These questions and answers are for the Louisiana Rural Health Facilities Capital Improvement Program, Year 1 Notice of Funding Opportunity (NOFO). Submitted questions were combined and modified in the interest of brevity. This document is intended to be a resource for all prospective applicants.

Application Details

1. **Will year 1 count in 2026 or 2027 will it start July 1 of that cycle year? Will there be a period to apply for year 2 funds as well?**

   RHTP Year 1 will begin upon full execution of a Cooperative Endeavor Agreement, anticipated by September 2026. All obligated Year 1 funds must be spent by September 30, 2027. An additional funding round will be executed in late 2026. Funds awarded for Year 2 must be spent by September 30, 2028. Successive funding rounds will be executed for the remaining three years. New and continued projects will be eligible in each year.

2. **What documentation would LDH expect to see to prove rural need, provider shortage, patient access barriers, and readiness for a project like this? What documentation or assessment is required to demonstrate "documented need," "**

   This documentation varies by project, and no specific template is required. If there is data available to support the need, this will receive higher points for consideration. For example, if a rural healthcare provider has data to support specific diagnostic tests ordered but unable to be conducted within a nearby range or number of referrals to specialty area that cannot be covered.

   Applicants are encouraged to provide objective data demonstrating the rural healthcare need being addressed, such as service gaps, referral patterns, wait times, travel barriers, workforce shortages, utilization trends, or community health indicators. Applications supported by clear and measurable evidence of need may receive higher consideration during review.

   Project readiness refers to the applicant's ability to begin implementation following award. In general, projects that are further along in planning and can demonstrate approvals, vendor engagement, project plans, cost estimates, architectural designs, equipment quotes, or other preparatory work may receive higher readiness scores.

   More guidance on data will be provided during CEA negotiation.

3. **Is there a preferred applicant structure for collaborative projects involving a property owner, licensed healthcare providers, nonprofit/community partners, and rural health service organizations?**
   Licensed healthcare providers are the preferred lead applicant for collaborative proposals including multiple partners. Lead applicants must qualify as "rural" under the

Louisiana Rural Health Transformation Program definition and methodology. To confirm your organization is rural, visit [RHTP Funding Opportunities]

For purposes of this funding opportunity, rural healthcare providers may include rural hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, community health centers, behavioral health and substance use disorder providers, dental providers, and other licensed healthcare entities serving rural populations as defined in the NOFO. When a proposal includes multiple partners, a licensed healthcare provider is the preferred lead applicant whenever practical, particularly when the project directly impacts patient care, clinical services, healthcare access, workforce capacity, or healthcare infrastructure. The lead applicant should have the administrative, financial, and operational capacity to manage grant funds, execute project activities, and report outcomes on behalf of the partnership.

4. **Does the budget cap apply to an entire organization, or just the facility within the larger organization applying to the grant? Can facilities apply for more than one project per year?**
The maximum award size of $10,000,000 is applicable to each project. Facilities can apply for more than one project per year. Project budgets must project expenditures for each project year.

   Organizations that operate multiple facilities may apply on behalf of one or more locations. Applications should clearly identify the specific facility or facilities that will benefit from the proposed project. For organizations with both rural and non-rural facilities, funding should support facilities serving rural populations and demonstrate a clear benefit to rural healthcare access, quality, or capacity.

5. **For larger integrated initiative what is the preferred approach to referencing the overall program goals, target population, outcomes framework and sustainability while ensuring each NOFO response remains focused on the specific eligible activities of that initiative? Is there any guidance on sequencing or layering funding while still allowing each response to stand alone and demonstrate clear linkage to the required outcomes and sustainability?**
When preparing Statements of Work, applicants should describe the larger initiative/project in Section I. Applicant Information.

   Provide information that will describe how the larger project will affect the organization and the individuals served by the organization, including the organization's intent to apply for funds through other RHTP initiatives/strategies. This may include references to other planned RHTP applications for funding.

   Section II. Program Description should focus on the capital improvement portion of the project specifically. The project description and project plan should outline the project's scope, objectives, tasks, milestones and resources related to the capital improvement portion of the larger project.

