

These questions and answers are for the Louisiana Rural Clinician Credit Bank, 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.

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## Application Details

- 1. Please confirm the correct application deadline for Year 1 funding (June 18 vs. June 25, 2026), as both dates appear in program materials.**

Applications are due June 25, 2026

- 2. Is there a page limit for the narrative, and will additional attachments such as logic models, cost benefit analysis, economic impact statements be accepted?**

There is no page limit. Attachments are accepted

- 3. Will applications be evaluated competitively by provider type; proven sustainability; Years in service; Financial Strength; and quality outcome, Or will all complete applications be evaluated by provider type only?**

Application evaluation will be based on program eligibility, completeness of application materials, availability of funds, demonstrated workforce need, rural impact, and alignment with program priorities.

- 4. For Year 1 awardees, what will be the process for continuation and renewal?**

All Cooperative Endeavor Agreements (CEAs) will be executed for a three-year period with an option to renew for an additional two years. This option will be exercised to allow for the mandated five-year reporting period. Applications must designate the budget year that the financial support is projected to be expended. Funds will be obligated to subrecipients each budget year, after the state receives notification of obligation from CMS.

## Federal Regulatory Compliance

- 1. With respect to the use of grant funding for retention bonus paid to physicians, is LDH aware of any federal guidance waiving the requirement for compliance with the Stark Law retention bonus exception (42 C.F.R. § 411.357(t))?**

No known blanket federal waiver exists for Stark compliance merely because federal grant funding is involved, absent a specific CMS waiver, statutory waiver authority, or emergency declaration authority. Retention bonuses are exempt from Stark Law prohibition, only if the bonus is set out in writing and signed, does not exceed fair market value, does not take into account the volume or value of referrals to DHS, satisfies commercial reasonableness standards, and complies with the detailed conditions in [42 C.F.R. § 411.357\(t\)](#). Otherwise, the arrangement will potentially violate the Stark Law and result in penalties.

Additionally, even if Stark is satisfied, physician retention incentives may also implicate the Federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b) & 42 C.F.R. § 1001.952) if remuneration could induce referrals of federally reimbursable services. Thus, compensation should: not be tied to referral volume; not reward DHS generation; and be consistent with FMV and commercial reasonableness.

Lastly, because the retention bonuses are federal grant dollars, all expenditures must comply with the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 C.F.R. Part 200). Thus, the Retention bonuses funded through the grant must satisfy: necessity, allocability, reasonableness, and programmatic purpose requirements.

**2. Since these are federal funds, will we be required to complete a single audit report?**

All subrecipients of federal funds, as defined in 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), shall comply with all applicable requirements of 2 CFR Part 200. Visit [here](#) to download the full announcement Rural Health Transformation Program for more details.

Whether an organization will be required to complete a Single Audit will depend on the total amount of federal funds the organization expends during its fiscal year, not solely on receipt of RCCB funds.

If the aggregate expenditures of Federal awards in a fiscal year total \$1 million or more beginning for federal fiscal year ended September 30, 2025, those subrecipients will be subject to single audit requirements.

**3. How will receipt of this grant funding impact a Rural Hospital's annual Medicare and Medicaid cost reports?**

Subrecipients are not automatically required to offset allowable costs on a hospital's Medicare of Medicaid cost report. The treatment of RCCB funding depends on the purpose and structure of the grant under the Medicare Provider Reimbursement Manual (PRM 15-1), Chapter 6.

However, grants specifically designated to reimburse certain operating expenses or patient care costs may be required to offset those costs on the cost report.

Because the reporting treatment can vary depending on the grant terms and the type of expense being funded, hospitals should review the grant structure with their reimbursement consultant and Medicare Administrative Contractor (MAC) prior to filing the cost report.

## Eligible Use of Funds

- 1. Can this help continue pay a current provider in the area? Are these strictly "bonuses" to be paid to staff or can it be used for salary? Can the funding be used for the payment of resident salaries by a resident program who has already gotten a commitment from an enrolled resident for employment? Does this supplement their pay or does it provide 100% of their compensation?**

Rural Clinician Credit Bank (RCCB) funds cannot be used to pay salaries or associated fringe benefits. RCCB funds are intended to supplement, not supplant, salaries for a set time period and purpose. Funding support should supplement and not replace existing compensation obligations, and employers should not reduce base compensation due to receipt of RCCB incentive funding.

