RURAL HEALTH TRANSFORMATION

October 28, 2025

FREQUENTLY ASKED QUESTIONS

I. General

1. How does a State access the full Notice of Funding Opportunity (NOFO)?

After release, the RHT Program NOFO is posted on Grants.gov. The link to the NOFO is also posted on CMS's website.

2. Where does the State submit an application?

The State can submit its application on Grants.gov. Applications are due by 11:59 p.m. ET on November 5, 2025.

3. What if I am having trouble accessing the NOFO or applying on Grants.gov? Who do I contact to get help?

Grants.gov provides 24/7 support:
Phone: 1-800-518-4726
Email: support@grants.gov

4. What are the deadlines to apply for the RHT Program?

The RHT Program application deadline is November 5, 2025, no later than 11:59 p.m. ET. These dates are outlined in the NOFO and on Grants.gov.

5. Can States submit their application earlier than the application deadline?

Yes, States may submit their application any time after the NOFO application window opened on September 15, 2025, and prior to the application deadline at 11:59 p.m. ET on November 5, 2025.

However, all applications will be scored at the same time.

6. Will there be subsequent opportunities to apply for the RHT Program?

No. There will be only one application period for the RHT Program with applications due at 11:59 p.m. ET on November 5, 2025.

7. How many applications can States submit?

States submit a single application that covers the entire five-year program. However, States will be reassessed annually to evaluate progress on initiatives and policy commitments.

8. How can a State receive additional information about the RHT Program?

These FAQs will be updated on a regular basis to include incoming questions. States may email MAHARural@cms.hhs.gov with technical questions and can sign up for the RHT Program Listserv on the program website. CMS also hosted informational webinars on September 19 and 25, 2025.

Materials from the informational webinars, this FAQ, and the sign-up link for the RHT Program Listserv are available on the program webpage at **https://www.cms.gov/RHTProgram**.

9. Will there be technical assistance available during the pre-application, post-application, or post-funding phases of the program?

For questions on the program and eligibility during the open application period, please email MAHARural@cms.hhs.gov. CMS also

expects to update this FAQ regularly and hosted two informational webinars (on September 19 and 25, 2025). Both webinars covered the same content, and materials can be found on the RHT Program website under the "RHT Program Applicants Webinar" heading.

During the implementation of the RHT Program, there will be significant technical assistance offered, and CMS will maintain regular communication with and support to States. Details can be found in the "Cooperative agreement terms" section of the NOFO.

10. Who should I contact at my State to discuss our involvement in the application submission?

Please contact your Governor's office for specific information regarding your State's application.

11. Will CMS amend the NOFO to incorporate points articulated in the FAQs?

No, the NOFO will not be amended. FAQs will be updated regularly. States are encouraged to review the FAQs for updated guidance and interpretation of content already in the NOFO.

12. For the pre-award budget review meetings, should State staff be on standby starting in December or could those conversations occur in late November?

States should monitor the email boxes listed on their SF-424 throughout the entirety of November and December 2025.

II. Eligibility

1. Who is eligible to apply for RHT Program Funds?

In accordance with Public Law 119-21, Section 71401, only the 50 States of the United States are eligible to receive an RHT Program award. U.S. Territories and the District of Columbia are not eligible to receive an RHT Program award.

Local governments, hospitals, universities, nonprofits, federally recognized Tribes, individuals, or other organizations may not apply. These organizations and individuals, including other health care providers, such as clinics and community mental health centers (CMHCs), may still be able to participate through subawards or partnerships if their State chooses to include them in its transformation plan. Each State will decide whether and how to involve these organizations and individuals.

2. Can multiple States apply together?

Each State should submit its own application, and a State may submit only one official application. Within their own applications, States may decide to coordinate with other States on planning and execution of proposed activities and initiatives.

3. Which State office or official is eligible to submit an application?

Each State's Governor may designate a lead State agency or office to develop and submit the application. The lead State agency or office must submit with the application a letter of endorsement from the Governor that expresses support for the proposed rural health transformation plan and certifies that the

application has been developed with certain key stakeholders. Additional details and information are outlined in the NOFO.

4. **Can the Governors' offices designate a non-State entity to submit an application?**
   No, the application must come from a State government agency or office.

5. **If the agency the Governor designates is a nonprofit, can it submit an application for the Rural Health Transformation Program?**
   The application must come from a State agency or office. In situations where a State agency or office is a nonprofit and the governor designates that State agency or office as the lead to develop and submit the application, that nonprofit may develop and submit the application.

6. **Who should organizations contact if they wish to partner with a State or receive subawarded RHT Program funding?**
   Each State will determine the best method to engage stakeholders and subaward funds if necessary to support the goals of their RHT Plan. Organizations should follow the guidance of their Governor's office for the most effective ways to get involved and/or receive funds.

7. **Will Tribes be considered contractors or subawardees in this funding?**
   States are the only entities that can apply, but States can partner with a range of organizations, including tribes and tribal lead organizations, depending on how States choose to structure their application and program. It is up to the State how it would like to subaward or contract funds, though it must make its selection process and criteria clear to CMS in its application, and as with all use of funds, spending is subject to approval from CMS.

8. **Can IHS facilities be subawardees of or contractors with RHT Program funds?**
   Tribally operated IHS facilities may be subawardees of RHT Program funds, but federally operated IHS facilities may not. Prior to subawarding or contracting funds, awardee States should work with CMS and individual facilities to ensure they are not federal entities. Note that as with all uses of funds, funding may not be used to duplicate or supplant existing federal funding sources.

III. Application and Rural Health Transformation Plan

1. **Is it possible to make changes to, resubmit, or update an application after it has been submitted but before the application due date/time?**
   A State may submit only one official application. CMS will not review multiple applications from the same State. If more than one application is received from a State, the last submitted application prior to the submission deadline will be determined to be official and will be reviewed, and any earlier submissions will be disregarded. States are encouraged to login to Grants.gov prior to the deadline to address any technical issues. States should carefully follow the NOFO instructions and use the applicant checklist to ensure completeness.

2. **Will there be an opportunity to preview the application in Grants.gov before submitting to confirm the contents?**
   Yes, you can preview your application in Grants.gov before submitting.

3. **If a State is unable to submit the application by the deadline, does it have any recourse?**
   Applications that are received late, fail to meet the eligibility requirements, or do not include all required content as detailed in the NOFO will not be approved. All submitted applications are timestamped in Grants.gov and those received after the application due date and time will not be accepted. CMS encourages States to not wait until the deadline to submit their application.

4. **What happens to the RHT Program application deadline if there is a federal government shutdown?**
   All applicants should continue to plan to meet the deadlines published in the NOFO, including the November 5, 2025 submission date.

5. **Can a State reapply if its application for the RHT Program is denied?**
   No. There is only one application period for the RHT Program. The application is due by November 5, 2025, at 11:59 p.m. ET.

6. **Are there page limits or other formatting requirements for the application?**
   Yes, the page limits are consistent with other CMS grant opportunities. The project summary is limited to one page, the project narrative to 60 pages, and the budget narrative to 20 pages. More information on page limits and other formatting requirements are described in the NOFO.

7. **Is there an example project and format to follow?**
   The NOFO includes details on how to describe a State's planned initiatives. The NOFO also includes example initiatives States may use as a starting point to develop their own initiatives. States should consider how each proposed initiative relates to the program's strategic goals, the statutory language on approved use of funds categories, what measurable outcomes will be used to assess the impact of the initiative, the sustainability of the initiative beyond the program period, the impact on rural communities, and key stakeholders needed for the success of each initiative.

8. **Should the implementation plan, stakeholder engagement, metrics and evaluation plan, and sustainability plan be provided for each initiative, or can they be consolidated for the entire program?**
   States are expected to provide this information for each initiative. Specifics on the scope of each section are specified in the "Project Narrative" section of the NOFO.

9. **What are the policy commitments that States should focus on and do these commitments need to be enacted by the time of application?**
   State policy commitments that impact scoring are outlined in the NOFO and detailed in the

appendix in Table 4. States will receive credit for State policy actions in effect at the time of the application and may also receive credit for committing within their application to future policy changes by a certain deadline. States should confirm or update their State policy status based on any source(s) listed in the 'Data Source Definition & Source' column of Table 4 to receive proper credit for State policy.

10. How does CMS define rural?

The definition of rural is in the NOFO and includes language required by Public Law 11921, Section 71401, and additional rural metrics as described in the NOFO.

11. Do provider organizations eligible for funding from the State under the RHT Program need to be located in rural areas?

There are no specific restrictions in the NOFO on which provider organizations can effectuate impact on rural communities and residents.

12. What should a State do if CMS' external data sources on State policy actions do not reflect the most recent State policy actions taken in the State?

States should provide information in the project narrative supporting the position that the State has advanced new policies since the publication date of the CMS external data source.

13. What specific information related to scoring factors should States include in their application?

In addition to confirming or correcting all State policy actions, States must provide information on scoring factors A. 2. (list of Certified Community Behavioral Health Clinics (CCBHCs) in a State) and A. 7. (number of hospitals receiving DSH payments). This requested information is described on page 32 of the NOFO. States do not need to include any other specific data-driven factor scoring data in their application.

14. What data should States examine to prepare their applications? Where can States look for good data references?

States can engage with the Governor's office and other major health care stakeholder organizations, including all relevant State health agencies. Various federal government agencies, such as CMS and the Health Resources and Services Administration (HRSA), also have useful health care data sets.

15. Will applicants need to submit third-party commitments of action or letters of support? Is a specific format required for such letters?

The NOFO requires a Governor's letter of endorsement. Letters of support to show evidence of support from key stakeholders are optional. The NOFO itself does not require a specific format for optional stakeholder letters. Therefore, States may submit either multiple individual letters or a joint/shared letter that includes logos and signatures from multiple stakeholders, as long as the Governor's required endorsement letter is provided separately. These requirements are outlined in the NOFO in the "Application Contents and Format" section.

16. What is the anticipated process for updating work plans and programming during implementation?

This funding opportunity is structured as a cooperative agreement between the State and CMS so there will be close collaboration between States and a CMS program officer. CMS understands that details in the work plan and timelines may shift as States move into the implementation phase of their initiatives, but the underlying strategy, themes, and general timing for use of funding should not change significantly throughout the program period.

17. In States that elect to use RHT Program funds to recruit and retain clinical workforce talent in rural areas, will there be flexibility, especially for non-physician professionals, on the five-year service obligation?

