



Rural Community Health Integration

Funding Guidance

Questions and Answers

July 2, 2026

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Questions below were received by the deadline announced in the Rural Community Health Integration guidance. New York State Department of Health is not responsible for any errors or misinterpretation of any questions received.

The responses to questions included herein are the official responses by the State to questions posted by potential bidders and are hereby incorporated into the **Rural Community Health Integration guidance and application documents**. In the event of any conflict between the guidance and application documents and these responses, the requirements or information contained in these responses will prevail.

Eligibility by County/ Location

Q1. A Lead Applicant must be “located in” the counties for which it applies. Does that require that its headquarters be inside the counties in the application, or is primary service area sufficient?

Response: Refer to Funding Guidance, Eligibility which specifies that the Lead Applicants must be *eligible entities located in counties defined as rural...and listed in Attachment 1*. Physical presence or legal domicile within an eligible county is required. For multi-county applications, the Lead Applicant must be located in at least one eligible county.

Q2. Are entities whose mission is to serve eligible counties in NYS but who are not located in those counties eligible to apply as lead applicant for this RCHI funding?

Response: Please see Q1

Q3. Can a hospital without a location in a specific county be the lead applicant for that county where they do not provide hospital-based services?

Response: Please see Q1

Q4. Does "located" in a rural county mean having a physical address in one of the listed counties or can organizations who have a demonstrated history and/or requirement to serve those counties apply as a lead organization?

Response: Please see Q1

Q5. The Funding Guidance states that the Lead Applicant must be 'an eligible entity located in counties defined as rural in New York's Rural Health Transformation Program application and listed in Attachment 1 of the Funding Guidance.' Does this

requirement mean that the Lead Applicant's physical office address must be within a county listed in Attachment 1?

Response: Yes.

Q6. If the lead applicant must be “located” in an eligible rural county, does this require a physical presence, or is it sufficient to serve patients or provide services in that county?

Response: Physical presence is required.

Q7. The funding guidance requires that the Lead Applicant be located in a county defined as rural and listed in Attachment 1. If a Federally Qualified Health Center (FQHC) operates a satellite facility or service site in an eligible county, but its primary/administrative office is located outside the eligible county list, does the FQHC satisfy the location requirement based on its satellite site presence? I

Response: Refer to Funding Guidance, Eligibility which specifies that the Lead Applicants must be *eligible entities located in counties defined as rural...and listed in Attachment 1*. Physical presence or legal domicile within an eligible county is required. Satellite site presence does satisfy the location requirement, but the satellite site must be the Lead Applicant, not the primary/administrative office that is located in an ineligible county.

Q8. Under the RFA, the “Lead Applicant” must be “an eligible entity located in counties defined as rural in New York's Rural Health Transformation Program application and listed in Attachment 1.” For purposes of this requirement, would an entity qualify if they have a satellite site in an eligible county or if an eligible county is included in the applicant's service area?

Response: Please see Q7

Q9. The guidance states Lead Applicants must be eligible entities located in counties defined as rural in Attachment 1. If the implementation project will serve some or all counties defined as rural in Attachment 1, please clarify if the Lead Applicant can be located in one of these counties to meet the requirement, assuming that at least one partner is located in each of the other counties to be served.

Or is it sufficient that the organization's service area encompasses one or more eligible rural counties, and it can demonstrate a documented history of serving rural residents in those counties?

Response: Please see Q1

Q10. How will a lead application be assessed if they care for a population in a rural county but are not physically located in that county. If a lead applicant wants to apply for multiple counties, must they be physically located in each county they will apply for? This may significantly impact who can be the lead applicant and if multi-county applications are feasible. How will Rural Health Networks, IPAs or other convening entities be evaluated in these scenarios, when they likely only have one physical location?

Response: Please see Q1

Q11. Can partner organizations be in an ineligible county if they are supporting the activities of the lead applicant in the eligible county?

Response: Yes

Q12. For purposes of determining eligibility, does the lead applicant, required hospital partner, and/or nonprofit partner need to be legally domiciled or headquartered in an eligible rural county, or is eligibility satisfied if the proposed project serves residents of one or more eligible rural counties? For example, if the application includes a hospital facility located in an eligible rural county and a partner that provides services or implementation support in those counties, but is headquartered outside those counties, would it be eligible?

Response: Partner Organizations must serve residents in the eligible rural counties but are not required to be physically located in one.

Q13. Can a hospital system that is based in Pennsylvania (PA) be a lead or partner applicant? If the hospital system is based in PA but operates a hospital in a NYS eligible county, can that hospital (in the eligible county) be the lead or partner applicant?

Response: The applicant may have a legal address in another state/location but the applicant must be the hospital/clinic site that is located in the qualifying county. Funding must be directly to qualifying sites and cannot go through parent organizations or sites that are not located in eligible counties.

Q14. Can a lead applicant have a legal address in another state/location, but have an office or facility in a qualified county or would they not qualify based on their legal main address? For example: Our health system is located in PA, but we have a hospital/clinical sites in a qualified county or should the hospital itself be the registered entity?

Response: Please see Q13

Q15. On the attached application, Yates County, is not listed as an eligible county. It should be. Can you please confirm?

Response: Yates County is eligible. This was corrected in the Funding Guidance.

Q16. Please confirm if all of Columbia and Ulster Counties are covered under the designated PCA for this RFP, and if Ulster County is officially designated as a rural area for grant purposes.

Response: Refer to Funding Guidance, Attachment 1 which lists both Columbia and Ulster Counties as eligible rural areas for this RFP.

Q17. Are we permitted to form multi-county partnerships to serve the eligible rural area if the partners themselves are outside of the rural area?

Response: Yes.

Q18. Can partner organizations, clinical operations partners, technology partners, or subcontracted implementation partners that are not physically located in an eligible rural county participate in, support, or be paid under an RCHI-funded project if their work directly benefits eligible rural counties and participating rural hospitals?

Response: Yes, partners and subcontractors not physically located in an eligible rural county can participate if their work directly benefits the eligible rural counties and participating rural hospitals, and aligns with project goals.

Q19. Page 2 and Attachment 3 of the guidance state, "At least one hospital located in the counties listed in Attachment 1 is included in the application." A. Not all counties listed in Attachment 1 have hospitals within them. Is it allowable for a project focused on an eligible county to partner with a hospital in another county as long as the chosen hospital is located in a county listed in Attachment 1? B. Is it allowable for a project focused on an eligible county to partner with a hospital in another county as long as the chosen hospital is located in a county listed in Attachment 1 even if there IS another hospital located in the county on which the application is focused? C. Many rural hospitals are now affiliates of larger hospital systems. If an applicant is partnering with an affiliated hospital, is the applicant required to actively partner on the grant with the larger hospital system to meet this eligibility requirement, or is it enough to partner with the local affiliate hospital alone? D. Can a single hospital be a partner on multiple grants?

Response: A. Yes. B. Yes. C. It is sufficient to partner with the local affiliate hospital. D. Yes.

Q20. Page 2 and Attachment 3 of the guidance states, "Lead Applicant is an eligible entity located in counties defined as rural in New York's Rural Health Transformation Program application and listed in Attachment 1 of the Funding Guidance." A. Must an applicant/Lead organization be physically located in the county listed in their application, or can serving the county (even if physically located elsewhere) count as being located there? B. If the application includes multiple counties, must the applicant/Lead organization have a physical location in EACH of the counties listed in their application? C. Does a mobile service presence or placing staff within partner agencies to provide services count as having a physical location in a county? D. If the application includes multiple counties, and the applicant has a single physical location in just one of the included counties, can partners located in the other included counties meet this requirement?

Response: A, B, D Please see Q1 C. No

Q21. If we propose to serve up to three eligible counties, but only have a hospital in one county with primary care sites in the other two, is this allowable?

Response: Yes, this is allowable as long as at least one hospital located in an eligible county (Attachment 1) is included in the application. The project can serve multiple eligible counties.

Q22. Does the statement below mean any one hospital that is physically located in any of the eligible counties can be included in an application? At least one hospital located in the counties listed in Attachment 1 is included in the application.

Response: Yes, refer to Funding Guidance, Eligibility which *requires at least one hospital located in the counties listed in Attachment 1 is included in the application.*

Q23. Can counties NOT listed in Attachment 1 be included in the application as long as 1 or more counties from Attachment 1 are also included?

Response: Yes, the counties not listed in Attachment 1 may be involved if their participation contributes positively to achieving RHTP goals.

Q24. Can a hospital system be a lead applicant, or does it have to be a specific hospital? If yes, please describe a viable, potential arrangement if the hospital system, as the lead or partner applicant, does not have any hospitals in the area where it intends to engage the other stakeholders?

Response: Refer to Funding Guidance, Eligibility which states in part that the *Lead Applicant is an eligible entity located in counties defined as rural in New York's Rural Health Transformation Program application and listed in Attachment 1*. The lead applicant must be an eligible site that is located in a qualifying county. Funding must be sent directly to qualifying sites and cannot go through parent organizations or sites that are not located in eligible counties.

Q25. Not all counties listed in Attachment 1 have hospitals within them. Is it allowable for a project focused on an eligible county to partner with a hospital in another county as long as the chosen hospital is located in a county listed in Attachment A?

Response: Yes.

Other Eligibility Requirements for applicants

Q26. Can a long-term care provider serve as the Lead Applicant while partnering with a hospital, and are long-term care provider-led applications evaluated equally to hospital-led applications?

Response: Refer to Funding Guidance, Eligibility which states in part:

Lead Applicants must meet the following minimum qualifications by completing the Attestation in Attachment 3 and submitting it with application.

- *Lead Applicant is a registered not-for-profit 501(c)(3) organization or municipal hospital.*
- *Lead Applicant has a three-year or more history of regulatory compliance including adherence to Department rules and other direction.*
- *Lead Applicant is an eligible entity located in counties defined as rural in New York's Rural Health Transformation Program application and listed in Attachment 1.*
- *Funded projects will be completed by June 30, 2027.*
- *At least one hospital located in the counties listed in Attachment 1 is included in the application.*

and

Eligible Lead Applicants and Partner Organization(s) include but are not limited to the following... Long-term care providers.

Long Term Care providers that meet eligibility requirements are welcome to apply as the Lead Applicant. Applications will be evaluated based on eligibility, project merits, and alignment with RHTP goals.

Three - Year Regulatory Compliance

Q27. How will the three-year regulatory compliance history be evaluated (e.g., treatment of minor vs. significant findings)?

Response: An applicant may demonstrate regulatory compliance by indicating a verifiable record showing continuous adherence with Department Rules and Regulations and other appropriate standards. Compliance history will be reviewed individually and will consider the nature, severity, and circumstances of any citation or issue. A single citation within the prior three years will not automatically disqualify a Lead Applicant. The intent of this requirement is not to exclude otherwise qualified applicants, but rather to assess an organization's demonstrated ability to administer the project in a manner that complies with all applicable regulatory requirements, Department rules, and directives.

Lead Applicants must sign and submit the attestation on Attachment 3 of the Funding Guidance.

Q28. The RFP requires a three-years history of regulatory compliance or more. We recently created an affiliation between Northwinds Integrated Health Network IPA and Omnes IPA, but both entities were founded in the original BHCC cohort in 2017 and retain the same TINs and corporate statuses. Does Omnes IPA, as a 501c3, qualify under this eligibility criteria?

Response: Please see Q27

Q29. Page 2 and Attachment 3 of the guidance state, "Lead Applicant has a three-year or more history of regulatory compliance including adherence to Department of Health rules and other direction." A. How is a "history of regulatory compliance" defined in this case? B. Does an organization need to have 3 or more years of experience directly contracting with NYS DOH to be eligible to apply, or can other compliance experience fully or partially meet this requirement? For example, can experience with other government or private funders, regulators, or contract offerors count? Does compliance experience from DSRIP projects, Social Care Network projects, and/or value-based payment arrangements and projects count? C. Must an organization have 3 or more years of health-related compliance to be eligible to apply, or can compliance in other topic areas count toward the requirement?

Response: Please see Q27 and Q30

Q30. The eligibility requirements reference a "three-year or more history of regulatory compliance including adherence to Department of Health rules and other direction." For nonprofit organizations organized as 501(c)(3) entities, how should this requirement be interpreted? Does the requirement apply only to organizations that hold healthcare facility licenses or provider certifications, or can it also be demonstrated through a nonprofit organization's history of compliance with Department of Health oversight, contractual requirements, grant requirements, EMS program requirements, and other applicable state and federal regulations?

Response: This may be demonstrated through a not-for-profit organization's history of compliance.

Q31. In the lead applicant eligibility requirements, the guidance states that the Lead Applicant must have a three-year or more history of regulatory compliance including adherence to Department of Health rules and other direction. Is regulatory compliance referred to broadly such as organizational regulatory compliance or specifically to licensed healthcare facility/provider compliance. Would a nonprofit organization that has a long history of NYSDOH grant administration with state and federal grant compliance qualify as a lead applicant even if that organization is not a healthcare provider, facility, or public health organization?

Response: Yes.

Q32. Would a 501(c)(3) organization with a longstanding history of the Department of Health-funded and regulated programs meet this requirement?

Response: Please see Q27 and Q30

Lead Applicant/Partner Organizations Questions

Q33. Can two or more rural hospitals or eligible organizations co-apply as joint Lead Applicants or must there be a single designated Lead Applicant with other hospitals participating as Partner Organizations?

Response: Refer to Funding Guidance, Eligibility which specifies a single Lead Applicant per application. Other eligible organizations, including hospitals, would participate as Partner Organizations.

Q34. Can there be two primary applicants?

Response: Please see Q33

Q35. Will the partnerships formed in this first initiative be eligible to apply for funding for the other initiatives in the future?

Response: Yes.

Q36. Are partners allowed to participate in budget periods 2-5 if they participate in budget period 1?

Response: Yes, it is likely that partners who participated in Budget Period 1 can continue to participate in subsequent budget periods, assuming their roles align with the project's evolution and funding availability.

Q37. Can a single application cover multiple counties with a single governance structure?

Response: Yes, multi-county applications are permitted, and a single governance structure may be appropriate for such an application.

Q38. Are there limits on the number of partner organizations included in an application?

Response: There is no limit on the number of partner organizations; the application should demonstrate a clear rationale for each partner's involvement.

Q39. Are there limits on the number of partner organizations included in an application?

Response: Please see Q38

Q40. What methodology did NYS DOH use to determine eligible counties for rural designation? Are awardees expected to serve the entire county, or just those zip codes that are determined to be rural?

Response: Please see the Department's application for funding at https://health.ny.gov/facilities/transforming_rural_healthcare/

Q41. Is it a requirement that each county applied for has a hospital located/based in that county as a partner?

Response: The minimum qualifications require a hospital be included in the application.

Q42. Will every 47 rural counties receive a planning grant?

Response: An application must be submitted that meets all minimum qualifications to be considered for a planning grant.

Q43. Can there be more than one planning grant per county?

Response: As stated in the Funding Guidance, page 3, Project Scope – Planning, *providers are encouraged to collaborate to maximize the use of these funds for planning. Multiple applications for planning funds from the same county will either be asked to collaborate or awards will be reduced accordingly.*

Eligibility by Institution Type

Q44. Can a provider (e.g. CCBHC) apply through multiple applications where another organization is the Lead?

Response: Yes.

Q45. Is it permissible to include a payer as a Partner Organization?

Response: Yes.

Q46. Can a health plan be the primary applicant?

Response: Refer to Funding Guidance, Eligibility which states in part:

Lead Applicants must meet the following minimum qualifications by completing the Attestation in Attachment 3 and submitting it with application.