Applicants should clearly distinguish the activities, costs, milestones, and outcomes supported by this funding from those supported through other funding sources. Leveraging multiple funding sources is encouraged; however, applicants must demonstrate how funds will complement one another and avoid duplication of payment for the same activities, equipment, services, or deliverables.

Note: All strategic NOFOs will all be released by mid July. Applications will be scored and awardees will be notified of selection by mid/late August.

Eligible Use of Funds

Note: Guidance provided by the Center for Medicaid and Medicare Services (CMS) allows states to utilize RHT Program funds to support capital expenditures and infrastructure defined as: 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 funding policies and limitations.

Limitations include:

- **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.**
- **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.**

1. **Would this opportunity allow a phased project where Year 1 funds support facility renovation and telehealth/clinical infrastructure, with future years supporting expanded service delivery capacity?**

   All five funding years of the Rural Health Facility Capital Improvement Program may support minor facility renovations, mobile healthcare units, medical equipment, and technology infrastructure. For multi-year projects, applicants should describe how the investment will increase healthcare access upon completion. Proposed investments must demonstrate measurable improvements in rural healthcare access, quality, operational capacity, and long-term sustainability.

Reporting of access and outcomes must occur throughout the grant process. See the NOFO for further breakdown of these three eligible funding uses. Requests for support of efforts other than these items are not eligible under this strategy, but may be under other initiatives/strategies.

2. **Would investments into mobile clinical units that expand access and reach of clinical programs in rural areas, or modifications to vehicles for clinical care delivery qualify as eligible under the Rural Health Facilities Capital Improvement Program? Would the applicant have to own these vehicles or can they be leased?**
   Yes, funding for mobile units is allowable under this program. LDH has submitted an inquiry to CMS regarding whether leasing of vehicles and mobile clinical units is allowable under this grant opportunity.

3. **Can vehicles for patient transportation to the clinic be purchased under the Capital Improvement Program? What about hiring a "driver" for the vehicle?**
   Vehicles for patient transportation to the clinic are allowable under the Capital Improvement Program. Drivers for patient transport are not eligible under the Capital Improvement program.

4. **Can funding be used to equip/outfit a new build dental practice that is in a rural and underserved area? Such as dental chairs, x-ray units, sterilization equipment, dental instruments.**
   Yes, dental practices qualify under “independent rural practices.” Applicants must qualify as “rural” under the Louisiana Rural Health Transformation Program definition and methodology. To confirm your organization is rural, visit RHTP Funding Opportunities.

5. **What are the non-allowable use of Capital Improvement funds?**
   a. Telehealth equipment (eligible under Telehealth Infrastructure for Rural Access Program)
   b. Electronic Health Records (EHR) (may be eligible under future EHR initiative/strategy)
   c. EHR data migration (may be eligible under future EHR initiative/strategy)
   d. Scheduling technology (may be eligible under Telehealth Infrastructure for Rural Access Program)
   e. Chronic Case Management infrastructure (eligible under Telehealth Infrastructure for Rural Access Program)
   f. Elevation costs for flood mitigation
   g. Repair due to water/storm damage that is covered (in whole or in part) by property insurance
   h. Exterior canopies, covered walkways or covered entries
   i. Construction of new clinical buildings on an existing campus
   j. ADA accessibility upgrades
   k. Parking/access improvements
   l. Labor related to setup configuration and testing of infrastructure or one time integration costs (may be eligible under Telehealth Infrastructure for Rural Access Program)
   m. Outreach and engagement services that are not reimbursed under Medicaid

n. Salaries/wages and fringe benefits for a newly recruited providers (may be eligible under the Rural Clinician Credit Bank)
o. AI-powered revenue-cycle-management or patient-billing platform — a subscription service handling eligibility verification, cost estimation, patient payments, statements, and collections that integrates with the EHR

6. **Can network, connectivity, and cybersecurity upgrades support telehealth operations, may they be funded under the Capital program's "Technology Infrastructure" category — and if an applicant also applies to the Telehealth program, how should these costs be partitioned to avoid duplication?**

   If the proposed upgrades support broader organizational needs beyond telehealth, such as overall network modernization, cybersecurity, interoperability, or operational infrastructure, they may be requested through the Capital Improvement Program. If the activity is directly related to supporting the telehealth operations, this should be requested through the Telehealth Improvement Program.

