

California Rural Health Transformation Program (CalRHT)

Spring Webinar – Questions and Answers

Tuesday, April 21, 2026

We appreciate the strong engagement and thoughtful questions submitted during the CalRHT Program Spring 2026 Webinar hosted by California Department of Health Care Access and Information (HCAI). This document reflects a point-in-time response to the questions that were not addressed during the webinar and will not be updated on a regular basis. For the most current information, visit the [CalRHT webpage](#), where you may also sign up for the mailing list.

While not every question is answered individually, participants should find their questions addressed within the thematic responses. These responses are not intended to assess or determine whether a particular organization, program, or proposal meets eligibility or selection criteria. Detailed requirements, evaluation criteria, and measures of success will be clearly defined in the formal application materials. Applicants are encouraged to review those materials closely once released on the [CalRHT webpage](#), along with program-specific guidance.

The Centers for Medicare & Medicaid Services (CMS) [Notice of Funding Opportunity \(NOFO\)](#) also contains detailed information regarding applicant eligibility. [In Section 11](#) below, you will find additional resources that we recommend you review. Together, these materials are intended to support a shared understanding of CalRHT program goals, expectations, and requirements as applicants prepare for upcoming funding opportunities.¹

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¹ 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.

Section 1: Grant Eligibility — Applicant Type & Organization

Questions about which types of organizations (nonprofits, FQHCs, CBOs, state agencies, Tribal entities, vendors, for-profits, health systems, counties, etc.) are eligible to apply.

1. How do I know if my organization is eligible to apply for a CalRHT grant opportunity when requests for applications (RFA) are released in late Spring/Summer?

When available, review the program-specific RFA eligibility criteria and the Centers for Medicare & Medicaid Services (CMS) [Notice of Funding Opportunity \(NOFO\)](#) allowable uses to confirm your organization type, service area, and proposed activities meet the program requirements. If they align, your organization, project, or program is eligible to apply.

Applications may be open to a range of provider and non-provider organizations, including but not limited to nonprofits and community-based organizations and state/local agencies, on the condition that services are delivered or support the coordination of service delivery to rural communities as defined by Health Resources and Services Administration (HRSA) and advance the goals of rural health transformation outlined by the CalRHT programs approved by Centers for Medicare & Medicaid Services (CMS).

To learn more about CMS requirements, please review the [CMS NOFO](#).

2. My organization is delocalized (for example, a traveling service), do we qualify?

Eligibility is based on where services are provided and who benefits – not on the organization’s primary physical location. Organizations whose teams travel to, or deliver services in, rural communities may be eligible if their proposed activities clearly serve rural populations and meet program requirements as approved by Centers for Medicare & Medicaid Services (CMS). Partnering with a rural California organization is not required but is encouraged.

Applicants who are located in a rural community, such as a clinic or hospital, may include in their proposals the use of services from a non-rural organization.

3. What are key constraints an applicant should consider when determining fit to the CalRHT goals?

Applicants will be assessed according to their alignment and ability to advance the CalRHT goals for rural health transformation as approved by Centers for Medicare & Medicaid Services (CMS).

All applicants must be able to demonstrate clear evidence of their services (direct or supporting) benefiting and being delivered to rural communities as defined by Health Resources and Services Administration (HRSA) and approved by CMS.

To learn more about CMS requirements, please review the [Notice of Funding Opportunity \(NOFO\)](#).

4. What are common characteristics of successful applicants for this funding, particularly for projects or programs focused on workforce development and retention?

A successful CalRHT workforce applicant clearly demonstrates alignment with Centers for Medicare & Medicaid Services (CMS) priorities; shows how the initiative will impact the rural workforce; has strong, cross-sector partnerships; demonstrates readiness for implementation; has a viable sustainability plan; and is responsive to region-specific needs. All of the proposal's components should be explicitly tied to strengthening health workforce capacity in rural California.

For applicants proposing programs or services under Technology & Tools or Transformative Care Models (TCMs), success is similarly defined by the ability to demonstrate clear CMS alignment, measurable and well-documented impact, and planning that supports long-term delivery and sustainability.

5. Can out-of-state organizations that serve areas of CA apply directly or do they have to partner with a local CA organization?

Yes. An organization not based in California may apply directly for CalRHT funding if it can meet California state contracting requirements and provides program services in rural California; partnering with a rural California organization is not required but is encouraged.