- *Lead Applicant is a registered not-for-profit 501(c)(3) organization or municipal hospital.*
- *Lead Applicant has a three-year or more history of regulatory compliance including adherence to Department rules and other direction.*
- *Lead Applicant is an eligible entity located in counties defined as rural in New York's Rural Health Transformation Program application and listed in Attachment 1.*
- *Funded projects will be completed by June 30, 2027.*
- *At least one hospital located in the counties listed in Attachment 1 is included in the application.*

Health plans that meet the eligibility requirements can be the lead applicant.

Q47. Can you confirm whether lead applicants must have 501(c)3 status or be a municipal hospital? This is stated on page 2, however, below that, there is a list of "Eligible Lead Applicants and Partner Organizations" which includes entities that typically do not have 501(c)3 status (e.g., county health departments, EMS providers).

Response: Refer to Funding Guidance, Eligibility which states in part that *Lead Applicants* must be a *registered not-for-profit 501(c)(3) organization or municipal hospital*. While county health departments and EMS providers are listed as *eligible Partner Organizations*; they would need to meet the Lead Applicant criteria to apply as a Lead Applicant but would not need to have 501(c)3 status to be a Partner Organization.

Q48. The eligibility criteria for a lead applicant in the guidance document states that the applicant must be a “registered not-for-profit 501(c)(3) organization or municipal hospital.” Article 28 defines a public hospital to mean a 'general hospital operated by a county, municipality, or public benefit corporation.' Are hospitals operated by a public benefit corporation excluded from being eligible as a lead applicant? Or is the term “municipal hospital” in the guidance intended to include the types of hospitals that are recognized as “public hospitals” under Article 28?

Response: The term "municipal hospital" in the guidance includes public hospitals operated by a county, municipality, or public benefit corporation.

Q49. The Eligibility section (Funding Guidance, p. 2) requires "at least one General Hospital or Rural Emergency Hospital," while the eligible-entity list (pp. 3-4) and the Attestation (Attachment 3) reference "at least one hospital." Do Critical Access Hospitals, sole community hospitals, and safety-net hospitals satisfy the hospital-participation requirement?

Response: Refer to Funding Guidance, Eligibility which states in part: *Hospitals including safety net hospitals, general hospitals, sole community hospitals, rural emergency hospitals, and critical access hospitals*; any of these entities would satisfy the hospital-participation requirement.

Q50. The RFA requires that at least “one hospital located in the counties listed in Attachment 1 is included in the application.” Does this use of the term "hospital" in statement refer to “general hospitals,” or “hospitals,” as defined in the Public Health Law?

Response: Please see Q49

Q51. Can an Ambulatory Service Center that does not have an ASC in a county apply to be a partner and/or the lead?

Response: Refer to Funding Guidance, Eligibility which states in part: *Primary care or multi-specialty practices* as eligible Partner Organizations. An ASC could fall under this category if its services align with the program's goals.

Q52. The guidance lists eligible Partner Organization types but does not specifically reference ambulatory infusion centers. Are freestanding multi specialty physician ambulatory infusion centers eligible to participate as Partner Organizations?

Response: Refer to Funding Guidance, Eligibility which lists *Primary care or multi-specialty practices* as eligible Partner Organizations. A freestanding multi-specialty physician ambulatory infusion center could fall under this category if its services align with the program's goals.

Q53. For a health system with multiple affiliated hospitals, can individual hospitals apply as separate lead applicants, or will applications be evaluated at the health system level (e.g., subject to a system-level cap)?

Response: Individual hospitals may apply as separate lead applicants if they meet all minimum eligibility requirements.

Q54. We are seeking clarification on a potential conflict between two sections of the guidance. The Eligibility section explicitly lists Federally Qualified Health Centers (FQHCs) as eligible Lead Applicants, and the CHCANYS summary of the guidance confirms that FQHCs may serve as Lead Applicants or Partner Organizations. However, the Attestation (Attachment 3) requires the Lead Applicant to attest that "at least one hospital located in the counties listed in Attachment 1 is included in the application," and the Eligibility section states that the application must include "at least one General Hospital or Rural Emergency Hospital."

Response: A hospital located in the counties listed in Attachment 1 must be included in the application. The hospital does not need to be the Lead Applicant.

Q55. Can a County Public Health Department serve as the Lead Applicant?

Response: Refer to Funding Guidance, Eligibility which states in part:

Lead Applicants must meet the following minimum qualifications by completing the Attestation in Attachment 3 and submitting it with application.

- *Lead Applicant is a registered not-for-profit 501(c)(3) organization or municipal hospital.*
- *Lead Applicant has a three-year or more history of regulatory compliance including adherence to Department rules and other direction.*
- *Lead Applicant is an eligible entity located in counties defined as rural in New York's Rural Health Transformation Program application and listed in Attachment 1.*
- *Funded projects will be completed by June 30, 2027.*
- *At least one hospital located in the counties listed in Attachment 1 is included in the application.*

County Public Health Departments that meet the outlined criteria can be Lead Applicants.

Q56. Can the county be a lead applicant for a planning grant?

Response: Please see Q52

Q57. Funding Guidance strongly encourages inclusion of County Public Health Departments as Partner Organizations. If the project is hospital-led, what form of County Public Health Department participation is sufficient: formal partner status, MOU, letter of support, participation in governance, CHNA alignment, community engagement role, or another form of documentation?

Response: While County Public Health Department inclusion as a Partner Organization is strongly encouraged it is not required.

Q58. Is it permissible for a 501c3 community-based provider to serve as the lead applicant across multiple counties, with one hospital partner whose service area includes these counties?

Response: Yes, a 501c3 community-based provider may serve as the lead applicant across multiple counties with one hospital partner whose service area includes these counties, as long as all minimum eligibility requirements are met.

Q59. I would greatly appreciate the opportunity for a brief call to ensure that we're approaching potential hospital partners in the intended way.

Response: NYSDOH has allowed for questions submission, as well as opportunities to attend program presentations; direct calls to applicants are not currently possible.

Q60. Can another not for profit be a lead for a planning grant?

Response: Yes, a registered not-for-profit 501(c)(3) organization can serve as a Lead Applicant, provided it meets all minimum eligibility requirements.

Q61. Are Certified Home Health Agencies, Licensed Home Care Services Agencies, medical model Adult Day Health Care, Medicaid assisted living programs, aging services providers, and other community-based organizations eligible partners to deliver health care and services under this RFA?

Response: Yes, the Guidance's eligibility section lists "other community-based organizations" as eligible Partner Organizations.

Project Eligibility

Q62. Can a hospital located in a designated rural county, provide services to a rural area within a county that is not RHTP designated? In other words, to be served by this grant, does a rural area have to be located within a RHTP designated county?

Response: Hospitals are expected to serve their entire patient population. For the purpose of this grant projects should focus on eligible counties.

Q63. In Niagara County there are at least four census tracts that are designated as rural by the Census Bureau. However, Niagara County as a whole is not designated as a rural county. Is it possible for a hospital located within a designated rural county to provide services to census tracts that are designated as rural, but are located in a county (i.e. Niagara) that is designated as an urban county?

Response: Please see Q62

Q64. Are planning projects a prerequisite for implementation project applications, or are planning projects intended primarily for counties that require additional time to develop implementation strategies beyond June 30, 2027?

Response: Planning projects are not a prerequisite for implementation applications. However, they are intended to support the development of implementation-ready plans and may be particularly beneficial for counties needing more time for strategy development.

Q65. The guidance states that activities must be either entirely new or expansions of existing programs. Can DOH provide examples of what qualifies under each category, and how will supplanting be determined – including what documentation applicants should provide to demonstrate that proposed activities are new or expanded?

Response: Applicants should outline current activities and how funding will be used to either expand existing programs or fund new initiatives.

Q66. Can the Department clarify what qualifies as a "transformational investment" vs. incremental program expansion, and what level of impact or system change is expected for a project to be competitive under that definition?

Response: A transformational investment is a project that changes how the rural health system functions, creates new capabilities, or strengthens partnerships in a way that delivers lasting, system-level impact.

An incremental expansion adds staff, capacity, or services within an existing model and does not shift the system on its own.

To be competitive, projects should show system-level change, cross-organization impact, and a path to long-term sustainability aligned with RHTP's transformation goals.

Q67. Can implementation projects build on existing initiatives if they represent a significant expansion?

Response: Yes.

Q68. How does DOH view community paramedicine programs within the context of the RCHI funding opportunity? Would community paramedicine initiatives be considered eligible uses of funding?

Response: All funded activities must relate to transformation of the rural health system. The Department is unable to comment on the merits of specific projects before applications are submitted.

Q69. The prohibition on telecommunications and video surveillance equipment may limit certain remote patient monitoring and home-based care models. Can DOH clarify whether technologies necessary to support telehealth, remote monitoring, or virtual care delivery would be considered eligible?

Response: Please see Q290

Q70. Can remote patient monitoring be used for chronic disease management and behavioral health?

Response: Please see Q68

Q71. Can workforce training include certification programs?

Response: Please see Q280

Q72. Will behavioral health integration in a long-term care setting be eligible for prioritization? (See P.5 of Application Guidance)

Response: All funded activities must relate to transformation of the rural health system. The Department is unable to comment on the merits of specific projects before applications are submitted.

Q73. Are newly formed collaboratives or networks eligible to serve as Lead Applicant if their member organizations meet eligibility criteria?

Response: A collaborative or network must meet the Lead Applicant criteria . If it does not, it would need to designate a member organization that meets the criteria as the Lead Applicant.

Q74. Can a single organization serve as Partner (or Lead Applicant) on more than one application, and is there any limit on the number of applications in which one organization may participate – or on how many as Lead vs. Partner?

Response: Yes. There is no limit.

Q75. If multiple applications are submitted within the same county, how will the Department determine whether applicants must merge vs. compete independently? Does the "collaborate or reduce" provision for multiple planning applications also apply to implementation projects, and how will two applications that each include the same county within a larger multi-county footprint be reconciled?

Response: The Department will reconcile this during the review process.

Q76. How is an organization that participates as a Partner across several distinct county or regional applications evaluated for review and award – should other its applications be referenced within each application, or are its activities and costs assessed independently within each application?

Response: Activities that relate to other transformation plans should be referenced.

Q77. The guidance strongly encourages including County Public Health Departments. What level of County Public Health Department (and County DSS) involvement is expected, and does formal partner status strengthen an application relative to a letter of support?

Response: Please see Q57

Q78. Can a single hospital participate in multiple applications across different county collaboratives?

Response: Yes.

Q79. For projects addressing Hospital-Wide All-Cause Unplanned Readmissions, are interventions occurring after discharge from post-acute care settings eligible when the objective is to reduce subsequent hospital utilization?

Response: Yes, interventions targeting post-discharge care are eligible.

Q80. Can transitional care initiatives include multiple transitions across the continuum of care (e.g., hospital, post-acute care, and community settings) when designed to reduce hospital readmissions and improve care coordination?

Response: Yes, initiative including multiple transitions across the continuum of care are eligible.

Q81. Can we include collaborative partnerships with other entities, such as Columbia Green for lab technician support, to expand specialty telehealth access? Can Telehealth projects (e.g., Teleradiology, Telestroke) be submitted as standalone specialty-access initiatives, or is packaging with broader infrastructure components preferred/required?

Response: Collaborative partnerships with other entities may be included as either standalone initiatives, or as part of a broader plan.

Q82. On Pg 2 and Pg 5, colorectal screening is listed as the measure for increasing preventive care spanning primary and specialty care. Will applications be considered that address other outcomes of this increased access or must it focus on colorectal screening for area #3.

Response: Applications that address other outcomes as well may be considered.

Q83. Which projects are appropriate for consideration in this first round. For example, if a cyber security, technology investment or workforce project can be accomplished within the timeframe, is that appropriate to include in this first cycle, or would that be something that is more appropriate for budget periods 2-5?

Response: Any project that meets the requirements, including completion by June 30, 2027, and aligns with project goals is appropriate.

Q84. Is startup of a community garden (raised beds, plants, water, etc) an eligible implementation project? Even though the produce would not be ready until after 6/30/27, all of the expenses would be incurred by that date, and the garden established.

Response: This is an eligible implementation if it contributes to positively achieving RHTP goals.

Q85. Confirm that dental service expansion is eligible under Implementation.

Response: Dental service expansion is an eligible project for an implementation application should all other eligibility requirements also be met.

Q86. Are there rural populations of interest outside of the 3 indicated in the application (behavioral health, substance use prevention, and maternal health)?

Response: Please see Q87

Q87. Is NYS DOH open to applications that focus on sub-specialty populations?

Response: Applications that focus on sub-specialty populations will be considered.

Q88. Is NYS DOH open to applications exclusively focused on rural behavioral health populations?

Response: Application projects exclusively focused on rural behavioral health populations will be considered.

Q89. While applications are at the county level, can proposed interventions target sub-county populations or priority geographies?

Response: Yes.

Q90. Is a data-dive/assessment of suicide statistics an eligible implementation project?

Response: This may be an eligible project but may be more appropriate as a planning activity.

Q91. Can a hospital-led application include non-hospital partners such as specialty provider organizations, telehealth implementation partners, FQHCs, behavioral health / SUD providers, EMS providers, regional referral partners, IPAs, rural health networks, and County Public Health Departments, with defined roles in the project budget and workplan?

Response: Yes, hospital-led applications can and should include non-hospital partners with defined roles, as this demonstrates a collaborative approach and comprehensive strategy.

Q92. What happens if providers collaborate in a county and want to apply for a planning grant, but there is not a willing hospital partner to serve as lead or partner applicant?

Response: The minimum qualifications require a hospital be included in the application.

Q93. Would the development of a Community Paramedicine program be considered as part of a planning application?

Response: The Department is unable to comment on the merits of specific projects before applications are submitted.

Q94. The Funding Guidance states that applications addressing behavioral health integration and substance use disorder prevention will be given priority. Would an ED / inpatient telepsychiatry pathway focused on crisis evaluation, behavioral health boarding reduction, withdrawal / agitation support, disposition planning, and connection to local behavioral health partners qualify under this priority area if it includes baseline measures and improvement targets?

Response: This project will be considered. The Department is unable to comment on the merits of specific projects before applications are submitted.

Deadlines

Q95. Will the state have any opportunity to revise the schedule for grant implementation? The deadline for applications is only two weeks after answers are posted, and awards and contract approvals are often delayed. Budget Period 1 contract period begins on September 1, 2026 and ends on June 30, 2027.

Response: The deadline for applications has been extended to July 14, 2026. Budget Period 1 contract dates will not change.

Q96. What are the dates for question submissions and application submissions. The DOH announcement and the NYS Contract Reporter have conflicting dates.

Response: Questions were due June 18, 2026, and applications are due July 14, 2026.

Q97. Questions are due June 18, responses will be posted on June 25, and applications are due July 9. Given the limited timeframe between the release of responses and the application deadline, particularly with two federal holidays occurring during the application period, will DOH consider providing flexibility regarding application deadlines, required documentation, or partnership commitments?

Response: Questions are were June 18, 2026, and applications are due July 14, 2026.

Q98. According to documents posted on the DOH website, applications are due on July 9th, and questions must be received by June 18th, with answers expected to be posted by June 25th. According to the same documents posted in the NYS Contract

Reporter, applications are due on July 8th, and questions must be received by June 17th. Would it be possible for you to issue a clarification?

Response: Questions were due June 18, 2026, and applications are due July 14, 2026.

Q99. I am writing to alert you that the dates on the documents for the RCHI are different based on the download site. Can you please clarify the date the questions are due?

Response: Questions were due June 18, 2026, and applications are due July 14, 2026.

