OMB Number: 4040-0004
Expiration Date: 11/30/2025

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Executive Office of the State of Hawaii

* b. Employer/Taxpayer Identification Number (EIN/TIN): 990275730

* c. UEI: L1SGJ7LKJKT3

d. Address:

* Street1: 415 S Beretania St
Street2: Fl 5
* City: Honolulu
County/Parish:
* State: HI: Hawaii
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 96813-2407

e. Organizational Unit:

Department Name: Department of Budget & Finance

Division Name: Office of Federal Awards Mgmt.

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: Mark
Middle Name:
* Last Name: Anderson
Suffix:

Title: Administrator, Office of Federal Awards Mgmt.

Organizational Affiliation:

* Telephone Number: ([redacted]
Fax Number:

* Email: [redacted]@hawaii.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Centers for Medicare & Medicaid Services

11. Assistance Listing Number:

93.798

Assistance Listing Title:

Rural Health Transformation Program

*** 12. Funding Opportunity Number:**

CMS-RHT-26-001

* Title:

Rural Health Transformation Program

13. Competition Identification Number:

CMS-RHT-26-001-117822

Title:

Rural Health Transformation Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

The Hawai'i Rural Health Transformation Plan will build a robust, sustainable rural health care system that will improve healthcare access, quality and outcomes through six interconnected initiatives.

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: HI-001 * b. Program/Project: HI-all

Attach an additional list of Program/Project Congressional Districts if needed.

SF-424 Congressional Districts.pdf | Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 12/31/2025 * b. End Date: 09/30/2031

18. Estimated Funding ($):

* a. Federal	1,000,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name: Mark

Middle Name:

* Last Name: Anderson

Suffix:

* Title: Administrator, Office of Federal Awards Mgmt.

* Telephone Number: [redacted] Fax Number:

* Email: [redacted]@hawaii.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

Supplemental Information on Congressional Districts

Please note that Hawai‘i has two congressional districts, HI-001 and HI-002. The applicant (the Executive Office of the State of Hawai‘i) and all sub-recipients are State agencies. They are headquartered in the State’s capital city, which falls within HI-001, but serves both districts.

If we receive this award, program work will be performed in several locations, the majority of which will likely fall in HI-002. However, due to the way in which the Hawai‘i State procurement process occurs, we don’t have specific program sites identified at this time.

Sub-Recipient State Agencies

1. State Health Planning and Development Agency (SHPDA): HI-001
2. University of Hawai‘i at Mānoa, Telecommunication and Social Informatics Program (TASI): HI-001
3. State Department of Health: HI-001
4. University of Hawai‘i John A. Burns School of Medicine (JABSOM): HI-001
5. State Department of Human Services: HI-001

Key Healthcare Facilities

The following are key healthcare facilities in the State. This program aims to benefit these facilities, though program work may not physically occur in each location.

Hospitals:

1. Kauai Veterans Memorial Hospital: HI-002
2. Samuel Mahelona Memorial Hospital: HI-002
3. Wilcox Medical Center: HI-002
4. Adventist Health Castle: HI-002
5. Kahuku Medical Center: HI-002
6. The Queen’s Medical Center – West Oahu: HI-001
7. Kula Hospital: HI-002
8. Lanai Community Hospital: HI-002
9. Maui Memorial Medical Center: HI-002
10. Molokai General Hospital: HI-002
11. Hilo Benioff Medical Center: HI-002
12. Honoka‘a Hospital and Skilled Nursing: HI-002
13. Ka‘u Hospital: HI-002
14. Kohala Hospital: HI-002
15. Kona Community Hospital: HI-002
16. Queen’s North Hawaii Community Hospital: HI-002

Federally Qualified Health Centers:

1. Ho‘ola Lahui Hawaii (Kauai Community Health Center): HI-002
2. Kalihi-Palama Health Center: HI-001
3. Kokua Kalihi Valley Comprehensive Family Services: HI-001
4. Ko‘olauloa Health Center: HI-002

5. Wahiawa Health: HI-002
6. Waianae Coast Comprehensive Health Center: HI-002
7. Waikiki Health: HI-001
8. Waimanalo Health Center: HI-002
9. Hana Health: HI-002
10. Lanai Community Health Center: HI-002
11. Malama I Ke Ola Health Center (Community Clinic of Maui): HI-002
12. Molokai Community Health Center: HI-002
13. Hamakua Health (multiple locations): HI-002
14. Hawai‘i Island Community Health Center (multiple locations): HI-002

Native Hawaiian Health Systems:

1. Ho‘ola Lahui Hawaii (multiple locations): HI-002
2. Ke Ola Mamo: HI-001
3. Hui No Ke Ola Pono (multiple locations): HI-002
4. Na Puuwai – Molokai: HI-002
5. Hui Malama Ola Na Oiwi – Hilo: HI-002

Certified Community Behavioral Health Clinics:

1. Maui Certified Community Behavioral Health Clinic (multiple locations): HI-002

Opioid Treatment Facilities:

1. Comprehensive Health and Attitude Management Program: HI-001
2. Ku Aloha Ola Mau: HI-001
3. Comprehensive Health and Attitude Management Program Clinic of Maui: HI-002
4. Ku Aloha Ola Mau: HI-002

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2028

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Assistance Listing Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Opportunity No. CMS-RHT-26-001 (Year 1)	93.798	$	$	$ 200,000,000.00	$	$ 200,000,000.00
2. Opportunity No. CMS-RHT-26-001 (Year 2)	93.798			200,000,000.00		200,000,000.00
3. Opportunity No. CMS-RHT-26-001 (Year 3)	93.798			200,000,000.00		200,000,000.00
4. Opportunity No. CMS-RHT-26-001 (Year 4)	93.798			200,000,000.00		200,000,000.00
5. Totals		$	$	$ 800,000,000.00	$	$ 800,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) Opportunity No. CMS-RHT-26-001 (Year 1)	(2) Opportunity No. CMS-RHT-26-001 (Year 2)	(3) Opportunity No. CMS-RHT-26-001 (Year 3)	(4) Opportunity No. CMS-RHT-26-001 (Year 4)	(5)
a. Personnel	$ 2,466,000.00	$ 2,466,000.00	$ 2,466,000.00	$ 2,466,000.00	$ 9,864,000.00
b. Fringe Benefits	1,560,484.00	1,560,484.00	1,560,484.00	1,560,484.00	6,241,936.00
c. Travel	10,552.00	10,552.00	10,552.00	10,552.00	42,208.00
d. Equipment					
e. Supplies					
f. Contractual	195,541,760.00	195,541,760.00	195,541,760.00	195,541,760.00	782,167,040.00
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a-6h)	199,578,796.00	199,578,796.00	199,578,796.00	199,578,796.00	$ 798,315,184.00
j. Indirect Charges	421,204.00	421,204.00	421,204.00	421,204.00	$ 1,684,816.00
k. TOTALS (sum of 6i and 6j)	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 800,000,000.00
7. Program Income	$	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Opportunity No. CMS-RHT-26-001 (Year 1)	$	$	$	$
9. Opportunity No. CMS-RHT-26-001 (Year 2)				
10. Opportunity No. CMS-RHT-26-001 (Year 3)				
11. Opportunity No. CMS-RHT-26-001 (Year 4)				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Opportunity No. CMS-RHT-26-001 (Year 1)	$	$	$	$
17. Opportunity No. CMS-RHT-26-001 (Year 2)				
18. Opportunity No. CMS-RHT-26-001 (Year 3)				
19. Opportunity No. CMS-RHT-26-001 (Year 4)				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges: 10% rate, calculated on MTDC base of $4,212,036

23. Remarks:

OMB Number: 4040-0019
Expiration Date: 06/30/2028

Project Abstract Summary

This Project Abstract Summary form must be submitted or the application will be considered incomplete. Ensure the Project Abstract field succinctly describes the project in plain language that the public can understand and use without the full proposal. Use 4,000 characters or less. Do not include personally identifiable, sensitive or proprietary information. Refer to Agency instructions for any additional Project Abstract field requirements. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

Funding Opportunity Number

CMS-RHT-26-001

Assistance Listing Number(s):

93.798

Applicant Name

Executive Office of the State of Hawaii

Descriptive Title of Applicant's Project

The Hawai‘i Rural Health Transformation Plan will build a robust, sustainable rural health care system that will improve healthcare access, quality and outcomes through six interconnected initiatives.

Project Abstract

The State of Hawai‘i requests a five-year, $1 billion Rural Health Transformation Program (RHTP) cooperative agreement from the Centers for Medicare and Medicaid Services (CMS) to achieve the RHT statutory goals of making rural America healthy again, promoting sustainable access, workforce development, innovative care, and technology innovation.

Healthcare access challenges are significant in the state of Hawai‘i due to its unique geography; 95.1% of the land area is rural. Healthcare services are centered in Honolulu, the state’s single urban core. There are serious deficiencies in the digital and physical health care infrastructure, along with severe workforce shortages and financial constraints that negatively impact rural residents’ access to physical and behavioral care at all levels.

The goal of the State of Hawai‘i’s RHTP is to transform the rural health care delivery system in a sustainable manner that will improve healthcare access, quality, and outcomes. The plan focuses on addressing prioritized challenges affecting rural populations. These include health information technology infrastructure, the emergency medical services (EMS) system, access to behavioral health care, overreliance on hospitals and emergency care, workforce shortages, and the inability of rural providers and networks to adopt innovative care models.

The RHTP includes six interconnected initiatives: (1) Rural Health Information Network (RHIN): A statewide digital backbone connecting rural hospitals, clinics, and health centers through interoperable EHRs, wireless networks, and integrated data hubs; (2) Pili Ola Telehealth Network: A statewide telehealth network connecting rural communities to providers and integrating digital health access, virtual care, and telehealth training; (3) Rural Infrastructure for Care Access (RICA): A physical access initiative to expand emergency medical services, implement evidence-based community care practices (healthcare team expansion, community paramedicine, and mobile healthcare), and bolster the behavioral health infrastructure; (4) Hawai‘i Outreach for Medical Education in Rural Under-resourced Neighborhoods (HOME RUN): A pipeline initiative expanding education, recruitment, and retention of healthcare workers through certificate programs, residencies, scholarships, and mentoring; (5) Rural Respite Network (RRN): An expansion of the effective medical respite model to rural areas to reduce preventable hospital use among unhoused or post-acute patients with low medical acuity; and (6) Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund: A competitive fund enabling rural providers to adopt innovative care models and succeed under the CMS Achieving Healthcare Efficiency through Accountable Design (AHEAD) model by financing local value-based innovations.

CMS funds will support personnel (RHTP Oversight Team), consultants for specialized technical and programmatic assistance, and subawards for initiative leads. Subawardees include the State Health Planning and Development Agency, the University of Hawai‘i (UH) Telecommunication and Social Informatics Program, the State Department of Health, UH John A. Burns School of Medicine, and the State Department of Human Services.

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** CMS RHTP HI Project Narrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

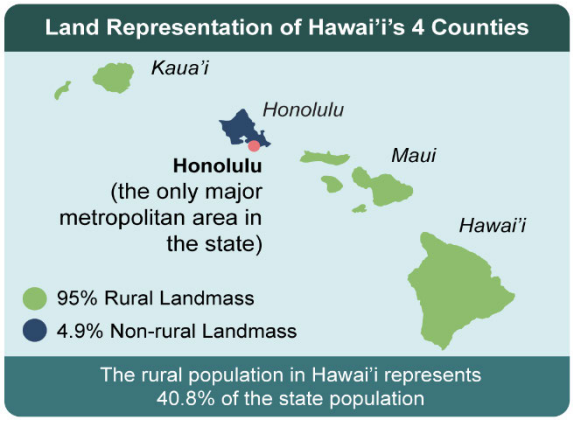
Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

State of Hawai‘i CMS Rural Health Transformation Plan Project Narrative

1. Rural Health Needs and Target Population

A. Rural Demographics

Hawai‘i, an isolated archipelago of Pacific Islands, is the most remote populated landmass on earth. Seven of the Hawaiian island are inhabited with a total population of 1.45 million. Hawai‘i is a five to six-hour flight from California and a five to six-hour time zone difference from the nation’s capital.[1] The only major metropolitan area in the state (Honolulu) is located on the island of O‘ahu. All other areas of O‘ahu and all other islands (known as the “neighbor islands”) are rural. The state’s rural areas are defined in Hawai‘i Revised Statutes §1B-1[2].