Under the uses of funds described in statute, there is a minimum five-year commitment for clinical workforce talent to serve rural communities who benefit from recruiting and retention initiatives funded by the RHT Program. Within relevant workforce initiatives, States should add guardrails to the proposed initiatives to meet this statutory requirement. For further specifics on allowable expenses and funding guidelines, please refer to the NOFO.

18. What will annual reporting requirements look like?

Annual reporting includes standard reporting required by HHS, CMS, and other relevant authorities as noted in the NOFO. The annual reporting is consistent with other CMS grant opportunities and is structured to ensure States use funding consistent with the terms of the cooperative agreement. CMS uses these reports to track progress on State initiatives, evaluate compliance with cooperative agreement terms, and inform decisions on future funding amounts. For the RHT Program, States will also report quarterly and annually on progress on their work plans, timelines, milestones, and achievement of measurable outcomes. Details are provided in the NOFO and Program Terms and Conditions of the grant award.

19. Do potential subawardees or subrecipients need to be specified in the application?

A State does not need to name specific subawardees or contractors in its application if these have not been specifically decided upon yet. Within the appropriate sections of the project and budget narrative, a State should document if it plans to distribute funds to a subawardee or contractor and for what purpose. For all areas in which a State anticipates distributing funds to subawardees or contractors, the State should clearly outline its methodology, process, and specific criteria for selection of who receives these allocations.

Similar to other CMS cooperative agreements, the use of funding by and payment of subawardees or contractors will have significant oversight from CMS' Program Office and Office of Acquisition & Grants Management.

20. If a State's application includes the names of subawardees or subrecipients, can the State amend the specific subrecipients later?

Yes, the State can amend this information later. Prior written approval from CMS would still be required (see 2 CFR 200.407).

21. How should States approach budgeting in their applications?

For purposes of the application, CMS requires States to use a hypothetical award amount of $200 million per budget period in their budget narrative. The program includes five budget periods, and States should narratively explain expenditures in each one using this figure. States should also include an extra column in every budget table to indicate which initiative, as described in the proposed initiatives and use of funds section, each budget line item supports. After applications are reviewed, the final award amount may differ, and States will have an opportunity to rescale their initiatives during the post-award budget reconciliation process. This approach is consistent with other federal grantmaking processes and allows for the evaluation of budget content and structure on a comparable basis.

22. We understand that we should use the hypothetical award amount of $200M/yr to develop the budget, noting that the awarded amount may be larger or smaller. If the final award amount differs from the hypothetical $200M/year used for budget development, must States scale all approved initiatives proportionately, or can they redistribute funds as desired (such as fully funding some initiatives while eliminating others)?

States have the discretion to scale initiatives larger or smaller based on the final award amounts, and the scaling does not have to be proportional across all initiatives. States should not eliminate initiatives entirely or add new initiatives not originally included in the State's application. Please keep in mind the 10% limit on administrative costs for each budget period which will be based on the final award amounts.

23. How will applications be assessed, and who conducts the review?

Applications will be reviewed through a merit review process similar to other federal procurement and grant-making programs. CMS convenes a merit review panel composed of federal and non-federal subject matter experts in relevant areas. All reviewers must be free from conflicts of interest and adhere to confidentiality standards.

24. Are some scoring factors weighed more heavily than others in the application review?

Yes. Different weights are assigned to different score factors. Rural facility and population score factors make up half of the overall score, and technical score factors make up the other half. Each individual factor also has its own weight, which can be found in Table 3 of the NOFO.

25. Must States propose initiatives for each initiative-based technical score factor? Relatedly, how are points for the

technical score factors calculated across multiple initiatives?

States are not required to pursue initiatives that touch upon all possible initiative-based technical score factors. Each initiative proposed will be scored individually by the merit review panel against the five published categories in Table 2 of the NOFO for each of the ten initiative-based technical score factors.

If a State does not propose an initiative that sufficiently addresses a technical score factor, as confirmed by the merit review panel, then the State will receive a zero for that factor. The final points awarded for each initiative-based technical score factor reflect a comprehensive assessment across all initiatives that impact that factor. The comprehensive assessment will consider whether each technical score factor is reflected by well-designed initiative(s) that are clearly aligned with program goals. States are encouraged to prioritize high-quality, feasible initiatives aligned with their Rural Health Transformation Plan.

26. How are percentile rankings applied in the scoring methodology?

Data-driven factors on rural facility and population score factors (such as rural population size and number of facilities) are scored using percentile rankings of each specific metric across all 50 States. The resulting percentile determines each State's relative share of points in that factor, where having a higher percentile results in a greater share of points for that factor.

27. What does the 90th percentile minimum for land area mean?

The 90th percentile minimum means that only those States that rank greater than or equal to the 90th percentile of this metric receive a share of points for this data-driven factor.

28. What does "Full Score Potential" mean, and how is it applied?

Full Score Potential (FSP) refers to the total possible points a State can earn for a particular initiative-based factor in its application. These factors include the initiatives, projects, and activities a State proposes to carry out with RHT Program funding. The merit review panel assesses what the FSP should be for each initiative-based factor based on the initiative's strategy, workplan and monitoring, outcomes, projected impact on rural residents, and sustainability beyond the program period (details can be found in Table 2 of the NOFO). In the first budget period, States receive 50 percent of the points associated with their FSP. In later budget periods, States can earn additional points as they demonstrate progress on their initiatives and policy commitments.

29. What is considered to be a strong initiative?

A strong initiative is one that clearly describes the rural health challenge being addressed, lays out a practical and evidence-based solution, aligns with the State's overall transformation plan, clearly explains how it can realistically be carried out with available resources on a stated timeline, has specific measurable outcomes, and demonstrates how improvements will last and can be sustained beyond the five-year award period.

30. Do States earn more points by proposing more initiatives?

No. Initiatives are evaluated on quality rather than quantity. Each initiative-based technical score factor is scored on how initiatives perform across five categories described in Table 2 of the NOFO. High-quality submissions will score more strongly than a larger number of less detailed, not aligned with this program, low-quality initiatives. Progress on initiatives is assessed each year, and States should propose initiatives that can realistically be achieved within the program period.

31. Will CMS approve some initiatives but not others within a State's application?

Applications are reviewed as a whole. All initiatives proposed by the State will be scored, but CMS does not make awards to individual initiatives. Instead, the award amount will be based on the State's score and available total funds in a given budget period. States may be asked to rescale initiatives during budget reconciliation. Additionally, States may be asked to eliminate initiatives if they do not align with the permissible uses of funds or require prohibited uses of funds.

32. Can States propose optional initiatives that would only be implemented if higher funding levels are awarded?

No, States should not propose optional initiatives that would only be implemented depending on final award amounts. States have the discretion to scale all proposed initiatives larger or smaller based on the final award amounts, and the scaling does not have to be proportional across all initiatives. The scoring of a State's application, and consequent State award funding, are based on all the initiatives described in a State's application. States should propose initiatives that are feasible to implement since subsequent year funding is dependent upon the State's progress in implementing their initiatives.

33. Can States add new or change initiatives after their application is submitted?

States should present their strongest plan in their initial application and will have a chance to update their budget and scale the funding of initiatives during budget reconciliation. While changes to a State's approved workplan may be accepted in extenuating circumstances, the intent is not to change the broader program goals or amount of funding awarded, but to offer States flexibility in response to unforeseen or extreme events. For this reason, States are encouraged to propose the initiatives that they believe will most effectively meet the needs of their rural populations from the outset.

34. How should States use the example initiatives in the NOFO appendix?

The example initiatives in the appendix are meant to serve as a starting point for initiatives that align with RHT strategic goals. States can use these examples when developing their own initiatives, but should further tailor, add detail to, and expand upon the initiative to ensure it aligns with the specific State's needs and goals. Any initiative States submit in their application should contain more detail than the provided example initiatives.

35. Will State applications be made public?

CMS will publish the project summary if a State receives an award and may release application

materials, including letters of intent (LOIs), through Freedom of Information Act (FOIA) requests or if required by law.

36. How should States submit supporting materials with their application?

Supporting materials should be uploaded as separate, clearly labeled documents in Grants.gov. If possible, do not submit zip files, as this may result in missing or incomplete information. Upload each file individually to ensure that all supporting materials are received and reviewed as intended.

37. Who may the Authorized Organizational Representative (AOR) be? Do they have to be associated with the State?

The Authorized Organizational Representative (AOR) is the person with authority to sign on behalf of the awardee and can make legally binding commitments for the awardee. This person is responsible for the oversight of the grant award and ensuring that there is communication between the federal government and the awarded entity.

Each State has its own standards and guidelines on who may qualify as an AOR. Given the AOR's scope of responsibility, it is highly recommended that the AOR be employed by the State government agency or office designated by the governor to develop and submit the RHT Program application, if possible. There should only be one AOR, not multiple AORs, for an awardee at any given period of time. The contact name within the optional Letter of Intent does not have to be the same as the AOR.

38. For some of the State policy actions (e.g., CON), would CMS allow additional time to achieve these changes beyond 2027 given complexity or challenges?

No. As stated in the NOFO, legislative or regulatory actions must be completed by December 31, 2027, with the exception of policy commitments for technical score factors B. 2 and B. 4, which must be completed by December 31, 2028. The formal action must be in place by the applicable deadline.

39. If a State has favorable policies not included in the technical score factors, can the State receive points for these policies? If so, how should these policies be noted in the application submission?

No. States will only receive points associated with State policy actions for the specific technical score factors identified in the NOFO. Policies outside of those factors will not generate additional points. States may reference such policies in their applications to provide context or demonstrate capacity.

40. Are States required to hold formal consultation with tribal stakeholders and/or develop applications in coordination with Tribal Nations during application formulation and program execution?

Formal tribal consultation is not required, but CMS emphasizes partnership with stakeholders, including tribes. States should engage with tribal stakeholders during application formation and program execution, as described in the NOFO. States must certify in the Governor's letter of endorsement that

they have collaborated with their State's tribal affairs office or tribal liaison and Indian health care providers, as applicable.

41. Will workload scoring of initiative-based technical score factors be negatively impacted if a State uses its own definition of "rural" to structure and operate initiatives? Would a State's use of its own definition of rural negatively affect baseline funding scoring/approval?

