convene the Council to advise the department on general issues affecting health in rural communities.

1.2 Advisory Capacity

1.2.1 Advisory role; no decision-making authority

The Council is advisory to HCAI, and it is convened as part of CalRHT's governance approach. It does not exercise decision-making authority over the administration, funding decisions, compliance determinations, or implementation of CalRHT. Council feedback is advisory and does not bind HCAI or any other state department.

HCAI retains responsibility for final program decisions, including policy development, program administration, financing strategy, implementation timelines, reporting, and compliance with applicable federal and state requirements.

2. RHPC Membership, Roles, & Responsibilities

2.1. Membership Composition and Selection

2.1.1 Membership categories represented; selection/appointment process

The HCAI Director, or their designee, will appoint members to the RHPC.

Members of the Council will come from various partner communities including rural hospitals, clinics, provider groups, patient groups, Tribal leaders, and state departments involved in health care policy.

The Council shall have no more than 21 members. Membership may include:

- Up to seven (7) state departments' representatives. State departments may include representatives from the Department of Aging, Emergency Medical Service Authority, California Public Employees' Retirement System, Covered California, California Department of Public Health, Department of Health Care Services, and the Department of Managed Health Care.
- Up to twelve (14) members from rural health care partner communities, including:
    - Rural patient and/or consumer advocate (2)
    - Rural provider (2)
    - Rural health clinic (2)
    - Rural hospital (2)
    - Health care finance (1)
    - Health plans active in rural California (2)
    - Tribal representatives (2)
    - Member At-Large, a discretionary appointment of the HCAI Director (1)

2.2 Terms of Service

Members of the Council shall serve three-year terms, unless otherwise specified by HCAI. Members may be considered for reappointment to additional terms at the discretion of the HCAI Director, or their designee. Members may be appointed to complete the term of a member who resigns or is otherwise unable to continue serving. A member who chooses to resign shall notify the HCAI Director, or their designee, in writing.

Members serve at the discretion of the HCAI Director, or their designee, who may remove or replace members at any time.

2.3 Member Expectations

Council members are expected to attend and actively participate in Council meetings during their terms. Members are expected to attend at least three (3) of the four (4) scheduled quarterly meetings per year. Members who miss more than two (2) consecutive meetings without prior notice may be subject to removal.

Members are also expected to:

- Review meeting materials in advance.
- Participate constructively and respectfully.
- Share expertise grounded in rural health care experience and community needs.
- Provide feedback on CalRHT implementation, program progress, and performance.
- Help identify practical barriers and solutions for rural communities.
- Support communication of CalRHT Program updates to their communities and networks, as appropriate.
- Promote coordination across rural health, state, and local partners.
- Follow applicable HCAI meeting procedures, disclosure expectations, and conflict-of-interest guidance.

HCAI may review and revise this charter as needed to reflect CalRHT Program needs, Council feedback, changes in federal or state requirements, or HCAI policy direction. HCAI may also reassess the Council's scope and operations as CalRHT implementation evolves, including after the initial three (3) year member terms and as federal RHTP funding periods conclude.

2.4 Roles and Responsibilities

2.4.1. Council members

Council members are responsible for preparing for and participating in meetings, providing input on matters within the Council's scope, identifying rural health implementation considerations, and supporting HCAI's understanding of community needs and operational realities.

Council members may provide input and subject matter expertise, but do not have authority to make binding decisions on behalf of HCAI or the CalRHT Program.

2.4.2. CalRHT Program Director

The CalRHT Program Director, or their designee, will administer the Council. The Program Director will also set the meeting schedule and develop the agenda(s).

2.4.3. HCAI staff

HCAI is responsible for leading CalRHT implementation and supporting the administration and operation of the Council. HCAI staff responsibilities may include, but are not limited to, the following:

- Providing overall program leadership and policy, program, and legal context to support the Council's work and broader CalRHT Program.
- Supporting compliance with applicable HCAI meeting procedures, disclosure expectations, and conflict-of-interest requirements.
    - Managing the appointment process and maintaining official membership records.
    - Coordinating meeting logistics, agendas, notices, materials, and minutes.
- Serving as the primary point of contact for Council administration.

