Budget Narrative (revised to reflect Budget Period 1 only)

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.

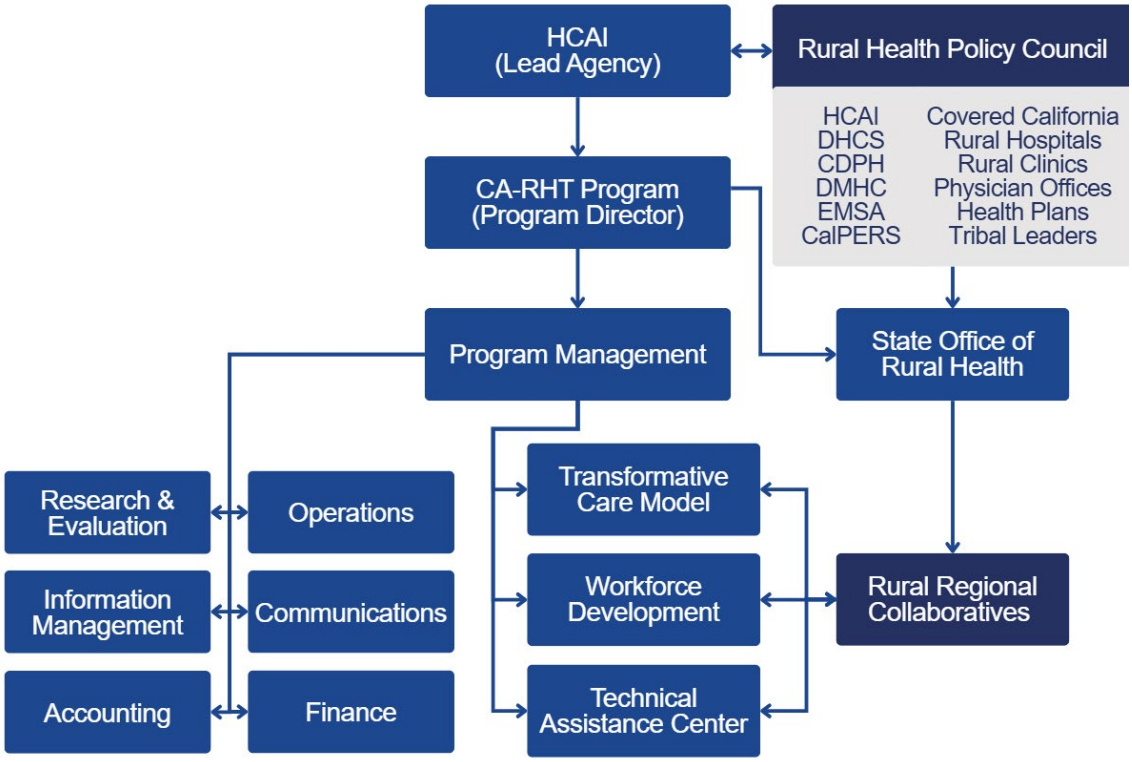

Figure 1 - CA-RHT program organization chart[1]

This proposal requests federal grant funds in the amount of **$233.6 million** in the first

[1] HCAI – CA Department of Health Care Access and Information
DHCS – CA Department of Health Care Services
CDPH – CA Department of Public Health
DMHC – CA Department of Managed Health Care
EMSA – CA Emergency Medical Services Authority
CalPERS – CA Public Employees Retirement System

budget period (federal fiscal years 2026 through 2027) for the following categories: Personnel, Fringe Benefits, Travel, Supplies, Consultants/ Contractors/ Subrecipients, and Indirect Costs. 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.

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.

A. Personnel (Salaries and Wages)

HCAI is requesting federal grant funds to support **29** **Full Time Equivalent (FTE) staff resources** in a range of roles and classifications as further described below.

Program Leadership Staff Resources

The CA-RHT program will be led by the interim Program Director until a full-time, permanent director is recruited specifically for CA-RHT. The Program Director will be supported by a Senior Health Program Specialist and Information Officer to help ensure the program remains aligned with federal requirements and engaged with statewide stakeholders. Additional staffing for CalSORH will help ensure rural health strategies are coordinated, consistent, and remain engaged with appropriate stakeholders throughout California's rural communities.

- **Program Director – Hovik Khosrovian (interim)** – Future Recruitment (1 FTE) 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.
- **Senior Health Program Specialist** – Future Recruitment (1 FTE)

Will work closely with the Program Director and senior executives of HCAI to provide overall program and policy support through the CA-RHT initiative design and management. This position will help direct policy analysis, program planning, and stakeholder engagement activities.

- **Information Officer** – Future Recruitment (1 FTE)
  Will provide overall leadership for formal program communications, stakeholder outreach, and engagement with inter-departmental stakeholders (e.g., sibling departments within the California HHS agency). This position will work closely with the Program Director to coordinate stakeholder engagement among all program initiatives.
- **CalSORH Senior Manager** – Future Recruitment (1 FTE)
  Serves as senior manager overseeing RHT program team within State Office of Rural Health. This position will provide strategic leadership and direction for program implementation, ensuring alignment with HCAI's rural health transformation goals and compliance with state and federal requirements. Will manage program operations, supervise senior specialists, and coordinate with executive leadership, stakeholders and the Rural Health Policy Council to advance program objectives. This position is separate in its role and function from the positions funded through SORH grants.
- **CalSORH Senior Health Program Specialists** – Future Recruitment (4 FTEs)
  Will serve as the senior health program leads for RHT within CalSORH, providing expert-level policy and program guidance. Will lead complex analysis, develop program strategies, and coordinate implementation activities for rural health initiatives. Works closely with Program Director, stakeholders, and internal teams to ensure effective delivery of program objectives and requirements. These positions are separate in their roles and functions from the positions funded through SORH grants.

Legal Office Staffing

HCAI requests one FTE (Senior Attorney) to provide legal support for CA-RHT.

- **Senior Attorney** – Future Recruitment (1 FTE)
  Will provide legal counsel and expert level support for contracts, grant agreements, and federal grant award terms and conditions.

Transformative Care Model Initiative Staff Resources

Transformative Care Facility Financing Staffing

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

- **Health Facility Financing Specialist** – Future Recruitment (1 FTE)
  Will administer provider transformation payments under the RHT program. This position will manage financial transactions, ensure compliance with state and federal funding requirements, and provide technical assistance to rural health providers participating in transformation initiatives. Will oversee payment processing, maintain accurate financial records, and coordinate with internal teams to ensure timely and accurate disbursement of funds.

Transformative Care Clinical Innovation Staffing

The Transformative Care Model team will include one physician medical officer, one senior health program specialist, one health program specialist, and a senior research data scientist to support the program design and establishment.

- **Physician Medical Officer** – Future Recruitment (1 FTE)
  Serves as the clinical lead for the Transformative Care Model team, providing expert medical guidance and oversight for program design and implementation. This position will help ensure that clinical strategies align with evidence-based practices and meet the needs of rural health providers participating in CA-RHT initiatives. Will collaborate with internal teams, external stakeholders, and consulting partners to develop innovative care models that improve access and quality of care in rural communities.
- **Senior Health Program Specialist** – Future Recruitment (1 FTE)
  Serves as the senior program specialist supporting the development and implementation of the Transformative Care Model. This position will lead policy analysis, program planning, and stakeholder engagement activities to ensure successful adoption of innovative care strategies. Works closely with the Physician Medical Officer to coordinate program activities, monitor performance and prepare reports for leadership.
- **Health Program Specialist** – Future Recruitment (1 FTE)
  Provides independent programmatic support for the Transformative Care Model team, assisting with implementation activities, research, and stakeholder coordination. Tracks program progress and supports evaluation efforts.
- **Senior Research Data Scientist** – Future Recruitment (1 FTE)
  Lead technical expert for advanced data science and analytics supporting RHT program evaluation and rural health transformation modeling. This position will design and implement predictive models and advanced statistical methodologies to assess program impact and forecast rural health workforce trends. The Senior Research Data Scientist will manage large, complex datasets, develop innovative analytical tools, and produce actionable insights for leadership and stakeholders. Responsibilities include leading research design, ensuring data integrity, and delivering high-level reports and visualizations to inform strategic decisions.

