Rural Health Transformation

5.12.2026

Grant Guidelines

Purpose

The Rural Health Transformation (RHT) Program, led by the Wisconsin Department of Health Services (DHS) is federally funded by The Centers for Medicare & Medicaid Services (CMS), a federal agency within the U.S. Department of Health and Human Services (DHHS).

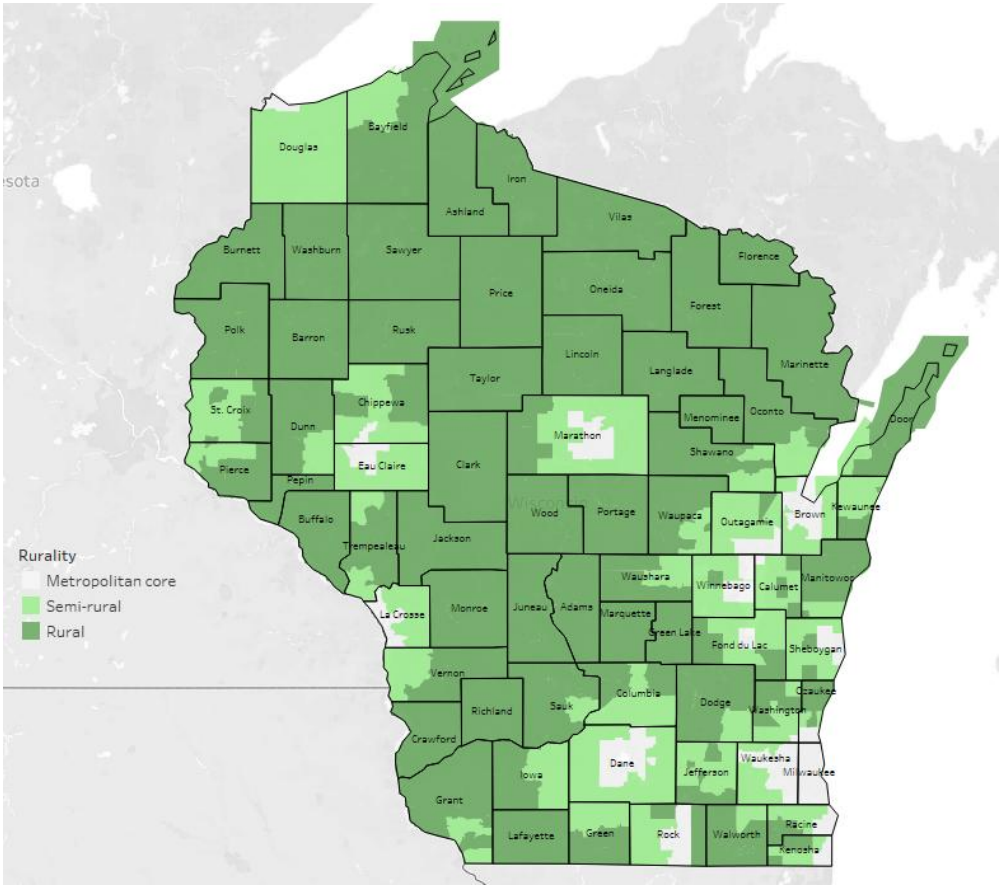
RHT will provide one-time funding for the Wisconsin Technical College System (WTCS) to develop health care workforce training programs. $22,139,403 will be allocated in Budget Year 1 while additional funds will be allocated upon confirmation of federal funding in subsequent federal budget years, planned for 4 additional years in the following amounts:

	Budget Year 1*	**Budget Year 2****	**Budget Year 3****	**Budget Year 4****	**Budget Year 5****
WTCS Award	**$ 22,139,403**	**$ 7,991,934**	**$ 7,964,004**	**$ 7,875,268**	**$ 6,068,348**