The initiative-based factors are scored based on a State's own baseline and how well it aligns with the rural health needs and Rural Health Transformation Plan goals established in the project narrative. As discussed in the NOFO, it is therefore important to describe the specific criteria or data that the State uses to identify rural areas in the project narrative. To be considered for baseline funding, State applications must fulfill completeness and responsiveness criteria, include all required content, show funds addressing at least three statutorily permissible uses of funds, and confirm funds will not be used for any prohibited spending.

42. Is there a restriction on types of entities that can be subawardees/contractors under the general initiatives?

States may consult and involve partners like universities, local health departments, and provider associations when designing and implementing the activities in their initiatives. States may subaward or contract RHT Program funds to such partners, or others, or enter into contracts with such entities for the performance of various activities, but the State must make the process and criteria for selecting such subawardees and contractors clear to CMS in the application. Both the selection process and the terms of the subaward or contract must be consistent with the requirements specified in the NOFO and in the State's approved application.

In their application, States should provide a narrative rationale for any anticipated or planned funding allocations like subawards, subgrants, or contracts to specific provider groups, health care systems, hospitals, health care facilities, organizations, or other entities. States should clearly outline the methodology, process, and specific criteria for selection of which entity or entities will receive these allocations. Note that the terms and conditions of federal awards generally flow down to subawards and subrecipients, including relevant cost limitations, as specified in 2 CFR 200.101(b)(1).

43. Could the workforce requirement of 5 years of service spent in rural areas (e.g., tied to residency training programs or fellowships) be fulfilled by clinicians providing telehealth to rural communities?

No. As Stated in Public Law 119-21 and the NOFO, Section 71401, funds used for workforce development must be used to "recruit and retain clinical workforce talent to rural areas for a minimum of 5 years." Therefore, any clinicians recruited or retained under this use of funds must be physically located in rural areas.

44. Within the Rural Tech Catalyst Fund, will the $3M funding limit per company be applied to the fund manager or to the

individual investments made by a fund manager? For example, if a State partners with an investment manager to make investments in a Rural Tech Catalyst Fund Initiative, is the total allocation to that manager limited to $3M, or could there be a greater allocation to the manager but each direct investment must be limited to $3M?

No more than 10% of funding allocated to a State in a budget period or $20M of total funding awarded to a State in a budget period, whichever is less, may be used to support the Rural Tech Catalyst Fund Initiative. The State, or the non-State entity where a State delegates fund management, will award the Rural Tech Catalyst Funds to one or more vendors selected from competitive proposals to develop the State defined technical solutions meeting the requirements of this initiative. Any one company selected to build the State-defined technical solution cannot be awarded more than $3M of non-dilutive funding (funding that does not require the recipient to give up equity or ownership) under the Rural Tech Fund initiative. All funds awarded to the State for this initiative **must be paid directly to the end product developer(s) and may not be used to pay for fund management**. State offices and non-State entities that are delegated with fund management activities in connection with this initiative **may not charge fees to the State for activities in connection with this initiative.**

45. Please confirm whether the subrecipient budget requires the same level of detail as the cost category breakdowns for recipient spending and if it is permissible to provide one total cost for each category by each budget year? For example, for a subrecipient that plans to spend funds in the Personnel and Equipment categories, is it sufficient to include one total Personnel cost and one total Equipment cost and associated justification for each budget year?

An applicant must provide detail in the budget narrative for each of the activities outlined in their Rural Health Transformation Plan. As noted in the NOFO in Section F of our CMS Guidance for Preparing a Budget Request and Narrative website, applicants must identify in the budget narrative which activities will be conducted by subrecipients and contractors, and, for each planned subrecipient, provide a budget and budget justification that includes itemized costs using the cost categories in the budget form (personnel, fringe, travel, supplies, etc.). Note that salary limitations are applicable for subrecipients. If applicable, include any indirect cost paid under the subrecipient.

Throughout the RHT Program, the expectation is that the State and any of their subrecipients or contractors provide the same level of detail so CMS can confirm all costs are allowable (i.e., necessary, reasonable, and allocable, and consistent with the terms of the NOFO). CMS recognizes, however, that at the time of application submission, States may not have all of the details pertaining to their program solidified (e.g., contractors selected via RFP process, line items of budgets managed by sub-awardees, etc.).

To the best of their ability, States should provide the greatest amount of detail that they can so CMS can adequately evaluate their application.

As noted in the NOFO, if States choose to subaward or contract using RHT Program funds, States must make their process and criteria for selecting such subawardees or contractors clear to CMS. If States do not have information on the specific subawardees or contractors that will be used at the time of application submission, States may update this information post-award (if selected for award) when this information is known and before incurring costs or drawing down funds for the subawardees or contractors.

For more information on subrecipient and contractual relationships, please refer to the applicable regulations, including 2 CFR 200.331 "Subrecipient and Contractor Determinations" and 2 CFR 200.332 "Requirements for passthrough entities". Note that the terms and conditions of federal awards generally flow down to subawards and subrecipients, as specified in 2 CFR 200.101(b)(1).

46. If a State proposes initiatives that involve allowable construction expenses (such as improving infrastructure in rural hospitals that will allow them to offer better care to new populations or provide procedures or other services that were not previously possible), should the costs be described in the Equipment section in the Budget Narrative? Construction expenses are labeled as "not applicable" on the CMS Budget Narrative Guidance webpage linked in the Notice of Funding Opportunity?

Costs should not be included in the construction line item of the SF-424A as construction costs are unallowable. Allowable capital expenditures and infrastructure include investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions stated in the NOFO (funding policies and limitations). See pages 12 and 18-20 of the NOFO. Costs for minor building alterations or renovations and equipment upgrades should be included in the appropriate budget category in the SF-424A and Budget Narrative (e.g., equipment in the equipment budget category, supplies in the supplies budget category). If States are unsure where to place the cost(s) and it does not obviously link to a budget category, States can include it in the "other" budget category.

47. If a State commits to enacting a policy change in its application, but the legislature declines to do so, how does that affect future awards?

As noted on pages 20 and 48 of the NOFO, if States do not fulfill their commitment by the end of calendar year 2027 (or 2028 for factors B. 2 and B. 4), their points will decrease to zero for the related factor and CMS will recover funds previously awarded based on technical score credit received from these commitments.

48. If a State subawards funding to or contracts with an organization for a specific purpose (e.g., remodeling an ER to support new telehealth equipment), does the funding expenditure timeline (i.e., the budget periods during which the

particular funds are available) also apply to the organization or does it count as expended if the State sends the funds to the organization?

Unexpended funds means the total amount of funds authorized by Congress and obligated by CMS but not drawn down by the State. Obligating funds via a subaward agreement would not be sufficient for funds to be considered spent; they must be drawn down. For example, in the case of a subaward arrangement, funding would be expended upon disbursement of funds to the subrecipient(s).

Similarly, in the case of a contractor, the State would expend funds upon disbursing payment to the contractor. As noted on page 40 in the NOFO, for each budget period, recipients will have until the end of the following fiscal year to spend awarded funding. Because of this, States might plan to spend part of the funds awarded for one budget period across the fiscal year in which it's awarded and the remainder across the next fiscal year. Keep this in mind when budgeting for the State's overall expected spending from federal FY26 to federal FY31.

49. For equipment purchased for a CAH, should it be listed on the CAH's cost report? What if the available RHT funds are not sufficient to cover the entire purchase price?

States should refer to their individual State reporting requirements for additional details regarding CAH cost reports.

50. What is the purpose of the Rural Tech Catalyst Fund initiative within the Rural Health Transformation Program, and what activities can be funded under this initiative?

Historically, rural populations have had less focus from health tech startups and from venture capital sources focused on technological solutions to health care needs. Rural residents also tended to have a slower uptake in digital health adoption. Initiatives similar to the Rural Tech Catalyst Fund are intended to help address these issues through provision of funds to States that will then issue subawards to or enter into contracts with vendors, selected by the State or its delegated fund manager based on a competitive proposal process, to develop one or more State-defined consumer-facing, technology-driven solutions that focus on the unique challenges of rural populations and have the potential to improve quality, expand access, reduce costs of care, and promote prevention and management of chronic diseases.

The State's proposal for a rural tech catalyst fund initiative must specifically describe the products or services that the State believes are currently unavailable and not likely to be obtainable through traditional government funding structures or private market incentives. Funds awarded under this initiative must go to support innovations that:

- Serve rural communities, with a focus on or special consideration for their particular needs and challenges;
- Benefit Medicaid, low-income, and/or vulnerable rural consumers;
- Focus on prevention and management of chronic diseases;

- Are significantly different from or fulfil an unmet need compared to the existing landscape of products and solutions; and
- Increase quality, affordability, and access to care.

Note that States may not use more than $20 million, or 10%, of funds allotted to the State for a budget period, whichever is less, for an approved Rural Tech Catalyst Fund Initiative. The funding going directly to end product developer(s) should be non-dilutive funding (funding that does not require the recipient to give up equity or ownership), and the funding should not generate profit back to the State or the delegated manager.

51. Will State Plan Amendments or Waivers be needed related to deliver innovative services like traditional healing?

Yes. States should apply for any relevant Medicaid authorities needed to implement innovative care delivery services. As with all initiatives and uses of funds, States should ensure that such care delivery is part of comprehensive initiative that is within the scope of this program, has a focus on benefits to rural communities, and will be sustainable beyond the life of the program.

52. Can States include additional materials in their applications beyond what is specified in the NOFO, such as a cover letter or a letter from the Authorized Organizational Representative's (AOR)?

States have discretion to include materials beyond what is specified in the NOFO, but such materials will be included in the application page limit. Please refer to the NOFO for more information regarding page limits and formatting for each application section.

53. What information should be included in the application submission for States considering tribal carve-outs and planned tribal initiatives? Can States outline a commitment to co-develop a detailed plan with tribal partners post-award, or must the specific use of funds be fully defined in the initial submission?

States should engage with tribal stakeholders during application formation and program execution, as described in the NOFO. We encourage States to design their programs working with tribal organizations as subawardees or sub-grantees as they see fit.

States who wish to partner with tribes through a subgrant, subawardee, or program, must provide a description in the project narrative explaining the initiative(s) with which the partnership aligns. We encourage States to include as much detail as possible in their application including how they will evaluate any subgrantees or sub-awardees in their program. Note that the same restrictions and requirements that apply to the States flow down to any subawardees and subgrantees.

