# Tennessee Hospital Association

***Tennessee Rural Health Transformation Fund Application: Hospital Funding Pathways***

June 11, 2026

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# Webinar Agenda & Introduction

| | |
|---|---|
| **Initiatives & Process** | Review the initiatives that are most relevant for hospitals, describe the very short timeline that hospitals are working with as they craft applications, and highlight the process to apply. |
| **RHTP FAQs** | Discuss answers to common questions TDOH and THA have received related to the TN RHTP. |
| **Proactive Compliance** | Describe compliance requirements and offer suggestions for how to proactively prepare to reduce the likelihood of funding recoupment. Organizations need to start thinking now about the processes they'll need to capture the information required to demonstrate compliance with grant requirements. |

# *Disclaimer*

The information set forth in this presentation contains the analysis and conclusions of the author(s) based upon his/her/their research and analysis of industry information and legal authorities. It is current as of June 11, 2026. Federal and state policies related to the RHTP may change frequently so links to the source documents have been provided within the document for your reference.

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or without changes in industry information and legal authorities.

# 01

## Key Initiatives & Application Process

# Requests for Application Timeline, Key Hospital Initiatives & Process

## Tight Timeline

- 30 days from when application goes live
- Hospitals must be prepared in advance of application opening
- Prepare for post-award contracting by reviewing sample contracts now, available in all open initiatives

## Key Initiatives

- Review initiatives that THA believe present the best/most needed funding opportunities for hospitals
  - Health Tech Innovations
  - HRP Service Line Expansion
  - Maternal and Child
  - MaRTHA

## Application Process

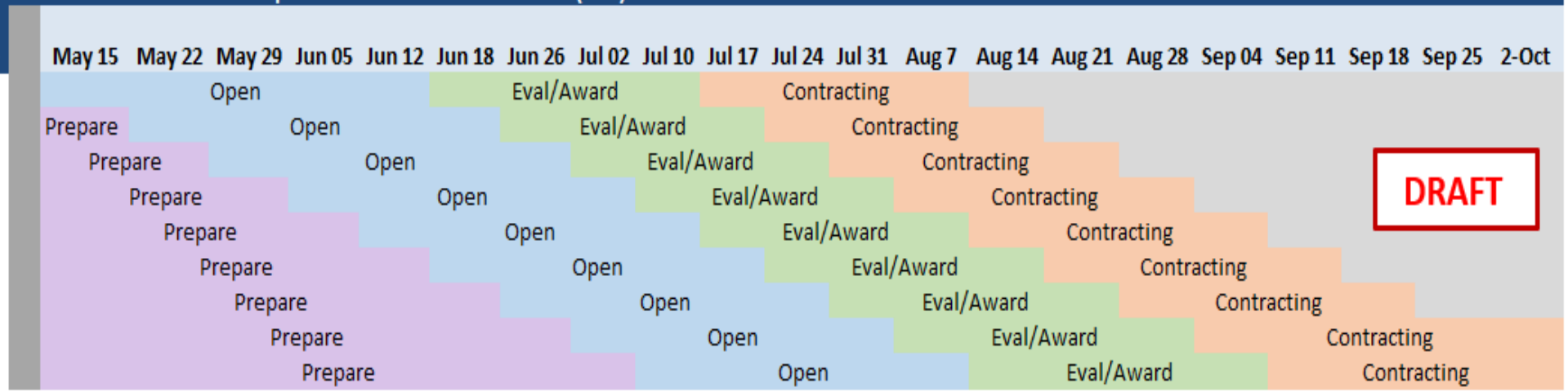
- What's required to apply
- How to best approach the application
- Access the portal to submit applications

# Compressed Timeline

## RHTP Draft RFA Schedule (Example)

**Example Rural Health Transformation (RHT) Release Cadence Model**

| Release | App Open | App Close | Eval Complete |
|---|---|---|---|
| 1 | May 15, 2026 | Jun 15, 2026 | Jul 2, 2026 |
| 2 | May 22, 2026 | Jun 22, 2026 | Jul 10, 2026 |
| 3 | May 29, 2026 | Jun 29, 2026 | Jul 17, 2026 |
| 4 | Jun 5, 2026 | Jul 6, 2026 | Jul 24, 2026 |
| 5 | Jun 12, 2026 | Jul 13, 2026 | Jul 31, 2026 |
| 6 | Jun 18, 2026 | Jul 20, 2026 | Aug 7, 2026 |
| 7 | Jun 26, 2026 | Jul 27, 2026 | Aug 14, 2026 |
| 8 | Jul 3, 2026 | Aug 3, 2026 | Aug 21, 2026 |
| 9 | Jul 10, 2026 | Aug 10, 2026 | Aug 28, 2026 |




- **30 Day Cadence:** 30 days to apply, 30 days for state review, and 30 days for contracting. *This is a draft schedule with dates subject to change.*
- **Limited State Flexibility:** Per CMS requirements, it must obligate all year 1 RHTP funding by October 31, 2026.
- **Small Providers Encouraged to Apply:** The state recognizes the challenges faced by smaller providers and designed the application process to be accessible and competitive and strongly encourages organizations of all sizes to apply.

# RHTP Initiative Timeline

| Application Window (2026) | Initiative | Description |
|---|---|---|
| May 15 – Jun 15 | Perinatal & Pediatric Behavioral Health Teleconsultation & Education | Expands rural maternal and pediatric behavioral health access and provider support |
| May 22 – Jun 22 | Healthy Active Rural Tennessee Grants | Promote active lifestyles, nutrition security, and chronic disease prevention |
| ***May 29 – Jun 29*** | ****Healthcare Resiliency Grants: Maternal & Child Health*** | ***Strengthen rural maternal and child health systems and outcomes*** |
| Jun 5 – Jul 6 | End Zone: Chronic Disease Prevention & Nutrition Security | Expand healthy food access and community prevention infrastructure |
| ***Jun 12 – Jul 13*** | ****Service Line Expansion & Co-Location Resiliency Grants*** | ***Expand rural service lines and co-located, integrated healthcare delivery*** |
| Jun 18 – Jul 20 | Memory Care Assessment Network | Develop a network improving rural dementia diagnosis, care access, and caregiver support |
| ***Jun 26 – Jul 27*** | ****Health Tech Innovation Grants*** | ***Advance rural health technology, interoperability, and innovation capacity*** |
| ***Jul 3 – Aug 3*** | ****MaRTHA Prevention & Community-Based Resiliency Grants*** | ***Fund community-based prevention, access, and holistic rural health improvements*** |
| Jul 10 – Aug 10 | County Health Council CARE Grants | Expand rural access to healthy environments and prevention through community partnerships. Hospitals may lead applications as fiscal agents with the County Health Council |

**Note:** The TennCare Shared Savings opportunity, which may support large capital projects, is expected to open soon; however, TDOH has not released a formal timeline. THA will provide updates as more information becomes available.

