Tennessee Hospital Association

Tennessee Rural Health Transformation Fund Application: Hospital Funding Pathways

April 1, 2026

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Executive Summary

The Tennessee Rural Health Transformation Program (RHTP) is a Centers for Medicare & Medicaid Services (CMS) approved multi-year federal and state investment to improve access, workforce capacity, infrastructure, and care delivery in rural and underserved communities. Created by the One Big Beautiful Bill Act (H.R. 1), administered by CMS, and implemented by the State of Tennessee, the program supports care redesign, technology adoption, workforce expansion, infrastructure development, and community partnerships. Tennessee operates a TennCare shared savings mechanism under its Section 1115 waiver, which allows the state to retain federal Medicaid savings when expenditures remain below the approved cap and quality standards are met. Tennessee is planning to direct a portion of these shared savings dollars toward reinvestment in healthcare priorities, including infrastructure improvements, workforce initiatives, and continued efforts to strengthen rural healthcare across the state. This approach is distinct from the Rural Health Transformation Program (RHTP), which provides dedicated, time-limited funding specifically structured to support rural transformation projects through competitive awards and defined transformation activities. Building on these complementary efforts, Tennessee's application for the RHTP focuses on scalable models that expand access beyond traditional settings, address persistent rural disparities, and align with national priorities around value and sustainability. Final initiative details and timelines will be determined through upcoming Request for Applications (RFAs) and additional guidance issued by the state.

Purpose of This Report: This report provides THA member hospitals with a concise, point-in-time summary of available RHTP information to support early strategic planning. It highlights key themes, funding pathways, and considerations emphasized during the Tennessee Department of Health webinar held on March 31, 2026. Forvis Mazars is developing a more comprehensive presentation covering all 17 RHTP initiatives, which will be shared through future webinars as additional state and federal guidance becomes available.

How Hospitals Should Use This Report:

Hospitals should use this document to understand the program's current structure, assess alignment with organizational strategy and Community Health Needs Assessments priorities, and begin preparing data, narratives, and early project concepts for future applications. Preparation should also include reviewing and understanding the compliance requirements associated with accepting federal and state transformation funding, as these obligations will influence project design, reporting processes, and operational readiness. Early planning should include evaluating readiness, workforce needs, and potential partnerships across public health, behavioral health, dental, academic, and community organizations. Because RFAs are expected soon after state and CMS approvals, hospitals may wish to assign internal leads to monitor updates and coordinate preparation.

CMS Goals for the Rural Health Transformation Program (RHTP)

Program Goals

- ***Improve rural health outcomes*** through expanded access to primary, behavioral, maternal, and preventive care.
- ***Strengthen sustainable access*** by supporting financially stable, efficient rural care models.
- ***Build the rural workforce*** through recruitment, training, and retention strategies tailored to local needs.
- ***Advance innovative care models*** that improve quality and reduce total cost of care through value-based arrangements.
- ***Expand technology & data capacity*** including telehealth, interoperability, cybersecurity, and population health tools.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Rural Health Transformation Program

https://www.cms.gov/priorities/rural-health-transformation-rht-program/overview

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Proposal, Oversight, and Evaluation Requirements

Proposal Requirements: Proposals must outline ***measurable deliverables***, ***timelines,*** and ***expected outcomes***

Cost Sharing: Applicants are responsible for initial funding for projects as competitive grants are reimbursement based.

Milestone-Based Oversight: Grant awards will be actively monitored against defined milestones rather than funded without follow-up

Progress Reporting: Funded recipients must report on advancement toward their approved commitments

Evaluation: Evaluation planning is incorporated directly into the competitive grant scoring process

Evaluation Embedded in Grant Scoring: 10 of 100 points in HRP competitive grants are allocated to the applicant's evaluation plan, ensuring alignment with broader transformation goals

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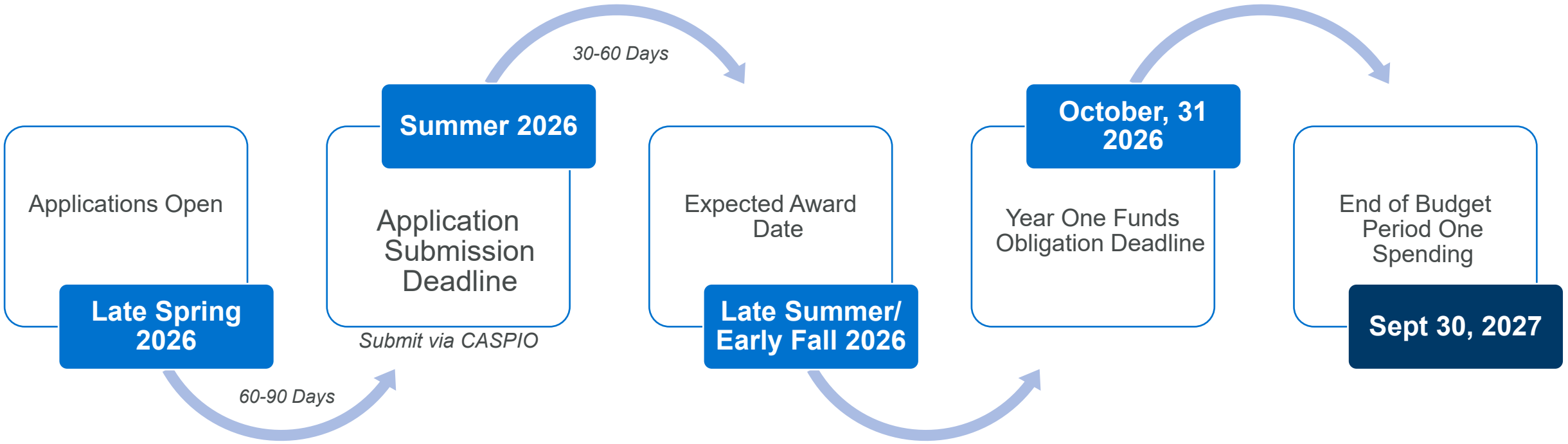
Year 1 Timeline