Rural Health Workforce Development Initiative Staff Resources

Health Workforce Policy Staffing

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

- **Senior Health Program Specialist** – Future Recruitment (1 FTE)
  Will serve as senior subject matter experts for rural health workforce policy and program development. Leads complex policy analysis, program design, and evaluation activities to enhance RHT objectives. Provides technical guidance to

program staff, coordinates stakeholder engagement, and ensures alignment with federal and state requirements.

- **Health Program Specialists** – Future Recruitment (2 FTEs)
  Will provide independent programmatic and policy support for RHT initiatives. Implements program activities, conducts landscape analysis research, and coordinates stakeholder engagement with a high degree of sensitivity. Prepares reports for leadership and external partners.

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.

- **Research Data Specialist** – Future Recruitment (1 FTE)
  Leads data collection, analysis, and reporting to support RHT program evaluation and outcomes development. Designs methodologies for assessing rural health workforce trends, analyze complex datasets, and produces actionable insights for program improvement. Collaborates with internal and external stakeholders to ensure data integrity and relevance.

Health Workforce Grants Management Staffing

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

- **Grants Management Supervisor** – Future Recruitment (1 FTE)
  Oversee policy and operational functions for RHT program. The position will manage grant analysts and provide leadership in grants management in coordination with interdepartmental partners. Will supervise analysts and provide guidance on administrative processes, monitor budgets, contracts, and other procurement activities.
- **Grants Management Analysts** – Future Recruitment (2 FTEs)
  Provides analytical and administrative grants management support for RHT program. Develops policies, tracks program performance, and prepares reports. Coordinates meetings and maintains documentation for program activities.

Technology & Tools Initiative Staff Resources

Information Services Staffing

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

- **Senior IT Specialist** – Future Recruitment (1 FTE)
  Serve as the lead for technology project management and contract administration for the RHT program. This position will oversee information technology vendor and consultant management, ensuring deliverables meet program objectives and state

technology standards for digital grant solutions. Responsibilities include managing complex IT projects, monitoring contractor performance, coordinating system integration efforts, and ensuring compliance with security, accessibility, and procurement requirements. Primary liaison between program leadership and technology vendors to ensure timely and cost-effective delivery of solutions.

- **Information Technology Specialist** – Future Recruitment (1 FTE)
  Provides project coordination and contract oversight for the RHT program and related technology solutions. This position will assist in managing vendor deliverables, tracking project milestones, and supporting IT infrastructure for program operations. Responsibilities include monitoring contractor performance, assisting with procurement and compliance documentation, and ensuring technology solutions meet program requirements. Supports system administration and provide technical assistance to program staff.

Administrative Services Staffing

Finance and Accounting Staffing

HCAI requests six FTEs (one administrator, 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.

- **Accounting Administrator**– Future Recruitment (1 FTE)
  Senior fiscal manager overseeing all accounting operations for the RHT program. This position will provide leadership in financial planning, budgeting, and reporting, ensuring compliance with state and federal requirements. The role includes managing subordinate accounting staff, developing fiscal policies, and coordinating audits and financial reviews.
- **Accounting Supervisor** – Future Recruitment (1 FTE)
  Supervises accounting staff and manages day-to-day fiscal operations for RHT program activities. This position will oversee accounts payable, accounts receivable, and grant disbursements, ensuring accuracy and timeliness. The role includes preparing financial statements, monitoring budgets, and supporting audits.
- **Senior Accountant** – Future Recruitment (1 FTE)
  Performs complex accounting tasks related to RHT program funds, including reconciliations, expenditure tracking, and financial reporting. This position will ensure accuracy in transactions and compliance with state accounting standards.
- **Accounting Analyst** – Future Recruitment (1 FTE)
  Provides analytical support for RHT program fiscal operations, including budget analysis, expenditure projections, and financial trend reporting. This position will assist in developing fiscal recommendations and preparing reports for management.
- **Accountant** – Future Recruitment (1 FTE)
  Provides accounting support for RHT program fiscal operations, performs entry-level accounting tasks to support RHT program fiscal operations. This position will assist with data entry, reconciliations, and preparation of basic financial reports under supervision.
- **Senior Program Analyst** – Future Recruitment (1 FTE)

Senior-level policy and fiscal analyst for RHT program implementation. This position will lead complex analyses related to program funding, performance metrics, and policy impacts. Prepares high-level reports, develop recommendations for leadership, and coordinate with stakeholders to ensure effective resource allocation.

Table 1 - Personnel Levels and Cost by Position, Budget Period 1

Position Title	Name (if known)	Annual Salary*	Positions	Months (BP 1)	Salary Totals, all positions over duration
Program Leadership					
Chief Deputy Director (Authorized Organizational Representative)	Scott Christman	In kind	0.1	10	$ 0
Deputy Director for Clinical Innovation, Chief Medical Officer (CMO)	Lemeneh Tefera, MD, MSc	In kind	0.1	10	$ 0
Deputy Director, Chief Data Officer (CDO)	Michael Valle	In kind	0.1	10	$ 0
Program Director (Interim)	Hovik Khosrovian	In kind	0.5	10	$ 0
Program Director (PD)	Future recruitment	$168,384	1	10	$ 140,320
Senior Health Program Specialist (Overall program design and policy support for initiative design and management)	Future recruitment	$98,292	1	10	$ 81,910
Information Officer (Overall leadership for formal program communications, outreach)	Future recruitment	$81,480	1	10	$ 67,900
CalSORH Senior Manager (Manage rural health program operations in alignment with CalSORH initiatives)	Future recruitment	$105,912	1	10	$ 88,260
CalSORH Senior Health Program Specialist (Guide rural health workforce development policy and program design in alignment with CalSORH initiatives)	Future recruitment	$98,292	4	10	$ 327,640
Senior Attorney (Legal support for contracts, grant agreements, CMS award terms)	Future recruitment	$168,534	1	10	$ 140,445
Transformative Care Model initiative personnel					

Position Title	Name (if known)	Annual Salary*	Positions	Months (BP 1)	Salary Totals, all positions over duration
Health Facility Financing Specialist (Transformation grant design and management)	Future recruitment	$89,472	1	10	$ 74,560
Physician Medical Officer (Clinical lead for the Transformative Care Model team)	Future recruitment	$225,700	1	10	$ 188,083
Senior Health Program Specialist (Program and policy design for Transformative Care Model team)	Future recruitment	$98,292	1	10	$ 81,910
Health Program Specialist (Support development and implementation of the Transformative Care Model)	Future recruitment	$89,472	1	10	$ 74,560
Senior Research Data Scientist (Outcomes data modeling and program evaluation guidance)	Future recruitment	$108,690	1	10	$ 90,575
Rural Health Workforce Development initiative personnel					
Senior Health Program Specialists (Program and policy design for rural health workforce development)	Future recruitment	$98,292	1	10	$ 81,910
Health Program Specialists (Program and policy design support for rural health workforce development)	Future recruitment	$89,472	2	10	$ 149,120
Research Data Specialist (Rural health workforce development program evaluation and outcomes development)	Future recruitment	$104,910	1	10	$ 87,425
Grant Management Supervisor (Rural health workforce development grant design and management)	Future recruitment	$96,492	1	10	$ 80,410
Grant Management Analysts (Rural health workforce development grant design and management support)	Future recruitment	$82,830	2	10	$ 138,050
Technology and Tools initiative personnel					
Senior IT Specialist (Oversee Rural Technical Assistance Center contractor)	Future recruitment	$123,174	1	10	$ 102,645