54. What elements are considered graphics, and what are the formatting requirements for the text within these graphics?

Tables and snapshots are categorized as graphics, and all text within these graphics should be no smaller than 10-point font. Note that graphics count toward page limits.

55. Does CMS have a preferred format for the data that States submit as part of their applications (CCBHC list, DSH hospital information)?

Yes, CMS has created an Excel template that States are encouraged to use for submitting data for score factors A. 2. (CCBHC site list). States may download the template from the RHT Program website. For submitting via grants.gov, applicants are encouraged to populate the Excel template with their State information and upload a PDF version of the spreadsheet. Word tables or other formats are discouraged. The data files are considered other supporting materials, and count toward the 35-page limit (page 44 of the NOFO).

56. Are States allowed to use landscape format in their applications?

Landscape format is acceptable as long as the page size does not exceed the standard 8.5 x 11 inches.

57. How does CMS want States to submit information pertaining to State policy action factors? When correcting or confirming a State policy action factor source described in the NOFO, how descriptive does a State need to be?

Applicants should describe their State's current policy for each State policy related to the "State policy actions" technical score factors as part of the project narrative. See details specified in the NOFO under the "Legislative or regulatory action" subsection on page 31 and the sources listed in appendix Table 4 of the NOFO. For confirmation or correction of the sources, States should provide citations of publicly accessible websites or provide attachments as part of the supporting materials while being mindful of page limits.

58. Can you expand on the difference between the "program key performance objectives" in the Goals and Strategies section and the "evaluation outcomes metrics" for the initiatives. Is the former a subset of the latter? Are they all in the Metrics and Evaluation section?

As noted in the NOFO (page 31), a State's "program key performance objectives" should paint a cohesive and comprehensive picture of what the overall program will achieve by the end of the funding period of the cooperative agreement (FY 2031). The evaluation and outcomes metrics should be defined for and specific to each initiative, as described in the metrics and evaluation plan (NOFO page 36), and should be consistent with and complementary to the overall program performance objectives. The evaluation outcomes metrics should outline the performance measures and outcomes you will track to evaluate success for each specific proposed initiative in your application. These initiative-level metrics should generally align with the same themes and categories as the broader and overarching "Program key performance objectives".

59. The NOFO mentions five strategic goals, (Make Rural America Healthy Again; sustainable access; workforce development; innovative care; and tech innovation) and the law requires a "detailed rural health transformation plan" that includes addressing eight

areas, including improving access to hospitals and other providers, and including health care outcomes. Does addressing specifically each of the five strategic goals listed in the NOFO also answer the requirements in the law that a detailed health transformation plan must address?

Within the project narrative, States must address all the requirements detailed in the Rural Health Transformation plan: Goals and strategies section of the NOFO. This section should include a detailed Rural Health Transformation Plan as required by statute in 42 U.S.C. 1397ee(h)(2)(A)(i), addressing each element required by statute as outlined in the bulleted list on pages 29 -31 of the NOFO. Note that applicants may organize this section by objectives or related groupings. For example, a State might combine discussion of access and outcomes or technology and data.

60. Is there an example of a sustainability plan for workforce development initiatives?

There is no example plan or template beyond guidance provided in the NOFO. An applicant must provide a project narrative which addresses all the requirements detailed in the NOFO (see page 37 of NOFO for guidance related to the sustainability plan).

61. Are costs for new clinical workforce training programs allowable if the programs are run by existing educational partners but via new subcontracts?

As discussed in the NOFO, RHT funding is designed to support expansion and scale to better serve rural communities, not to replace or duplicate existing funding sources. When a State uses RHT funds to expand an existing pilot program or initiative or to develop new training programs with existing partners, the funds may only be applied to the costs associated with the new population, new activities, new program milestones, etc. The original program's programmatic costs, administrative expenses, and activities—those already funded by the State or existing fiduciaries—must continue to be funded by those original sources.

62. Can you specify the indirect cost limit and its applicability to State staff that are assigned to work exclusively on the grant award program for the next 5 years? To the extent that staff salaries are assigned to the grant award as a line item in the budget narrative, are the salaries of those individuals subject to the 10% indirect cost rate ceiling or would they be considered a direct cost?

According to Section 71401 of Public Law 119-21, not more than 10% of the amount allotted to a State for a budget period may be used by the State for administrative expenses. This 10% limit on administrative costs for your budget includes indirect and direct costs that are considered administrative costs.

States should explicitly show that your administrative expenses are less than or equal to 10%. Identify which line items count as administrative expenses (such as salaries of program management and contracts for administrative support) and show that their sum is 10% or less of the total. Note that this portion includes any indirect costs used for administrative expenses. If you include indirect costs in your budget using an approved rate or

cost allocation plan, include a copy of your current agreement approved by your Cognizant Federal Agency for indirect costs. Also note the salary rate limitation described on page 22 of the NOFO.

63. SF-424A Section B (budget categories) seems to include 4 columns for different grant programs, not different funding years. Should applicants treat each year as if it's a different program, or is there a different way to break down the costs by category for each year?

The SF-424A has attachments where the applicant can break down each year of the budget across all categories. Note that since the attachment as downloaded only provides four columns, applicants for the RHT program will need to add an additional sheet to capture the entire 5-year span for the application. Your SF-424A attachment submission should include the following:

- Page 1: The first column will reflect year 1; the second column should reflect year 2; the third column should reflect year 3; and the fourth column should reflect year 4;
- Page 2: Add an additional sheet which will reflect year 5 in column 1.

Applicants will break down the hypothetical $200 million per year, for each of those columns, based upon line item category.

64. On technical scores, there are points available for States that work toward requiring mandatory continuing medical education (CME) on the topic of nutrition. Do States that include nutrition education in medical school curriculum and offer it in CME receive credit?

As discussed in Table 4 of the NOFO, States will receive credit for having a proposed, finalized, and/or implemented requirement for nutrition in continuing medical education for physicians.

65. Can implementation plans and timelines be submitted as Gantt charts in the supplemental materials, as opposed to including in the project narrative?

No. As discussed in the NOFO, the implementation plan and timeline should be in the Project Narrative section and is subject to the 60-page limit for the Project Narrative. The Project Narrative can have an appendix which may include charts, but the 60-page limit still applies.

66. For programs that include a 5-year service requirement, how will the States report success since the program may be over by the time that 5 years is completed?

For these types of programs, States should explain in their application what internal controls and reporting mechanisms they will put in place to ensure the 5-year requirement is met and how the initiative will continue to meet the 5-year requirement beyond the life of the RHT Program.

67. Do contracts for compliance, evaluation, and data collection need to be included in the administrative budget (total no more than 10% of award)?

Yes. These costs would be considered administrative and subject to the 10% cap on administrative costs.

68. Can an applicant exclusively use endnotes, rather than footnotes, in its project narrative?

There is no prohibition on using exclusively endnotes rather than footnotes in the project narrative.

69. The standard SF-424A budget categories don't align with the cost limitation categories specified in the NOFO. How should applicants demonstrate compliance with the NOFO limits in the budget narrative?

State applicants should apply any relevant budget caps to the overall amount awarded for each Budget period. To ensure that the cap is met and does not exceed the limit, State applicants should do a thorough review of the final budget prior to submitting the application. Relevant budget line items broken down in the Budget Narrative that are subject to caps can be identified and summed together to show that the costs are less than the cost limitations.

70. If States plan to competitively procure or award subcontracts as part of an initiative, how should they break down costs in the budget request and budget narratives? Should a State estimate costs for subawards or contracts which have not yet been awarded?

State applicants should include ALL Consultant/Subawardee/Contractual costs in the "Consultant/Subrecipient/Contractual Costs" line-item category. States should estimate the amount they plan to allot for the subcontractor and provide as much information as they can to justify the cost and describe intended subcontractor activities. If for any reason the State has not made a decision on the subcontractor, they should provide the estimated amount for the subcontract and a detailed justification on the role the subcontractor will play for this program. Please see our Guidance for Preparing a Budget Request and Narrative for additional information.

71. Are States expected to capture all costs applied to the 10% indirect cap in a single indirect line?

Yes. States should include a cumulative total in their budget. Please see CMS Guidance for Preparing a Budget Request and Narrative for more information.

72. What level of detail is required for the budget analysis of funding streams within the Program Duplication Assessment? Can we see some approved samples of this grant requirement?

In the Program Duplication Assessment, applicants are required to provide a detailed summary clearly demonstrating that there is no duplication or overlap with other funding sources. Due to privacy and confidentiality requirements, we are unable to provide examples or excerpts from previously approved applications.

73. The SF-424a form/section of the grants.gov workspace only allows for one file to be uploaded. Should an additional sheet be uploaded within the Other Attachments Form?

The second SF-424A can be uploaded with other/miscellaneous forms.

74. Do workforce recruitment and retention programs focused on K-12 populations still need to meet the minimum 5-year workforce requirement?

Generally, no. Workforce recruitment and retention programs focused on K-12 populations are typically excluded from the minimum 5-year workforce commitment requirement, but it depends on the nature of the program.

Initiatives such as career exploration camps, mentoring programs, or high school health career clubs that are considered upstream pipeline activities would not be subject to the minimum 5-year workforce requirement. Their purpose is to foster interest and exposure, not to provide the direct, career-enabling training that the commitment is designed to track.

Any determination to apply the 5-year commitment to a K-12 population program will be made on a case-by-case basis by the Program Office. For example, if a program focused on a high school population

offers a structured, certifiable pathway that leads directly and immediately to a specific job within the rural healthcare system upon completion (e.g., a highly specialized high school technical program resulting in a certified CNA qualification required for local employment), the 5-year workforce requirement would apply.

The RHT Program requires that performance measures for typical K-12 programs focus on appropriate pipeline metrics, such as the number of participants served and their rate of continued progression into higher education or more advanced pipeline activities.

IV. Funding Awards

1. Do States need to formally apply to receive the funding described in Public Law 11921, Section 71401?

Yes. States must apply and be awarded a cooperative agreement to participate in the RHT Program and receive funding.

2. How much funding will be available to a State each year of the program?

The total funding for the program is $50 billion. In accordance with Public Law 119-21, Section 71401, funding will be awarded annually, with $10 billion available each fiscal year. Half of each year's total funding will be distributed equally between all approved States. The second half of funding will be distributed to no less than 25 percent of approved States based on the number of points allocated to each State's approved application using the method outlined in the "Funds distribution" section of the NOFO.