- 2. Does the "salary" include what's paid out for things like CME, insurance, etc?**  
Salary, no fringe benefits, can be utilized to determine appropriate requested financial support as designated in the NOFO.

- 3. Can retention bonuses be offered to existing qualified staff, or are they intended only for newly hired clinicians? If allowed, are there any restrictions on using Rural Clinician Credit Bank funds for retention incentives for current clinicians? Can funds be used for retention incentives for existing staff, or are they limited to new hires?**

RCCB funds may be utilized for four types of financial support

- **Sign-on bonuses** for newly hired rural clinicians
- **Retention bonuses** for clinicians already working with an eligible organization in hard-to-fill or high-turnover positions
- **Relocation assistance**, stipends, or transition costs tied to recruitment of new staff
- **Training, certification, or skill development stipends** that directly support long-term retention of existing staff or support scope-of-practice expansion

- 4. Could this apply to a provider we are currently trying to recruit, but having been able to sign on yet?, In other words, could we apply for the upcoming provider if they are not officially hired as of yet? For sign-on bonus funding, at what stage would a candidate qualify (e.g., active recruitment discussions vs. signed contract vs. net-new candidate)?**

Financial support should be prospective and not retroactive. RCCB funds can only be utilized for the purpose of sign-on bonuses for positions filled after the full execution of the CEA.

- 5. Can funding be used to assist with student loan repayment?**

No, student loan repayment is not allowable by CMS.

- 6. Can funds support recruitment pipeline activities (e.g., partnerships with residency programs, preceptorships) in addition to retention-focused strategies?**

No, RCCB funds cannot support recruitment pipeline activities. RCCB funds will only be reimbursed to subrecipients for direct payments to eligible staff. The Louisiana Rural Health Transformation Program has multiple strategies making funding available to rural providers. Visit [LDHs Rural Health Transformation webpage](#) for more information.

- 7. Can the employer's required cash match come from Medicaid reimbursement revenue (which has federal pass-through), or must it be from sources with no federal nexus at all (e.g., commercial payor revenue, owner capital)?**

No, match/cost share may not come from any federal source including Medicaid reimbursement.

- 8. If a clinic has existing employment contracts that already include any bonus, retention payment, or productivity incentive, does that bar a Rural Clinician Credit Bank bonus for the same clinician, or only bar duplicating the same specific payment?**

Eligibility for RCCB funding will be dependent on the source of any other bonus, retention or incentive payments. Applications should include the amount and source of existing incentives.

## Eligible Organizations

- 1. In the NOFO, what is meant by "Small Rural Hospital"?**

A small rural hospital is defined under Louisiana state law as a general acute care facility with 60 or fewer licensed beds, located in a parish with a population under 50,000, or a municipality with fewer than 20,000 residents.

A Rural Emergency Hospital (REH) is a Medicare designation established to help rural communities maintain access to emergency and outpatient medical services, especially in areas where full-service hospitals are struggling financially.

A Critical Access Hospital (CAH) is a special designation given to eligible rural hospitals by the Centers for Medicare & Medicaid Services (CMS). This designation was created in 1997 to help rural hospitals

- 2. Can Associations, Hospital Groups, Foundations apply on behalf of members/benefactors?**

Eligible organizations must be the employer of record for all staff/clinicians receiving RCCB funds. In Budget Year 1, non-employer organizations are not eligible to apply for RCCB funds.

- 3. Can facilities partner together to recruit or retain a position, and if so, is the application or reimbursement process different in those situations?**

Yes, rural facilities/employers can partner to financially support staff affiliated with both organizations. An application must be submitted from each partner to execute separate CEAs, and receive reimbursement. As the subrecipient holding a contract with the State of Louisiana, the employer (subrecipient) is financially liable for repaying the State of Louisiana if the clinician/staff do not meet the five-year commitment.