Position Title	Name (if known)	Annual Salary*	Positions	Months (BP 1)	Salary Totals, all positions over duration
IT Specialist (Support oversight of Rural Technical Assistance Center)	Future recruitment	$104,184	1	10	$ 86,820
Administrative Services personnel					
Accounting Administrator, Senior fiscal manager (Manage RHTP financial planning, budgeting, and reporting)	Future recruitment	$105,918	1	10	$ 88,265
Accounting Supervisor (Supervise RHTP accounting staff)	Future recruitment	$96,480	1	10	$ 80,400
Senior Accountant (Accounting support for RHTP funds)	Future recruitment	$72,330	1	10	$ 60,275
Accounting Analyst (Accounting support for RHTP funds)	Future recruitment	$86,964	1	10	$ 72,470
Accountant (Accounting support for RHTP funds)	Future recruitment	$59,376	1	10	$ 49,480
Program Analyst (Program funding, performance metrics, and policy impact analysis)	Future recruitment	$82,830	1	10	$ 69,025
Total			**29**		**$ 2,502,458**

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 Period.

Table 2 - Personnel Costs, Budget Period 1

Personnel Category	Positions	Amount Requested BP 1 only
Program Leadership positions	9	$846,475
Transformative Care Model initiative positions	5	$509,688
Health Workforce Development initiative positions	7	$536,915
Technology and Tools initiative positions	2	$189,465
Administrative positions	6	$419,915
Subtotals	**29**	**$2,502,458**

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 Personnel, Budget Period 1

Fringe Benefits	Rate	Total Salary Requested	Amount Requested BP 1 only
OASDI, Tax	7.65%	$2,502,458	$191,438
Retirement	26.31%	$2,502,458	$658,397
Health and related benefits	19.10%	$2,502,458	$477,969
Total			**$1,327,804**

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 four (4) 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), Budget Period 1

Category	BP 1
Personal vehicle mileage	$7,550
Lodging	$7,920
Per diem	$4,536
Incidentals	$360
Subtotals	**$20,366**

Table 5 - Travel (in-state southern California), Budget Period 1

Category	BP 1
Airfare	$8,000
Ground transportation	$2,400

Category	BP 1
Lodging	$13,632
Per diem	$7,200
Incidentals	$480
Subtotals	**$31,712**

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 **three (3)** 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 for Washington, DC and Baltimore, MD. Where GSA provided varying rates based on time of year, the budget used peak rates for planning purposes given future CMS meeting dates are not yet available.
- 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 in Budget Period 1, by Location

Category	If meeting is in Washington, DC	If meeting is in Baltimore, MD
Airfare	$2,280	$2,280
Ground transportation	$300	$300
Lodging	$3,300	$1,800
Per diem	$1,044	$1,032
Incidentals	$60	$60
Subtotals	**$6,984**	**$5,472**

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 $349,233 in Budget Period 1 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 29 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.

Table 7 - Supplies, Budget Period 1

Category	Cost per Individual	Total Cost
General ofice supplies	$1,000	$29,000
Training sies (including licensed training materials)	$1,000	$29,000
Informatiechnology supplies	$10,000	$290,000
Specializraining materials for workforce programs (manuals,oolkits)	n/a	$1,233
Subtotals	**$12,000**	**$349,233**

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

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 *$23,500,000*

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 *$5,000,000*

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 8 - Consultant Budget, Budget Period 1 (figures in millions)

Initiative	Purpose	BP 1
Transformative Care Model	Evaluate Rural Pathways to Value Based Payment	$ 1.00
Support for all Initiatives and Administration	Program Management	$ 4.70
Administrative	Developer Support for Electronic Applications	$ 1.90
Subtotals		**$ 7.60**

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, education awards, 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: *$35,000,000*

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. If appropriate, awardees will implement feasible Transformative Care Model components. 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.

Preamble	Changed from **previous budget revision (2/13/26)** $50.0M, decreased **revised** proposed budget amount by $**15.0**M in Budget Period 1 (BP1) funds made available under the CMS NOA for California, for a revised total of $**35M**. Budget amount scaled for feasibility, *condensed timeline,* and expedited obligation requirements during the program's first year. This one-time funding will stabilize qualifying rural facilities and support meaningful engagement in CA-RHTP TCM activities. Funds will be distributed through a structured subaward process designed to meet expedited obligation requirements during the program's first year.
Budget period 1 amount	BP1 $35.0M (one-time)
Number of awards	*Refer to Appendix A, page 35 of this document*
How big per award	*Refer to Appendix A, page 35 of this document*
Type and number of awardees	*Refer to Appendix A, page 35 of this document*
Process and scoring mechanics	*Refer to Appendix A, page 35 of this document*
Data and documentation	*Refer to Appendix A, page 35 of this document*
Risk and compliance	*Refer to Appendix A, page 35 of this document*
Initiative and use of funds categories	Initiative: The Rural Health Transformative Care Model Initiative (TCM) (1) Use of funds: A. Prevention and Chronic Disease, C. Consumer tech solutions, D. Training and Technical Assistance, E. Workforce, F. IT Advances, G. Appropriate Care Availability, I. Innovative Care, H. Behavioral Health, K. Fostering Collaboration

Establish Regional Hub-and-Spoke Networks *$39,010,000*

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.[2]

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

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

Partners will inform statewide scaling and continuous improvement of the Hub-and-Spoke framework in future years.

Preamble	Change from original $27M, increased original proposed budget amount by $12.1M in additional Budget Period 1 (BP1) funds made available under the CMS NOA for California, for a revised total of $39.01M. Budget amount scaled for feasibility*, condensed timeline,* and expedited obligation requirements during the program's first year This funding supports implementation of regional Hub-and-Spoke networks and year-over-year scaling. It will fund consultants with specialized expertise in health care policy, delivery system transformation, rural payment models, and health system coordination to develop statewide program policy and design regional Hub-and-Spoke networks. These networks will leverage economies of scale in clinical operations, workforce, technology, and revenue generation strategies. Together, these efforts will create regional collaborative networks that strengthen long-term financial stability for rural hospitals, clinics, and other related providers, while reducing rural bypass. The regional network counts and participating hub-and-spoke counts will be set, and funds will be distributed through a structured award process and/or CA-RHT strategic selection. Eligibility will be determined by regional planning efforts and ability to support meaningful engagement in CA-RHT TCM activities (including primary, maternity, chronic condition, geriatric, oral health, and/or specialty care).
Budget period 1 amount	BP1 $39.01M.
How big per award	Tiered award planning ranges: Hub-and-Spoke regions $6M to $8M annually; scaling regions $3M to $6M annually; spoke facility subawards by scope (for example $250K to $1.5M per year) based on demand, eligibility, and applicant needs. Awards will be tiered, not equal, based on rurality, community needs, regional network needs, applicant readiness.
Number of awards	Up to 4 regional awards in BP1.
Justification for number of subawardees	Up to 4 Hub-and-Spoke regional awards concentrating resources to support measurable care redesign, governance, and interoperability improvements rather than thin distribution. Scaling is paced to match regional implementation capacity and technical assistance availability. This count is a directional planning assumption and will be validated through the assessment of the applicant pool and system readiness. Planning assumption: BP1 funds multiple Accelerator Partnerships based on readiness with an expectation to identify regional partners among northern, central and southern regions of the state. Additional partnerships and regions will be added in BP2-BP5 based on readiness and need.
Process and scoring mechanics	Two-step process: (1) threshold eligibility screening of applicants; and where appropriate (2) Request for Application (RFA) with a scored rubric with rank ordering. Proposed rubric domains include: regional need and access gaps, readiness and leadership commitment, applicant ability to participate in a regional network or accelerator partnership, interoperability and telehealth plan, workforce and care model implementation plan, and sustainability plan.
Data and documentation	• Regional gap assessment • Network governance documentation (MOUs, referral and transfer protocols, participation agreements) • Interoperability baseline and target-state architecture

