Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

Budget Narrative

Proposed Initiatives

As described in the Project Narrative, California's Rural Health Transformation (CA-RHT) program includes three interrelated initiatives designed to achieve the goals in Section 71401 of Public Law 119-21 and the CMS-RHT-26-001 Notice of Funding Opportunity (NOFO). Together, they form a comprehensive strategy to expand access, strengthen the workforce, and modernize technology infrastructure in rural and frontier communities, each aligned with authorized uses of funds and sustainability requirements.

Initiative 1: The Rural Health Transformative Care Model Initiative

Description: Establish coordinated, regional Hub-and-Spoke networks that link rural hospitals, clinics, alternate birth centers, and community providers to hubs and telehealth systems, so patients get the right care, at the right time, close to home. The model integrates standardized care pathways, evidence-based models, evaluates rural payment approaches, and supports a digital "nervous system" to stabilize services, and improve health outcomes.

Initiative 2: The Rural Health Workforce Development Initiative

Description: Build and sustain a homegrown rural health workforce so people can access high-quality care close to home. The initiative aligns data-informed planning with pipeline development, practical training, and retention supports to expand primary, maternity, specialty, and behavioral health capacity across rural and frontier California.

Initiative 3: The Rural Health Technology & Tools Initiative

Description: Equip California's rural providers with modern technology, skills, and shared services to deliver coordinated, high-quality primary, maternity, and specialty care. The Technology & Tools initiative helps to ensure technology infrastructure is in place (e.g., connectivity, cybersecurity, virtual care platforms, consumer-facing apps and technology) to advance clinical integration and efficiency.

Program Structure

The CA-RHT program aims to address longstanding rural health divides, workforce shortages, and technology infrastructure deficits in California's rural communities. To ensure its success, the program will be led by a dedicated team in the California Department of Health Care Access and Information (HCAI). Within the departmental structure, the CA-RHT program will be supported by the California State Office of Rural Health (CalSORH). CalSORH's mission directly aligns with the goals of the RHTP: *"To transform rural health systems through innovation, collaboration, and targeted investment."*

HCAI's health workforce development team is well-positioned to coordinate with California's integrated state Medicaid agency, State Mental Health Authority, Single State Agency for Substance Abuse, Department of Public Health, behavioral health agencies, and state policymakers. By leveraging current relationships with the rural health leaders and organizations, such as the California Association of Rural Health Clinics, California Hospital Association, California Primary Care Association, Area

Health Education Centers, and more, HCAI is situated to create a program that involves the majority of California. HCAI already maintains strong relationships with rural hospitals, clinics, Tribal organizations, local health departments, and community-based organizations. These established partnerships provide an immediate foundation for CA-RHT program implementation, avoiding costly delays in relationship-building and trust development that a new or external agency would face. Additional resources will allow HCAI to administer this program sufficiently and expediently. The following proposed plan for staffing allows for the most impact.

HCAI envisions a structure for the CA-RHT program that aligns the three initiatives under the direction and management of a Program Director guided by department executives and informed by a Rural Health Policy Council. The Council will leverage HCAI's current relationships among health-related state departments, community and Tribal organizations, and partners on the front lines of rural health care delivery. The inputs will inform and direct the CA-RHT program with support from other business units and central program management coordination. The program organization is illustrated below.

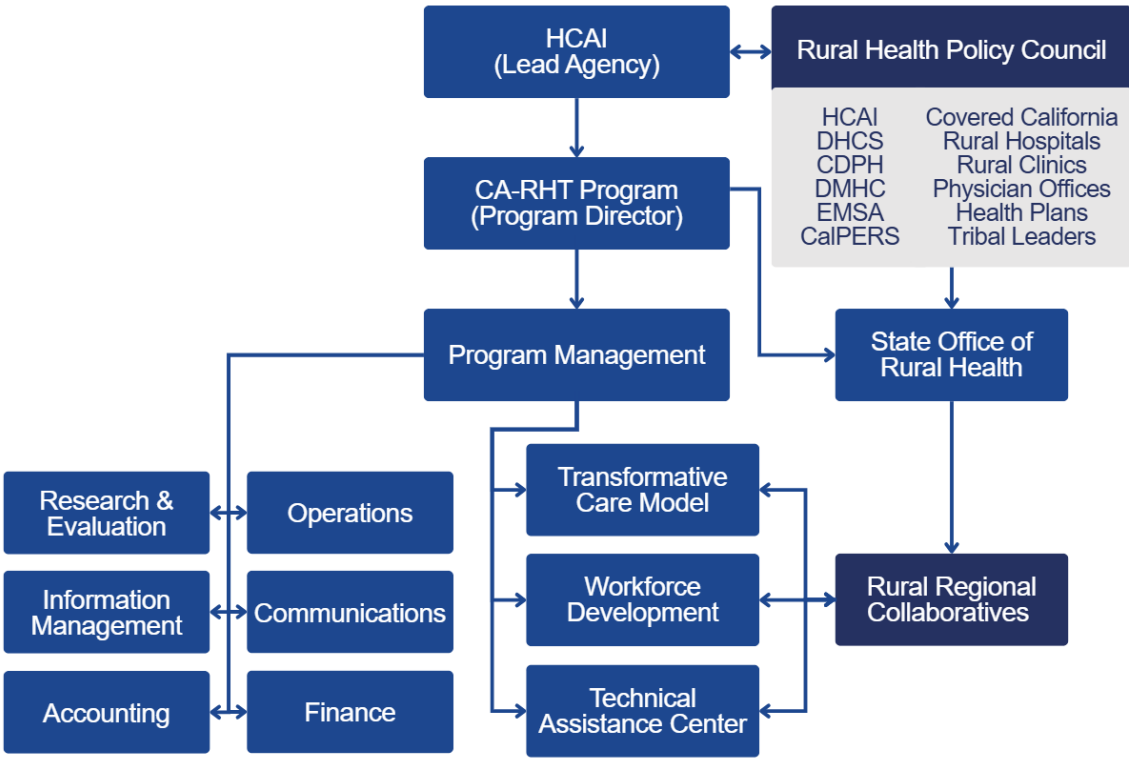

Figure 1 - CA-RHT program organization chart

This proposal requests federal grant funds in the amount of **$200 million** for each of the five budget periods to be expended over six years (federal fiscal years 2026 through 2031) for the following categories: Personnel, Fringe Benefits, Travel, Supplies, Consultants/ Contractors/ Subrecipients, and Indirect Cost. HCAI is committed to being a strong steward of this cooperative agreement through clear policies and procedures, strong performance-based subaward agreements, and regular monitoring of subrecipients (including financial reviews, data validation, and follow-up on any

corrective actions). HCAI will monitor expenditures, including those of subrecipients, to comply with appropriate uses of funds described in the NOFO, uniform guidance (e.g., 2 CFR Part 200), and applicable state requirements. HCAI's grant management practices will be supported by internal controls that help ensure costs are allowable, reasonable, and allocable under the terms of the grant award.