Hawai‘i is divided into four counties, including Honolulu, Maui, Kaua‘i, and Hawai‘i (for this application, Kalawao County—a county of less than 90 people and administered by the Hawai‘i Department of Health—is considered part of Maui County). The majority (95%) of Hawai‘i’s land area is considered rural, representing 5,999 square miles. The rurality of Hawai‘i is compounded by the vast ocean space between islands. The absolute size of the rural population is 593,603, representing 40.8% of the state’s population. The map in Appendix D demonstrates Hawai‘i’s unique geographic landscape.

B. Health Outcomes

Hawai‘i performs better than the national median on a variety of health indicators and overall health status[3], although the prevalence of most of these chronic conditions has been increasing over time (Table 1).

Table 1. Chronic Condition Prevalence & Trend Data, Hawai‘i (HI) and U.S.[4]				
Health Outcome Indicator	**HI, 2021**	**HI, 2022**	**HI, 2023**	**U.S., 2023**
Asthma	8.1%	9.1%	9.8%	10.3%
COPD	3.5%	3.5%	4.3%	6.4%
Cardiovascular Disease	4.5%	5.5%	5.5%	6.3%
Diabetes	9.5%	11.7%	11.3%	11.5%
Kidney Disease	2.8%	3.4%	3.8%	3.7%
Health Status, Good or Better Health	87.8%	86%	83.5%	81.8%
High Blood Pressure	29.8%	--	32.4%	34%
High Cholesterol	34.9%	--	37.5%	36.9%

While there is limited data comparing health outcome indicators in all rural areas versus the urban core, given Hawai‘i’s unique geographic landscape and lack of an integrated health information network, rural residents in Hawai‘i report poorer health and more days of physical and mental health limitation than their urban counterparts.[5]

C. Health Care Access

Residents of Hawai‘i face a variety of challenges related to health care access due to the non-contiguous nature and geographic isolation of the state. Serious deficiencies in the digital and physical health care infrastructure, along with severe workforce shortages and financial constraints, negatively affect access to care for rural residents and impede innovation.

A disproportionate share of the state’s health care system (including specialists and the only Level 1 Trauma Center) is located in the state’s urban core. Residents of the neighbor islands often have to travel to O‘ahu (Honolulu) for routine and emergency care, which can be accomplished only by commercial flight or, in the case of an emergency, via air ambulance. Inter-island commercial flights are costly (approximately $120-$300) and can be unreliable.[6] Emergency air transport options are limited and can lead to delays in care since there is only one provider of air ambulances for inter-facility transports.

Even travel within islands is difficult. Hawai‘i is one of the worst states for road connections, ranking last in total length of public roads out of all states, despite being larger in land mass than other high-ranking states.[7] Many existing roads are winding mountain roads that are treacherous and time-consuming to traverse. A 2025 report from the University of Hawai‘i Rural Health Research and Policy Center reinforced that “transportation/travel access is one of the most important barriers to adequate health care, particularly in rural areas.”[8]

These barriers, as described in greater detail below, result in high rates of avoidable emergency room visits, preventable hospitalizations, and unmanaged chronic conditions. At the same time, rural providers often lack the infrastructure, data systems, workforce training, and team-based capacity required to succeed under value-based payment models. Additionally, behavioral health integration in primary care is limited, leaving significant gaps in access to behavioral health services.

Access and care coordination barriers related to an inadequate health information technology (HIT) infrastructure: Limited broadband and wireless connectivity in Hawai‘i have impeded the adoption of modern HIT tools such as interoperable electronic health record (EHR) systems and telehealth capabilities. The fragmented data, referral, and consultation systems across and within islands impede care coordination and follow-up care, resulting in gaps in treatment and exacerbating chronic conditions. Many rural providers, including some critical access hospitals, FQHCs, Native Hawaiian Health Centers, and behavioral health and substance abuse facilities, either lack a HITECH-certified EHR or operate on outdated, non-interoperable systems. This results in serious barriers to care coordination, delays in information sharing as patients move across the care continuum, and a significant administrative burden for providers.

Ninety (90) percent of Hawai‘i’s hospitals are either on or transitioning to a single

HITECH-certified EHR vendor. For providers using EHRs, some of which are HITECH certified but not on the dominant hospital platform in the state, or using more rudimentary data systems, interoperability remains a material challenge and impediment to optimal care. Their systems cannot seamlessly integrate with medical facilities on the dominant platform. The highest level of data compatibility, information sharing, and care coordination for patients in rural communities will be achieved by expanding the dominant EHR platform to the extent possible and then using a second level of integration for the providers not on the dominant platform.

Most rural clinics have historically lacked robust broadband and/or reliable internal wireless networks. Broadband and fiber are currently being deployed to rural and frontier communities, which will provide the bandwidth required for telehealth and data exchange. Hawai‘i was awarded over $390 million in federal funding for a statewide broadband initiative for middle-mile and last-mile infrastructure development. The largest of these efforts, the Broadband Equity, Access, and Deployment (BEAD) program, includes nearly $150 million to provide access to unserved and underserved locations in Hawai‘i where high-speed internet is not available. Hawai‘i anticipates receiving approval by the end of 2025 for the final phase of BEAD execution for last-mile buildouts in roughly 8,000 locations. Additional investment, however, is needed to enable rural health facilities to tap into these broadband lines through on-site connections and secure in-building wireless networks.

In addition, Hawai‘i lacks a statewide telehealth network, leaving rural communities without a digital connection to specialists and sub-specialist providers. This is a significant impediment for patients unable to travel due to frailty, financial burden, pregnancy, immobility, and other health conditions. The lack of a statewide telehealth network also limits the use of consumer-facing telehealth tools such as blood pressure monitors, scales, and pulse oximeters for

evidence-based chronic disease prevention and management.

Fragmented and under-resourced emergency medical services (EMS) system: Hawai‘i has a uniquely challenging topography and lacks a unified, real-time communications and coordination system. Existing care pathways are fragmented; EMS, hospitals, and air medical providers operate independently, limiting visibility across counties and reducing the efficiency of triage and transport decisions. Hawai‘i relies almost entirely on air medical transport for inter-island patient transfers. While this capability is essential for connecting rural and neighbor-island communities to advanced medical services, it also underscores persistent disparities in timely access to specialty care.

Critical Access Hospitals (CAHs) and rural community facilities often serve as the first point of emergency care but are dependent on air transport for patients requiring higher-level acute care services. Air transports across Hawai‘i average 274 minutes (4.6 hours) from dispatch to arrival at a hospital. Of the patients transported by air, 73% take more than three hours, 47% exceed four hours, and 20% wait more than six hours to reach definitive care. This level of delay significantly impacts outcomes for time-sensitive conditions such as trauma, stroke, sepsis, and cardiac emergencies. Prolonged transfer times also contribute to higher rural healthcare system costs, preventable disability, and reduced capacity for rural hospitals to manage concurrent emergencies or disasters. The burden of transferring patients falls on an informal system of individual providers and facilities, resulting in communication bottlenecks and operational inefficiencies.

There is no unified, real-time statewide transfer and coordination system to efficiently manage emergency and trauma response. The State EMS system currently operates on a unified Electronic Health Record (EHR) platform, and the State’s broadband initiative will soon enable

connectivity to rural and frontier communities. Hawai‘i is poised to implement a statewide, real-time coordination hub to connect all EMS, hospital, and telehealth systems. The State’s EMS system, including the rural care teams it will coordinate, will be compatible with the Hawai‘i Rural Health Transformation Plan’s broader aims for data integration and EHR interoperability.

Another challenge related to the EMS system is inappropriate use of emergency services for non-emergent and preventable conditions. Limited local care options, geographic isolation, and fragmented physical and behavioral health infrastructure force many rural residents to depend on emergency services and transport for both urgent and routine needs. Hawai‘i’s EMS system responds to approximately 20,000 911 calls annually from high-frequency patients, contributing to operational inefficiencies and elevated costs. Over the past 12 months (10/1/2024-9/30/2025), 20.8% of EMS calls were among repeat users. While this rate is comparable to the national average, it reflects a 30–40% higher call load per EMS unit than the continental U.S. average because of the state’s limited EMS fleet size and geographic isolation. This overreliance strains EMS capacity, drives up the total cost of care, and leaves rural residents without reliable access to timely, coordinated, and preventive health services.

Barriers to behavioral health care: Hawai‘i’s rural communities also face significant obstacles to accessing behavioral health care, including crisis care. Geographic isolation, small populations, and limited provider availability contribute to long response times and reliance on emergency departments and law enforcement for crisis stabilization. The age-adjusted rate for reporting poor mental health for at least 14 of the past 30 days was approximately 20% higher in rural counties compared to Honolulu County.[9] The suicide death rates in Hawai‘i’s more rural counties are 50-75% higher than in Honolulu County.[10] Similarly, emergency room visit rates for substance use are higher in rural counties.[11]

The State Department of Health, CARE Hawai‘i Inc., and Aloha United Way 211 collaboratively operate a Crisis Mobile Outreach (CMO) program (“Hawai‘i 288”), providing phone-based triage and connection to local crisis therapists. However, the response time is impeded by workforce shortages. In 2024, the average CMO response time was 51.5 minutes.[12] Workforce shortages at all levels—particularly in psychiatry, substance use counseling, and peer support—are compounded by long hiring delays and inconsistent service coverage.[13]

Youth and older adults are especially underserved; one-third of high school students report depressive symptoms, and older adults with complex comorbidities exceed current clinic expertise.[14] Over half (57.1%) of youth (ages 12-17) with a major depressive episode did not receive any treatment or counseling for depression in the past year, for which Hawai‘i ranks 41st in the nation.[15] Hawai‘i ranks 37th for identifying students with emotional disturbance for individualized education programs, suggesting that many youth with mental health needs may not be receiving the specialized supports required.[16] Rural areas also lack access to psychosocial rehabilitation supports. These factors underscore the urgent need for mobile units, CCBHC expansion, and telehealth-enabled crisis response.

Overreliance on hospitals and emergency care: In addition to limited access to primary and behavioral health care, rural communities in Hawai‘i face significant barriers to meeting health-related social needs that directly impact health outcomes. Patients often struggle to access food, stable housing, transportation, and other services due to provider shortages, geographic isolation, the high cost of inter-island travel, and limited resources for social support services. Social service agencies and healthcare providers in rural areas frequently operate in silos, with limited infrastructure to coordinate care or track whether the referrals result in patients receiving needed services. As a result, rural residents experience higher rates of preventable

hospitalizations, avoidable emergency department visits, and unmanaged chronic conditions. The Maui wildfire disaster in August 2023 further strained the social service and health care systems in both rural and urban areas on the island of Maui. Without an organized hub with a closed-loop referral system, providers cannot consistently link patients to critical services and monitor whether social needs have been met.

One of many daily challenges faced by rural hospitals is dealing with "discharge dilemmas," patients who no longer need acute care but cannot be safely released to their original communities. These patients occupy beds that could serve others, straining the limited capacity and raising costs. Without safe discharge options, hospitals face higher uncompensated care, especially from uninsured or underinsured patients who frequently return to emergency departments. A critical factor of this challenge is severely limited post-acute care options. Skilled nursing facilities and long-term care beds are scarce.

Patients discharged into homelessness, a significant and growing population, are particularly vulnerable and often rotate through emergency departments with preventable visits. Hawai'i's homeless crisis has exacerbated over the past several years in both urban and rural areas. According to the 2024 Point in Time (PIT) Count[17], 4,494 people across Honolulu County were experiencing homelessness, 62% of whom were experiencing unsheltered homelessness. Across all three rural counties, 1,895 people were experiencing homelessness, 67% of whom were experiencing unsheltered homelessness.

Hawai'i's rural communities have a higher proportion of unsheltered homeless individuals, a subpopulation that tends to have higher use of costly emergency medical services. Between 2022 and 2024, unsheltered homelessness increased by 17% in Honolulu County. This was heightened in the county's three rural areas; the unsheltered population in one of those rural

areas alone increased by 85% in the same time frame. Notably, in the rural counties of Hawai‘i, Maui, and Kaua‘i, more than half of unsheltered individuals reported having a physical disability or disabling chronic health condition.