***Subject to availability of federal funds.*

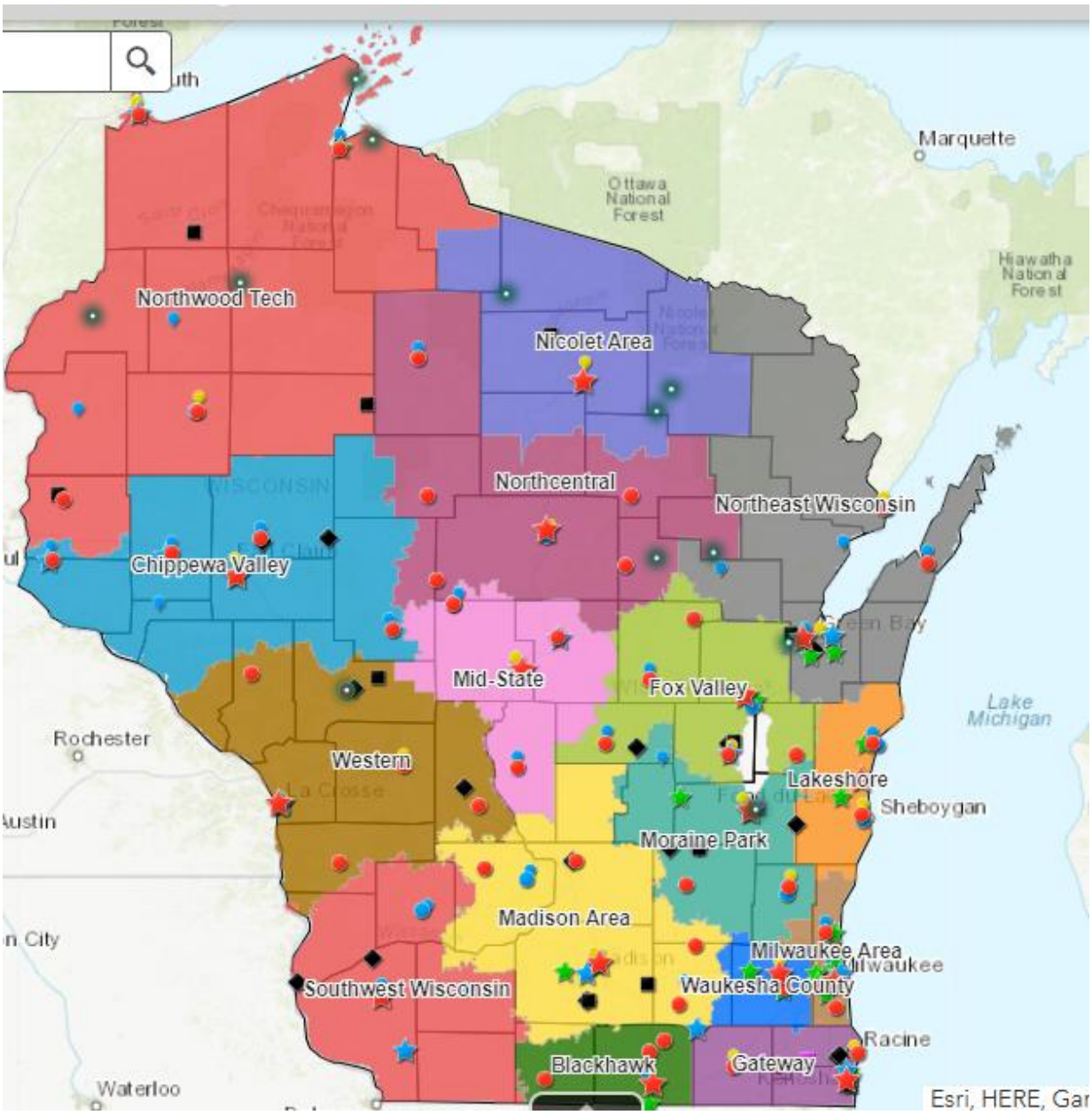
The System will solicit applications and coordinate investments strategically across rural campuses. WTCS will invest in clinical training opportunities, simulation labs and health care programs across rural Wisconsin. Additionally, funds can cover initial accreditation fees, preceptor training and compensation, curriculum design, and recruitment outreach. Campuses will be responsible for designing and maintaining long-lasting partnerships that connect students with high-quality clinical experiences.

