LOUISIANA DEPARTMENT OF HEALTH
Office of Rural Health Transformation and Sustainability

Rural Medicaid Alternative Payment Model Program
Notice of Funding Opportunity (NOFO)

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A. Program Description and Goals

A1. Purpose of this Notice of Funding Opportunity

The Louisiana Department of Health (LDH), through the Office of Rural Health Transformation and Sustainability, is issuing this Notice of Funding Opportunity (NOFO) to support rural providers in building the infrastructure needed to participate in value-based care (VBC) and implementing LDH's target primary-care led VBC model. The population of focus is Louisiana Medicaid members residing in rural communities and the providers that serve them.

For purposes of "rural" eligibility for this NOFO, eligible applicants must establish programs designed to serve Louisiana Medicaid members residing in rural zip codes as defined by the United States Department of Agriculture (USDA), Economic Research Service's (ERS) Rural-Urban Commuting Area (RUCA) codes. Applicants must demonstrate the intention to serve members residing in ZIP codes classified as rural (RUCA 4–10). For more information on RUCA codes visit USDA Rural Urban Commuting Area Codes.

A2. Program goals and expected outcomes

LDH seeks proposals that aim to take the initial steps that over time will support single VBC model that helps to ach ieve the following goals:

- Improve outcomes for rural Louisiana Medicaid members, especially those with chronic conditions such as diabetes, hypertension, obesity, heart disease, COPD/asthma, and behavioral health (BH) or substance use disorder (SUD) needs.
- Reduce or slow growth in Total Cost of Care (TCOC) while maintaining or improving quality, access, and patient experience.
- Expand access to primary care, care coordination, follow-up services, care gap closure, and Health Related Social Needs (HRSN) navigation in rural communities.
- Improve rural provider sustainability by aligning payment and care delivery with value and outcomes.
- Create a pathway for providers to enter VBC and progress toward greater accountability over time.

A3. LDH Target Care Delivery Model

The LDH target care delivery model is a primary-care-led rural Medicaid model that helps providers move from reactive care toward proactive, coordinated, data-enabled care.

The model is organized around four core elements:

Element	What rural health is today: reactive care	What rural health could look like tomorrow: transformed LDH rural Medicaid primary care model
1. Data analytics and attribution	Patient needs, care gaps, utilization patterns, and provider accountability may not be visible in a timely or actionable way.	Providers and LDH can identify target or attributed rural Medicaid members, stratify risk, track care gaps, monitor utilization, and use data to guide outreach, performance improvement, and future VBC participation.
2. Care team capacity	Care delivery is often constrained by limited staffing, single setting-focused workflows, and inconsistent team-based operating models.	Providers have defined care team roles, staffing models, workflows, and operating routines that support proactive, team-based care across participating rural providers.
3. Access and care coordination	Access, referrals, handoffs, post-acute follow-up, and social need referrals are often limited, manual, inconsistent, or dependent on patient follow-through.	Patients have more reliable access to primary care-connected support, while providers coordinate across care settings and community resources, close referral loops, follow up after ED/IP events, and help address non-clinical barriers that affect access and outcomes.
4. Whole-person condition management	Treatment plans are often developed during visits, with limited longitudinal management between encounters; behavioral health and SUD needs may be under-identified or referred externally.	Providers deliver proactive, evidence-informed chronic disease management for priority conditions and behavioral health needs through planned follow-up, medication support, patient education, and integrated or coordinated support.

A4. Two-lane provider glidepath

Every applicant will be responsible for working toward the same primary-care-led rural Medicaid model described above. However, LDH recognizes that rural providers may have significantly different capabilities to successfully implement VBC models to impact TCOC and quality today and will therefore have different funding needs. As a result, all applicants must complete the TCOC & Quality Readiness Assessment in Appendix C as

part of the application. This assessment will determine whether an applicant qualifies for Lane 1 “Paid to get ready” or Lane 2 “Paid on results.”