- 4. Would the LDH support a model in which the dental school helps identify, prepare, and connect graduating dentists and dental hygienists with eligible rural employers that apply for the Rural Clinician Credit Bank?**

In Budget Year 1, non-employer organizations are not eligible to apply for RCCB funds. Eligible organizations must be the employer of record for all staff/clinicians receiving RCCB funds.

- 5. Are mobile dental programs, school-based dental programs, or community based dental education programs eligible if they are operated by or affiliated with an eligible rural provider?**

Dental offices are eligible to apply for RCCB funds under “Other facilities or providers in rural areas.” As the subrecipient holding a contract with the State of Louisiana, the employer (subrecipient) is financially liable for repaying the State of Louisiana if the clinician/staff do not meet the five-year commitment.

- 6. In regards to "training, certification, or skills development stipends, can a dental school serve as a formal workforce-development partner to eligible rural employers, even if the school itself is not the applicant or subrecipient?**

In Budget Year 1, non-employer organizations are not eligible to apply for RCCB funds. Eligible organizations must be the employer of record for all staff/clinicians receiving RCCB funds.

- 7. Are home health companies and home health contract companies eligible?**

In Budget Year 1, home health companies and home health contract companies are not eligible to apply for RCCB funds. This is subject to change in years 2-5.

- 8. Are there any specific regulatory requirements, credentialing obligations, or operational standards that the office would need to meet in order to participate in this program? Would participation require the practice or providers to enroll as in-network with any specific insurance plans, Medicaid managed care organizations, or other payors?**

Eligible organizations must provide proof of valid license by the Louisiana Department of Health or applicable licensing agency. Eligible organizations must be enrolled and credentialed with Louisiana Medicaid for that facility.

- 9. Would a medical spa that is otherwise a valid recipient that performs medical treatments be allowed/considered for award under this program? Clinicians performing medical treatments include medical physician, NP, PA, RN, Medical Assistant, etc..**

In Budget Year 1, medical spas are not eligible to apply for RCCB funds.

- 10. The NOFO states that participating clinicians may not be subject to non-compete agreements—can LDH clarify the scope of this restriction and whether it applies to existing employment agreements?**

Per CMS, the restriction does apply to existing employment agreements.

## Eligible Staff Types

**1. Would podiatrists be included in the eligible staff types under this program?**

Podiatrists are to be considered “Physicians” for the purpose of the RCCB.

**2. Are Physical Therapist, Physical Therapist Assistants, Occupational Therapists, Occupational Therapist Assistants, Speech Therapists, Chiropractors, Massage Therapist, Speech-Language Pathologists. If yes, at what reimbursement tier? Does the "Allied Health Professionals" eligible staff category include medical assistants? If yes, must they hold an active national certification (CMA, RMA, CCMA, etc.), or are on-the-job-trained uncertified medical assistants also eligible?**

In cases where staff types are not listed in the NOFO, they must qualify as an “Allied Health Professional” and meet the following definition:

A health professional (other than a registered nurse or physician assistant)— (A) who has received a certificate, an associate’s degree, a bachelor’s degree, a master’s degree, a doctoral degree, or postbaccalaureate training, in a science relating to health care; (B) who shares in the responsibility for the delivery of health care services or related services, including— (i) services relating to the identification, evaluation, and prevention of disease and disorders; (ii) dietary and nutrition services; (iii) health promotion services; (iv) rehabilitation services; or (v) health systems management services; and (C) who has not received a degree of doctor of medicine, a degree of doctor of osteopathy, a degree of doctor of dentistry or an equivalent degree, a degree of doctor of veterinary medicine or an equivalent degree, a degree of doctor of optometry or an equivalent degree, a degree of doctor of podiatric medicine or an equivalent degree, a degree of bachelor of science in pharmacy or an equivalent degree, a degree of doctor of pharmacy or an equivalent degree, a graduate degree in public health or an equivalent degree, a degree of doctor of chiropractic or an equivalent degree, a graduate degree in health administration or an equivalent degree, a doctoral degree in clinical psychology or an equivalent degree, or a degree in social work or an equivalent degree or a degree in counseling or an equivalent degree.