WTCS will leverage funds to establish new programs in high-demand fields, for example, rural programs in dental therapy, behavioral health, nursing and allied health (radiology, laboratory and surgical technologists). Funds will help expand experiential learning and train instructors on use. Funds will cover curriculum development, equipment, facility and staff costs associated with start-up and operational deficits during the first two years while initial student cohorts are established. Programs will be sustained for more than five years through tuition, fees and other fund sources. Campuses will be responsible for designing and maintaining long-lasting partnerships that connect students with high-quality clinical experiences.



Target Areas of Wisconsin

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



Updated 5.12.2026

Funds Available & Period of Performance

$22,139,403 is available to WTCS colleges in Year 1. Grant period of performance will be the date of grant approval or October 30, 2026 (whichever is first) through September 30, 2027. Applicants should leave grant start date blank when submitting the application. Grant start date will be assigned by WTCS in grant award letter upon grant approval.

Applications will be accepted on a rolling basis starting June 1, 2026. The deadline for submitting applications is August 1, 2026. Grants will be awarded to colleges prior to October 30, 2026, and funds must be spent no later than September 30, 2027.

Each college is eligible to apply for the amount listed in the chart below. Each college receives a $300,000 base amount. The remaining funds are distributed by county with 60% of funds divided through 32 rural counties; 40% of funds divided through 39 semi-rural counties. From here, county funding will be split based upon county funding formula that is already used for AEFLA and WTCS Board purposes.

	Year 1 Grant Allocation
Blackhawk	603,380
Chippewa Valley	1,928,291
Fox Valley	1,154,615
Gateway	826,788
Lakeshore	658,830
Madison	1,506,464
Mid-State	1,282,347
Milwaukee	511,135
Moraine Park	1,116,848
Nicolet	1,750,025
Northcentral	1,886,333
Northeast	1,796,276
Northwood	3,199,618
Southwest	1,572,292
Waukesha	512,140
Western	1,834,021
Total Award	22,139,403

Technical Requirements

The 16 technical college districts are eligible to develop rural health training programs and equip rural training facilities. Each college is eligible to submit an application to the System Office that outlines their approach and activities for meeting the goals of the grant. Each college will focus their application on the activities and efforts that will be most effective in their district. Applications will be evaluated for how well the activities align with the statement of work and how sustainable the programs will be. Colleges may apply individually or as a consortium. A consortium application would be eligible to apply for up to the combined amount of the colleges included in the consortium application.

Eligible Programs

All Healthcare Cluster programs; new programs with prior approval by WTCS Director for Healthcare.

Protective Services Cluster programs:

> EMS: EMR, EMT, AEMT, Paramedic, Fire Medic; new programs with prior approval by WTCS Director for Protective Services.

Human Services Cluster programs:

> Substance Use Disorder Counseling (SUDC); Gerontology; new programs with prior approval by WTCS Director for Human Services.

Measurable Objectives

Colleges will be expected to work on and report on progress toward the following in Year 1:

- By August 2028, create or expand healthcare programs (aid codes 61,30,31,32,10,11) and/or apprenticeship programs (aid code 50) with a five-year commitment to serving rural areas.
- By August 2029, increase the number of locations and number of students enrolled or completing new or expanded healthcare and/or apprenticeship programs.
- By August 2029, increase the number of locations and number of students enrolled or completing rural or semi-rural clinical rotations or simulation-based training and locations of participating facilities.

To demonstrate meeting the above measurable objectives, colleges must write to one or more of the following goals in their grant applications:

- Create or expand healthcare programs (aid codes 61,30,31,32,10,11,50) with a five-year commitment to serving rural areas.

- Increase the number of locations and number of students enrolled or completing new or expanded healthcare and/or apprenticeship programs.
- Increase the number of locations and number of students enrolled or completing rural or semi-rural clinical rotations or simulation-based training and locations of participating facilities.