6. Are fiscally sponsored organizations eligible to apply?

Yes. Fiscally sponsored organizations may apply for CalRHT funding through an eligible fiscal sponsor that can assume legal and financial responsibility, provided the proposed activities deliver allowable benefits to rural communities in California. Partnering with a rural California organization is not required but is encouraged.

7. What role can county public health departments play?

County public health departments may participate in CalRHT initiatives, including through subawards or partnerships, if proposed activities deliver clear and measurable benefits to rural communities. As noted in the [Centers for Medicare & Medicaid Services \(CMS\) FAQ](#), county health departments are not eligible to apply directly for federal RHTP awards and cannot be primary recipients of RHTP funding but may be selected by the State as partners or subrecipients.

Consistent with CMS guidance, any activities undertaken by county public health departments must comply with federal requirements, including restrictions on duplication or supplanting of existing federal, State, or local funding. States are responsible for ensuring that all proposed uses of funds align with the [CMS Notice of Funding Opportunity \(NOFO\)](#) and applicable funding limitations.

For additional details, please refer to the [CMS FAQs](#) on the [CMS Rural Health Transformation \(RHT\) Program webpage](#).

8. Is there a preference for funding to be spearheaded by a particular body (whether it's the county, a hospital, or a nonprofit) in a community where there is a coalition around addressing these goals?

CalRHT does not prefer a specific type of lead applicant across all possible subawards. Subawards or grants through the CalRHT program are specific to an initiative and workstream programs within that initiative, each with their own eligibility requirements and alignment to priorities and program activities. Generally, funding may be led by a hospital, nonprofit, or other eligible entity, and proposals are strongest when the lead organization is clearly positioned to coordinate partners, deliver rural impact, and sustain the work within a collaborative, communitywide approach. Partnering with a rural California organization is not required but is encouraged.

9. Will there be a focus on supporting rural Community Based Organizations (CBOs) and Hospitals over urban agencies that "serve" rural communities?

There is an intent to prioritize support for rural community-based organizations and rural hospitals, but urban-based agencies can still be funded when (and only when) their proposed activities deliver direct, demonstrable benefits to rural communities. For urban-based applicants, partnering with a rural California organization is not required but is encouraged.

10. How can programs demonstrate that their services are delivered to rural communities?

Programs are eligible if they clearly demonstrate that their services, activities, and funding benefit patients or providers from rural communities, using data such as patient residence, travel patterns, partnerships, and rural-specific outcomes. For urban-based applicants, partnering with a rural California organization is not required but is encouraged.

11. Are providers located in non-Health Resources and Services Administration (HRSA) designated areas who qualify as a reclassified rural referral center eligible?

Yes. Providers that are located in non-Health Resources and Services Administration (HRSA) designated areas but qualify as reclassified Rural Referral Centers may be eligible if their proposed activities demonstrably provide services to, or deliver clear benefits for, rural communities in California; reclassification alone is not sufficient without documented rural impact.

12. Are there limitations for large systems that have a mix of urban and rural facilities to use these funds for their rural efforts? Do they need to isolate rural-specific initiatives to ensure their urban facilities are not benefiting from funds?

Yes. Large systems with both urban and rural facilities may use these funds for their rural efforts, but they must clearly isolate and attribute funded activities, costs, and outcomes to rural-specific initiatives to ensure that rural sites directly benefit from the funds. You can determine whether you qualify as rural by checking the location of your service site(s) or the

communities you serve using the [Health Resources and Services Administration \(HRSA\) Rural Health Grants Eligibility Analyzer](#), which is the federal standard referenced by HCAI and Centers for Medicare & Medicaid Services (CMS).

Section 2: Grant Eligibility — Rural Definition

Questions about how 'rural' is defined, Health Resources and Services Administration (HRSA) rural designations, super-rural priority, and eligibility for organizations not physically located in rural areas.

1. How do we determine if we qualify as rural to be eligible for these grants?

You can determine whether you qualify as rural by checking the location of your service site(s) or the communities you serve using the [Health Resources and Services Administration \(HRSA\) Rural Health Grants Eligibility Analyzer](#), which is the federal standard referenced by HCAI and Centers for Medicare & Medicaid Services (CMS). California is basing eligibility on HRSA's rural definitions and applies if your location or the populations you serve fall within a rural area.

