Coordinating care across Wisconsin: Innovating healthcare through partnership grants

Contents

Funding Opportunity Summary

This five-year grant funding opportunity is intended to catalyze innovative healthcare service models through partnerships across communities, systems, and sectors in rural Wisconsin. Through these grants, the Wisconsin Department of Health Services (DHS) aims to address those points in a care continuum where community members are most likely to experience barriers to health-related services or fall out of care, and to directly address fragmented systems of care. Applicants may apply to multiple Rural Health Transformation Program (RHTP) funding opportunities for which their organizations are eligible.

Application Phases

Applications for funding will be released in two distinct phases:

- **Phase 1: Planning grant**. Applicants will submit a letter of application for an initial six-month planning or pilot grant. The planning period will provide an opportunity for awardees to receive technical assistance for application development, build a strong foundation for program implementation, and develop strong partnership models. We recognize that programs may be at different stages of development, from initial idea generation to ready-to-go projects and partnerships. We welcome a range of planning period activities.
- **Phase 2: Full award**. Planning grant awardees will be eligible to submit an application for a full award covering the remaining four-year grant period. The full application will be released in February 2027. Only recipients of an approved letter of application will be eligible to apply for the full award. Full award applications should reflect and build on the work done during the planning period and provide more in-depth program designs.

Key Dates

- Phase 1 Planning Grant
  - Letter of application due: Aug. 21, 2026
  - Application questions due: June 30, 2026. Responses will be posted within one week. Please send questions to: dhsruralhealth@dhs.wisconsin.gov, and place CHW Application Questions in the Subject line.
  - Estimated date for award notification: October 2026
- Phase 2 Full Award
  - Full application due: February or March 2027
  - Estimated date for full award notification: March or April 2027

Estimated funding: A total of $10 million will be available for the first six-month planning period. For the remaining four-year full project period, an estimated $205 million will be available *pending CMS approval, as shown in the table below.

Award phase	Planning Period	Year 1	Year 2	Year 3	Year 4
Dates	Nov. 1, 2026–April 30, 2027	May 1, 2027–April 30, 2028	May 1, 2028–April 30, 2029	May 1, 2029–April 30, 2030	May 1, 2030–Sept. 30, 2031
Total funding available	$10,000,000*	$25,000,000*	$60,000,000*	$60,000,000*	$60,000,000*

Number of available awards: The number of available awards will be determined by the variety and scope of projects submitted. Awards will be made to ensure distribution across regions and counties, with an emphasis on rural communities.

In the letter of application, applicants should estimate their full four-year project budget range. Based on this information, DHS will announce the number of potential full awards that will be made during Phase 2.

Award amount: During the full application process awards will be assessed within funding tiers, by type of project scope, and by regional focus. Broad estimates of the four-year budget tiers are below.

- Tier A: $400,000–$1,999,999
- Tier B: $2,000,000–$4,999,999
- Tier C: $5,000,000–$9,999,999
- Tier D: $10,000,000–$20,000,000

Application submission: All applications must be submitted online through the DHS Coordinating Care Across Wisconsin Grant Application form.

Background

The Wisconsin Rural Health Transformation Program is focused on improving healthcare access and health outcomes in rural communities across Wisconsin. This funding opportunity is part of the Rural Health Transformation Program (RHTP), a federal funding opportunity provided to states through the Centers for Medicare and Medicaid Services (CMS). The Wisconsin Department of Health Services (DHS) received a first-year award from CMS for $203,670,005.21 to invest in rural capacity, sustainability, and innovation. The program aims to improve access to care through three initiatives: strengthening the healthcare workforce, enhancing technology innovation, and cultivating coordinated care partnerships. Through collaboration among healthcare providers, public health agencies, and community-based organizations, the program seeks to improve health and well-being in rural communities.

This funding opportunity is part of the RHTP coordinated care initiative. Rural residents in Wisconsin experience higher rates of chronic diseases, including heart disease and diabetes,

and worse behavioral health outcomes than urban residents. Rural residents struggle to receive appropriate, high-quality, and timely care because of workforce shortages, particularly for primary care and behavioral health. Two-thirds of rural residents must travel more than 30 minutes to access emergency care. Out of 72 counties in Wisconsin, 40 are federally designated as mental health professional shortage areas, 37 as primary care shortage areas, and 34 as dental care shortage areas.

Purpose

Through this funding opportunity, DHS aims to address these challenges by leveraging the resources and innovation within Wisconsin's rural communities. This funding will ensure that healthcare services and resources can be delivered in the most efficient, accessible, and high-quality manner possible.

This grant funding opportunity is intended to catalyze innovative partnership models that coordinate care across systems and sectors in rural Wisconsin. Through these grants, the state of Wisconsin aims to address those points in a care continuum where community members are most likely to experience barriers to health-related services or fall out of care, and to directly address fragmented systems of care.

The goals of this funding are to:

- Establish strong, sustainable, and community-centered healthcare delivery systems
- Increase primary, specialty, and behavioral healthcare access
- Improve prevention, behavioral, and chronic health outcomes in rural communities
- Reduce avoidable hospital admissions and emergency department visits among rural residents

Program Requirements & Letter of Application Scoring

Successful letters of application will address the following:

COMMUNITY NEED & IMPACT (5 points)

- **Community-based evidence of need:** The grant funds should address specific, evidence-based healthcare needs and health outcomes within a community. The state recognizes that the needs and capacity in each rural community vary greatly across the state. For that reason, each applicant should identify the specific healthcare and health issue(s) of greatest need in the area they will serve and that their proposed intervention is best placed to address.