The two lanes are designed as follows:

Lane	What the lane means	Potential support offered
Lane 1: Paid to get ready	Provider cannot yet reliably impact TCOC because foundational capabilities such as data visibility, workflows, or care team capacity are still developing.	1. **Infrastructure / capacity building** to enable future TCOC reduction and quality improvement 2. **New activities** aligned with target model (e.g., disease management) 3. **Annual performance payment** for achieving quality metrics
Lane 2: Paid on results	Provider has sufficient panel, data, care delivery, and operating capabilities to improve quality / utilization measures associated with TCOC (e.g., avoidable ED visits) for a defined rural Medicaid population. In Year 1, the provider is expected to impact TCOC but not measure TCOC.	1. **Infrastructure / capacity building** support to scale / tailor the model to rural providers 2. **Interim performance payment for achieving shared savings** while meeting quality gates (with an expectation that shared savings will eventually be sustained through separate agreements with healthcare payers)

Applicants in Lane 1 may move into Lane 2 once readiness thresholds are met and validated by LDH. LDH does not expect all applicants to be ready for shared savings, downside risk, or TCOC accountability at the beginning of the grant period.

The State may provide centralized analytics in Year 2 onward to support quality and cost calculations.

B. Eligibility Information

B1. Eligible lead applicants/subrecipients

Eligible applicants must be legal entities capable of receiving and administering federal funds and implementing the proposed project. The lead applicant must be a Louisiana Medicaid-enrolled provider, and must remain as such, or a legal entity that includes Louisiana Medicaid-enrolled providers as required participants. Eligible organizations include:

- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Rural Hospitals and Critical Access Hospitals (CAHs)
- Independent primary care providers or provider groups
- Provider coalitions or provider-led collaboratives, including Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), Independent Physician Associations (IPAs), rural hospital-led partnerships, FQHC/RHC networks, or similar provider-accountable entities

Providers can only apply for funding once per year through this APM RHTP opportunity. For example, providers **may not** apply as a lead applicant and again as a part of a separate provider coalition.

B2. Eligible partners

Lead applicants may partner with VBC-enablement vendors, technology vendors, care management organizations, community-based organizations, management services organizations, MCOs, and other operational partners. Vendors and other non-provider entities may support implementation, but applicants must explain how funds will support patient-facing care delivery, reporting, or performance improvement and avoid unsupported pass-through spending to vendors.

Eligible partners **may** be part of multiple applicant teams.

C. Application Information & Provider Expectations

Application section	All applicants must provide	Lane 1: Paid to get ready — additionally provide	Lane 2: Paid on results — additionally provide
1. Executive summary	Brief description of target rural Medicaid population, participating providers, proposed care model, requested lane, funding request, and expected outcomes	Summary of how requested funding will build readiness to impact TCOC and quality over time	Summary of how the applicant will reduce or slow TCOC, improve quality and plans to generate shared savings
2. TCOC readiness assessment	Completed 1–5 self-assessment across readiness dimensions, average score, proposed lane, and explanation for each score *(Assessment can be found in Appendix C)*	*No additional requirements*	Evidence supporting readiness to impact TCOC, such as existing VBC experience, attributed population, data infrastructure, or savings history
3. Applicant and provider participation	Lead applicant, Medicaid enrollment status, participating providers / sites, partner roles, TINs / NPIs where available, and provider commitment documentation	Description of providers or partners needed to build capabilities and implement proposed activities	Description of accountable entity, governance model, and provider funds-flow approach
4. Target population	Population definition, geography, demographics, clinical focus, estimated Medicaid members / member-years, and approach to identifying patients	*No additional requirements*	Attributed population with denominator, panel size, participating providers, and data inputs sufficient to measure efficiency metrics that can serve as proxies for TCOC (e.g., non-emergent emergency department admissions, inpatient admissions)
5. Care delivery model and activities	Description of how the proposed interventions are aligned to LDH's target care model	Proposed activities *(See Appendix B),* evidence / research on the potential for such activities	Interventions expected to produce TCOC savings, including utilization or cost drivers targeted and evidence