A. Personnel (Salaries and Wages)

Program Director – Hovik Khosrovian

The CA-RHT Program Director will be responsible for the coordination and implementation of HCAI's three rural health initiatives throughout the program period. From program initiation, this position will be filled by Hovik Khosrovian, HCAI's Senior Policy Advisor for Health Workforce Development. This will provide the CA-RHT program with leadership directly connected to HCAI's workforce development, rural health, and policy resources. During the first year of program implementation, HCAI plans to recruit a full-time Program Director to provide longevity and focus to the CA-RHT program for its duration. The Program Director will serve as the principal point for gaining input from the Rural Health Policy Council, directing the activities of the project initiatives, and helping ensure the program has the proper resources to achieve agreed upon outcomes. The Program Director will be the primary point of contact for the CMS Project Officer throughout the duration of the RHTP cooperative agreement.

HCAI is requesting federal grant funds to support 28 Full Time Equivalent (FTE) staff resources in a range of classifications as further described below.

Health Workforce Development Staff Resources

Health Workforce Policy Staffing

To implement the CA-RHT program, HCAI would need to create a new team dedicated to implementing this rural health transformation program. This team will be composed of one senior manager, one manager, one senior health program specialist, three health program specialists, and two analysts to assist in rural policy development and analysis.

Health Workforce Grants Management Staffing

To create and administer this program, HCAI will need a new unit for grants management that includes one manager and three analysts. This team would also take on additional grant funding opportunities to support CA-RHT, including grant implementation, administrative oversight, and grantee reporting.

Health Workforce Operations/Communications Staffing

To ensure program efficiency, two analysts will support HCAI's finance and operations unit to monitor program contracts, invoices, and program budgets. One analyst will support the communications team to issue timely announcements to rural stakeholders about CA-RHT.

Health Workforce Research and Evaluation Staffing

To assist with evaluation of grant program scoring criteria and outcome measures, HCAI proposes adding one research data specialist that will act as a rural health data subject matter expert.

Health Facility Financing Staffing

One health facility financing specialist will administer provider transformation payments for CA-RHT.

Clinical Innovation Staffing

The Transformative Care Model team will include one physician medical officer, one senior health program specialist, and one manager, plus consulting support.

Information Services Staffing

The Technology & Tools team will deploy consulting support to staff the Technical Assistance Center and administer IT grants. In addition, one research scientist will support rural health modeling and evaluation, and two information technology specialists will provide general IT support for the new program.

Administrative Services Staffing

HCAI requests five FTEs (one supervisor, one senior accountant, three analysts) for CA-RHT fiscal services support for the new program to support new accounting and general administrative workload, including monitoring of federal fund usage, and ensuring necessary reporting of federal funds.

The Rural Health Transformation Program represents a critical opportunity in California to advance accessibility and sustainability in California's rural health systems. These opportunities include structural IT and telehealth changes, substantial investments in rural and hospital workforce, and opportunities to increase the financial stability and sustainability of rural entities for years into the future. Housing the plan within HCAI ensures alignment with state goals, continuity with existing efforts, and responsiveness to the unique needs of rural Californians.

Table 1 - Personnel Levels and Cost by Position

Position Title	Name (if known)	Annual Salary*	FTE	Months (4.75 years)	Subtotal
Project Leadership					
Program Director (Interim) and Authorizing Officer (PD)	Hovik Khosrovian	In kind	0.5	9	$ 0
Chief Deputy Director (CDD)	Scott Christman	In kind	0.1	9	$ 0
Deputy Director for Clinical Innovation, Chief Medical Officer (CMO)	Lemeneh Tefera, MD, MSc	In kind	0.1	9	$ 0
Deputy Director, Chief Data Officer (CDO)	Michael Valle	In kind	0.1	9	$ 0
Program Director (PD)	Future recruitment	$ 122,622	1	57	$610,585
Health Workforce Development positions (Policy, Grants Management, Operations/ Communications, Research and Evaluation)					
Senior manager	TBD	$ 105,912	1	57	$527,379

Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

Position Title	Name (if known)	Annual Salary*	FTE	Months (4.75 years)	Subtotal
Senior health program specialist	TBD	$ 98,292	1	57	$489,436
Manager	TBD	$ 96,480	2	57	$960,826
Health program specialist	TBD	$ 89,472	3	57	$1,336,552
Analyst	TBD	$ 82,830	7	57	$2,887,110
Research data specialist	TBD	$ 104,910	1	57	$522,390
Health Facility Financing positions					
Health facility financing specialist	TBD	$ 89,472	1	33	$252,814
Clinical Innovation positions					
Supervising physician medical officer	TBD	$ 225,700	1	57	$1,123,852
Health program specialist	TBD	$ 98,292	1	57	$489,436
Manager	TBD	$ 96,480	1	57	$480,413
Information Services positions					
Senior IT specialist	TBD	$ 123,174	1	57	$613,333
IT specialist	TBD	$ 104,184	1	57	$518,774
Research scientist (modeling/evaluation)	TBD	$ 108,690	1	57	$541,212
Administrative Services positions					
Accounting supervisor	TBD	$ 96,480	1	57	$480,413
Senior accountant	TBD	$ 72,330	1	57	$360,160
Accounting analyst	TBD	$ 86,964	1	57	$433,029
Accounting analyst	TBD	$ 59,376	1	57	$295,657
Analyst	TBD	$ 82,830	1	57	$412,444
Total			**28**		**$13,335,816**

The table above reflects annualized mid-range salaries by position classification in Year 1. The requested staffing budget includes annual cost of living adjustments (COLA) of 2.5 percent. The following table summarizes the proposed CA-RHT Personnel Costs by Budget Year.