Application Requirements (Planning/Implementation)

Q100. The Cover Sheet (Attachment 2) captures both a "Total Planning Amount Requested" and a "Total Implementation Amount Requested," implying a single package. Should an applicant pursuing both tracks submit one combined package (one Cover Sheet plus separate Planning and Implementation narratives), or two separate submissions?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Q101. Can implementation projects be proposed without first receiving planning funding under this initiative?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Q102. May an applicant apply directly for Budget Period 1 implementation funding with no corresponding planning application?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Q103. Are applicants expected to apply for both planning grants and implementation grants or are these separate programs?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Q104. May applicants submit a proposal focused exclusively on planning activities or exclusively on implementation activities? Additionally, may planning and implementation occur concurrently within the same project period?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas. The Department acknowledges that integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.

Q105. Can DOH confirm whether the RHTP application is intended to be a single integrated submission that includes both planning and implementation activities? Specifically: a. Can eligible entities apply just for planning dollars? b. Can eligible entities apply just for implementation? c. Do applicants need to apply for both planning and implementation? d. Do planning activities need to be directly tied to implementation activities? e. If implementation-only applications are technically

allowed, will they be viewed as less competitive than applications that include both planning and implementation?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.

All applications will be reviewed using the same criteria.

Q106. Do the proposed implementation projects need to relate to the proposed planning project?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Q107. If an organization applies for multiple counties, do all counties have to include project implementation for Year 1 or can we take a multiple-year approach for an initiative?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.

All applications will be reviewed using the same criteria.

Q108. For multi-county applications, does the \$3,000,000 implementation cap remain fixed regardless of the number of counties served, or does it scale with geographic scope? Relatedly, is the \$500,000 planning allocation additive per county within a single multi-county application?

Response: The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. Funding caps are applied per county in multi-county applications. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants

covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.

Q109. Does the statement below mean we can submit one planning and implementation proposal that asks for \$.5m and \$3m per county included in the proposal? The minimum geographic unit for any application is the county. County-level geography is required for all applications. Multi-county applications are permitted and encouraged where regional collaboration supports the goals of the project. Funding levels will reflect the scope of the geographic area proposed.

Response: The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. Funding caps are applied per county in multi-county applications. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.

Q110. Is it allowable for several counties to come together for one planning application?

Response: Yes, multi-county applications are permitted and encouraged where regional collaboration supports the project goals.

Q111. Does the Implementation Lead Applicant/Partner Organization have to be the same two organizations as the Planning Project? In other words, can an Implementation Project's Lead Applicant/Partner Organization be different organizations than the Planning Project Lead Applicant/Partner Organization so long as one is still the municipal hospital and the lead applicant still meeting all eligibility requirements?

Response: The Department acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. The Lead Applicant may be a different organization.

Q112. If planning and implementation across specified counties is aligned and part of the same initiative, can the lead applicant for Planning be different than the lead applicant for Implementation?

Response: Yes.

Q113. Can a lead applicant submit or participate in more than one RCHI application if the proposed projects are distinct by geography, partners, scope, and budget? If yes, how will DOH evaluate potential overlap?

Response: Yes. The Department will evaluate overlap during the review process.

Q114. The funding guidance indicates that multiple applications from within the same county are allowable but applicants will be asked to collaborate or reduce funding. Is this the same for implementation applications as well?

Response: Implementation projects must be related to a plan to transform the rural health system. Applicants will be requested to collaborate where feasible.

Q115. Will preference be given to applications that already have existing partnerships in place?

Response: No

Q116. Does DOH expect implementation projects to demonstrate full operationalization within Year 1, or is it acceptable to launch a defined “initial model” (e.g., a subset of sites or services) with phased scale over subsequent years?

Response: The Guidance document states on page 4 that, "Implementation activities that lay the groundwork for future program iterations to transform care delivery will be considered if they are slated for completion by June 30, 2027." It also mentions, "These projects must be able to be completed within the Budget Period 1 contract period, which begins on September 1, 2026 and ends on June 30, 2027."

While full operationalization is not explicitly required within Year 1, implementation projects must be completed by June 30, 2027. A phased approach with subsequent scale-up is acceptable, as long as the Budget Period 1 implementation activities are completed June 30, 2027.

Q117. Will other/future RFAs also include planning activities, or is this the only opportunity to apply for planning funds?

Response: Budget periods 2 – 5 will focus on implementation.

Q118. What level of detail is expected in the implementation-ready plan?

Response: Applicants should provide sufficient detail to explain the need for the project, how it contributes to RHTP goals, and the activities that will be implemented to complete the project by June 30, 2027.

Q119. How does the Department distinguish planning activities from early-stage implementation (e.g., pilots, workflow redesign)?

Response: Planning activities focus on assessment, strategy, and readiness. Early-stage implementation involves the initial execution of project activities to achieve deliverables within Budget Period 1.

Q120. What level of evidence or validation is required for proposed technology solutions (e.g., AI, remote monitoring)?

Response: The required level of evidence should scale dynamically with the risk to the patient, the intended use of the technology, and the financial impact on the healthcare system. In addition to clinical efficacy, proposed solutions should include strict non-clinical evidence gates for data security and privacy, economic value, and workflow integration.

Q121. Are pilot or early-stage deployments acceptable, or must technologies already demonstrate proven outcomes?

Response: While full operationalization is not explicitly required within Year 1, implementation projects must be completed by June 30, 2027. A phased approach with subsequent scale-up is acceptable, as long as the Budget Period 1 implementation activities are completed June 30, 2027.

Q122. For projects focused on maternal and infant health, what outcome measures would be appropriate to demonstrate progress during Budget Period 1? May applicants propose maternal-specific measures in addition to the required RHTP measures? (colorectal screening is not going to resonate for maternal health).

Response: The Guidance document on page 5 states that, "Applications addressing maternity services and maternal child health, behavioral health integration, and substance abuse disorder prevention will be given priority. Proposed activities should result in interventions that will address maternal and infant mortality, behavioral health integration, and/or substance abuse disorder prevention. These activities should be evidence based

and include baseline measures and targets for improvement." It also lists under "Outcomes & Metrics":

- "Quality: lower readmission rates, improved maternal-child health indicators"
- "Admissions and Readmission: quarterly tracking of inpatient admission and readmission rates, benchmarked against county-level baseline data."

Additional maternal-specific measures in addition to the required RHTP measures are acceptable.

Q123. How many budget summaries and budget narratives are needed? Is it just 1 budget summary and 1 budget narrative, or should applicants be submitting multiple budget summaries and budget narratives up to 4 of each to separately address planning activities and each proposed implementation project?

Response: Each planning application and each implementation application should contain their own budget summary and narrative.

Q124. The guidance identifies expected outcomes and metrics, including potentially preventable emergency visits, readmission rates, and all-cause admissions/readmissions. Will DOH provide baseline data, definitions, and measurement methodologies for these outcomes, or should applicants propose their own measurement approach and demonstrate progress using available project-level or county-level data? Additionally, if an applicant needs to obtain baseline or comparison data from an external data source or vendor, would those data acquisition costs be considered an allowable/reimbursable project expense?

Response: Refer to Funding Guidance under Project Scope – Implementation which states in part: *All applications must address at least one key area specified in New York's RHTP application:*

1. *Increased access to the right care at the right time*
 - *Potentially Preventable Emergency Visits*
2. *Decreased readmissions due to high-quality discharge planning and post-acute supports*
 - *Hospital-wide all-cause unplanned readmission*
3. *Increased preventive care spanning primary and specialty care*
 - *Colorectal screening*

The Department will provide baseline data and target measures for the required performance measures listed above.

Applicants are expected to propose specific baseline and target metrics relevant to their project's outcomes for all other activities.

Q125. Are baseline metrics required at application, and what data sources are acceptable?

Response: Page 8 of the Guidance document states that "Applicants should outline the specific outcomes that will be achieved and the metrics that will be used to measure progress." Proposed activities should be evidence based and include baseline measures and targets for improvement. Progress can be measured using county-level baseline data.

Q126. The guidance lists 'Potentially Preventable Emergency Visits' as a key result metric. Does DOH have a specified methodology or data source for measuring this metric (e.g., NYS SPARCS, payer claims data, hospital-reported ED data)? Is there a required timeframe for demonstrating movement on this metric within Budget Period 1, or is it sufficient to demonstrate improved enrollment and care coordination processes as proximate indicators?

Response: Refer to Funding Guidance under Project Scope – Implementation which states in part: *All applications must address at least one key area specified in New York’s RHTP application:*

4. *Increased access to the right care at the right time*
 - *Potentially Preventable Emergency Visits*
5. *Decreased readmissions due to high-quality discharge planning and post-acute supports*
 - *Hospital-wide all-cause unplanned readmission*
6. *Increased preventive care spanning primary and specialty care*
 - *Colorectal screening*

The Department will provide baseline data and target measures for the required performance measures listed above.

Applicants are expected to propose specific baseline and target metrics relevant to their project's outcomes for all other activities.

Q127. Regarding the key result of increased preventive care spanning primary and specialty care, is the colorectal screening measure required? Can we focus on other/additional measures based on our community health indicators to demonstrate successful outcomes in this key area?

Response: Refer to Funding Guidance under Project Scope – Implementation which states in part: *All applications must address at least one key area specified in New York’s RHTP application:*

7. *Increased access to the right care at the right time*
 - *Potentially Preventable Emergency Visits*
8. *Decreased readmissions due to high-quality discharge planning and post-acute supports*
 - *Hospital-wide all-cause unplanned readmission*
9. *Increased preventive care spanning primary and specialty care*
 - *Colorectal screening*

The Department will provide baseline data and target measures for the required performance measures listed above.

Applicants are expected to propose specific baseline and target metrics relevant to their project's outcomes for all other activities.

Q128. Are there specific requirements for governance for this initiative?

Response: The Guidance document states on page 3 under "Project Scope – Planning": "Activities should focus on community engagement, assessing community needs using County Community Health Needs Assessments, conducting feasibility studies, developing a governance structure, building integrated partnerships, and developing an implementation ready plan." Developing a governance structure that meets the needs of the collaborative is a required component of the planning phase.

Q.129. The guidance references 'baseline measures and targets for improvement' for priority areas (maternal-child health, behavioral health, substance use). Must baseline data be established from county-level public sources (e.g., CHNA, SPARCS), or may applicants use program-level administrative data as the baseline (e.g., existing program enrollment rates, screening completion rates at current operating sites)? Is a baseline data plan describing how baseline will be established after award acceptable if county-level data for a new geographic site is not yet available?

Response: While the Guidance document emphasizes the importance of baseline measures and targets for improvement, it does not explicitly restrict the data sources to only county-level public sources. The general expectation is that applicants will "outline the specific outcomes that will be achieved and the metrics that will be used to measure progress," as stated on page 8.

Q130. The application requires a description of 'existing agreements' between Lead Applicant and Partner Organizations. If the existing relationship is governed by a Clinically Integrated Network participation agreement (a multi-party contract covering network governance, data sharing, and quality obligations) rather than a program-specific MOU, does that constitute a sufficient 'existing agreement' for purposes of the application? Must new project-specific agreements be in place at time of application, or is a letter of intent sufficient?

Response: While a multi-party contract covering network governance, data sharing, and quality obligations may be provided to illustrate formal partnerships among applicant parties, a letter of intent should also be included within the application package until a new project-specific agreement is in place.

Q131. How are you defining a preventable ED visit?

Response: The rate of emergency department visits defined as PPV per 100 people. Denominator population base by county was identified through the use of proprietary Claritas files.

Q132. If we submit more than one implementation project, should we rank those projects in order of priority?

Response: Ranking projects within an implementation application is not required; all projects will be evaluated utilizing the same criteria.

Q133. Please further elaborate on the purpose of the planning portion. For example, if hospitals, FQHCs, Social Care Networks and Counties are already required to do routine/regional needs assessments and community engagement, what should this additional planning exercise focus on?

Response: The planning portion should focus on developing collaborative plans for integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas. This includes strategizing for the RCHI initiative, building partnerships, developing governance, and creating an implementation-ready plan, going beyond routine assessments.

Q134. For the planning portion, is the project scope listed on Pg 3 intended to be related to broad community health needs, or more specific to the projects. For example, if an application proposes two projects related to OB and Behavioral Health, should the planning portion focus on those two areas or is the intent for it to focus on the broad, regional community health needs.

Response: Planning applications should focus on collaborative plans that result in integrated health networks that enhance health care delivery, care coordination, and outcomes in rural areas.

Q135. Pg 7, Section 7.1 of the application – should this read ‘the above Implementation Activities’ instead of ‘the above Planning Activities’?.

Response: Yes. This has been corrected.

Q136. Some counties have been collaborating with ideas for projects, but the RFP is not necessarily aligned to their prior goals. The application is due in 3 weeks from today, without much time to convene and revise the plan. Some of the planning application questions will require more time than 3 weeks to prepare. Can the planning application be significantly abbreviated?

Q137. If a collaborative proposes a shared specialty access model with several service pathways, such as telepsychiatry, teleneurology / telestroke, and cardiology support, should those pathways be presented as separate implementation projects or as one integrated implementation project with multiple service-line workstreams?

Response: The Guidance document states on Page 4 under "Project Scope – Implementation" that "In addition to planning, applicants may submit up to three implementation projects for consideration in Budget Period 1." Applicants will need to determine the best way to present their proposed model within the limit of three implementation projects.

Application Submission Process

Q138. Please confirm submission is via email to rchi@health.ny.gov ONLY, and nothing specific to this grant needs to be submitted in SFS (other than those items required for the general prequalification process)?

Response: Yes, completed applications must be submitted by email only to rchi@health.ny.gov.

Q139. Please confirm whether all components (Cover Sheet, Attestation, planning narrative, and implementation project descriptions) should be submitted as a single document or as separate attachments.

Response: A single PDF is recommended. Please also see Q183

Q140. Please confirm whether there is a page limit for any section of the planning or implementation applications, and if so, provide the applicable limits by section.

Response: A single PDF is recommended. Please also see Q183

Q141. Please confirm whether attachments are permitted. If there is a page limit, please identify if those attachments count toward the page limit.

Response: A single PDF is recommended. Please also see Q183

Q142. Will there be an opportunity for technical assistance organizations to engage with awardees after funding decisions are made, or will the Department provide a mechanism for funded organizations to identify and connect with qualified technical assistance providers? If so, could the Department clarify how and when those connections may occur? (Our organization has previously served as a technical assistance provider for telehealth initiatives in New York State and has extensive experience providing a broader range of technical assistance services to rural hospitals, federally qualified health centers, and other healthcare organizations. We would like to ensure that potential applicants are aware of these capabilities as they prepare for implementation).

Response: Applicants may work directly with technical assistance organizations. The Department may identify technical assistance organizations but this has not yet been determined.

Q143. The funding guidance indicates that awardees will have an initial planning period before full implementation activities begin. During this planning phase, may applicants propose engaging external technical assistance providers to support planning and implementation activities? If so, are applicants required to identify those providers in their application, or may they select and procure technical assistance providers after an award is made?

Response: Yes. Applicants should provide as much information as is known at the time of application submission. Vendors may be identified during the contract period as needed.

Q144. What level of project readiness is expected at submission?

Response: At submission, applicants should demonstrate project readiness, including established partnerships, a clear governance structure, a feasible workplan, and the capacity to initiate activities within the specified timeframe.

Q145. Many prospective applicants have spent the past six to nine months preparing for this opportunity with limited information regarding program requirements. How

does DOH recommend applicants efficiently establish formal partnerships, secure necessary approvals, and develop high-quality, multi-organizational applications within the current timeline?

Response: The above-described activities may be completed during the planning period.

Q146. Please confirm that completed applications are submitted by email only to rchi@health.ny.gov, and that no separate online portal, grants management system submission, hard-copy mailing, or other submission method is required.

Response: Completed applications must be submitted by email only to rchi@health.ny.gov

Q147. Please confirm the required attachments for submission. In addition to the Application Cover Sheet, Application Checklist, and Attestation, should applicants include a draft organizational chart, partner commitment documentation, budget narrative, workplan detail, or other attachments at the time of submission?