Application section	All applicants must provide	Lane 1: Paid to get ready — additionally provide	Lane 2: Paid on results — additionally provide
		to improve quality and/or reduce TCOC, estimated rural Medicaid patients or member-years, non-duplication attestation, activity documentation / reporting plan	from prior performance where available
6. Infrastructure and capability plan	Current state infrastructure / capabilities and gaps *(see Appendix B),* partners / vendors, how each investment supports care delivery, reporting or performance improvement	Proposed additional infrastructure, milestones, timeline	Infrastructure needed to support impact on TCOC / shared savings or expansion into rural areas
7. Measures and reporting plan	Selected LDH quality / process measures for reporting *(see Appendix B)*, baseline where available, target improvements, data sources, reporting cadence, and plan to improve data completeness	*No additional requirements*	Baseline quality / utilization measures, proposed quality gates and performance measures required for shared savings eligibility, including reporting / validation approach
8. TCOC / performance approach	Description of how proposed model, interventions and infrastructure will enable future impact on TCOC, including supporting rationale	*No additional requirements*	*LDH recognizes that TCOC measurement for individual providers is challenging. As such, LDH is exploring options for centralized reporting.* In the interim, Lane 2 applicants must indicate how they will impact quality / utilization measures that are associated with TCOC, examples include: • Non-emergent Emergency Department admissions • Inpatient admissions

Application section	All applicants must provide	Lane 1: Paid to get ready — additionally provide	Lane 2: Paid on results — additionally provide
			• 14-day readmissions • 30-day readmissions Lane 2 applicants should estimate savings based on how they expect to perform on these metrics relative to the regional average for Medicaid members. Data on regional averages will be provided by LDH upon request to support these estimates.
9. Budget and budget narrative	Requested funding by payment stream, line-item justification, non-duplication attestation, and sustainability plan for recurring costs	Infrastructure cost by line item; proposed milestones; requested PMPY for approved activities; population size; estimated cost of activities; requested quality performance payment amount per measure	Infrastructure cost by line item; estimated shared savings; proposed distribution of savings / funds flow to providers (note, providers must receive at least 70% of any savings generated; administrators may only receive up to 30%)
10. Governance and implementation plan	Operating model, decision rights, provider engagement, vendor management, potential risks / mitigation, performance review cadence, overview of plan for future years (if applicable)	*No additional requirements*	Governance and operating model for accountability, shared savings distribution, provider performance management, and long-term VBC sustainability

D. Funding Overview, Payment Streams, and Allowable Uses of Funds

D1. Funding overview

LDH anticipates making up to $30 million available in Year 1 for this NOFO, subject to available RHTP funding, Centers for Medicare and Medicaid Services approvals and requirements, state and federal law, satisfactory performance, and execution of required agreements. Proposed multi-year projects will be subject annual obligation based on available funds and performance. Year 1 funds must be expended by September 30, 2027. Project plans must allocate projected expenses monthly. LDH may adjust the amount, timing, and allocation of funding based on the quality of applications received, program priorities, provider readiness, available funding, and other considerations.

LDH may reserve a portion of available funds for state-led, shared, or centralized infrastructure if such investments are necessary to support attribution, data exchange, reporting, analytics, performance monitoring, or evaluation across awardees.

Award Size: $100,000-$2,000,000 (based on project scope)

Applicants are required to demonstrate a mandatory minimum cost share/matching contribution of 10% of the requested funding. Matching support may include cash contributions or in-kind contributions reflecting organizational commitment, partnerships with local health systems or MCOs and philanthropic contributions.

Funding for this opportunity is made available through the U.S. Department of Health and Human Services (HHS) Center for Medicare and Medicaid Services (CMS) Cooperative Agreement. All terms and conditions of the Cooperative Agreement for Rural Health Transformation Program (RHTP) Centers for Medicare & Medicaid Services that apply to the Louisiana Department of Health (LDH) also apply to subrecipients and subrecipient agreements awarded under this NOFO
If selected for funding, the subrecipient must:

1. Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award.
2. Comply with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.
3. Cover eligible activity costs upfront and receive reimbursement through the grant process.
4. Comply with applicable State statutes and regulations.

