

Request for Applications (RFA)

Rural Health Transformation Program (RHTP)

Alternative Payment Model Pilot for Specialty Care Access — Key Action FAST 4.3

1. Overview

Issuing Agency: *Utah Healthcare Education and Research Foundation, a subsidiary of the Utah Hospital Association (UHA)*

Funding Source: *Rural Health Transformation Program, authorized under Public Law 119-21, Sec. 71401*

Total Funding Available: *\$3,000,000*

Number of Awards: *As many awards as available funding allows; award size will be scaled to the specialty service line proposed and the length of the requested subsidy period. While there is no maximum amount for individual awards, we suggest keeping total amount requested at or below \$250,000.*

Period of Performance: *January 1, 2027 through September 30, 2027*

Purpose: As part of Public Law 119-21, Congress established the RHT Program to help rural communities reimagine their health care delivery systems and improve health outcomes. This program addresses longstanding health-care challenges facing rural communities. This RFA funds a pilot under RHTP Key Action 4.3 — Implement a Pilot to Increase Specialty Care Access. The pilot provides per diem payments to specialists delivering on-site specialty care at small rural hospitals and clinics that do not currently have a sustainable specialty service line. This payment model stabilizes specialist earnings during the start-up phase, directly offsetting barriers such as travel time and initially low patient volume. The goal is not ongoing subsidy: support is structured to mitigate financial risk while the specialist builds a consistent patient load, so the on-site practice can transition to a financially self-sustaining service line and provide rural residents a reliable, long-term pathway to specialty care.

Because this pilot compensates providers directly for delivering care, and does so through a defined alternative payment arrangement, it is expected to draw primarily on the RHTP use-of-funds Category B Provider Payments.

2. Eligible Activity

Applicants may request per diem payments to compensate a specialist (physician or other licensed provider) for providing on-site specialty care at the applicant facility, where:

- The specialty service line does not currently exist at the facility, or exists at a volume too low to be self-sustaining
- The specialist's on-site time is structured on a recurring basis (e.g., a fixed number of clinic days per month)
- The per diem payment is designed to decline over the award period as patient volume grows, consistent with the applicant's proposed step-down schedule (see Section 5)

Funds under this RFA may not be used to subsidize an already-sustainable service line, nor to replace compensation a specialist would otherwise receive through normal billing at adequate volume.

3. Eligibility Criteria

Eligible applicants must meet the following criteria:

- Must be physically located in one of Utah's 25 rural counties (all counties except Davis, Salt Lake, Utah, and Weber).
- Be a provider billing Medicare / Medicaid
- Be in good standing with no unresolved findings from a prior state or federal award
- Certify requested funds will supplement, not replace, funding already planned or obligated from another source

4. Key Dates

Milestone	Date
RFA released	October 26, 2026
Informational webinar / Q&A session	[date]
Deadline for written questions	November 13, 2026, 5:00pm MT
Application deadline	Friday, November 20, 2026, 5:00pm MT
Review period	November 23, 2026 – December 3, 2026
Award notification	December 4, 2026
Anticipated project start date	December 1, 2026
Project end date (deadline for fund expenditure)	September 30, 2027

5. Application Requirements

A. Narrative

- Specialty & Staffing Plan — proposed specialty service line, specialist arrangement (employed, contracted, locum, telehealth-supported), and on-site cadence (days per month)
- Statement of Need — current access gap for the proposed specialty (distance to nearest provider, wait times, outmigration or referral data)
- Per Diem Rate & Justification — proposed rate and how it compares to market/contracted rates for the specialty
- Volume Ramp-Up Plan — projected patient volume by quarter or year across the subsidy period
- Sustainability Plan— how the proposed specialty service line will reach a sufficient volume level to become sustainable long term
- Community Impact — population and geographic area served by the new or expanded service line
- Results-Based Accountability (RBA) - identify performance measures and outcomes to monitor and report on each quarter

B. Budget

- Per diem rate × proposed on-site days, by year or quarter, showing the step-down schedule
- Budget narrative justifying the rate and the pace of the step-down

C. Required Attachments

- Specialist agreement or letter of intent (draft or executed)
- W-9 or equivalent taxpayer identification form
- Referral/outmigration data supporting the statement of need, if available
- Authorizing signature or board resolution

6. Review Process & Scoring Criteria

Applications will be reviewed by a scoring committee against the following proposed criteria:

Category	Points Possible	Total
Project cost share rate	10	10
Need – Specialty & site justification	15	35
Need – Distance to nearest provider	6	
Need – Wait time for specialty	6	
Need – Estimated outmigration	6	
Need – Data quality	2	
Per Diem Justification	20	20
Volume – Ramp up plan	15	15
Community Impact	15	15

		95
Bonus points:		
Frontier county	5	10
		100

Scoring Rubric Details

Project Cost Share (10 points)

Match %	Points
100% or more	10
90-99%	9
80-89%	8
70-79%	7
60-69%	6
50-59%	5
40-49%	4
30-39%	3
20-29%	2
Up to 10%	1
No cost share	0

Specialty and Site Justification (15 points)

Specialty and Staffing Plan: the proposed service line, the specialist arrangement, and the on-site cadence.