- **Linkages between intervention and proposed outcomes:** Applicants should clearly outline in text, table, or visual model how the proposed activities and partnerships will address the specific needs in the community, and the anticipated outcomes for this work.

PROGRAM DESIGN & IMPLEMENTATION (5 points)

- **New or enhanced care coordination partnerships:** RHTP is focused on transformative work that goes beyond existing service provision or partnerships. Funds awarded under this program must be used to support new or expanded partnerships, services, or activities. Applicants may not use grant funds to maintain existing services or programs. Letters of application should clearly describe how the proposed project represents a new initiative or a substantive expansion of current efforts including any new partners, populations served, geographic areas, or service capacity.

- **Nature of partnerships:** Projects should emphasize collaborations, such as care coordination, service integration, and system-level improvements rather than isolated service delivery. We strongly encourage collaborations between dissimilar community partners, including but not limited to:
  - Collaborations between sectors (e.g. local health department and hospital or health system; social work services and emergency medical services; pharmacies and nutrition support services; community health centers and schools)
  - Collaborations between larger health systems and smaller community-based organizations (e.g. hospitals and youth after-school programs)
  - Collaborations between community-based providers and specialty care providers in other settings (e.g. via telehealth)
  - Collaborations between a service provider and community members to identify the best strategy for bringing care closer to those who need it most.

  We define partnerships broadly for the purposes of this funding. Partnerships that qualify for this funding include any collaborations that bring innovative health service delivery closer to rural residents and communities and break down care silos. Where applicable, when a more formal partnership between institutions is proposed, letters of support from each partner are required in the letter of application and in the full application.

- **Bringing care closer to home:** Many rural residents must travel long distances to access care. Projects should clearly describe how the proposed work will ensure that care is delivered in trusted settings as close to clients' homes as possible.

- **Sustainability:** Applications must include a clear and feasible plan for sustainability beyond the grant period. Proposals should describe how projects will be maintained over time through reimbursement, payer mix, patient volume, operational efficiencies, and other funding sources. In addition, applicants should articulate how their project will contribute to sustainable infrastructure that supports long-term population health improvement.

BUDGET (5 points)

In your letter of application, please include both items below.

- The total amount you request for the planning period (Nov. 1, 2026–April 30, 2027)
- The estimated tier for years 1-4 (cumulative for the four years)
  - Tier A: $400,000–$1,999,999
  - Tier B: $2,000,000–$4,999,999
  - Tier C: $5,000,000–$9,999,999
  - Tier D: $10,000,000–$20,000,000

In the letters of application survey form, you must upload a budget using the template with the following details for your **planning period budget**. This level of detail is not needed within the letter itself.

- **Salary:** Describe your personnel expenses for this project. If none, mark N/A.
- **Fringe:** Describe your fringe expenses. If none, mark N/A.
- **Travel:** Describe travel expenses (transportation, lodging, per diem, etc.) for this project. If none, mark N/A.
- **Contractual Services:** Describe any contractual partners you will fund for this project. If none, mark N/A.
- **Equipment:** Describe any equipment purchases that will be made for this project. Equipment is defined as having a per-unit cost of over $10,000, which requires approval from CMS. Applicants interested in obtaining equipment should include the item and cost in their proposed budget. If the applicant is selected for the planning grant, the state will work with the applicant and CMS to obtain the required approvals. If none, mark N/A.
- **Supplies:** Describe your supply costs for this project. If none, mark N/A.
- **Other:** Describe any other costs associated with this project. If none, mark N/A.
- **Indirect:** Describe costs incurred for a common or joint purpose benefiting more than one cost objective and readily assignable to the cost objectives specifically benefitted. Limited to 8% of the total award amount. If none, mark N/A.

Reporting Requirements: Evaluation

A combination of quantitative and qualitative data will be required quarterly for state and federal evaluation purposes. During the planning period these reports will take the form of brief progress updates and financial reports.

Eligible Applicants

Applicants must be health service providers, or community partners of health service providers, in areas of Wisconsin located outside of Milwaukee County. See Addendum Exhibit 1 for a definition of semi-rural and rural counties. Health services are broadly defined as those entities providing chronic, preventative, wraparound, social services, acute or emergency, and/or behavioral and mental health services to rural and semi-rural residents. Providers can take many forms, including but not limited to the following potential applicants:

- Aging and disability resource centers
- Behavioral health clinics

- Community-based organizations
- Community health centers and primary care clinics
- County human service agencies
- Emergency medical services
- Hospitals and health systems
- Local and Tribal health departments
- Long-term care providers and skilled nursing facilities
- Non-emergency medical transportation
- Pharmacists and pharmacies
- Rural health clinics
- Schools and educational institutions
- Other rural partners

Funding Availability

Submission does not guarantee funding within this opportunity. This allows DHS to assess capacity of interested parties to conduct the work outlined in the scope of work. DHS reserves the right not to award funding to any applicant, and to award fewer or more grants than initially indicated. DHS also reserves the right to award grants for less than an applicant's proposed amount. DHS may award additional funding if more funding becomes available. Should additional funding become available at any point during the grant period, DHS reserves the right to use the results of this grant funding opportunity to increase funding to the selected agencies or to fund additional agencies that submitted an application but were not selected.