	• Telehealth, primary, maternity, chronic condition, and/or specialty care plan • Care model implementation milestones • Workforce plan and training commitments • Detailed budget with hub and spoke allocations • To be eligible to receive funds, other data and documentation may be requested of awardees in addition to the items listed to confirm initial and continued alignment, and agreement to, RHTP initiatives, metrics and reporting compliance requirements and activities per the CA-RHTP Project Narrative and Work Plan.
Tribal participation	HCAI will track the 5% minimum Tribal commitment across the full subaward portfolio and operationalize the 5% minimum via one or more mechanisms: dedicated solicitation track for Tribal participation, minimum award floor for Tribal hubs and/or spokes, and/or scoring preference for networks with strong Tribal partnership plans. Awards and expenditures will be tracked by Tribal entity and by initiative for reporting.
Risk and compliance	Subaward agreements will include allowable-use language (including non-permissible use of funds under the CA-RHTP initiative(s), *e.g. B. Provider Payments*), non-supplanting attestation, separate cost tracking, milestone tracking, quarterly financial and performance reporting, audit and site-visit rights, state procurement compliance, and corrective-action and repayment remedies for unallowable or unsupported costs. Permissible uses of funds are restricted to the use of funds disclosed in the CMS-approved proposal, in addition to required compliance with applicable state and HHS/CMS subrecipient/awardee terms and conditions.
Initiative and use of funds categories	Initiative: The Rural Health Transformative Care Model Initiative (TCM) (1) Use of funds: A. Prevention and Chronic Disease, C Consumer tech solutions, D. Training and Technical Assistance, E. Workforce, F. IT Advances, G. Appropriate Care Availability, I. Innovative Care, H. Behavioral Health, K. Fostering Collaboration

Expand Support for Non-Physician Clinical Roles *$0*

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

Preamble	Change from original $5.0M decreased original proposed budget amount by $5.0M in Budget Period 1 (BP1) funds made available under the CMS NOA for California, for a revised total of $0. Budget amount scaled for feasibility, *condensed timeline,* and expedited obligation requirements during the program's first year. BP1 planned funds are now allocated to the relocation program. During this time, the workforce development team

	will be working with educators and stakeholders to prepare for BP2 planned activities and program development.
Budget period 1 amount	BP1 $0.
Initiative and use of funds categories	Initiative: The Rural Health Transformative Care Model Initiative (TCM) (1) Use of funds: A. Prevention and Chronic Disease, C Consumer tech solutions, D. Training and Technical Assistance, E. Workforce, F. IT Advances, G. Appropriate Care Availability, I. Innovative Care, H. Behavioral Health, K. Fostering Collaboration

Expand Rural Health Train-the-Trainer *$2,000,000*

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.

Preamble	Changed from previous budget revision (2/13/26) $1.0M, increased revised proposed budget amount by $1.0M in additional Budget Period 1 (BP1) funds made available under the CMS NOA for California, for a revised total of $2.0M. Budget amount scaled for feasibility, condensed timeline, and expedited obligation requirements during the program’s first year. Activities funded during award period include program planning and development and initial program launch. Subawards will be determined by program applicant eligibility based on qualifiers such as priority competencies, regional population needs, and facility capacity.
Budget period 1 amount	BP1 $2.0M.
How big per award	Up to $20k per participant for mentorship time, curriculum, and participation costs, plus centralized program administration and evaluation within the annual budget.
Justification for number of subawardees	Funding supports up to 50 health care providers within the primary care team and maternal health team participate in train-the-trainer tracks to build competencies in behavioral health, chronic disease management, geriatric care, and telehealth. Unit of support is a trainer-the trainer track with co-distribution of training aligning to Hub-and-Spoke priorities. 50 participants per year is sufficient to create repeated practice change across multiple sites while maintaining a manageable mentorship model that is more durable than one-time training.
Process and scoring mechanics	Request for Application (RFA). Selection based on program applicant / team fit to priority competencies (maternal health, chronic disease, behavioral health integration, telehealth), site readiness to operationalize changes, and commitment to share learning within the regional network.
Data and documentation	• Applicant site readiness plan • Trainee baseline competency self-assessment • Supervisor endorsement • Planned practice-change project tied to Hub-and-Spoke workflows • Budget and protected time plan • To be eligible to receive funds, other data and documentation may be requested of awardees in addition to the items listed to confirm

	initial and continued alignment, and agreement to, RHTP initiatives, metrics and reporting compliance requirements and activities per the CA-RHTP Project Narrative and Work Plan.
Tribal participation	Apply a preference to recruit qualifying team(s) to ensure meaningful Tribal participation and to support the 5% minimum commitment.
Risk and compliance	Subaward agreements will include allowable-use language (including non-permissible use of funds under the CA-RHTP initiative(s), *e.g. B. Provider Payments*), non-supplanting attestation, separate cost tracking, require documentation of participation and practice-change deliverables, quarterly financial and performance reporting, audit and site-visit rights, and corrective-action and repayment remedies for unallowable or unsupported costs. Permissible uses of funds are restricted to the use of funds disclosed in the CMS-approved proposal, in addition to required compliance with applicable state and HHS/CMS subrecipient/awardee terms and conditions.
Initiative and use of funds categories	Initiative: The Rural Health Transformative Care Model Initiative (TCM) (1) Use of funds: A. Prevention and Chronic Disease, C Consumer tech solutions, D. Training and Technical Assistance, E. Workforce, F. IT Advances, G. Appropriate Care Availability, I. Innovative Care, H. Behavioral Health, K. Fostering Collaboration

Expand and Support Rural Workforce Capacity *$11,500,000*

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.

Preamble	Changed from previous budget revision (2/13/26) $8M, increased revised proposed budget amount by $3.5M in additional Budget Period 1 (BP1) funds made available under the CMS NOA for California, for a revised total of $11.5M. **$6.5M** for all non-tribal fellowships and $5M tribal. Budget amount scaled for feasibility, condensed timeline, and expedited obligation requirements during the program's first year. Dedicated funding of $5.0M will prioritize Tribal entities currently providing or developing cohorts and fellowships. Funds during BP1 will go toward program development, planning and direct program funding for family medicine obstetric training fellowship sites; supporting oral health care; and funding allied health professionals including nurses, pharmacy technicians, and emergency medical service personnel to pursue CHW training that enhances collaborative care for chronic conditions, and care coordination. HCAI has previous and current workforce programs to assist in developing out structure and implementing processes to have funding obligated to support an annual cohort for qualifying fellowship sites in the program's first year.
Budget Period 1 amount	BP1 $11.5M.