Score	What it means
15	Explains why this specialty was chosen, using at least two evidence sources (community health needs assessment, referral and transfer patterns, ED or inpatient data, disease burden). Explains why this facility is the right site (population served, location relative to other facilities). Documents what the site already has for the service (clinic space, equipment, diagnostics, support staff, scheduling and referral workflow). Names the specialist arrangement (employed, contracted, locum, telehealth-supported) and attaches a letter of intent, draft agreement, or credentialing plan for a named or identified specialist. States the on-site cadence (days per month, hours per day) and shows it fits the volume plan. Documents current volume for the specialty (zero, or a figure below self-sustaining) to confirm eligibility.
12	Specialty rationale supported by at least one data source. Site fit explained with most readiness items covered. Specialist arrangement and cadence stated, with a specialist identified or in active recruitment. Minor gaps, such as missing equipment detail or no letter of intent.
9	Specialty rationale supported by at least one data sources, but site fit is lacking or will need additional time/funds before specialist can provide services. Specialist is not identified and recruitment has not begun.
6	Specialty and arrangement are stated, but the rationale is general or rests on anecdote. Site readiness is asserted without detail. No specialist identified.
3	Specialty or site choice is unexplained, the specialist arrangement or cadence is unclear, or the facility lacks key resources with no plan to obtain them.

Need for the Specialty (20 points)

Statement of Need: the current access gap for the proposed specialty. Need is scored on four elements. Within each, a higher score requires both a more severe documented gap and stronger documentation.

Element	Points
a. Distance to nearest provider	6
b. Average wait time for the specialty	6
c. Estimated patient outmigration	6
d. Data quality and overall gap	2

a. Distance to Nearest Provider (6 points)

Score	What it means
6	Distance in miles and drive time from the facility (and from the main communities it serves) to the nearest provider of this specialty who accepts new patients and the applicant's major payers, including Medicaid. Nearest provider is at least 60 miles away. Method and source stated (mapping tool, provider directory, calls to offices). Notes whether telehealth is available and how well it substitutes.
4	Distance and drive time documented with a source. Nearest provider is at least 40 miles away. May not confirm that the provider accepts new patients or Medicaid.
2	Distance given in miles or time only, or from the facility only, without a source. Nearest provider is 20 to 40 miles away.

b. Average Wait Time for the Specialty (6 points)

Score	What it means
6	Average wait for a new-patient appointment with the nearest providers is at least 90 days, based on measured data: scheduling calls to the offices, referral tracking logs, payer or health system data. States the date and method, and the number of offices or records sampled. Distinguishes routine from urgent wait times.
4	Average wait of at least 60 days with a stated method and source. Sample size or date may be incomplete.
2	Wait time given from a single call, a provider's statement, or secondary sources without method. Wait is under 30 days or not clearly an average.

c. Estimated Patient Outmigration (6 points)

Score	What it means
6	An estimated annual number of patients leaving the area for this specialty, with the time period and the method (referral logs, claims or discharge data, ED transfers, payer data, primary care panel review). Shows where patients go and how the estimate was calculated. The number is large enough to support the projected year-one visit volume in Criterion 4 with a realistic capture rate (e.g., out-migrating patients are at least twice the projected visits).
4	A numeric estimate with time period and a described method. Some gaps, such as destinations not shown or capture rate not linked to the volume plan.
2	A rough number based on provider estimates or a small sample, with an unclear method or period. Not linked to projected volume.

d. Data Quality and Overall Gap (2 points)

Score	What it means
2	All data elements come from identifiable sources, use consistent time periods, and together tell a coherent story of unmet need. Any limits of the data are acknowledged.
1	Most data identifiable, but sources or periods are inconsistent, or the elements do not clearly connect.

Per Diem Rate Justification (20 points)

Per Diem Rate and Justification: the proposed rate.

Score	What it means
20	A proposed daily rate with a breakdown of what it covers (clinical time, travel time, mileage and lodging, malpractice or credentialing costs). Shows that grant funds do not replace normal compensation. Defines the day (hours on site, patients per day expected). Budget arithmetic (rate times days per quarter) is correct and matches the budget.
15	Rate with a component breakdown. Addresses the non-replacement requirement. Minor gaps in the breakdown or hours defined.
10	Rate stated. No clear explanation of how the rate avoids replacing normal billing compensation.
5	Rate stated without justification or the budget arithmetic does not match the stated rate and days.