DHS uses a cost-based reimbursement model that limits reimbursement to actual allowable incurred costs. If funding is awarded, expenses can be submitted for reimbursement only after they have been incurred.

Use of Funds

Grant recipients will be required to comply with the DHS Allowable Cost Policy Manual and all applicable state and federal reporting, fiscal, and audit requirements, including those incorporated through Addendum Exhibit 2: Federal Compliance Requirements Rural Health Transformation Program. Applicants must clearly describe how grant funds will be used, what technologies will be purchased, and how this will meet community needs. The following allowable and unallowable costs and activities are provided as examples only and are not intended to be exhaustive.

Allowable Costs and Activities (examples)
Direct service and provider payments are subject to the requirements and limitations described in the Direct Service & Provider Payment Details section below. Funds may be used for administration, staff supervision, education, training, coordination etc.

Meeting expenses related to the project: meeting room, audiovisual (AV) equipment, travel, speakers, etc.
Infrastructure to support collaboration, such as billing and/or fiscal infrastructure, technology for billing and tracking services, and administrative support
Program evaluation
Office supplies, postage, copying, etc. related to the project
Consultant and contract services needed to implement the project
Unallowable Costs and Activities (**examples)**
Direct or indirect lobbying activities
Costs or activities not directly related to the overall project description and scope of work
Independent research and development, including associated indirect costs in accordance with 2 CFR 300.477
Construction or building expansion, purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other direct cost that materially increases the value or useful life of the capital
Meals, unless in limited circumstances such as subjects and patients under study, if specifically approved as part of the project or program activity, or as part of a per diem in conjunction with allowable travel
Capital expenditures and capital equipment. Capital equipment costs are defined as all costs associated with the acquisition of assets having a value of more than $10,000, and a useful life of more than one year.
Projects outside of Wisconsin

Direct Service & Provider Payment Details

- At no time may these funds be used to pay for clinical provider salaries or services covered by other funding or insurance mechanisms.
- During the planning period (Nov. 1, 2026–April 30, 2027), **no** funds may be used to cover clinical provider salaries related to direct service provision. **Note**: This only applies to clinical service provision and does not apply to most services provided by allied health professionals. See the Rural Health Transformation Provider Payments Fact Sheet for more information.
- During Year 1 (May 1, 2027–April 30, 2028), **no more than 60%** of a subaward may be used for direct clinical services.
- During years 2–4 (May 1, 2028–Sept. 30, 2031), **no more than 35%** of annual subawards may be used for direct clinical services (see the Fact Sheet for more information).
- A separate funding opportunity is available for Community Health Worker program development, and projects covered by these funds cannot overlap with the scope of that funding opportunity. However, DHS does encourage strategic braiding of funding and initiatives that are synergistic across RHTP funding streams.

Administrative Cost Limits and Determinations

- No more than 8% of the award amount may be used for administrative expenses. This is based on CMS requirements: a 10% cap is applied to the cumulative administrative costs for the entire program, including those incurred by both the State and any subrecipients.
- Personnel costs associated with administering RHTP grant activities may be considered administrative costs. In contrast, if staff are directly carrying out program initiatives, the cost may be considered programmatic.
- Administrative costs support the day-to-day operations and general grant oversight. These costs generally include indirect costs, audit expenses, and salary and fringe benefits for personnel whose primary responsibilities involve managing, tracking, and overseeing the grant.
- More information is available in the Budget Supplemental Guidance document (see Exhibit 3).

Allowable Costs for Construction and Renovations

- Under federal grant regulations, alteration and renovation must be necessary and reasonable for performance of the award and directly related to program objectives. Any renovation or alteration costs will require prior approval from CMS. RHTP staff will submit required renovations requests to CMS for approval on behalf of grantees prior to purchase or start of work. Renovations may not proceed until written approval is received. Additionally, no more than 20% of the total award can be spent on minor alterations and renovations.
- See Exhibit 2: Federal Compliance Requirements for more information.

Project and use of funds examples

- A small hospital partners with a behavioral health provider and school district to expand school-based counseling, increase access to services, and decrease emergency room visits. Components could include:
    - Funding upfront costs like retrofitting school space for confidentiality and setting up a billing system.
    - Hiring specialized counselors.

- A community-based peer support organization partners with local law enforcement and a hospital to provide peer support in jails and emergency rooms. Project goals are to increase access to peer support, reduce overdoses and mental health crises, and increase uptake of other healthcare and services after discharge. Funding could be leveraged to:
    - Pay peer-support specialists not covered by other insurance or payers.
    - Add a module to an existing electronic health record system (EHR) so that peer-support specialists can document progress and share data with other care team members.

    - Train peer-support specialists to use the EHR.

- A community health center uses funds to develop a comprehensive diabetes program, focused on general diabetes prevention and preventing amputation and vision loss. Components could include:
    - Establishing an evidence-based lifestyle change program.
    - Training staff on diabetic retina and foot screenings.
    - Equipping staff with screening technology to provide off-site screenings.
    - Partnering with local entities to bring screenings and nutrition education into the community, such as:
        - Developing culturally tailored education materials.
        - Hosting culturally tailored nutrition classes.
    - Partnering with local health systems to share data and results, refer patients to primary or specialized care, and plan for program sustainability.

- A large health system uses funds to implement several initiatives, including:
    - Establishing or expanding transitional care management (TCM) teams to improve post-discharge outcomes.
    - Implementing a community-based model for obstetrics care management in rural areas that engages patients in prenatal care and assists with social drivers of health like transportation, housing, and health literacy.
    - Integrating behavioral health professionals into rural primary health clinics.
    - Bolstering population health initiatives that focus on chronic disease prevention and lifestyle medicine.