Review Criteria

Grant review rubric will be established prior to grant review. Applications will be evaluated for how well the activities align with the statement of work and how sustainable the programs will be.

Reporting Requirements

One annual and three quarterly progress reports are required each year. Reports shall cover all work completed during the specified period and shall present the work to be accomplished during the subsequent period. Reports shall include qualitative progress updates on milestones and implementation, quantitative updates on metrics that the subgrantee is tracking as a part of their workplan, quantitative description of funds expenditure by initiative and use of funds, and any additional information requested. Reports shall also identify any problems that arose and a statement explaining how the problem was resolved. Reports shall also identify any problems that have arisen but have not been completely resolved and provide an explanation. Additional reporting requirements will be developed by the Wisconsin Office of Rural Health, and reporting templates will be provided by DHS. Client reporting is required.

Deliverable	**Reporting Period**	**College Report Due to WTCS**	**WTCS Report Due to DHS**
Annual Report #1	**Grant award date to July 31, 2026**	**August 1, 2026**	**August 10, 2026**
Quarterly Report #1	August 1, 2026 to October 30, 2026	November 1, 2026	November 10, 2026
Quarterly Report #2	October 31, 2026 to January 30, 2027	February 1, 2027	February 10, 2027
Quarterly Report #3	January 31, 2027 to April 30, 2027	May 1, 2027	May 10, 2027

Annual Report #2	August 1, 2026 to July 31, 2027	August 1, 2027	August 10, 2027
Quarterly Report #4	August 1, 2027 to September 30, 2027	October 1, 2027	November 10, 2027

Monitoring Requirements

Additional monitoring requirements will be disclosed in the grant award letter. Colleges should expect monitoring through 2031.

Allowable Activities

- Up to 5% administrative costs allowed for each district.
- Establish new programs in high-demand healthcare fields, for example, rural programs in dental therapy, behavioral health, nursing and allied health (radiology, laboratory and surgical technologists).
- Investment in clinical training opportunities.
- Replicate evidence-based models to expand rural training opportunities.
- Create and expand simulation labs.
- Invest in experiential learning tools.
- Initial accreditation fees.
- Preceptor training and compensation; subject to restrictions on compensation.
- Curriculum design and development.
- Recruitment.
- Outreach.
- Equipment.
- Student access to patient-care documentation systems.
- Tools for tele-precepting and patient-care documentation systems.
- Facility and staff costs associated with program start-up.
    - Operational deficits during the first two years while initial student cohorts are established. Programs will be sustained for more than five years through tuition, fees and other fund sources.
- Student transportation.
- Standard maintenance contracts included by the equipment manufacturer. Any additional equipment maintenance contracts must fall within the performance period of the grant
- Personnel (responsible for implementing/ executing/ delivering approved projects)
    - Staff salary and fringe benefits.
    - Travel.
    - Supplies.

    - Allocated direct costs.
- Clinical preceptor stipends or compensation.
- Simulation lab development, subject to restrictions on new construction.
- Simulation lab equipment.
- Simulation lab training costs.
- Contractual services.
- Minor Renovations or Alterations. Funds may be used for minor renovations or alterations if they are clearly linked to program goals and receive CMS prior approval. See NOFO, Program requirements and expectations, Use of Funds (pages 11-13), and Program-specific limitations, Unallowable Costs (pages 19-20)
    - Funding used for renovation or alterations cannot exceed 20% of the total funding awarded to the Recipient in each budget period.
- Other, if allowable and approved.