3. Can States roll over unused funds from year-to-year?

In accordance with Public Law 119-21, Section 71401, funding that is allotted in any given budget period is available until the end of the subsequent fiscal year, except for funding States may receive in FY 2032. Any funding received in FY 2032 that is not used by September 30, 2032, will not roll over to the following fiscal year, and will be returned to the United States Treasury.

4. **Are there circumstances where a State must return any funding that it has already received?**
   Yes. In accordance with Public Law 119-21, Section 71401, using funds in a manner inconsistent with activities described in a State's application and/or on activities CMS has not approved may result in withholding, reducing, or recovering funding. CMS may also reduce, withhold, or recover funding if a State fails to demonstrate satisfactory progress, does not submit required reports, misuses funds, or otherwise does not comply with the terms of the award. Additionally, any funds the State has not spent by the end of the fiscal year following the fiscal year in which the funds were allotted will be redistributed according to the structure described in the "Funds distribution" section of the NOFO. Any funds that remain unspent or unobligated as of October 1, 2032, must be returned to the U.S. Treasury.

5. **How is "satisfactory progress" defined for continued funding?**
   Satisfactory progress means a State is meeting the milestones, timelines, and commitments described in its approved application. CMS will reassess annually and will partner closely with States in successful execution of their programs.

6. **Should the Project/Performance Site Location form include only the location of the primary, requesting agency or the location of all proposed initiatives as well?** The Project/Performance Site Location form
   should include the main address where the program will be run. States may also include any additional addresses for locations where the program will take place, such as proposed service locations, facilities, or sites, if known at the time of application. If the additional sites are unknown at the time of application, States are requested to update this information immediately with CMS once this information is known.

7. **How does CMS intend to interact with States after funds are awarded?**
   The awards are cooperative agreements, and CMS will have substantial project involvement after an award is made to ensure a successful program. Details on our involvement is specified in the NOFO under the "Cooperative agreement terms" section.

8. **When will funding be awarded?**
   Awards will be announced by 11:59 p.m. ET on December 31, 2025.

9. **Will all funding be distributed by December 31, 2025?**
   Awards will be announced by 11:59 p.m. ET on December 31, 2025, and funding for budget period 1 will be distributed in early January shortly after the award announcement. Funding for subsequent budget periods will be awarded annually as described in the NOFO, with $10 billion available each fiscal year FY 2026 – FY2030. Any unexpended or unobligated funds will be redistributed in the nearest following fiscal year possible according to the same structure outlined in the NOFO.

10. **Will States receive all funding immediately, or will the funding be**

distributed progressively over the five-year period?

Consistent with the statute, $10 billion is available each fiscal year from FY 2026 – FY 2030 for awarding among States with approved applications. Any unexpended or unobligated funds will be redistributed in the nearest following fiscal year possible according to the same structure outlined in the NOFO.

11. Is there only one application to apply for all funding? Are there subsequent applications for each of the five years?

There is only one application period with one submission deadline for this funding opportunity. Similar to other multi-period CMS grant opportunities, States will be required to submit annual non-competing continuation (NCC) applications to receive funding for each subsequent budget period. These are not new applications and provide information updates to the State's budget, progress on meeting project goals and objectives, and other information.

12. How should States craft their budget when they are not certain how much funding they will receive? How specific should the spending plan be?

The NOFO provides additional guidance on how to complete the Budget Narrative. Similar to other CMS grant opportunities, the amount that States use to budget in their initial application compared to a potential final award amount may be different following CMS's assessment of all applications.

13. Can States award some of their grant funds to other entities?

Yes. If a State chooses to award some of its RHT Program funds to another entity, the State must make its process and criteria for selecting such subrecipients, contractors, or subcontractors clear to CMS. Note that the terms and conditions of federal awards generally flow down to subrecipients, contractors, and subcontractors, as specified in 2 CFR § 200.101(b)(1).

14. Can all 50 States be approved for the funding?

Yes. There is no statutory barrier to awarding all 50 States funding.

15. Is the second half of funding limited to only 25 percent of approved applications from States?

No. Public Law 119-21, Section 71401, specifies that all States with an approved application will receive a portion of the first 50% of funding and that not less than ¼ of the States with an approved application must also receive part of the second 50% of funding. The ¼ requirement is not a cap on number of eligible participants.

16. Can a State be approved for baseline funds but not workload funds?

No. There is one application and one approval process that covers both baseline and workload funding. All approved awardee States will receive the baseline funding, distributed equally, as well as workload funding, distributed according to the formula described in the NOFO.

17. If a State does not commit to a policy change but makes it later, will that affect award?

States can achieve high or maximum points for each factor either by having an existing policy or by committing to make policy changes by the end of calendar year 2027 (or calendar year 2028 for factors B. 2 and B. 4) that align with the policy described in Table 4 of the NOFO. In order to be scored properly and receive credit, the State's application should:

- Confirm (or correct any CMS-supplied information about) the current State policy related to the "State policy actions" technical score factors (see sources listed in appendix Table 4 of the NOFO), and
- Include information about any policy commitments the State is making as part of its application, which includes legislative or regulatory actions related to the technical score factors that the State is committed to pursuing, the timeline, and other details specified in the NOFO under the "Legislative or regulatory action" subsection on page 31. Existing policy and policy changes that are later made by States but not reported in the application will not be considered in the scoring of factors.

Note that these State policy changes, which are made by the State through its normal legislative and/or regulatory processes without using RHT Program funding, are optional to pursue. Additionally, note that there are restrictions on federal funds being used for lobbying activities as outlined in the Funding Limitations on page 19 in the NOFO.

18. What time frame will States have to adjust their budget to align with their actual award amount (if different than the hypothetical $200 million)?

CMS will collaborate with States receiving awards greater or less than $200 million to ensure they have ample time for budget adjustments. Any information requested by CMS from the States during the budget reconciliation period will not count towards page limit restrictions. The time frame for submitting additional information will depend on the extent of the adjustments needed and the specific details requested by CMS.

19. Will the RHT Program application review process and date of award be impacted by the federal government shutdown?

CMS has a statutory deadline to make awards by December 31, 2025, and expects to meet this timeline.

20. If a State is approved, do they receive the full baseline funding? Or are there areas that may be removed/disqualified?

All States that have submitted an approved application will receive baseline funding. Baseline funding will be 50% of the total available funding for each budget period and will be distributed equally amongst all approved States.

21. Since States can use 10% for administrative costs, if some of the funds were pulled for not meeting goals would a State have to repay administrative funds that were spent on the program?

If CMS must recover funds for an initiative, the recovered amount is not based on specific expenditures. As described in the NOFO, any funds that must be recovered due to non-compliance will be calculated as follows:

- For violations that affect your technical score: Proportional to the incremental award funds granted based on the technical score points you were previously awarded.
- For violations that do not directly affect your technical score: Assessed on a case-by-case basis. All prior and future payments become eligible for withholding and/or recovery.

V. Use of Funds

1. How do initiatives relate to the required uses of funds in the application?

Initiatives are comprehensive projects or activities within the scope of the RHT Program that involve one or more of the permissible uses of funds described in the Use of Funds section of the NOFO. States must include at least three permissible uses of funds in their applications, but they are not required to pursue every possible use of fund (or initiative-based technical score factor) described in the NOFO. States may decide on the number of initiatives and allowable use(s) of funds within the initiatives that are best for transforming rural healthcare in their State.

2. Could you clarify the criteria by which award funds under a competitive grant are considered "expended"? More specifically, is the announcement of an award sufficient for funds to be deemed expended, or must all funds be disbursed and processed by the end of the budget period, to count as expended?

Unexpended funds means the total amount of funds authorized by Congress and obligated by CMS but not drawn down by the State. This may refer to funds that the State has included in their Rural Health Transformation plan but have not been paid out on initiatives run at the State-level by the end of the subsequent fiscal year with respect to each budget period start date.

3. How does CMS define "unobligated funds"?

Unobligated funds refer to the portion of budget authority that has not been legally committed by CMS to the States in any given year.

4. Can funding be used for Medicare or Medicaid reimbursement?

Funding cannot be used to replace or modify payment for clinical services that could be reimbursed by insurance or another form of health coverage. States will also submit a program duplication assessment to ensure funding is not being used to pay for the same activities or providing the same services to the same beneficiaries as other federal funding sources or programs. Please refer to page 43 in the NOFO for additional information.

5. What are allowable expenditures (e.g., investments) that provide sustainable benefits beyond the funding period? Can any of the funding be used for building health care facilities?

Information on the specific uses of funds and restrictions is provided in the NOFO.

6. What is considered program duplication? Can funding be used to expand existing programs to include more communities and systems of care?

Like other federal grant programs, the RHT Program application must include a program duplication assessment to ensure funding is not being used to pay for the same activities or providing the same services to the same beneficiaries as other federal funding sources or programs.

Applicants are restricted from using RHT funding on any project or initiative that is currently funded (or planned to be funded) via other sources. Applicants need to make sure that the work and initiative is not the same exact activities being performed on the same beneficiaries as other programs and ensure that there are internal controls in place to avoid program duplication.

As discussed in detail in the NOFO, RHT funding is designed to support expansion and scale to better serve rural communities, not to replace or duplicate existing funding sources. When a State uses RHT funds to expand an existing pilot program or initiative, the funds may only be applied to the costs associated with the new population, new activities, and new milestones. The original program's programmatic costs, administrative expenses, and activities—those already funded by the State or existing fiduciaries—must continue to be funded by those original sources.

For example, if a State currently operates a successful chronic disease management pilot program with existing staff and resources in one rural county (County A) and the State wants to use RHT funding to expand this exact program to three additional rural counties (Counties B, C, and D), allowable use of RHT funds (Expansion) would include:

- Hiring and training new community health workers to serve the residents of Counties B, C, and D.
- Purchasing new patient monitoring devices and educational materials, specifically for the populations in Counties B, C, and D.
- Startup costs to establish new contracts or agreements for service delivery in the new counties.

Unallowable use of funds (Duplication) would include:

- Paying for the training or salaries of the project manager or existing staff whose role is centered in County A. Should the staff members be shared across Counties A, B, C and D, only their work on Counties B, C, and D may be funded by RHT funds.
- Replacing equipment, renovations, or covering any other costs for the established office location in County A.
- Covering any expense that was previously, or currently is, paid by the State, a pre-existing grant, or any other organization in County A.