Letter of Application Instructions

Letters of application will be reviewed, and contracts will be awarded for a funded planning period. A total of $10 million dollars is available for funding during this phase. Following the planning period, planning awardees will be invited to submit a full grant proposal, with detailed budgets and workplans, for subsequent funding. The funded planning period will allow grantees to collect and leverage data to support their full proposal, develop strong partnership models, and receive technical assistance.

Please submit a one- or two-page letter of application describing the innovative approach and partnership model that you hope to implement with these funds. Letters should:

- Respond to the points outlined in the Program Requirements section.
- Make the case for a proposed partnership. What problem have you have repeatedly seen in your community that could be solved with more resources to connect partners?
- Be clear and logical, using straightforward and compelling language.
- Include a budget outlining how you will use the funds during the six-month planning period.

Strong letters of application will clearly articulate a problem and/or health issue and provide data to quantify the issue. Organizations may request technical assistance for preparing their applications from the University of Wisconsin-Population Health Institute, Wisconsin Office of Rural Health, and Wisconsin Collaborative for Healthcare Quality. Technical assistance can be requested for describing local health needs using community data, accessing information to quantify the local health context, project evaluation planning, and/or developing performance measures. These partners have no input on funding decisions. To learn more, send a request to RHTP-evaluation@wisc.edu.

Applicants should reach out directly to DHS at DHSRuralHealth@dhs.wisconsin.gov for questions regarding technical difficulties with the application submission process. **Note:** questions about the funding opportunity, including eligibility requirements, budgets, allowable and unallowable expenses, and related topics must be submitted by June 30, 2026, and will be answered through published FAQs.

Details will be shared later about additional technical assistance to support the development of full grant proposals.

Letter of Application Scoring Rubric and Review Process

Letters of application will be reviewed and scored by an evaluation team using the 15-point scale below. Those programs located and providing services in rural counties (rather than semi-rural *alone*) will receive an additional weight of 0.15 on the total scale score. **Note**: All programs must benefit people living in rural and semi-rural areas of Wisconsin, outside of metropolitan hubs. See Addendum Exhibit 1 for a definition of rural counties.

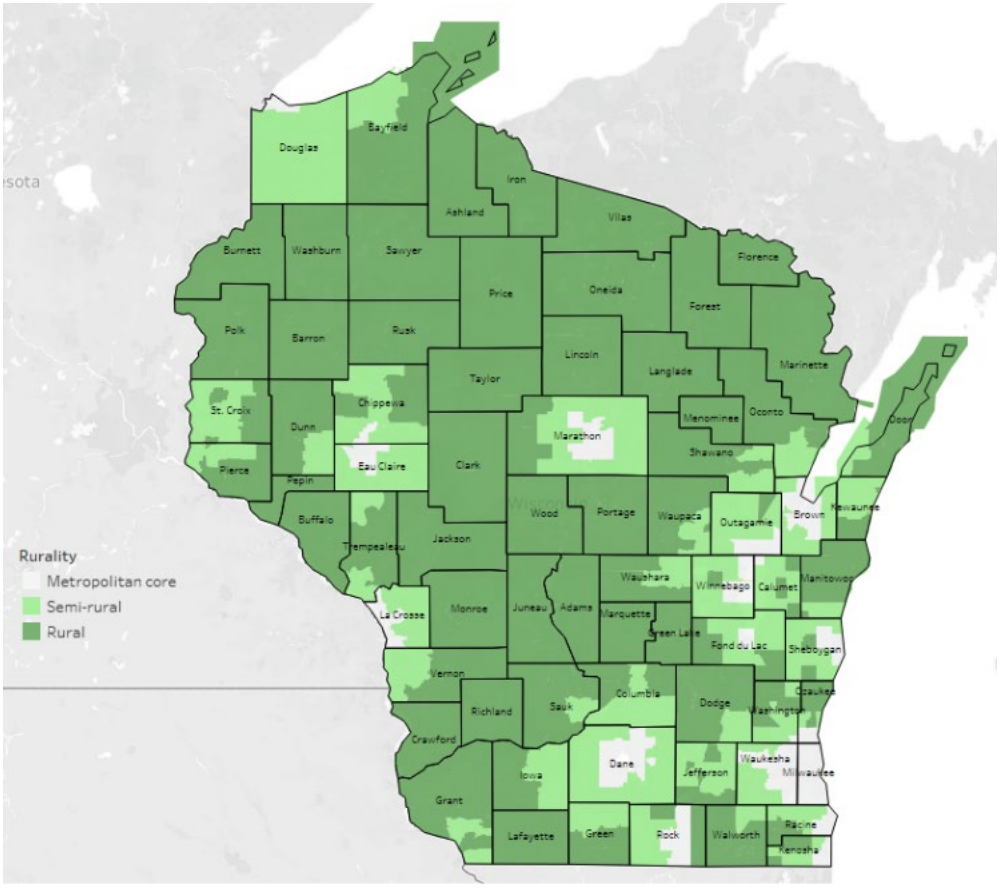
- Community Need and Impact: 5 points
- Program Design and Implementation: 5 points
- Planning Budget: 5 points

All on-time proposals that include all required information will be eligible for review. A committee of subject matter experts and knowledgeable external partners will review proposals and make recommendations for funding applications. Contextual factors such as past performance and spending history, geographic coverage and program reach, and project feasibility may also be considered when making final award decisions.