2. How does HCAI define “rural serving” for organizations that are not physically located in rural ZIP codes but serve rural or underserved populations?

HCAI defines “rural serving” based on who benefits from the services, not where the organization is physically located. Organizations outside rural areas are considered rural serving if they can clearly demonstrate that their funded activities deliver direct, measurable benefits to rural California communities, as defined by federal rural criteria, even when services are delivered from non-rural locations. For urban-based applicants, partnering with a rural California organization is not required but is encouraged.

3. Will 'super rural' areas have higher priority for funding?

There is no separate or automatic funding preference for “super rural” areas, but applications serving very high needs rural communities are often more competitive because scoring emphasizes severity of need, workforce shortages, access barriers, and the potential for meaningful rural impact.

Section 3: Grant Application Process — Timeline & Deadlines

Questions about when Request for Applications (RFAs) will be released, application deadlines, how long applicants have to respond, which programs open in 2026, and funds rollover.

1. When and where will application information be released?

Application information, including RFAs, eligibility criteria, timelines, and submission instructions, will be released on the CalRHT webpage hosted by HCAI. Announcements will

also be shared via HCAI and CalRHT email listservs and during upcoming stakeholder webinars. Applicants are encouraged to monitor the CalRHT webpage regularly and sign up for email updates to ensure they receive the most current information as it becomes available.

2. How long will applicants have to complete the RFA?

The application period for each RFA will be at least 30 calendar days. At the time of release, each RFA will have a clearly defined application period. HCAI anticipates providing an application period that allows sufficient time for applicants to review requirements, develop partnerships as needed, and prepare thoughtful and competitive proposals, consistent with CMS expectations. Specific timelines and deadlines will be detailed in the RFA materials when they are posted.

3. Is first-year funding disbursed to all awardees at the same time, or is it released based on each organization's contracting date?

Funding disbursement will be tied to the completion of required contracting and approvals. As a result, first-year funds will be released on a rolling basis, based on when each awardee completes its contracting process and receives final approval, rather than all awardees receiving funds at the same time.

4. Can awarded funds be carried over into subsequent years, such as through continued service delivery into Year 2 or via a no-cost extension?

Under current CMS guidance, CalRHT funds may not be carried over beyond the applicable budget period. Policies regarding fund carryover, including continued service delivery into future years or no-cost extensions, will be outlined in each individual RFA and are subject to Centers for Medicare & Medicaid Services (CMS) approval. CMS may allow or deny the carry-over of funds.

Section 4: Grant Application Process — Structure & Requirements

Questions about application structure, partnering requirements, number of awardees, county limits, milestone-based grants, reporting, and evaluation.

1. Do we have to have all partners identified and contracted before submission?

No. Applicants do not need to have all partners fully identified or contracted at the time of application; however, applications should describe anticipated partners, their roles, and how partnerships will support implementation. Final agreements may be required during the contracting phase, as outlined in the RFA.

2. Is it expected that grantees will propose annual projects or long-term (5-year) projects given the Centers for Medicare & Medicaid Services (CMS) funding approach?

Applicants should describe initiatives with a focus on the period of performance defined in each RFA but can also include their program strategy for subsequent program years. While CMS funding supports a multi-year transformation vision, individual awards confirmed in the first budget period will be structured in phased increments, with an emphasis on the grantee successfully administering the first grant award by September 2027. Applicants can include their planning and strategy for long-term impact and sustainability. Applicants may include anticipated budgets for additional program years, but the initial grant determination will be based on 2026-27 program plans and related budget.

3. Will counties be allowed multiple awardees, or is it only one per county?

Multiple awardees may be permitted within a single county. CalRHT grant determinations will depend on the specific RFA, applicant program design, and how the proposed projects demonstrate transformative rural impact.

4. What are the evaluation and reporting requirements? Is it expected that organizations partner with an external evaluator?

Evaluation and reporting requirements will be defined in each RFA and grant agreement and will align with Centers for Medicare & Medicaid Services (CMS) and HCAI reporting expectations. Grant applicants will be required to meet federal grant reporting expectations. Applicant proposals should demonstrate a clear and feasible approach to performance measurement, monitoring, and reporting. Specific evaluation expectations will be outlined in the RFA. Applicants are not required to partner with an external evaluator but may choose to do so. CalRHT will offer technical assistance to support grant recipients in meeting the grant reporting requirements.