   Applicants may apply to both programs as part of a larger initiative; however, funding requests must be clearly delineated, and the same costs may not be requested or reimbursed through multiple funding opportunities. Applicants should describe how the proposed projects complement one another and identify the specific activities, costs, and outcomes associated with each funding request.

7. **Would renovation of non-clinical support areas, such as community education space, patient intake/waiting areas, HVAC, plumbing, electrical, expansion of an existing structure or shared workspace for visiting providers, be allowable if directly tied to rural healthcare access and service delivery?**
   Yes, these capital improvement expenditures are allowable if directly tied to rural healthcare access and service delivery.

8. **Is the build-out or renovation of dedicated telehealth and behavioral-health rooms within an existing facility considered an allowable "renovation or alteration to an existing building," as distinct from prohibited new construction? Does expanding/adding square footage to an existing building count as renovation or as new construction?**
   The Rural Health Transformation Grant allows for “minor renovations”; individual scenarios may require CMS review and guidance to determine if the proposed project is compliant with the funding opportunity. Expanding/adding square footage to an existing building new construction, and it cannot be funded through this funding opportunity.

9. **Would costs associated with obtaining Rural Health Clinic (RHC) certification qualify as an eligible project expense if the certification activities are directly tied to improving rural healthcare access, operational sustainability, care coordination, and service delivery capacity? If RHC certification itself is not an allowable expense, can projects that directly support RHC readiness and compliance be funded?**
   Capital Improvement costs, listed as eligible in the NOFO, associated with obtaining RHC certification are allowed if they can be tied to priority funding areas.

10. **Would an existing rural property/building be eligible for renovation funding if the proposed project converts the space into a rural health access hub offering clinical exam/consultation space, telehealth access, care coordination, and scheduled services from licensed healthcare providers?**

    No. The Rural Health Facilities Capital Improvement Program is intended to support existing licensed rural healthcare providers and healthcare facilities. Renovation of an existing property or building for the purpose of creating a new healthcare facility, health access hub, or similar site that is not currently operated by a licensed rural healthcare provider would not be eligible under this funding opportunity.

11. **Would Capital Improvement funds be eligible for the renovation and expansion of an existing building that is not currently being used as a healthcare clinic in order to create clinical space for the operation of an SBHC?**

    No. The Rural Health Facilities Capital Improvement Program is intended to support existing licensed rural healthcare providers and healthcare facilities. Renovation, expansion, or conversion of a building that is not currently being used as a healthcare facility for the purpose of establishing a new school-based health center or other new healthcare site would not be eligible under this funding opportunity.

12. **What are the limitations on equipment purchases?**
    Requested equipment purchases must be tied to documented need for priorities listed in the NOFO. Further federal guidance see, § 200.439 Equipment and other capital expenditures

13. **We need to move our chemotherapy and infusion center into a new building. Are renovation costs eligible for funding?**
    Yes. Renovation costs related to relocation for improved or expanded access are allowable.

14. **Is renovation meant to allow for greater compliance (eg- glassing in a nursing station to better protect patient privacy) eligible for reimbursement?**
    Yes. Renovations that improve patient care, privacy, safety, operational efficiency, or compliance with healthcare standards may be eligible. Applicants should provide documentation demonstrating the need for the renovation and describe the expected impact on healthcare delivery, patient experience, or measurable outcomes.

15. **Are equipment deposits eligible for reimbursement?**
    Non refundable equipment deposits paid during the grant period are eligible for reimbursement.

16. **Would one time investments into technology infrastructure such as purchase, set up and configuration of EMRs, care management systems, data warehouses and analytic applications to manage rural populations qualify? Would one-time systems integration costs qualify (for example, integration of multiple rural computer systems)?**
    The Rural Health Facilities Capital Improvement Program is intended to support capital investments such as facility improvements, medical equipment, mobile healthcare units, and related healthcare infrastructure. Applicants seeking support for EMR, telehealth or technology system modernization initiatives should consider other applicable RHTP funding opportunities (telehealth, EMR, interoperability)

17. **Are there any limitations or documentation requirements that applicants should consider when budgeting for these associated infrastructure modifications?**

    Review the NOFO for limitations.