For people experiencing homelessness or unstable housing, hospital discharge often means returning to the street where wounds re-open, medications go untaken, and chronic conditions spiral. A minor infection or missed medication can quickly escalate into hospitalization. Many patients experiencing homelessness also struggle with behavioral health conditions or substance use disorders. Without appropriate discharge options, people experiencing homelessness often fall back into crisis, returning to the ER or jail. These higher users drive up uncompensated care costs for hospitals, particularly in rural communities where financial margins are already thin.

Fragmented coverage for dual eligibles: Residents who are dually eligible for Medicare and Medicaid often experience fragmented coverage as they navigate two sets of benefits and grievance systems with little coordinated support. Evidence shows that enrollment in integrated care models via a type of Medicare Advantage plan—Dual Eligible Special Needs Plans (D-SNP)—can reduce costs and improve outcomes. Currently, Hawai‘i’s Medicaid program (Med-QUEST) has two types of special needs plans: Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNP) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP). Med-QUEST has invested significant resources over the past several years to improve alignment and integration, yet only about half of the 50,000 duals are in D-SNPs. Evaluation data on the impacts of these investments locally are not readily available.

By January 2027, all Medicaid managed care plans will be required to have exclusively aligned enrollment in FIDE-SNP. Although this will provide the most integrated and streamlined

care, the transition process may be difficult for dually eligible members to understand and navigate. Ensuring continued enrollment in integrated plans among rural residents requires state-led action to expand enrollment support, improve data integration, and provide sustainable, coordinated care for duals across the state.

Workforce shortages: All of the above-noted barriers are exacerbated by severe workforce shortages. There is a shortage of at least 5,000 healthcare workers in the state, including over 500 physicians, according to the 2025 Hawai‘i Medical Education Council Annual Report to the Legislature.[18] Hawai‘i fares worse than the national median for the ratio of mental health providers and non-physician primary care providers per population, and just slightly higher than the national median for primary care physicians (Table 2). For example, there is only one primary care provider other than a physician per 1,040 people registered in Hawai‘i; the comparative ratio for the national median is 1:680. This includes nurse practitioners (NPs) and physician assistants (PAs) who provide important routine and preventive care.

Table 2. Ratio of Population to Health Care Professionals, Hawai‘i and U.S.[19]

Health Care Professionals	Hawai‘i	United States
Primary Care Physicians	1:1,150	1:1,310
Other Primary Care Providers	1:1,040	1:680
Mental Health Providers	1:310	1:290

Physician shortages, in particular, are more severe on neighbor islands than on O‘ahu (Honolulu County) and for the state as a whole. The physician shortages in Hawai‘i and Maui counties are more than twice the rate in Honolulu County (Table 3).

Table 3. Physician Shortage by Rural County[20]

	Hawai‘i	Honolulu	Kaua‘i	Maui
Shortage	201	328	43	174
Percent of Workforce Need Unmet	40%	13%	24%	41%

Workforce shortages not only impact timely access to care but also strain the existing

workforce. Existing providers must work long hours, cover wide service areas, and take on roles outside their specialty. This accelerates burnout, worsening the shortage.

Inability of rural providers and networks to adopt innovative care models: Rural provider networks are underpowered compared to their urban counterparts, yet they typically face higher costs, workforce shortages, and limited provider choice. On a per capita basis, costs are higher and margins are thinner. In addition, primary care practices lack the capacity to participate in multi-payer, value-based payment models that rely on integrated behavioral health, maternal health, chronic disease management, robust reporting and tracking of population health, and accountability for the total cost of care. Rural hospitals need intensive transitional support to adopt value-based delivery and payment models without destabilizing services.

Hawai‘i is one of six states participating in the CMS “Achieving Healthcare Efficiency through Accountable Design (AHEAD)” model, a voluntary all-payer model focused on controlling health care expenditures and improving population health outcomes. However, rural providers face challenges in adopting alternative payment models such as AHEAD, given their limited resources and capacity.

For rural providers to adopt innovative care models, they require various infrastructure supports such as quality reporting, advanced analytics, practice transformation coaching, as well as digital and contractual connections with provider organizations (POs) for coordinated and integrated care management, streamlined administrative and back-office supports, analytic capabilities, real-time reporting on total cost of care and population health trends at the practice level. POs also need infrastructure support to bridge to accountable care organizations and/or directly to payers. Investments are lacking in many rural-based POs for sophisticated analytic capabilities, real-time reporting, coordinated care management for affiliated practices, and real-

time reporting health information exchanges that help ensure timely access to care in the most appropriate setting.

D. Rural Facility Financial Health

Rural health facilities are financially burdened by a poor payer mix, low patient volumes, and relatively high levels of uncompensated care. The instability of small rural hospitals further threatens the healthcare safety net.

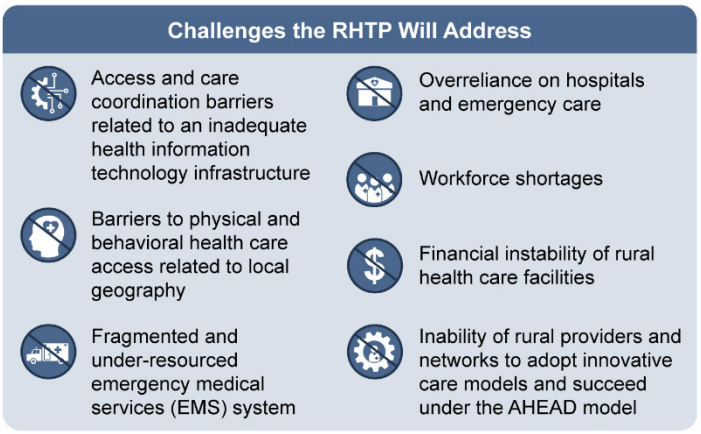
Rural facilities typically have a higher proportion of Medicare, Medicaid, and uninsured patients than non-rural areas due to socioeconomic demographics. For example, there are higher levels of poverty and lower rates of postsecondary education in rural areas of the state compared to urban areas.[21] Rural hospitals in Hawai‘i have a higher proportion of Medicare, Medicaid, self-pay, and charitable care than urban hospitals (73% vs. 68%, respectively, using 2024 inpatient discharge data).

In addition to a lack of specialty services, patient volumes in rural facilities are also impacted by infrastructure challenges. Decades of underinvestment in the infrastructure of rural health facilities have exacerbated outmigration to the urban core for health care. The majority of critical access and rural hospitals in Hawai‘i are part of a public/private system, the Hawai‘i Health Systems Corporation. Because of the higher proportion of Medicare and Medicaid patients in rural areas, along with a higher proportion of uninsured residents, these hospitals require a material annual subsidy from the State General Fund approved by the Legislature and Governor. These subsidies are intended to sustain operations but leave insufficient funds for expanding services and innovating care. Already operating on thin margins, rural hospitals lose revenue when patients bypass local facilities for the urban core in O‘ahu.

While Hawai‘i has one of the lowest rates of the uninsured in the nation because of the 1974 Pre-Paid Health Care Act (which mandates employer-provided medical coverage), there is limited commercial competition for health insurance in the state, leaving employers to shoulder the overwhelming majority of the cost of healthcare. Limited commercial competition also means that payments from commercial insurers to providers are materially lower than in many states. These low rates, along with the higher proportion of Medicare, Medicaid, and uninsured patients in rural areas, further constrict healthcare margins for rural facilities.

E. Target Population and Summary of the Challenges the RHTP Seeks to Address

Given the extent of rurality in the state and the unique challenges to Hawai‘i’s rural health care system, the target population for the proposed Rural Health Transformation Plan (RHTP) is rural communities across all four counties in the state, including the nearly 593,603 residents of rural areas.



2. Rural Health Transformation Plan: Goals and Strategies

A. Statutory Requirements

The goal of the State of Hawai‘i’s RHTP is to transform the rural health care delivery system in a sustainable manner that will improve healthcare access, quality, and outcomes. The RHTP Planning Team (see Section 4) has strategically designed six interconnected initiatives to address the challenges identified in Section 1. These are summarized in Table 4.

Table 4. Summary of Proposed RHTP Initiatives	
Initiative Name	**Description**
Rural Health Information Network (RHIN)	A statewide digital backbone connecting rural hospitals, clinics, and health centers to the rest of the state through interoperable EHRs, wireless networks, and integrated data hubs, enabling care coordination and practice transformation.
Pili Ola Telehealth Network	A statewide telehealth network connecting rural communities to providers, integrating digital health access, virtual care, and telehealth training.
Rural Infrastructure for Care Access (RICA)	A physical access initiative to expand emergency medical services, implement evidence-based community care practices (healthcare team expansion, community paramedicine, and mobile healthcare), and bolster the behavioral health infrastructure in rural communities.
Hawai‘i Outreach for Medical Education in Rural Under-resourced Neighborhoods (HOME RUN)	A pipeline-to-practice initiative expanding education, recruitment, and retention of healthcare workers across rural Hawai‘i through certificate programs, tailored education programs, residencies, scholarships, incentives, support for rural practice, and mentoring.
Rural Respite Network (RRN)	An expansion of the effective medical respite model to rural areas to reduce preventable hospital use among unhoused or post-acute patients with low medical acuity.
Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund	A competitive fund enabling rural providers to adopt innovative care models and succeed under the AHEAD model by financing local value-based innovations.

These initiatives are aligned with all CMS RHT statutory elements (Table 5).

Table 5. Alignment of CMS RHTP Statutory Elements with Proposed Initiatives	
Statutory Elements	**Initiative Alignment**
Improving access	• RHIN – Connect primary, secondary, and tertiary medical providers to one another and to social service providers through tech innovation. • Pili Ola – Expand statewide telehealth access points and teleconsult programs so rural residents can access primary, specialty, behavioral, pediatric, and maternal health services without travel. • RICA - Upgrade EMS infrastructure via MEDICOM Center and fleet modernization to maintain 24/7 emergency coverage and reduce transfer times across islands. • RICA - Deploy mobile clinics, care teams, and community paramedics to deliver preventive, chronic, and behavioral health care directly in rural communities. • HOME RUN - Fill vacancies in rural health facilities through rural workforce investments. • RRN - Free up high-cost health services through providing low-cost settings of care for high-frequency visitors. • RRN - Expand access to transitional, post-acute care for vulnerable populations. • RVBI Fund - Fund innovative approaches to care delivery in rural areas.
Improving outcomes	• RHIN - Employ RHIN data systems to enable and expand care coordination. • Pili Ola - Use digital health to support chronic disease, maternal health, and behavioral health.

	• Pili Ola - Increase access to timely care and follow-up, promote early intervention, and reduce hospital/ER readmissions. • RICA - Target improved control of chronic diseases (diabetes, hypertension, heart disease) through team-based care integrating clinical pharmacists and community health workers. • RICA - Deliver preventive outreach (screenings, vaccinations, education) through CHWs and public health nurses to lower disease risk factors. • RICA - Integrate behavioral health services into primary care settings and expand mobile mental-health outreach. • RRN - Provide stabilizing, step-down care for high-cost patients returning to difficult living conditions post-care. • RRN, RICA - Reduce readmissions, repeat EMS calls, and avoidable ED visits. • RVBI Fund - Provide value-based incentives to measure and reward improvements in control of chronic conditions and preventable hospitalizations.
Technology use	• RHIN - Provide centralized support for rural providers to connect to an integrative health information network (primary, secondary, and tertiary care). • Pili Ola - Deploy telehealth, remote patient monitoring, and consumer-facing technology to improve prevention and chronic disease management. • Pili Ola - Research into AI-powered diagnostic and management tools. • Pili Ola - Embed telehealth navigators and IT facilitators to train local users and gather feedback. • Pili Ola - Integrate successful technologies into health plan contracts and value-based payment models for long-term sustainability. *The RHTP Oversight Team will evaluate the suitability of new technologies on an ongoing basis in collaboration with the State's Office of Enterprise Technology Services and the University of Hawai'i Health Analytics Program.*
Partnerships	• RHIN - Unite hospitals, FQHCs, rural health clinics, EMS, and behavioral providers into a statewide data-exchange and care-coordination consortium. • Pili Ola - Build partnerships with schools, libraries, and community organizations to host telehealth access points. Thoroughly integrate the state's telehealth resources into a single hub. • RICA - Integrate EMS, hospitals, and behavioral health into a statewide emergency coordination and community-based care network. • HOME RUN - Establish education-to-practice consortia between UH, DOH, and rural facilities to strengthen workforce pipelines. • RVBI Fund - Create regional collaboratives and alliances to innovate with shared-savings and value-based models. *The RHTP Oversight Team will establish a formal governance structure and coordinate an advisory body, ensuring alignment, accountability, and community representation across all initiatives.*
Workforce	• Pili Ola - Provide telehealth mentoring, continuing education, and peer-support networks to retain rural providers and mitigate burnout. • RICA - Integrate CHWs and pharmacists into rural care teams to extend preventive and chronic disease management capacity. • HOME RUN - Build a rural workforce pipeline through high-school certificate programs, training expansions, and rural residency programs.