This role builds on HCAI's oversight of longstanding federal rural health programs including the Medicare Rural Hospital Flexibility Program, Small Rural Hospital Improvement Program, and Conrad 30 J-1 Visa Waiver Program. Through these initiatives and the launch of CalRHT, HCAI supports rural communities in developing sustainable solutions to address workforce shortages, improve care coordination, expand access to behavioral health and specialty care, strengthen emergency and hospital services, advance health information technology, and improve health outcomes for rural Californians.

2.4.4 Contractor support

HCAI may engage contractors or consultants to provide project management, facilitation, drafting, analytic, meeting support, or other administrative assistance for the Council. Contractors serve in a support role and do not exercise independent decision-making authority on behalf of HCAI.

2.5 Conflict of Interest and Required Disclosures

Council members shall disclose any actual or perceived conflict of interest as soon as the member becomes aware of the actual or perceived conflict of interest. Members shall recuse themselves for deliberations on matters where the member has an actual or perceived personal conflict of interest. Questions regarding recusal or related requirements may be routed through the CalRHT Director or other designated HCAI staff.

Members may be required to disclose certain financial interests by filing Statements of Economic Interest (Form 700).

3. Council Operations and Meeting Procedures

3.1 Public Meeting Framework

3.1.1 Public transparency and participation

Council meetings are intended to provide a public forum for rural health partner engagement. HCAI shall make reasonable efforts to promote transparency and public access, including by posting meeting agendas, providing information on how the public may attend, posting meeting materials, minutes, or summaries on the HCAI website, and providing information on how to request reasonable modifications or accommodations. Committee work will be subject to the California Public Records Act. Meetings will not be recorded or transcribed. The Council is an advisory body and does not exercise decision-making authority.

Although meetings of the Council are not subject to the Bagley-Keene Open Meeting Act, all meetings will be open to the public and HCAI will allow individuals to provide comments directly to the Council.

3.2 Meeting Cadence and Format

3.2.1 Frequency

The Council will meet at least quarterly and as needed.

3.2.2 Virtual, in-person, or hybrid format; accessibility commitments

To maximize Council participation by rural health partners across the state, meetings will be held virtually unless otherwise directed by HCAI, and video conferencing information will be provided in advance of each meeting. If in-person meetings are determined necessary by HCAI, details will be sent out two weeks prior with logistical details for attendance. Virtual options will remain available to ensure that participation is accessible for RHPC members and the public.

On occasion, ad hoc RHPC meetings may be necessary. Unless otherwise communicated by HCAI, the attendance procedures, participation options, and logistics are the same as quarterly meetings.

3.3 Public Comment

HCAI shall provide opportunities for public comment during Council meetings. Public comment procedures may be established by HCAI to support an orderly meeting process and ensure that public input can be received efficiently.

3.4 Meeting Minutes, Summaries, and Records

HCAI shall document Council meetings through meeting minutes, summaries, or other written records, as determined by HCAI. Meeting records may include agenda items discussed, key themes, public comments, Council feedback, implementation barriers, performance reporting updates, and advisory input.

Meeting minutes or summaries shall be posted on the HCAI website, consistent with HCAI practice.

3.5 Travel and Reimbursement

In person attendance is not a requirement for Council participation and HCAI will provide video-conferencing options for both Council and public participation.

The members of the Council will serve without compensation. Council members may seek HCAI consideration for reimbursement for actual and necessary travel expenses incurred in connection with their duties as members. When possible, members shall make requests for reimbursement to HCAI before incurring expenses.

Reference Documents

- HCAI California State Office of Rural Health Webpage
- CalRHT Frequently Asked Questions
- CalRHT Program Briefing
- CalRHT Project Narrative
- HCAI Notice of Award
- CMS Notice of Funding Opportunity

The CalRHT program is 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 $233,639,308.46 with 100 percent funded by CMS/HHS. The contents are those of CalRHT and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.