5. Take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings.
6. Be prepared to execute the Cooperative Endeavor Agreement within two weeks of receiving the final document.

D2. Payment streams

Available to	Payment stream	What it supports	How payment works
Lane 1 applicants	Infrastructure/capacity building	One-time or time-limited investments needed to deliver, document, and report on the target care delivery model	Reimbursement for initial start-up costs and milestone-based reimbursement tied to implementation deliverables.
	New activities payment	New or expanded activities aligned with the target model and not duplicative of existing reimbursement	PMPY payment for approved target population or activity population, subject to documentation and non-duplication.
	Annual quality/process performance payment	Meeting or exceeding quality or process measures from LDH-provided list of priority measures	Annual performance payment available per measure met or improved, as defined in the award agreement.
Lane 2 applicants	Infrastructure / capacity building	Scaling or tailoring of the model to rural providers	Reimbursement for initial start-up costs and milestone-based reimbursement tied to implementation deliverables.
	Interim performance payment for achieving shared savings	Reduction in TCOC (or appropriate proxy metrics) for providers ready to impact TCOC	Providers may earn shared savings only where quality gates, attribution, savings validation, and funds flow requirements are met.

Providers may request up to an additional 1.5% of total funding request for administrative costs.

D3. Allowable uses of funds

- Technical assistance for readiness, implementation, or practice transformation, including gap assessment, workflow redesign, intervention implementation, or Year 2 readiness
- IT and data readiness assessment, integration support, and interim data solutions for Year 1 implementation, excluding long-term platform purchases or costs covered elsewhere
- Staff or FTE support tied to a specific intervention, population, volume, and justified role, for a specified period (e.g., not to exceed 6 months)
- Care coordination or administrative support for In-Lieu of Services (ILOS) / HRSN-type services, if unreimbursed and tied to a defined population
- Currently unreimbursed clinical or related activities that support defined quality, process, or outcomes milestones and eligibility for outcomes-based performance payments and reduction in TCOC

D4. Non-allowable uses of funds

The following list is non-exhaustive. LDH may further restrict uses during contracting based on federal rules, state requirements, payment integrity, and program priorities.

- Standalone platform purchases, including analytics, population health management, EHR, or other vendor systems, without a defined population, intervention, implementation plan, and outcomes-focused use case
- Platform-only proposals without a defined population, intervention, or outcomes-focused use case
- Brick-and-mortar (capital improvement), Electronic Health Record (EHR), interoperability, telehealth, or other infrastructure investments that are fundable through other RHTP/LDH programs or covered elsewhere
- Direct food, housing, transportation, or other Health Related Social Needs (HRSN) services unless specifically approved by LDH and permitted under applicable requirements
- Services already reimbursed through Medicaid, Managed Care Organizations (MCOs), fee schedules, grants, or other funding sources for the same activity, service, population, period, or outcome
- Staffing requests not linked to a defined population, intervention, implementation plan, or reporting requirement
- Infrastructure or capacity-building investments lacking a clear Year 1 use case, budget, implementation plan, patient impact, or outcomes connection
- Vague or overly complex requests that cannot be readily contracted, monitored, or reconciled within the Year 1 timeline

E. Application and Submission Information

This opportunity will be available once per grant budget year. **To be considered for Year 1 Funds, applications must be received no later than August 7, 2026.** Projects can be multi-year, but funds awarded for Year 1 must be expended by September 30, 2027.

June 29, 2026	Notice of Funding Opportunity Issued
July 7, 2026	Deadline to Submit Written Questions Submit Questions Here
July 14, 2026	Answers to Written Questions Posted
August 7, 2026	Application Submission Deadline for Year 1 Funds
Early August, 2026	Application Evaluation Period for Year 1 Funds
Mid August	Notice of Intent to Contract Announcements

Note: There will be opportunities for applicants awarded Year 1 funds to apply for continuation/additional funds in future RHTP budget years. Applicants proposing multi-year projects must provide a phased implementation timeline, and projected annual expenditures.

Please submit an application here.

Applicants will be required to provide the following information **AND** attach a Statement of Work compliant with Appendix B. Statement of Work Requirements.