Table 2 - Personnel Costs by Budget Year

Personnel Category	FTE	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
Program Director	1	$91,967	$125,688	$128,830	$132,050	$132,050	**$610,585**

Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

Personnel Category	FTE	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
Health Workforce Development positions	15	$1,012,725	$1,384,058	$1,418,659	$1,454,125	$1,454,125	**$6,723,692**
Health Facility Financing positions	1	$67,104	$91,709	$94,002	$-	$-	**$252,814**
Transformative Care Model positions	3	$315,354	$430,984	$441,758	$452,802	$452,802	**$2,093,701**
Information Services positions	3	$252,036	$344,449	$353,060	$361,887	$361,887	**$1,673,320**
Administrative Services positions	5	$298,485	$407,930	$418,128	$428,581	$428,581	**$1,981,704**
Subtotals	**28**	**$2,037,671**	**$2,784,816**	**$2,854,437**	**$2,829,446**	**$2,829,446**	**$13,335,816**

B. Fringe Benefits

Rates for fringe benefits are identical for all the personnel classifications listed above. The current benefit rates for the proposed positions are listed in the table below.

Table 3 - Fringe Benefit Rates and Costs for Proposed Personnel

Fringe Benefits	Rate	Total Salary Requested	Amount Requested
OASDI, Tax	7.65%	$ 13,335,816	$1,020,190
Retirement	26.31%	$ 13,335,816	$3,508,653
Health and related benefits	19.10%	$ 13,335,816	$2,547,141
Total			**$7,075,984**

C. Travel

HCAI is proposing periodic travel to several rural regions throughout the state to support the Transformative Care Model initiative, meet with stakeholders, and directly observe outcomes at the county and community level. For budgeting purposes, we have estimated these "site visit" travel costs based on the following assumptions:

- There will be three (3) site visits in northern California and three (3) site visits in southern California per quarter. Each site visit will involve two (2) HCAI staff members. Each site visit will average three (3) days in total duration.
- Site visits in northern California will typically utilize personal vehicles within an average roundtrip of 440 miles from-to Sacramento.
- Mileage reimbursement follows federal standards for business mileage and is estimated to increase 1.5 cents per year.
- Costs for hotel accommodation, per diem, and incidentals are based on standard rates from United States General Services Administration (GSA).
- Site visits in southern California will typically involve flights and rental vehicles.
- Airfares are estimated based on average mid-week, fully refundable, coach class tickets on standard in-state airlines.

- Rental vehicle costs are estimated based on average mid-week, short-term, standard size vehicles from rental agencies typically found at southern California airports.
- Costs for accommodations, airfare, rental vehicles, ground transportation, and per diem assume increases of 2.5 percent annually.

Table 4 - Travel (in-state northern California) by Budget Year

Category	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
Personal vehicle mileage	$ 629	$ 642	$ 656	$ 669	$ 682	**$ 3,278**
Lodging	$ 7,920	$ 8,118	$ 8,321	$ 8,529	$ 8,742	**$ 41,630**
Per diem	$ 4,536	$ 4,649	$ 4,766	$ 4,885	$ 5,007	**$ 23,843**
Incidentals	$ 360	$ 360	$ 360	$ 360	$ 360	**$ 1,800**
Subtotals	**$ 13,445**	**$ 13,770**	**$ 14,102**	**$ 14,443**	**$ 14,791**	**$ 70,551**

Table 5 - Travel (in-state southern California) by Budget Year

Category	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
Airfare	$ 500	$ 513	$ 525	$ 538	$ 552	**$ 2,628**
Ground transportation	$ 1,800	$ 1,845	$ 1,891	$ 1,938	$ 1,987	**$ 9,461**
Lodging	$ 10,224	$ 10,480	$ 10,742	$ 11,010	$ 11,285	**$ 53,741**
Per diem	$ 5,400	$ 5,535	$ 5,673	$ 5,815	$ 5,961	**$ 28,384**
Incidentals	$ 360	$ 360	$ 360	$ 360	$ 360	**$ 1,800**
Subtotals	**$ 18,284**	**$ 18,732**	**$ 19,191**	**$ 19,662**	**$ 20,145**	**$ 96,014**

Note: HCAI has classified travel related to site visits as Non-administrative Expenses and anticipates the majority of in-state travel will be in direct support of the Rural Health Transformative Care Model initiative.

In addition to the in-state travel, HCAI understands the expectation for annual meetings with CMS to be held in or around the CMS headquarters in Baltimore, MD. For budgeting purposes, we have estimated these CMS-related travel costs based on the following assumptions:

- There will be one (1) meeting per year in Baltimore, MD or Washington, DC (or similar). Each meeting will involve two (2) HCAI staff members. Each trip will average four (4) days in total duration, inclusive of travel time.
- Costs for hotel accommodation, per diem, and incidentals are based on standard rates from United States GSA.
- Airfares are estimated based on average mid-week, fully refundable, coach class tickets on standard domestic airlines.
- Rental vehicle costs are estimated based on average mid-week, short-term, standard size vehicles from rental agencies typically found at Baltimore-area airports.

- Ground transportation (e.g., taxicabs) may be used in lieu of rental vehicles, depending on availability and distances between airports, meeting venues, and lodging.
- Costs for accommodations, airfare, rental vehicles, ground transportation, and per diem assume increases of 2.5 percent annually.

Table 6 - Travel for CMS meetings by Budget Year

Category	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
Airfare	$1,520	$1,558	$1,597	$1,637	$1,678	**$7,990**
Ground transportation	$300	$308	$315	$323	$331	**$1,577**
Lodging	$2,200	$2,255	$2,311	$2,369	$2,428	**$11,564**
Per diem	$696	$713	$731	$750	$768	**$3,658**
Incidentals	$40	$40	$40	$40	$40	**$200**
Subtotals	**$4,756**	**$4,874**	**$4,995**	**$5,119**	**$5,246**	**$24,989**

Note: HCAI has classified CMS meeting travel as Administrative Expenses in its budget.

D. Equipment

None.

E. Supplies

HCAI is proposing a modest budget of $555,737 for supplies, primarily related to laptops, technology peripherals, and training materials required for new employees as well as typical consumable items (e.g., paper, copier/printer ink). The planned expenditures are aligned with the addition of 28 FTEs in Year 1, and allow for periodic replacement of technology, refreshing of consumables, and staff turnover prompting new and/or added supplies over the five-year program period.