*Official dates and deadlines are forthcoming

Tennessee RHTP: 5 Objectives; 17 Initiatives

Funding	Goal	Objective	Baseline (2025)	Target (FY 2031)
$382M	Rural Healthcare Transformation ***RHT***	Expand integrated primary, behavioral, and specialty care access across rural Tennessee by increasing the number of clinics offering co-located services and connected referral systems	Few rural clinics offering co-located behavioral or specialty care; limited referral connectivity	≥20 rural clinics providing co-located care and a 50% increase in organizations connected through TN Community Compass
$238M	Maternal and Child Health ***M&CH***	Expand access to comprehensive maternity care in all Tennessee maternity-care-desert counties and improve perinatal quality outcomes	0 maternity-care-desert counties served; Postpartum depression screening 84%; postpartum visit attendance 92.6%	100% of maternity-care-desert counties served; postpartum Depression screening 91%; postpartum visit attendance 93.8%
$111M	Make Rural Tennessee Healthy Again ***MaRTHA***	Improve preventive health and chronic disease outcomes in rural Tennessee by expanding access to health-promoting environments and strengthening County Health Councils	45 counties with funded health-promotion environments; 0% of rural residents within one mile of such environments; 42 tailored resources for Health Councils	89 counties funded; ≥25% of rural residents within one mile; 73 tailored resources
$194M	Technology Infrastructure ***TECH***	Modernize rural health technology systems to strengthen data exchange, interoperability, and care coordination statewide	Structured data exchange at 60% of encounters; 0 providers enrolled in HIE; ~20,000 annual referrals through TN Community Compass	Structured data exchange at 85% of encounters; 500 providers enrolled in HIE; 200,000 annual TNCC referrals
$53M	Workforce Development ***WD***	Expand rural health workforce pipeline by increasing residencies, apprenticeships, and internships that establish sustained training and placement capacity statewide	0 rural residencies; 38 apprenticeships; 0 student internships	20 rural residencies; 80 apprenticeships; 1,000 student internships

Tennessee Shared Savings Program
Considerations for Hospitals

Program Structure & Timing Advantages

- Independent from RHTP
- Capital expenditures may be eligible

Strategic Positioning for Funding Requests

- Smaller, phased or partial funding request to increase likelihood of approval
- Strongest applications show organizational match or co-investment, demonstrating sustainability and shared risk
- Proposals should emphasize partnerships with community partner engagement
- Hospitals are viewed as well-aligned applicants

Priority Areas Aligned With TennCare Goals:

- Rural access preservation to maintain services like emergency care, obstetrics, and behavioral health
- Workforce stabilization
- Rural and maternal health supports, including health system resilience, disaster-related preparedness, disaster recovery, and programs addressing social needs

Funding

- Tennessee's RHTF application illustrated $125 million available for competitive awards
- As of 3/23/26, the Governor's Administration submitted a budget amendment to the legislature to reduce this amount to approximately $104 million
- Funding through shared savings has not been finalized

Quality & Accountability Requirements

- Award decisions will be influenced by TennCare's federal quality metric framework (BP control, cervical cancer screening, immunizations, prenatal care, behavioral health follow-up, and other CMS-core set metrics)
- Hospital proposals that directly strengthen quality, throughput, compliance, or avoidable utilization align more closely with TennCare's performance-based funding structure

Risk, Feasibility, & Competitiveness

- Considered lower risk and more straightforward than RHTP due to its structure, earlier timing, and familiar scoring process
- Hospitals that serve large TennCare populations and have the reporting and quality infrastructure to demonstrate improvements are better positioned for selection and stronger impact

Case Study: System Backed Strategy for Strengthening Rural Access

West Tennessee Healthcare is building a replacement hospital in Bolivar to modernize care delivery for Hardeman County and nearby rural communities. The new micro-hospital replaces a 1974 structure and incorporates expanded emergency and inpatient capacity, updated imaging and diagnostic services, and negative-pressure isolation rooms to strengthen readiness for future infectious-disease events. The project is supported in part by a $9.61 million Healthcare Resiliency Program–Capital Investment (HRP-CI) award and is being constructed on land donated by the City of Bolivar, reflecting a strong public-health system partnership.

As construction advances, the hospital intends to use time-limited operational funds, including HRP-CI, to enhance the value of the capital investment without funding construction. These resources would support equipping ED bays for tele-enabled consults, enhancing imaging workflows to shorten time-to-diagnosis, and optimizing stabilization during high-volume periods. Flexible outpatient pods and procedure spaces would allow scheduled services and basic diagnostics to be delivered locally, creating predictable access for Medicaid members and reducing unnecessary travel out of the county. This strategy is consistent with established state practice, under which Tennessee has supported rural access initiatives and operational improvements to reinforce hospital resiliency and service capacity.