Information required for application:

- Organization Name
- Organization Type
- Program Contact Name
- Program Contact Phone Number
- Program Contact Email Address
- Physical Address, City, State, Zip Code
- Tax Identification Number
- Louisiana Department of Revenue Number
- Justification for rural designation in alignment with the RHTP definition and methodology
- Parishes or ZIP codes Served
- Brief Program Description
- Total Amount of Funds Requested

F. Required Registrations for Applicants

All organizations are required to provide the following documents if chosen for award:

a. Federal Tax Identification Number
b. IRS Form W-9 (Taxpayer Identification and Certification)
c. Louisiana Vendor Profile Data Form. State of Louisiana Self-service Request for Vendor https://www.doa.la.gov/Pages/osrap/VendorPayments.aspx
d. Board Resolution designating signature authority (if applicable)
e. Disclosure of Ownership from the Louisiana Secretary of State (if applicable)
f. Applicable Louisiana Department of Health License (current and in good standing)
g. SAM (System for Award Management) Number and current expiration date

G. Notice of Award, Post-Award Requirements and Grant Administration

Applications will be reviewed on an annual basis. Submission of an application does not guarantee funding. LDH may approve, partially fund, defer, or deny any application based on available resources, readiness, program fit, and program considerations.

LDH may request additional information, clarifications, or supporting documentation during application review. Awardees will receive a formal Notice of Intent to Contract outlining Cooperative Endeavor Agreement requirements.

Awardees will be required to submit quarterly and annual reports documenting progress toward approved milestones, activities delivered, member counts or member-years, financial status, quality/process measures, and outcomes. LDH may require standardized reporting templates, supporting documentation, baseline data submission, expenditure tracking, site verification, and participation in evaluation or technical assistance.

For infrastructure payments, awardees must document costs and milestone completion. For PMPY activity payments, awardees must document eligible member-years, approved activities, and non-duplication. For annual measure performance payments, awardees must submit or validate measure performance as defined in the agreement. For shared savings, LDH will calculate performance payment amount before payments are made.

H. Special Conditions and Disclaimers

Funding is contingent on the availability and distribution of RHTP funds, CMS approvals and requirements, state and federal law, satisfactory performance, and execution of all required agreements. LDH reserves the right to modify, reduce, delay, discontinue, or reallocate funding in any year based on available funding, program performance, compliance, CMS approvals, state priorities, or other considerations.

Funding under this NOFO does not guarantee continued funding in later years and does not create an entitlement to ongoing Medicaid, MCO, or LDH support after the RHTP funding period. Downside risk is not assumed during the initial grant period and would require separate LDH/MCO design and approval.

Appendix A. Common Terminology and Definitions

Alternative Payment Model (APM): A payment or funding arrangement that differs from traditional fee-for-service reimbursement and may include activity-based payments, PMPY payments, quality performance payments, shared savings, shared risk, capitation, or other outcomes-based approaches.

Attribution: The approach used to identify, assign, or maintain accountability for a specified patient population over time.

Duplicative Payment: Payment from multiple sources for the same activity, service, measure, outcome, or beneficiary population where such payment is not permitted.

Health-Related Social Needs (HRSN): Individual-level social and economic factors that may affect health outcomes, including food insecurity, housing instability, transportation barriers, utility needs, and interpersonal safety concerns.

Per Member Per Year (PMPY): A standardized measure of cost, payment, utilization, or savings expressed on an annual basis for each attributed or target member.

Shared Savings: A payment arrangement in which providers or accountable entities may receive a portion of savings generated when actual costs are below an established benchmark, subject to quality and access requirements.

Total Cost of Care (TCOC): The total cost of healthcare services for a defined population over a specified period, which may include inpatient, outpatient, professional, behavioral health, pharmacy, emergency department, and other covered services depending on methodology. *TCOC measurement for individual providers is challenging. As such, LDH is exploring options for centralized reporting. In the interim, Lane 2 applicants must indicate how they will impact quality / utilization measures that are associated with TCOC.*

Value-Based Care (VBC): A care delivery and payment approach that links payment, incentives, or accountability to quality, outcomes, access, utilization, or total cost of care rather than solely to volume of services delivered.