Response: Please review the application checklist to confirm all attachments that should be included with each submission. The checklist may be found at https://health.ny.gov/facilities/transforming_rural_healthcare/

Q148. Can one email submission include more than one application?

Response: One application should be submitted per email submission.

Needs Assessment

Q149. Please clarify what are the activities for “assessing community needs using County Community Health Needs Assessments” We are assuming assessments conducted previously can be used to guide year 1 implementation projects?

Response: Recently completed County Community Health Needs Assessments may be used.

Q150. If one entity within an application has completed a county community health assessment, do other partners need to complete that also, or is one sufficient?

Response: One County Community Health Assessment is sufficient.

Requests for Checklists

Q151. Where is the application checklist located that must be submitted with all other materials on July 9th?

Response: The application checklist is Attachment 4 and may be found at the following link within in the Funding Guidance Final Addendum posted on July 2, 2026:

https://health.ny.gov/facilities/transforming_rural_healthcare/

Q152. Page 4 of the application form provided on the program page states the following for planning applications: "Applications, including the Application Cover Sheet, Application Checklist, and Attestation must be submitted to rchi@health.ny.gov by 4:00 pm EST on July 9, 2026." I noticed that the program guidance document provided on the program page does not include the application checklist as an attachment. Just to confirm, is there a link to the application checklist document available?

Response: Please see Q151.

Q153. Where is attachment 3: application checklist?

Response: Please see Q151.

Multi-County Applications

Q154. Can one hospital-led collaborative application include multiple eligible counties and multiple rural hospitals under one lead applicant, with site-specific deliverables, county-level geography, and a shared regional workplan? If yes, how should applicants present the counties served, hospital sites, partner roles, and site-level deliverables?

Response: Yes, such an application is possible. Applicants should clearly present counties served, hospital sites, partner roles, and site-level deliverables in the project narrative, workplan, and budget, ensuring alignment with the shared regional workplan and governance.

Q155. How many counties working together is considered regional?

Response: Multi-county applications are encouraged where regional collaboration supports the project goals.

Q156. Can hospitals from the same health system partner together as lead and partner organization applicant?

Response: Yes.

Application Evaluation

Q157. How much weight will be assigned to proposals addressing maternal health, behavioral health integration, and substance use disorder prevention?

Response: As stated in the Project Scope – Implementation section of the Guidance, applications addressing maternity services and maternal child health, behavioral health integration, and substance abuse disorder prevention will be given priority. Proposed activities should result in interventions that will address maternal and infant mortality, behavioral health integration, and/or substance abuse disorder prevention. These activities should be evidence based and include baseline measures and targets for improvement.

Q158. To receive priority, must these areas be directly addressed, or are indirect/supporting interventions sufficient?

Response: As stated in the Project Scope – Implementation section of the Guidance, applications addressing maternity services and maternal child health, behavioral health integration, and substance abuse disorder prevention will be given priority. Proposed activities should result in interventions that will address maternal and infant mortality, behavioral health integration, and/or substance abuse disorder prevention. These activities should be evidence based and include baseline measures and targets for improvement.

Q159. Will planning projects be evaluated independently from implementation projects, or will applicants submitting both receive a combined score?

Response: Planning and implementation projects will be reviewed separately.

Q160. Will implementation projects be scored individually or collectively within a single application?

Response: Planning and implementation projects will be reviewed separately.

Q161. Will a scoring rubric be released prior to application submission?

Response: No.

Q162. What are the relative weights assigned to community need, partnership strength, sustainability, innovation, budget, and measurable outcomes?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q163. Is there an expected number of awards for planning projects and implementation projects?

Response: No.

Q164. What is the scoring and awarding process for the implementation projects, assuming that there is not enough funding for all of the applicants?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q165. What is DOH's criteria for determining awardees in this solicitation?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q166. When DOH evaluates proposals will they be evaluating the planning proposal and 1-3 implementation projects as one “package” or individually? Could some implementation projects get a green light while some don't?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q167. Will NYS DOH give preference to awardees receiving Planning funds in Year 1 when applying for Years 2 and beyond?

Response: Refer to Funding Guidance, Project Scope – Planning which states in part: *Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants*

covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.

Q168. For applications with up to three implementation projects, will these be evaluated independently or as an integrated portfolio?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q169. What are the RFA section scoring weights, and is there a scoring rubric?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

The scoring rubric is not available.

Q170. How will performance be assessed for key measures such as potentially preventable emergency visits, hospital-wide readmissions, and colorectal screening rates?

Response: Refer to Funding Guidance under Project Scope – Implementation which states in part: *All applications must address at least one key area specified in New York’s RHTP application:*

1. *Increased access to the right care at the right time*
 - *Potentially Preventable Emergency Visits*
2. *Decreased readmissions due to high-quality discharge planning and post-acute supports*
 - *Hospital-wide all-cause unplanned readmission*
3. *Increased preventive care spanning primary and specialty care*
 - *Colorectal screening*

The Department will provide baseline data and target measures for the required performance measures listed above.

Applicants are expected to propose specific baseline and target metrics relevant to their project's outcomes for all other activities.

Progress will be measured based on the applicant's deliverables. Applicants will be required to demonstrate progress towards completing deliverables during the contract period and completion of all deliverables by June 30, 2027. The Department will work with grantees to identify appropriate time frames to improve patient outcomes beyond Budget Period 1.

Q171. How will the Department evaluate whether a project is duplicative vs. complementary to other funding sources?

Response: The Guidance document states on page 7 under "Use of Funds - Ineligible Expenses": "Using RHTP funds for any project or initiative that is currently funded (or planned to be funded) by other sources." It also states on page 5 under "Use of Funds - Allowable Costs": "When expanding a program or initiative, grantees may only apply RHTP funds to costs associated with the new population and/or new activities. The costs of the original program must continue to be funded by their current funding sources."

The Department will request that grantees sign an attestation affirming that funding is not duplicative.

Q172. If an application proposes implementation activities that benefit the entire county regardless of provider affiliation or patient choice, will those activities be viewed more favorably than provider-specific initiatives?

Response: The Guidance document states on page 3 under "Project Scope – Planning": "The minimum geographic unit for any application is the county. County-level geography is required for all applications. Multi-county applications are permitted and encouraged where regional collaboration supports the goals of the project." Broader, county-wide approaches are encouraged.

Q173. Applications addressing maternal health, behavioral health integration, and substance use disorder prevention will receive priority consideration. Will projects that integrate multiple priority areas, such as behavioral health, substance use disorder prevention, EMS, and care coordination, receive additional consideration compared to projects focused on a single area?

Response: The document states: "Applications addressing maternity services and maternal child health, behavioral health integration, and substance abuse disorder prevention will be given priority."

All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and

enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q174. The guidance states that applications addressing maternity services and maternal-child health will receive priority consideration. How will this priority be incorporated into the review process? Is there a specific scoring preference or weighting for maternal-child health projects?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Maternity services and maternal-child health will receive priority consideration during the review process.

Q175. How does the Department define "Community Health Integration" for purposes of application review, scoring, and evaluation?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q176. How will the DOH evaluate outcomes? What data will be provided to awardees?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q177. Will NYS DOH publish any scoring criteria?

Response: No.

Financial Sustainability

Q178. What evidence is required to demonstrate sustainability beyond the grant period?

Response: Evidence required includes specific strategies for future funding, reimbursement mechanisms, and operational viability.

Q179. What level of financial sustainability planning is expected?

Response: A clear and realistic plan outlining future funding sources, reimbursement mechanisms, and operational viability is expected.

Q180. How will sustainability be weighted during application review?

Response: Rubric information regarding application evaluation, including relative weights of application portions, is not available to applicants.

Community Engagement

Q181. Are community engagement activities required in every participating county?

Response: The Guidance document states on page 3 under "Project Scope – Planning": "Activities should focus on community engagement, assessing community needs using County Community Health Needs Assessments, conducting feasibility studies, developing a governance structure, building integrated partnerships, and developing an implementation ready plan." Community engagement should be included in all funded projects.

Q182. The guidance encourages activities that engage the community. Can DOH provide examples of eligible community engagement strategies? Would public awareness, outreach, or advertising campaigns qualify as allowable activities?

Response: Specific examples of community engagement strategies include public forums, information booths at community events, social media campaigns, outreach through community-based organizations, and forming Community Advisory Boards.

Application Fonts, Page Numbers, Etc.

Q183. Are there any formatting requirements for the narrative? For example, are there restrictions on numbers of pages or characters, font types of sizes, and/or spacing?

Response: Applications should not exceed 20 pages of narrative. Section 7. Budget Summary and Budget Narrative may be submitted as attachments and are not included in the 20-page limit. Other attachments supporting the application may also be submitted.

Font size should be no smaller than 11 and font type should be Arial, Aptos, or Calibri.

Margins should be 1 inch.

There are no file naming convention requirements.

Q184. Are there page limits, word limits, font-size requirements, margin requirements, attachment format requirements, file naming conventions, email size limits, or other formatting instructions for the application narrative and attachments beyond the application template itself?

Response: Applications should not exceed 20 pages of narrative. Section 7. Budget Summary and Budget Narrative may be submitted as attachments and are not included in the 20-page limit. Other attachments supporting the application may also be submitted.

Font size should be no smaller than 11 and font type should be Arial, Aptos, or Calibri.

Margins should be 1 inch.

There are no file naming convention requirements.

Q185. For email submission to rchi@health.ny.gov, is there a preferred format (single combined PDF vs. separate files; PDF vs. Word), an attachment size limit, and will the Department confirm receipt?

Response: Applications should not exceed 20 pages of narrative. Section 7. Budget Summary and Budget Narrative may be submitted as attachments and are not included in the 20-page limit. Other attachments supporting the application may also be submitted.

Font size should be no smaller than 11 and font type should be Arial, Aptos, or Calibri.

Margins should be 1 inch.

A combined PDF is preferred.

Q186. Can applicants submit appendices beyond the required attachments (e.g., letters of support, organizational charts, CHNA summaries, data tables, or implementation plans)?

Response: Yes.

Q187. The Implementation Application's Section 3 states that activities "should be consistent with the objectives described under Planning Objectives and Activities Overview," and Section 7.1 references "each deliverable described in the above Planning Activities section." Please confirm if these are typographical carryovers and that, in the Implementation Application, they should read "Implementation."

Response: This has been corrected in the Application posted on July 2, 2026.

Implementation

Q188. Is the primary/specialty care topic for eligibility of projects restricted to colorectal services or is that an example and urology services might qualify as well?

Response: Refer to Funding Guidance, Project Scope – Implementation which states in part: *All applications must address at least one key area specified in New York’s RHTP application:*

1. *Increased access to the right care at the right time*
 - *Potentially Preventable Emergency Visits*
2. *Decreased readmissions due to high-quality discharge planning and post-acute supports*
 - *Hospital-wide all-cause unplanned readmission*
3. *Increased preventive care spanning primary and specialty care*
 - *Colorectal screening*

Other primary and specialty care services may qualify if they align with the program's goals of increasing access and improving outcomes.

Q189. For projects funded during Budget Period 1, what criteria will be used to determine eligibility and competitiveness for implementation funding in subsequent budget periods?

Response: Implementation activities in subsequent budget periods must relate to rural health system transformation plans identified in Budget Period 1. Refer to Funding Guidance, Project Scope – Planning which states in part: *Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Periods 2 – 3 and Budget Periods 4 – 5.*

Q190. Can DOH provide additional information regarding the anticipated contracting, procurement, and award administration process, including expected timelines following award announcements?

Response: It is anticipated that award announcements will be made by the end of August. Contract execution will immediately follow. All funded projects must be completed by June 30, 2027.

Q191. Are there preferred implementation models or evidence-based approaches?

Response: No. Approaches should be agreed upon by all partner organizations and should result in rural health system transformation.

Q192. Is there opportunity in the planning phase to recruit future partners?

Response: Yes.

Q193. What is the expected cadence and format of progress/expenditure reporting during Budget Period 1 (monthly, quarterly)? Is there a draft reporting template available now to inform a planning and budget narrative?

Q194. Request clarification on reporting frequency and required metrics for Implementation projects.

Response: The expected reporting cadence will be monthly or quarterly depending upon grantee needs. The draft reporting template is under development. Applicants should include as many known metrics as possible in their applications. Metrics should clearly track implementation progress.

Q195. Will the learning collaboratives established under the program be open only to award recipients, or will participation opportunities be available to non-awarded organizations seeking to develop future rural health initiatives? It would be useful to allow broad participation in learning collaboratives beyond only successful grantees.

Response: This will be determined at a later date.

Q196. According to a January 2026 survey of IHA member hospitals, the registered nurse vacancy rate is 13.5%, approximately 45% above pre-pandemic levels. In recognition of ongoing workforce shortages, will the State consider regulatory flexibilities that could support successful implementation of RCHI projects, including staffing-related requirements where appropriate?

Response: This is not under consideration at this time.

Q197. Are executed MOUs and data-sharing/partnership agreements required at submission, or can they be in development with letters of intent/commitment submitted instead?

Response: Agreements may be developed during the contract period.

Q198. Must a specific technology or care-management vendor be named in the application, or may applicants include a placeholder and complete procurement/selection during the contract period as a funded planning activity?

Response: Vendors should be named if known. Applicants may complete selection during the contract period.

Q199. Can an implementation application include implementation-enabling planning activities, such as readiness assessments, governance finalization, workflow design, credentialing preparation, data dictionary development, technology testing, training design, and sustainability planning, if those activities are directly tied to a Budget Period 1 go-live and completed within the Budget Period 1 contract period?

Response: Yes.

Q200. What level of participation is expected from the required hospital partner? Must the hospital be directly involved in implementation activities, or is participation through governance, planning, and collaboration sufficient?

Response: Participation levels of Partner Organizations should be appropriate to proposed activities and the plan that is developed for rural health system transformation.

Q201. The guidance states all implementation activities must be completable by June 30, 2027, and that projects should be 'able to implement within 30–60 days of award.' For an applicant expanding an existing, operational program to new geographic sites (e.g., extending a telehealth newborn follow-up program already operational in one county to two additional rural counties), does the 30–60 day expectation apply to the expansion launch, or to the first deliverable milestone?

Response: The expectation is that project implementation will begin with 30-60 days of the award. Specific deliverables and milestones are dependent upon activities.

Updating/modifying project plans in future

Q202. Will there be an opportunity to update plans created during Initiative 1 based on lessons learned from implementation projects and future initiatives?

Response: Yes.

Q203. What is the process for modifying implementation project plans if circumstances change?

Response: The Department will work with grantees on modifications during the project period.

Q204. Can additional partners be added to projects after application or after grants are awarded?

Response: Yes.

Q205. Will the grant Budget Periods 2-3 and 4-5 allow new applicants, or do only Budget Period 1 grant awardees carry forward their projects?

Response: Yes.

Baseline and Target/Outcome Measures/Deliverables

Q206. Will NYSDOH provide baseline data and target benchmarks for the required performance measures (Preventable ED Visits, Readmissions, and Colorectal Screening), or are applicants expected to establish their own baselines and targets?

Response: Please see Q210

Q207. Does DOH expect applicants to propose specific baseline and target metrics (e.g., PPVs, transfers, ED utilization), or are there defined measures that all applicants will be required to report against?

Response: Please see Q210

Q208. The guidance references potentially preventable emergency department visits, hospital-wide all-cause unplanned readmissions, and colorectal cancer screening rates. Are these intended as illustrative examples, or should applicants prioritize projects addressing these specific measures? Can DOH provide additional examples of priority outcome areas?

Response: The referenced measures are part of the Department's application to CMS. Other outcome areas will also be considered.