5. For comprehensive, multi-faceted programs, do you expect one application for all facets or a separate application for each program?

Application structure will be defined in each RFA. Depending on the initiative and scope, applicants may be asked to submit a single, integrated application or separate applications for distinct program areas. The RFA will specify whether and how multi-faceted proposals should be submitted. CalRHT will offer technical assistance to help choose between single versus integrated submissions.

6. Are complete results from funded proposals required by the end of the funding year, even if some interventions require more than one year to collect outcome measures?

No. Awardees are expected to report on progress, implementation activities, and any available interim outcomes within the funding year. Final or long-term outcome results may extend beyond a single funding period and will be addressed through ongoing reporting, as specified in the RFA and grant agreement.

7. Who is the primary contact person for the CalRHT grant application process? Is there a unique person per initiative?

HCAI will serve as the primary point of contact for the CalRHT application process. A general program contact and application support information will be provided with each RFA, and some initiatives may identify additional or initiative-specific contacts as appropriate. All official points of contact will be clearly listed in the RFA materials. CalRHT will offer technical assistance to answer grant application questions.

Section 5: Funding — Scope & Federal Alignment

Questions about allowable and non-allowable uses of CalRHT funds and how they align with other federal programs, including budget structure and avoiding duplication.

1. Can CalRHT funds be used to pilot innovative tools or diagnostics?

CalRHT funds may be used to pilot innovative tools or diagnostics when they are directly aligned with CalRHT goals, support rural health transformation, and meet allowable use of funds criteria under CMS requirements. For a complete list of allowable uses and funding restrictions, please refer to pages 18–22 of the Centers for Medicare & Medicaid Services (CMS) [Notice of Funding Opportunity \(NOFO\)](#) and review the [CMS FAQ](#).

2. Can organizations seek funding for technology investments?

Organizations may seek funding for technology investments when those investments are directly aligned with CalRHT goals, support rural health transformation, and comply with Centers for Medicare & Medicaid Services (CMS) allowable use requirements. Specific eligibility, scope, and conditions for technology investments will be detailed in the applicable RFA. For a complete list of allowable uses and funding restrictions, please refer to pages 18–22 of the [CMS NOFO](#) and review the [CMS FAQ](#).

3. Are there particular technological tools or devices that will be prioritized, such as at-home diagnostics or screening tools?

Grant determinations will be driven by how the applicant's initiatives align with CalRHT program goals and the applicant's demonstrable ability to implement the proposed program, track its performance, and administer federal funds. Applicants will determine which specific technologies or devices to include based on how well the technologies or devices support their program goals, align with CalRHT goals, support rural access and care delivery, and comply with CMS requirements. Any priorities or eligible categories will be clearly outlined in the applicable RFA.

4. Do proposed technologies need to be already deployed, or can CalRHT funds support implementation and configuration activities?

CalRHT funds may support the deployment, configuration, integration, and optimization of existing technologies, as well as the design and implementation of new activities that align with CalRHT goals and Centers for Medicare & Medicaid Services (CMS) requirements.

CaIRHT funds are not intended to support the development of new commercial products. Specific allowable uses, expectations, and conditions will be defined in the applicable RFA.

For a complete list of allowable uses and funding restrictions, please refer to pages 18–22 of the [CMS Notice of Funding Opportunity \(NOFO\)](#) and review the [CMS FAQ](#).

5. Can CaIRHT funds be used to support mobile care equipment, such as non-emergency medical vans, that expand access to rural care?

CaIRHT funds may support mobile care equipment, including non-emergency medical vans, when such investments are directly tied to CMS-approved CaIRHT objectives and demonstrably expand access to care in rural communities. Any equipment supported must meet CMS allowable use requirements and be clearly linked to program-approved care delivery models, rather than general transportation purposes. Specific eligibility criteria, conditions, and limitations will be defined in the applicable RFA.

6. Any plans to support expanded and affordable Broadband access to support telehealth?

No. Establishing and expanding broadband access is not a permissible use of funds under the CaIRHT program. Applicants seeking to expand telehealth capacity should focus proposals on clinical technology tools and workflows, which may be eligible. For a complete list of allowable uses and funding restrictions, please refer to pages 18–22 of the Centers for Medicare & Medicaid Services (CMS) [Notice of Funding Opportunity \(NOFO\)](#) and review the [CMS FAQ](#).