Volume Ramp-Up Plan (15 points)

Volume Ramp-Up Plan & Sustainability: projected patient volume across the subsidy period and beyond. Sustainability how the service line becomes self-sustaining.

Score	What it means
15	Projected patient visits by quarter for the Jan 1 to Sep 30, 2027 period and by quarter or year for the rest of the subsidy period, through the point the service line is self-sustaining. Visits per clinic day shown and consistent with facility capacity and the specialist's cadence. Justification from at least two sources. Capture rate and payer mix assumptions stated. A referral and scheduling pathway (marketing, outreach). Projections realistic given the number of patients available. A break-even analysis that includes the full cost of the service line (specialist, staff, supplies, overhead), not only the per diem. A specific projected date when the service line is self-sustaining without grant support. A trigger or adjustment rule if volume falls short. A named plan and funding source for any remaining gap after the grant. Clearly does not subsidize a sustainable service line or replace normal compensation at adequate volume.
11	Quarterly projections for the performance period and a longer-range view. Justified by at least one data source tied to Criterion 2. Visits per clinic day and capture rate stated. Minor gaps in referral pathway or payer mix. Projected self-sustaining date stated. Break-even considers most costs. A basic plan if volume falls short. Minor gaps in revenue assumptions.
7	Projections stated by year only, or without visits per clinic day. Justification is general ("demand is high") or growth assumptions are not tied to local data. Self-sustaining date given without a break-even analysis. No contingency plan.
3	Projections are unsupported, unrealistic given available patients or capacity, or do not cover the subsidy period. No referral or scheduling plan. No self-sustaining date is given. Subsidy appears to continue indefinitely.

Community Impact (15 points)

Score	What it means
15	Names the counties, towns, and tribal areas in the service area and gives the population served, with a source. Estimates the number of unique patients served per year once the service line is established. Quantifies the travel burden removed (e.g., patient times round-trip miles or hours saved). Identifies the groups most affected (Medicaid enrollees, older adults, tribal members, uninsured, people without reliable transportation) with data. Shows additional community benefits, such as keeping care and revenue local, supporting hospital or primary care services, reducing avoidable transfers, or supporting the local workforce. Includes letters of support from community partners such as referring providers, public health, county government, or tribal health leadership. Explains whether neighboring facilities can also use the service.
12	Service area and population stated with a source. Patient estimates and some measure of travel burden. Affected groups identified. At least one additional community benefit. At least one letter of support.
9	Service area or population stated with a source. Patient estimates and travel burden are specifically stated but lacking data. Letters of support are drafted but not implemented.

6	Service area described in general terms, population figures without a source, or no quantified patient or travel estimate. Benefits described broadly. Letters of support missing or generic.
3	Community served is poorly defined, the benefit is asserted without numbers, or the service line would serve very few residents relative to the cost.

DHHS reserves the right to fund in whole, in part, or not at all, and to negotiate the per diem rate, step-down schedule, or subsidy period prior to final award.

7. Award Terms & Conditions

- Per diem payments must decline according to the awardee's approved step-down schedule; DHHS may adjust future-year payments based on actual reported patient volume
- Awardees must report patient volume, billing revenue, and per diem payments made each reporting period
- Funds must supplement, not replace, expenditures already planned or obligated through other funding sources
- Funds cannot be used for administrative overhead, salaries, travel, etc.
- Awardees are subject to monitoring, which may include desk reviews and/or site visits
- If the specialty service line does not progress toward self-sustainability as projected, DHHS may reduce, pause, or discontinue funding pending a corrective plan
- Quarterly and annual reports are due on the first day of the month following the end of the quarter or year. If the due date falls on a weekend or holiday, it is due the next business day. Report templates will be provided to awardees and must include the results of the outcome measures completed, spending data broken down by use of funds, milestone progress, sustainability planning, and success stories.
- Awardees must report on outcomes and measures identified in the application and finalized in the contract.
- Awardees are encouraged to submit high expense invoices as they are received. All invoices, including small or recurring invoices, shall be submitted no later than the 10th of each month following the month of the expenditure. Invoices for allowable costs will be paid within 30 days of a correct invoice being received.

8. Submission Instructions

Submission method: Applications will be submitted through a secure online platform called Submittable. The link will be provided on the UHA website at <https://utahhospitals.org/> and on the Utah RHTP website at <https://dhhs.utah.gov/ruralhealth/funding-opportunities/>

Deadline: Friday, November 20, 2026, 5:00 p.m. MT

9. Questions & Contact

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This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$9,891,739 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.