	• HOME RUN - Offer scholarships and service-commitment incentives for rural providers across all islands.
Data-driven solutions	• RHIN - Connect all rural providers to interoperable EHRs and the statewide health information exchange for real-time care coordination. • RHIN - Enable local providers to manage more complex care in place through shared data and remote consults, reducing unnecessary transfers. • RHIN, RICA - Use data analytics to guide deployment of mobile clinics, preventive programs, and resource allocation for maximum community impact. • Pili Ola - Use the Telehealth Analytics Coordinating Center to create dashboards tracking telehealth access, quality, and cost metrics across counties. • RICA - Employ rapid-cycle data reviews and community dashboards to identify gaps and target interventions (e.g., frequent EMS users, chronic disease hotspots).
Financial solvency strategies	• Pili Ola, RICA - Reduce "patient leakage" by expanding local telehealth, behavioral, and preventive services so residents stay within rural systems. • RICA, RRN - Diversify revenue through new outpatient services, partnerships, and improved Medicaid reimbursement policies. • RVBI Fund - Transition rural providers to value-based payment models under the AHEAD framework to ensure predictable revenue.
Cause identification	• Identified causes: Low patient volume, poor payer mix, limited-service scope, and competition from urban systems. • RHIN - Combat bypass and leakage by enabling local hospitals to provide high-quality, comprehensive care linked to statewide systems. • RHIN, RHTP Oversight Team - Develop early identification of at-risk rural facilities and proactive intervention before service reductions or closures occur. • Pili Ola, RICA - Improve service scope and quality through telehealth connectivity, new behavioral and maternal programs, and specialist support to rebuild community trust. • RVBI Fund - Address low volume via alternative payment models that decouple revenue from admissions. *The RHTP Oversight Team will replace competition with coordination through regional networks and affiliations—shared governance, service planning, and resource pooling—to sustain all key rural facilities.*

B. Key Performance Objectives

The six RHTP initiatives are complementary, interconnected, and strategically designed to transform the rural health care environment in Hawai‘i into a more effective, sustainable ecosystem. The RHIN initiative will develop the state's healthcare backbone, the Pili Ola Telehealth initiative will enable virtual access to care, the RICA initiative will ensure physical access to medical and behavioral care, and HOME RUN will supply the necessary workforce to

staff the system. The RRN initiative is a unique approach to caring for cost-intensive patients, and the RVBI & AHEAD Readiness Fund will provide flexible capital for grassroots innovation.

By the end of the five-year cooperative agreement, 90% of rural provider sites will be using fully interoperable EHRs, and there will be a 20% increase in the number of rural patients using telehealth visits. There will also be a 25% decrease in the amount of time from dispatch to hospital arrival for emergency and trauma transfers resulting from the MEDICOM system, 1,000 new healthcare workers will be working in rural communities, and there will be a 15% reduction in 30-day hospital readmissions among rural medical respite users. There will also be at least three new organized rural provider collaborative value-based networks. High-level outcome indicators are described for each initiative in Section 3 (Proposed Initiatives and Use of Funds) and Section 6 (Metrics and Evaluation Plan).

C. Strategic Goals Alignment

The proposed initiatives are aligned with all five CMS RHTP strategic goals (Table 6).

Table 6. Summary of Initiatives Alignment with CMS Strategic Goals

Strategic Goal	Initiatives
Make Rural America Healthy Again	• RICA - expands community-based preventive health for disease prevention, chronic disease management, behavioral health, and prenatal care. • Pili Ola - expands access to care for behavioral, prenatal, and chronic conditions via telehealth.
Sustainable Access	• RICA - strengthens critical physical access infrastructure. • Pili Ola – reduces travel barriers, lowers system strain, and increases rural patient access to primary and specialty care. • HOME RUN - ensures future staffing for rural access points. • RRN - reduces strain on hospitals and improves care transitions.
Workforce Development	• HOME RUN - recruitment, training, scholarships, incentives, and rural service tracks. • Pili Ola - Provide telehealth-specific mentoring, continuing education, and peer support.
Innovative Care	• RVBI & AHEAD Readiness Fund – funds the creation and expansion of advanced payment models and ACO development alongside AHEAD. • RHIN – provides backend support for advanced payment models, value-based networks, and care coordination.

Technology Innovation	• RHIN - advances interoperability, real-time data exchange, and closed-loop referrals across rural providers and rural organizations. • Pili Ola - uses emerging and consumer-facing technology along with digital connectivity platforms to provide remote care to rural communities.

D. Legislative or Regulatory Action

Hawai‘i recognizes the importance of state policy commitments to improve the access, quality, and cost of health care, including legislative and regulatory action related to sustainable access, workforce development, innovative care models, and technology innovation. Table 7 summarizes relevant policies and commitments; further details are provided in Appendix F.

Table 7. Current and Proposed State Legislative and Regulatory Actions

Topics	Current Policies	Intended Actions	Initiative Alignment
B.2. Health and lifestyle	Hawai‘i does not currently require public schools to establish the Presidential Fitness Test.	The State of Hawai‘i RHTP Oversight Team, in collaboration with the State Department of Education, will propose a bill requiring public schools to establish the Presidential Fitness Test for the 2026 State legislative session.	Embeds preventive health and physical activity directly into school curricula, aligning with RICA's emphasis on community-based lifestyle-based disease prevention.
B.3. SNAP waivers	The Hawai‘i Department of Human Services submitted a waiver on October 1, 2025, to restrict carbonated sugary and artificially sweetened beverages (sodas and energy drinks).	The State of Hawai‘i will pursue USDA's approval of the State's waiver prohibiting the purchase of carbonated sugary and artificially sweetened beverages (sodas and energy drinks).	Reduces preventable chronic diseases (diabetes, obesity) that burden rural health systems, advancing value-based (RVBI) and prevention-focused goals (RICA).
B.4. Nutrition continuing medical education	Hawai‘i does not currently have a requirement for nutrition to be included in CME for physicians, and there is no relevant State bill pending.	The State will propose a bill for the legislature related to the inclusion of nutrition in CME before the 2026 legislative session.	Promotes provider education on nutrition and preventive medicine—aligned with HOME RUN expansion of rural education programs—thereby improving chronic-disease counseling and lifestyle interventions in rural practice, aligning with RICA's community-based preventive care.

C.3. Certificate of Need	Hawai‘i has moderate CONs across facility categories, with a total score of 65 per the Cicero ranking system.	No additional action is planned or required.	N/A
D.2. Licensure compacts	Physician: A bill regarding the Interstate Medical Licensure Compact (IMLC) was passed by the State Legislature in 2023, Act 116, and became law on 6/22/2023, with an effective date of 1/1/2025. Act 163, SLH 2025 passed legislation to enable full compliance with the IMLC, with an effective date of 7/1/2025. Nursing: Hawai‘i is not currently a member of the Nursing Licensure Compact (NLC). Psychology: Hawai‘i is not currently a member of the PSYPACT. Physician Assistant (PA): Hawai‘i is not currently a member of the PA Compact.	As the State of Hawai‘i is in full compliance with the IMLC, no further action is required for physician licensure compacts. Hawai‘i will continue to introduce legislation to become an NLC state and a PSYPACT state. Articles of legislation to join the NLC and PSYPACT were introduced in 2025 (HB897 2025 and SB1552 2025, respectively); these will be reintroduced in 2026 until they are passed. EMS licensure compacts are not applicable in Hawai‘i. The RHTP Oversight Team will work with legislators to introduce a bill to become a PA compact member in the 2026 legislative session.	Expands interstate practice for health providers, directly addressing rural workforce shortages with HOME RUN, expanding the initiative’s potential reach.
D.3. Scope of practice	PA: Reduced scope.[22] Nurse practitioner (NP): Full scope.[23] Pharmacist: Score of 4.[24] Dental hygienist: 4 types of tasks.[25]	No action is proposed on this topic, given the extent of the State’s current scope-of-practice regulations.	N/A
E.3. Short-term, limited-duration insurance (STLDI)	State law regarding short-term health insurance prevents insurers from offering plans. Residents can explore other options, including ACA plans, Medicaid, or COBRA for coverage.	No action is needed. Hawai‘i’s Prepaid Health Care Act (PHCA) guarantees all workers and their families access to health care. Originally enacted in 1974, the Hawai‘i PHCA remains an efficient, popular, and unique asset that covers approximately 60% of the population, provided largely by two commercial payers and without tax subsidy.	N/A

F.1. Remote care services	The State Medicaid plan currently covers live video, Store and Forward, and Remote Patient Monitoring in full (HRS 346-59.1). State law allows for licensing exemptions on a limited basis. All healthcare providers in Hawai‘i are able to provide telehealth services with their existing medical licenses (HRS 432:1-601.5).	No policy changes or additions are proposed.	N/A

E. Other Required Information

State policies: State policy actions related to technical score factors are summarized in Table 4, above, and detailed in Appendix F. **Proportion of rural health facilities in the state (Factor A.2):** As detailed in Appendix F, over half (56%) of all health care facilities in Hawai‘i are located in rural areas. There are two Certified Community Behavioral Health Clinic (CCBHC) entities in Hawai‘i, of which one is located in an HRSA-designated rural area (Appendix F). **Percent of hospitals that receive Medicaid DSH payments (Factor A.7):** The majority (87.5%) of hospitals in Hawai‘i receive Medicaid DSH payments according to the most recent data available (FY 2024). This percentage represents 21 of 24 facilities.

3. Proposed Initiatives and Use of Funds

The proposed initiatives will collectively transform the rural health care delivery system in Hawai‘i and improve healthcare access, quality, and outcomes. These initiatives are described in greater detail below. Appendix A demonstrates the alignment of each initiative with RHTP strategic goals, use of funds, technical score factors, key stakeholders, outcomes, impacted counties, and estimated required funding.

The Rural Health Information Network (RHIN) and Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund are aligned with and supportive of the broader statewide

transformation of care taking place through the AHEAD model, empowering rural communities to lead this transformation. The Pili Ola Telehealth Network, Rural Infrastructure for Care Access, and Rural Respite Network initiatives are focused on access and cost of care and will be sustainable post-RHTP by the AHEAD model's incentive structure reformation. The workforce (HOME RUN) initiative will build the capacity of the workforce to implement and sustain these efforts.

❖ **Rural Health Information Network (RHIN)**

Strategic Goal	Use of Funds	Technical Score Factors	Impacted Counties	Est. Funding
Technology innovation	• Training and technical assistance • Innovative care • IT advances • Fostering collaboration	B.1, B.2, C.1, C.2, E.1, E.2, F.2	Entire state (FIPS Code 15)	$45M per year

Description: The Rural Health Information Network (RHIN) will modernize Hawai‘i’s rural health system by combining critical technology upgrades with a suite of tech-enabled hubs that transform care delivery, data exchange, and community coordination. Through competitive contracts, the initiative will connect rural hospitals, clinics, and Native Hawaiian Health Centers to a statewide network by supporting EHR onboarding and in-facility wired and wireless systems, complementary to federal BEAD investments.

Building on this foundation, RHIN will establish hubs that expand capacity and improve outcomes: a Care Quality Information Exchange (CQIE) to aggregate clinical data, provide longitudinal records, and deliver real-time alerts; a Community Care Coordination Hub (C-Hub) to link patients to housing, food, and transportation through a closed-loop referral system anchored in Medicaid and scalable statewide; an Analytics and Technical Assistance Hub to integrate claims and clinical data into dashboards and provide value-based care coaching that

supports workflow redesign, behavioral health integration, and telehealth adoption; and a Duals Data Dashboard and Support Hub (DDDASH) to align Medicare–Medicaid data, assist providers with duals management, and improve enrollment in integrated plans. Together, these coordinated investments will ensure that Hawai‘i’s rural providers and communities are connected, data-driven, and prepared to thrive under value-based care models.