West Tennessee Healthcare contributes the capital match, project leadership, and long-term operating oversight that ensure the new facility remains sustainable after initial implementation support phases end. As new care coordination and diagnostic workflows reduce avoidable transfers, shorten ED revisits, and improve episode level efficiency, the system plans to absorb successful roles such as navigators, transfer coordinators, or tele consult coverage into its ongoing budget. This approach enables Shared Savings funds to function as a launch platform rather than a recurring subsidy, transitioning to a stable operating model supported by demonstrated performance improvements.

The resulting emergency and outpatient platform offers faster diagnostics, reduced delays, and strengthened care continuity, while the modern footprint improves preparedness for future public health emergencies. By pairing HRP-funded infrastructure with targeted operational investments and sustained system participation, the Bolivar project demonstrates how rural hospitals can leverage capital improvements into long-term gains in access, quality, and community health.

- https://www.wth.org/services/west-tennessee-healthcare-bolivar-hospital/wth-bolivar-rural-emergency-hospital-construction/
- https://www.wth.org/news/west-tennessee-healthcare-breaks-ground-on-new-bolivar-hospital/

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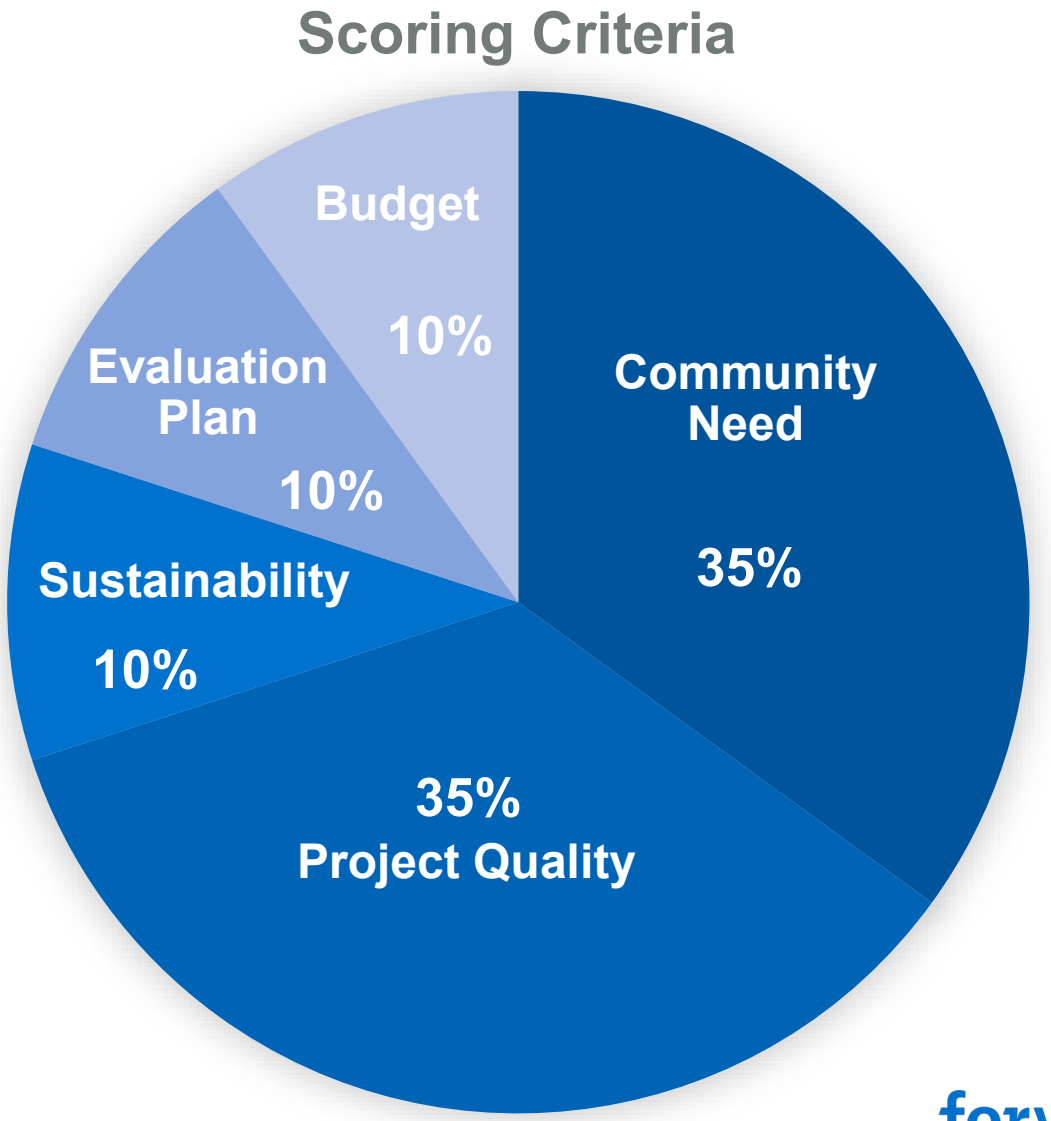
Healthcare Resiliency Program (HRP) Illustrative[1] Scoring Criteria