**3. Are Air Med flight paramedics and flight crew stationed at rural air bases eligible for participation in this program? If so, under what provider type would they be classified?**

No.

**4. Will state employees (classified and unclassified) be eligible for this type of payment? Are there any restrictions related to offering incentive payments to non-exempt employees?**

No, state employees are not eligible.

**5. Are telehealth or remote service delivery models eligible for funding when serving rural populations?**

Yes. Telehealth or remote service delivery would be eligible if required documentation is submitted establishing a RUCA-based Patient-Serving Pathway. For more information on the Rural Eligibility Definition and Methodology, visit [the RHTP website](#).

**6. The board of commissioners of our hospital service district entered into a contract for a medical scholarship under the state statute LSA RS 46:1101 with a medical student in July**

**2017 that requires the student to return to the area for three years after residency. The award was capped at \$250,000 and the student actually used about \$120,000. The student is finishing her residency in psychiatry and has many offers to go elsewhere other than rural Delhi. We are very concerned that she will accept another position, and her employer will pay off the student loan outstanding debt. We would like to design a supplemental recruitment agreement with her which would include a sign on bonus and relocation assistance. Could we, for example, design a recruitment agreement that provided her with additional funding in the form of a sign on bonus and relocation assistance that would require her to remain for five years and, if affirmative, what is the most that we can offer under your program.**

The Hospital Service District may enter into a supplemental recruitment and retention agreement with the physician in addition to the existing scholarship agreement executed pursuant to [La. R.S. 46:1101](#), provided the supplemental arrangement is properly structured to comply with applicable federal and state law. The arrangement must comply with the federal Stark Law, including applicable exceptions relating to physician recruitment and retention, particularly 42 C.F.R. § 411.357(e) and, potentially, [42 C.F.R. § 411.357\(t\)](#), as well as the federal Anti-Kickback Statute. Accordingly, the agreement should not condition compensation upon the volume or value of referrals and should reflect fair market value for the services and obligations undertaken by the physician.

Additionally, because the Hospital Service District is a political subdivision of the State of Louisiana, the agreement must comply with Article VII, Section 14 of the Louisiana Constitution, which prohibits the donation of public funds. Therefore, any supplemental incentives must be supported by enforceable service obligations and a demonstrable public benefit to the district through the provision of psychiatric services to the community.

There is no specific statutory maximum under La. R.S. 46:1101 governing the amount of additional recruitment or retention assistance that may be offered under a separate supplemental agreement. However, the total compensation package should remain commercially reasonable and consistent with fair market value for rural psychiatry recruitment arrangements. The District should maintain documentation supporting the community's need for psychiatric services and the reasonableness of the compensation package offered.

**7. Are clinicians with an H1-B visa (or other visa allowing a clinician to work in the United States) eligible for retention or recruitment payments?**

There is no eligibility exclusion for clinicians with an H1-B visa.

**8. Can financial support be applied to individuals sponsored through provider-owned training academies who begin employment upon certification, or is eligibility limited to already-licensed clinicians at the time of hire?**

Eligibility is limited to clinicians licensed at the time of hire.

**9. We have rural healthcare facilities in Mississippi and Alabama. Is there any opportunity to use these funds outside of Louisiana?**

No, RCCB funds cannot be used outside of Louisiana.

**10. As an owner of the practice does this apply for me as well?**

Yes, if the owner is licensed as an eligible staff type and delivering services that meet a rural eligibility pathway.

**11. Can a provider work part time in the clinic. What constitutes part time?**

Yes. Providers may receive RCCB support proportional to the clinician's rural Full-Time Equivalent (FTE) allocation. For clinicians practicing part time rural settings, eligible reimbursement shall be calculated based on the percentage of total compensated hours worked in qualifying rural locations for example, a clinician working 0.5 FTE in a rural setting would be eligible for 50% of the applicable reimbursement amount.

### **Five-year service commitment**

- 1. If a clinician leaves before completing the 5-year service commitment (voluntarily or involuntarily), who is ultimately responsible for repayment—the clinician or the employer? If repayment cannot be recovered from the clinician, does financial liability transfer to the provider? If repayment is assigned to the clinician, what responsibilities does the provider have for facilitating, tracking, or enforcing repayment?**

As the subrecipient holding a contract with the State of Louisiana, the employer/facility is financially liable for repaying the State of Louisiana.