Another example is if a State has an existing program that currently provides tele-diabetes education and basic general practitioner check-ins for patients with Type 2 Diabetes across ten rural sites (existing activity). The State wants to use RHT funds to add remote specialized endocrinology consults and continuous glucose monitoring (CGM) interpretation (new activities) to these sites. Allowable use of RHT funds (Expansion) would be:

- Purchasing new CGM devices and supplies needed specifically for the enhanced remote monitoring service.
- Paying the pay-for-performance bonus/alternative payment model for the newly hired specialized endocrinologist dedicated to the advanced consults and CGM interpretation.
- Securing an upgraded, higher-tier software license that enables the required secure CGM data integration and specialist workflow features, provided the cost difference is directly attributable to the upgraded, incremental, specialized functionality.

Unallowable use of funds would be (Duplication):

- Paying the salaries for the existing general practitioners or basic educators already providing the tele-diabetes education.
- Covering the cost of the original, basic telehealth platform that was already being paid by the State for general check-ins.
- Replacing office equipment used by the existing staff.

7. Is there a limit for the administrative portion of funds?

Yes. As required by Public Law 119-21, Section 71401, there is a 10% cap on funding that can be used for administrative costs, including both indirect and direct costs. Note that the 10% cap on indirect and direct administrative costs applies to all subawardees and contractors as well.

8. In the submitted proposal and budget, can States use administrative dollars for State staffing costs?

Yes. If a State staff member is directly working on the program administration of the Rural Health Transformation Program for their State, that staff member could be paid with RHT Program funds. This expenditure would be considered an administrative cost and would factor into the 10% administrative cost limit.

9. How do indirect cost rates & restrictions and the 10% administrative cost restriction flow down to subawardees and contractors?

Subawardees and contractors are subject to the same cost restrictions as the primary awardee. Subawardees and contractors are subject to the State's relevant indirect cost rates, and they are also subject to the 10% limit on program administrative costs.

10. In some places in the notice of funding opportunity document, it lists an approved indirect rate, an approved cost allocation plan, or the de minimis rate. Are all three methods available for States to choose from?

For guidance on indirect rates, States should follow either their approved indirect rate, cost allocation plan, or the de minimis rate in that order. Keep in mind that all administrative costs, including indirect costs that are program administrative costs, are included in the 10% administrative cost limit required by statute.

11. Could you clarify how the NOFO salary rate limitation ($225,700, p.22) applies—

does it cover only project staff, or also physicians receiving incentives, and how does it extend to subawardees or partial salary support?

Any program funding going towards paying the salary of an individual who is doing any work (including executing parts of an initiative) directly related to the RHT Program is subject to the salary rate limit. This includes funding going towards paying the salary of individuals at subawardees and contractors. This is the maximum amount that can be billed to this program for an individual's salary. If for any reason the individual working on this program makes over the salary cap amount, the remaining would need to be covered by other funding sources.

12. Will a list of allowable expenditures be released?

Public Law 119-21, Section 71401, includes details on statutorily approved uses of funds and unallowable expenses.

States must spend their RHT Program funds on at least three permissible uses (see pages 11-12 of the NOFO). Information on unallowable costs and funding limitations can be found on pages 18-20 of the NOFO.

13. What types of costs are not allowed under the RHT Program?

Costs that may not be covered with RHT Program funds include costs incurred pre-award, lobbying activities, and expenses that are the legal responsibility of another federal, State, or tribal program, such as education or vocational rehabilitation services. States also may not use funds for new construction or major building expansions, though minor alterations and renovations tied to program goals may be permitted. Use of funds for broadband infrastructure is unallowable.

Other restrictions include using funds to supplant existing State or local funding, replacing or duplicating payments for clinical services that are already reimbursable by insurance, and funding perpetual ongoing operating expenses with no path to sustainability rather than transformational investments. The NOFO specifies percentage limitations on some cost categories, detailed in the Program specific unallowable costs section.

Mobile health units and funding of telehealth capabilities & infrastructure **are allowable**. As with all use of funds for this program, specific use of funds should be part of comprehensive initiative that is within the scope of this program and has a focus on benefits to rural communities.

14. Does the program limit funding to certain types of providers or facilities?

No. Each State has the discretion to determine whether and to whom to subaward or contract funds. There are no limits on the types of entities that may receive funds through subawards, contracts, or contracts. However, States must clearly describe the criteria and process for selecting subrecipients in their application, and federal award conditions apply to any subawardees, contractors or contractors.

15. How should States consider initiative sustainability after the RHT Program funding period?

CMS expects States to design initiatives that invest in long-term, sustainable improvements rather than temporary fixes or funding perpetual operating expenses. States should consider whether initiatives can be supported through existing payment systems, State budgets, alternative funding streams, or are self sustainable once federal funding from this program concludes. This includes strengthening rural provider networks, expanding preventive and value-based care models, and investing in technology or workforce strategies that create lasting capacity.

16. Can States use funds to upgrade or enhance their existing electronic medical record (EMR)/electronic health record (EHR) systems? What does the 5% EMR/EHR limitation mean?

The 5% limitation is for funding the replacement of an EMR system if a previous Health Information Technology for Economic and Clinical Health (HITECH) Act certified EMR system is already in place as of September 1, 2025. Replacement refers to the purchase of a completely new EMR system to take the place of an existing one.

Upgrades, enhancements, and added modules, interfaces, or functionality to existing EMR/EHR systems are allowable uses of funds and are not subject to the 5% limitation. Furthermore, providers may substitute G10 certified modules to meet their needs and this substitution is not subject to the 5% limitation.

These upgrades, enhancements, and added modules, interfaces, or functionality to existing EMR systems should be aligned with CMS's Health Technology Ecosystem criteria (including the CMS Interoperability Framework) and ASTP/ONC criteria, as applicable for the contemplated use of fund.

As with all program use of funds, use of funds related to EMR/EHR systems should be associated with an initiative that adheres to the scope and furthers the strategic goals of the RHT Program.

17. Will States know their funding amounts in future budget periods?

Funding amounts beyond the first budget period will depend on a State's demonstrated progress on its initiatives and any committed policy actions and compliance with its cooperative agreement. CMS will reassess each State annually to determine performance and compliance with cooperative agreement terms. While the initial budget narrative in a State's application is based on a hypothetical $200 million per budget period, actual funding for each budget period may vary.

18. Will baseline and workload funds be awarded separately or together?

Baseline and workload funding are awarded as a single award, not in separate awards. When preparing the budget narrative using the hypothetical $200 million per budget period, States should plan for that total amount across both baseline and workload funds. The distinction between baseline and workload funding is for calculation of funding amounts;

from the State's perspective, the award is made as one combined sum.

19. How long do States have to spend funds from each budget period?

The RHT Program has five budget periods. States have until the end of the following fiscal year to spend funds awarded in a given budget period. For example, funds awarded in the first budget period (FY 2026) may be spent through September 30, 2027. Similarly, funds from the fifth budget period (FY 2030) may be spent through September 30, 2031.

20. Can States shift funds amongst initiatives after the award is made?

Yes. Within the scope of their approved Rural Health Transformation Plan, States have some flexibility to adjust allocation of funds amongst initiatives for allowable use of funds. Significant changes to initiatives, budgets, or subawardees will require CMS review and approval.

21. What is considered "minor alterations or renovations"? Can you explain what sort of additional retrofitting would be permissible under the program versus when it would be impermissible? Is there a "bright line" on when renovations are permissible?

Minor Alterations and Renovations projects include small modifications aimed at enhancing the functionality of the facility where the project will take place. In general, minor modifications to an existing building footprint, existing infrastructure, and existing rooms within a facility would be considered minor building alterations or renovations. For example, renovations or retrofitting to convert underutilized cost intensive spaces within existing health care facilities to clinic or community-based treatment spaces would qualify (e.g., in a purely hypothetical example, converting a hospital space to be a standalone ER + OB and NICU ward with retrofitting remaining space to serve as telehealth or primary care).

Similar to all uses of funds for this program, minor alterations and renovations require prior approval from CMS. Hypothetical, illustrative examples include but are not limited to:

- Interior Modifications: Installing or relocating interior walls and partitions to create new offices or meeting rooms.
- Lighting and Electrical: Upgrading light fixtures to more energy-efficient systems.
- HVAC and Plumbing: Replacing vents and thermostats for better climate control.
- Accessibility Improvements: Installing automatic door openers to enhance accessibility.
- Security and Safety: Installing or upgrading security cameras or access control panels.
- Workspace Reconfiguration: Creating open office layouts or converting private offices to better suit needs.

As with all use of funds, use of funds for minor alterations or renovations should be part of an initiative that is within the scope of the RHT Program and adheres to all requirements as described in the NOFO, including the 20% cap on capital expenditures and infrastructure. Please note that major renovations or new construction activities are unallowable.

After submitting applications and throughout the life of the program, CMS will work with recipient States on ensuring funding is used in a manner consistent with federal regulations & guidance, program requirements, and the State's approved initiatives & activities under the Rural Health Transformation Plan.

22. Can you clarify the definition of capital expenditures?

Capital expenditures are expenditures to acquire capital assets or expenditures to make additions, improvements, modifications, replacements, rearrangements, reinstallations, renovations, or alterations to capital assets that materially increase their value or useful life. Construction is unallowable for this grant program. Please refer to 2 CFR 200.439 for additional information.

23. Can you share CMS rules around depreciation of capital assets?

For this program, depreciation charges for equipment and buildings may be made. Land is not an allowable use of funds so depreciation charges for land are not relevant. Refer to 2 CFR 200.436 and 2 CFR 200.439 for additional information regarding equipment depreciation.

24. Are medically tailored meals or nutritious foods (fruits/vegetables) for schools an allowable use of funds?

Funding meals, including medically-tailored meals, in schools (or in any other context) is not an allowable use of funds as this represents an ongoing cost. However, initiatives that focus on developing the infrastructure for healthy living, such as funding the infrastructure necessary to facilitate nutrition improvement programs at schools in rural communities, would be allowed.

25. What happens if Congress does not appropriate funds in later years?

The $50B of funding has already been appropriated. There is no other Congressional action required to appropriate the funds.