100 Point Framework

This is a competitive process

Strong applications demonstrate:

- Integration of Community Health Needs Assessment
- Data-supported community need
- Direct alignment between need and proposed activities
- Credible sustainability beyond the grant period



1) *Scoring criteria are based on prior awards from the **Healthcare Resiliency Program (HRP)** and are provided for reference only. Final criteria, methodology, and award determinations are subject to change at the discretion of the awarding authority.*

HRP – Service Line Expansion & Co-Location

Program Overview

Hospital Eligible
Yes

Eligible Facilities
GACHs and CAHs located in rural counties that meet defined eligibility criteria

Funding Type
Competitive grant funding to strengthen and sustain select hospital service lines

Summary
Priority service lines are advanced through tightly planned, collaborative use of existing hospital and clinic space, aligned with TDOH's limited awards:

- 10 rural clinics adding integrated behavioral health
- 10 rural primary care clinics adding specialty care,
- 10 new or upgraded exam/treatment room

Planning emphasizes collaboration, targeted staffing, and telehealth to sustain services at rural volumes.

Key Details

Key Timeframe
Q2 2026 – Request for Applications (RFA) released

Key Stakeholders
Hospitals; primary and behavioral health providers; nonprofit and community-based organizations (CBOs)

TN RHTF Reference
Pages 16-18

Estimated Required Funding (USD)
5-year total: $95,000,000
Annual average: $19,000,000

Goal
RHT

Case Study: Building Local Behavioral Health Capacity in Rural Tennessee

Macon Community Hospital serves a rural area where limited outpatient behavioral health capacity has placed growing pressure on the emergency department and primary care providers. Patients experiencing mental health or substance use crises often presented repeatedly due to delays in follow up care and limited local options. To address these challenges, the hospital partnered with HOPE Family Health to strengthen the transition from emergency stabilization to ongoing community based behavioral health care, drawing on EmPATH principles to support timely assessment, stabilization, and discharge planning.

Under the model, patients presenting to the emergency department with behavioral health needs receive timely assessment and stabilization, followed by active care coordination prior to discharge. Rather than relying on passive referrals or distant inpatient placement, patients are connected directly to outpatient therapy, medication management, and enabling services through HOPE Family Health. A dedicated behavioral health case management function supports discharge planning, facilitates referrals, and helps address barriers such as transportation, medication access, and insurance eligibility, ensuring clear next steps after an ED visit.

From the hospital perspective, aligning outpatient behavioral health capacity with emergency care improved patient flow while reducing avoidable repeat emergency department visits. The model limited unnecessary transfers for stabilization and follow up care and created more predictable discharge pathways for patients with high behavioral health needs. By formalizing the partnerships required to move patients efficiently from crisis to community-based treatment, the initiative strengthened local behavioral health infrastructure in a manner appropriate for rural volumes and demonstrated how integrated hospital-community partnerships can improve access, patient flow, and sustainability without creating standalone programs.

https://mainstreetmediatn.com/articles/gallatinnews/hope-family-health-expands-to-gallatin/

Case Study: Expanding Rural Access to Oncology Services

A rural hospital serving a multi-county region faced limited access to oncology services, requiring patients to travel long distances for chemotherapy and specialty care. This created delays in treatment, reduced adherence, and lost downstream revenue for the hospital. To address these gaps, the hospital partnered with an urban health system to co-locate oncology service lines within its facility, enabling specialty providers to deliver care locally while also establishing infusion services administered by local clinical staff with appropriate specialty support.

Under the model, urban-based oncologists and care teams rotated into the rural hospital or supported services through coordinated scheduling and tele-oncology. The rural hospital invested in space, equipment, and infusion capabilities, enabling patients to receive treatment closer to home. Shared protocols, data integration, and care coordination ensured consistency in clinical quality and patient experience across sites.

The partnership structure allowed the rural hospital to retain a portion of facility and service-line revenue while leveraging the specialty expertise of the urban partner. Over time, patient volumes increased, outmigration declined, and care continuity improved. Hospital leadership reported strengthened financial performance, expanded service offerings, and improved access to cancer care, while establishing a sustainable model for specialty service expansion in a rural setting.

Major vs. Minor Capital Renovations: Funding Pathway Guidance

Major Capital Expenditures

Projects involving substantial physical investment should be directed to the Shared Savings funding pathway. This includes new construction, major facility expansions, or extensive renovations that significantly increase a hospital's physical footprint, structural capacity, or core infrastructure. Because these projects require larger upfront investment, longer timelines, and more complex procurement and compliance oversight, they fall outside the scope and intent of RHTP Initiative 1 and are more appropriately addressed through the Shared Savings capital pool.

Prohibition on Overlapping Funding

Hospitals may not request overlapping renovation or construction costs across Shared Savings and RHTP funding sources. Each cost must be assigned to a single funding pathway, and duplicate funding for the same component is not allowed. Separate requests may be appropriate when they address distinct elements of a project. For example, construction of a new intensive care unit would be pursued through Shared Savings, while related technology or workforce investments needed to operationalize the unit could be pursued under applicable RHTP initiatives.