Number of awards	Up to 20 sites.
How big per award	Tiered award planning ranges: Award sizes vary by program type and site capacity. Across up to 20 awards in BP1, awards are expected to range from $150K up to $500K per site per year, with participant stipends and training costs bundled. A portion of funds may support shared curriculum and technical assistance.
Justification for number of subawardees	Up to 20 subawards balances statewide rural coverage with manageable award sizes under the $11.5M BP1 cap and aligns with known supervision and preceptor capacity limits. This volume supports a mix of higher-intensity fellowship placements and lower-intensity cohort and upskilling sites, enabling regional distribution across multiple Hub-and-Spoke networks while maintaining feasible participant-to-preceptor ratios, recruitment pipelines, and reporting oversight. Final volumes will be set through RFAs based on demonstrated regional workforce gaps, documented training capacity, and readiness to launch within BP1.
Process and scoring mechanics	Request for Application (RFA). Proposed rubric domains include: measurable rural service expansion, shortage alignment, training capacity and preceptor availability, linkage to Hub-and-Spoke operational needs, participant recruitment and retention plan, budget reasonableness.
Data and documentation	• Training program design • Preceptor and supervision plan • Participating site letters • Curriculum and schedule • Participant selection process • Budget and stipend plan • Outcome measurement plan for skills gained and service expansion. • To be eligible to receive funds, other data and documentation may be requested of awardees in addition to the items listed to confirm initial and continued alignment, and agreement to, RHTP initiatives, metrics and reporting compliance requirements and activities per the CA-RHTP Project Narrative and Work Plan.
Tribal participation	Total $5.0M. Enable Tribal clinics to participate as training sites and or as recipients of upskilling support. Track Tribal participation and expenditures toward the 5% minimum commitment.
Risk and compliance	Subaward agreements will include allowable-use language (including non-permissible use of funds under the CA-RHTP initiative(s), *e.g. B. Provider Payments*), non-supplanting attestation, separate cost tracking, require documentation of participation and practice-change deliverables, quarterly financial and performance reporting, deliverable verification, audit and site-visit rights, and corrective-action and repayment remedies for unallowable or unsupported costs. Permissible uses of funds are restricted to the use of funds disclosed in the CMS-approved proposal, in addition to required compliance with applicable state and HHS/CMS subrecipient/awardee terms and conditions.
Initiative and use of funds categories	Initiative: The Rural Health Transformative Care Model Initiative (TCM) (1) Use of funds: A. Prevention and Chronic Disease, C Consumer tech solutions, D. Training and Technical Assistance, E. Workforce, F. IT Advances, G. Appropriate Care Availability, I. Innovative Care, H. Behavioral Health, K. Fostering Collaboration

In support of the Rural Health Workforce Development Initiative:

Career Pathways Grants *$7,000,000*

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.

Preamble	Changed from original $6.0M increased original proposed budget amount by $1.0M in additional Budget Period 1 (BP1) funds made available under the CMS NOA for California, for a revised total of $7.0M. Participant counts are directional and depend on opt-in and readiness. Budget amount scaled for feasibility, condensed timeline, and expedited obligation requirements during the program's first year. Activities funded during award period include program planning and development and initial program launch. Subawards will be determined by a competitive grant application process / request for application (RFA) with eligibility based on qualifiers such as priority competencies and commitment to fulfilling program requirements.
Budget Period 1 amount	BP1 $7.0M.
Number of awards	Up to 20.
How big per award	Up to $750k per location to establish pathways, counseling, mentorship, and wraparound supports. Later years may include tiered awards based on enrollment volume and program scope.
Justification for number of subawardees	A cohort up to 20 locations balances statewide access impact with sufficient per location funding up to $750K to support planning, development, and initial program launch. This count scales the program from 20 to 50 locations to ensure supporting broad coverage across rural regions while allowing meaningful per-site investment for program launch and aligns with expected growth in participating schools and students.
Process and scoring mechanics	Request for Application (RFA). Rubric emphasizes pipeline / pathway impact, rural need and student reach, strength of partnerships with local providers and training programs, quality of career lattice design and supports, feasibility and sustainability.
Data and documentation	• Program design and timeline • Student recruitment and support plan • Partnership letters (facilities, colleges, workforce boards) • Budget • Proposed metrics for enrollment, completion, credentials, and placement • To be eligible to receive funds, other data and documentation may be requested of awardees in addition to the items listed to confirm initial and continued alignment, and agreement to, RHTP initiatives, metrics and reporting compliance requirements and activities per the CA-RHTP Project Narrative and Work Plan.

Tribal participation	Include Tribal schools and Tribal serving institutions through scoring preference. Track awards and outcomes for Tribal participants toward the 5% minimum.
Risk and compliance	Subaward agreements will include allowable-use language (including non-permissible use of funds under the CA-RHTP initiative(s), *e.g. B. Provider Payments*), non-supplanting attestation, separate cost tracking, quarterly financial and performance reporting, annual outcome reporting, audit and site-visit rights, and corrective-action and repayment remedies for unallowable or unsupported costs. Permissible uses of funds are restricted to the use of funds disclosed in the CMS-approved proposal, in addition to required compliance with applicable state and HHS/CMS subrecipient/awardee terms and conditions.
Initiative and use of funds categories	Initiative: The Rural Health Workforce Development Initiative (2) Use of funds: A. Prevention and Chronic Disease, D. Training and Technical Assistance, G. Appropriate Care Availability, E. Workforce Development and Recruitment, H. Behavioral Health, K. Fostering Collaboration

Rural Clinical Placement Support and Training Pathways *$6,400,000*

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 education awards, 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.

Preamble	Changed from original $0, increased original proposed budget amount by $6.4M in additional Budget Period 1 (BP1) funds made available under the CMS NOA for California, for a revised total of $6.4M. Budget amount scaled for feasibility, condensed timeline, and expedited obligation requirements during the program's first year. Activities funded during the award period include clinical placement tool planning, design, development, and coordination with potential users such as rural facilities and education programs. Subaward will be determined through a competitive grant application / request for application (RFA) process with eligibility based on experience with clinical placement strategies, previous experience in design of related tools and commitment to fulfilling program requirements.
Budget Period 1 amount	BP1 $6.4M.
Number of awards	Up to 2.
How big per award	Up to 2 grantees for a total of $6.4M in award funds, will be selected to build a statewide rural clinical placement tool.
Justification for number of subawardees	Centralizing the development of the placement tool allows for operational efficiency and improved statewide planning of training needs. The

	statewide network approach reduces administrative burden and improves reliability for schools and facilities.
Process and scoring mechanics	Request for Application (RFA). Selection prioritizes organizations that have demonstrated experience in clinical placement knowledge, experience coordinating with education programs and health facilities to meet clinical training needs, experience in the development of related tools, and budget reasonableness.
Data and documentation	• Agreements with education programs and clinical sites • Process document for use of the tool • Training availability for education programs and facilities on the use of the tool • To be eligible to receive funds, other data and documentation may be requested of awardees in addition to the items listed to confirm initial and continued alignment, and agreement to, RHTP initiatives, metrics and reporting compliance requirements and activities per the CA-RHTP Project Narrative and Work Plan.
Tribal participation	Efforts will be made so that the tool includes tribal facilities as participants for training placement.
Risk and compliance	Subaward agreements will include allowable-use language (including non-permissible use of funds under the CA-RHTP initiative(s), *e.g. B. Provider Payments*), non-supplanting attestation, separate cost tracking, quarterly financial and performance reporting, annual outcome reporting, audit and site-visit rights, and corrective-action and repayment remedies for unallowable or unsupported costs. Permissible uses of funds are restricted to the use of funds disclosed in the CMS-approved proposal, in addition to required compliance with applicable state and HHS/CMS subrecipient/awardee terms and conditions.
Initiative and use of funds categories	Initiative: The Rural Health Workforce Development Initiative (2) Use of funds: A. Prevention and Chronic Disease, D. Training and Technical Assistance, G. Appropriate Care Availability, E. Workforce Development and Recruitment, H. Behavioral Health, K. Fostering Collaboration

Expand Rural Provider Retention and Relocation *$54,170,000*

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.