- 2. How will the recoupment process work? When would funds be due back to the state? and who would pay them? The organizations that received the funds, or the individuals who received them and broke their commitment?**

As the subrecipient, the employer/facility will be responsible for notifying LDH of an unmet commitment. Once reported, a mutually agreed upon plan for repayment will be established.

- 3. Are there any additional penalties, fees, or financial consequences beyond repayment of incentive funds?**

No, there are no additional penalties, fees, or financial consequences beyond repayment.

- 4. Is there an approved repayment agreement template, and what happens if a departing clinician cannot repay? What are LDH's expectations around the enforcement and collections process?**

The subrecipient will be responsible for developing an agreement with supported staff that includes repayments, enforcement and collections. LDH will not provide an approved repayment agreement template.

- 5. Will LDH provide a standardized agreement or contract that clinicians must sign outlining the 5-year service commitment and repayment obligations? Does the requirement to “ensure clinician attestation to a 5-year service commitment” constitute a formal contractual agreement? If so, what are the minimum required provisions?**

The subrecipient will be responsible for developing an agreement with supported staff that includes attestation to a five-year service commitment. Proof of this attestation shall be provided to LDH.

- 6. Does repayment apply in cases of medical disability? Are there circumstances under which repayment of the MD credit would be waived if a physician leaves before the 5-year requirement is met (e.g., physician illness/disability)? Is there any waiver to the repayment obligation in case of hardship, such as the death or disability of the clinician?**

In instances of disability or death, the subrecipient may submit a request to LDH to waive the repayment. This request is subject to approval by CMS.

- 7. Does repayment apply if the employee is terminated without cause?**

Yes.

- 8. Does repayment apply due termination related to quality or HR concerns?**

Yes.

- 9. Does repayment apply if the employer materially changes compensation or work requirements?**

No, as long as the staff receiving financial support continues to practice in the same professional capacity and works in a rural facility. In cases where work requirements reduce effort in rural settings, the formula for proportional support must be utilized.

- 10. Is the 5-year service commitment tied to a specific position/program, or can it be fulfilled through continuous service in rural communities across roles within the same organization?**

Yes, as long as it falls within the eligible staff types and facilities.

## **Budget Questions**

- 1. We are a BHSP provider with separate tax id/ NPI numbers that services multiple rural areas across the State of Louisiana. Do we need to submit separate applications for each of them?**

Applications must include the tax identification number that is associated with the W-2 or 1099 associated with employees receiving financial support through RCCB. A separate application will need to be submitted for each tax identification number. For clinicians practicing part time rural settings, eligible reimbursement shall be calculated based on the percentage of total compensated hours worked in qualifying rural locations for example, a clinician working 0.5 FTE in a rural setting would be eligible for 50% of the applicable reimbursement amount.

- 2. Section C.3, "Maximum Total Reimbursement Amount." Please confirm whether the dollar amounts listed in the Section C.3 table represent (a) the maximum reimbursement allowable per clinician per budget year, replenishing each year over the five-year grant period, or (b) the cumulative maximum reimbursement allowable per clinician across the entire five-year grant period. Is the \$75,000 cap for a physician a lifetime maximum across all RHTP-funded payments to that clinician, or per bonus type/event? Can a clinician receive a sign-on bonus AND a later retention bonus, with both reimbursed, up to that cap? Are the amounts listed in the schedule (e.g., \$75,000 for physician recruitment) the maximum total amount available for the recruitment of a physician, or does that amount apply only to the first year? Are the maximum reimbursement amounts annual or over the 5-year period?**

The “Maximum Total Reimbursement Amount” is per clinician/staff for the five-year grant period. Clinician/staff can receive more than one type of financial support, but total compensation cannot exceed the “Maximum Total Reimbursement Amount”.