Minor Capital Expenditures

Projects involving limited physical investment that support the activation, enhancement, or expansion of existing services may be appropriate under RHTP Initiative 1. This includes modest renovations, space reconfiguration, equipment installation, or build outs within existing facilities that do not materially expand the hospital's footprint or core infrastructure. These expenditures are intended to enable service delivery and are expected to remain within applicable capital or renovation limits, including an approximate 20 percent cap at the project level.

Segmentation of Applications

The Department of Health has indicated that awards will be segmented by project component. As a result, hospitals pursuing large, multi-part initiatives will need to divide the overall project into discrete components and submit separate applications aligned to the appropriate funding categories. For example, a plan to develop a new outpatient center while also investing in technology and workforce capacity would likely require separate applications for the facility, technology, and staffing elements rather than a single bundled request.

The appropriate funding pathway should be determined by the magnitude of the capital investment, while strategic importance should guide project prioritization. Hospitals are strongly encouraged to structure and segment projects deliberately to align with program rules and avoid compliance issues downstream.

HRP – Maternal & Child Health

Program Overview

Hospital Eligible
Yes

Eligible Facilities
Rural birthing hospitals; CAHs; hospitals linked to regional perinatal centers

Funding Type
HRP competitive grants to birthing hospitals, offering up to 100 awards across two categories: 1) Small awards up to $1.25 million; 2) Large awards from $1.25 million to $12.5 million over five years, to support targeted technology, teleconsults, minor upgrades, and workforce supported service expansion.

Summary
Strengthens rural maternity care by advancing maternity access, perinatal quality, postpartum and maternal behavioral health, and technology-enabled care, linking rural providers to regional perinatal centers to support maternity-care-desert counties, expand TIPQC participation, and improve maternal outcomes.

Key Details

Key Timeframe
Q2 2026 RFA released; FY27 Round-1 grants; FY28 full operations; FY31 final report

Key Stakeholders
Title V Maternal & Child Health Partners, Maternal Health Task Force, Infant Health Advisory Committee, and the Rural Health Association of Tennessee

TN RHTF Reference
Pages 26-27

Estimated Required Funding (USD)
5-year total: $97,000,000
Annual average: $19,400,000

Goal
M&CH

Case Study: Maternal and Child Health Capacity Expansion in a Rural Birthing Hospital

A rural birthing hospital in a large maternity care desert had been facing delayed obstetric triage, prolonged neonatal transfer times, and inconsistent postpartum follow up. Through a maternal and child health initiative, the hospital partnered with regional perinatal experts to standardize emergency drills and clinical pathways across the emergency department, labor and delivery, and transport teams. Teleconsultation for obstetric and neonatal concerns was introduced to provide timely specialty input that previously required long travel. Upgraded call center systems enabled real time routing of referrals, while a mobile pregnancy application delivered education reminders and resource links to support prenatal care, postpartum visits, and behavioral health screening.

To operationalize these changes, the hospital implemented monthly obstetric and neonatal simulations that involved emergency nurses, respiratory therapy, and transport partners. Perinatal readiness drills were added to charge nurse huddles, and standardized hemorrhage and hypertensive crisis kits were placed in both the emergency department and labor and delivery. A same day teleconsult pathway supported non urgent specialty questions, while rapid teleconsultation was used for time sensitive cases without immediate onsite coverage. Before discharge, staff scheduled postpartum appointments and placed warm behavioral health referrals through the enhanced call center platform to ensure follow through.

Within six months, the hospital saw earlier specialty input, higher postpartum visit completion, more consistent depression screening, and smoother neonatal transfers. Clearer workflows and regular drills reduced last minute diversions. The hospital aligned its tracking to initiative metrics, allowing progress to be monitored alongside peer facilities.

HRP – Health Tech

Program Overview

Hospital Eligible
Yes

Eligible Facilities
Facility-led by a rural provider, or partner-led by a technology or virtual care organization applying in partnership with, or delivering services directly to, rural providers

Funding Type
Competitive, milestone-based tech modernization grants; requires compliance with federal interoperability and privacy standards

Summary
Modernizes the rural digital backbone through scalable, interoperable, and secure digital solutions, including telehealth expansion; data integration and EHR interoperability; advanced analytics and AI-enabled clinical or revenue cycle workflow tools; wearable and remote patient monitoring (RPM) technologies; cybersecurity upgrades; and workflow automation.

Key Details

Key Timeframe
Q2 FY26 RFA, FY26 awards; FY27 pilots; FY28–FY30 scale; FY31 evaluation

Key Stakeholders
Hospitals, providers, patients, associations, vendors & infrastructure builders

TN RHTF Reference
Pages 31-33

Estimated Required Funding (USD)
5-year total: $92,000,000
Annual average: $18,400,000

Goal
TECH

Case Study: Hospital-Directed Digital Modernization to Extend Access

A rural hospital serving four small towns relied on fragmented legacy systems that limited telehealth reach, slowed information exchange, and increased documentation burden. Using the health technology initiative, the hospital created a unified digital framework focused on telehealth, interoperability, analytics, automation, and cybersecurity. A technology assessment guided priorities, leading to expanded video visits and remote patient monitoring, timely exchange of labs, imaging, and referral updates with regional partners, and automated intake, scheduling prompts, and results routing to reduce clinician workload.