Limitations

- All costs must also be reasonable, allocable, and adequately documented, and not prohibited by the award terms or applicable state and federal law.
- All equipment purchases $10,000 or above require prior approval from the federal oversight agency, CMS.
- All public-facing communications must be submitted to WTCS for review and comment by CMS prior to publication. This includes materials intended for the general public, such as external presentations, public materials, press releases, media interviews, releases of information, web content, social media posts, and other communications included under the Stevens Amendment. The Department of Health Services will serve as the Wisconsin liaison with CMS. College must only use approved communications materials.
- Milwaukee County locations are not eligible under this grant.
- Funds may not be used for new construction. Internal reorganizing and remodeling of existing buildings is allowable. Renovations may not add to the square footage of the building. Fixtures attached to the building (including fixed equipment) should be included in renovation costs. See Exhibit 2 and the FAQ from CMS for additional guidance. Funds also may not be used for the following:
    - To supplant funding for in-process or planned construction projects or directing funding towards new construction builds.
    - Construction or building expansion, purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increases the value of the capital or useful life as a direct cost.

- Tuition, financial aid, course fees or other student costs are not allowed under the grant. Subsidizing student costs does not meet program sustainability metrics.
- Funds may not be used to replace payment for clinical services that could be reimbursed by insurance. Funds also may not be used for payments to clinical services if they duplicate billable services and/or attempt to change the payment amounts of existing fee schedules. If the Recipient plans to fund direct health care services, the Recipient must justify why they are not already reimbursable, how the payment will fill a gap in care coverage (such as uncompensated care or services not covered by insurance), and/or how they transform the current care delivery model. CMS will have final approval of whether proposed services are allowable.
    - Funding used for provider payments, defined in the NOFO as providing payments to health care providers for the provision of health care items or services, cannot exceed 15% of the total funding awarded to the Recipient in a given budget period.
    - Funding cannot be used for initiatives that fund certain cosmetic and experimental procedures that fall within the definition of a specified sex-trait modification procedure at 45 CFR 156.400 because that is beyond the scope of this program.
- No more than 5% of total funding awarded to the Recipient in a given budget period can support funding the replacement of an Electronic Medical Record (EMR) system if a previous HITECH certified EMR system is already in place as of September 1, 2025.
- Funding towards initiatives similar to the "Rural Tech Catalyst Fund Initiative", as described in the NOFO Appendix (pages 115-118), cannot exceed the lesser of (1) 10% of total funding awarded to the Recipient in a given budget period or (2) $20M of total funding awarded to the Recipient in a given budget period. Funding is subject to all restrictions and requirements described in the example initiative.
- Funds may not be used for clinician salaries. Funds also may not be used for clinician salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations. This applies only to salaries and wages funded by the 8 Category J funding (Capital Expenditures and infrastructure) is described in the NOFO as investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions in the funding policies and limitations section of the NOFO.
- Category J funding cannot exceed 20% of the total funding CMS has awarded the Recipient in a given budget period.
- None of the funding shall be used by the Recipient for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or

any other expenditure to finance the non-Federal share of expenditures required under any provision of law.

- SSA 2105(c), paragraphs (1), (7), and (9) apply as funding limitations. These limitations are related to general limitations, limitations on payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.

Exhibit 2: Federal Compliance Requirements

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

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

1. Pre-award costs.
2. Meeting matching requirements for any other federal funds or local entities.
3. Services, equipment, or supports that are the legal responsibility of another party under federal, State, or tribal law, such as vocational rehabilitation or education services.
4. Services, equipment, or supports that are the legal responsibility of another party under any civil rights law, such as modifying a workplace or providing accommodations that are obligations under law.
5. Goods or services not allocable to the project.
6. Supplanting existing State, local, tribal, or private funding of infrastructure or services, such as staff salaries.
7. Construction or building expansion, purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increases the value of the capital or useful life as a direct cost.
8. The cost of independent research and development, including their proportionate share of indirect costs. See 2 CFR 300.477.
9. Funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order.

10. Purchase of covered telecommunications and video surveillance equipment (See 2 CFR 200.216) as well as financial assistance to households for installation and monthly broadband internet costs.

11. Meals, unless in limited circumstances such as:

    a. Subjects and patients under study.

    b. Where specifically approved as part of the project or program activity, such as in programs providing children's services.

    c. As part of a per diem or subsistence allowance provided in conjunction with allowable travel.