Addendum

Exhibit 1: Target Areas of Wisconsin

Wisconsin applied to the federal Centers for Medicare and Medicaid Services (CMS) to participate in the Rural Health Transformation Program from 2026 to 2030. The program will improve rural health in rural and semi-rural counties, as defined by the 2020 U.S. Census.



Rural Counties	Semi-Rural Counties
Adams, Ashland, Barron, Buffalo, Burnett, Clark, Crawford, Florence, Forest, Green Lake, Iron, Jackson, Juneau, Lafayette, Langlade, Lincoln, Marinette, Marquette, Menominee, Monroe, Oneida, Pepin, Polk, Portage, Price, Richland, Rusk, Sawyer, Taylor, Vilas, Washburn, Wood	Bayfield, Brown, Calumet, Chippewa, Columbia, Dane, Dodge, Door, Douglas, Dunn, Eau Claire, Fond du Lac, Grant, Green, Iowa, Jefferson, Kenosha, Kewaunee, La Crosse, Manitowoc, Marathon, Oconto, Outagamie, Ozaukee, Pierce, Racine, Rock, Sauk, Shawano, Sheboygan, St. Croix, Trempealeau, Vernon, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago

Exhibit 2: Federal Compliance Requirements
Rural Health Transformation Program

This document sets forth federal funding requirements applicable to federal funds under the Rural Health Transformation Program, authorized by Public Law 119-21 (The One Big Beautiful Bill Act), Section 71401. Subgrantees agree to comply with the federal regulations applicable to this award listed below and all other applicable federal statutes, regulations, executive orders, and requirements applicable to this agreement not described in this document. Awards are also subject to applicable provisions of 2 CFR Part 200 and 2 CFR Part 300. Awards are also subject to CMS reporting requirements.

Limitations - the following costs are not allowed, unless otherwise noted:

1. Pre-award costs.
2. Meeting matching requirements for any other federal funds or local entities.
3. Services, equipment, or supports that are the legal responsibility of another party under federal, state, or tribal law, such as vocational rehabilitation or education services.
4. Services, equipment, or supports that are the legal responsibility of another party under any civil rights law, such as modifying a workplace or providing accommodations that are obligations under law.
5. Goods or services not allocable to the project.
6. Supplanting existing State, local, tribal, or private funding of infrastructure or services, such as staff salaries.
7. Construction or building expansion, purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increases the value of the capital or useful life as a direct cost.
8. The cost of independent research and development, including their proportionate share of indirect costs. See 2 CFR 300.477.
9. Funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order.
10. Purchase of covered telecommunications and video surveillance equipment (See 2 CFR 200.216) as well as financial assistance to households for installation and monthly broadband internet costs.
11. Meals, unless in limited circumstances such as:
    a. Subjects and patients under study.
    b. Where specifically approved as part of the project or program activity, such as in programs providing children's services.
    c. As part of a per diem or subsistence allowance provided in conjunction with allowable travel.
12. Activities prohibited under 2 CFR 200.450 and the HHS Grants Policy Statement, including but not limited to: Paying the salary or expenses of any grant recipient, or

agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any state government, state legislature, or local legislature or legislative body.

13. Lobbying. Awardees can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying.
14. New construction is unallowable. Supplanting funding for in-process or planned construction projects or directing funding towards new construction builds is unallowable. Renovations or alterations, as described in Category J of the program requirements and expectations use of funds section, are allowed if they are clearly linked to program goals.
    a. 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.
    b. Hypothetical, illustrative examples include but are not limited to:
        i. Interior modifications: Installing or relocating interior walls and partitions to create new offices or meeting rooms.
        ii. Lighting and electrical: Upgrading light fixtures to more energy-efficient systems.
        iii. HVAC and plumbing: Replacing vents and thermostats for better climate control.
        iv. Accessibility improvements: Installing automatic door openers to enhance accessibility.
        v. Security and safety: Installing or upgrading security cameras or access control panels.
        vi. Workspace reconfiguration: Creating open office layouts or converting private offices to better suit needs.
    c. Category J funding cannot exceed 20% of the total funding CMS awards states in a given budget period.
15. To replace payment for clinical services that could be reimbursed by insurance. We will not accept payments to clinical services if they duplicate billable services and/or attempt to change payment amounts of existing fee schedules.
    a. If you plan to fund direct healthcare services, you must justify why they are not already reimbursable, how the payment will fill a gap in care coverage (such as uncompensated care or services not covered by insurance), and/or how they transform the current care delivery model.

b. Funding for provider payments, as described in Category B of the program requirements and expectations use of funds section, cannot exceed 15% of the total funding CMS awards states in a given budget period.
c. Funding cannot be used for initiatives that fund certain cosmetic and experimental procedures that fall within the definition of a specified sex-trait modification procedure at 45 CFR 156.400 because that is beyond the scope of this program.

16. No more than 5% of total funding CMS awards to a state in a given budget period can support funding the replacement of an EMR system if a previous HITECH certified EMR system is already in place as of September 1, 2025.
    a. Upgrades, enhancements, and added modules, interfaces, or functionality to existing EMR/EHR systems are allowable uses of funds and are not subject to the 5% limitation.
17. Funding towards initiatives similar to the Rural Tech Catalyst Fund Initiative (as described in the appendix) cannot exceed the lesser of (1) 10% of total funding awarded to a state in a given budget period or (2) $20M of total funding awarded to a state in a given budget period, and funding is subject to all restrictions and requirements described in the example initiative.
18. Clinician salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations.
19. None of the funding shall be used by the state for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-federal share of expenditures required under any provision of law.
20. SSA Section 2105(c), paragraphs (1), (7), and (9) apply as funding limitations. These limitations are related to general limitations, limitations on payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.