**** Key initiatives for hospitals, with additional details provided***





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# Advancing Maternal and Infant Health Outcomes in Rural Tennessee

## HRP: Maternal & Child Health

**Application Timing:** Opened/Closes – May 29/June 29

**Overview:** Strengthens maternal, infant, and child health systems of care in rural Tennessee by expanding access, improving quality, and closing coordination gaps across pregnancy, delivery, postpartum, and early childhood, with an emphasis on introducing new or enhanced services.

- Focuses on maternity care desert counties and rural hospitals through care coordination, linking local providers with regional perinatal centers.

**Funding: $97 million total** over five years through HRP competitive grants

- Funds may support targeted staffing, training, tele-consults, technology, and minor facility upgrades (large or new construction is not eligible), consistent with RFA terms.
- Two award tracks:
  - Small awards: up to $1.25M over five years
  - Large awards: $1.25M–$12.5M over five years

**Key Interventions/Examples:**

- Supports perinatal quality improvement initiatives
- Expands postpartum and maternal behavioral health integration
- Leverages technology-enabled care, including tele-OB, tele-neonatal consults, remote monitoring, and virtual maternity platforms

# HRP: Maternal & Child Health

## RFP Details – Key Application Questions

### Community Context & Needs ( Q3 - Q5)

- Describe the rural population, access barriers, and supporting county-level data to demonstrate key needs and disparities.
- Identify the priority health need and justify it based on community impact and alignment with state priorities.

### Project Approach & Goals (Q6 – Q8)

- State the project's purpose and intended rural healthcare improvement, aligned with broader health priorities.
- Provide a data-driven rationale demonstrating need, expected impact on outcomes, and a clear, feasible implementation plan (activities, timeline, and management).

### Outcomes & Sustainability (Q9 – Q12)

- Define how progress and outcomes will be measured using key metrics and how results will drive improvement.
- Describe sustainability, contingency plans if underfunded, and how the budget supports project activities and outcomes.





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# HRP: Maternal & Child Health

## Logic Model Requirements

| | |
|---|---|
| **Identify** | • Clearly define program inputs (resources), activities (what you will do), and outputs (immediate products of those activities). |
| **Specify** | • Articulate short-term, mid-term, and long-term outcomes, describing what changes are expected immediately, within a few years, and ultimately as a result of the program. |
| **State assumptions** | • Document key assumptions about conditions, capacities, or external factors required for the program to succeed. |
| **Demonstrate theory of change** | • Show clear, logical linkages—if inputs support activities, then activities produce outputs, which lead to outcomes—using a coherent left-to-right flow. |
| **Align** | • Confirm that resources, activities, and outcomes are tightly aligned and mutually reinforcing, reflecting a realistic and intentional strategy to achieve program goals. |





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# Strengthening Rural Systems Through Hospital Service Integration

## HRP: Service Line Expansion & Co-Location

**Application Timing:** Opens/Closes – June 12/July 13

**Overview:** Supports expansion and co-location of integrated primary, behavioral, specialty, and diagnostic services within existing rural hospital and clinic settings to improve access and sustainability.

- Emphasizes portfolio based rural delivery models, where multiple service lines together support financial viability rather than reliance on a single inpatient driven model.
- Encourages partnerships between rural facilities and urban or regional specialty providers, using shared protocols, tele-enabled consults, and defined collaborator roles to keep patients local.

**Funding: $95 million total** in competitive grants over five years to support targeted staffing, equipment, telehealth, and minor facility modifications consistent with RFA terms (large or new construction is not eligible – these projects should be submitted in the funding provided by TennCare shared savings which is anticipated to be available in July).

## Minor Capital Projects Note

**Minor Capital Projects Note**

- Modest renovations, space reconfiguration, equipment installation, or build-outs within existing facilities that support service activation or expansion may be appropriate for HRP Service Line Expansion and Co-location, subject to applicable capital limits (approximately 20 percent at the project level).

# Priority Rural Health Investments: Modernizing Rural Health Technology

## HRP: HealthTech

**Application Timing:** Opens/Closes – June 26/July 27

**Overview:** Modernizes rural health technology to improve access, quality, efficiency, and sustainability across hospitals and clinics.

**Funding: $92 million total** over five years through HRP competitive grants.

- Applications may be facility led (rural provider leads and names technology partners) or partner led (technology or virtual care organizations apply in partnership with rural providers).
- Funds may support software, hardware, implementation, training, and change management, consistent with RFA terms and approvals.

**Example:** Projects primarily focused on reducing administrative burden, improving care coordination, or increasing efficiency (for example, AI documentation tools, EHR optimization, or billing accuracy improvements).

# Expanding Rural Prevention & Access

## MaRTHA

**Application Timing:** Opens/Closes – July 3/August 3

**Overview:** Program designed to improve rural health through community-driven prevention, expanding access to services, and addressing root causes like chronic disease, limited care access, and health disparities across rural Tennessee.

**Opportunity for Hospitals:** Hospitals can engage as lead applicants or partners in community-based initiatives that expand access to care and prevention services.

**Examples:** Opportunities include scaling telehealth, mobile, and in-home care for underserved populations, strengthening connections to primary care “medical homes” to reduce avoidable emergency department use, and collaborating with schools, public health agencies, and community organizations to improve population health outcomes. This may also include expanding access to screening and preventive services—such as mammography, colonoscopy, CT calcium scoring, and other mobile or facility-based offerings—to increase early detection and improve long-term outcomes.