Q209. For the three key result areas (Potentially Preventable Emergency Visits, Hospital-wide All-Cause Unplanned Readmission, Colorectal Screening), will NYDOH

provide county-level baseline data centrally to serve as a comparison for success metrics?

Response: Please see Q210

Q210. With regards to the metrics (PPV, unplanned readmissions, and colorectal screening) – will the state be monitoring those? Or does the applicant/awardee need to have a method to monitor/measure those?

Response: Refer to Funding Guidance under Project Scope – Implementation which states in part: *All applications must address at least one key area specified in New York’s RHTP application:*

1. *Increased access to the right care at the right time*
 - *Potentially Preventable Emergency Visits*
2. *Decreased readmissions due to high-quality discharge planning and post-acute supports*
 - *Hospital-wide all-cause unplanned readmission*
3. *Increased preventive care spanning primary and specialty care*
 - *Colorectal screening*

The Department will provide baseline data and target measures for the required performance measures listed above.

Applicants are expected to propose specific baseline and target metrics relevant to their project's outcomes for all other activities.

Q211. Can applicants propose alternative outcome measures in addition to the required CMS measures?

Response: Yes.

Q212. How will progress toward targets (required by June 30, 2027) be defined and scored for planning-only grantees, given planning deliverables don't intrinsically move clinical outcome metrics?

Response: The application should outline planning activities and goals that will lead to improved outcomes

Q213. For implementation projects focused on infrastructure or network development, what performance metrics are expected when patient-level outcomes may not be observable within the contract period?

Response: Progress will be measured based on the applicant's deliverables. Applicants will be required to demonstrate progress towards completing deliverables during the contract period and completion of all deliverables by June 30, 2027. The Department will work with grantees to identify appropriate time frames to improve patient outcomes beyond Budget Period 1.

Q214. The guidance requires recipients to demonstrate progress toward targets by June 30, 2027. For implementation projects, what level of progress is expected during Budget Period 1?

Response: All funded projects must be completed by June 30, 2027.

Q215. What level of improvement constitutes "demonstrative progress" by June 30, 2027?

Response: Please see Q216

Q216. What level of completion constitutes "demonstrative progress" toward targets by June 30, 2027, and must all implementation deliverables be fully completed and vouchered by July 31, 2027 in order to be reimbursed?

Response: Targets and deliverables must be met and all funded projects must be completed by June 30, 2027. Vouchers and other required reports must be submitted by July 31, 2027.

Q217. Will applicants be expected to demonstrate measurable improvement in outcome metrics, or is successful implementation of activities and demonstration of early progress sufficient?

Response: Successful implementation of activities is sufficient. All funded projects must be completed by June 30, 2027.

Q218. The guidance references the requirement to demonstrate progress toward project goals. How will progress be measured? What reporting requirements will apply? What consequences, if any, would be levied if milestones or performance targets are not achieved?

Response: Progress will be measured based on the applicant's deliverables. Applicants will be required to demonstrate progress towards completing outcomes during the contract period and completion of all deliverables by June 30, 2027. The Department will work with grantees to mitigate circumstances preventing completion of all deliverables by June 30, 2027. Funds may not be carried forward if projects are not fully completed by June 30, 2027.

Q219. The workforce metrics include clinician-to-resident ratios and vacancy rates. How will these measures be defined and calculated, and what data sources will DOH use to assess performance?

Response: These are examples of workforce metrics. Applicants should include measures that are specific to proposed activities to demonstrate need and proposed progress. The Department will work with grantees to refine measures and identify data sources as needed during contract execution.

Q220. Because reimbursement is tied to completion of deliverables, please provide examples of acceptable planning deliverables and implementation deliverables, including examples of documentation that would support reimbursement.

Response: Refer to Funding Guidance, Outcomes & Metrics which states in part *Applicants should outline the specific outcomes that will be achieved and the metrics that will be used to measure progress. Examples include, but are not limited to, the following:*

- *Integration: Collaborative plans to develop and strengthen partnerships between providers to enable delivery of expanded services in rural areas through shared learning, collaborative approaches, and advanced technology interventions*
- *Access: reduced travel times, increased primary care visits, creating new access points for community-based screenings, preventive care, and chronic disease management*
- *Quality: lower readmission rates, improved maternal-child health indicators*
- *Financial: improved operating margins & reduced uncompensated care and increasing viability through strategic investments in technology, data infrastructure, and collaboration*
- *Workforce: increased clinician-to-resident ratios, reduced vacancy rates*
- *Technology: expanded telehealth utilization, improved electronic health record interoperability*
- *Admissions and Readmission: quarterly tracking of inpatient admission and readmission rates, benchmarked against county-level baseline data.*

Note that these are examples and not an exhaustive list. Documentation that supports reimbursement includes, but is not limited to, the following: project plans, resource requirements, project schedules, governance documents, partner agreements, communication plans, purchase agreements, and proof of payment.

Q221. How much outcome data must be available by June 30, 2027?

Response: Sufficient data and information must be provided to indicate that targets have been met and that projects are complete.

Q222. How detailed must deliverable definitions be to support reimbursement (milestones vs. outcomes)?

Response: Deliverables should be designed to support project completion by June 30, 2027. Deliverables may be outcome based as appropriate.

Q223. Will partial completion of deliverables result in partial reimbursement or disallowance of funds?

Response: Partial completion may result in partial reimbursement. The Department will work with grantees to refine deliverables as needed.

Q224. For specialty access and acute-care telehealth projects, may applicants use supplemental operational metrics in addition to the required RHTP key-result areas? Examples could include time to specialty consult, avoided transfers, ED behavioral health boarding hours, retained admissions, local capacity preserved, labor relief, and clinician confidence.

Response: Yes, applicants may propose supplemental operational metrics in addition to the required RHTP key-result areas.

Q225. What level of baseline data is expected at the time of submission versus after award? For a multi-hospital collaborative, may applicants propose a standard baseline data collection process to be completed during early implementation, followed by quarterly reporting once data systems and workflows are established?

Response: Baseline data that is available at the time of application submission should be provided. Yes, applicants may propose data collection processes to be completed during the contract period.

Q226. The guidance states funded recipients must provide 'demonstrable progress' towards meeting targets by June 30, 2027, meaning 'sufficient data and information are provided to indicate that targets have been met.' For a program with a 10-month contract period, how does DOH define a sufficient level of target attainment? Is partial attainment (e.g., 60–70% of enrolled patient target) considered demonstrable progress, or must the full target be met by June 30?

Response: Targets identified in the application must be achieved by June 30, 2027.

Q227. Do planning projects need to meet the three key results? There are listed in the application for Implementation but not Planning.

Response: All applications must address at least one of the key results. Refer to Funding Guidance – Eligibility which states in part: *Additionally, applicants must address at least one key area specified in New York’s RHTP application:*

1. *Increased access to the right care at the right time*
 - *Potentially Preventable Emergency Visits*
2. *Decreased readmissions due to high quality discharge planning and post-acute supports*
 - *Hospital-wide all-cause unplanned readmission*
3. *Increased preventative care spanning primary and specialty care*
 - *Colorectal screening*

Q228. Are the examples provided in the Key Results section (Potentially Preventable Emergency Visits, Hospital-wide all-cause unplanned readmission, colorectal screening) suggestions or requirements?

Response: These are requirements of the New York State Rural Health Transformation Application.

Implementation Funding Vs. Planning Funding

Q229. Are planning project applications a prerequisite for implementation project applications, or are planning projects intended primarily for counties that require additional time to develop implementation strategies beyond June 30, 2027?

Response: Please see Q230

Q230. Do all applicants have to apply for both planning and implementation dollars? Can an applicant group only apply for implementation funds?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027.

Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.

Q231. The guidance references a maximum award of \$500,000 for planning projects and up to \$3 million for implementation projects. Are these funding caps applied on a per-county basis or a per-applicant basis? If awards are expected to be structured around a single lead applicant per county, please clarify how funding limits will be applied.

Response: Please see Q 234

Q232. The Funding Guidance (pp. 3) states that there will be only \$500,000 available for Planning Initiatives per county, is there a similar ceiling per county for Implementation funding?

Response: Please see Q 234

Q233. For multi-county applications, how will funding levels be determined?

Response: Please see Q 234

Q234. May implementation project applications be submitted only along with proposals for planning funds? Or may any eligible entity apply for up to three implementation projects, regardless of whether they are applying for planning funds?

Response: The \$500,000 planning maximum is per county. The \$3 million implementation cap is per application. Implementation applications must be directly linked to a plan to transform rural health care services.

The Department acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county application

in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Q235. Is it expected that budget period one will exclusively be used for planning for implementation in periods 2-5 OR should the proposal plan to implement in whole or part in budget period 1?

Response: Refer to Funding Guidance, Project Scope – Planning which states in part: *Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.*

Refer to Funding Guidance, Project Scope – Implementation which states in part: *In addition to planning, applicants may submit up to three implementation projects for consideration in Budget Period 1. Implementation activities that lay the groundwork for future program iterations to transform care delivery will be considered if they are slated for completion by June 30, 2027.*

Q236. The guidance states budgets are deliverable-based and expenses reimbursed upon completion of deliverables. The application requires respondents to list deliverables and associated funding to achieve it. Rather than tying funding to milestones, are respondents permitted to propose tying funding to the number of clients or patients served by the proposed Implementation Application?

Response: Funding is tied to the completion of deliverables. While client numbers can be a metric for success, funding should be primarily linked to achieving defined deliverables, not solely to the number of clients served.

Q237. Can you further elaborate how the \$500K should be used for planning, if administrative costs greater than 5% are not allowed? Is the expectation that consultants will be hired? What type of expenses/budget items would be appropriate for the planning budget line items. Can stipends be used to support participation in meetings/regional convening?

Response: Applicants should propose to spend funds on planning activities, such as needs assessments, feasibility studies, partnership development, and creating an implementation-ready plan.

Refer to Planning Application – Budget Summary which states in part: *List each deliverable described in the above Planning Activities section and the amount of funding needed to achieve it. Add as many rows as needed to list all deliverables.*

Deliverable	Amount
Total	

Refer to Planning Application – Budget Narrative which states in part: *Describe how the amount was determined for each deliverable listed in the Budget Summary. Allowable and ineligible expenses are listed in the Application Guidance on pages 5 - 8.*

Stipends are allowed to reduce financial barriers for community members and is a payment to offset expenses. Stipends should not be based on an hourly, daily, weekly, or monthly pay rate. All state and local laws regarding stipends must be followed.

Q238. Can planning funds support community engagement activities such as stipends for community members, focus group participants, or patient advisors?

Response: Stipends are allowed to reduce financial barriers for community members and is a payment to offset expenses. Stipends should not be based on an hourly, daily, weekly, or monthly pay rate. All state and local laws regarding stipends must be followed.

Q239. Can planning funds support consultant services, facilitation, and project management?

Response: Yes.

Q240. Can direct expenses to support execution be included in Planning and/or Implementation funding (e.g. HR, accounting, compliance, etc.)?

Response: Please see Q241

Q241. Can the majority of the \$500,000 be paid to participating parties for the human capital investment (ie: people resources) in order to plan?

Response: Refer to Funding Guidance, Use of Funds – Ineligible Expenses which states in part: *Ineligible expenses include the following.*

- *Administrative costs, including direct and indirect costs, exceeding the 5% limit for Budget Period 1.*

- *Supplanting existing state, local, Tribal, or private funding of infrastructure or services, such as staff salaries.*

Direct expenses as described above may be included in administrative costs but may not exceed 5% of the total award.

Q242. Can planning funds support staff time dedicated to planning activities if those staff are performing new project-related work?

Response: Yes.

Q243. If the award is \$500,000 for planning phase, but only 5% can be spent on Admin, what does NYS expect the remaining \$475,000 to be spent on specifically?

Response: Please see Q244

Q244. Can the majority of the \$500,000 be paid to participating parties for the human capital investment (i.e.: people resources) in order to plan?

Response: Applicants should propose to spend funds on planning activities, such as needs assessments, feasibility studies, partnership development, and creating an implementation-ready plan.

Q245. Regarding the Project Scope: Planning - Will future initiatives provide similar funding levels for Planning, or should we consider this Planning project as the major planning effort for the rest of the BP1 or the full RHTP?

Response: Planning activities may be funded in subsequent years if the activities are necessary to achieve RHTP goals subject to the availability of funding.

Q246. The guidance indicates that Budget Period 1 planning activities include community engagement, needs assessment, partnership development, governance development, and creation of an implementation-ready plan. At the same time, applicants may request implementation funding for projects that "lay the groundwork" for future transformation activities. Given that planning activities will inform the priorities of the integrated health network, what level of specificity is expected for implementation projects proposed during Budget Period 1? Can applicants propose implementation activities that align with RHTP goals even if those activities have not yet been formally identified through the planning process?

Response: Implementation projects should support rural health care transformation. Requested funding should position providers to meet RHTP goals to transform and sustain the health care system.

Q247. In the Funding Guidance, it states that "...projects must be able to be completed within the Budget Period 1 contract period which begins on September 1, 2026 and ends on June 30, 2027." The Funding Guidance also states "Funding opportunities to implement activities identified during Budget Period 1 planning period will be available in Budget Periods 2-5." Can you clarify?

Response: Budget Period 1 activities must be completed by June 30, 2027. Planning activities from Budget Period 1 can inform implementation activities funded in subsequent Budget Periods (2-5), allowing for longer-term projects.

Administrative Costs

Q248. The guidance limits administrative costs to 5%. How does DOH define administrative costs versus programmatic project management costs?

Response: Please see Q253

Q249. The guidance limits administrative costs, including direct and indirect costs, to 5% of the total budget. Can NYSDOH clarify what expenses are considered administrative costs?

Response: Please see Q253

Q250. The RFA references a 5% administrative cost limitation. Could NYSDOH please clarify what expenses are included within this cap and whether it is separate from allowable indirect costs? We would also appreciate any guidance regarding how personnel costs associated with project management, coordination, and grant administration should be classified.

Response: Please see Q253

Q251. The Funding Guidance limits administrative costs, including direct and indirect costs, to 5% for Budget Period 1 (Use of Funds, Ineligible Expenses, page 7). The same guidance provides that budgets for planning and implementation projects will be deliverable-based and that contracts will be cost reimbursable based on achieving deliverables (Project Scope, page 4; Use of Funds, Allowable Costs, page 5). The Planning and Implementation Applications ask applicants to build the budget by deliverable, listing the amount needed to achieve each deliverable and explaining in a narrative how each amount was determined (Planning Application, Section 4;

Implementation Application, Section 7). Can you clarify how the 5% administrative cost limit should be applied within a deliverable-based budget structure?

Response: Please see Q253

Q252. What specific costs are included in the 5% administrative cost cap (e.g., indirect costs, grant management, shared services)?

Response: Please see Q253

Q253. The Funding Guidance identifies administrative costs, including direct and indirect costs exceeding the 5% limit for Budget Period 1, as ineligible. Please clarify what costs count toward the 5% administrative cap. For example, are project management, legal / contracting support, fiscal administration, reporting, compliance oversight, and partner coordination considered administrative costs, or may some of these be treated as direct implementation deliverables when necessary to build the collaborative infrastructure?

Response: Administrative costs support overall operations and cannot be tied to a single outcome.

Q254. Does the 5% administrative cap apply separately to planning and implementation budgets or to the total award?

Response: Please see Q257

Q255. Is the cap calculated across the entire award? Are there differing levels for Lead vs. Partner organizations, and do administrative costs incurred by Partner organizations count toward the Lead Applicant's cap?

Response: Please see Q257. Administrative costs incurred by Partner Organizations do count towards the cap.

Q256. Does the 5% administrative cost cap for Budget Period 1 apply to the Lead Applicant only, or in aggregate across the Lead and all Partner Organizations/subcontractors?