- 3. Re: "Recommended financial support up to 25% of annual base salary" — does this 25% apply (a) annually, so a clinician may receive up to 25% of that year's base salary each year, subject to the lifetime staff-type maximum reimbursement; (b) per bonus event; or (c) as a total program-period cap across all years? Please provide an example calculation for a physician earning \$200,000/year and a nurse practitioner earning \$125,000/year.**

The recommendation of up to 25% is based on annual base salary per year, not including additional bonuses. RCCB financial support cannot exceed the “Maximum Total Reimbursement Amount” is per clinician/staff for the five-year grant period.

Nurse Practitioner		Annual Salary \$125,000	
<i>RCCB Maximum Total Reimbursement Amount: \$50,000</i>		<b>Recommended yearly financial support (up to 25% of annual salary)</b> \$31,250	
	RCCB funded	Employer Match	Total Annual Financial Support
Year 1	\$23,437	\$7,813	\$31,250
Year 2	\$23,437	\$7,813	\$31,250
Total	\$46,874	\$15,626	\$62,500

- 4. How would a medical practice who pays a clinician's personal s-corp who then has W-2 salary for the clinician be handled under this program?**

The employer of record on W-2 or 1099 is the entity who receives the benefit, and must meet eligibility requirements.

- 5. If a clinic executes a \$75,000 bonus agreement with a physician in August 2026, structured to vest and pay out over the 5-year service period, must the full \$75k be disbursed (and reimbursed) by September 30, 2027 — or does committing/encumbering the funds in Year 1 satisfy the deadline?**

The \$75,000 financial support can be spread out over the five year grant period; however, the state match dollars are only paid to the facility after the payment has been made to the clinician. Additionally, to promote sustainability, matching financial support will be reduced over the grant period. The year that it is disbursed / reimbursed will be the applicable state match amount. See NOFO for more information.

- 6. Is there a cap per organization or only per clinician? Is there a maximum funding amount per facility, and are the reimbursement amounts annual limits or total limits over the five-year period?**

There is no cap per subrecipient organization. The “Maximum Total Reimbursement Amount” is per clinician/staff for the five-year grant period.

**7. If one entity is urban and another rural under the same NPI/TaxID, can clinicians split time?**

Yes. For clinicians practicing in both rural and non-rural settings, eligible reimbursement shall be calculated based on the percentage of total compensated hours worked in qualifying rural locations using the following formula: **Rural FTE = (Hours Worked in Eligible Rural Setting ÷ Total Compensated Clinical Hours)**; for example, a clinician working 0.5 FTE in a rural setting and 0.5 FTE in an urban setting would be eligible for 50% of the applicable reimbursement amount.

**8. Can a rural hospital request funding for a physician position in addition to other disciplines? Can you apply for assistance for more than one provider position, such as both a nurse practitioner and an LPN?**

Yes.

**9. Is there an administrative cost cap applicable to this program, and does it apply to subrecipients?**

Administrative costs are not allowed.

**10. Are clinicians permitted to receive retention or recruitment payments in more than one year of the program? For example, could a clinician who is paid a sign-on bonus in Year 1 be eligible for a retention bonus in Year 5? If a clinician can receive more than one bonus during the five-year period, do the “Maximum Total Reimbursement Amounts” represent the maximum to be paid in any one year or the maximum over the five-year period?**

The “Maximum Total Reimbursement Amount” is per clinician/staff for the five-year grant period and can cover multiple types of financial support.

**11. Are the “Maximum Total Reimbursement Amounts” the maximum amount that will be provided by the state, or the maximum that will be received by the clinician (together with the employer’s cash match)? For example, if a hospital’s employed physician is eligible for a retention bonus in Year 1, could the physician receive \$75,000 from the RHTS funding to be matched by an additional \$25,000 from the employer, for a total retention bonus of \$100,000? In Year 5, if the employer provides a \$75,000 retention bonus, would the RHTS funding provide an additional \$25,000?**

The “Maximum Total Reimbursement Amount” is the maximum amount that LDH will provide for the clinician/staff based on 25% of the salary, not including the bonus, and not more than the maximum amount listed per clinician / staff.