**Funding Available: Approximately $50 million**

### Potential Use Case Examples

**Establish community health centers** with extended hours and same-day appointments.

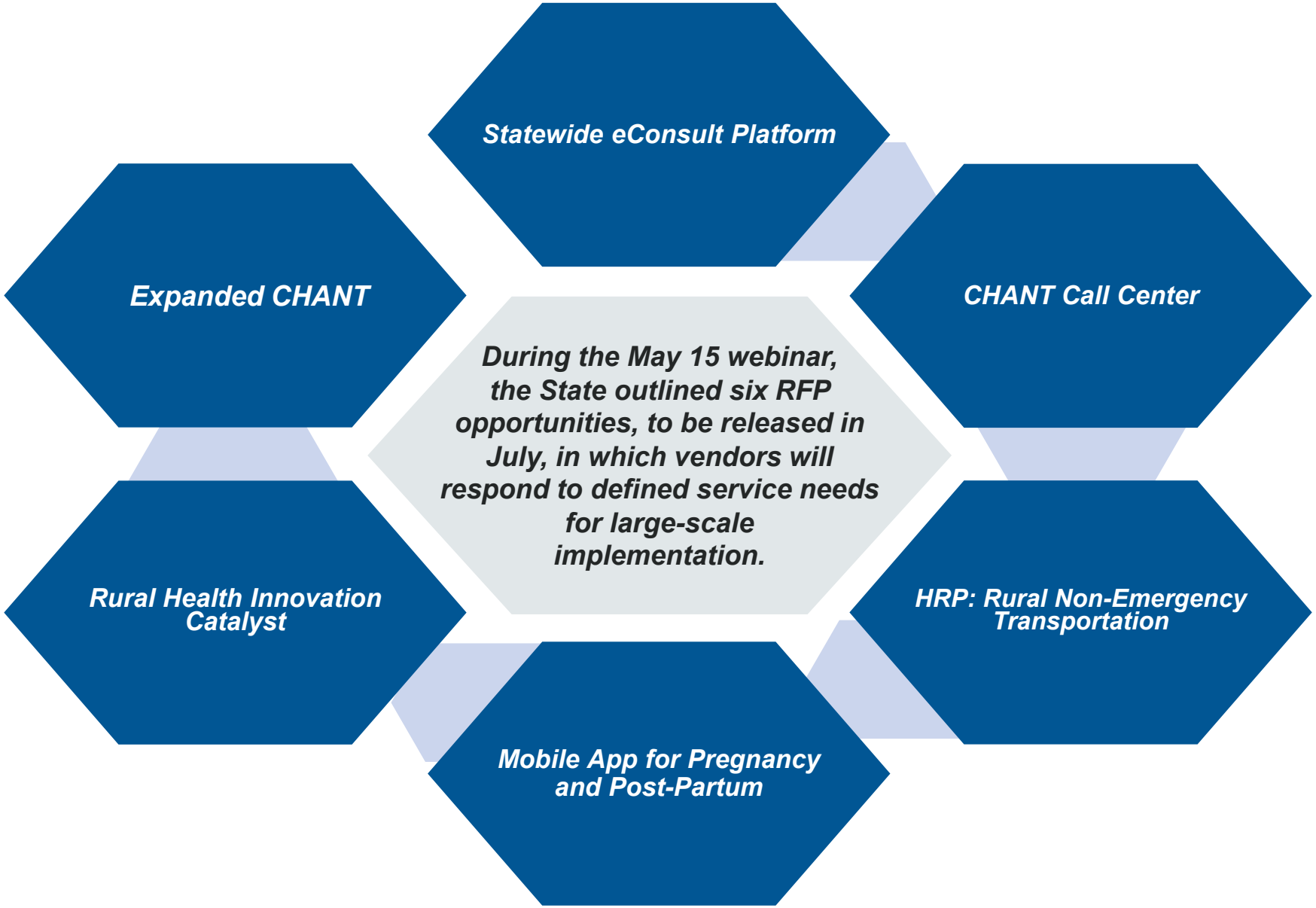
**Expand telehealth infrastructure and training** to deliver remote consultations, improve specialty access, enhance coordination, and reduce travel burdens.

**Deploy mobile and in-home care teams** to provide screenings, prevention, and chronic disease management.

**Increase school-based health services** by adding nurses, increasing screenings, managing chronic conditions, and connecting families to local care resources.

**Build coordinated care systems** linking patients to primary care and preventive services, streamlining referrals.

# Request for Proposal Opportunities



# Application Portal: Getting Started

## Logging In:

- Users must create a portal profile AND an organizational record to access opportunities.
- Some required information (e.g., UEI, Edison number) can be added later, but it must be provided before the award; ***see instructions below.***
- Expect account validation, organization approval, and setup steps before accessing opportunities.

## References:

- UEI Entity Registration: (Entity Registration | SAM.gov)
- Edison number: Tennessee Supplier Public Home Page

## DON'T WAIT!

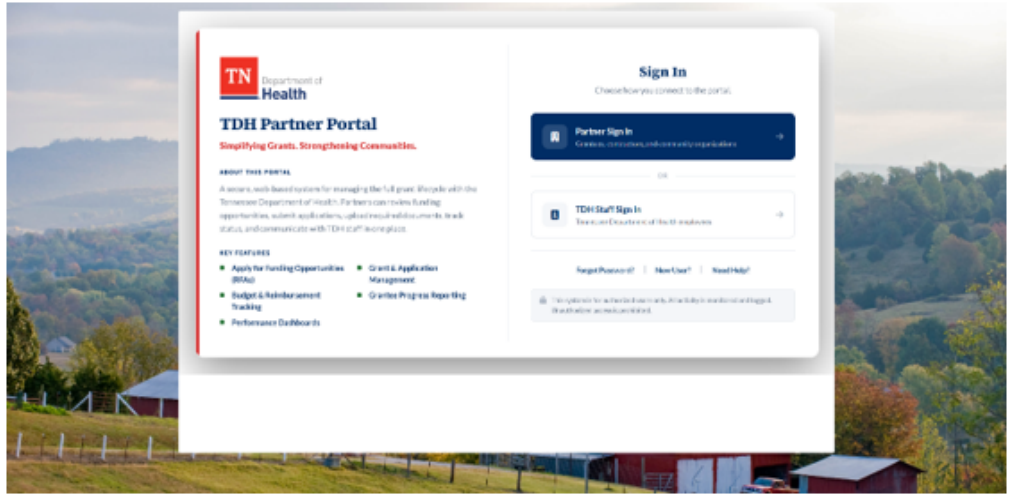
Portal information must be created in advance. Applicants should complete this step before beginning the application process, allowing adequate time to address any unexpected issues that may arise.

## Step 1: Create Your Account

First, you need to sign up for the portal. This only takes a few minutes.

### Go to the Portal

1. Open a web browser.
2. **Website:** Go to:
3. https://tndeptofhealth.caspio.app/tdh-partner-portal/home
4. You will see the TDH Partner Portal login page.




### Fill Out the Sign-Up Form

5. Click New User? on the login page.
6. Enter your first name, last name, and email address.
7. Create a password. Use at least 8 characters.
8. Click Register.