Response: The 5% administrative cost cap applies in aggregate across the Lead and all Partner Organizations.

Q257. Is the 5% limit measured against the total award, or is it evaluated for each individual deliverable? Should administrative and indirect costs appear as a separate budget line, or are they expected to be embedded within each deliverable amount and detailed in the budget narrative?

Response: The administrative cap applies to the entire award.

Q258. Can subcontractor expenses exceed 5% if they are directly tied to project implementation rather than administration?

Response: Subcontractor expenses may exceed the 5% limit if they are included in project deliverables.

Q259. Please define direct and indirect admin costs.

Response: Direct costs are expenses that can be traced to a specific deliverable or project, while indirect costs are shared expenses that support overall operations and cannot be tied to a single outcome.

Q260. For an applicant or partner organization with a federally negotiated indirect cost rate, may indirect costs be recovered up to the 5% administrative limit, and are indirect costs counted within the 5% cap consistent with the federal Rural Health Transformation Program administrative cost limitation?

Response: Administrative costs that support overall operations and cannot be tied to a single outcome may be included in the 5% limit. Costs counted within the RCHI 5% administrative limitation will be counted toward New York State's administrative cost limitation.

Q261. The memo flags the 5% administrative cost cap as a tight constraint and suggests front-loading deliverable-based costs. Since AHP is acting as the operational "backbone" but not the Lead Applicant, how will the 5% administrative allowance be split between the rural Lead Applicant's internal overhead and AHP's project management costs? Is 5% enough to cover the legal and compliance work required for these multi-institutional agreements?

Response: Please see Q256. Applicants should work together to ensure they remain below the administrative cap.

Q262. How should the programmatic coordination activities of a backbone or community-integration partner (e.g., partner onboarding, workflow integration, provider training) be classified relative to administrative costs under the cap?

Response: Coordination activities, including legal and compliance costs, should be built into deliverable costs.

Funding for Specific Types of Staff/Technology

Q263. Can planning funds support staff time dedicated to planning activities if those staff are performing new project-related work?

Response: Staff may be hired to perform new project-related work. Salaries for staff hired to perform new project-related work should not supplant existing funding.

Q264. While funds cannot be used to supplant current funding for a position, could new positions be financed by these funds?

Response: Please see Q263

Q265. Can DOH give more guidance on how the funds may be used to hire employees related directly to initiatives?

Response: Please see Q263

Q266. Can planning and implementation funds support new positions, expanded FTEs, contracted staff, care coordinators, community health workers, community paramedics, or project-specific personnel when those positions represent new activities and do not supplant existing funding?

Response: Please see Q263

Q267. Can care coordinators, community health workers, and patient navigators be supported through implementation funding?

Response: Please see Q263

Q268. Are care coordination or program management personnel allowable if tied exclusively to new or expanded activities, given restrictions on supplanting?

Respond: Please see Q263

Q269. Confirm that care coordination and behavioral health integration staff are allowable.

Response: Please see Q270

Q270. Can RCHI funds support partial personnel time for new or expanded project functions, such as project management, training, data reporting, workflow redesign, and implementation coordination, if the funds are tied to specific deliverables and do not replace existing state, local, Tribal, private, or operating funds?

Response: Staff may be hired to perform new project-related work. Salaries for staff hired to perform new project-related work should not supplant existing funding.

Q271. The guidance lists training and technical assistance for technology-enabled solutions as allowable. Please confirm whether staff training on telehealth platforms (e.g., training/onboarding clinical staff at a partner provider organization) is an allowable cost.

Response: Please see Funding Guidance, "[Training and Technical Assistance](#)" and "[Information Technology Advances](#)."

Q272. Are locum coverage/temporary staff expenses an allowable expense?

Response: No. Refer to Funding Guidance, Use of Funds – Ineligible Expenses which states in part: *Ineligible expenses include the following.*

- *Payment for direct health care services including replacing payment for clinical services that could be reimbursed by insurance or another form of health coverage.*

Q273. To what extent can RHTP funding support clinical and non-clinical FTEs during startup (e.g., partial or time-limited support for providers, care coordinators, or program staff), particularly where those roles are required to establish new care models?

Response: Please see Q274

Q274. Confirm that startup staffing cost are allowable.

Response: RHTP funding may support clinical and non-clinical FTEs during startup for new or expanded service. These expenses are time-limited, must not supplant existing funding, and should be sustainable.

Q275. Can you provide clarification on the use of RHTP funds for clinician salaries? The guidance indicates that the use of RHTP funds for clinician salaries or workforce development initiatives are ineligible expenses only when the clinicians or initiative beneficiaries are subject to a noncompete agreement. If a clinician is not subject to a noncompete agreement, are clinician salaries an allowable cost?

Response: RHTP funding may support clinical and non-clinical FTEs during startup for new or expanded service. These expenses are time-limited, must not supplant existing funding, and should be sustainable.

Q276. We see in the guidance the following two elements: Payment for direct health care services including replacing payment for clinical services that could be reimbursed by insurance or another form of health coverage. Clinician salaries or 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. It does not say that all clinician salaries or workforce development initiatives are ineligible overall, just that there cannot be a noncompete. Supporting this is the fact that one of the outcomes and measures listed in the funding guidance is workforce: increased clinician to resident ratios, reduced vacancy rates. So is it acceptable as long as it directly ties back into one of the three key areas?

Response: RHTP funding may support clinical and non-clinical FTEs during startup for new or expanded service. These expenses are time-limited, must not supplant existing funding, and should be sustainable.

Q277. The guidance states that clinician salaries or workforce development initiatives are prohibited where they are subject to noncompete agreements. Are they permissible if a noncompete agreement is not in place?

Response: RHTP funding may support clinical and non-clinical FTEs during startup for new or expanded service. These expenses are time-limited, must not supplant existing funding, and should be sustainable.

Q278. Please clarify bullet 8 on Page 7 of the guidance – are all clinician salaries ineligible or only those that are subject to a non-compete agreement. Please also define clinicians.

Response: RHTP funding may support clinical and non-clinical FTEs during startup for new or expanded service. These expenses are time-limited, must not supplant existing funding, and should be sustainable.

Q279. Can funding support expenses for clinicians or operating expenses for under reimbursed/underfunded services that receive partial payer reimbursement? Two examples include OB and Behavioral Health, which are priority projects but have significant gaps between reimbursement and expenses in rural areas.

Response: RHTP funding may support clinical and non-clinical FTEs during startup for new or expanded service. These expenses are time-limited, must not supplant existing funding, and should be sustainable.

Q280. We are looking at developing an LPN training and pipeline program to address staffing shortages in our rural community. The application lists "developing and sustaining workforce" as an area of consideration under Planning Objectives and funding guidance includes workforce outcomes such as vacancy rates and clinician to resident ratios program metrics. Based on that, I want to confirm that the LPN training initiative would be an eligible planning or implementation activity under RCHI, or would this type of workforce development be better reserved under another initiative? I would also like to confirm that as a county operated facility, the CNR would qualify as a municipal entity for lead applicant eligibility purposes.

Response: Developmental costs to establish training program may be an eligible expense. CMS requires that any projects that provide direct training that results in certification or licensure are subject a 5-year service obligation. More information is available at this link: <https://www.cms.gov/files/document/5-year-service-commitment-fact-sheet.pdf>

Refer to Funding Guidance, Eligibility which states in part: *Lead Applicants must meet the following minimum qualifications by completing the Attestation in Attachment 3 and submitting it with application.*

- *Lead Applicant is a registered not-for-profit 501(c)(3) organization or municipal hospital.*
- *Lead Applicant has a three-year or more history of regulatory compliance including adherence to Department rules and other direction.*
- *Lead Applicant is an eligible entity located in counties defined as rural in New York's Rural Health Transformation Program application and listed in Attachment 1.*
- *Funded projects will be completed by June 30, 2027.*
- *At least one hospital located in the counties listed in Attachment 1 is included in the application.*

Q281. Are workforce development activities allowable if focused on training existing staff rather than hiring new clinicians? Or should all such funding requests wait for a subsequent RHTP funding guidance?

Response: Developmental costs to establish training program may be an eligible expense. CMS requires that any projects that provide direct training that results in certification or licensure are subject a 5-year service obligation. More information is available at this link: <https://www.cms.gov/files/document/5-year-service-commitment-fact-sheet.pdf>

Q282. If individuals are hired specifically to complete allowable tasks, might we expect to retain them for full RHTP lifecycle?

Response: Subsequent Budget Period funding opportunities will be competitive and subject to CMS approval.

Q283. Can planning and implementation funds be used for care coordination platforms, referral management systems, interoperability solutions, remote monitoring technologies, EMS-provider communication tools, population health systems, and other technology investments that support community health integration and care coordination?

Response: Please see Q290

Q284. Can funding support software licenses, interoperability solutions, data-sharing platforms, and health information exchange fees under Information Technology Advances?

Response: Please see Q290

Q285. Can funds support shared data platforms across hospitals, FQHCs, EMS, and community organizations?

Response: Please see Q290

Q286. What types of AI-enabled tools are considered eligible?

Response: Please see Q290

Q287. Can interoperability projects involving multiple EHR systems be funded?

Response: Please see Q290

Q288. Will purchase and implementation of remote patient monitoring technology to support care for post-acute or long-term home care or assisted living patients qualify as allowable costs under Consumer Tech Solutions? Under any other category? (See P. 6 of Application Guidance)

Response: Please see Q290

Q289. Are consumer-facing technology costs, including software subscriptions, licenses, devices, connectivity, implementation support, training, and technical assistance, allowable costs when used to support eligible project goals in one or more eligible rural counties?

Response: Please see Q290

Q290. Are software licensing and implementation costs for a care-coordination/population-health platform allowable under "Information Technology

Advances," and may subscription costs be charged for the portion of the subscription term falling within the contract period through June 30, 2027.

Response: Refer to Funding Guidance, Use of Funds – Allowable Costs which states:

Examples of allowable costs include, but are not limited to, the following.

Funding Category	Use of Funding
<i>Collaboration and Integration</i>	<i>Initiating, fostering, and strengthening local and regional strategic partnerships between rural facilities, providers, and community-based organizations to expand access to care, promote quality improvement, and improve financial sustainability.</i>
<i>Appropriate Care Availability</i>	<i>Optimizing rural care delivery systems across service lines.</i>
<i>Behavioral health</i>	<i>Access to opioid use disorder treatment services, other substance abuse disorder treatment services, and mental health services.</i>
<i>Capital Expenditures and Infrastructure Minor Renovations</i>	<p><i>Minor renovations or alterations if they are clearly linked to program goals and receive Department and CMS prior approval. For example, minor renovations to repurpose a hotel for short-term trainee housing or a commercial building for a health care training facility may be eligible.</i></p> <p><i>Examples of minor renovations or alterations include, but are not limited to, installing or relocating interior walls and partitions; upgrading lighting to more energy-efficient systems; replacing vents and thermostats for better climate control; installing automatic door openers to enhance accessibility; and converting private offices to a more open office layout.</i></p> <p><i>New York’s RHTP award has an overall limit on infrastructure and capital expenditures. Review of requests for prior approval of minor renovations or alterations will consider the limit on this type of spending.</i></p>
<i>Consumer Tech Solutions</i>	<i>Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.</i>
<i>Emergency Medical Services</i>	<i>Forming regional collaboratives to share resources, developing new services to meet community need, and training staff.</i>

<i>Information Technology Advances</i>	<i>Technical assistance, software, hardware for information technology advances to improve efficiency and patient health outcomes.</i>
<i>Maternal Health and Maternity Services</i>	<i>Training, technology deployment to implementing remote prenatal monitoring and artificial intelligence-enabled coaching, expanding access, deploying mobile clinics for prenatal and postpartum care.</i>
<i>Prevention & Chronic Disease</i>	<i>Evidence-based interventions to improve prevention and chronic disease management.</i>
<i>Training and Technical Assistance</i>	<i>Training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural facilities, including remote monitoring, robotics, artificial intelligence, and other advanced technologies</i>

Q291. Are expenditures for transportation of workers/clinicians or patients to increase access to care eligible expenses under the program? Would the purchase of vehicles or contracts for transportation of workers/patients qualify as allowable expenses? Would the purchase of mobile clinic vehicles be an allowable expense?

Response: Please see Q292

Q292. Are emergency/non-emergency vehicles such as an Ambulette eligible for funding, given their impact on access to care and their ability to be used not only to expand access to regional points of care, but also for services such as medication delivery, discharge transport, and mobile health? Are Patient Navigator roles and EMS/student education initiatives for workforce development fundable under this RFP? We understand that any support for salaries must be for new/currently unfunded roles that are not otherwise reimbursable under health care plans, public or private.

Response: All funded activities must relate to the collaborative plan to transform the rural health system and must be sustainable. The Department is unable to comment on the merits of specific projects before applications are submitted.

Q293. Is the physical expansion and conversion of existing rooms into birthing center rooms, including addressing critical access barriers like anesthesia, an eligible activity for funding? Are Patient Navigator roles to enhance maternal health access fundable as part of a birthing center expansion project?

Response: Please see Q290 and 306

Q294. If a county/hospital needed to hire a consultant to assist with the Rural Community Health Integration projects, would this be considered an allowable use of funds?

Response: Please see Q290 and Q270

Q295. Are personnel costs an eligible expense?

Response: Yes, personnel costs for new or expanded project functions are allowable if tied to specific deliverables and do not supplant existing funding.

Q296. The EMR exclusion applies where a HITECH-certified EMR system is already in place as of September 1, 2025. Does this exclusion apply to Health IT Modules that are HITECH-certified, such as patient portals, data integration engines, etc.? Are any health technology platforms that are not HITECH-certified excluded?

Response: This question was referred to CMS. This document will be updated when a response is received.

Q297. If utilizing a telehealth platform, please confirm they do not need to be located in eligible counties.

Response: The recipient of the telehealth services must be located in eligible counties. The telehealth providers do not need to be located in eligible counties.

Q298. The guidance states that “ineligible expenses include...payment for direct health care services including replacing payment for clinical services that could be reimbursed through insurance or another form of health coverage.” Is this statement intended to indicate that the delivery of services (e.g., innovative technology-enabled service to enhance access) cannot be covered through funds from this Rural Community Health Integration grant, even if provided via a rural health partnership that meets all other solicitation requirements including population health improvement, care coordination and increased access to the right care at the right time?

Response: This prohibition applies to direct payment for clinical services that are reimbursable by other sources. Innovative services that enhance access and align with program goals, and are not simply replacing existing reimbursable services, may be allowable.

Q299. The guidance identifies independent research and development as an ineligible expense. How does DOH distinguish prohibited research activities from data

collection, evaluation, and performance measurement activities that may be necessary to demonstrate project outcomes?

Response: Data collection, evaluation, and performance measurement activities are not considered independent research.

Capital/Minor Construction/Equipment Funding

Q300. Capital for construction is a clear non-allowable expense; what about the purchase of equipment?

Response: Equipment purchases are an allowable expense if they lead to achieving RHTP goals.

Q301. Can leased or non-capital equipment (e.g., diagnostic equipment required to enable services) be funded as part of implementation if it is necessary to deliver care but does not constitute construction or major capital investment?

Response: Leased or non-capital equipment purchases are an allowable expense if they lead to achieving RHTP goals and are sustainable following the RHTP 5-year period.

Q302. The guidance permits certain infrastructure-related expenditures. Will projects involving facility modifications or equipment installation require Certificate of Need (CON) approval or other state review processes?

Response: All existing state review processes will be applied to RHTP projects.

Q303. The guidance identifies construction and building expenses as ineligible while also permitting certain capital expenditures and minor renovations. Can DOH provide additional clarification and examples of allowable versus prohibited facility-related expenses?