Preamble	**Changed from** previous budget revision (2/13/26) **$43.67M, increased revised proposed budget amount by $10.5M in additional Budget Period 1 (BP1) funds made available under the CMS NOA for California, for a revised total of $54.17M.** Significant increase due to allocating funds from TCM Expansion of Clinical Non-physician Support Roles and increase of overall RHTP award funds. Budget amount scaled for feasibility, condensed timeline, and expedited obligation requirements during the program's first year. Activities funded during the award period include program planning and development and initial program launch. Subawards will be determined through a request for application process with eligibility based on priority competencies and commitment to fulfilling program requirements.
Budget Period 1 amount	BP1 $54.17M.
Number of awards	Awards to organizations and regional collaboratives, up to 40 subawards with up to 400 health providers awarded through those subawards.
How big per award	Retention and relocation packages are expected to be tiered by profession, shortage severity, and participation in other CA-RHT activities. Planning ranges: retention bonuses up to $75k per clinician; relocation bonuses up to $100k per clinician; additional supports for onboarding, temporary housing, and supervision costs as needed.
Justification for number of subawardees	Annual investment levels align with the scale of rural provider shortages and the five-year service obligation. Regional collaborative awards promote coordinated placement and reduce competition among neighboring rural facilities.
Process and scoring mechanics	Request for Application (RFA). Based on the output of the workforce planning tool, the rubric prioritizes shortage severity and likelihood of retention: regional need and vacancy rates, collaborative governance and sharing model, recruitment and retention strategy, service obligation enforcement plan, budget reasonableness, and participation in other CA-RHT activities.
Data and documentation	• Provider vacancy and turnover data • Recruitment pipeline / pathway plan • Collaborative agreements among facilities • Bonus policy and service obligation terms • Budget • Onboarding and housing support plan • Tracking system for service completion • To be eligible to receive funds, other data and documentation may be requested of awardees in addition to the items listed to confirm initial and continued alignment, and agreement to, RHTP initiatives, metrics and reporting compliance requirements and activities per the CA-RHTP Project Narrative and Work Plan.
Tribal participation	Structure a Tribal set-aside or dedicated solicitation for Tribal health programs and track Tribal awards and expenditures to meet the 5% minimum commitment.
Risk and compliance	Subaward agreements will include allowable-use language (including non-permissible use of funds under the CA-RHTP initiative(s), *e.g. B. Provider Payments*), non-supplanting attestation, separate cost tracking, quarterly financial and performance reporting, annual outcome reporting, audit and site-visit rights, documentation requirements, and corrective-

	action and repayment remedies for unallowable or unsupported costs as well as repayment provisions for unmet service obligations. Permissible uses of funds are restricted to the use of funds disclosed in the CMS-approved proposal, in addition to required compliance with applicable state and HHS/CMS subrecipient/awardee terms and conditions.
Initiative and use of funds categories	Initiative: The Rural Health Workforce Development Initiative (2) Use of funds: A. Prevention and Chronic Disease, D. Training and Technical Assistance, G. Appropriate Care Availability, E. Workforce Development and Recruitment, H. Behavioral Health, K. Fostering Collaboration

In support of the Rural Health Technology & Tools Initiative:

Technology & Tools: EHR Modernization Grants *$11,650,000*

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.

Preamble	Changed from original $10.0M, increased original proposed budget amount by $1.6M in additional Budget Period 1 (BP1) funds made available under the CMS NOA for California, for a revised total of $11.6M. Funds will upgrade, enhance, and extend needed infrastructure technology, including EHR systems, for rural, frontier, and Tribal facilities that cannot effectively exchange patient data. Funds are allocated separately from other technology grants to safeguard compliance with permissible use constraints related to EHR replacements.
Budget Period 1 amount	BP1 $11.6M.
Number of Awards	Up to 18 awards sized to support higher cost interoperability upgrades and an intended mix of rural, frontier, and Tribal facilities.
How big per award	Tiered grants with an increased floor: small $100K to $500K, medium $500K to $1.0M, large $1.0M to $2.0M for complex interoperability upgrades and EHR modernization. Planning assumption based on market pricing is approximately $2.0M per major upgrade.
Justification for number of subawardees	Award volume is calibrated to the expected unit cost of major interoperability upgrades and to keep awards large enough to fund meaningful modernization work. The planned count supports a mix of higher intensity upgrades and smaller readiness activities while maintaining HCAI capacity to verify allowability and compliance with EHR replacement constraints.
Process and scoring mechanics	Request for Application (RFA). Rubric emphasizes interoperability impact: baseline capability gap, feasibility and vendor readiness, regional network integration value, cybersecurity and privacy plan, budget and sustainability.
Data and documentation	• Current-state interoperability baseline • EHR certification and replacement status documentation • Vendor quotes and implementation plan • Cybersecurity risk assessment • Data-sharing agreements • Budget and project timeline

Tribal participation	Apply a Tribal set-aside and or scoring preference to ensure Tribal facilities have access to modernization funds; track Tribal expenditures toward the 5% minimum.
Risk and compliance	Subaward agreements will include allowable-use language (including non-permissible use of funds under the CA-RHTP initiative(s), *e.g. B. Provider Payments*), non-supplanting attestation, separate cost tracking, quarterly financial and performance reporting, annual outcome reporting, audit and site-visit rights, milestone reporting, and corrective-action and repayment remedies for unallowable or unsupported costs. Permissible uses of funds are restricted to the use of funds disclosed in the CMS-approved proposal, in addition to required compliance with applicable state and HHS/CMS subrecipient/awardee terms and conditions.
Initiative and use of funds categories	Initiative: The Rural Health Technology & Tools Initiative (3) Use of funds: A. Prevention and chronic disease, C. Consumer tech solutions, D. Training and technical assistance, F. IT Advances, G. Appropriate Care Availability, K. Fostering Collaboration

Technology & Tools: Improvement Grants *$0*

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.

Preamble	No change from original budget amount.
Budget Period 1 amount	BP1 $0.
Initiative and use of funds categories	Initiative: The Rural Health Technology & Tools Initiative (3) Use of funds: A. Prevention and chronic disease, C. Consumer tech solutions, D. Training and technical assistance, F. IT Advances, G. Appropriate Care Availability, K. Fostering Collaboration

Subrecipient Budget Summary

Table 9 - Subrecipient Budget, Budget Period 1 (figures in millions)

Initiative	Purpose	BP 1
Transformative Care Model	Transformation Payments to Support Strategically Located Hospitals	35.00
Transformative Care Model	Establish Regional Hub-and-Spoke Networks	39.01
Transformative Care Model	Expand Support for Non-Physician Clinical Roles	0.00
Transformative Care Model	Expand Rural Health Train-the-Trainer	2.00
Transformative Care Model	Expand and Support Rural Workforce Capacity	6.50

Initiative	Purpose	BP 1
Transformative Care Model	Expand and Support Tribal Rural Workforce Capacity	5.00
Workforce Development	Career Pathways Grants	6.99
Workforce Development	Rural Clinical Placement Support and Training Pathways	6.40
Workforce Development	Expand Rural Provider Retention and Relocation	54.17
Technology & Tools	EHR Modernization Grants	11.65
Technology & Tools	Improvement Grants	0.00
Subtotals		**166.72**

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 *$12,447,250*

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.