# Steps to Access and Begin Using the Portal

**Go to the portal and create an account**
- Navigate to the portal login
- Register as a new user with name, email and password

**Confirm your email**
- Activate your account via confirmation email

**Set up/link your organization**
- Search for an existing organization OR create a new one
- Submit for administrator approval, if applicable

**Access your dashboard**
View applications, drafts, and status updates
Complete required setup items (e.g., UEI, Edison registration)

**Find funding opportunities**
- Browse available grants and review details, such as eligibility, deadlines and countdown of “days left” and funding available

**Complete and submit your application prior to the deadline**

## Important Tips

- You can start these steps NOW – no need to wait.
- You do not have to complete the application in one sitting.
  - Click ***“Save Draft”*** any time to save your progress.
  - Your draft is saved but not submitted; TDH cannot see your application until it is submitted.
- Enter project details, complete required questions, upload materials, and submit.
- Before you submit, do a final check:
  - Did you answer all required questions?
  - Did you upload all required files?
  - Is your contact information correct?
- The portal will display a warning if any required items are missing.
- Need help? Use message panel on the portal dashboard; TDH staff will respond as quickly as possible.
- Hospitals with questions about initiative fit are encouraged to contact **RuralHealth@TN.gov** before applying.

# Characteristics of a Strong Application

## Required Items:

**Project Summary**
- Brief overview of the proposed initiative, including rural focus, core problem being addressed, high-level approach and expected impact.

**Project Narrative**
- Summarize rural community need, disparities, and target population using data; outline project goals, strategies, TN alignment, and engagement with communities, partners, and local health stakeholders.

**Evaluation Plan**
- Defined performance measures and outcomes, approach to data collection and reporting, monitoring progress and identifying improvements.

**Sustainability Plan**
- Strategy to sustain initiative beyond RHTP funding, with focus on long-term financial and programmatic viability.

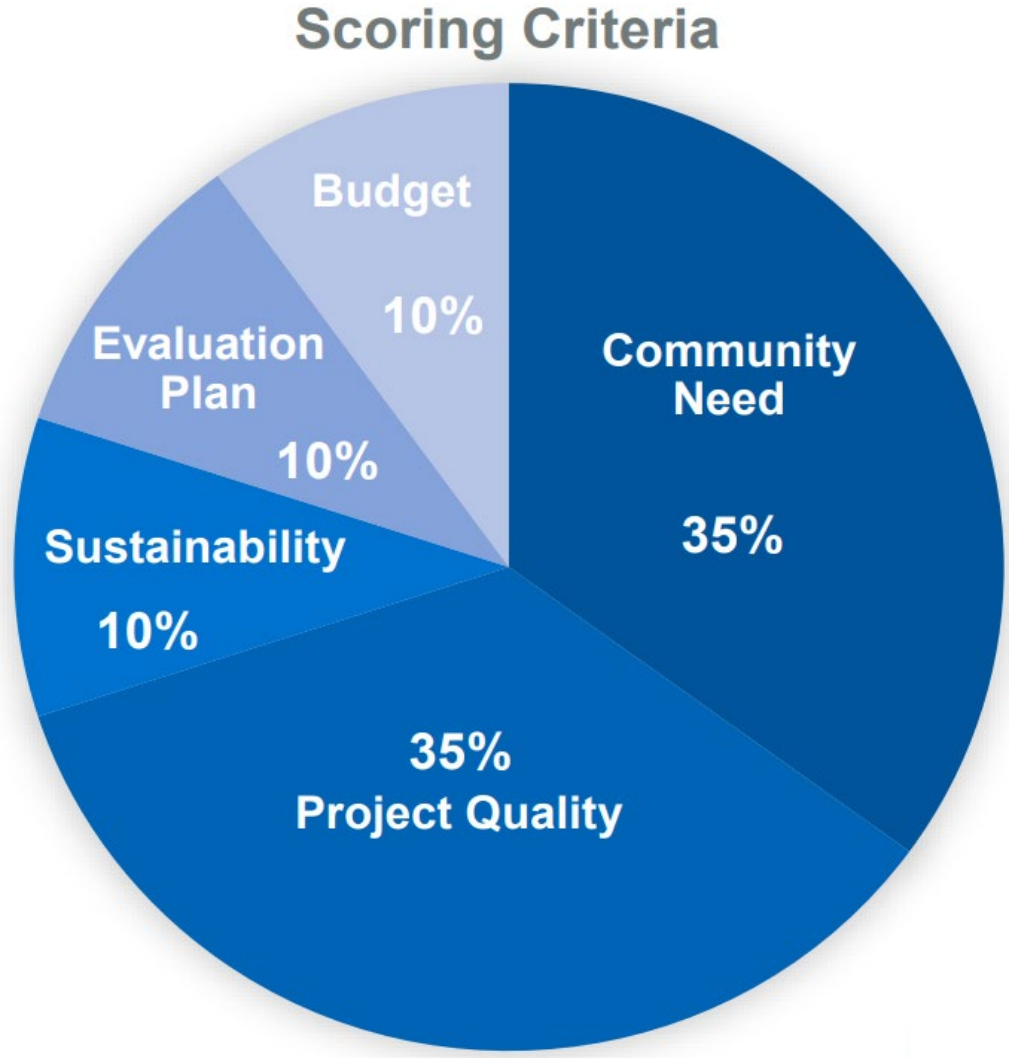
**Budget Narrative**
- Summarize budget aligned to project scope; define how progress is monitored, performance gaps identified, and implementation adjusted to meet targets.

- **Writing Tip:** Be direct and concise across all application sections. TDOH has indicated it does not want overly long narratives, and applicants have reported word-count limits in the portal.
- For additional information, see slides 17-18 THA RHTP Preparation Webinar,

# Elements of a Strong RHTP Application: Scoring Criteria

### *Five Critical Application Components (Reflected in Scoring)*

1) **Community Need (35%):** Demonstrates clear alignment with CMS and Tennessee RHTP priorities and uses local data to define a specific, high-impact rural need.
2) **Project Quality (35%):** Shows meaningful community and cross-sector partnerships, proposes an outcome-focused solution to a significant rural health challenge, and demonstrates strong execution capability, including experienced leadership and operational readiness.
3) **Sustainability (10%):** Presents a credible plan for lasting system change that continues beyond the grant period and reduces reliance on future state or federal funding.
4) **Evaluation and Measurement (10%):** Defines clear metrics, data sources, and methods to track progress and report outcomes.
5) **Budget (10%):** Aligns costs to proposed activities, complies with applicable caps, and avoids ineligible expenses.