Tech Upgrades: The State will contract with a non-profit contractor for EHR onboarding and integration services to ensure that as many rural and neighbor island providers as possible can exchange data in real time. Use of a standard interoperable platform with centralized support will reduce implementation timeframes, simplify installation, and reduce installation and maintenance costs. This will allow rural hospitals, FQHCs, Native Hawaiian Health Centers, behavioral health and substance abuse centers, and private practices to update their existing health record system (electronic or otherwise) to a system or program that will enable integration into a statewide network.

Contract for the installation of on-site wired and wireless networks for rural clinics and healthcare providers, completing their connection to state broadband networks. The proposed contracts for installing wireless networks in rural clinics and healthcare providers’ sites directly complement Hawai‘i’s federal BEAD grant, which funds expansion of broadband infrastructure in underserved areas. While BEAD focuses on extending high-speed fiber and technology-neutral connectivity to communities, RHIN’s investment ensures that rural health facilities are able to tap into those new "last mile" broadband lines through on-site connections and secure in-building wireless networks. In effect, BEAD brings high-speed broadband to rural communities, and RHIN extends that connectivity inside hospitals, FQHCs, and clinics so providers can fully utilize electronic health records, telehealth, real-time data exchange, and AI technological

innovations. By aligning BEAD's infrastructure build-out with RHIN's health-specific wireless deployments, Hawai‘i ensures that federal broadband investments translate into measurable improvements in healthcare access and outcomes.

Tech Hubs: Hawai‘i proposes the Care Quality Information Exchange (CQIE) to enable clinical data aggregation, longitudinal records, and real-time notifications for providers about their patients. The CQIE will provide Hawai‘i with a modernized, statewide platform for clinical data aggregation, longitudinal records, and real-time event notifications, serving as the backbone for rural health transformation. The state will competitively procure a contractor to build and support the operations of this exchange, ensuring full interoperability across EHR systems and integration with claims and social service data. By contracting for a robust CQIE, the state will establish a single, sustainable infrastructure that connects rural hospitals, FQHCs, Native Hawaiian Health Centers, behavioral health providers, and private practices to the same network used by major hospital systems. This exchange will enable more timely care coordination, reduce duplication, and improve patient safety, while also supplying the foundation for the Analytics and Technical Assistance Hub (see below). The CQIE will begin by addressing the most urgent rural connectivity gaps but will be designed for scalability, ensuring that all providers and payers in Hawai‘i can participate in a single, statewide data exchange system over time.

Community Care Coordination Hub (C-Hub) - The Community Care Coordination Hub (C-Hub) will serve as Hawai‘i's first statewide closed-loop referral system, beginning with Medicaid as the anchor payer and expanding to other payers and providers over time. The state will competitively procure a vendor to provide the technical platform, while the Med-QUEST Division (MQD) leads on policy alignment, payer integration, and community onboarding.

This C-Hub with a closed-loop referral system will link rural patients to health-related

social services for health management and illness prevention. The Hub will enable rural providers to screen for needs related to housing, food, and transportation, make referrals to organizations that can provide support, and track whether patients received the services through a closed-loop referral system.

The program will invest in both the technology infrastructure and the support required for implementation, including onboarding rural healthcare and social service partners, training providers and staff, and building workflows that embed referral tools into practice operations. This work also directly supports the AHEAD model's focus on whole-person, value-based care to improve outcomes and reduce avoidable costs in rural communities.

By beginning with Medicaid managed care contracts, the C-Hub ensures that closed-loop referrals are embedded into provider workflows and payment models from the outset, creating sustainable demand. The contracted platform will be designed to support interoperability and scalability, enabling other payers, providers, and community-based organizations to participate over time. In this way, C-Hub starts as a Medicaid-anchored initiative and establishes the foundation for Hawai‘i's universal closed-loop referral system, avoiding duplicative platforms and ensuring that all rural residents benefit from seamless connections to social supports and health services like fresh food providers and medical respite, thereby enabling the health system to tackle disease and illness at its source.

An Analytics and Technical Assistance Hub will integrate clinical and claims data, produce statewide evaluation dashboards, and provide actuarial and professional support for the development of value-based care models in rural areas through practice transformation. Value-based care models link provider reimbursement to improved health outcomes, reduced avoidable usage, and better patient experience, while shifting care to lower-cost, community-based settings.

The Analytics and Technical Assistance Hub will integrate clinical, claims, and social health data into a single evaluation and reporting environment, producing statewide dashboards and providing payment/practice transformation coaching. By consolidating data streams from the CQIE, the All-Payer Claims Database (APCD), and other state systems, the Hub will deliver actionable insights on cost, quality, and access at both state and county levels. It will also provide technical assistance to rural providers and payers, helping them succeed under value-based care arrangements by offering practice-level analytics, modeling of total cost of care, and support for contract readiness. Initially focused on rural health priorities, the Analytics Hub will be designed for scalability, enabling all payers and stakeholders to access consistent, statewide data for population health management, evaluation, and payment reform over time.

Practice transformation includes workflow redesign, team-based care training, use of data to improve quality, reduce avoidable ED visits, and prevent hospitalizations. Behavioral health integration support will enable practices to implement evidence-based behavioral health integration models that will expand access to behavioral health services for rural residents. The program will also connect innovation in rural practices to the workforce training, telehealth, and technological support programs in this initiative and others to ensure that rural practices can sustain innovations and deliver better outcomes under value-based arrangements.

Duals Data Dashboard and Support Hub (DDDASH): To address the needs of the Medicaid/Medicare duals population, the state will (1) develop a robust AI-driven duals data dashboard that will provide increased oversight capabilities, be used to identify cost savings opportunities, and be leveraged to advance care for rural dual eligible populations including driving improvements in supplemental benefits and enhancing quality; and (2) undertake a comprehensive education and engagement strategy to retain and drive further enrollment in

Hawai‘i’s integrated program options.

The State will stand up a secure, AI-enabled Duals Data Dashboard that will build from the Health Analytics, All-Payer Claims Data warehouse, and the Hawai‘i Health Information Exchange, integrating various Medicaid and Medicare data sources to deliver prioritized measures for rural communities and embed risk stratification and opportunity flags.

To help retain and drive enrollment in Hawai‘i’s FIDE-SNPs, Med-QUEST (MQD) will launch a comprehensive education and engagement strategy to build educational resources, trainings, and share strategies for supporting increased integrated care program enrollment. Robust training supports will be developed for MQD navigators, brokers, and State Health Insurance Program (SHIP) counselors, including recorded videos to be used with new counselors and brokers, FAQs, and enrollment guides to help navigate the unique considerations of plan selection for rural dual eligible populations. This will provide ongoing resources as well. MQD will also develop and execute collaborative strategies with its health plans and D-SNPs in supporting our rural dual eligible population to better understand integrated care options and choose a plan best suited for each individual’s unique needs.

Key stakeholders: Lead agencies: State Health Planning and Development Agency (SHPDA) for infrastructure, analytics, and exchange; Med-QUEST Division (MQD) for Medicaid integration, care coordination, and practice transformation. Other key stakeholders: FQHCs, primary care clinics, community-based organizations, rural health clinics, CAH, rural hospitals, State Office of Rural Health, State Primary Care Association, Native Hawaiian Health Centers, independent practices, community-based organizations, payers, independent primary care practices, and provider organizations established by the Hawai‘i Medical Service Association, Medicaid, Medicare, and commercial insurers, Hawaii Health Information

Exchange, Executive Office on Aging's State Health Insurance Program (SHIP), CMS Medicare-Medicaid Coordination Office, Integrated plans (D-SNPs), and the University of Hawai'i.

Outcomes: The RHIN initiative will enable care coordination, practice transformation, and dual eligible enrollment. Detailed metrics are in Section 6 (Table 9).

❖ **Pili Ola Telehealth Network**

Strategic Goal	Use of Funds	Technical Score Factors	Impacted Counties	Est. Funding
Sustainable access	Prevention and chronic disease; Provider Payments; Consumer tech solutions; Training and technical assistance; IT advances; Appropriate care availability; Behavioral health; Fostering collaboration	B.1, C.1, C.2, D.1, F. 1, F.2, F.3	Entire state (FIPS Code 15)	$12 - 16M per year

Description: The Pili Ola Telehealth Network will integrate maternal health, chronic disease management, infectious disease care, behavioral health, telehealth expansion, school-based health programs, education on health access, and workforce development into a unified, statewide initiative. Hawai'i will establish rural telehealth kiosks and access points, deploy community telehealth navigators, support pregnancy and perinatal programs, and build data-sharing and cybersecurity frameworks, a state employee workplace health education campaign, consumer-facing technology, and virtual disease management platforms.

This initiative will strengthen programs focused on primary and specialty care, substance use, and mental health services, while also expanding school-based care and education. Telehealth training, analytics, and e-consult hubs will enable providers across the islands to collaborate, with capabilities to reach industries beyond state employees, effectively preventing and treating health disparities in rural regions. By integrating local innovation with coordinated state leadership, the Pili Ola Telehealth Network will address Hawai'i's fragmented rural health

infrastructure, reduces disparities, and establishes lasting networks of care. This will occur through the following strategies:

Assess rural health care needs and digital health solutions: The initiative will use existing data on digital health needs in rural communities and conduct new assessments to address identified gaps. These data will serve as the baseline for continuous quality improvement over the five-year initiative. Rural communities, including patients, families, patient support services, and health care providers, will have opportunities to provide feedback throughout the project lifecycle to adjust and improve activities.

Establish a stakeholder engagement framework that includes an overarching Coordinating Council and Working Groups on Digital Health Law, Technology and AI, Clinical Applications, Telehealth Access, and Training and Workforce Development. The administration of this initiative will connect to the other proposed RHTP initiatives to ensure alignment across programs and to avoid duplication of efforts.

Build a team of telehealth navigators and facilitators embedded in rural communities across the state, identifying and coordinating with networks of community health workers, patient coordinators, digital navigators, and other grassroots patient and family support services.

Scale the number of telehealth access points in rural communities by establishing them in places such as schools, libraries, community centers, churches, and other community-based locations. Pili Ola will implement telehealth in the workplace, starting with very remote hotels on Hawai‘i Island, where employees travel three hours by bus to and from work. And to quickly scale awareness of the RHT initiatives, Pili Ola will prioritize the State of Hawai‘i government agencies as one of our largest employers.

Create a Telehealth Safety Net with a critical mass of services statewide, including maternal telehealth, stroke care, infectious disease, behavioral health services, pediatric care, and primary care. The program will build out high-priority service areas throughout the five years of the initiative with provider training and infrastructure development.

Establish an innovation technology laboratory to develop and pilot AI applications in health care, such as patient feedback and follow-up communications; piloting remote patient monitoring and consumer smart technology; and AI analytics applications.

Develop telehealth training for health care providers, telehealth navigators, facilitators, patients, and families. Working groups will identify priority training needs and partner with telehealth stakeholders in the development of the training materials and, through the Pili Ola network, will implement unified training across the state of Hawai`i.

Establish a Pili Ola information management system to connect resources for improved referral, care coordination, and scheduling. This shared platform will serve as a centralized information and scheduling hub that integrates social services, telehealth access points, and community resources to reduce duplication, improve service navigation, and ensure timely care. By capturing referral patterns, service usage, and outcomes, the system also supports continuous evaluation and accountability, helping partners measure impact and strengthen resource coordination across the community. The RHTP Oversight Team, in collaboration with SHPDA and DOH, will ensure interoperability with other proposed networks since Pili Ola will serve as the telehealth hub for other information systems and care teams to tap into.

Establish a Pili Ola Telehealth Analytics Coordinating Center (TACC) to standardize data collection across programs, conduct analyses led by health data scientists, and deliver clear reporting. A performance dashboard will track access, usage, quality, and cost metrics to guide

decisions and demonstrate impact. TACC will host monthly technical assistance calls to streamline metrics, evaluation methods, and reporting; run quarterly Rapid Cycle Assessments (RCAs) to provide timely feedback on access, quality, and patient experience; publish quarterly research briefs and annual reports summarizing service outcomes; and support data-sharing and cybersecurity best practices. Transparent reporting will ensure public accountability and ongoing stakeholder engagement.