12. Activities prohibited under 2 CFR 200.450 and the HHS Grants Policy Statement, including but not limited to: paying the salary or expenses of any grant recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any State government, State legislature, or local legislature or legislative body.

13. Lobbying, but awardees can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying.

14. New construction is unallowable. Supplanting funding for in-process or planned construction projects or directing funding towards new construction builds is unallowable. Renovations or alterations, as described in category J of the program requirements and expectations use of funds section, are allowed if they are clearly linked to program goals.
    a. Minor Alterations and Renovations projects include small modifications aimed at enhancing the functionality of the facility where the project will take place. In general, minor modifications to an existing building footprint, existing infrastructure, and existing rooms within a facility would be considered minor building alterations or renovations.
    b. Hypothetical, illustrative examples include but are not limited to:
        i. Interior Modifications: Installing or relocating interior walls and partitions to create new offices or meeting rooms.
        ii. Lighting and Electrical: Upgrading light fixtures to more energy-efficient systems.
        iii. HVAC and Plumbing: Replacing vents and thermostats for better climate control.
        iv. Accessibility Improvements: Installing automatic door openers to enhance accessibility.
        v. Security and Safety: Installing or upgrading security cameras or access control panels.
        vi. Workspace Reconfiguration: Creating open office layouts or converting private offices to better suit needs.

c. Category J funding cannot exceed 20% of the total funding CMS awards States in a given budget period.

15. To replace payment for clinical services that could be reimbursed by insurance. We will not accept payments to clinical services if they duplicate billable services and/or attempt to change payment amounts of existing fee schedules.

    a. If you plan to fund direct health care services, you must justify why they are not already reimbursable, how the payment will fill a gap in care coverage (such as uncompensated care or services not covered by insurance), and/or how they transform the current care delivery model.

    b. Funding for provider payments, as described in category B of the program requirements and expectations use of funds section, cannot exceed 15% of the total funding CMS awards States in a given budget period.

    c. Funding cannot be used for initiatives that fund certain cosmetic and experimental procedures that fall within the definition of a specified sex-trait modification procedure at 45 CFR 156.400 because that is beyond the scope of this program.

16. No more than 5% of total funding CMS awards to a State in a given budget period can support funding the replacement of an EMR system if a previous HITECH certified EMR system is already in place as of September 1, 2025.

    a. Upgrades, enhancements, and added modules, interfaces, or functionality to existing EMR/EHR systems are allowable uses of funds and are not subject to the 5% limitation.

17. Funding towards initiatives similar to the "Rural Tech Catalyst Fund Initiative" (as described in the appendix) cannot exceed the lesser of (1) 10% of total funding awarded to a State in a given budget period or (2) $20M of total funding awarded to a State in a given budget period, and funding is subject to all restrictions and requirements described in the example initiative.

18. Clinician salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations.

19. None of the funding shall be used by the State for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law.

20. SSA Section 2105(c), paragraphs (1), (7), and (9) apply as funding limitations. These limitations are related to general limitations, limitations on payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.

21. Consistent with **2 CFR 200.113, Mandatory disclosures**, applicants and recipients must promptly disclose, in writing, to CMS with a copy to the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Additionally, subrecipients must promptly disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to CMS and to the HHS OIG at the following addresses:

    U.S. Department of Health & Human Services Centers for Medicare & Medicaid Services
    Office of Acquisition and Grants Management
    Attn: Director, Division of Grants Management, Mandatory Grant Disclosures 7500 Security Blvd, Mail Stop B3-30-03
    Baltimore, MD 21244-1850

    Materials must also be scanned and emailed to your Grants Management Specialist.

    AND

    U.S. Department of Health & Human Services
    Office of Inspector General
    ATTN: Mandatory Grant Disclosures, Intake Coordinator
    330 Independence Avenue, SW, Cohen Building
    Room 5527
    Washington, DC 20201 Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
    Email: MandatoryGranteeDisclosures@oig.hhs.gov

    Failure to make required disclosures can result in any of the remedies described in 2 CFR 200.339, Remedies for noncompliance, including suspension or debarment (See 2 CFR 200 Part 180 & 2 CFR 200 Part 376 and 31 U.S.C. 3321).