7. Could this grant help fund contracting medical doctors for primary care physician services, mid-levels, or RN nurses?

No. CaIRHT grants may not be used to pay for direct patient care services provided by physicians, hospitals, and other clinical providers. Consistent with the Centers for Medicare & Medicaid Services (CMS) [Notice of Funding Opportunity \(NOFO\)](#), CaIRHT funds must be non-duplicative and non-supplanting and may not replace or offset any other available funding sources, including federal, state, commercial, or insurance payments. For a complete list of allowable uses and funding restrictions, please refer to pages 18–22 of the [CMS NOFO](#) and review the [CMS FAQ](#).

8. Does Centers for Medicare & Medicaid Services (CMS) allow rollover if any of the \$233 million is not spent in year 1?

All Budget Period 1 funding must be obligated by October 30, 2026 and spent within a one-year period. For example, any 2026 grant funding must be spent by September 30, 2027. Unspent or unallocated funds will be identified by CMS and redistributed to other states. Annual funding levels may be recalculated based on CMS's ongoing monitoring and updating of scores and states' progress. Under current CMS guidance, CaIRHT funds may

not be carried over beyond the applicable budget period. CMS may allow or deny the carryover of funds.

Section 6: Transformative Care Model (TCM) — Overview

Questions seeking clarification on what the TCM is, how hub-and-spoke models work, regional collaborative design, specialty care inclusion, and TCM terminology.

1. Where can more information be found on the Transformative Care Model (TCM)?

To learn more about TCM, please see the [CalRHT Project Narrative](#) and [Budget Narrative](#).

2. Are the rural healthcare collaboratives assigned or are these to be designed as part of the funding?

At the local level, rural collaboratives are not assigned by the state. Instead, applicants will design and propose rural collaboratives as part of their CalRHT funding application. Applicants will describe the composition, partnerships, and structure of their proposed collaborative, consistent with CalRHT goals, local rural needs, and CMS-approved program objectives.

3. Where can we learn more about the Hub-and-Spoke model and how participants are organized?

Additional information about the Hub-and-Spoke model, including participant roles, structure, and expectations, will be provided through official CalRHT program materials shared on the [CalRHT webpage](#). To learn more about TCM, you can also review the [CalRHT Project Narrative](#) and [Budget Narrative](#).

Section 7: Transformative Care Model (TCM) — Accelerator Partners

Questions about what an Accelerator Partnership is, who qualifies, evaluation criteria, and structure.

1. What is an accelerator partner and where can I learn more about it?

An accelerator partner is an organization that seeks to implement feasible components of the Transformative Care Model (TCM). Accelerator partners incubate, test, implement, and scale strategies related to workforce development, care delivery, technology, and sustainability. Accelerator partners identify local challenges, develop site-specific solutions, and seek to implement evidence-based approaches into scalable regional models that advance feasible components of the TCM and CMS-approved CalRHT goals.

To learn more about Accelerator Partners, please see the [CalRHT Project Narrative](#) and [Budget Narrative](#).

2. What type of organization might qualify as an accelerator partner?

Accelerator partners are organizations capable of functioning as innovation hubs within the CalRHT Transformative Care Model (TCM). They support rural health transformation by incubating, testing, and scaling workforce strategies, technologies, regional partnerships, and innovative care or payment approaches that can be replicated across rural areas. Accelerator partners are positioned to lead implementation and demonstrate locally developed solutions that strengthen rural care delivery across the state.

3. How are accelerator partners evaluated?

Accelerator partners are evaluated based on their readiness, capacity, and alignment with CalRHT and CMS-approved objectives, including their ability to incubate, test, and scale locally feasible components of the Transformative Care Model. Evaluation considerations include operational readiness, experience supporting regional implementation, and demonstrated ability to develop approaches that can be expanded across rural communities to advance sustainable transformation.

4. Will a list of eligible organizations be provided prior to the application period, and will a list of awarded organizations be publicly posted?

No. A list of eligible organizations will not be posted. Detailed eligibility requirements will be outlined in program guidance and application materials released prior to the application period.