# Preparing a Competitive Application
# Connecting Opportunity, Organizational Strategy/Capabilities, and Community Need

## Opportunity & Competition

- Funding is limited and will be highly competitive
- Projects must advance CMS & state transformation goals

## Alignment & Execution Capacity

- Participation requires sustained leadership and staff investment
- Projects must align with organizational strategy and capabilities

## Impact & Return on Investment

- Applications should be treated as a business case
- Strong proposals define need, partnerships, and measurable results that last beyond the funding period

# Participate in Tennessee's Health Information Exchange (if eligible)

## What we know:

- RHTP awardees are expected/required to participate in the HIE.
- TDH has confirmed that there are no anticipated costs for HIE participation during the 5-year grant period; there is no commitment beyond that period.
- HIE participation is designed to support:
  - Clinical data sharing across providers.
  - Improved care coordination.
  - Population health and public health reporting.
- Timing (per the state's RHTP application - obviously subject to change…):
  - HIE design/development: FY27-29 (calendar 2026 thru 2029)
  - Provider onboarding (when they would actually be asked to connect): FY 30
- This represents a "commit now, connect later" approach.

## What is still being defined:

- Which provider types must participate, which are optional/exempt?
- Details about the specific technical requirements that define "participation."
- Governance structure and data use policies.
- Longer-term sustainability model - post FY31 when RHTP funding ends.
- Contract terms are in development, ETA unknown.

## Apply for Funds Despite Some Unknowns:

- Apply despite evolving requirements; review contract terms and discuss with TDOH if awarded.
- You can decline later if needed—but not applying forfeits both the option and potential funding.

# Engage with Tennessee Community Compass (if eligible)

- Where aligned with project scope and eligibility, awardees may be required to engage with Community Compass, a centralized, statewide care coordination platform that can help meet identified social drivers of health.
- TennCare selected a Closed Loop Referral System (CLRS) vendor, Findhelp. It is branded Tennessee Community Compass. This public directory is a free resource.
- Link to https://communitycompass.tn.gov/.
- Once the CLRS is embedded in MCO case management and clinic/hospital EHRs, the program:
  - Streamlines social drivers of health screening and referral workflows.
  - Enhances coordination between providers and community partners.
  - Provides visibility into referral status and service outcomes.
  - Supports the health of Tennesseans.
- Early adopters of the CLRS have been MCOs and outpatient clinics. The program has been piloted in two TN acute care hospitals – West TN Healthcare and UT Medical.

# Additional Requirements for Awardees

**Provide annual updates to local County Health Council to maintain alignment with community priorities.**

- Summarize progress against project goals and milestones.
- Highest measurable outcomes or early impact.
- Identify barriers, risks, and proposed adjustments.

**Seek opportunities to connect with existing TN RHT projects to support a connected, statewide transformation effort.**

- Share best practices.
- Align with complementary initiatives.
- Contribute to a more integrated rural health system.

**Be provided with support and technical assistance from the TDH team throughout the process.**

- TDH will provide ongoing support and technical assistance to awardees throughout the grant lifecycle to ensure compliant implementation and sustainability.


# Key Application Steps

1. ***Do Not Delay:*** Start early. If you wait until the last minute, you risk portal issues, missing registrations, internal approvals, or an unexpected operational issues that limit your ability to submit a strong, compliant application.

2. ***Go to Partner Portal and Register:*** https://tndeptofhealth.caspio.app/tdh-partner-portal/home
   i. Create a user account, confirm your email, and complete organization setup (link to existing organization or create a new one).

3. ***Bookmark www.tn.gov/health/rural*** and check site regularly for updates – this site is the central hub for updates and guidance as opportunities are released.

4. ***Sign up for list-serves*:** for the opportunities you are interested in; you will be notified of future funding opportunities & FAQs.

5. ***Begin Preparing your application:***
   i. Confirm prerequisites/registrations: organizations must be registered with the Secretary of State and have an active SAM.gov registration.
   ii. Build partnerships early: the strongest applications demonstrate real collaboration (not just letters) with community partners, local health entities, and cross-sector organizations.
      a. Obtain letters of support from partners and other key community stakeholders.
      i. Pre-draft core narrative components.
      ii. Plan for reimbursement-based funding.
      iii. Don't spend early: do not begin spending until the contract is completed and signed.

6. ***Consider pre-approvals with Commissions/Boards*:** Internal approval cycles (board, finance, contracting) can consume a significant portion of the 30-day RFA period. Hospitals should begin governance, partner alignment, and application preparation prior to RFA release to avoid submission risk.

***Use the post-announcement question window: TDOH allows about one week after each grant release to submit a brief project summary to competitive.health@tn.gov for scope and implementation guidance.***

# 02

FAQ Review

# Provider Payments or Category B Limitations

*Category B funding refers to capped provider payments for non-reimbursed or outcome-based activities tied to a specific RHTP initiative.*

## What Qualifies as Provider Payments?

- Payments to providers for healthcare services not otherwise reimbursed by insurance or other programs.
- May include incentive payments tied to quality, outcomes, or alternative payment models (APMs).
- The next slide lists examples of “Category B” funding in the RHTP Program.

## 15% Cap

- Total spending on provider payments cannot exceed 15% of total RHTP funding awarded to the state in a budget period.

## Key Restrictions

- Cannot duplicate or supplant existing funding streams.
- Cannot increase payment rates for already billable services.
- Must be tied to specific RHTP initiatives and program goals and demonstrate sustainability beyond the grant period.

### *Practical Implications:*

Funding can support new or non-reimbursed services, care models, or incentive structures, but not routine service reimbursement or general provider compensation.

This cap ensures that RHTP funds are primarily used for transformation and innovation, rather than ongoing provider reimbursement.

Cannot be used to:

- Offset existing financial losses or margin pressure.
- Fund routine service delivery already reimbursed elsewhere.
- Provide general provider compensation or rate increases.