18. **If only part of a building is used for direct healthcare access and part is used for farm products, wellness retail, or community programming, how should costs be allocated to ensure only eligible healthcare-related capital improvements are requested?**
    Projected capital improvement funds should only be requested for the portion of the building related to healthcare access. A separate quote for the eligible portion of the building should be obtained for application preparation. A separate invoice for the eligible portion of the building should be obtained for reimbursement purposes.

19. **If awarded, may grant funds be used to replenish working capital that was spent on eligible startup or equipment expenses?**
    Grant funds may only be requested for eligible expenses that are expended during the contract period.

20. **How does the five-year maintenance requirement apply to technology and equipment whose useful life is shorter than five years (for example, end-user devices and certain software)? Is the requirement satisfied by maintaining the funded capability or service line for five years, including through routine refresh at the subrecipient's expense?**
    Yes, the requirement can be met by maintaining the capability or service line for five years**.**

28 **For a Federally Qualified Health Center that operates both rural and non-rural sites, is the funding scope limited to the rural sites, and may a cross-site technology project that primarily serves the applicant's rural sites and rural patients be funded? Which basis — geographic location, rural patient population served, or provider-shortage designation — should a multi-site FQHC use to document rural eligibility?**
    Capital improvement funding is available for improvements of rural sites only.

Project Specific Questions

1. **Would capital improvements to shared-use clinical/community health space be eligible if the space supports rural access to primary care, maternal health, behavioral health, telehealth, health education, care coordination, and referrals?**
   Capital improvements to shared-use clinical and community health space may be eligible if the proposed project primarily supports rural healthcare access and delivery, including services such as primary care, maternal health, behavioral health, telehealth, care coordination, health education, and referral services.

   The lead applicant should be a licensed rural healthcare provider that is responsible for delivering or coordinating healthcare services within the space. Applicants should clearly describe the ownership, lease, operating, or partnership structure governing the facility and demonstrate that the arrangement supports the intended healthcare use of the space for the duration of the project. Applications should also demonstrate how the proposed improvements will result in measurable benefits to rural patients and healthcare outcomes.

2. **Would a rural community-based wellness center focused on chronic disease prevention, nutrition education, food-as-medicine initiatives, telehealth access, and preventive health programming qualify as an eligible healthcare service delivery model under the Rural Health Facilities Capital Improvement Program?**
   A rural community-based wellness center may be eligible if it supports a healthcare delivery model that improves rural health access, prevention, chronic disease management, care coordination, or other measurable health outcomes. The lead applicant should be a licensed rural healthcare provider, and the application should demonstrate how the proposed services are integrated with healthcare delivery and benefit rural patients.

3. **Can capital investments (equipment, technology infrastructure, allowable clinical space upgrades/renovations) be used to equip or modernize school-based or school-linked clinics that function as new or expanded rural access points for primary care, behavioral health, and preventive services? How should we best document the direct linkage to rural health facility goals and measurable access outcomes when primary delivery sites are schools or school partnerships? Can we apply for technology infrastructure for the overall school based health initiative as a capital expenditure?**
   Capital investments supporting school-based or school-linked health clinics may be eligible when the project expands access to healthcare services for rural populations, including primary care, behavioral health, preventive services, telehealth, or care coordination. The lead applicant should be a licensed rural healthcare provider, and the application should demonstrate how the proposed investments support healthcare delivery and measurable rural health outcomes.

   Technology infrastructure, equipment, and allowable facility improvements may be included when directly tied to healthcare services provided through the school-based health initiative. Applicants should clearly identify the specific healthcare services, target population, and expected access or health outcome improvements associated with the proposed investment.

4. **Would a commercial kitchen or food preparation area be eligible if it supports medically relevant community health programming, such as nutrition education, food-as-medicine programming, maternal health support, chronic disease prevention, or access to healthy local foods for rural residents? Can food access infrastructure be considered an eligible rural health investment when the project is designed to address documented food insecurity, chronic disease, maternal health, nutrition-related conditions, or other social determinants of health in rural communities?**
   A commercial kitchen, food preparation area, or food access infrastructure may be eligible when it is part of a healthcare delivery model designed to address documented food insecurity, chronic disease, maternal health, nutrition-related conditions, or other health needs affecting rural populations. The lead applicant should be a licensed rural healthcare provider, and the application should demonstrate how the proposed investment is integrated with healthcare services and will produce measurable health or access outcomes for rural patients.