**12. Can the Rural Clinician Credit Bank be paired with a dental school rural-track scholarship program, provided there is no duplication or supplanting of funds? How should employers and the dental school avoid duplication when graduates have already received philanthropic scholarship support tied to rural service? Can the 5-year service commitment under this program run concurrently with another rural service obligation, or must it be separate?**

While partnerships are encouraged, schools are not eligible applicants for the RCCB. There is no prohibition on receiving additional funds from other RHTP strategies. The 5-year service commitment can run concurrently once they receive their license and work in rural areas.

- 13. Some employers already invests significantly in recruitment through their training academies — covering tuition, uniforms, testing fees, and training costs for new recruits. Do these pre-hire investments count toward the employer match requirement, or must the match be limited to direct bonus payments made after the clinician's hire date?**

The match/cost share is limited to direct financial support after the clinician's hire date.

- 14. Is there a specific timeframe allowed between the award of the funding and the recruited provider's coming to work? For example, funding is awarded, a recruiter is hired, and a candidate is secured, but this takes a year. Is the funding still allowed or must there be a candidate already identified and ready to sign to obtain the funding?**

This is reimbursement based payment after the contract is signed and the person begins working.

- 15. Can an ambulance organization enroll new hires and existing staff on a rolling basis throughout the 5-year Cooperative Endeavor Agreement period, or must all enrolled clinicians be identified at program initiation?**

Payments are reimbursement based after the facility makes a payment to the clinician/staff. Year 1 applications can include projections for new hires and existing staff financial support throughout the five-year project period. In addition, there will be annual opportunities to apply for financial support for additional positions.

- 16. For multi-year installment bonuses (e.g., a sign-on bonus paid 50% at hire and 50% at the one-year mark), which year's match ratio governs each installment — the year of original hire or the year each installment payment is actually disbursed? The match ratio shifts from 25% employer / 75% RHTP in Years 1–2 to 75% employer / 25% RHTP in Year 5.**

The match rate is determined by the budget year that the installment payment is actually disbursed.

- 17. How do the program timelines work? For example, if I hire a recruiter for a specific physician specialty and they are unable to identify a candidate for six months, or if I recruit a resident who will not complete training for another three years, would the facility still be eligible to apply for funding?**

The candidate does not have to be identified at the time of application. You are allowed to make projections for payments, as they are only paid out following clinician/staff starting work and receiving payment. Obligated funds must be spent in the projected budget year designated in the application. Obligated funds cannot be carried forward into future budget years.

- 18. For Year 1 awardees, what will be the process for continuation and renewal?**

Subrecipient-provided quarterly and annual reports will be evaluated to determine eligibility for continuation and obligation of future year funding. The contractual agreement will cover a three year period, with the option to extend two additional years.

- 19. Will LDH accept consolidated batch invoicing (e.g., monthly payroll-level submissions covering all enrolled staff), or is a separate invoice required for each individual clinician payment?**

Yes, consolidated batch invoicing and reporting will be accepted.

**20. What is the projected turnaround time for reimbursement after eligible expenses have been submitted?**

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.

## Performance Metrics

**1. Can LDH provide additional guidance on required workforce reporting metrics and expectations for data submission feasibility?**

Grantees will be required to report quarterly on progress to meet the Key Performance Indicators (KPIs) as part of their reporting obligations:

- Retention Rate (Number of supported clinicians still employed at milestone date ÷ Total clinicians who received financial support in that cohort) × 100 Measure at 1, 3, and 5 years.
- Annual Recruitment Growth (Current year clinicians hired – Prior year clinicians hired) ÷ Prior year clinicians hired × 100
- Vacancy Rate (Number of vacant approved positions ÷ Total approved positions) × 100
- Turnover Rate (Number of clinician separations during year ÷ Average filled clinician positions during year) × 100
- Time-to-Hire Average number of days from job posting date to accepted offer/start date. Compare pre- and post-financial support.
- Patient Access Improvement Average days to next available appointment (new and established patients). Measure reduction over time.
- Continuity of Care (Number of patients seen by same clinician for follow-up visits ÷ Total eligible follow-up patients) × 100
- ROI per Hire Total financial support dollars paid ÷ Number of clinicians recruited
- ROI per Retained Clinician Total financial support dollars paid ÷ Number of clinicians retained at 3 or 5 years

Failure to provide data could result in ineligibility.