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# Examples of “Category B” Funding by Initiative

**HRP: Service Line Expansion & Co-Location (#1)**
May include incentives tied to service expansion, capacity building or participation in new care models:

- Expanding service lines
- Staffing supports and retention incentives
- Care model redesign

**Optimizing Rural Health Care (Safety Net Expansion) (#3)**
May include:

- Support for uninsured/underinsured care delivery
- Payments tied to access expansion or care coordination for non-reimbursed populations

**Value-Based Payment: Maternal, Hospitals, Dental (#8)**
***Explicitly tied to:***

- Value-based payment models
- Quality and outcome incentives
- Participation in alternative payment models (APMs)

**HRP: Make Rural TN Healthy Again (MaRTHA) (#9)**
May include:

- Incentives for preventive care delivery models
- Payments tied to mobile care, telehealth, or community-based service expansion

**Statewide Health Information Exchange (HIE) (#13)**
Indirectly related to provider payments:

- Incentives for provider participation, onboarding, or data-sharing adoption

# TDOH FAQ: Eligibility and Applicant Structure

***Q: Only one RHTP grant will be awarded per entity per program pillar. Will further clarification be provided on how "entity" is defined for the purposes of this limitation?***

A: For RHTP purposes, an "entity" is generally an organization participating in or seeking funding through the program. TIN/EIN status may be considered, but entity determinations will not be based solely on TIN/EIN status. The State may also consider organizational name, affiliations, operational structure, and other relevant factors, with final determinations made based on the specific circumstances presented.

***Q: Our organization was a subrecipient of the Rural Healthcare Resiliency Program grant. Can we apply for funds under RHTP?***

A: For subrecipients of Rural Healthcare Resiliency grants: RHTP funding is intended to support expansion and scaling of initiatives to improve services in rural communities and may not duplicate or supplant existing federal, state, or local funding. Additional detail is provided in CMS FAQs (pp. 47–48).

***Q: Do we need sponsor hospitals to apply for a grant, and if so, how many? Should we base this on the number of hospitals that might sign an intent to participate if funding were available?***

A: While detailed requirements will be released in the coming weeks, applicants should begin identifying potential hospital partners aligned with their proposed initiative, as participation and alignment with rural service goals are expected to be key considerations.





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# TDOH FAQ: Funding Structure & Mechanics

### *Q: Is this a reimbursement style grant?*

- Sub-recipients pay costs up front, submit procurement documentation and proof of payment, then get reimbursed.

### *Q: What is the maximum award amount an entity can apply for?*

- Maximum award per entity will be defined in application materials once released.
- Award levels will align with the scale, scope, and expected impact of proposed initiatives and overall program funding parameters.

### *Q: Are there any obligations or budget maximums within any of the Healthcare Resiliency Program opportunities?*

- Details on budget limits and obligation requirements will be in the grant application materials once released.
- Expect budget ceilings, allowable costs, and obligation timelines tied to initiative scope and CMS funding guardrails.
- Review Tennessee's RHTP application for anticipated structure and expectations.

### *Q: How do indirect cost rates & restrictions around the 10% administrative cost restriction flow down to sub-awardees?*

- Sub-awardees must follow the same indirect cost rate requirements and the 10% administrative cost cap as the State.
- The 10% cap applies across the full funding structure, including sub-awards.
- Applicants must clearly allocate administrative vs. program costs at both the prime and sub-awardee levels to ensure compliance.

# TDOH FAQ: Allowable Uses of Funds

***Q: What kinds of activities can Rural Health Transformation funds support in Tennessee?***

A: ***Allowable Activities:***

- Evidence-based interventions to improve prevention and chronic disease management.
- Support for behavioral health, substance use treatment, and mental health services.
- Workforce recruitment and retention strategies with rural commitments.
- Training and technical assistance for emerging care technologies.
- IT improvements like telehealth expansion and cybersecurity.
- Innovative care models and alternative payment approaches.

# TDOH FAQ: Award Process & Timeline

***Q: How quickly will applications be reviewed?***

A: TDOH plans to accelerate its award process to meet federal deadlines, with applications evaluated within approximately 30 days of submission.

***Q: How will applicants be notified?***

A: Successful applicants will receive a formal Notice of Award (NOA) via email on TDOH letterhead identifying the approved funding amount; unsuccessful applicants will receive separate notification letters.

***Q: What happens after award?***

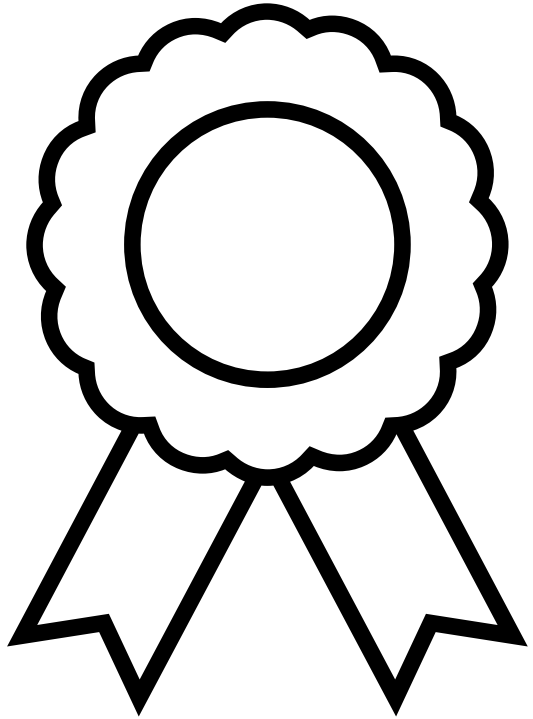
A: Contracts will follow shortly thereafter, with ~30 days for execution.

***Q: How should applicants prepare?***

A: TDOH encourages reviewing sample contracts in advance to expedite execution.

***Q: Will awards be publicly announced?***

A: Yes—awardees and funding amounts will be announced via rolling press releases.







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# 03

Questions/Discussion

# 04

## Navigating RHTP Compliance

# Why Getting Ahead of Compliance Matters Now

## Leadership Questions to Ask Now

- Where are our highest-risk cost categories, and how do we mitigate these risks now?
- Who has authority to approve changes, and are approval levels appropriate?
- What documentation will support each draw, milestone, and decision?
- How do we build processes to meet requirements and remain efficient throughout the process?

## Steps to Prioritize

| | |
|---|---|
| Build | Build compliance considerations into project design from the beginning. |
| Engage | Engage finance, procurement, HR, and operations early to confirm roles, approvals, and internal controls. |
| Align | Align vendors, partners, and internal stakeholders to federal requirements before costs are incurred. |
| Plan | Plan proactively for reporting, monitoring, audit readiness, and sustainability. |





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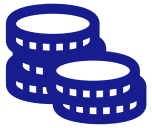
# 1.1 What Makes a Cost Allowable

**Necessary:** Tied to the approved initiative and its intended purpose.

**Reasonable:** In light of market conditions and the nature of the activity.

**Allocable:** To the project based on a supportable benefit.

**Documented:** With sufficient detail to withstand monitoring or audit.



**Consistent:** With the approved budget, cost categories, and award terms.

## Where Issues Often Arise

- Costs that appear beneficial but are not clearly tied to approved outcomes.
- Broad or catch-all budget lines that do not provide enough specificity for review.
- Operational costs shifted into the award to address unrelated funding pressure.