An implementation office worked with clinical leads from the emergency department, primary care, and imaging to standardize telehealth workflows, incorporate device checks, and ensure contingencies for limited bandwidth. Remote monitoring kits were assigned at discharge, with nurse care managers reviewing vital signs and escalating as needed. Interoperability improvements ensured faster posting of external results, analytics linked digital encounters to outcomes, and automation reduced documentation time. Cybersecurity controls were reinforced through updated protections and role-based training.

Over the first year of implementation, telehealth follow-up increased among remote residents, external results posted more quickly, documentation time decreased, and short-interval follow-up improved. Clinician rework declined, and privacy audits showed full compliance. The hospital reported gains across initiative metrics, including telehealth adoption, interoperability performance, workflow efficiency, and user satisfaction with digital tools.

Case Study: EMR Upgrades and AI Integration

A critical access hospital in Tennessee operated across multiple electronic medical record (EMR) platforms spanning the hospital, outpatient surgery center, and affiliated primary care clinic, creating fragmentation in patient information, billing, and care coordination. This lack of interoperability led to inefficiencies in clinical workflows, delays in claims processing, and challenges maintaining continuity of care across settings.

To address these gaps, the hospital received a Healthcare Resiliency Program-Practice Transformation grant to modernize its core EMR infrastructure and align all outpatient sites onto a single, integrated platform. The initiative focused on improving data sharing, streamlining documentation, and enhancing revenue cycle performance.

With a unified EMR platform in place, the hospital is now well positioned to pursue additional grant opportunities focused on cybersecurity and advanced technologies. Planned investments include strengthening systemwide cybersecurity protections to safeguard patient data and meet evolving compliance standards. The hospital is also evaluating ambient AI tools to reduce provider documentation burden by generating real-time clinical notes, alongside revenue cycle automation solutions designed to improve coding accuracy, reduce claims denials, and accelerate reimbursement.

Together, these efforts position the hospital to operate more efficiently, improve care continuity, and compete effectively in an increasingly data-driven environment.

HRP – Make Rural Tennessee Healthy Again (MaRTHA)

Program Overview

Hospital Eligible
Yes, formal partnerships between health/healthcare providers and community organizations are highly recommended.

Eligible Facilities
CAHs; rural PPS hospitals; system affiliates; FQHCs/RHCs; technology companies and virtual care organizations as implementation partners

Funding Type
Competitive HRP prevention grants to local coalitions/ providers

Summary
Funds community-driven prevention and access (mobile/in-home services, telehealth, school health) anchored by local coalitions and providers to reduce missed visits, improve chronic disease management, and strengthen medical-home connections.

Key Details

Key Timeframe
Q2 2026 RFA released; FY27–FY28 pilots; FY30 scale; FY31 sustainment report

Key Stakeholders
Hospitals, FQHCs/RHCs, EMS/mobile teams, County Health Councils, CBOs, schools

TN RHTF Reference
Pages 28-29

Estimated Required Funding (USD)
5-year total: $50,000,000
Annual average: $10,000,000

Goal
MaRTHA

Case Study: Hospital-Led Community Prevention and Access Model

A small rural hospital serving three dispersed counties faced high no-show rates, limited access to preventive services in remote areas, and avoidable emergency department use tied to unmanaged chronic conditions. Through a community health initiative, the hospital launched a prevention and access model centered on bringing mobile screening into isolated zones and linking those encounters back to a consistent medical home through coordinated telehealth follow-up.

Two high-need areas were identified, and grant funds supported a weekly rotating mobile clinic offering point-of-care testing, immunizations, hypertension and diabetes screenings, and immediate scheduling of follow-up care. School partners layered on screening and health-education visits, with results fed back into a shared scheduling system so families could be connected to primary care rather than relying on episodic care.

To support continuity, the hospital created a unified intake calendar for mobile, telehealth, and clinic visits, ensuring that every mobile encounter resulted in a booked appointment with standardized reminders. Call-center staff used consistent scripts to verify eligibility, coordinate transportation, and assist with telehealth device setup. The clinical team built preventive-care pathways that began with screening in the mobile unit, shifted to telehealth within a week for results review and coaching, and transitioned to in-clinic visits when medication changes or diagnostics were needed.

Within two quarters, missed-visit rates declined among patients engaged through mobile and school channels, and care-plan completion improved for hypertension and diabetes. Emergency department visits for outpatient-sensitive conditions decreased as more preventive issues were identified early through mobile screening and managed through telehealth. The hospital reported progress through the initiative’s framework, demonstrating stronger linkage to primary care, expanded mobile reach, and measurable gains tied to timely preventive screening in hard-to-access areas.

HRP – Rural Non-Emergency Transportation

Program Overview

Hospital Eligible
Hospitals are not excluded but seen as participants through a vendor network supporting non-emergency medical transport and scheduling

Eligible Facilities
Businesses specialized in transportation, CAHs/rural hospitals participating in coordinated transportation networks with transit agencies, community-based organizations, and state-selected or regionally designated vendors

Funding Type
HRP grants for coordination platforms and local models

Summary
Technology-enabled coordination system aligned across hospitals, clinics and community networks, leveraging a limited number of statewide vendors (1-2) to establish regional transport hubs, a coordination platform, and integrated clinical-transport data that connect hospitals, clinics, and transit/CBO networks to ensure reliable rides for rural patients.