Key stakeholders: Lead agencies: University of Hawai‘i (UH) Social Science Research Institute (SSRI), UH Telecommunication and Social Informatics (TASI), Pacific Basin Telehealth Resource Center (PBTRC). Other key stakeholders: Kapiolani Medical Center for Women and Children, UH John A. Burns School of Medicine (JABSOM), University Health Partners of Hawai‘i, UH Mānoa School of Nursing and Dental Hygiene, UH Health Policy Initiative, UH Rural Health Research and Policy Center (RHRPC), health systems, community health centers, rural health clinics, critical access hospitals, Hawai‘i Med-QUEST, AlohaCare, State Department of Health, Hawai‘i State Rural Health Association, and others.

Outcomes: The Pili Ola Telehealth Network initiative will enable rural residents to access primary, behavioral, and specialty care remotely. Detailed metrics are in Table 9.

- **Rural Infrastructure for Care Access**

Strategic Goal	Use of Funds	Technical Score Factors	Impacted Counties	Est. Funding
MRAHA; Sustainable access	Prevention and chronic disease; Provider payments; Training and technical assistance; Workforce; IT advances; Appropriate care availability; Behavioral health; Fostering collaboration; Capital expenditures and infrastructure	B.1, B.2, C.1, C.2, D.1, F.1, F.2, F.3	Entire state (FIPS Code 15)	$56 - 64M per year

Description: The RICA initiative will modernize and connect Hawai‘i’s rural healthcare system through a statewide communications center for emergency and trauma transfers and rural

care coordination. This will be accomplished by a two-pronged strategy: (1) modernizing Hawai‘i’s emergency and trauma coordination system to ensure rapid, data-driven response and care delivery; and (2) expanding community-based, preventive, chronic disease, and behavioral health services to reduce preventable emergencies and hospitalizations. Over time, RICA will enable emergency care to be reserved for the most severe challenges while empowering rural providers locally. This initiative thus serves as both a bridge and a pathway, meeting the urgent needs of today while building the sustainable care networks of tomorrow.

At the center of RICA is the proposed Medical Communications Center (MEDICOM), a statewide nexus for patient transfers and rural care coordination. The MEDICOM will serve as the state’s care command center. It will strengthen rural connectivity to emergency, trauma, and acute care through coordinating unaligned facilities and services across the islands. It will also enhance population health by empowering community-based teams to tackle preventive care, behavioral health, the root causes of diseases, and burdens to health care access.

The MEDICOM Center will unify all county EMS dispatch centers, hospitals, and air and ground transport providers through a real-time, technology-driven communication platform featuring CAD-to-CAD interoperability, a statewide hospital and rural healthcare capabilities platform for real-time capacity tracking, as well as universal Starlink satellite connectivity for rural ambulances, rapid response, and mobile medical care. In addition to the systems upgrade, aging rural EMS transportation assets will be replaced with tech-enabled units equipped with advanced communications, telehealth, and bi-directional data transmission capabilities. These vehicles will seamlessly integrate with the MEDICOM Center’s platform, providing real-time patient monitoring, two-way data exchange, and location tracking to improve reliability, reduce downtime, and expand access to care in rural and underserved areas.

Developing the emergency coordination of MEDICOM and reinvesting in emergency transportation will modernize the state's EMS system. However, recognizing that rural Hawai‘i's reliance on EMS and inter-island transfers is a symptom, not the cause, of many chronic diseases and avoidable 911 calls and hospital visits, the center will not only improve the efficiency of workflows but will also serve as a critical population health asset. The MEDICOM center has the potential to serve as the platform to evolve from an emergency dispatch system into a population health command center. While Pili Ola will serve as the telehealth hub/center, MEDICOM will serve as the command center for patient and care team management. The RHIN initiative will enable data to be fed into both systems.

RICA will optimize the full potential of the MEDICOM center to expand community-based care capacity to prevent unnecessary emergency use and improve population health. From its position as the statewide coordination communications and coordination center, MEDICOM will use real-time EMS data, RHIN information, and DOH's Hawai‘i Health Data Warehouse to identify high-need communities and direct the mobilization of rural care resources. Where the data and community identify need, RICA will invest in rural facilities, such as CCBHCs, and MEDICOM's operational command will organize and deploy healthcare units in collaboration with local partners to implement strategies that address health needs, increase the use of preventive care, provide care in lower-cost settings such as homes, and reduce preventable hospital admissions and emergency room visits. Local leaders have identified community-based care teams of several types:

Community paramedicine and home-based care models to reduce preventable 911 calls, emergency department usage, and readmissions. The community paramedicine network will comprise combinations of community-based volunteers, CHWs, community paramedicine

specialists, emergency medical technicians, and paramedics using in-person and telehealth to provide in-home assessments, chronic disease management, and preventive care. These community paramedicine teams will be embedded within rural communities and work jointly with rural primary care teams to support holistic, community-based health.

Establish mobile clinics to deliver essential healthcare directly to rural communities where care is hardest to reach. Mobile clinics will bring primary care, preventive screenings, and chronic disease management directly to underserved areas while also providing access to specialty consultations through telehealth and rotating providers. This approach has already been shown in Hawai‘i to expand sustainable access, reduce missed appointments, and ensure that no family is left behind because of geography.

Mobile mental health and substance use teams consisting of mental health professionals and peer support specialists will deploy from CCBHCs to extend the reach of CCBHCs into sparsely populated areas where permanent clinics are not sustainable.

Primary care teams of clinical pharmacists and CHWs will be deployed to manage chronic conditions (e.g., diabetes, hypertension, COPD) into rural areas through comprehensive medication management. These pharmacists will work with physician-led primary care teams through collaborative practice agreements to optimize prescriptions, order labs, and provide patient education to improve adherence and long-term health outcomes.

Integrate CHWs with public health nurses to reach a broader population in need of services. This program will use CHWs in a cost-saving manner to support and expand key rural public health services such as elder health (in particular, fall prevention and physical activity support), school-based health care, and chronic disease prevention. Adding CHWs who are from the community and are trusted by the people will act as a “force multiplier” to reach more

communities and individuals in a culturally congruent manner, resulting in improved health outcomes and decreased health care usage and costs.

These preventative efforts will preserve the independence of rural and emergency care providers while allowing locals to remain close to home. MEDICOM operations will integrate with the Community Care Coordination Hub (C-Hub) of the Rural Health Information Network (RHIN) for data sharing, with the Pili Ola Telehealth Network to expand remote consultation capacity statewide, and with HOME RUN for training and awareness in rural communities, all of which will be coordinated by the RHTP Oversight Team.

By building the community-based care teams in tandem with each other and the emergency system, the state will avoid the risks of duplicating data, delaying responses, wasting resources, and missing cross-sector trends since they depend on the same underlying information: 911 caller identification, occurrences of chronic condition or behavioral crises clusters, hospital capacity, and available transport resources. By investing in both emergency and preventive services, the MEDICOM center will prevent duplication, coordinate operations, and transform the EMS system from an isolated responder network into the central nervous system of Hawai‘i’s rural health ecosystem.

Key stakeholders: Lead agency: Hawai‘i Department of Health (DOH). Other key stakeholders: Hawai‘i Emergency Management Agency (HI-EMA), Hawai‘i Fire Departments and EMS agencies, Hawai‘i Health Systems Corporation (HHSC), Office of Rural Health, University of Hawai‘i Rural Health Research and Policy Center (RHRPC), Federally Qualified Health Centers (FQHCs), Rural Health Clinics, Critical Access Hospitals, State Department of Education (DOE), commercial air ambulance providers, public libraries, community-based

organizations, peer-run organizations, Native Hawaiian health systems, crisis line providers, the Daniel K. Inouye College of Pharmacy, and telehealth technology partners.

Outcomes: The RICA initiative will build a resilient rural health infrastructure by transforming Hawai‘i’s emergency-dependent care model into a coordinated, preventive, and community-based system of access. RICA will establish the foundation required to ensure timely, coordinated, and high-quality outreach capabilities to every community on every island. This hub will enable faster routing, reduce transfer times, and provide continuous situational awareness during disasters or high-volume incidents. Detailed metrics are in Section 6 (Table 9).

- **HOME RUN**

Strategic Goal	Use of Funds	Technical Score Factors	Impacted Counties	Est. Funding
Workforce development	• Workforce • Fostering collaboration	C.1, D.1	Entire state (FIPS Code 15)	$45M per year

Description: The HOME RUN initiative will support rural communities in Hawai‘i to fully develop their health workforce infrastructure through a combination of educational programs from high school through the life span of their health careers. The HOME RUN program partners with rural hospitals, health centers, communities, colleges, and schools to identify, train, and support workers in all health fields. It leverages existing state and local funding sources to maximize long-term benefits to all rural communities in Hawai‘i, and will fully maximize the workforce by the end of the five-year grant period through a combination of high school training and support activities, rural clinical and didactic education, scholarships, provider incentives, expanded residency programs, and a collaborative provider wellness and health improvement campaign based on each rural communities’ strengths and needs. The HOME RUN initiative includes the following activities.

Expanding Hawai‘i’s successful high school health certificate training and health careers support programs: This will include two major components. First, Hawai‘i will expand its existing High School Workforce Development Certificate Programs by 20 healthcare certificate training programs in at least ten rural schools. The High School Workforce Development Certificate Programs[26] were established by the Healthcare Association of Hawai‘i in 2022 and currently operate in 18 schools, most of which are in urban areas. HOME RUN will facilitate over 500 rural certificate graduates over the five years of the initiative. Certificate tracks will prepare students for at least the following professions: patient service representative, medical assistant, certified nurse assistant, dental assistant, emergency medical specialist, pharmacy technician, and phlebotomist.

This component of the HOME RUN initiative will also support Health Occupation Students of America (HOSA) Future Health Professionals programs in rural schools for students interested in health careers and related high school-focused initiatives. The statewide Area Health Education Center (AHEC) network has created a statewide HOSA program for students at schools without a HOSA mentor. The group currently has 46 members, mostly in urban areas. HOME RUN will support rural students by expanding knowledge of HOSA, providing mentoring and guidance for students in schools without an active HOSA club, matching student fundraising for travel, lodging, and entry fees for state, national, and international HOSA competitions, and promoting scholarships in health professions education. Additionally, HOME RUN will expand neighbor island high school student opportunities to become Neighbor Island Medical Scholars to participate in a one-week summer program at the medical school. This funding will also support the implementation of a core training program and incentives for health and science teachers, counselors, and health academy leaders to improve their knowledge and

ability to support students' interest in health professions and incorporate health profession-relevant core competencies into their classes or programs.

Expanding rural clinical training: While Hawai‘i has healthcare training programs for allied health, nursing, and medical careers, they are predominantly located in urban Honolulu. In order to develop interest in working in rural areas, students and residents must train in rural areas to understand the beauty and welcoming nature of these neighborhoods. HOME RUN will support rural clinical education and medical and nursing residency development across the state through the following evidence-based approaches.

Clinical preceptorships and clinical training: Currently, most medical, NP, and PA training programs support travel for students to rural areas through AHEC funding and fundraising. Opportunities are more limited than desired because of the high cost of housing and air travel. The HOME RUN initiative will triple the number of rural opportunities, enabling every student to train for at least a month in a rural location.

Developing rural residency programs and expanding specialty services: Supported by an HRSA Rural Residency Training Program Grant in 2024, JABSOM received accreditation for a new Family Medicine Rural Residency Program on Kaua‘i, starting in July 2027. There is a second Family Medicine Rural Training track on Hawai‘i Island in development with a target of recruiting the first cohort of residents beginning in July 2028. HOME RUN proposes to start a similar community-engaged process on the major neighbor islands with the goal of a new rural residency program in primary care internal medicine or family medicine, and rural residency tracks in surgery, obstetrics/gynecology, pediatrics, and/or psychiatry, depending on the health system capacity and breadth of patients and procedures required for accreditation. In addition, three new long-term care/post-acute care nursing transition to practice programs will be started

in rural areas. The statewide acute care nurse residency program has demonstrated a 96% retention rate of nurses, far higher than the national rate of 82%. This program will train 300 nurses over the grant period in transition to practice, new specialty roles, and precepting skills

Recruitment and retention of trained providers in rural areas to practice in rural Hawai‘i for at least five years. Hawai‘i expects to be able to recruit and retain 1000 new healthcare providers from health IT, to CHWs, to primary care providers and endocrinologists, through a combination of scholarships and incentive programs for service in and to rural Hawai‘i. The HOME RUN initiative will expand on existing statewide recruitment opportunities, including DocJobsHawaii.org, Loan Repayment, and Preceptor Tax Credit, by introducing a new provider incentive program only for rural areas. These incentive payments will support the needs of new and retained healthcare workers in rural Hawai‘i through a binding contract for a five-year commitment to practice in rural Hawai‘i. The penalty for leaving the program early will be the revocation of funds for the remainder of one’s work requirement, which will be returned to the HOME RUN program to support additional participants. HOME RUN will also offer full tuition scholarships for online and in-state healthcare training in exchange for a five-year commitment to serve in rural areas for all healthcare workers, with similar penalties for non-compliance.