Examples of allowable costs:

21. States must focus funding on the following categories as described in Section 71401 of Public Law 119-21:
    a. **Prevention and chronic disease:** Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.
    b. **Provider payments:** Providing payments to healthcare providers for the provision of healthcare items or services, subject to restrictions described in the funding policies and limitations.
    c. **Consumer tech solutions:** Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.
    d. **Training and technical assistance:** Providing training and technical assistance for the development and adoption of technology-enabled solutions

that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.

e. **Workforce:** Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for at least 5 years.
f. **IT advances:** Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.
g. **Appropriate care availability:** Assisting rural communities to right-size their healthcare delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
h. **Behavioral health:** Supporting access to opioid use disorder treatment services, other substance use disorder treatment services, and mental health services.
i. **Innovative care:** Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.

22. Additional uses designed to promote sustainable access to high quality rural healthcare services, as determined by the CMS Administrator, including:
    a. **Capital expenditures and infrastructure:** Investing in existing rural healthcare facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions in the funding policies and limitations.
    b. **Fostering collaboration:** Initiating, fostering, and strengthening local and regional strategic partnerships between rural facilities and other healthcare providers to promote quality improvement, improve financial stability of rural facilities, and expand access to care.
23. Specific examples provided in the Notice of Funding Opportunity include:
    a. States can offer certain incentives to attract clinical workforce to work in rural areas provided the recipient of the incentive commits to working in rural areas for a minimum of 5 years. Funding for local housing for students or trainees in rural areas may be allowable if included as part of an approved initiative within the scope of the RHT Program. Note that payment for student or trainee housing is limited to short-term (less than 6 months) housing for rotations.
    b. Targeted technical assistance and training to help clinicians, medical coders, and other personnel better understand and use existing payment mechanisms already in place for care coordination services via Medicare and Medicaid or other payers.

c. Creating, implementing, or enhancing IT systems, software, or data sharing infrastructure to streamline population health management and care coordination by sharing resources, making referrals, and ensuring the completion of the referral process that help with coordinating amongst stakeholders and/or population health management. Promoting community engagement, awareness of programs, and community input on program development, structure, and oversight.
d. Training and integrating community health workers, care coordinators, peer support specialists, community paramedics, other auxiliary personnel, and behavioral health specialists into the care delivery system. Such personnel can then launch and support targeted outreach programs to engage and educate rural populations.
e. Developing multidisciplinary frameworks to formally integrate non-physician providers such as paramedics, community paramedics, emergency medical technicians, community health workers, and pharmacists into care teams, in collaboration with rural facilities.
f. Developing community-based programs to promote health literacy and healthy behaviors within a population, such as tobacco cessation programs, diabetes management education, or nutrition education.
g. Improving access to primary care and preventative services in innovative sites of care, such as schools, retail centers, public libraries, and home-based visits, and/or via mobile care delivery, such as use of mobile screening vans, community paramedicine, and mobile clinics.
h. Assistance in setting up the legal and organizational framework to create and operate a rural health network including, but not limited to, articles of incorporation, network operating practices, dues structure, and network decision making procedures.
i. Technical assistance to organizations developing or enhancing integrated rural health networks.
j. Technical assistance with restarting closed service lines, such as with recruitment, compliance, or infrastructure.
k. Technical assistance on legal and regulatory issues, such as antitrust navigation and contracting and data sharing between members.
l. Needs assessments for rural communities related to strategic planning of services, including maternity care.
m. Start-up funding to cover providers' initial staffing and equipment to support strategically targeted service line expansion linked to local need until enough volume develops to reach sustainability.
n. IT systems, software, or data sharing infrastructure, such as health information exchanges or frameworks like The Trusted Exchange Framework and Common

Agreement (TEFCA), that help with coordinating amongst providers and supporting population health management.

Additional Resources

- Notice of Funding Opportunity (NOFO)
  - Pages 11-12, 18-20, 97-118
- Rural Health Transformation FAQ
  - Section V. Use of Funds, pages 34-53

Exhibit 3: Budget Instructions

Applicants must submit a detailed budget for the planning period using the required budget template provided with this application. The completed budget template must be uploaded in Excel format as part of the application submission.

The budget should clearly demonstrate how grant funds will be used to support proposed activities and must be consistent with the program design.

This information will be shared with the federal government as part of cooperative agreement oversight. Non-state entities should adapt as necessary to comply with their budget policies. See CMS's website for additional guidance.

Completing the Budget Template

- Use the provided budget template. Please do not modify the format or formulas. Add additional rows as necessary to provide a detailed description of the budget.
- Locate Row 3 and type your organization's name in the designated field.
- Complete columns A through F in the budget table for each line item of your proposed expenses. Provide a detailed line-item breakdown for each cost category, including a description and justification for every budgeted expense.
- Navigate to Column G for every line item. Use this column to ensure your administrative and programmatic funding percentages are properly defined and sum up to 100%.
- Complete all applicable budget categories. When all line items are added, locate cell C54 to verify that your total administrative costs do not exceed the funding limits.
- Ensure all costs are reasonable, necessary, and directly related to the proposed project.
- Submit the budget template for the planning period. This applies to funds allocated from 11/2/2026–4/30/2027.
- The completed budget template must be:
    - Submitted in Excel format (.xlsx).
    - Uploaded under the Budget section with the remainder of the application materials.
    - Included at the time of application submission.