Increased from original proposed budget amount BP1 $4.0M to $12.45M.
Initiative: The Rural Health Transformative Care Model Initiative (TCM) (1)

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.

Unchanged from original proposed budget amount BP1 $6.0M to $6.0M.
Initiative: The Rural Health Workforce Development Initiative (2)

In support of the Rural Health Technology & Tools Initiative:

Rural Technical Assistance Center Contractor *$23,550,000*

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 $23.6 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 $21-24 million annually.

Increased from original proposed budget amount BP1 $5.0M to $23.55M.
Initiative: The Rural Health Technology & Tools Initiative (3)

In support of the CA-RHT implementation:

Third-Party Administrators for Grants *$6,910,530*

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.

Increased from original proposed budget amount BP1 $1.6M to $6.91M. Not initiative specific.

Financial Audit Services *$0*

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.

Unchanged from original proposed budget amount BP1 $0 to $0. Not initiative specific.

Contractor Budget Summary

Table 10 - Contractor Budget, Budget Period 1 (figures in millions)

Initiative	Purpose	BP 1
Transformative Care Model	Hub-and-Spoke Implementation and Technical Assistance Support	12.45
Workforce Development	Workforce Mapping Tool Expansion	6.00
Technology & Tools	Rural Technical Assistance Center	23.55
Administrative	Third Party Administrators for Grants	6.91
Administrative	Financial Audit Services	0.00
Subtotals		**48.91**

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 11 - Total Direct Costs, Budget Period 1

Category	BP1
a. Personnel	2,502,458
b. Fringe Benefits	1,327,804
c. Travel	57,550
d. Equipment	-
e. Supplies	349,233
f. Consultant/ Contractor/ Subrecipient	223,227,780
g. Construction	-
h. Other	-
Subtotals	**227,464,826**

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.

Table 12 - Modified Total Direct Costs and Indirect Cost, Budget Period 1

Category	BP 1
a. Personnel	2,502,458
b. Fringe Benefits	1,327,804
c. Travel	57,550
e. Supplies	349,233
f. Consultant/ Contractor services	56,507,780
f. Subawards (up to first $50,000 only)	1,000,000
Number of new subawards anticipated	20
Subtotal MTDC	61,744,826
Subtotals Indirect Cost	**6,174,483**

Cost Summary

The tables below summarize the proposed CA-RHT cost by initiative and budget period based on an award of $233.6 million in Budget Period 1 and the hypothetical model of $200 million in future Budget Periods. 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 13 - Spending by initiative, Budget Period 1

Initiative	BP 1
1: Transformative Care Model	112,219,100
2: Workforce Development	62,364,799
3: Technology & Tools	35,689,045
0: Administrative Cost	23,366,364
Subtotals	**233,639,308**

CA-RHT Program : Selection & Procurement Flow Snapshot

How the State selects subrecipients and contractors, including a direct-to-individual pathway (if authorized).

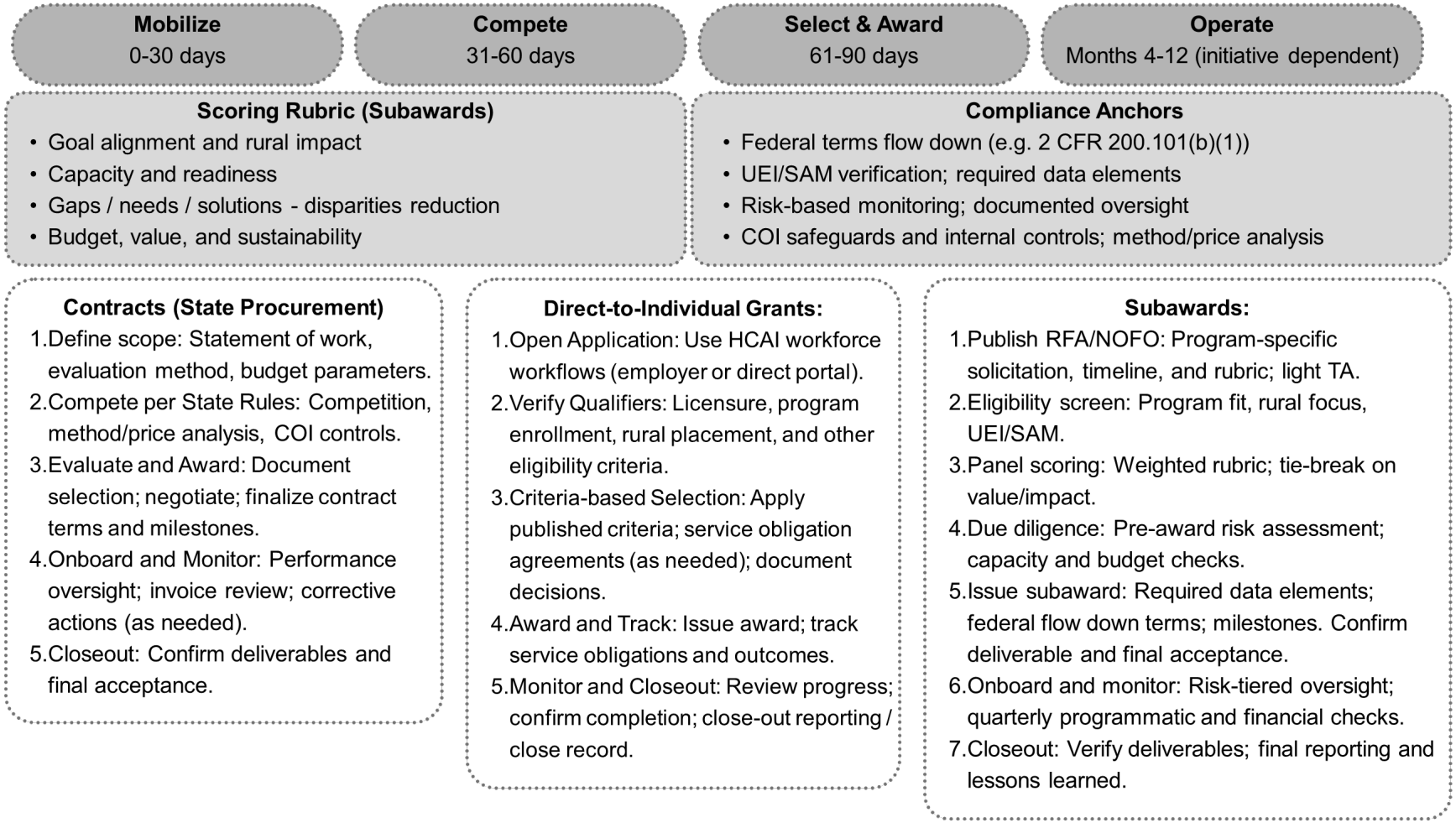

Figure 2 - CA-RHT Subrecipient, Contractor, and Consultant Process Overview *For Illustrative Purposes Only*

Appendix A

Transformative Payments Under the Rural Health Transformative Care Model

Purpose and Context

Transformative Payments within the Rural Health Transformative Care Model (TCM) are investments in a select group of rural hospitals whose stabilization is essential to increasing rural access in California. As described in the Project Narrative, California's rural communities are geographically expansive, demographically diverse, and operate under widely varying conditions. Rural hospitals vary substantially in service mix, financial condition, workforce capacity, and community health needs. Transformative Payments recognize this heterogeneity and provide time-limited support tied to structured initiatives with clear metrics that will drive measurable rural hospital improvements and transformation. These payments are not provider reimbursement for billable services and will not supplant existing payment streams. Rather, they are conditional, milestone-based transformation investments to support hospital participation in feasible components of the Transformative Care Model (TCM) to advance long-term sustainability, improve local utilization, and optimize rural and frontier health outcomes. Transformative Payments are exclusively under Initiative 1: The Rural Health Transformative Care Model and are aligned with the program's strategic goals of sustainable access, innovative care, workforce development, and technology modernization.