Examples of allowable costs:

22. States must focus funding on the following categories as described in Section 71401 of Public Law 119-21:
    a. **Prevention and chronic disease**: Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.

b. **Provider payments**: Providing payments to health care providers for the provision of health care items or services, subject to restrictions described in the funding policies and limitations.
c. **Consumer tech solutions**: Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.
d. **Training and technical assistance**: Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence and other advanced technologies.
e. **Workforce**: Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for at least five years.
f. **IT advances**: Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.
g. **Appropriate care availability**: Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care and post-acute care service lines.
h. **Behavioral health**: Supporting access to opioid use disorder treatment services, other substance use disorder treatment services and mental health services.
i. **Innovative care**: Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.

23. Additional uses designed to promote sustainable access to high quality rural health care services, as determined by the CMS Administrator, including:
    a. **Capital expenditures and infrastructure**: Investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions in the funding policies and limitations.
    b. **Fostering collaboration**: Initiating, fostering and strengthening local and regional strategic partnerships between rural facilities and other health care providers to promote quality improvement, improve financial stability of rural facilities and expand access to care.

24. Specific examples provided in the Notice of Funding Opportunity include:
    a. States can offer certain incentives to attract clinical workforce to work in rural areas provided the recipient of the incentive commits to working in rural areas for a minimum of **5 years**. Funding for local housing for students or trainees in rural areas may be allowable if included as part of an approved initiative within the scope of the RHT Program. Note that payment for student

or trainee housing is limited to short-term (less than 6 months) housing for rotations.

b. Targeted technical assistance and training to help clinicians, medical coders, and other personnel better understand and use existing payment mechanisms already in place for care coordination services via Medicare and Medicaid or other payers.

c. Creating, implementing, or enhancing IT systems, software, or data sharing infrastructure to streamline population health management and care coordination by sharing resources, making referrals and ensuring the completion of the referral process that helps with coordinating amongst stakeholders and/or population health management. Promoting community engagement, awareness of programs and community input on program development, structure and oversight.

d. Training and integrating community health workers, care coordinators, peer support specialists, community paramedics, other auxiliary personnel and behavioral health specialists into the care delivery system. Such personnel can then launch and support targeted outreach programs to engage and educate rural populations.

e. Developing multidisciplinary frameworks to formally integrate non-physician providers such as paramedics, community paramedics, emergency medical technicians, community health workers and pharmacists into care teams, in collaboration with rural facilities.

f. Developing community-based programs to promote health literacy and healthy behaviors within a population, such as tobacco cessation programs, diabetes management education, or nutrition education.

g. Improving access to primary care and preventative services in innovative sites of care, such as schools, retail centers, public libraries and home-based visits, and/or via mobile care delivery, such as use of mobile screening vans, community paramedicine and mobile clinics.

h. Assistance in setting up the legal and organizational framework to create and operate a rural health network including, but not limited to, articles of incorporation, network operating practices, dues structure and network decision making procedures.

i. Technical assistance to organizations developing or enhancing integrated rural health networks.

j. Technical assistance with restarting closed service lines, such as with recruitment, compliance, or infrastructure.

k. Technical assistance on legal and regulatory issues (such as antitrust navigation and contracting and data sharing between members).

l. Needs assessments for rural communities related to strategic planning of services, including maternity care.

m. Start-up funding to cover providers' initial staffing and equipment to support strategically targeted service line expansion linked to local need until enough volume develops to reach sustainability.

n. IT systems, software, or data sharing infrastructure, such as health information exchanges or frameworks like The Trusted Exchange Framework and Common Agreement (TEFCA), that help with coordinating amongst providers and supporting population health management.

Additional Resources

→ Notice of Funding Opportunity (NOFO)
- Pages 11-12, 18-20, 97-118

→ Rural Health Transformation FAQ
- Section V. Use of Funds, pages 34-53