26. Please provide additional guidance on allowable use of funds for Use of Funds Category B, provider payments.

Use of Funds Category B includes provider payments for clinical services that are not paid by insurers and/or other programs (see Program Duplication assessment in the NOFO). Provider payments should tie directly to strategic goals of the RHT Program and directly support initiatives described in the State's Rural Health Transformation Plan. Given the scope of provider payments, these should be targeted investments designed to advance Make Rural America Healthy Again, workforce recruitment and retention, sustainable access to care, innovative care, and tech innovation. Provider payments must be consistent with the authorizing statute of this program and with the NOFO. Examples of allowable funding under Use of Funds Category B include:

- Payments to providers for performance in alterative payment models tied to outcomes
- Payments to providers for services that are not paid by insurers but support the strategic goals of the RHT Program and tie to a specific initiative within the Rural Health Transformation Plan

Examples of unallowable funding under Use of Funds Category B include:

- Payments to employees not tied to specific quality improvements or an initiative within the scope of the RHT Program
  - Enhanced payment rates for currently billable services without ties to outcomes
  - Uncompensated care that is not tied to a specific initiative within the Rural Health Transformation Plan

Note that allowable funding under Use of Funds Category B are limited to 15% of the total funding CMS awards a State in a given budget period. While provider payments under the Use of Funds Category B are limited to 15%, there are other ways that providers may receive payments under the RHT Program, including but not limited to:

- Funding salaries or payments directly related to new or expanded workforce development initiatives provided the clinical workforce employee commits to five years of service and the contract does not have a non-compete clause (Use of Funds Category E)
- Funding the development of innovative models of care, such as model infrastructure or technical assistance for model implementation (Use of Funds Category I)
- Funding comprehensive initiatives aimed at supporting access to opioid use disorder treatment services, other substance use disorder treatment services, and mental health services (Use of Funds Category H)
- Funding comprehensive initiatives aimed at supporting evidence-based, measurable interventions to improve prevention and chronic disease management (Use of Funds Category A)

For all proposed use of funds, consider the sustainability of initiatives past the RHT Program period. States should explain how these provider payments are uniform and broad based as appropriate.

27. Please provide additional guidance on the unallowable cost "clinician salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations". Does this mean that any facility that has non-competes cannot receive RHT Program funding?

RHT Program funding should not be used to directly fund clinician salaries or fund workforce development initiatives where the clinicians or initiative beneficiaries (e.g. new clinicians in a rural area because of a funded workforce development initiative) are subject to a noncompete agreement.

This does not preclude facilities that have clinician non-competes from receiving RHT Program funding, subject to the restrictions on specific use of funds described above and in the NOFO.

28. What is considered "clinical workforce talent" (Use of Funds Category E)?

Clinical workforce talent encompasses a variety of healthcare professionals who directly provide or support patient care. Examples include clinicians, allied health professionals, behavioral health providers, non-clinician providers, and clinical support staff.

29. Can States use funding for broadband infrastructure?

Use of funds for broadband infrastructure is unallowable.

30. Can States fund an endowment, capital fund, or other vehicle resembling an investment fund with the purpose of generating income?

No. States cannot fund an endowment, capital fund, or other vehicle resembling an investment fund with the purpose of generating income as these generate profit/additional funds. As described in the Code of Federal Regulations, generally recipients or subrecipients may not earn or keep any profit resulting from Federal financial assistance (refer to 2 CFR 200.400). The purpose of the RHT Program is to invest directly in initiatives that will improve healthcare in rural communities. See additional information on allowable use of funds outlined in the NOFO.

31. Can States use RHT Program funds to pay for a helicopter or plane to allow access to care for patients in rural areas?

Vehicle purchase requests will be reviewed on a case-by-case basis and approval is not guaranteed.

32. Is there a limit to the amount of funding that can be allocated to an individual subawardee/contractor for an initiative that is not the Rural Tech Catalyst Fund?

States may subaward or contract using RHT Program funds to partners like universities, local health departments, provider associations, and other entities for various activities, but the State must make its process and criteria for selecting such subawardees and contractors clear to CMS. Note that the terms and conditions of federal awards generally flow down to subawards and subrecipients, as specified in 2 CFR 200.101(b)(1), and all awards (including funds subawarded) will be subject to any applicable provisions of 2 CFR Part 200 and 2 CFR Part 300 as well as the program-specific limitations outlined in page 18 -20 of the NOFO. As of October 1, 2025, HHS will adopt 2 CFR Part 200, with some modifications included in 2 CFR Part 300. These regulations can be found at 89 FR 80055 and replace those in 45 CFR Part 75 (see 89 *Fed. Reg.* 80055 (Oct. 2, 2024)).

Funding towards initiatives that are substantially similar to "Rural Tech Catalyst Fund Initiatives" as outlined in the NOFO cannot exceed the lesser of (1) 10% of total funding awarded to a State in a given budget period or (2) $20 million of total funding awarded to a State in a given budget period, and funding is subject to all restrictions and requirements described in the example initiative, including the $3 million cap on funds going to any one company.

33. For new technology and services purchased for a hospital, could RHT Program funds be used if there is a diagnosis related group (DRG) that covers the new technology but doesn't cover the full price?

RHT Program funds cannot be used to replace billable services, as this would be considered duplication (see page 43 of the NOFO). If the provision of new technology and services

results in uncompensated care, then RHT Program funds can be used to cover that care in accordance with the restrictions in the NOFO. All use of funds should be associated with comprehensive initiatives within the scope of the RHT Program. In addition, note that initiatives should be sustainable beyond the life of the program, so take into consideration the underlying nature of proposed use of funds (i.e. consider if use of funds are perpetual operating expenses with no path to a sustainable initiative after the end of the RHT Program).

34. Does the 15% cap on payments to providers just apply to health care services, or does the 15% cap apply to all subawards made to or contracts with providers?

Funding for provider payments, as described in Category B of the Program Requirements and Expectations use of funds section of the NOFO, are payments provided to healthcare providers for the provision of healthcare items or services. These payments cannot exceed 15% of the total funding CMS awards States in a given budget period.

35. If a State made investments in infrastructure in a community that support health and nutrition (e.g., outdoor play or exercise equipment or sidewalks) does that count towards the 20% infrastructure cap?

Yes, such expenditures would count towards the 20% cap and be subject to all restrictions stated in the NOFO related to capital expenditures (funding policies and limitations). Note that these expenditures must be a part of a comprehensive initiative that is clearly linked to program goals.
See pages 12 and 18-20 of the NOFO.

Costs for minor building alterations or renovations and equipment upgrades should be included in the appropriate budget category in the SF-424A and Budget Narrative (e.g., equipment in the equipment budget category, supplies in the supplies budget category). If States are unsure where to place the cost(s) and it does not obviously link to a budget category, they can include it in the "other" budget category.

36. If an entity besides the State purchases a building, could RHT Program funds be used to remodel the building for a specific purpose consistent with an approved RHT Program initiative? (e.g., closed nursing home remodeled to become a regional dorm for health care students/workforce and a regional training simulation center)?

Yes, as long as such remodels only include minor alterations or renovations. Allowable capital expenditures and infrastructure, as described in Category J of the Program Requirements and Expectations use of funds section of the NOFO, include investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions stated in the NOFO (funding policies and limitations). Note that these expenditures must be a part of a comprehensive initiative that is clearly linked to

program goals. See pages 12 and 18-20 of the NOFO.

37. Can the State fund renovations or subawards to support housing for training rural students or trainees in health care settings?

Funding for local housing for students or trainees in rural areas may be allowable if included as part of an approved initiative within the scope of the RHT Program. Note that payment for student or trainee housing is limited to short-term (less than 6 months) housing for rotations.

Use of funds for minor building alterations or renovations is subject to restrictions stated in the NOFO (funding policies and limitations) and must be clearly linked to program goals. See pages 12 and 18-20 of the NOFO for more information on funding limitations related to infrastructure and capital expenditures and NOFO page 117 for example rural talent recruitment initiatives.

38. Can a State subsidize the purchase of an EMR/EHR through a cooperative purchasing contract? The State wouldn't outrightly purchase the EMR/EHR, but would subsidize implementation and onboarding costs for a provider to join a cooperative purchasing agreement. Would that be subject to the 5% cap on replacement EMR/EHR systems?

The 5% limitation is for funding the replacement of an EMR/EHR system if a previous Health Information Technology for Economic and Clinical Health (HITECH) Act certified EMR/EHR system is already in place as of September 1, 2025. Replacement refers to the purchase of a new EMR/EHR system to take the place of an existing one. If funding is applied to the purchase and implementation of a new EMR/EHR system where no prior HITECH certified EHR system was in place, then the 5% cap on funding to replace an EMR/EHR system would not apply.

39. Could States put money in an innovation fund and then draw down those funds as the State identifies promising new ideas?

No. States must use funds awarded under this opportunity only for the permissible uses specified in the statute and described in the NOFO. As a condition of approval, the State's application must reflect that they will use awarded funds to invest in at least three of these permissible uses that are described in Section 71401 of Public Law 119-21 and in the Program Requirements and Expectations in the NOFO. States must also spend funds by the end of the fiscal year following the fiscal year in which they are awarded. See question V.2. for more information.

40. Can the State use funds for incentives for communities and other partners to perform certain activities? (e.g., Rural schools to adopt BH training curriculum for a certain % of staff; Communities to start physical activity or nutrition programs, etc.)?

States must use funds awarded under this opportunity only for the permissible uses specified in the statute and described in the NOFO. As a condition of approval, the State's application must reflect that they will use awarded funds to invest in at least three of

these permissible uses that are described in Section 71401 of Public Law 119-21 and in the Program Requirements and Expectations in the NOFO. Additionally, the State's application must include all required components as outlined in the application checklist (see NOFO page 26).

41. Are States allowed to utilize alternative asset managers to invest the Rural Tech Catalyst Funds into appropriate companies?

Per the NOFO, page 166 - 168, States may provide for the Rural Tech Catalyst funds to be managed by an office with deep health care expertise, health care company operating experience, and experience assessing early stage health care companies. This deep expertise and infrastructure should either already exist at the State level (e.g. an existing State-run startup funding vehicle) or be delegated from the State to a sophisticated strategic-aligned group (e.g. local health system startup incubator or payor startup incubator). States that intend to delegate to a non-State entity should select an entity that is associated with a strategic-aligned healthcare organization (e.g. health system, payor, academic institution, etc.). The process to select the non-State entity must be approved by CMS and should be transparent to avoid conflicts of interest.