5. **Are the following considered allowable capital improvements: Renovation of EMS or CP facilities to support telehealth or chronic care programs Construction or expansion of community paramedicine hubs Acquisition of non-transport CP vehicles Outfitting vehicles with telehealth or diagnostic equipment**
   Capital improvements supporting EMS or community paramedicine programs may be eligible when they expand access to healthcare services for rural populations and are integrated with a broader healthcare delivery model. The lead applicant should be a licensed rural healthcare provider, and the application should demonstrate measurable improvements in healthcare access, care coordination, chronic disease management, emergency care, or other health outcomes. Eligible investments may include facility renovations, community paramedicine infrastructure, non-transport vehicles, telehealth equipment, and diagnostic technology when directly tied to the delivery of healthcare services.

6. **The project seeks to replace an existing CT scanner and/or MRI unit that has reached end-of-life and is currently limited by technical specifications that restrict our ability to adequately serve our rural population. The proposed project would involve replacement of the imaging equipment within its current location and may require associated room modifications necessary for installation and operation of the new equipment, including electrical upgrades, HVAC/cooling modifications, shielding enhancements, and other site preparation activities required to support the equipment specifications. Would this project be considered as eligible expenses under contractual services or facility renovation/alteration activities; or**
   Yes. Replacement of existing clinical equipment may be eligible under the Rural Health Facilities Capital Improvement Program when the investment supports enhanced access to healthcare services for rural populations. Associated site preparation and facility modifications necessary for installation and operation of the equipment, including electrical, HVAC, shielding, structural, and other required infrastructure upgrades, may also be eligible. Applicants should clearly identify the equipment being replaced, document the operational or clinical limitations of the existing equipment, and demonstrate how the proposed investment will improve access, capacity, quality, or other measurable healthcare outcomes for rural patients.

Eligible Organizations

1. **Does the eligible applicant need to own the building, or can a licensed healthcare provider or eligible rural health organization apply in partnership with the property owner through a lease, memorandum of understanding, or other formal partnership agreement?**
   Licensed healthcare providers are the preferred lead applicant when leased space is involved. Lead applicants must qualify as "rural" under the Louisiana Rural Health Transformation Program definition and methodology. To confirm your organization is rural, visit RHTP Funding Opportunities

2. **Which licensing agency provides for independent rural practices or rural physicians? does the provider have to accept medicaid to participate in the initiative #5?**
   Healthcare providers, including physicians, nurse practitioners, and physician assistants, must be licensed by the Louisiana State Board of Medical Examiners (LSBME). Medicaid acceptance is not required.

3. **Under the eligibility category of "Independent Rural Practices," are independently owned speech-language pathology practices eligible applicants under this funding opportunity?**
   Yes, speech language pathology practices are eligible.

4. **Are chiropractic, maternal health, behavioral health, nutrition, and preventive health services considered eligible service areas if they are provided by appropriately licensed professionals and tied to measurable rural health outcomes? Does a currently operating primary care clinic qualify if not yet certified as an RHC? Do independent NP-owned primary care clinics qualify?**
   Yes, they qualify as independent rural practices. Healthcare providers affiliated with the practice, including physicians, nurse practitioners, and physician assistants, must be licensed by the Louisiana State Board of Medical Examiners (LSBME). Other providers must provide proof of licensing by the appropriate body.

5. **The NOFO describes small rural hospitals as having 50 beds or less. Does this number only include acute beds or other beds which are part of different departments such as distinct-part inpatient psychiatric units? If a hospital has 44 acute beds and 16 "distinct-part" psychiatric beds, does it still qualify as a rural hospital?**
   The NOFO has been revised to remove "small rural hospital" and replaced the term with "rural hospital."

6. **Are public entities that run urgent care centers eligible? Are public entities eligible (FQHC/Hospital)?**
   Yes. Applicants must qualify as "rural" under the Louisiana Rural Health Transformation Program definition and methodology. To confirm your organization is rural, visit RHTP Funding Opportunities.