Appendix B. Infrastructure, Care Delivery Activities & Priority Quality Measures for Target Model *(non-exhaustive)*

Baseline capabilities and implementation gaps to describe:
Applicants should briefly describe the infrastructure, data access, staffing, workflows, and governance they have in place today, as well as any gaps that could affect implementation of the target model. This may include:

- How relevant patients are identified; limitations in roster, registry, or panel management
- EHR, HIE, ADT, claims/encounter, or MCO reporting access; reporting pain points
- Staffing, referral, discharge, chronic care, and care coordination processes
- Quality improvement routines, provider feedback, and governance processes
- Ability to use utilization, cost, or claims data, including data access limitations

Illustrative activities and priority quality measures for target model:

Care Delivery Element	Illustrative activities	Priority quality measures
1. Data analytics & attribution	• Patient rosters • Panel lists • Attribution inputs • Registry development • Risk stratification • Care gap lists • Utilization reports • Quality dashboards • Data quality improvement • Outreach lists	*N/A*
2. Care team capacity	• Team huddles • Workflow redesign • Escalation protocols • Provider feedback loops • Training	*N/A*
3. Access & care coordination	• Same-day / next-day access • After-hours or 24/7 clinical advice	• Adult Access to Preventive / Ambulatory Health Services (AAP) • Well-Child Visits in the First 30 Months of Life (W30)

Care Delivery Element	Illustrative activities	Priority quality measures
	• Telehealth • Mobile outreach • Outreach to patients overdue for care • ED/IP follow-up • Discharge summary review • Medication reconciliation • Referral follow-up • Specialist loop closure • HRSN screening • Transportation, food, housing, or community resource referrals • Closed-loop referrals	• Child and Adolescent Well-Care Visits (WCV) • Prenatal and Postpartum Care (PPC) • Plan All-Cause Readmissions (PCR) • Acute Hospital Utilization (AHU) • Ambulatory Care: Emergency Department Visits (AMB-ED) • Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) • Transitions of Care (TRC) • CAHPS access / care coordination composites, where available
4. Whole-person condition management	• Evidence-informed care plans • Diabetes workflows • Hypertension workflows • COPD / asthma workflows • Obesity and heart disease management • Medication management • Self-management support • Remote patient monitoring, where feasible • Planned follow-up for higher-risk patients • Depression / SUD screening • Referral workflows • Warm handoffs • Tele-behavioral health • BH/SUD follow-up • Co-management	• Controlling High Blood Pressure (CBP) • Glycemic Status Assessment for Patients With Diabetes (GSD) • Blood Pressure Control for Patients With Diabetes (BPD) • Eye Exam for Patients With Diabetes (EED) • Diabetes Short-Term Complications Admission Rate • Statin Therapy for Patients With Cardiovascular Disease (SPC) • Asthma Medication Ratio (AMR) • Follow-Up After Acute / Urgent Care Visits for Asthma (AAF) • Heart Failure Admission Rate• Depression Screening and Follow-Up (DSF) • Follow-Up After Hospitalization for Mental Illness (FUH) • Follow-Up After ED Visit for Mental Illness (FUM) • Follow-Up After ED Visit for Substance Use (FUA)

Care Delivery Element	Illustrative activities	Priority quality measures
		• Initiation and Engagement of Substance Use Disorder Treatment (IET)

Appendix C. TCOC & Quality Readiness Rubric

Applicants must score themselves 1-5 on each dimension based on current capabilities, not aspirational future capabilities. The average score should be used to propose Lane 1 or Lane 2 placement. LDH may validate or adjust placement during review or contracting.

Average score 1.0-3.49: Suggested Lane 1.

Average score 3.50-5.0: Suggested Lane 2.