The RFA will describe applicant eligibility criteria and review the Centers for Medicare & Medicaid Services (CMS) [Notice of Funding Opportunity \(NOFO\)](#) permissible use of funds. If your organization type, service area, and proposed activities meet these program requirements, you are eligible to apply.

5. Will there be communities of practice or ongoing forums for grantees, and how will progress be shared with the broader community?

CalRHT may support opportunities for grantees to participate in communities of practice, peer-learning forums, or other structured engagement activities to support shared learning and continuous improvement. These forums are intended to facilitate collaboration, knowledge exchange, and alignment with CMS-approved CalRHT goals.

Progress and lessons learned may be shared more broadly through program updates, webinars, reports, or other public communications, consistent with program guidance and CMS requirements.

Section 8: Workforce Development — Eligible Roles & Pipeline

Questions about which workforce roles are eligible under CalRHT, how they are defined and integrated, and how CalRHT supports workforce training, pipelines, and clinical placements.

1. Are there opportunities for Community Health Workers (CHWs) to be included in CalRHT funding and initiatives?

Yes. There are opportunities for CHWs to be included in CalRHT initiatives. CHWs are recognized as an important part of the rural health workforce, particularly for care coordination, patient navigation, and community outreach. Specific roles and eligible activities will be defined in the applicable RFA. To learn more about the roles of health professions such as Community Health Workers in CalRHT initiatives, please see the [CalRHT Project Narrative](#) and [Budget Narrative](#).

2. Will California create new billing codes to support the workforce providing essential services that are not currently reimbursed?

Centers for Medicare & Medicaid Services (CMS) permissible use of funds limit states to use only 15% of their total award for provider payments. California may continue to explore reimbursement and policy changes through other state and federal processes, but those efforts are separate from CalRHT. For more details regarding permissible use of funds, please see the [CMS Notice of Funding Opportunity \(NOFO\)](#).

3. Will CalRHT support innovation that improves integration of support staff and allied health professionals, promoting whole person care?

Yes. CalRHT may support innovative approaches that strengthen the integration of support staff and allied health professionals as part of team-based care models that advance whole-person care in rural communities. Eligible activities must align with CMS-approved CalRHT objectives and focus on improving care delivery, coordination, and workforce capacity rather than direct patient care services. To learn more about the Workforce Initiative, please see the [CalRHT Project Narrative](#) and [Budget Narrative](#).

4. Will the state's home and community-based caregiver workforce be eligible for workforce development initiatives, such as those supporting the state's aging population in their homes?

CalRHT workforce initiative focuses on strengthening the health care workforce in rural communities in alignment with CMS-approved program goals. Workforce development activities related to home and community-based care may be considered when they are part of a broader proposal and when the proposed roles, settings, and activities clearly align with CalRHT objectives and allowable uses of funds. Proposals focused exclusively on home and community-based services would require additional consideration to assess alignment with CalRHT goals.

For more information on the Workforce Initiative, please refer to the [CalRHT Project Narrative](#) and [Budget Narrative](#).

5. How does the CalRHT's workforce initiative align with HCAI's Workforce Education and Training Plan (WET) under development?

CalRHT's workforce initiative focuses on addressing rural health workforce needs by complementing HCAI's existing programs and developing new efforts tailored to the unique challenges of rural communities. While HCAI's Workforce Education and Training (WET) 5-year plan specifically supports the county behavioral health workforce, including those in rural communities, the CalRHT workforce initiative focuses on strengthening and expanding the rural health workforce without duplicating the efforts of the WET plan and HCAI's other behavioral health initiatives.

To learn more about the Workforce Initiative, please see the [CalRHT Project Narrative](#) and [Budget Narrative](#).

6. How will travelers fulfill the 5-year terms? Is this possible via their hybrid approach?

The five-year service commitment is intended to ensure sustained, onsite delivery of care in rural communities and must comply with Centers for Medicare & Medicaid Services (CMS) requirements. To fulfill the commitment, travelers must be physically located and provide services in a rural area, consistent with CMS standards.

7. Where can more information on the "Workforce Development" initiative be found?

Additional information about the CalRHT Workforce Development initiative will be shared through official CalRHT communications, including program guidance, informational webinars, FAQs, and updates posted on the [CalRHT webpage](#) as materials are finalized. As the initiative is further developed and approved, consistent with CMS requirements, HCAI will provide more detailed information regarding goals, eligible activities, and participation opportunities.