F. Consultant/Subrecipient/Contractor Costs

In accordance with the permissible uses of RHT program grant funds, the proposed initiatives are based on new programs as well as expansions of past or current programs specifically designed to address rural regions. The cost estimates, timeframes, and rationale for the consultants, subrecipients, and contractors listed below are based on prior experience, input from existing regional care networks, and relevant prior proposals from technology providers. HCAI expects to finalize service scope, budgets, and timeframes with CMS input and approval prior to drawing down federal funds for the services described. A description and cost breakdown is provided below for each consultant, subrecipient, and contract proposed.

Consultants

Consultant Selection Process and Criteria

HCAI will award consulting contracts in accordance with California's Public Contract Code, standard procurement practices, and using leveraged procurement agreements (LPAs) where appropriate. Selection of awardee(s) for each consulting role described below will be based on factors specific to the services required. In all cases, selection criteria will include:

- Proven experience delivering similar, relevant services

- Prior work with federal, state, or local government agencies
- Availability and experience of appropriate staff resources
- Location in, near, or accessible to rural communities as needed for participation in CA-RHT initiatives
- Reasonableness of cost

In support of the Rural Health Transformative Care Model Initiative:

Evaluating Rural Pathways to Value Based Payment *$2,000,000*

Consultants with specialized experience in health care financing and rural payment models will be instrumental in helping California evaluate payment model types that can provide long-term support for rural hospitals. This funding will support a consultant to conduct a national and state landscape assessment of rural primary care, maternity, and hospital payment models. The consultant will evaluate hospital payment models, including their evidence base, financial sustainability, and identify the specific operational, workforce, technology, and revenue generating options that rural facilities could adopt to support rural hospitals' long-term financial stability. Lastly, the consultant will provide recommendations on how to successfully incorporate innovative payment models into the CA-RHT's Transformative Care Model and other CA-RHT future investments.

In support of the CA-RHT Implementation:

Program Management Support *$24,250,000*

HCAI is proposing to engage program management consultants to support the Program Director and HCAI staff members during the CA-RHT period of performance. Due to the fixed duration of federal RHTP funding and the temporary need for certain services, it is more cost-effective to acquire limited duration consulting services than add sufficient full-time, permanent civil service staff positions to address all the temporary service needs. Program management services should include:

- Development and implementation services for CA-RHT: Assist HCAI with CA-RHT development, strategic planning, and technical assistance to guide effective and efficient plan implementation. Support HCAI in communicating and coordinating with grantees and stakeholders to help ensure successful implementation of the initiative. Aid in establishing CA-RHT governance to include a new Rural Health Policy Council. Subject matter expertise in rural health systems, financing, and information technology infrastructure will accelerate progress and help maintain compliance with state and federal grant requirements.
- Initiative-level support and evaluation: Provide a range of subject matter expertise in developing initiative-level evaluation plans for CA-RHT to measure the near-term and long-term impacts of systemic changes and improvement of the rural health capabilities. This work includes support on program design, evaluation methodology, performance metrics, and impact analysis.
- Research and data development support: Aid HCAI in collecting, analyzing, and interpreting rural health data, identifying gaps, and generating actionable insights to support evidence-based decision-making including assessment of health workforce needs and health service delivery.

- Community outreach and communications: Consultants experienced in rural community engagement can develop targeted messaging, design outreach campaigns, and foster strong partnerships with local stakeholders helping ensure CA-RHT initiatives are visible, accessible, and well-supported through the duration of the implementation period.

Developer Support for Electronic Grant Applications *$5,0000,000*

Provide development resources for electronic applications to facilitate efficient management of subaward grant agreements from request through award. This includes applications to aid the oversight and administration of grant agreements and funding distribution, accounting and budget services for fund tracking, contract and grant agreement processing, data collection, and analysis and evaluation of the proposed grant type. Consultant services will be inclusive of project management activities, requirement planning and lifecycle management, software configuration and development, and knowledge transfer.

Consultant Budget Summary

Table 7 - Consultant Budget by Budget Year (figures in millions)

Initiative	Purpose	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
Transformative Care Model	Evaluate Rural Pathways to Value Based Payment	$ 1.00	$ 1.00	$-	$-	$-	**$ 2.00**
Administrative	Program Management	$ 3.75	$ 5.25	$ 5.50	$ 5.25	$ 4.50	**$ 24.25**
Administrative	Developer Support for Electronic Applications	$ 1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00	**$ 5.00**
Subtotals		**$ 5.75**	**$ 7.25**	**$ 6.50**	**$ 6.25**	**$ 5.50**	**$ 31.25**

Subrecipients

HCAI is proposing to provide several different types of subawards to a wide variety of subrecipients that will fulfill the RHTP objectives in targeted rural regions and statewide. Subrecipients will include hospitals, clinics, Tribal health programs, and healthcare facilities throughout rural regions that HCAI identifies as suitable partners to develop Hub-and-Spoke networks. Some of the subawards will be specifically to add, expand, or enhance critical technology and tools to enable widespread interoperability and coordination among healthcare providers in targeted rural regions.

Subrecipient Selection Process and Criteria

HCAI will determine subaward recipients based on factors including:

- Strategic locations to directly support rural communities in greatest need
- Hospital and facility capability, readiness, and willingness to participate in Transformative Care Models (e.g., as demonstrated by processes and programs in use)
- Financial criteria that indicate hospital hubs are not in immediate danger of closure

HCAI intends to provide subawards to community colleges and other educational institutions in or near rural regions that will contribute to learning pathways, clinical education, licensing programs, scholarships, and other approaches to expand a capable workforce throughout rural California.

Additionally, HCAI will dedicate a minimum of five percent (5%) of its overall budget to support participation of Tribal clinics and health centers in fulfilling the RHTP objectives.

To ensure accountability, transparency, and effective management of these funds, HCAI will implement a structured grant administration process spanning the full lifecycle of each subaward. Budgets and timelines will be aligned during funding setup, and standardized materials will be prepared to support consistent administration. Eligible entities will submit proposals through a formal review and scoring process, with award criteria finalized following community needs and capacity assessments. Prior to disbursement, HCAI will verify selected applications, issue agreements, and confirm funding commitments. Monitoring and closeout activities will include deliverable tracking, financial reconciliation, and performance evaluation to ensure responsible implementation and measurable impact aligned with CA-RHT objectives.