Dimension	(1) Limited readiness	(2) Early readiness	(3) Developing readiness	(4) Advanced readiness	(5) Ready to impact TCOC
1. Data analytics and attribution	No defined rural Medicaid panel; limited visibility into claims, utilization, quality, or care gaps.	Partial patient lists or MCO reports; data are delayed, incomplete, or not actionable.	Defined target population or panel; some care gap, quality, utilization, or claims visibility.	Routine panel management, risk stratification, care gap tracking, and utilization review across most participating providers.	Reliable attributed/target population, refreshed data, risk stratification, and analytical capabilities sufficient to support quality measure analysis.
2. VBC experience and financial accounta-bility	No current participation in APMs, quality incentives, shared savings, or TCOC-based arrangements.	Limited experience with pay-for-reporting, cost-efficient/quality-backed activities, or basic quality incentives.	Participates in pay-for-reporting, quality incentives, or care management payments; limited TCOC experience.	Experience with upside-only shared savings, ACO/CIN/IPA arrangements, MCO value-based contracts, or internal cost/utilization performance management.	Experience with achieving meaningful change in patient quality outcomes through value-based care. Existing ability to estimate impact on quality metrics associated with TCOC, manage attribution, quality gates, benchmarks, funds flow, and provider accountability for TCOC performance.
3. Access and care coordination	Access is primarily office-based; ED/IP follow-up, referral tracking, and	Some expanded access or care coordination exists, but	Defined workflows for access, outreach, ED/IP follow-up, referrals,	Standardized workflows for timely access, transitions, referral closure, MCO	Reliable access and coordination model that can reduce avoidable ED/IP use, close referral loops, and

Dimension	(1) Limited readiness	(2) Early readiness	(3) Developing readiness	(4) Advanced readiness	(5) Ready to impact TCOC
	HRSN referrals are ad hoc.	limited to certain sites, staff, or patient groups.	and HRSN navigation for target patients.	coordination, and community resource navigation.	address non-clinical barriers affecting utilization and outcomes.
4. Care team capacity	Limited staff capacity beyond visit-based clinical care; no dedicated care coordination or population health roles.	Some informal care coordination or quality support, but roles and workflows are inconsistent.	Defined care team roles for care coordination, outreach, quality, or chronic disease support for a subset of patients.	Standardized care team roles, staffing model, workflows, huddles, escalation processes, and provider feedback loops across most sites.	Scalable care team operating model with sufficient staffing and workflows to manage a defined rural Medicaid population and respond to performance data.

Appendix D. Budget Template and Budget Narrative Instructions

Applicants should use the LDH budget workbook and classify requested funds by payment stream. Each line item must include cost basis, timing, funding source (including applicants' cost share/matching contribution), non-duplication explanation, and sustainability plan for recurring costs.

The budget template can be downloaded at https://ldh.la.gov/page/rhtp-funding-opportunities.

The Budget Narrative should serve as a higher-level explanation of the overall funding request, including the assumptions, rationale, and implementation approach underlying the proposed budget. The narrative should be completed by the lead applicant and accompany the APM Notice of Funding Opportunity (NOFO). The narrative should help reviewers understand how requested funds support the applicant's proposed activities, align with the selected lane[1], and contribute to improved outcomes for rural Medicaid members. This is intended to supplement / complement applicants' brief, in-line justifications for individual budget items within the budget template (separate document). The narrative is intended to explain year one costs in detail, and provide a longer-term sustainability plan and overview of costs in future years, if applicable.

1. Overall Budget Summary: Explain the total funding request, how it aligns with the proposed lane, and how requested funds support improved quality and access outcomes for rural Medicaid members. Summarize the major investments and describe how the budget supports the applicant's overall strategy and goals.

2. Infrastructure / Capacity Building: Explain why each infrastructure or capacity-building investment is needed, how costs were estimated, and how implementation milestones will be documented and tracked. Categorize each cost according to federal cost categories[2].

3. Per Member Per Year (PMPY) Activities (Lane 1 Only): Explain the target population, proposed activities, cost basis, member-year assumptions, and documentation plan supporting the PMPY funding request. Categorize each activity according to federal cost categories[2].