Key Details

Key Timeframe
FY26 RFA/baseline; FY27–FY29 roll-out; FY30–FY31 evaluation/sustainability

Key Stakeholders
Transportation vendors, Hospitals, regional health networks, transit agencies, CBOs, TennCare

TN RHTF Reference
Pages 31-33

Estimated Required Funding (USD)
5-year total: $9,000,000
Annual average: $1,800,000

Goal
MaRTHA

Awardee Participation and Coordination Expectations

Health Information Exchange

When eligible, awardees are expected to *connect to Tennessee's statewide Health Information Exchange* (once implemented) to support timely access to patient information and systemwide interoperability.

TN Community Compass

Eligible awardees are expected to *engage TN Community Compass* to improve referral completion, track outcomes, and strengthen coordination with community-based organizations

County Health Council Alignment

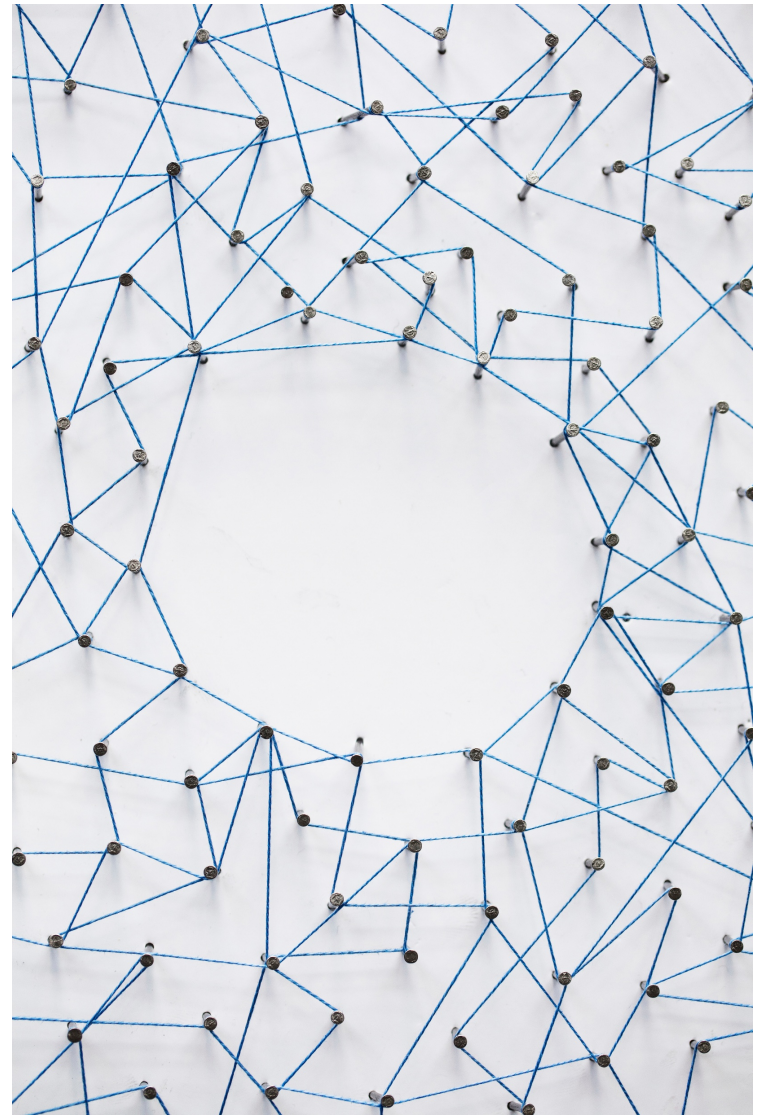
Awardees are expected to provide *annual updates to their County Health Council* to maintain alignment with community-identified priorities. These updates support transparency, reinforce local partnerships, and ensure RHTP activities remain grounded in county health assessments and improvement plans.

Statewide Collaboration

Awardees are expected to *coordinate with other Tennessee Rural Health Transformation projects* to reduce duplication and amplify impact. Connecting across initiatives supports shared learning, regional alignment, and more efficient use of statewide resources.

Awardee Support

The Tennessee Department of Health provides *ongoing technical assistance and implementation support* to participating hospitals. This includes guidance on program expectations, data and reporting requirements, and coordination with statewide systems as initiatives move from planning to execution.



RHTP Compliance[1]: Use of Funds and Fiscal Guardrails

1. Allowable Use of Funds (2 CFR 200)

Costs must be necessary, reasonable, allocable, and documented.

Spending should align with Tennessee's CMS-approved RHTP plan and the NOFO, and support transformational activities rather than routine operations, pre-award costs, or activities that are another entity's responsibilities.

Lump-sum amounts or "to be determined" budget entries are not permitted.

Common compliance risk: Costs not clearly tied to an approved RHTP initiative or lacking itemized support.

2. Supplanting and Duplication Prohibited

RHTP funding is designed to supplement existing resources, not replace them.

Funds cannot duplicate Medicaid, Medicare, commercial insurance, or other payer sources.

Duplicative provider payments, ongoing salaries or services that are reimbursable by another funding source cannot be charged to RHTP.

Common compliance risk: Using RHTP funding to address operating gaps or to cover services that are eligible for other reimbursement.

3. Awareness of Unallowable Costs

Federal restrictions apply, including prohibition on lobbying, fundraising, entertainment, and meals.