Eligibility and Selection Framework

California will apply a structured, multi-stage process to identify hospitals eligible for Transformative Payments. The objective is to ensure that awards are directed to hospitals that are (1) strategically important to regional access, (2) capable of engaging in transformation, and (3) positioned to demonstrate measurable improvement.

Filter 1: Objective Eligibility Criteria

HCAI will narrow the universe of California's rural hospitals (approximately 108 statewide) to an estimated subset of approximately 25 hospitals meeting the following criteria:

- Fewer than 200 licensed beds
- Positive but minimal operating margin (greater than 0.01%)
- Greater than 60 days cash on hand
- Located in rural or frontier Medical Service Study Areas (MSSAs) and HRSA-defined rural areas

Consistent with subrecipient selection criteria in the Budget Narrative, this filter ensures that participating hospitals serve rural communities, have leadership with demonstrable revenue management skills, and are not in immediate danger of closure.

Filter 2: Strategic and Readiness Criteria

HCAI will apply additional criteria to further narrow the cohort. These criteria include:

- Geographic necessity (e.g., maternity care desert, high chronic disease burden, Tribal service area)

- Demonstrated willingness to participate in site-specific data reporting and award monitoring
- An HCAI assessment of the applicant's management and operations to confirm that the hospital is capable to implement feasible TCM components and demonstrate measurable improvement in outcomes such as utilization, access, quality, coordination, or sustainability
- Commitment to service line operations assessment and willingness to align with TCM objectives and receive technical assistance
- Evidence of readiness to implement feasible workforce and technology components
- Commitment to employ targeted care coordination strategies focused on improving rural health care and achieving financial and operational goals

Filter 3: Capacity and Access Profile
HCAI will conduct a structured capacity and access profile to narrow from the identified 25 hospitals to a finite number that Transformative Payments can sufficiently fund with the $35 million budget. This profile will assess:

- Catchment area
- Number of rural and frontier residents served
- Local disease and chronic condition burden
- Lines of business and service mix (e.g., maternity, primary care, specialty care, chronic disease, emergency, behavioral health)
- Utilization
- Workforce configuration and reliance on locums
- Technology maturity and interoperability gaps

This individualized profile ensures that transformation is tailored to each hospital's unique role within its community and region.

Structured Transformation Process
For each Transformative Payment grantee, HCAI will administer a standardized four-step process to successfully implement the hospital-identified feasible TCM component(s).

1. Line of Business Analysis
HCAI, with consultant support as outlined in the Budget Narrative, will conduct a detailed analysis of each hospital's lines of business. The purpose is to identify which service lines are strategically important, performing well, underperforming, at risk, or underutilized.

2. Operations Analysis
HCAI will conduct a focused analysis that will evaluate the hospital's operational, workforce, financial, and technological baseline. The analysis will then identify barriers preventing the hospital from stabilizing or expanding targeted service lines and propose solutions, including technical assistance, for any identified barrier. The analysis will identify existing site resources, clinical expertise, and other relevant capabilities that can

be leveraged to participate in and support feasible TCM components and the hospital's potential participation in a regional care collaborative. The analysis will explicitly examine opportunities to implement TCM components such as hub-and-spoke collaboratives, telehealth, workforce development, evidence-based care models, eConsult, revenue cycle management, and care coordination.

3. Collaborative Transformation Plan

Based on the operations analysis, hospitals will implement transformation activities tied to overcoming the identified barriers and enhancing specific lines of business. These transformation activities may include:

Maternal Health

- Implementation of OB Nest prenatal model
- Establishment of telehealth or eConsult pathways
- Development of perinatal Community Health Worker programs
- Standardized transfer protocols and readiness drills

Chronic Disease and Primary Care

- Deployment of evidenced-based care models such as Project ECHO
- Expansion of remote patient self-monitoring
- Integration of behavioral health through collaborative care or psychiatry access programs, such as Train-the-Trainer

Specialty Access

- Telehealth and eConsult expansion
- Regional referral and scheduling optimization
- Shared staffing or rotating specialty coverage

Operational Sustainability

- Billing modernization and revenue cycle optimization
- Shared service agreements within regional collaboratives
- Transition of low-volume inpatient services to outpatient or telehealth-enabled pathways
- Efficiencies through care coordination
- Regional workforce sharing
- Revenue diversification
- Administrative services simplification.

Allowable uses will align with the intent of Rural Health Transformation and will be detailed in grant agreements. Hospitals must comply with all applicable federal requirements, including allowable use of funds, financial reporting, and compliance standards, and participate in required monitoring and ongoing coordination with the awarding agency and regional care collaborative support contractors.

Hospitals may also participate in separate Workforce or Technology & Tools grants for additional support; however, activities funded through those initiatives must be financially and operationally distinct.

No Duplication of Payments

HCAI will implement strict accounting, budget attestation, and milestone tracking protocols to ensure that Transformative Payments do not duplicate:

- Medicaid, Medicare, or commercial provider reimbursement
- Workforce Development grants
- Technology & Tools grants
- Other state or federal funding streams

Each Transformation Plan will include a line-item budget mapping uses of funds to discrete transformation activities. Annual audits and reporting will verify compliance. Funds may not be used to pay for routine operating losses, billable services, or activities already funded under other CalRHT initiatives.

4. Utilization and Outcome Targets

Each hospital will establish baseline utilization metrics tied to the targeted line of business, and will be accountable for reporting year-over-year progress on the agreed-upon metrics. Metrics may include:

- Increase in local maternity deliveries
- Increase in empaneled primary care patients
- Increase in telehealth or eConsult billing
- Improvement in operating margin or service line contribution margin for targeted programs

The YoY utilization targets will reflect realistic, data-informed improvement expectations.

Payment Structure and Accountability

Hospitals will receive payments to support implementation of agreed transformation activities. Hospitals must demonstrate engagement and progress toward TCM goals to remain eligible. Prior to disbursing funds, HCAI will confirm that the hospital has the leadership commitment, operational readiness, and implementation plan necessary to begin transformation activities.

Transformative Care Facility Financing Staffing

One health facility financing specialist will administer Transformative Payments under the CalRHT program. This position will manage financial transactions, ensure compliance with state and federal funding requirements, provide technical assistance to rural health providers participating in transformation initiatives, oversee payment processing, maintain accurate financial records, and coordinate with internal teams to ensure timely and accurate disbursement of funds.

Expected Impact

Transformative Payments are intended to:

- Preserve and expand access to primary, maternity, chronic, and specialty care, or other identified lines of business needed in a given rural area
- Increase rural care utilization
- Strengthen integration within local regional care collaboratives
- Provide technical assistance to help strategically important rural hospitals solve barriers identified in their operations analysis

By pairing structured financial support with measurable transformation, the program advances the CalRHT vision of a connected, resilient rural health system that delivers person-centered care close to home.