# 1.2 Costs That Are Not Allowable

## Unallowable RHTP costs

- Supplanting Medicaid, Medicare, or commercial reimbursement streams.
- Pre-award costs incurred before approval or the allowable period.
- New construction or major facility build-out.
- Broadband infrastructure construction.
- Meals, entertainment, lobbying, or similar prohibited expenditures.
- Debt-related costs or revolving loan activity.

**A cost does not become allowable simply because it supports a worthwhile hospital objective. It must also align with federal requirements, award terms, and the intended use of RHTP funds.**

# 2.1 Key Caps to Monitor

Each opportunity will have specific requirements. Hospitals should monitor these high-visibility limits closely as they plan, budget, and implement RHTP-funded work:

| | | | |
|---|---|---|---|
| **Administrative costs (direct and indirect components):** 10% | **Provider payments:** 15% | **EMR replacement:** 5% | **Capital or renovation activity:** 20% |

*Note: It is important to follow the instructions for each project to remain compliant. Specific requirements will be listed in each opportunity's scope of work and budget guidance.*

# 2.2 Indirect Cost Considerations

Hospitals may generally use one of two approaches:

- **Federally negotiated indirect cost rate:** An approved rate from the hospital's cognizant agency.
- **De minimis rate:** Up to 15% of modified total direct costs (MTDC).

## Common Risks and Pitfalls:

- Using an incorrect MTDC base.
- Double counting indirect cost components.
- Causing the organization to exceed the 10% administrative cap without realizing it.

## Operational Note:

Hospitals should align finance, grants, and procurement teams early so the indirect cost approach is documented, consistently applied, and sustainable over the life of the project.

# 2.3 How to Calculate Indirect Costs

## Approved Negotiated Indirect Cost Rate

- Apply the approved rate to the specified base in the organization's indirect cost agreement.

Example: $40,000 salaries and wages x 25% = $50,000 indirect costs.

## De Minimis Rate

- Apply up to 15% of modified total direct costs (MTDC).

Example: $670,000 MTDC x 15% = $100,500 indirect costs.

| MTDC Included | MTDC Excluded |
|---|---|
| **Direct salaries and wages**<br>**Applicable fringe benefits**<br>**Materials and supplies**<br>**Services and travel**<br>**Up to the first $50,000 of each subaward** | Equipment<br>Capital expenditures<br>Patient care charges<br>Rental costs<br>Tuition remission, scholarships, and fellowships<br>Participant support costs<br>Subaward amounts above $50,000 |

| Category | Calculation |
|---|---|
| **Salaries and wages: $500,000** | $500,000 |
| **Supplies: $75,000** | $75,000 |
| **Subaward 1: $250,000** | $50,000 eligible |
| **Subaward 2: $45,000** | $45,000 eligible |
| **MTDC Total** | $670,000 |
| **Indirect Costs at 15%** | $100,500 |

# 3.1 Procurement Controls

For hospitals, procurement controls are a practical part of operational readiness and long-term compliance—not just a back-office requirement.

- Use competitive procurement processes where required.
- Maintain conflict-of-interest safeguards throughout sourcing and selection.
- Perform SAM.gov suspension and debarment checks before award or payment.
- Retain complete procurement files that show how the decision was made.

**Why This Matters:**

***Weak procurement practices can create avoidable compliance exposure and undermine the hospital's ability to demonstrate accountability, value, and readiness to perform.***

# 3.2 Cash Management

- RHTP funding should be managed as a **reimbursement-based award.**
- Draw funds only for immediate cash needs tied to allowable expenditures.
- Minimize the time between receipt of funds and disbursement.
- Support each draw with general ledger detail, payroll documentation, invoices, and internal approvals.

# Single Audit Preparation

## What is a Single Audit?

- Specific Audit for Federal Grants under Uniform Guidance.
- Required for entities that expend more than $1,000,000 in total federal awards in a single fiscal year.
- Considers financial statements, internal controls, and compliance with laws and regulations surrounding the federal award.
- Does not rely on materiality and is more focused on if the auditee is in compliance with the grant agreement as well as applicable laws and regulations.

# Single Audit Requirements

## The Schedule of Federal Expenditures (SEFA)

- The SEFA is the key report required by Uniform Guidance for entities who undergo a single audit.
- It is a supplemental schedule to an entity's financial statements that recaps expenditures of federal funds for the fiscal year.
- Prepared based on accrual accounting and expenditures must be reconciled to match what is reported on the SEFA.
- What is it for?
  - Used to determine which programs will be audited as part of the single audit.
  - Informs agencies that award federal assistance that their grants are included in the single audit.

# Single Audit Requirements

## The Schedule of Federal Expenditures (SEFA)

SEFA Requirements – 2 CFR 200 Subpart F

**List individual programs by Federal Agency**

- If award is received as a subrecipient, the name and ID number assisted by the pass-through entity must be listed.

**Provide total amount expended and the Assistance Listing Number for each Federal Award**

**List expenditures for loan programs**

- In the notes, identity any balances outstanding at the end of the period.

**Identify accounting policies used to prepare the SEFA**

**Identify the Federal Agency approved indirect cost rate, if used**





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# Compliance Supplement – Example Testing Requirements

**ASSISTANCE LISTING 21.027 CORONAVIRUS STATE AND LOCAL FISCAL RECOVERY FUNDS**

| A | B | C | E | F | G | H | I | J | L | M | N |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Activities Allowed or Unallowed | Allowable Costs/Cost Principles | Cash Management | Eligibility | Equipment and Real Property Management | Matching, Level of Effort, Earmarking | Period Of Performance | Procurement and Suspension and Debarment | Program Income | Reporting | Subrecipient Monitoring | Special Tests and Provisions |
| Y | Y | N | N | N | Y | Y | Y | N | Y | Y | N |

- Compliance supplement identifies what auditors are required to test for each federal program.
- Can be used as a good guide for what to expect during single audit.
- The compliance supplement identifies what auditors are required to test, not what is/isn't applicable to the awarded agency (i.e., granting agency may have procurement requirements included in award that organization needs to be in compliance with, but auditor may/may not test).