Interprofessional, multi-tiered mentoring for rural healthcare workers: An AHEC education and mentoring coordinator will work with all scholarship and incentive recipients to find mentors for all trainees and providers, which will provide training in mentoring and being mentored. Monthly contact will be required for all scholarship and incentive recipients, and practicing providers will be asked to mentor students and present on the ECHO distance learning program at local and statewide health workforce conferences. Each rural area of Hawai‘i has a UH Extension Center where students can take courses online and an AHEC center where

students can be mentored by local AHEC staff. The AHEC Directors will work with all local students and offer to make them AHEC Scholars, thus allowing them a stipend for completing their course of study. In addition, HOME RUN will fund a tutor on each island who will lead rural healthcare trainings, mentor, and support students.

Healthcare worker community wellness campaign: Reflecting interest demonstrated by rural communities, the HOME RUN initiative will facilitate health workforce summits in rural communities (at least one per island per year) and local meetings with providers (monthly or quarterly) to develop, implement, and monitor programs. In addition, the HOME RUN Outreach Coordinator will help establish and coordinate local community groups to engage their own community members in assessing needs and developing programs to promote healthy living. A local organization will be contracted to promote all resiliency activities and make mini-grants available for rural provider groups to implement solutions.

Training and upskilling: In addition to the scholarships mentioned above, the HOME RUN team will facilitate multiple continuing education activities. Examples include a special rural track for ECHO tele-education and the annual AHEC Health Workforce Summit, as well as additional educational programs beginning with maternal-child health. Rural communities will receive training in comprehensive newborn care through the Neonatal Education, Support & Technology (NEST) program. This will include quarterly Neonatal Resuscitation Team and palliative care/bereavement training, plus an annual two-day S.T.A.B.L.E. (Sugar, Temperature, Airway, Blood pressure, Lab Work, and Emotional Support) course at seven hospitals. These trainings will focus on resuscitation and post-resuscitation care, equipping nurses, respiratory therapists, and physicians to maintain critical skills.

In addition, palliative care training will enable families to remain on-island, avoiding transfers to O‘ahu. Local champions will be trained to sustain education and support between sessions. The trainings offered will be coordinated with other RHTP initiatives (i.e., Pili Ola, RICA) and leverage the resources of the University of Hawai‘i and other state agencies.

Key stakeholders: Lead agency: University of Hawai‘i JABSOM. Other key stakeholders: All health professions, allied health, and healthcare-related training programs within the UH System, FQHCs, practices, hospitals, Healthcare Association of Hawai‘i, high schools, healthcare workers, Hawai‘i Department of Education, Department of Labor and Industrial Relations, Hawai‘i Pacific Health, Maui Health System, Queen’s Health System, Hawai‘i Health System Corporation, State Primary Care Association, Hawai‘i Department of Health, and others.

Outcomes: The HOME RUN initiative will build the workforce necessary for rural health care transformation. Detailed metrics are in Section 6 (Table 9).

- **Rural Respite Network**

Strategic Goal	Use of Funds	Technical Score Factors	Impacted Counties	Est. Funding
Sustainable access	Prevention and chronic disease; Provider payments; Appropriate care availability; Behavioral health; Capital expenditures and infrastructure; Fostering collaboration	B.1, B.2, C.1	Entire state (FIPS Code 15)	$3 - 8M per year

Description: This initiative will establish five rural medical respite centers across Hawai‘i—in Kaua‘i, Maui, Kona, Hilo, and Wai‘anae—to provide short-term residential care for residents of rural communities who are too ill or frail to recover on the street but not sick enough to remain in a hospital. Each center will offer 24/7 medical and behavioral health staffing, hygienic facilities with bathrooms and showers, primary care access, and case management services. In 2026, Med-QUEST will begin reimbursing for medical respite care, but financial

barriers have limited the availability of lower-cost care settings. Hence, this initiative will support the startup and the non-reimbursable services for these new sites.

This initiative builds directly on the successful implementation of medical respite facilities serving areas of the state with a high concentration of unsheltered individuals. Pūlama Ola, Hawai‘i’s first medical respite *kauhale* in Honolulu, provides a safe, stable place for unsheltered individuals with health needs that could not be met in existing homeless shelters or on the streets. The project demonstrated the effectiveness of pairing 12 tiny home-style units with on-site nursing rounds, behavioral health supports, hygiene facilities, and drop-in services open to other unsheltered community members. Pūlama Ola also included a weekly psychologist, mobile showers, and a medical-legal partnership to address residents’ civil legal needs. A 2024 evaluation showed that Pūlama Ola program participants were less likely than a comparison group to be experiencing literal homelessness and were more likely to be housed in permanent, transitional, and institutional settings after their time in the program.

In July 2024, the State of Hawai‘i and the City and County of Honolulu partnered to open an expanded medical respite *kauhale* with a capacity of up to 62 individuals just outside the urban core. A‘ala Medical Respite has served approximately 211 medically fragile, unsheltered individuals to date; 43% of those who have exited the program have been stably housed.

Medical respite programs have experienced similar success in rural areas of the state, although at a more limited capacity. For example, the Wilder House medical respite program, established with state and private funds, provides eight medical respite beds for homeless individuals who would otherwise remain hospitalized. Lessons from this effort, including low-barrier access, wraparound supportive services, and integration with community-based services, have informed the design of the RRN initiative.

The proposed RRN will achieve the following goals:

Create a low-barrier environment to reach those in need of respite services. RRN facilities will best serve high-frequency users of emergency medical services. Hawai‘i’s existing *kauhale* respite sites are intentionally low barrier to extend the program’s reach and impact while ensuring that all sites have proper safety protocols and security measures.

Centralize wraparound supportive services: On-site housing navigation and wraparound services designed to stabilize and improve participants’ outcomes are critical to ensuring long-term success. RRN providers will deliver on-site housing navigation and case management services to ensure that residents have the resources they need to successfully transition into a *kauhale* housing community, rapid rehousing, or a permanent housing placement.

Fully integrate with community-based services: While the RRN is, first and foremost, a healthcare program, the target population has a range of needs to become successfully housed and avoid recidivism into homelessness. Each rural area on the island has its own unique ecosystem of homelessness and other community-based service providers. The RRN will expand efforts already underway on *kauhale* respite sites to map community-based resources available in each jurisdiction and ensure full integration of these services for program participants. To this end, the RRN will partner with the closed-loop referral system developed through the RHIN initiative to refer residents of rural areas to and from medical respite.

Key stakeholders: Lead agency: Hawai‘i Department of Human Services (DHS). Other key stakeholders: State Office on Homelessness and Housing Solutions, State Med-QUEST Division, State Department of Health Behavioral Health Services Administration, rural health facilities (hospitals, FQHCs, and rural health clinics), community-based organizations such as homeless service providers and behavioral health agencies.

Outcomes: The RRN initiative will reduce avoidable emergency service utilization, hospital readmissions, and average length of stay among those who are unstably housed. Detailed metrics are in Section 6 (Table 9).

❖ **Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund**

Strategic Goal	Use of Funds	Technical Score Factors	Impacted Counties	Est. Funding
Innovative care	Prevention and chronic disease; Provider payments; Training and technical assistance; IT advances; Appropriate care availability; Innovative care; Fostering collaboration	B.1, B.2, C.1, E.1	Entire state (FIPS Code 15)	$25M per year

Description: This initiative will establish a competitive statewide fund to ensure Hawai‘i’s rural providers and hospitals succeed under the federal AHEAD model while fostering local innovation in value-based care. FQHCs, Critical Access Hospitals, rural health clinics, independent physician associations (IPAs), payers, community-based organizations in or serving rural areas, and other experts and consultants will be eligible to submit proposals for the fund.

All awards must advance at least two of the following areas to support AHEAD’s success: 1) control of Total Cost of Care (TCOC) growth; 2) improve quality of care and population health outcomes; 3) grow innovative payment and delivery models to improve health outcomes, coordinate care, shift care to lower cost settings, and/or promote flexible care arrangements; 4) improve access to care in value-based payment and delivery models; 5) support provider participation in and readiness for new AHEAD payment and delivery models; 6) expand multi-payer participation and alignment; and 7) advance the Centers for Medicare and Medicaid Innovation’s (CMMI’s) pillars.

Applicants will be required to include a TCOC and Population Health Impact Statement describing how their project will impact cost growth or improve efficiency, quality of care, and population health outcomes. Examples of allowable uses of the Fund include: (a) providing

access to timely, actionable data and reports that enable providers to achieve the AHEAD goals, provider transition supports (time-limited and performance-tied); (b) payer-provider alignment pilots; (c) incentivizing payer participation in APCD and aligned contracts; (d) collaborative provider networks (ACOs, IPAs, FQHC consortia) that align attribution with AHEAD without duplicating or undermining hospital global budgets; (e) primary care payment and integration pilots; and (f) community-driven initiatives to reduce preventable utilization and increase care coordination.

By giving rural communities the flexibility to design locally tailored solutions while holding all projects accountable to AHEAD's framework and state oversight, the Fund will ensure that Hawai'i's rural communities thrive under the state's transition to the AHEAD model. The Fund will not duplicate AHEAD cooperative agreement funding. AHEAD resources support the development of the new payment and delivery system methodologies. The Fund will support the development of infrastructure needed for successful value-based payment and delivery models, provider and payer-facing implementation, such as APCD connectivity, local analytics, hospital transition supports, collaborative networks, and sustainability incentives that will transition RHTP pilots into permanent financing streams**.** Together, they are complementary: AHEAD sets the framework and this Fund will ensure the implementation is successful. Fund recipients will be connected to complementary initiatives in the state's RHT plan, particularly RHIN's Analytics and Technical Assistance Hub when possible. The Fund will not provide continuation grants for existing RHTP projects (e.g., mobile care teams). Instead, it will create incentive structures that enable RHTP initiatives and projects to become self-sustaining, including payer match incentives, transitional global budget adjustments, performance-based

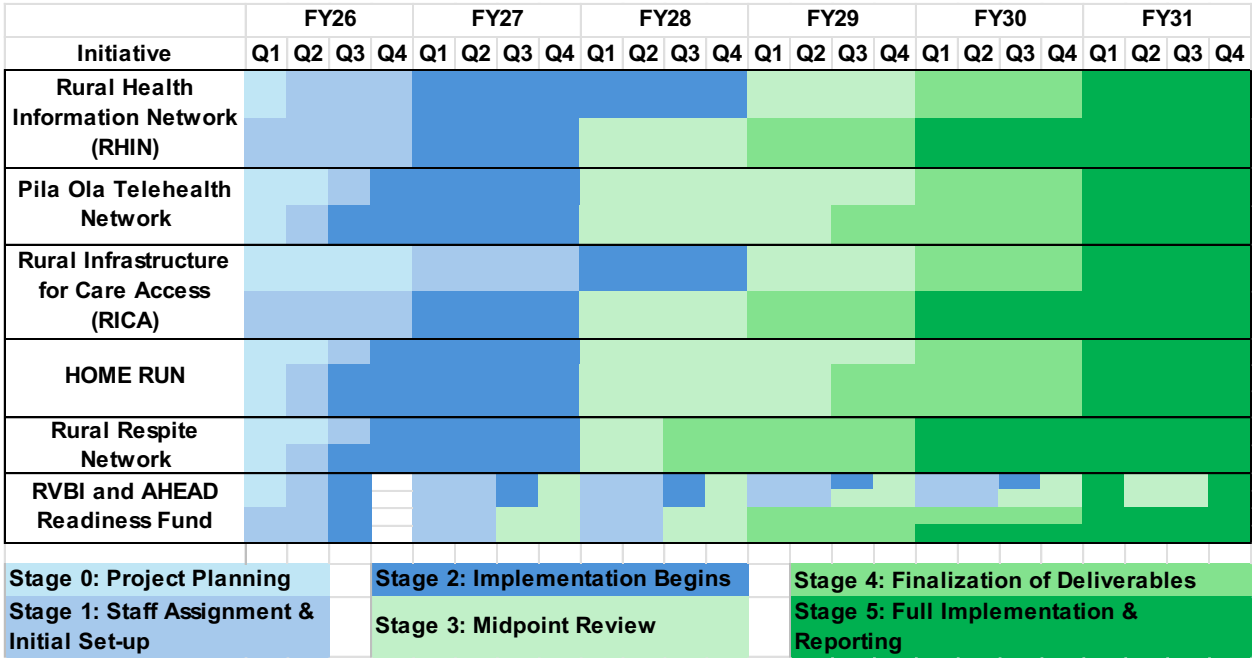
payments tied to reductions in avoidable utilization, and technical assistance for contract development unavailable from the Analytics and Technical Assistance Hub.