[1] Lanes are determined based on the TCOC readiness assessment provided in the APM NOFO. Lane 1 providers are paid to get ready, and Lane 2 providers are paid on results

[2] Direct costs: salaries and wages, fringe benefits, total personnel costs, equipment, supplies, travel, construction (match only), other and contractual; Indirect costs

4. Annual Quality / Process Performance (Lane 1 Only): Explain the selected measures, baseline performance, and validation approach.

5. Shared Savings (Lane 2 Only): Given the complexity of calculating TCOC, shared savings and quality measures, applicants should use this section to provide a 1-2 page overview of their proposed approach. This plan should give reviewers a clear understanding of the applicant's strategy, capabilities, and readiness to impact TCOC. Final methodology will be determined in partnership with LDH during the award agreement process.

This section should include the following components:

- Interventions and Estimated TCOC and Quality Impact:

  TCOC measures the overall spending required to care for a specific population, combining the prices of medical and pharmacy services with the frequency / utilization of how often those services are accessed.

  - Target Population: Describe the specific rural Medicaid population you will be accountable for (e.g., members with congestive heart failure and hypertension in specific parishes).
  - Interventions: Detail the evidence-based interventions you will implement to reduce avoidable costs and improve outcomes for this population (e.g., nurse-led care management, timely post-discharge follow-up, medication adherence program).
  - Savings Hypothesis: Explain how these interventions are expected to generate savings. If possible, provide a high-level estimate of the potential impact on TCOC, citing all assumptions (e.g., "We project a 15% reduction in hospital readmissions, which we estimate will save $X PMPY based on our historical data. The historical data indicates...").

- Proposed funds flow
  - Provider share: Explain what percentage of RHTP funding will flow to providers and how this was determined.

- Proposed Quality Measures and Performance Targets:
  - Quality Gates: Propose a set of 3-5 priority quality measures from the NOFO (Appendix B) that would serve as "quality gates." These are the minimum performance standards that must be met to be eligible for a

shared savings payment (e.g., achieving a 70% or better score on Controlling High Blood Pressure).

6. Non-Duplication: Explain how requested funding will supplement, rather than duplicate, Medicaid, MCO, grant, or other funding sources for the same activity, service, population, period, or outcome.

7. Sustainability: Explain which costs are one-time, time-limited, or recurring, and how successful activities will be sustained after RHTP funding ends.

LOUISIANA DEPARTMENT OF HEALTH
Office of Rural Health Transformation and Sustainability

Budget Narrative Template

Section	Contents
Overall Budget Summary	
Infrastructure / Capability Building	
Per Member Per Year (PMPY) Activities *(Lane 1 Only)*	
Annual Quality / Process Performance *(Lane 1 Only)*	
Shared Savings *(Lane 2 Only)*	
Non-duplication	
Sustainability	

Appendix E. Application Evaluation Information

Scoring criteria	Maximum points	What LDH may evaluate
Program fit and rural Medicaid impact	15	Alignment with RHTP goals, rural Medicaid focus, target population need, and potential to improve TCOC, quality, outcomes, avoidable utilization, or provider sustainability.
Readiness assessment and lane fit	15	Completeness and credibility of self-assessment; alignment between readiness level, proposed lane or payment stream, target model, and implementation approach
Care delivery model, investment rationale, and impact	25	Clarity and feasibility of proposed care delivery model, activities, and investments; strength of rationale for how requested funds support the target model; evidence-informed logic; potential impact on access, care coordination, whole-person condition management, and avoidable utilization
Provider participation and governance	15	Provider-led or provider-accountable model; clear provider, partner, and vendor roles; funds flow to providers; governance and accountability structure; avoidance of unsupported vendor pass-through
Quality, efficiency, and TCOC accountability	15	Use of priority measures; feasibility of reporting and documenting activities and outcomes; near-term quality and process improvement plan; readiness for longer-term TCOC accountability through shared savings or path to readiness
Budget value, non-duplication, sustainability	15	Reasonable cost relative to scope and expected impact (e.g., number of Medicaid members impacted); one-time vs recurring costs; non-duplication; administrative reasonableness; path beyond RHTP.