# Common Single Audit Findings

| Common Finding | Risk Mitigation Approach |
| --- | --- |
| **Unallowable or inadequately supported costs** | • Implement pre-charge allowability review for all expenditures.<br>• Maintain payroll support (time/effort, allocation methodology).<br>• Reconcile grant expenses to general ledger and supporting documents.<br>• Require supervisory approval of cost allocations. |
| **Financial and performance reporting lapses** | • Establish reporting calendar with internal deadlines.<br>• Reconcile SF-425 and reports to general ledger before submission.<br>• Require documented management review and approval.<br>• Retain reconciliation workpapers and support. |
| **Equipment and asset management weaknesses** | • Maintain complete asset inventory (funding source, location, condition).<br>• Tag and track equipment upon receipt.<br>• Perform and document periodic physical inventory.<br>• Assign responsibility for asset oversight. |

# Common Single Audit Findings (Continued)

| Common Finding | Risk Mitigation Approach |
| --- | --- |
| **Procurement and suspension/debarment noncompliance** | • Use procurement checklists to confirm required documentation.<br>• Document sole-source justifications and approvals.<br>• Perform and retain SAM.gov checks for vendors.<br>• Train staff on procurement and compliance requirements. |
| **Subrecipient monitoring deficiencies** | • Perform and document pre-award risk assessments.<br>• Define compliance requirements in subaward agreements.<br>• Establish monitoring procedures (report review, audit follow-up).<br>• Document monitoring activities and corrective actions. |
| **Other compliance issues (period of performance, cash management)** | • Track grant periods and validate cost timing prior to approval.<br>• Align drawdowns closely with actual expenditures.<br>• Reconcile cash draws regularly.<br>• Implement review controls over draw requests. |

# Prior Approval Triggers

## Prior Approval Triggers

Hospitals should understand these approval triggers early so project changes do not disrupt implementation, reimbursement, or compliance standing:

- Budget revisions that exceed 10% of the approved amount.
- Material changes in project scope, activities, or objectives.
- Key personnel changes.
- Capital or equipment purchases not included in the approved budget.
- Participant support costs that were not originally approved.

## Workforce Commitments & Closeout

### Workforce Commitments:

- Workforce initiatives generally require a five-year rural service commitment for supported individuals.
- Hospitals should implement practical processes to track commitments, document compliance, and address nonperformance when needed.

### Closeout Requirements:

- Submit final performance and financial information.
- Return unused funds when required.
- Complete any equipment or property disposition steps.

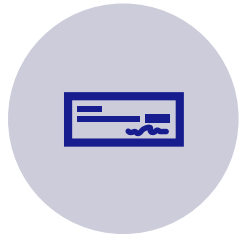
# Key Takeaways: Strengthening Grant Compliance Practices

**Apply consistent cost review and documentation standards**
Confirm allowability and allocability before charging costs and retain complete supporting documentation for all expenditures.

**Track capped and restricted costs across the full budget period**
Use centralized tools to monitor cumulative spending and avoid exceeding program limits.

**Maintain complete and well-documented procurement files**
Include competition support, conflict-of-interest disclosures, and evidence of SAM.gov checks.

**Obtain and retain written approvals before implementing changes**
CONFIRM updates to scope, budget, personnel, or capital activities are formally approved in advance.



**Align draw requests with fully supported expenditures**
Submit drawdowns based on recorded costs and maintain clear documentation, including ledger detail, invoices, payroll, and approvals.

# Concluding Thoughts

1. **Do Not Delay – start planning now:** Given the compressed application window, organizations should begin internal coordination, partnership discussions, and documentation development in advance to ensure a complete and competitive submission.
2. **Create your portal account:** Applicants should establish and validate access to the application portal as soon as possible to avoid technical delays, confirm user permissions, and become familiar with submission requirements and system functionality.
3. **Prepare for compliance requirements:** Organizations should proactively review contractual, financial, and regulatory expectations—including reporting, allowable use of funds, and audit readiness—to ensure alignment and avoid delays or disqualification during application review.
4. **Align with early with regional partners:** Successful applications will demonstrate strong collaboration across providers and stakeholders, so organizations should begin solidifying partnerships, roles, and care models early to present a cohesive, scalable approach.

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# Appendix I

Case Studies

# Case Study: Strengthening Rural Maternity Care

A rural birthing hospital in a maternity-care-desert region faced delayed obstetric triage, inconsistent postpartum follow-up, and frequent neonatal transfers. Through the Maternal & Child Health initiative, the hospital partnered with a regional perinatal center to standardize emergency protocols, implement tele-OB and neonatal consults, and integrate maternal behavioral health screening and referral pathways.

Grant support enabled simulation-based obstetric and neonatal training, remote blood pressure monitoring for postpartum hypertension, and technology-enabled care coordination to ensure follow-up appointments were scheduled prior to discharge. As the model matured, the hospital noted earlier specialty input, improved postpartum visit completion, more consistent depression screening, and smoother neonatal transfers. The initiative strengthened access and quality while positioning the hospital to sustain improvements over time as grant support phased out through established regional partnerships and standardized workflows.

# Case Study: Expanding Local Specialty Access

A rural hospital serving a multicounty area experienced consistent outmigration for oncology and specialty services, requiring patients to travel long distances and delaying care. Through a service line expansion model, the hospital partnered with an urban specialty provider to co-locate infusion and outpatient specialty services within its existing facility. Shared clinical protocols, credentialing support, and tele-specialty consults enabled local delivery without expanding the hospital's physical footprint.

As services stabilized, time from diagnosis to treatment shortened, specialty referrals were completed more reliably, and avoidable transfers declined. Predictable outpatient volumes supported improved throughput and patient retention, positioning the hospital to absorb ongoing staffing and operational costs as grant support phased out. The model strengthened access, improved care continuity, and supported long-term sustainability through partnership rather than standalone service development.

# Case Study: Hospital-Directed Digital Modernization

A rural hospital serving multiple small communities relied on fragmented legacy systems that limited telehealth reach, slowed information exchange, and increased clinician documentation burden. Through the Health Technology initiative, the hospital implemented a coordinated digital modernization strategy focused on telehealth expansion, interoperability, workflow automation, and cybersecurity.

Grant support was used for EHR optimization, automated intake and scheduling tools, faster exchange of labs and imaging with regional partners, and remote patient monitoring for high-risk patients following discharge. AI enabled documentation and revenue cycle tools reduced manual work and supported improved billing accuracy, while standardized telehealth workflows extended specialty and behavioral health access beyond the hospital's walls.

As implementation progressed, follow-up completion improved, documentation time declined, external results posted more quickly, and care teams reported smoother coordination across settings. The initiative strengthened patient access and operational efficiency while positioning the hospital to sustain digital capabilities as grant support phased out through improved performance and workflow integration