In support of the Rural Health Transformative Care Model Initiative:

Transformative Payments to Support Strategically Located Hospitals *$40,000,000*

HCAI will issue these funds through grants for approximately 16 subrecipient hospitals with financial and operational challenges that are strategically important to retain in effective operations for targeted rural regional access. Awardees will commit to implementing feasible Transformative Care Model components as a condition of receiving funds. This proposal offers upfront funding to these rural hospitals, paired with a five-year transformation plan modeled on RHTP to implement financial solvency strategies. In Year 1, hospitals will conduct root-cause analyses of financial instability; in Years 2-5, they will implement targeted reforms (e.g., modernizing billing, adopting sustainable staffing models, participating in Hub-and-Spoke to reduce rural bypass, and strengthening community partnerships) to address systemic vulnerabilities. These funds are not intended to replace payment for billable services or to supplant existing adequate sources of hospital funding. HCAI intends to execute agreements with each subrecipient specifying allowable uses of funds that are compliant with CMS requirements– including those related to permissible uses of funds, subaward monitoring, financial reporting, and compliance.

Establish Regional Hub-and-Spoke Networks *$227,000,000*

Participating hospitals, clinics, and affiliated rural providers will receive annual grant funding to directly implement the Transformative Care Model (TCM) within their regional Hub-and-Spoke networks. Funding will enable each facility to operationalize the evidence-based care delivery, workforce, and technology changes identified through regional planning and gap assessments. Facilities (hubs and spokes) will focus on redesigning internal care flows, integrating telehealth and interoperable EHR systems, establishing transfer and referral pathways, and expanding service lines such as maternity, chronic disease, and specialty care. Additionally, spoke partners will use funds to extend access to coordinated, specialty-supported care (e.g., CHWs), align

with new regional governance and protocols, and integrate digital health and data-sharing capabilities needed for active participation in the network. This could also include consumer-facing app-based technology with prevention-based programs that can target chronic disease conditions, link patients to clinical teams, and promote healthy habits for patients.[1]

Grant funds will also support workforce expansion and training essential to sustaining new care models in rural settings. Facilities may hire or retrain staff in care coordination or telehealth operations; provide stipends for clinical staff to complete evidence-based training (e.g., Project ECHO, OB Nest, tele-OB and tele-cardiology modules); and establish shared scheduling, call coverage, or transfer coordination systems that strengthen service continuity across the network. Hospitals and clinics will be expected to embed these workforce and operational changes into their local structures, ensuring that care transformation is integrated, measurable, and sustainable beyond the grant period.

While the statewide contractor provides overall technical assistance and facilitates regional collaboration, facilities serve as the operational engines of transformation — implementing care redesign, adopting new technologies, and maintaining workforce and governance systems on the ground. Annual funding will thus prioritize tangible improvements in care delivery capacity, interoperability, and local system performance — ensuring that rural hospitals and clinics are fully equipped to function as active, resilient participants within California's evolving Hub-and-Spoke model for rural health transformation.

In Year 1, the CA-RHT program will launch select "Accelerator Partners"— hospitals or other organizations in rural regions that demonstrate strong readiness and commitment to implement the TCM through a Hub-and-Spoke network. These early partners will serve as testing sites for new innovations and models, demonstrating how integrated service delivery and value-based care can strengthen access, quality, and sustainability in rural and frontier communities. Accelerator regions will receive $6-8 million annually to support hospitals, clinics, Tribal health programs, and affiliated providers in implementing evidence-based care models, building workforce capacity, expanding telehealth, and advancing interoperability. Lessons learned from these Accelerator Partners will inform statewide scaling and continuous improvement of the Hub-and-Spoke framework in future years.

Expand Support for Non-Physician Clinical Roles *$35,000,000*

This component will help address critical workforce shortages in primary, maternity, and specialty care by expanding the utilization of doulas, midwives, and perinatal CHWs. Intended programs include five midwifery education programs, which includes licensed midwife and certified nurse midwife programs ($2 million each annually) and 10 varied health professions education programs, based on regional need, supported by funding for program development for rurally located schools ($1 million per program annually). This will support the growth of CHWs, LVNs, doulas, midwives, entry level behavioral

[1] This application is in alignment with the CMS Health Technology Ecosystem referenced at https://www.cms.gov/health-technology-ecosystem/categories

health providers, and other allied health roles who provide critical frontline care and improve access, quality, and continuity of services.

Expand Rural Health Train-the-Trainer *$4,000,000*

Launch scalable "train-the-trainer" programs for physicians, nurse practitioners, nurses and allied staff to build competencies in maternal health, chronic disease management, behavioral health, and telehealth delivery. Intended training includes integrating behavioral health into primary and maternal care through clinician train-the-trainer programs including providers working with the aging population. HCAI will design and introduce the program in Year 1, then expects to support the mentoring relationships for approximately 50 trainer-student teams per year estimated at $0.5-1 million annually in Years 1-5.

Expand and Support Rural Workforce Capacity *$26,000,000*

HCAI will build this program in Year 1 and in Years 2-5, will invest $4-8 million annually to implement clinician upskilling programs, family medicine obstetric fellowships, and Project ECHO and OB Nest programs. This will include offering obstetric training fellowship opportunities to family medicine physicians and advanced practitioners to train in obstetric care. It will leverage entry-level and allied roles to build skills aligning with system priorities like telehealth and remote monitoring, integrating these capabilities into clinical workflows. The program will help incentivize allied health professionals including nurses, pharmacy technicians, and emergency medical service personnel to pursue CHW training that enhances collaborative care for chronic conditions, care coordination, and transport support.

In support of the Rural Health Workforce Development Initiative:

Career Pathways Grants *$65,000,000*

Beginning in Year 1 and growing in Years 2-5, provide funding to rural region high schools, community colleges, and California State University campuses to connect local students to health professions through career education and counseling, mentorships, internships, and fellowships. Connect entry-level job roles (e.g., CNA/technicians) to a career lattice for apprenticeships and continuing education to expand the ability and breadth of medical professional capabilities. Funds will include wrap-around support to enable students to access these programs. The budget plans for $5 million in the first year as HCAI establishes grant terms and identifies up to 20 participating schools. As more schools and students opt into the programs, grants will grow to $12 million per year to support up to 50 locations.