Note that all funds Rural Tech Catalyst funds awarded to the State for this initiative must be paid directly to the end product developer(s) and **may not be used to pay for fund management activities.** State offices and non-State entities that are delegated with fund management activities **may not charge fees to the State for activities in connection with this initiative.**

Note that States cannot fund any vehicle resembling an investment fund that generates income as this produces profit/additional funds.

See response to V. 30 for additional information.

42. Can States fund subawards to individuals, either administered by the State or by a subrecipient entity, where the funds are provided to the individual for the purpose of clinical workforce training in connection with the individual's commitment to practice in rural areas?

Yes, as defined by the authorizing statute, allowable uses of funds include recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years. This can include awards to individuals for the purpose of funding their participation in training programs focused on a subject matter area considered part of the clinical workforce and tied to a commitment to serve in rural communities for a minimum of 5 years. Training programs could be run by organizations including but not limited to trade schools, community colleges, high schools, colleges, universities, technical institutes, and academic medical centers. Should educational and/or credentialing requirements that are prerequisites to clinical practice not be met or the 5 year service requirement otherwise not be

fulfilled, CMS reserves the right to recoup the funds.

Additionally, there are a number of other initiatives, as outlined in the NOFO, that States may consider for workforce talent recruitment, including (but not limited to) starting healthcare career pathway programs in high schools, funding new medical school or residency programs, and relocation grants for clinicians moving to rural communities for at least 5 years of services.

43. Can States issue student loans that would be repaid under the RHT Program? What about repayment of student loans?

No. Issuing direct student loans and funding student loan repayment programs are unallowable uses of RHT funds. These types of financial transactions fall outside the Program's scope of designing and implementing transformative initiatives.

The RHT Program is designed to foster sustainable, transformative programs aimed at long-term improvement in rural healthcare access and quality. As such, the intent of the program is to support systemic change, not to function as a direct lending or repayment institution.

As outlined in the authorizing statute, the focus must remain on developing comprehensive initiatives to recruit and retain clinical workforce talent to rural areas for the long term. Allowable activities are those that establish the systems and infrastructure needed for a sustainable talent pipeline, with commitments to serve rural communities for a minimum of 5 years. Some allowable uses of funds to develop the clinical rural workforce might include: funding partnerships with local schools or universities to create rural health career training tracks, creating a shared clinical supervision or mentorship network across multiple rural clinics to prevent burnout and support new recruits, developing programs for continuing medical education (CME) and clinical workforce professional development directly related to the 5-year service commitment.

44. If there are changes to Medicaid where previously covered services are no longer covered, can these funds be used to pay for services that may become non-covered?

Considerations for payment for previously covered services for Medicaid will be reviewed on a case-by-case basis. The RHT Program is intended to transform care in rural communities with strategic initiatives as described in the NOFO, not to fill gaps in budgets. The services in question must be within the scope of the RHT Program, clearly part of a more comprehensive initiative in the transformation plan, and should not be a perpetual operating expense cost that will reach a funding cliff and have no means of sustainability.

As with all uses of funds, States must ensure that such payments are part of a specific initiative, are aligned with the State's broader Rural Health Transformation Plan, will be sustainable beyond the life of the program, and are not duplicative of existing funding. Further, all uses of funds must comply with applicable

cost limitations, including the 15% cap on provider payments.

45. Can you please clarify whether this restriction on supplanting existing funding also applies to Indian Health Service (IHS) funding?

Applicants are restricted from using RHT funding on any project or initiative that is currently funded (or planned to be funded) via other sources. As outlined on pages 18 and 19 of the NOFO, funding cannot be used for services, equipment, or supports that are the legal responsibility of another party under federal, State, or tribal law; supplanting existing State, local, tribal, or private funding of infrastructure or services; or to replace or modify payment for items and services that could be reimbursed by insurance or another form of health coverage.

Like other federal grant programs, the RHT Program application must include a program duplication assessment which addresses all the requirements detailed in the NOFO (page 43) to ensure funding is not being used to pay for the same activities or providing the same services to the same beneficiaries as other funding sources or programs.

46. Can States offer incentives to attract clinical workforce to work in rural areas?

States can offer certain incentives to attract clinical workforce to work in rural areas provided the recipient of the incentive commits to working in rural areas for a minimum of 5 years, as required by statute. States should be clear on why the incentive is needed for their specific rural context. Examples of incentives that could be allowed, with State justification and approval by CMS, include relocation expenses; a subsidy to travel back and forth between an approved work location and a family home at a defined periodicity (e.g., “home leave”); transit costs, per diem, and lodging to work at an approved rural work site on a short-term basis (e.g., visiting one rural location from another rural location on a weekly or monthly basis); childcare subsidy; recruitment incentive; retention incentive. As with all funds, the incentive should be clearly tied to an approved use of funds category.

47. Can States renovate an existing space to make childcare available for the clinical workforce?

States can renovate an existing space to establish a childcare center for children of the clinical workforce as a way to recruit and retain the clinical workforce in rural areas. The State must justify why such a need exists in the specific rural site proposed; CMS approval is not guaranteed. As a reminder, new construction is not allowed. Minor alterations and renovations are also capped at 20% of the total award. The State can also pay for start-up costs such as licensure, staff training, and equipment.

48. For the purposes of the non-supplanting requirement, how does CMS define "current or existing funding"? What is the specific baseline States should use to ensure RHT Program funds are not replacing other available funds?

RHT funding is designed to support expansion and scale to better serve rural communities. Funds may not be used to duplicate or supplant

current federal, State, or local funding. Thus, using RHT Program funds to replace State funds for an existing program would be unallowable. Adding to an existing program may be an allowable use of funds. States must ensure funds are not being used to pay for the same activities or provide the same services to the same beneficiaries as other State or federal funding sources or programs. When a State uses RHT funds to expand an existing pilot program or initiative, the funds may only be applied to the costs associated with the new population, new activities, and new milestones. The original program's programmatic costs, administrative expenses, and activities—those already funded by the State or existing fiduciaries—must continue to be funded by those original sources. Further, States must explain how such funding would build upon current State and Federal programs and initiatives while avoiding duplication.

49. Can States fund Graduate Medical Education slots with these funds? Such as residencies and internships?

Applicants are restricted from using RHT funding on any project or initiative that is currently funded (or planned to be funded) via other sources. When part of an approved initiative, funds may be used in support of expansion of an existing program, so long as the Rural Health Transformation funds are being used only for the new parts of the program, new population, new milestones, new activities, etc. Any parts of the existing program would need to be continued through the original funding source. Applicants need to make sure that the work and initiative are not the same exact activities being performed on the same beneficiaries as other programs and ensure that there are internal controls in place to avoid program duplication.

Like other federal grant programs, the RHT Program application must include a program duplication assessment which addresses all the requirements detailed in the NOFO (page 43) to ensure funding is not being used to pay for the same activities or providing the same services to the same beneficiaries as other funding sources or programs.

50. Can food costs be covered for community meetings for programming related to outcomes of the grants in the program (Use of Funds (3))?

Funding meals, including food costs for community meetings, is not an allowable use of funds.

51. If this funding is used to expand access to trainings, any individual taking a one-off training or a training series or a single course, is held to a five-year commitment?

As defined by the authorizing statute, allowable uses of funds include recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years. These initiatives will be reviewed on a case-by-case basis, but generally, the 5-year commitment applies to individuals who attain additional abilities or certifications/degrees to fulfill a career in the rural health care setting. Generally, non-degree courses or training sessions would not be held to a 5-year commitment.

52. Is "special purpose equipment," like CT scans or x-rays, classified under Category J funds (infrastructure cap)? Or can initiatives include the equipment (e.g., next generation mobile clinics) without tapping into those funds?

Special purpose equipment including CT scans and x-rays may be classified as equipment within the Standard Form 424-A and the budget narrative and are not subject to the Category J infrastructure cap if the equipment is not part of investment in an existing rural health care building and infrastructure to ensure overhead and upkeep are commensurate with patient volume.

Note that HHS now uses the definitions for equipment and supplies in 2 CFR 200.1. The new definitions change the threshold for equipment to the lesser of the recipient's capitalization level or $10,000 and the threshold for supplies to below that amount. For more information and examples to guide capture of special purpose equipment within the budget request and narrative, see the CMS Guidance for Preparing a Budget Request and Narrative webpage (https://www.cms.gov/about-cms/work-us/cms-grants/cooperative-agreements/how-apply-cms-grants/cms-guidance-preparing-budget-request-and-narrative).

53. Can States have a scholarship program where they enforce a residency obligation by imposing debt if the provider does not work in a rural part of the State long enough?

No. States generally may not earn any income from federal programs, including by imposing a debt. States should consider alternative evaluation and enforcement mechanisms, such as paying the scholarships out on a yearly basis and funding being forfeited for any years of service not completed, with the condition that any funds forfeited are reinvested in that specific initiative in the State's Rural Health Transformation plan more generally, or returned to the U.S. Treasury.

54. Can States pay for fuel stipends for rural patients while establishing other transportation strategies?

Gas costs are allowable. If recipients wish to revise their award for any reason, they must submit a prior approval request. If a State knows what transportation strategy it will be establishing, they can say in their plan that they will pay fuel stipends in the interim, so they do not have to revise their award.

55. Can funding be used for demolition costs of aged buildings?

This grant cannot be used for demolition activities. Such activities are considered construction or major renovation, which are not allowed under this program.

56. Are communications technology/equipment for individuals that are deaf or hard of hearing considered consumer-facing devices?

Yes, they are considered consumer-focused devices.

57. Can States carry funds for activities that haven't been completed from one budget period to the next?

States cannot carry funds from one budget period to another. However, states have approximately two fiscal years to spend funds awarded for each budget period. This means a state will apply with an outlined budget for each budget period and they will have access to that money for an additional fiscal year to complete the approved activities. A grantee can only pay for expenses that have been approved for the budget period outlined in the application over those two fiscal years. No new activities for the second year can be proposed once the budget period ends, but the grantee can still access the funds in the fiscal year following the budget period to pay for activities in the approved in the original application.

For example, consider the scenario where a state is awarded funding for the Budget Period 1, December 31, 2025 – October 30, 2026, to implement an initiative that will take 18 months to complete. In this scenario, the state would have access to the funding after the Year 1 budget period ends on October 30, 2026, to pay the contractor for those services until the end of the next fiscal year on September 30, 2027. That means if the contractor did work from January to June 2027, and that work was an approved activity for Budget Period 1, the state could pay for those costs incurred in January-June 2027 from Budget Period 1 funds.