Response: Please see Q306

Q304. Can the Department clarify the distinction between allowable "minor renovations" and prohibited capital expenditures?

Response: Please see Q306

Q305. Confirm that equipment and cosmetic refresh for a fully constructed dental/medical suite are allowable under Implementation.

Response: Please see Q306

Q306. Confirm that capital below the CON threshold and not involving structural work is eligible.

Response: Limitations on capital funding are based on Center for Medicare and Medicaid Services guidance. The following information may be found on page 39 of this Frequently Asked Question document: <https://www.cms.gov/files/document/rural-health-transformation-frequently-asked-questions.pdf>

Major renovations or new construction activities are unallowable. 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 CMS Notice of Funding Opportunity, including the 20% cap on capital expenditures and infrastructure.

Funding Per County Questions

Q307. Will awards be limited to one awardee per eligible county (going with the \$500K planning funds per county)?

Response: Please see Q43

Q308. If a project spans several counties, can planning dollars exceed the \$500,000 allotment per county (e.g., if an initiative spans three counties, could the lead applicant receive up to \$1.5 million in planning dollars)?

Response: Please see Q313

Q309. Is the planning allocation strictly up to \$500,000 per county, or can regional applications request more?

Response: Please see Q313

Q310. Page 3 of the Funding Guidance states that each county will be allocated up to \$500,000 to develop collaborative plans and that funding levels will reflect the scope of the geographic area proposed. For a collaborative planning application serving four eligible counties under one lead applicant, may the applicant request up to \$2,000,000 in planning funds, calculated as four counties x \$500,000, provided the proposed scope and budget justify the request? If not, how should the maximum planning amount be calculated for a multi-county planning application?

Response: Please see Q313

Q311. If an application for more than one county is submitted, is it the expectation that the planning dollars would be multiplied by the number of counties. For example, an application for 3 counties would be eligible for up to \$1.5M in planning?

Response: Please see Q313

Q312. Hypothetically, if three (3) counties come together with a planning application, will the total award be \$1,500,000 (\$500,000 x 3) or will the award be \$500,000 for one planning application, spread across the three counties that collaborate?

Response: Please see Q313

Q313. If a project spans several counties, can planning dollars exceed the \$500,000 allotment per county (e.g., if an initiative spans three counties, could the lead applicant receive up to \$1.5 million in planning dollars)? Yes.

Response: Refer to Funding Guidance, Project Scope – Planning which states in part: *Each county will be allocated up to \$500,000 to develop collaborative plans resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.* This means that applicants submitting planning applications are eligible to receive up to \$500,000 per included county.

Q314. For applicants serving broad, multi-county rural regions, how will DOH account for scale and breadth of service area in funding decisions?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q315. Budget Period 1 has \$212M and the allocated budget for Community Health Integration is \$76M. If all 47 counties receive \$500K for planning services, that leaves \$52.5M - less than \$3M per county for implementation. Can you provide guidance on how the state is planning to address the implementation requests - Does the funding come from the remaining \$212M or is that money slated for future initiatives? Is the applicant competing against other applicants for implementation dollars and therefore adjust our implementation approach accordingly?

Response: Budget Period 1 funding is fully allocated among the 4 Initiatives outlined in New York's RHTP funding application. Funding for RCHI implementation activities will be available in Budget Periods 2 – 5. Implementation activities in subsequent budget periods must relate to rural health system transformation plans identified in Budget Period 1. Refer to Funding Guidance, Project Scope – Planning which states in part: *Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Periods 2 – 3 and Budget Periods 4 – 5.*

Q316. The Funding Guidance notes that multi-county applications are permitted and encouraged where regional collaboration supports the goals of the project, and that funding levels will reflect the scope of the geographic area proposed. Beyond proportional funding adjustments, how does the Department plan to incentivize or give scoring preference to applications that demonstrate meaningful collaboration across two or more eligible counties? Will there be explicit criteria in the application review process that recognize the complexity and community reach of regional partnerships?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q317. If an applicant requests funding for the same function (e.g., a care-management or population-health platform) across multiple county applications: (a) are platform costs treated on a per-county/per-user basis or as a single shared cost that cannot be charged more than once; and (b) what happens to a project's financing if only some of those county applications are awarded, or if each application requested only partial cost?

Response: For shared functions like a care-management or population-health platform, platform costs should be budgeted based on the actual cost structure proposed by the applicant. If the platform is a single shared system, it cannot be charged multiple times across counties. Applicants should allocate costs proportionally (e.g., per-user, per-site, or another reasonable method) and explain the basis for that allocation.

If only some county applications are awarded, or if each county requested only a portion of the cost, the applicant must restate how the remaining cost will be covered. New York State cannot increase award amounts to fill gaps. Applicants should demonstrate that the project remains fully financed and can still be implemented with the counties that are funded.

Q318. How is the up-to-\$500,000-per-county planning allocation determined? If one application asks for \$300,000 for planning and a second application in the same county asks for \$300,00 for planning, will the state give the applicants the option to share \$500,000 in planning at the county level, or operate independently and each receive \$250,000? Or might one application get a steeper reduction?

Response: Refer to Funding Guidance, Project Scope – Planning which states in part: *Providers are encouraged to collaborate to maximize the use of these funds for planning. Multiple applications for planning funds from the same county will either be asked to collaborate or awards will be reduced accordingly.*

Q319. Will there be \$500,000 of planning awards for each eligible county?

Response: Refer to Funding Guidance, Project Scope – Planning which states in part: *Each county will be allocated up to \$500,000 to develop collaborative plans resulting in integrated health networks that enhance health care delivery, coordination, and outcomes*

in rural areas. Activities should focus on community engagement, assessing community needs using County Community Health Needs Assessments, conducting feasibility studies, developing a governance structure, building integrated partnerships, and developing an implementation ready plan. Activities may also include, but are not limited to, clinical workflow design, financial modeling, and developing plans for technology integration, care coordination, population health improvement, and workforce development.

Q320. Will counties have control over how planning funds are spent, or once awarded will the partners in each application control how funds are spent?

Response: Lead Applicants and Partner Organizations should collaboratively determine how funds are allocated to achieve project goals.

Q321. For multi-county applications, are implementation dollars also able to be multiplied since the project would be covering a larger region? Otherwise, collaboration across counties for planning would limit the amount of implementation dollars for the region. A larger region may have multiple hospital and provider partners that have complimentary implementation priorities.

Response: Please see Q329

Q322. If we propose to implement a project in up to three eligible counties, what is the maximum amount we can request?

Response: Please see Q329

Q323. Is it \$3,000,000 for implementation projects per county/awardee? Or is the \$3,000,000 per awardee, and awardees can cover multiple counties (and there can be multiple awardees per county)?

Response: Please see Q329

Q324. For implementation funding, will multiple applications that provide services in the same counties as each other be considered? Or is it one award per county?

Response: Please see Q329

Q325. Is there a cap to the \$500,000 for Planning and \$3M for implementation per county if an organization is applying for multiple counties? Is the maximum amount available equivalent to the number of counties applied for?

Response: Please see Q329

Q326. For the implementation grants is the \$3,000,000 cap for the total of the potential 3 applications per entity or is that for the entire implementation program?

Response: Please see Q329

Q327. May one lead applicant submit both a planning request and one or more implementation projects in the same application package? If yes, should the planning request be budgeted separately from the \$3.0M implementation cap?

Response: Please see Q329

Q328. Please confirm whether the \$3.0M implementation cap applies to the total implementation request submitted by one lead applicant across all proposed Budget Period 1 implementation projects, rather than to each individual implementation project. Please also confirm whether any approved planning funds are excluded from the \$3.0M implementation cap.

Response: Please see Q329

Q329. Can DOH confirm whether the \$3 million implementation cap applies per project, or across all implementation projects combined? For applicants serving large, multi-county geographies, is there flexibility to adjust this cap?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.

Q330. What happens to the \$500,000 per county if a county does not have a viable application?

Response: The allocated planning funds may not be awarded or may be reallocated if a county does not have a viable application, depending on the Department's discretion.

Funding Caps/Ceilings/Years 2-5 Funding

Q331. Is the \$3,000,000 implementation ceiling applied per application/Lead Applicant, or per county? And could an applicant apply for the ceiling for one project?

Response: The \$3,000,000 implementation limit is per application. Yes, it could be for one project.

Q332. Is the \$3 million cap applied per application or per lead applicant?

Response: Please see Q331

Q333. Can DOH confirm whether the \$3 million implementation cap applies per project, or across all implementation projects combined? More specifically: a. For applicants serving large, multi-county geographies, is there flexibility to adjust this cap?

Response: Implementation applications should be submitted with an application for planning and should be consistent with a collaborative plan resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.

The Department acknowledges that an integrated plan may be in the development stage and will consider implementation applications that lay the groundwork for future program iterations to transform care delivery if they are slated for completion by June 30, 2027. Applications should demonstrate how these implementation projects lead to transformation in subsequent years.

The Department also acknowledges that there may be implementation applications from applicants that are participating in a multi-county planning application. The applicant submitting the implementation application should reference the multi-county planning application in which they are participating. Additionally, the implementation project should be consistent with the planning application.

Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants

covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.

Q334. Can DOH confirm that the \$3 million implementation cap applies to Year 1 only (September 1, 2026 – June 30, 2027), and how funding is expected to change or scale in future years? Will similar caps apply in Years 2–5?

Response: Please see Q335

Q335. Can DOH confirm that the \$3 million implementation cap applies to Year 1 only (September 1, 2026 – June 30, 2027), and how funding is expected to change or scale in future years? Will similar caps apply in Years 2–5?

Response: Maximum funding amounts for Budget Periods 2 – 5 have not been determined and are subject to CMS approval.

Q336. For Budget Periods 2–5, will funding be awarded through a new competitive application process, or does DOH anticipate inviting successful Budget Period 1 recipients to continue? If both approaches are under consideration, can DOH provide additional detail regarding how continuation funding decisions will be made?

Response: Refer to Funding Guidance, Project Scope – Planning which states in part: *Funding opportunities to implement activities identified during the Budget Period 1 planning period will be available in Budget Periods 2 – 5. It is anticipated that grants covering a two-year period will be available to implement activities in Budget Period 2 – 3 and Budget Periods 4 – 5.*

These funding opportunities will be competitive and will cover two-year periods subject to CMS approval.

Q337. How much funding will be available for years 2-5 to support implementation activities? This impacts the work of the integrated health networks to understand the size and scope of their planning activities.

Response: Future funding amounts are subject to CMS approval.

Q338. Can implementation projects be structured in phases, with Budget Period 1 funding supporting initial implementation activities and subsequent phases continuing through Budget Periods 2–5?

Response: Please see Q339

Q339. The implementation projects under budget period 1 can serve as an accelerator for budget periods 2-5 if planned and executed efficiently. Would DOH consider

allowing applicants to submit a tiered or menu-based set of implementation projects that collectively exceed the \$3,000,000 budget and/or 2-3 project limitation listed? This way, DOH could holistically evaluate implementation project proposals and select the best combination of projects to maximize impact, efficiency, and scalability.

Response: Implement projects funded in Budget Period 1 must be completed by June 30, 2027. Subsequent phases may be considered but are subject to availability of funding and CMS approval.

Q340. Is the \$3 million implementation funding cap applied per application, per lead applicant, or per participating entity within a network?

Response: The \$3 million implementation funding cap is applied per application/Lead Applicant.

Q341. It appears that planning funds may be used to develop plans for projects to be funded in later budget periods that will not be completed in 2027. Is that correct? However, the guidance also says: “Implementation activities that lay the groundwork for future program iterations to transform care delivery will be considered if they are slated for completion by June 30, 2027.” Please explain the timing requirements.

Response: All projects must be completed by June 30, 2027 to ensure that funds are fully expended by September 30, 2027.

Q342. Will subsequent initiatives include scope for dedicated planning and design phases, similar to budget period 1?

Response: Budget Periods 2 – 5 will focus on implementation. However, planning activities may be funded in subsequent years if the activities are necessary to achieve RHTP goals subject to the availability of funding.

Q343. Should applications reference Year 2-5 projects and funding estimates? The value of the work done in Year 1 may not be evident without reference to future years.

Response: Applicants should provide information that supports Budget Period 1 proposed projects.

Q344. Is eligibility for implementation funding in Budget Periods 2–5 contingent on project inclusion in Budget Period 1 planning, or participant inclusion in Budget Period 1?

Response: Yes.

Q345. What is the anticipated year 2 process and timing?

Response: Please see Q346

Q346. What is the anticipated timeline for releasing an RFP for Year 2?

Response: Budget Period 2 begins on November 1, 2026. It is anticipated that Funding Guidance documents will be available in the second quarter of 2007 subject to CMS approval.

Q347. Is there a maximum amount that can be requested for an implementation project in Budget Period 1?

Response: Please see Q349

Q348. What is the funding max for implementation for each project?

Response: Please see Q349

Q349. Is the \$3,000,000 implementation ceiling applied per application/Lead Applicant, or per county?

Response: Refer to Funding Guidance, Project Scope – Implementation which states in part: *The total budget for all proposed implement projects should not exceed \$3,000,000.*

Q350. Is there a salary cap for providers?

Response: As required by CMS, the U.S. Department of Health & Human Services (HHS) Executive Level II Salary Cap applies. Any amount paid above the salary cap will be required to be paid with non-federal funds. <https://www.hrsa.gov/grants/manage-your-grant/policies-regulations-guidance/hhs-salary-cap>

General Funding Questions

Q351. Are recruitment incentives allowable if tied to sustainability plans?

Response: Please see Q370

Q352. Please provide additional information on the funding methodology requirements. What should be included in the question on “Describe how the amount was determined for each deliverable listed in the Budget Summary”? Is this a

narrative response or a funding methodology that list a breakdown of staff, hours, salaries, supplies, and other expenses?

Response: Grant contracts resulting from this announcement will be cost reimbursable based on achieving deliverables that are described in the Planning Activities and Implementation Activities section of the Application.

Refer to Planning or Implementation Application – Budget Summary which states in part: *List each deliverable described in the above Planning Activities section and the amount of funding needed to achieve it. Add as many rows as needed to list all deliverables.*

Deliverable	Amount
Total	

Refer to Planning or Implementation Application – Budget Narrative which states in part: *Describe how the amount was determined for each deliverable listed in the Budget Summary. Allowable and ineligible expenses are listed in the Application Guidance on pages 5 - 8.*

Q353. The guidance indicates that planning and implementation projects will be reimbursed based on completion of deliverables. Can NYSDOH provide additional guidance regarding how deliverable-based reimbursement will be structured, including whether reimbursement may occur upon completion of interim milestones or only upon completion of final deliverables

Response: Progress will be measured based on the applicant’s deliverables. Applicants will be required to demonstrate progress towards completing outcomes during the contract period and completion of all deliverables by June 30, 2027. The Department will work with grantees to identify appropriate time frames to achieve outcomes and deliverables.

Q354. What documentation will be required to demonstrate completion of deliverables?

Response: Documentation that supports reimbursement includes, but is not limited to, the following: project plans, resource requirements, project schedules, governance documents, partner agreements, communication plans, purchase agreements, and proof of payment. The Department will work with grantees to define required documentation.

Q355. Will deliverables be structured as phased milestones to support project cash flow?

Response: Yes.

Q356. The guidance prohibits matching funds. Is this prohibition required under CMS guidance, or is it a state program requirement?

Response: This is a CMS requirement.

Q357. How will DOH operationally appropriate and allocate funding to applicants?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs.

Q358. If the delivery of services cannot be covered by this Rural Community Health Integration grants under this solicitation, what funding vehicle will the New York State Rural Health Transformation Program offer to cover the delivery of innovative technology-enabled services that do not readily fit into traditional service delivery categories?