Rural Clinical Placement Support and Training Pathways *$39,000,000*

Develop a clinical placement network to connect health profession students (e.g., RNs, AA, BS and MS degree level professions) with rural facilities, including Tribal clinics. Expand regional training capacity in rural areas including clinical rotations and practicum opportunities for health professionals This network and training capacity expansion will create opportunities for students to gain increased access to rural health training and allows local rural colleges and training programs to have consistent and reliable clinical opportunities for their students in rural communities. HCAI proposes to build this program in Year 1 following the design of similar successful programs. In Years 2-5, the CA-RHT program will expand opportunities for individuals pursuing

health careers or currently in entry level health professions to receive scholarships, stipends, upskilling, and apprenticeships to find right-fit training and education programs in rural counties/regions focused on meeting the workforce needs of those communities aligned with service commitments following their education and training.

Expand Rural Provider Retention and Relocation *$130,000,000*

Funds awarded within this initiative will focus on supporting regional collaborations of rural facilities to ensure coordination of services across the community and sharing of funds between organizations of varying sizes and resources. The funds will focus on rural facility needs, including Tribal clinics. Support includes facilities' use of funds for retention and relocation bonuses for providers who commit to the five-year service obligation. HCAI proposes expanding prior programs and extending them to specifically targeted rural regions to help ensure pipelines of new, qualified resources are prepared to complement the Transformative Care Model. This will include:

- Retention bonuses to help clinics maintain and support providers that are already practicing in rural and frontier communities
- Relocation bonuses with fixed-term service requirements
- Funding for onboarding, precepting, temporary housing, and the supervision of students to ensure rural facilities have the capacity to offer licensure and or certificate-mandated supervision time for providers that are in greatest need for that region or community.
- A funding set-aside specifically for Tribal health programs to implement organization-based retention and relocation efforts.

HCAI proposes spending $20-30 million annually in Years 1-5. HCAI will require facilities in a community or region to work together to ensure providers are fully utilized across the community.

In support of the Rural Health Technology & Tools Initiative:

Technology & Tools: EHR Modernization Grants *$50,000,000*

Provide funds to upgrade, enhance, and extend needed infrastructure technology, including Electronic Health Record (EHR) systems, with a focus on rural, frontier, and Tribal health facilities that are currently unable to effectively exchange patient data with other providers. These funds are allocated separately from other technology grants as a safeguard to remain within the constraints of the permissible use of funds for EHR replacements.

Technology & Tools: Improvement Grants *$152,000,000*

Support and optimize technical systems needed for rural hospitals, clinics, and other facilities to effectively collaborate with regional care partners. HCAI proposes to institute a technology grant program funding approximately $38 million annually in Years 2-5 to help rural providers and Tribal health programs implement and enhance their technical capabilities to support access to telehealth and transformative care models. HCAI intends to utilize the services of a third-party administrator to help award and disburse these grants efficiently.

Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

Subrecipient Budget Summary

Table 8 - Subrecipient Budget by Budget Year (figures in millions)

Initiative	Purpose	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
Transformative Care Model	Transformation Payments to Support Strategically Located Hospitals	$ 40.00	$-	$-	$-	$-	**$ 40.00**
Transformative Care Model	Establish Regional Hub-and-Spoke Networks	$ 27.00	$ 50.00	$ 50.00	$ 50.00	$ 50.00	**$ 227.00**
Transformative Care Model	Expand Support for Non-Physician Clinical Roles	$ 5.00	$ 10.00	$ 10.00	$ 5.00	$ 5.00	**$ 35.00**
Transformative Care Model	Expand Rural Health Train-the-Trainer	$ 0.50	$ 1.00	$ 1.00	$ 1.00	$ 0.50	**$ 4.00**
Transformative Care Model	Expand and Support Rural Workforce Capacity	$-	$ 6.00	$ 8.00	$ 8.00	$ 4.00	**$ 26.00**
Workforce Development	Career Pathways Grants	$ 6.00	$ 16.00	$ 15.00	$ 14.00	$ 14.00	**$ 65.00**
Workforce Development	Rural Clinical Placement Support and Training Pathways	$-	$ 12.00	$ 12.00	$ 10.00	$ 5.00	**$ 39.00**
Workforce Development	Expand Rural Provider Retention and Relocation	$ 25.00	$ 30.00	$ 30.00	$ 25.00	$ 20.00	**$ 130.00**
Technology & Tools	EHR Modernization Grants	$ 10.00	$ 10.00	$ 10.00	$ 10.00	$ 10.00	**$ 50.00**
Technology & Tools	Improvement Grants	$-	$ 38.00	$ 38.00	$ 38.00	$ 38.00	**$ 152.00**
Subtotals		**$ 113.50**	**$ 173.00**	**$ 174.00**	**$ 161.00**	**$ 146.50**	**$ 768.00**

Contractors

Contractor Selection Process and Criteria

HCAI will award services contracts in accordance with California's Public Contract Code, standard procurement practices, and using leveraged procurement agreements (LPAs) where appropriate. Selection of awardee(s) for each contract described below will be based on factors specific to the services required. In all cases, selection criteria will include:

- Proven experience delivering similar, relevant services
- Prior work with federal, state, or local government agencies
- Availability and experience of appropriate staff resources

- Location in, near, or accessible to rural communities as needed for participation in CA-RHT initiatives
- Reasonableness of cost

In support of the Rural Health Transformative Care Model Initiative:

Hub-and-Spoke Implementation and Change Management Support *$47,000,000*

The contractor will provide specialized consulting and technical assistance services to help rural hospitals and healthcare providers successfully design, implement, and sustain regional Hub-and-Spoke (H&S) networks that strengthen primary, maternal, specialty, and behavioral health care across rural California. While the state has used H&S structures in other program areas, adapting this model to meet the diverse needs of rural regions requires targeted expertise in network design, workforce development, technology integration, and governance. The contractor will conduct regional gap assessments to identify workforce, telehealth, and care delivery infrastructure needs; support the establishment of appropriate governance and partnership structures; and facilitate implementation of hospital and clinic levels of care for primary, maternity, chronic disease, and specialty services. This work will help ensure that each regional hub is focused on the right components to upskill and enhance its spokes through effective technical assistance and coordinated support.