7. **A Regional Medical Center is a hospital service district licensed for 96 beds is qualified under the Rural Protection Act and serves a population of 38,000. What category or licensing agent should we apply under?**
   The organization should apply as a Rural Hospital and provide proof of rural qualification under the Rural Protection Act.

8. **If a site is a CMS designated Rural Health Clinic but is not identified as rural using the HRSA Eligibility Analyzer website, does the RHC need to provide proof of 50% of patients living in rural census tracts (Eligibility Pathway 3)?**
   The organization should provide proof of rural designation provided by CMS or requested documentation for Eligibility Pathway 3.

9. **Can a nonprofit RHC association, apply directly for this grant, or must each individual RHC apply separately for capital improvements at its own facility?**
   Each individual rural provider must apply for capital improvements at its own facility.

10. **If a rural community organization is not itself a licensed healthcare provider, can it participate as a formal project partner under an application submitted by an eligible rural healthcare organization?**

    Yes, a non-licensed organization can partner with a licensed healthcare provider.

11. **Can an applicant partner with licensed healthcare providers, such as physicians, nurse practitioners, chiropractors, behavioral health providers, midwives, doulas, or other qualified rural health professionals, if the property owner is not currently licensed by LDH as a healthcare facility?**
    No.

12. **Our proposed model uses school-based clinics as innovative access points for whole-person primary and behavioral health care serving rural Medicaid children. Can we qualify directly (or through a formal partnership with a licensed rural entity), and what is the preferred application structure (lead applicant vs. subrecipient/partner) if a licensed entity is required? Are providers who deliver care in rural school settings eligible for this NOFO?**
    A rural health care provider must be the lead applicant. For the purposes of capital improvement, school settings are not considered eligible; however, school based health clinics are eligible to apply for funding. School based health clinics must be in a rural parish, per Pathway 3.

13. **Can a rural food cooperative partner with an eligible healthcare organization to apply for funding if the project demonstrates measurable healthcare outcomes related to nutrition access, chronic disease management, maternal health, or food insecurity? Are refrigerated vehicles, mobile food distribution units, or mobile market infrastructure considered eligible capital expenses when directly connected to improving health outcomes in medically underserved rural populations?**

Yes.

Scoring Questions

1. **What project types are expected to score highest for rural primary care clinics?**
   Projects that leverage funds to enable ongoing revenue generation, reduce operating costs, or support scalable service models (e.g., telehealth, care coordination infrastructure) will be viewed more favorably.
   - Applicants must describe the anticipated post-grant operating model for the proposed telehealth infrastructure investment, including expected utilization, staffing support model, reimbursement strategy, payer alignment, anticipated telehealth-related revenue generation, and long-term maintenance or technology support plans.
   - Sustainability plans should clearly explain how the proposed investment will remain operational, financially viable, and integrated into routine care delivery workflows following the conclusion of grant funding.
   - Projects that demonstrate scalable and sustainable service models, improved operational efficiency, reduced long-term costs, enhanced reimbursement opportunities, or measurable support for ongoing rural healthcare access and care coordination will be viewed more favorably during application review.

2. **Would letters of commitment or MOUs from collaborating licensed healthcare providers strengthen eligibility and competitiveness?**
   Yes, proof of community partnerships and collaboration strengthens both eligibility and competitiveness of projects.

Budget and Invoicing Questions

1. **What level of financial documentation is expected?**
   Subrecipients must maintain source documentation such as paid bills, payroll records, receipts and vendor contracts to justify all expenditures. This documentation should be included with invoices requesting reimbursement for allowable expenses.

   The expenditures should be allowable, allocable, and reasonable and invoices should include sufficient detail for audit purposes.

2. **Are assets or funds originally derived from federal sources excluded from the match, consistent with federal cost principles?**
   Yes.