RHTP-specific restrictions include broadband construction, facility construction, and debt-related expenses.

Provider payments may not alter established fee schedules. Clinician salary support may not be charged when non-compete clauses apply.

Common compliance risk: Charging prohibited costs due to limited familiarity with federal requirements.

4. Spending Limits and Cost Caps

Applicable cost caps include Admin 10%, Payments made directly to healthcare providers 15%[2], EMR replacement 5%, Capital/renovation 20% (CMS approval required). Other technology investments must comply with CMS and NOFO controls.

Noncompliance, exceeding caps, misuse of funds, or insufficient tracking may result in CMS withholding or recovery of funds.

Common compliance risk: Exceeding caps due to indirect costs or adjustments made without tracking cumulative totals.

5. Indirect Cost Requirements

Entities may claim Indirect Costs under this program. If indirect costs are claimed, the following requirements apply:

Entities may use either a negotiated indirect cost rate or the 15% de minimis rate, which is calculated using the Modified Total Direct Cost (MTDC) base.

Indirect costs claimed under either method count toward the 10% administrative cost cap.

The MTDC base must be calculated correctly, including all required exclusions.

Common compliance risk: Incorrect calculation of the MTDC base or double counting indirect costs.

1) Please click **here** for a detailed listing of RHTP compliance and reporting requirements.
2) See CMS RHTP FAQ #26 (Section V Use of Funds) for additional guidance on provider payments.

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RHTP Compliance: Reporting, Oversight, and Governance

Budgeting and Procurement Discipline

- Line-item budgets with justification are required.
- Federal procurement thresholds must be followed.
- Conflict-of-interest and SAM.gov checks are required.
- Providing at least three quotes up front can demonstrate reasonableness and may enhance scoring.
- ***Common compliance risk: Limited procurement documentation or missing justification for noncompetitive actions.***

Cash Management and Drawdowns

- Funds may be drawn only for immediate cash needs.
- The time between drawdown and disbursement should be minimized.
- Documentation must be ready for Payment Management System (PMS) review.
- ***Common compliance risk: Drawing funds early or maintaining excess federal cash.***

Reporting and Transparency Requirements

- Quarterly and annual program and financial reports are required.
- SAM.gov registration and a Unique Entity Identifier (UEI) must remain active.
- FFATA and FAPIIS disclosures apply when required.
- ***Common compliance risk: Lapsed SAM.gov registration causing payment delays or reporting issues.***

Audit, Monitoring, and Record Retention

- A Single Audit is required when federal spending meets or exceeds $1 million.
- Records must be retained for at least three years.
- Organizations may be reviewed by the state, CMS, or the Office of Inspector General.
- ***Common compliance risk: Missing or incomplete documentation during audit or monitoring review.***

Prior Approvals and Workforce Conditions

- CMS approval is required for major changes to budget, scope, staffing, or capital projects.
- Workforce investments require a five-year rural service commitment.
- Strong internal controls and documented policies are expected.
- ***Common compliance risk: Making program or budget changes before receiving written CMS approval.***

*Please click **here** for a detailed listing of RHTP compliance and reporting requirements.*

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Reporting Requirements

Program & Performance

- Quarterly and annual progress reports
- Workplan updates (milestones, timelines, outcomes)

Financial & Transparency Reporting

- Federal Financial Report (FFR)
- Payment Management System (PMS)
- Federal Funding Accountability and Transparency Act (FFATA)
    - https://www.fsrs.gov
    - https://www.ecfr.gov/current/title-2/subtitle-A/chapter-I/part-170

Oversight & Eligibility Compliance

- SAM.gov registration (active UEI)
        - https://www.ecfr.gov/current/title-2/subtitle-A/chapter-I/part-25
    - Responsibility / qualification records
        - https://www.acquisition.gov/far/subpart-9.1
    - Debarment, suspension, and exclusion certification
        - https://www.ecfr.gov/current/title-2/subtitle-A/chapter-I/part-180

Audit & Accountability

- Audit reporting (Federal Audit Clearinghouse)

Important Caveats

Preliminary Interpretation

The information presented reflects a moment-in-time understanding based solely on materials currently available, including the Notice of Funding Opportunity (NOFO), the state's RHTP application, CMS acceptance documents, and THA expert discussions. Because several program components remain subject to state and federal approval, all descriptions, timelines, and interpretations should be considered preliminary.

Pending Approvals

Many program details, including initiative design, funding parameters, reporting requirements, and implementation sequencing, remain pending until the State of Tennessee releases its RFAs. Timelines referenced reflect the state's initial application but will not be operational until RFAs and accompanying guidance are issued. Hospitals should expect adjustments as the state refines program requirements and should remain flexible as the structure continues to evolve.

Not a Substitute for Official Guidance

This report is not formal state or federal guidance and should not be used to determine compliance, eligibility, or final application requirements. Future RFAs and state instructions will provide definitive direction regarding allowable uses, documentation needs, evaluation criteria, and initiative-specific expectations.

Program Will Evolve

RHTP is expected to change over time as implementation progresses and additional state and federal guidance is issued. THA will continue to monitor developments, offer timely updates, and provide educational support to help hospitals remain aligned with emerging requirements. This report is intended to position hospitals for early preparation so they can mobilize quickly and develop strong, competitive proposals once RFAs are issued.

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