Through a structured change management process, the contractor will work directly with subrecipients to redesign workflows and adopt evidence-based care models including Project ECHO, OB Nest, CalMAP, and Perinatal Psychiatry Access Program (PPAP). Activities will include developing tailored implementation plans, change management, facilitating workforce training around new evidence-based models, when appropriate implementing new payment models and providing on-site and virtual assistance and implementation support to ensure successful operationalization of new systems and practices. The contractor will also assist regional partners in creating shared call centers, transfer protocols, and governance structures that promote continuity of care and resource sharing. These services will ensure that TCM Hub-and-Spoke networks are not only well-designed but also fully supported through ongoing, hands-on technical assistance to achieve sustainable transformation in rural health delivery.

In support of the Rural Health Workforce Development Initiative:

Workforce Mapping Tool Expansion *$6,000,000*

HCAI will develop a dynamic data platform to map existing rural and frontier workforce supply, identify demand trends, and pinpoint regional capacity gaps across licensed professionals, support staff, and allied health roles. This work will be completed during Year 1 of RHTP funding to focus the training and pathway initiatives on areas and professions with greatest need and address maldistribution of providers in targeted rural regions. HCAI will develop a request for information opportunity to identify potential contractors to develop this tool. Criteria used to select the contractor includes experience in workforce data modeling; knowledge of multiple data/technology tools such as geographic information systems, statistical analysis software, and multiple programming languages; and a proven track record of completing services on time and meeting the needs of their clients.

Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

In support of the Rural Health Technology & Tools Initiative:

Rural Technical Assistance Center Contractor *$85,000,000*

Develop a Rural Technical Assistance Center (RTAC) that provides expert advice and hands-on, on-site support to grantees. The RTAC will support improved access to technology and tools, including connectivity and health information exchange, telehealth, remote patient monitoring, and e-consult and cybersecurity fortification. The RTAC will support the technical implementation of TCM, Rural Health Workforce Development, and Rural Health Technology & Tools Initiatives through progress measurement, learning and diffusion. Services will range from access to hands-on implementation support; technology coaching and other technical assistance; security risk assessments; guidance on vendor management; and technical training and certification to develop and sustain local expertise. Based on its front-line experience with rural health care facilities and providers, RTAC teams will aim to reduce technology costs and staffing burden for rural providers by creating opportunities for group purchasing, shared management of technological services, and shared service development. The budget plans for $5 million in Year 1 as HCAI solicits, selects, and onboards a qualified RTAC contractor and evaluates existing telehealth platforms, e-consult tools, interoperability solutions, and population health and revenue cycle systems to help identify persistent technology or workflow gaps that limit efficiency or scalability. Years 2-5 are planned at approximately $20 million annually.

In support of the CA-RHT implementation:

Third-Party Administrators for Grants *$22,400,000*

Serve as third-party administrators for grants related to rural health technology & tools improvement, and Hub-and-Spoke implementations. Assist HCAI with execution of subaward payments by creating grant management plans, award and monitoring protocols, and oversight processes. Additionally, provide technical assistance to grantees in relation to documentation required to issue payments, monitor grantees' service obligations, and close grant agreements. Working closely with HCAI, third-party administrators will help ensure adequate controls over the award of grants, provision of subrecipient monitoring, permissible use of federal funds, pre-authorization for equipment purchase, and overall expenditure tracking. The contractor will also design a data dashboard to track a subrecipient's site-specific outcomes and performance, enabling continuous improvement and accountability.

Financial Audit Services *$2,000,000*

In recognition of federal and state requirements related to grant awards, HCAI is budgeting funds to support annual external auditor services beginning in Year 2.

Contractor Budget Summary

Table 9 - Contractor Budget by Budget Year (figures in millions)

Initiative	Purpose	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
Transformative Care Model	Hub-and-Spoke Implementation and Technical Assistance Support	$ 4.00	$ 14.00	$ 11.00	$ 11.00	$ 7.00	**$ 47.00**

Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

Initiative	Purpose	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
Workforce Development	Workforce Mapping Tool Expansion	$ 6.00	$-	$-	$-	$-	**$ 6.00**
Technology & Tools	Rural Technical Assistance Center	$ 5.00	$ 20.00	$ 20.00	$ 20.00	$ 20.00	**$ 85.00**
Administrative	Third Party Administrators for Grants	$ 1.60	$ 5.20	$ 5.20	$ 5.20	$ 5.20	**$ 22.40**
Administrative	Financial Audit Services	$-	$ 0.50	$ 0.50	$ 0.50	$ 0.50	**$ 2.00**
Subtotals		**$ 16.60**	**$ 39.70**	**$ 36.70**	**$ 36.70**	**$ 32.70**	**$ 162.40**

G. Construction

Not applicable.

H. Other

None.

I. Total Direct Costs

The following table summarizes the proposed CA-RHT total Direct Costs described in the sections above.

Table 10 - Total Direct Costs by Budget Year

Category	BY1	BY2	BY3	BY4	BY5	Subtotal
a. Personnel	$2,037,671	$2,784,816	$2,854,437	$2,829,446	$2,829,446	**$13,335,816**
b. Fringe Benefits	$1,081,188	$1,477,624	$1,514,564	$1,501,304	$1,501,304	**$7,075,984**
c. Travel	$36,485	$37,376	$38,288	$39,223	$40,181	**$191,554**
d. Equipment	$-	$-	$-	$-	$-	**$-**
e. Supplies	$337,737	$48,000	$120,000	$50,000	$-	**$555,737**
f. Consultant/ Contractor/ Subrecipient	$135,850,000	$219,950,000	$217,200,000	$203,950,000	$184,700,000	**$961,650,000**
g. Construction	$-	$-	$-	$-	$-	**$-**
h. Other	$-	$-	$-	$-	$-	**$-**
Subtotals	**$139,343,081**	**$224,297,816**	**$221,727,289**	**$208,369,974**	**$189,070,932**	**$982,809,091**

J. Indirect Costs

HCAI has never received an indirect cost rate agreement and is opting to charge a *de minimis* rate based on modified total direct costs (MTDC). The table below provides the MTDC by year used as the basis for calculating the 10 percent *de minimis* rate for Indirect Costs.

Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

Table 11 - Modified Total Direct Costs and Indirect Cost by Budget Year

Category	BY 1	BY 2	BY 3	BY 4	BY 5	Subtotal
a. Personnel	$2,037,671	$2,784,816	$2,854,437	$2,829,446	$2,829,446	**$13,335,816**
b. Fringe Benefits	$1,081,188	$1,477,624	$1,514,564	$1,501,304	$1,501,304	**$7,075,984**
c. Travel	$36,485	$37,376	$38,288	$39,223	$40,181	**$191,554**
e. Supplies	$337,737	$48,000	$120,000	$50,000	$-	**$555,737**
f. Consultant/ Contractor services	$18,350,000	$32,950,000	$32,200,000	$31,950,000	$31,200,000	**$146,650,000**
f. Subawards (up to first $50,000 only)	$1,000,000	$1,000,000	$800,000	$650,000	$650,000	**$4,100,000**
Number of new subawards anticipated	20	20	16	13	13	
Subtotal MTDC	$22,843,081	$38,297,816	$37,527,289	$37,019,974	$36,220,932	**$171,909,091**
Subtotals Indirect Cost	**$2,284,308**	**$3,829,782**	**$3,752,729**	**$3,701,997**	**$3,622,093**	**$17,190,909**

Cost Summary

The tables below summarize the proposed CA-RHT cost by initiative and federal fiscal year based on the hypothetical model of $200 million per budget period. This illustrates the overall planned rate of expenditure is consistent with the allowable two-fiscal-year timeframe for expending funds disbursed in each of the five budget periods. In addition, the budgeted Administrative Cost is under the maximum 10 percent allowed by the NOFO.

Table 12 - Spending by initiative, by Budget Year

Initiative	BY 1	BY 2	BY 3
1: Transformative Care Model	$77,531,729	$82,032,502	$80,033,294
2: Workforce Development	$37,000,000	$58,000,000	$57,000,000
3: Technology & Tools	$15,000,000	$68,000,000	$68,000,000
0: Administrative Cost	$12,095,660	$20,095,095	$20,446,725
Subtotals	**$141,627,389**	**$228,127,597**	**$225,480,018**

Initiative	BY 4	BY 5	Subtotal
1: Transformative Care Model	$75,034,105	$66,534,936	**$381,166,565**
2: Workforce Development	$49,000,000	$39,000,000	**$240,000,000**
3: Technology & Tools	$68,000,000	$68,000,000	**$287,000,000**
0: Administrative Cost	$20,037,866	$19,158,089	**$91,833,435**
Subtotals	**$212,071,971**	**$192,693,025**	**$1,000,000,000**

Application is currently under review with CMS.
The final activities and budget may change pending CMS award decisions.

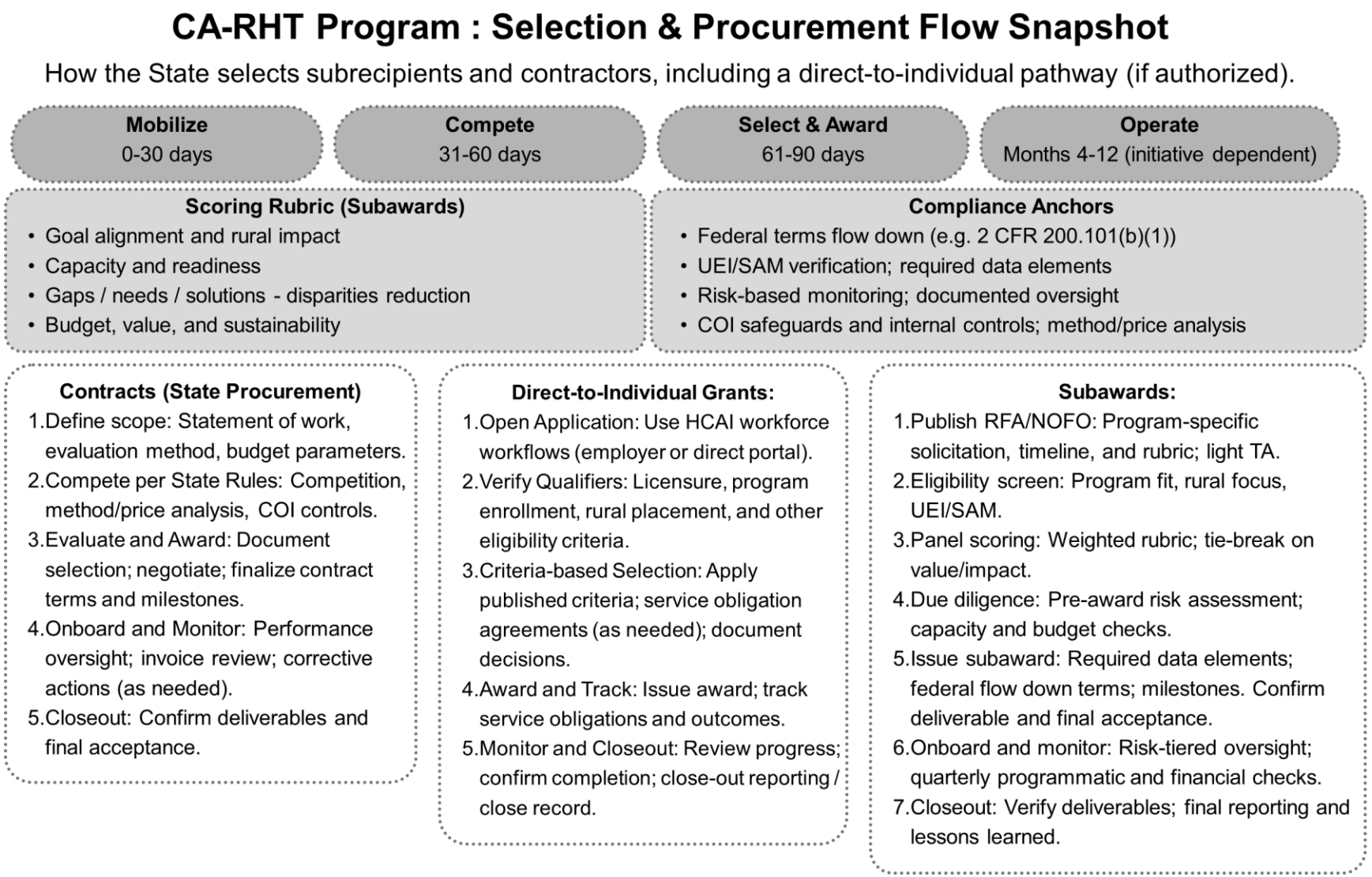

Figure 2 - CA-RHT Subrecipient, Contractor, and Consultant Process Overview