  Applications submitted without a completed budget template may be considered incomplete.

Line-item Breakdown

Budgets must be broken down into specific line-items and assigned to a cost category. For example, salary costs should identify individual positions, and associated salary amounts rather than a single salary total. Similarly, travel costs should be separated into specific expenses such as mileage, lodging, registration fees, or other anticipated travel-related costs. Supplies, contractual services, and other expenses should also be itemized. Providing detailed line-item information allows for a complete review of proposed expenditures and supports the

development of funding agreements, reporting requirements, and grant monitoring activities. Line-items must be rounded to the nearest dollar.

Budget Description and Justification

For each line-item, applicants must provide sufficient detail to explain:

- What the expense is.
- How the cost was calculated.
- Why the expense is necessary for the project.
- How the expense supports project goals and activities.

Examples include:

- Position title, percentage of time devoted to the project, and fringe percentage for personnel costs.
- Number of units and unit cost for supplies and materials.
- Number of trips, travelers, mileage, lodging, or registration costs for travel.
- Scope of work and estimated cost for consultants or contractors.

Budget descriptions should provide enough information for reviewers to understand and evaluate the proposed expenditure without requiring additional clarification.

Administrative Cost Limits and Determinations

Administrative costs are limited to 8% of the total amount allocated to a subrecipient during a budget year. Administrative costs for your budget includes indirect and direct costs that are considered administrative costs. Applicants should explicitly show that administrative expenses are less than or equal to 8%. **Note:** In the budget template, applicants will identify which line items count as administrative expenses (such as program management salaries) and show that their sum is 8% or less of the total.

This cap is based on CMS requirements that no more than 10% of the amount allotted to a State for a fiscal year may be used by the State for administrative expenses (Public Law 119-21). This cap applies to the cumulative administrative costs for the entire program—including those incurred by both the state and any subrecipients. Therefore DHS has determined an 8% allowable administrative cap for this grant funding opportunity. Please see CMS's RHTP Frequently Asked Questions (October 31, 2025), Section II, Question 91, and Section V, Questions 8 and 9, for additional guidance.

The FAQ provides the following further guidance:

- Personnel costs *for administering RHTP grant activities* may be considered administrative costs (FAQ Sec. III, No. 91 and Sec. III, No. 92). If staff are *directly carrying out program initiatives*, the cost may be considered programmatic (FAQ Sec. III No. 92, Sec. III, No. 109).

- Determinations about whether a cost is "programmatic" or "administrative" depends on the nature of the activities performed (FAQ Sec. III, No. 101, Sec. V, No. 62, Sec. V, No. 63).
- Final determinations on costs will be made by CMS. Detailed justifications for requested expenses are necessary to ensure they are approved (FAQ Sec. III, No. 101 and 103).

Examples of costs that are **administrative** (See FAQ):

- General oversight and expenses "such as director's office, accounting, administrative personnel, and other types of expenditures classified as administrative" (FAQ Sec. V, No. 67)
- Salaries for program management staff (FAQ Sec. III, No. 62)
- State personnel costs administering the grant (FAQ Sec. III, No. 92)
- Staff "managing or overseeing the grant itself" (FAQ Sec. III, No. 109)
- Hiring an independent evaluator to collect data and evaluate the program (FAQ Sec. V, No. 62)
- Hiring an accountant to keep track of RHT program funds (FAQ Sec. V, No. 63)
- Hiring staff to train faculty on program or project management (FAQ Sec. V, No. 63)

Examples of costs that are likely **programmatic** (See FAQ):

- Costs are **programmatic** if they are "directly related to implementing, executing, and/or delivering activities described within specific initiatives in the state's application and the state provides sufficient detail in their application to justify their initiatives budget." (FAQ Sec. III, No. 103)
    - Costs directly related to implementing, executing, or delivering activities specifically identified in the state's application are presumed to be programmatic in nature.
    - Any programmatic costs must "support expansion and scale to better serve rural communities, not to replace or duplicate existing funding sources" (FAQ Sec. III, No. 61). If funds are used to expand a pre-existing pilot or program, RHT funds shall only apply "to the costs associated with the new population, new activities, new program milestones" and *not* to supplement costs previously funded by the state or existing fiduciaries.
- Directly carrying out program activities, such as providing technical services, technical assistance, or supporting program operations like expanding programs to rural areas or implementing new initiatives (FAQ Sec. III, No. 109)
- Hiring and training new community health workers to serve residents in a clinical workforce area. (FAQ Sec. V, No. 6)
- Purchasing new patient monitoring devices and educational materials to specifically serve populations in the clinical workforce area. (FAQ Sec. V, No. 6)
- Startup costs to establish new contracts or agreements for service delivery in the counties (FAQ Sec. V, No. 6)

- Hiring preceptors or equipment to facilitate training residents on how to access RHT services or programs. (FAQ Sec. III, No. 103)
- Community colleges using funds to create "a structured, certifiable pathway to a new degree, new certification, or to a career and/or new job opportunity in the clinical workforce area." (FAQ Sec. III, No. 105; **note** the 5-year commitment requirements)
- Hiring an independent evaluator to conduct a needs assessment in rural areas related to a core component one of the state's initiatives. (FAQ Sec. V, No. 62)

Program-Specific Use of Funds Categories

CMS requires RHTP funds are assigned toward at least three of the specified statutory use categories described in the Notice of Funding Opportunity (NOFO) program requirements and expectations. In the application form, applicants will be asked to estimate how much of planning period budget category totals will be allocated to the use of funds categories below. If a cost category applies to more than one use of funds, please estimate the category it primarily falls into.