3. **Will reimbursements be processed monthly as milestones are completed, or must the subrecipient fully complete and pay for a project before reimbursement? For multi-year capital projects under the reimbursement (incur-then-invoice) model, can milestone-based reimbursement schedules be established to limit upfront cash outlay, is any advance or accelerated payment available, and what is the expected reimbursement turnaround after an**

approved invoice? How quickly are reimbursement requests processed? (Avg Turn around time)
Subrecipients may submit monthly invoices to LDH for reimbursement of allowed expenditures. Proof of payment must accompany invoices. Subrecipients must maintain source documentation such as paid bills, payroll records, receipts and vendor contracts to justify all expenditures. This documentation should be included with invoices requesting reimbursement for allowable expenses.

Invoices requesting payment for reimbursement and accompanying supportive documents will be accepted on a monthly basis. All payments will be processed promptly, as prescribed by CMS, once invoices are approved by LDH.

4. **Is there a minimum reimbursement request amount?**
   There is a minimum award amount of $100,000.

5. **If an organization applies to more than one program, may the same in-kind contribution be counted toward the 10% match on more than one application, or must the match be distinct for each award?**
   In kind or in cash contributions must be distinct for each award.

6. **Is a specific valuation methodology or documentation required for in-kind staff time and donated platform/connectivity? Can letters of support, donated professional services, staff implementation time, vendor discounts, and hospital partnerships be counted toward the required 10% match, and what documentation is required? Are applicants permitted to include in-kind contributions such as donated space, discounted lease value, volunteer professional time, donated equipment, or partner-provided services toward the required 10% match? Both Initiative 4 and Initiative 5 require a mandatory minimum 10% cost share/match and a detailed sustainability/post-grant operating model. What types of in-kind contributions (e.g., existing technology platforms, data integration capabilities, school partnership agreements, or development of Alternative Payment Model/VBC infrastructure) qualify toward the match? What level of detail is expected in the sustainability plan when the post-grant model relies on a combination of existing and future VBC/APM contracts with Louisiana MCOs? What are not acceptable matching pathways? Are newly established clinics eligible to include startup costs as matching funds or in-kind contributions? May the required match be satisfied entirely through in-kind contributions — specifically applicant staff time and existing applicant-owned equipment or board-designated funds — without any cash match? Can the cost share or 10% "match" come from a loan through local bank for the project or does it have to be self funded?**
   Applications should include for LDH review and approval:
   1. A description/itemization of each contribution that will make up the minimum 10% cost share, including the relationship of the contribution to the project goals.
   2. A proposed method of documentation for each contribution.
   3. All contributions must be expended during the contracted project period.
   4. Contributions may be in-kind or in-cash.

7. **As a rural primary care clinic established within the last year, can previously purchased clinical equipment, diagnostic devices, EHR implementation costs, telehealth technology, office buildout expenses, and other startup investments be included for reimbursement or credit toward matching fund requirements?**
   All expenses whether requested for reimbursement or serving as match must be expended during the contracted project period.

Performance Metrics

1. **Are there any specific preferences or requirements in the Statement of Work appendices, quarterly/annual reporting, or measurable outcomes expectations for Initiatives 4 and 5 regarding pediatric/school-based populations, integration with school data systems, Health Information Exchanges, or MCOs, or alignment with broader RHTP goals such as innovative care models and long-term sustainability?**
   Examples of performance measures may include, but are not limited to:
   - Expansion of patient access capacity or service availability
   - Increase in patient volume or number of rural residents served
   - Reduction in wait times, delays in care, or patient transfers
   - Expansion or stabilization of essential rural healthcare services
   - Improvement in patient and workforce experience
   - Improvement in care coordination, referral management, or operational workflows
   - Increased access to behavioral health, maternal health, specialty, emergency, or chronic disease services
   - Improvement in technology infrastructure, interoperability, connectivity, or digital health capabilities
   - Completion of infrastructure modernization milestones, facility upgrades, equipment implementation, or operational readiness targets
   - Improvement in operational efficiency, sustainability, resiliency, or healthcare delivery capacity
   - Reduction in infrastructure, equipment, or facility limitations that negatively impact patient care or access

Rural Determination

1. **Where eligibility is based on "rural patient population served," is there a minimum threshold (e.g., a percentage of patients residing in rural parishes or ZIP codes), and how is a "rural patient" defined for this purpose?**
   Per the Louisiana Rural Health Transformation Program definition and methodology. 50% or more of served patients must be rural as determined by their residential zip code. For more information visit, visit RHTP Funding Opportunities