**2. The NOFO requires KPI reporting including "Patient Access Improvement" (average days to next available appointment). This metric is not directly applicable to emergency/911 EMS operations where response is more demand-driven rather than scheduled. Will the LDH accept the following Metrics? EMT/Paramedic student Certification Rates, Retention and turnover statistics, Increase in staffing levels in rural parishes? The NOFO requires reporting on "Continuity of Care" (patients seen by the same clinician for follow-up visits). EMS care is episodic and typically non-recurring for the same patient-provider pairing. What alternative care quality metric would LDH accept for EMS providers in place of this standard?**

LDH recognizes that suggested KPIs may not be applicable to all subrecipient types. In the case of inapplicability, applicants should propose alternative KPIs. If awarded the CEA will dictate mutually agreed upon KPIs.

## Rural Determination

- 1. Can providers qualify if their physical site is located in a non-rural area, but clinicians primarily deliver services in rural communities (e.g., via community-based services or telehealth)?**

Yes. Per the Rural Eligibility Definition and Methodology, a RUCA-based Patient-Serving Pathway is allowed. For more information on the Rural Eligibility Definition and Methodology, visit [the RHTP website](#).

- 2. Section C.2 of the NOFO requires that providers qualify as rural under the Louisiana RHTP definition and methodology. Section C.4 establishes a Rural FTE formula based on hours worked in qualifying rural settings, suggesting that service location (rather than office location alone) may be relevant to eligibility. Please confirm whether LDH will recognize the Federal Office of Rural Health Policy's (FORHP) RUCA-based definition of a "rural provider"—including entities that "operate in or serve patients living in" a FORHP-defined rural area—for purposes of this NOFO. Specifically, would a service that operates from an administrative office in a non-rural census tract, but delivers the majority of clinical service hours in clients' homes and communities located in rural parishes, qualify as an eligible behavioral health provider in a rural area? If yes, please confirm that the Rural FTE formula in Section**

Section C.2 relates to Organizational Eligibility for inclusion in the RCCB program. Section C.4 refers to the % of financial support a clinician/staff is eligible for if they serve a population that includes both urban and rural populations.

An organization that operates from an administrative office in a non-rural area must provide documentation proving a RUCA-based Patient-Serving Pathway. For more information on the Rural Eligibility Definition and Methodology, visit [the RHTP website](#)

- 3. What documentation or methodology is required to validate and track clinician time in rural versus non-rural service locations for FTE and reimbursement purposes?**

This will be established in the Contract. The same documentation required to establish a RUCA-based Patient-Serving Pathway applies to patient services and documentation of services provided should be defined in the Contract and proposed by the employer.

- Patient ZIP code distribution data
- RUCA crosswalk methodology
- Calculation of rural population share

- 4. Does rural eligibility apply on a parish-by-parish or station-by-station basis?**

Station or address of where service was performed.

- 5. EMS crews frequently rotate across multiple rural station assignments within a single parish or across adjacent rural parishes. For these rotating crew members, how is the rural FTE percentage calculated — based on scheduled station assignment, actual call response location, or the primary home station designation?**

Station or address of where service was performed.

**6. Our clinic is located in an urban area but we serve outside the clinic in rural areas. Are we eligible for this funding?**

An organization that is located in an urban area must provide documentation proving a RUCA-based Patient-Serving Pathway. For more information on the Rural Eligibility Definition and Methodology, visit [the RHTP website](#).

**7. Is rural determination made in accordance with the rural areas in which an agency is permitted to provide emergency medical services rather than where its headquarters are located?**

It is based on where the station is located or address of where service was performed.

**8. Using the HRSA Rural Health Grants Eligibility Analyzer to recognize hospitals that are rural providers, does the hospital itself need to be in a rural area to be considered for this grant opportunity or can the hospital serve rural patients in the area for it to be considered?**

A hospital that is not recognized as rural, must provide documentation proving a RUCA-based Patient-Serving Pathway. For more information on the Rural Eligibility Definition and Methodology, visit [the RHTP website](#).