Response: The Department is not able to provide funding beyond the awarded amounts or outside the CMS-approved funding categories under the Rural Health Transformation Program. If a proposed project requires additional resources to deliver technology-enabled services or other activities that fall outside allowable uses, applicants should identify the supplemental funding sources in their application.

Q359. What happens to unspent funds at the end of the first year?

Response: All projects must be completed and fully expended by June 30, 2027.

Q360. How will the \$76.19M in Budget Period 1 be allocated? If there are any formula-based distributions, can they be shared?

Response: All applications will be reviewed to determine how effectively they will establish coordinated rural health partnerships that facilitate comprehensive care coordination and enhance patient access to a wide range of providers across the care continuum, effectively addressing both health and social needs. There are no formula-based distributions.

Q361. Can RCHI funding support expansion of partially funded programs if applied to new populations or services?

Response: Yes, RCHI funding can support expansion if applied to new populations or services, provided these are new activities and do not supplant existing funding.

Q362. Are produce prescriptions or farmers market vouchers an eligible expense for cardiac patients and others with chronic disease?

Response: Yes. However, all funded activities must be sustainable following the grant period.

Q363. Could funds be used for community kitchen equipment such as refrigeration?

Response: Yes. However, all funded activities must be sustainable following the grant period.

Q364. Can funds be used for hydroponic equipment for K-12+ students to grow healthy food within an institutional setting?

Response: Yes. However, all funded activities must be sustainable following the grant period.

Q365. Could funds be used for nutrition education, healthy meal planning, cooking demonstrations and/or cooking equipment for patients?

Response: This may be allowed but is subject to CMS review and approval. Refer to Funding Guidance, Use of Funds – Ineligible Expenses which states in part: *Ineligible expenses include the following.*

- *Meals, including food costs for community meetings and medically tailored meals in schools or in any other context. 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. Meals are allowed as part of a per diem or allowance in conjunction with allowable travel.*

Note that all funded activities must be sustainable following the grant period.

Q366. What is the anticipated timeline for award notifications and contract execution following the July 9 application deadline?

Response: The Department intends to have all contracts executed by September 30, 2026.

Q367. If costs that are eligible for reimbursement are not eligible, is there any impact on our Medicare reimbursement, being that the Critical Access Hospital rate is based on expenses?

Response: This question should be reviewed with the institution's financial advisors.

Q368. Clarify whether signing bonuses or relocation stipends are allowable if tied to workforce stabilization.

Response: Please see Q370

Q369. May funds be used for recruitment incentives?

Response: Please see Q370

Q370. May funds be used for retention of staff?

Response: Funds used for signing bonuses, recruitment, and retention may be subject to a 5-Year Service Obligation. More information is available at this link:

<https://www.cms.gov/files/document/5-year-service-commitment-fact-sheet.pdf>

Q371. Can you describe if the County allocated planning dollars can be shared with partner organizations?

Response: Yes.

Q372. For applicants designated as Social Care Network lead entities under the 1115 Waiver, how should the line between existing waiver-funded HRSN/social-care activities and new RHTP-funded activities be drawn to avoid supplanting - for example, can RHTP fund the extension of HRSN screening and social-care services to non-Medicaid populations not covered by the waiver?

Response: Refer to Funding Guidance, Use of Funds – Ineligible Expenses which states in part: *Ineligible expenses include the following.*

- Supplanting existing state, local, Tribal, or private funding of infrastructure or services, such as staff salaries.
- Using RHTP funds for any project or initiative that is currently funded (or planned to be funded) by other sources.

Funding may be used for activities not currently funded by other sources.

Q373. What level of detail is required to demonstrate a "path to sustainability" for funded initiatives?

Response: Sustainability plans should include clear and realistic plan outlining future funding sources, reimbursement mechanisms, and operational viability.

Q374. Must applicants identify specific future funding sources or reimbursement mechanisms, or is a conceptual sustainability plan sufficient?

Response: Applicants should provide as much detail as is known at the time of submission.

Q375. Are telehealth platform configuration, audio-video endpoint enablement, secure access configuration, endpoint standardization, dashboard development, data integration, interoperability work, documentation workflow design, credentialing support, privileging support, and staff training eligible as technology and implementation costs when tied to specific transformation deliverables and sustainability?

Response: Yes, these are eligible expenses.

Q376. What level of sustainability detail is expected in the Budget Period 1 application? Should applicants include a Year 2–5 sustainability model that may include payer reimbursement, hospital member contributions, retained-revenue value, reduced transfer leakage, shared-service funding, or other post-grant financing approaches?

Response: Sustainability plans should include clear and realistic plan outlining future funding sources, reimbursement mechanisms, and operational viability. As much detail as is known at the time of application submission should be provided.

Q377. Funding Guidance states that grantees are expected to participate in statewide learning collaboratives. Should applicants budget staff time, travel, reporting preparation, and participation support for these learning collaborative activities as part of the project budget?

Response: Yes.

Q378. Can a project cover more than one year? (Note on page 4 of the Funding Guidance it states "It is anticipated that grants covering a two-year period will be available to implement activities in Budget Periods 2-3 and Budget Periods 4-5.")

Response: Refer to Funding Guidance, Project Scope – Implementation which states in part: *In addition to planning, applicants may submit up to three implementation projects for consideration in Budget Period 1. Implementation activities that lay the groundwork for future program iterations to transform care delivery will be considered if they are slated for completion by June 30, 2027.*

The total budget for all proposed implement projects should not exceed \$3,000,000. These projects must be able to be completed within the Budget Period 1 contract period, which begins on September 1, 2026 and ends on June 30, 2027. Projects not able to be fully vouchered by July 31, 2027 will not be considered for Budget Period 1.

Q379. Can a single application include up to three implementation projects that address different key result areas, or must all implementation projects align with a single key result area?

Response: A single application can include up to three implementation projects that address different key result areas.

Q380. Does the Department anticipate that successful applicants will implement new models of care during Budget Period 1, or is the expectation that Budget Period 1 implementation projects primarily establish the infrastructure and partnerships needed to support broader transformation in future budget periods?

Response: Refer to Funding Guidance, Project Scope – Planning which states in part: *Each county will be allocated up to \$500,000 to develop collaborative plans resulting in integrated health networks that enhance health care delivery, coordination, and outcomes in rural areas.*

Refer to Funding Guidance, Project Scope – Implementation which states in part: *In addition to planning, applicants may submit up to three implementation projects for consideration in Budget Period 1. Implementation activities that lay the groundwork for future program iterations to transform care delivery will be considered if they are slated for completion by June 30, 2027.*

Q381. For costs that support multiple deliverables (i.e. personnel), should applicants allocate expenses proportionally across each deliverable, or present them as separate line items outside the deliverable structure?

Response: Costs should be allocated across deliverables as appropriate to support completion.

Q382. The list of allowable costs is based on strategies/activities vs. unallowable costs that are based on type of expenses. It's difficult to determine allowable expenses that align with the strategies/activities proposed in the funding categories/use of funding. Can a list of allowable expenses, based on type of expense, be provided?

Response: Allowable expenses include those that are necessary to complete deliverables, achieve RHTP goals, and are not included in the list of ineligible expenses on page 7 – 8 of the Funding Guidance.

Q383. Is there guidance or limit on subcontracts, vendor, or consultant contracts?

Response: Applicants may propose the use of a subcontractor. Successful applicants shall obtain prior written approval from the Department before entering into an agreement for services to be provided by a subcontractor. Successful applicants are solely responsible for assuring that all the requirements of the funding announcement are met. All subcontracts shall contain provisions specifying that the work performed by the subcontractor must be in accordance with the terms of the prime contract, and that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the agreement between the Department and a successful Applicants. The Department reserves the right to request removal of any successful applicant’s staff or subcontractor’s staff if, in the Department’s discretion, such staff is not performing in accordance with the Agreement. Subcontractors whose contracts are valued at or above \$100,000 will be required to submit the Vendor Responsibility Questionnaire upon selection of the prime contractor.

Q384. Do detailed budgets need to be supplied or just total amount of request that supports activities outlined?

Response: Applicants should submit a budget that includes the total amount of requested funds.

Q385. Should we indicate our request by year, understanding that planning funds requested in Year One may be lower than implementation funds requested in periods 2-5?

Response: Applications submitted in response to this Funding Guidance should be for the period beginning on September 1, 2026 and ending on June 30, 2027.

Q386. Budget Year 1: What is the correct amount of Budget Period 1 funds? Page 1 says \$212,058,207.80 and page 2 says \$76,190,022.?

Response: The total New York State Rural Transformation Program award for Budget Period 1 is \$212,058, 207.80. The amount to be awarded for this Rural Community Health Integration Funding Guidance is \$76,190,022.

Q387. May planning funds be used to support consultant services for feasibility studies, governance design, financial modeling, and strategic planning?

Response: Yes.

Q388. Can planning funds support staff time dedicated to planning activities if those staff are performing new project-related work?

Response: Yes, if they represent new activities and do not supplant existing funding.

Q389. The application allows applicants to submit up to three implementation projects for consideration. Can a hospital-led collaborative submit multiple related implementation projects under one lead applicant using a shared governance model, shared project management structure, shared reporting framework, and common budget oversight?

Response: Yes.

Advance Payments

Q390. Given that awards are structured as deliverable-based reimbursements, will NYSDOH provide advance payments to support project startup costs, staffing, community engagement activities, and planning efforts? If advances are available, please provide guidance on eligibility, amount, timing, and recoupment requirements.

Response: Please see Q395

Q391. The Funding Guidance states that advance payments may be available to not-for-profit organizations. Will advance funding be available under this initiative, and if so, what percentage of the award may be advanced, what documentation will be required, and how will advances be reconciled under the deliverable-based reimbursement model?

Response: Please see Q395

Q392. Under what circumstances will the Department make advance payments to not-for-profit recipients?

Response: Please see Q395

Q393. The guidance references the possibility of advance payments for eligible not-for-profit organizations. Will advance funding be available under this initiative and, if so: a. What percentage of the award may be advanced; b. What documentation will be required; c. How advances will be reconciled under the deliverable-based reimbursement model.

Response: Please see Q395

Q394. The Funding Guidance states that grant contracts will be cost reimbursable based on achievement of deliverables, with advance payments potentially available at the State's discretion for not-for-profit recipients. What advance-payment process, timing, documentation, and limits should applicants anticipate, particularly for small rural hospitals with limited cash flow?

Response: Please see Q395

Q395. Will advance payments be available for municipal entities as well as nonprofit organizations?

Response: Advance payments may be made at the State's discretion to not-for-profit recipients, as outlined in State Finance Law Section 179-u.

Other RHTP Questions

Q396. Are partners allowed to participate in upcoming RHTP solicitations (ex. RHTP Initiative 2: Strengthening Rural Communities with Technology-Enhanced Primary Care) if they participate in this current solicitation for RHTP Initiative 1: Rural Community Health Integration?

Response: Participation in multiple RHTP initiatives is allowed.

Q397. The Funding Guidance states that the Lead Applicant must have 'a three-year or more history of regulatory compliance including adherence to Department of Health rules and other directions. Can a community-based organization fulfill the regulatory compliance requirement to be a lead applicant, given a documented history of compliance with applicable state and federal program requirements outside of the Department of Health and outstanding history serving the identified rural counties?

Response: Yes, if all minimum eligibility requirements are met.

Q398. Will the Department consider community-based organizations with regulatory compliance history acceptable for non-clinical Lead Applicants?

Response: Yes, if all minimum eligibility requirements are met.

Q399. The RFA states the Lead Applicant must have a three-year or more history of regulatory compliance including adherence to Department rules and other directives. Please elaborate on this requirement. For example, would a single regulatory citation in the prior 3 years disqualify a Lead Applicant?

Response: Please see Q400

Q400. How will the three-year regulatory compliance history be evaluated (e.g., treatment of minor vs. significant findings)?

Response: An applicant may demonstrate regulatory compliance by indicating a verifiable record showing continuous adherence with Department Rules and Regulations and other appropriate standards. Compliance history will be reviewed individually and will consider the nature, severity, and circumstances of any citation or issue. A single citation within the prior three years will not automatically disqualify a Lead Applicant. The intent of this requirement is not to exclude otherwise qualified applicants, but rather to assess an organization's demonstrated ability to administer the project in a manner that complies with all applicable regulatory requirements, Department rules, and directives.

Lead Applicants must sign and submit the attestation on Attachment 3 of the Funding Guidance.

Q401. How will the Department evaluate the depth and effectiveness of collaboration among partners?

Response: Collaboration among partners should support the goal of developing a plan to transform rural health care in the service area.

Q402. What level of participation is required from the hospital partner (e.g., formal governance role vs. advisory participation)?

Response: The role of the hospital partner should be appropriate to successfully implement a coordinated partnership to transform rural health care. Active involvement in project activities that align with the hospital's capabilities is expected.

Q403. What documentation is preferred at the time of submission to evidence partner commitment: signed MOUs, letters of participation, letters of support, board resolutions, governance charters, draft subaward agreements, or some combination? Are non-binding MOUs acceptable if definitive agreements will follow after award?

Response: A combination is acceptable. Draft agreements are acceptable.

Q404. If a lead applicant identifies a specific implementation partner, clinical operations partner, telehealth partner, or technology partner in the application, what procurement, subcontracting, conflict-of-interest, or documentation requirements will apply before funds can be used? Should applicants name specific partners in the application, or describe required capabilities and complete procurement

Response: A named partner should be included in the application to confirm the lead applicant has identified the necessary implementation partner(s) prior to award. All procurement, subcontracting, conflict-of-interest, and documentation requirements will follow standard New York State grant processes and must be fully satisfied before any **funds are disbursed.**

Q405. Can an organization apply to the other initiatives once RFPs are released even if they received funding for the Rural Community Health Integration project?

Response: Participation in multiple RHTP initiatives is not prohibited.

Q406. When does DOH anticipate releasing funding opportunities for the remaining Rural Health Transformation Program priority areas?

Response: Please see Q414

Q407. Given the compressed timeline for the RCHI funding opportunity, how does DOH anticipate coordinating the application, procurement, and implementation timelines for the remaining three funding opportunities under the RHTP?

Response: Please see Q414

Q408. Applicants will need to make strategic decisions regarding partnerships, project design, and resource commitments across multiple RHTP funding opportunities. How can organizations best plan for future opportunities when information regarding the remaining funding streams and timelines has not yet been released?

Response: Please see Q414

Q409. Will there be future rounds of RHTP funding released this year for other areas (e.g. rural roots, investments in technology innovation and cybersecurity enhancements for rural New York, etc.)?

Response: Please see Q414

Q410. How does DOH intend to allocate the remaining ~\$136 million of RHTP Year 1 funding not already designated for Rural Community Health Integration?

Response: Please see Q414

Q411. For Initiative 4, is Year 1 funding primarily being used for cybersecurity assessments?

Response: Please see Q414

Q412. Is DOH putting out additional guidance for other initiatives in Year 1?

Response: Please see Q414

Q413. Can you provide the overall roadmap for the full period of the RHTP? Examples include: dates for applications, implementation timeframes, overall grant amounts, and any pertinent details?

Response: Please see Q414

Q414. The Rural Health Transformation Program provides New York State with approximately \$212 million across four priority areas. This funding opportunity proposes to distribute approximately \$76.2 million. Can DOH provide additional information regarding the allocation of the remaining program funds, including anticipated funding amounts?

Response: More information regarding the RHTP may be found at https://health.ny.gov/facilities/transforming_rural_healthcare/. Information regarding additional funding opportunities will be provided soon.

Q415. Could you please clarify whether there is a limit to the number of questions that can be submitted, and confirm the final deadline for submitting questions?

Response: The guidance does not specify a limit to the number of questions. The final deadline for submitting questions was June 18, 2026.