- **Prevention and chronic disease**: Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.
- **Provider payments**: Providing payments to health care providers for the provision of health care items or services, subject to restrictions described in the funding policies and limitations.
- **Consumer tech solutions**: Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.
- **Training and technical assistance**: Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.
- **Workforce**: Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.
- **IT advances**: Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.
- **Appropriate care availability**: Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
- **Behavioral health**: Supporting access to opioid use disorder treatment services (as defined in section 1861(jjj)(1) of the Social Security Act), other substance use disorder treatment services, and mental health services.
- **Innovative care**: Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.
- **Capital expenditures and infrastructure**: Investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations

and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions in the NOFO funding policies and limitations. Under federal grant regulations, alteration and renovation must be necessary and reasonable for performance of the award and directly related to program objectives. Any renovation or alteration costs will require prior approval from CMS. RHTP staff will submit required renovations requests to CMS for approval on behalf of grantees prior to purchase or start of work. Renovations may not proceed until written approval is received. Additionally, no more than 20% of the total award can be spent on minor alterations and renovations. See Addendum Exhibit 2: Federal Compliance Requirements for more information

- **Fostering collaboration**: Initiating, fostering, and strengthening local and regional strategic partnerships between rural facilities and other health care providers to promote quality improvement, improve financial stability of rural facilities, and expand access to care.

Cost Category Definitions

Term	Definition	Budget line-item specificity	Budget line-item descriptions should include the following:
Contractual Services	Legal instruments for purchasing professional services or property needed for the project. Includes consultants and vendors providing specific expertise rather than performing a significant part of the program scope.	One line item per contract	Vendor, method of selection (RFP, piggyback on existing contract, etc.), contract end date, scope of work, monitoring agency, notes, and budget justification.
Equipment	Tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost that equals or exceeds $10,000.	One line item per equipment type	
Fringe	Employer-paid benefits provided as compensation in addition to regular salaries. This typically includes Social Security, retirement (WRS), health insurance, and worker's compensation, allocated equitably to all project activities.	One line item per fringe benefits for each individual employee	Fringe rate calculations used by your agency.

Term	Definition	Budget line-item specificity	Budget line-item descriptions should include the following:
Indirect Costs	2 CFR 200.1 defines an "indirect cost" as "costs incurred for a common or joint purpose benefiting more than one cost objective and readily assignable to the cost objectives specifically benefitted. Includes "overhead" or general operating expenses of an organization required to operationalize a grant (also known as Facilities and Administrative [F&A] costs). Indirect costs are typically calculated through an indirect cost rate. Note administrative expenses are limited to 8% of the total award amount. Most indirect cost will meet the definition of an "administrative cost" and subrecipients should use a 8% indirect rate. This applies to Modified Total Direct Cost (MTDC) - all direct salaries and wages, applicable fringe benefits, materials and supplies, services, and travel. MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, and participant support costs. Federally negotiated indirect cost rates should not be used. A subrecipient who believes they have an indirect cost that is not administrative should provide more information and a justification for DHS review.	All indirect costs may be grouped into a single line item	

Term	Definition	Budget line-item specificity	Budget line-item descriptions should include the following:
Salary	Compensation for personal services, including all remuneration, paid currently or accrued, for services of employees rendered during the period of performance, including but not necessarily limited to wages and salaries. Note: The salary rate limitation in the current federal appropriations act applies to this program. As of January 2025, the salary rate limitation is $225,700. In addition, funds cannot be used to supplant existing state, local, tribal, or private funding.	One line item per individual employee salary	Hourly salary, time %, annual salary, months of time
Supplies	All tangible personal property other than equipment. This includes "computing devices" (laptops/tablets) if the unit cost is below the $10,000 threshold. Includes basic office tools such as pens, pencils, notepads, staples, paper clips, print cartridges and toners. This may also include services like telecommunications and IT subscriptions.	One line per supply type	
Other	A "catch-all" category for direct costs not fitting elsewhere.	One line per other type	

Term	Definition	Budget line-item specificity	Budget line-item descriptions should include the following:
Travel	Reimbursable expenses for transportation, lodging, and meals incurred by employees on official project business. Please use the uniform travel schedule amounts (UTSAs) in estimating travel costs. In accordance with Wisconsin State Statute, the Division of Personnel Management Administrator, with the approval of the Joint Committee on Employment Relations, establishes the UTSAs. These amounts include mileage reimbursement rates, airfare costs, porterage tips, moving expenses, temporary lodging allowances, and meal and lodging rates. The approved travel schedule amounts are incorporated into the state employee compensation plan and are used by state agencies for budgeting purposes.	One line type of travel and specify in-state or out-of-state travel (e.g. in-state transportation, in-state parking, in-state lodging, in-state per diem, out-of-state airfare, out-of-state baggage fees, out-of-state conference registration, out-of-state taxi/ground transportation, out-of-state lodging, out-of-state per diem)	Purpose, locations, and frequency of travel.