Stakeholders are encouraged to monitor the [CalRHT webpage](#) for the most up-to-date information. More information may also be found in the [CalRHT Project Narrative](#) and [Budget Narrative](#).

8. What is the vision for retention payments to providers, should these be tied to a metric or is there opportunity to reward longevity of current providers.

The CalRHT program seeks to grow a highly skilled rural health workforce by strengthening retention, recruiting, and relocation opportunities. Applicants can use these funds to recruit and relocate new providers and also help retain existing providers.

The primary metric is that all recipients complete the CMS required five-year service commitment to work in a rural community. Additional details will be included when the Request for Application is released but CalRHT's goal is to provide employers with flexibility in determining how best to distribute retention and relocation awards to their providers.

More information about relocation and retention program may be found in the [CalRHT Project Narrative](#). More information will also be made available as subaward opportunities are announced.

Section 9: Technology & Tools — Digital Infrastructure & Vendor Engagement

Questions about telehealth and digital infrastructure, and how vendors engage with CalRHT, including Regional Technical Assistance Center (RTAC) structure and group purchasing opportunities.

1. Will participation in nationwide interoperability networks be required for applicants?

Additional information will be outlined in program guidance and application materials released prior to the application period. Applicants are encouraged to consider electronic health record (EHR), health information exchange, cybersecurity, and revenue cycle management initiatives in their CalRHT applications. To learn more about the Technology and Tools Initiative, please see the [CalRHT Project Narrative](#) and [Budget Narrative](#).

2. Are Community Information Exchange model networks positioned to contribute to the CalRHT goals as approved by Centers for Medicare & Medicaid Services (CMS)?

Community Information Exchange (CIE) model networks may support CalRHT goals to the extent that their activities align with CMS-approved program objectives and allowable uses of funds. Any CalRHT funding used to support CIE-related activities must be non-duplicative and non-supplanting and may not replace other available funding sources, including federal, state, commercial, or insurance payments.

3. Is California exploring state-led approaches to help rural organizations identify, vet, and partner with vendors aligned to the state's rural health priorities?

California is exploring ways to support rural organizations by sharing information, facilitating learning, and encouraging alignment with CalRHT goals and CMS-approved program objectives. While the state does not endorse or select specific vendors, CalRHT and/or Rural Technical Assistance Center can offer guidance, technical assistance, or peer-learning opportunities that help rural organizations identify and evaluate potential partners aligned with rural health priorities.

4. When is Rural Technical Assistance Center (RTAC) expected to launch?

HCAI expects to launch the RTAC in late 2026 or early 2027. Additional details on timing will be shared through CalRHT communications as they become available.

Section 10: Rural Health Policy Council (RHPC) & Stakeholder Engagement

Questions about RHPC membership, stakeholder selection process, how to join, ongoing community engagement, and community of practice.

1. How will you include community input to ensure change meets the needs of the community and honors their voice?

CalRHT incorporates stakeholder input through multiple channels. Ongoing engagement includes the CalRHT web page as the central hub for program information, updates, timelines, plus a dedicated email inbox (CalRHT@hcai.ca.gov) for questions. The CalRHT web page and emails will also offer an opportunity to subscribe to a CalRHT listserv for updates. In addition, the RHPC will be a public forum for rural health stakeholders to discuss CalRHT program implementation.

2. How are stakeholders being identified for the Rural Health Policy Council? Is there an interest form or other application opportunity?

The HCAI Director will appoint members to the RHPC starting in Spring or Summer 2026. The Council will have stakeholders with rural health experience and subject matter expertise to ensure a qualified, representative Council. If you are interested in being considered for the Council, you can email your resume and an expression of interest to CalRHT@hcai.ca.gov.

Section 11: Resources

Please review the resources below for any further questions, and if not found there, contact the email below.

- [HCAI CalRHT webpage](#)
- [Centers for Medicare & Medicaid Services \(CMS\) RHT Program webpage](#)
- [CMS RHT Program FAQs - April 2026](#)
- [CMS RHT Program FAQs - October 2025](#)
- [CMS Notice of Funding Opportunity \(NOFO\)](#)
- [Health Resources and Services Administration \(HRSA\) Rural Health Grants Eligibility Analyzer](#)
- **Email:** CalRHT@hcai.ca.gov