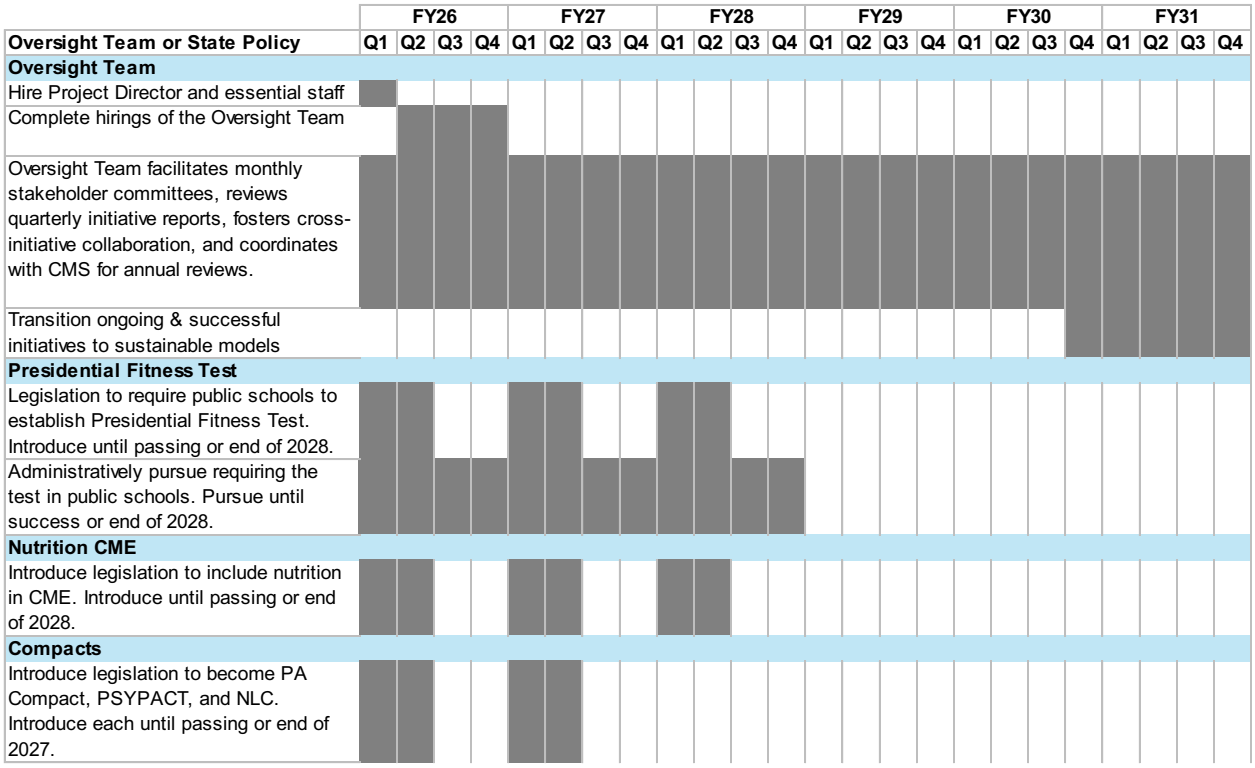
Key stakeholders: Lead agencies: State Health Planning and Development Agency (SHPDA) in partnership with Med-QUEST Division (MQD), DOH's Office of Rural Health, and the RHTP Oversight Team (together, the four comprise the Rural Innovation Council). Other: Rural hospitals, CAH, FQHCs, RHCs, IPAs, commercial insurers, UH, local organizations, and other experts and consultants. Governance: SHPDA will administer the Fund; the AHEAD Steering Committee will review applications and advise, but final award authority rests with the Rural Innovation Council (SHPDA, MQD, DOH's Office of Rural Health, and the RHTP Oversight Team). SHPDA will ensure compliance with RHTP and AHEAD requirements.

Outcomes: The RVBI & AHEAD Fund initiative will enable rural providers and networks to adopt innovative care models and succeed under the AHEAD model. Detailed metrics are in Section 6 (Table 10).

4. Implementation Plan and Timeline

The following graphics illustrate the implementation plans for each initiative as well as key administrative and legislative activities. See Appendix B for detailed Gantt charts.





The lead agency is the Office of the Governor of the State of Hawai‘i. The authorized organizational representative agency is the Hawai‘i Department of Budget and Finance (B&F).

B&F's Office of Federal Awards Management (OFAM) has a deep track record of federal funds management, such as grants, contracts and cooperative agreements related to COVID-19, the Infrastructure Investment and Jobs Act (IIJA), Inflation Reduction Act (IRA), and the Maui Wildfires. As such, B&F has established policies and procedures for the management of federal awards that will be applied to this program and incorporated into all sub-award agreements.

B&F will closely collaborate with the RHTP Oversight Team for fiscal and programmatic management of the cooperative agreement. B&F will assist the Oversight Team in developing an oversight and monitoring plan for the subrecipient State agencies of this award, as B&F has done for previous awards, such as the Capital Projects Fund (CPF) and BEAD. Oversight typically includes methods such as formal program management plans, monthly subrecipient monitoring meetings, and quarterly and annual reports. The RHTP Oversight Team will facilitate coordination among state health agencies and with external stakeholders.

The Oversight Team will operationalize the foundation laid by the RHTP Planning Team as detailed in Section 5. The Oversight Team will be responsible for the following key functions: provide expert consultation and guidance to the initiative leaders; ensure and lead continued stakeholder engagement and the alignment of the RHTP with rural communities; ensure alignment among initiatives, prevent duplication, and strengthen collective impact of all initiatives; manage program budget and financials; ensure regulatory compliance; and gather and manage project data to assess progress, outcomes, and obstacles.

The Oversight Team will be an ongoing resource for initiative leaders. Initiative leaders will be required to participate in the monthly RHTP Stakeholder Advisory Committee meetings and provide quarterly reports on progress towards their timeline and outcomes.

The Oversight Team will be led by the RHTP Project Director, Jeremy Lakin, who will transition into the role upon notice of cooperative agreement award. Mr. Lakin has served as General Counsel for Hawai‘i Governor Josh Green for the past three years, as well as a top legal and policy advisor to the state's chief executive. Roles include overseeing the Mental Health Policy Housing Project, which spearheaded the Hawai‘i *kauhale* (medical respite) initiative. Mr. Lakin previously served as Policy Attorney for Hawai‘i State Senator Josh Green (three years), where he worked directly on health and human services policy as the Senator chaired the Senate Health and Human Services committee, establishing early expertise in Hawai‘i's healthcare landscape. Following this, Mr. Lakin served as Manager of Policy and Legislation for the Healthcare Association of Hawai‘i, where he gained a crucial industry perspective on healthcare delivery, policy challenges, and legislative advocacy. Afterward, he served as Deputy Chief of Staff for Lieutenant Governor Josh Green for four years, where he was involved in high-level executive branch operations, providing a broad understanding of state government management and interagency coordination.

The Project Director will have the authority to implement the cooperative agreement with CMS, aided by his Oversight Team, overseeing the distribution of funds, reporting from initiative leaders, facilitating monthly meetings, engaging with community members, annually reporting to and dialoguing with CMS, troubleshooting, and ensuring compliance. Other members of the RHTP Oversight Team, as listed in Table 9, will be hired as quickly as possible throughout 2026. The governance and project management structure is illustrated in Appendix C.

Table 9. Hawai‘i RHTP Oversight Team

Position	Roles
Project Director (1.0 FTE)	Oversee the state's rural health transformation plan.
Project Manager (1.0 FTE)	Oversee the day-to-day operations of the Oversight Team.
Project Advisor (3.0 FTE)	Provide expert guidance to the Oversight Team.

Project Analyst (3.0 FTE)	Gather, manage, and interpret project data to assess progress, outcomes, and obstacles.
Project Specialist (6.0 FTE)	Provide subject-matter expertise and technical support to RHTP initiatives and the Oversight Team.
Project Assistant (2.0 FTE)	Provide administrative and logistical support to the Oversight Team.

The Oversight Team will include experts in budget management and will be partially housed in the Department of Budget and Finance. Expert planning with key stakeholders and department/division leaders will ensure that all initiatives, including major coordinating initiatives such as those involving interoperability, can be successfully deployed as planned. The Oversight Team will engage the Office of Enterprise Technology Services for expertise on IT and technology innovation.

The RHTP Stakeholder Advisory Committee will assist with addressing any barriers that may arise. Other significant stakeholders will participate in the Stakeholder Advisory Committee, where they will learn about RHTP updates and provide insight into future action. Interagency conflicts will be addressed by the Project Director in consultation with the Office of the Governor.

5. Stakeholder Engagement

The proposed initiatives and RHTP governance structure were carefully designed and coordinated by an RHTP Planning Team. This multidisciplinary, cross-agency stakeholder group of public and private, state-level and community-level stakeholders started preparing for this application in July 2025, with formal weekly meetings beginning in August.

Stakeholders have been consulted by various means throughout the planning process. The Office of the Governor established and promoted the RHTP through the Hawai‘i State Public Library System and a public-facing “Engage Hawai‘i” webpage, enabling idea submissions and comments from the public.[27] The RHTP Planning Team reviewed and evaluated over 170 public comments and proposed submissions to the “Engage Hawai‘i” platform. The State plans to

maintain the “Engage Hawai‘i” website throughout the cooperative agreement period to solicit ongoing feedback on the RHTP implementation. Through this page and through formal and informal discussions and meetings, the public and other stakeholders submitted concepts to the Planning Team for the RHTP application.

Initiative concepts were also introduced and vetted through several forums facilitated by the Healthcare Association of Hawai‘i (HAH) and the Med-QUEST Division. Examples include meetings with leaders of acute care hospitals across the state (37 participants), the chief medical officers of Hawai‘i hospitals (28 participants), chief financial officers of Hawai‘i hospitals (27 participants), and government relations leads of HAH members (49 participants). Other venues in which the RHTP plans were discussed include the Fall 2025 Medicaid Healthcare Advisory Committee meeting (which included 35 Medicaid members, advocates, primary care providers, and members of the public) and the annual Critical Access Hospital – Payment Flexibility conference with the Department of Health’s Office of Rural Health and Med-QUEST.

The State of Hawai‘i is committed to continuing to engage stakeholders on an ongoing basis during the cooperative agreement period through several mechanisms. The RHTP Oversight Team will sustain the engagement framework administratively. They will work with key stakeholders to track milestones, assess impacts, and engage in continuous quality and process improvement. These key stakeholders include the Director of the Hawai‘i Department of Health (Kenneth Fink), Administrator of the Med-QUEST Division (Judy Mohr Peterson), and the Director of the State Office of Rural Health (Scott Daniels).

RHTP Stakeholder Advisory Committee: The Oversight Team will establish a Stakeholder Advisory Committee consisting of initiative leaders and a variety of stakeholders representing rural healthcare facilities and institutions across the state, including rural hospitals,

CAH, FQHCs, rural health clinics, behavioral health providers, EMS, long-term care, home health, Native Hawaiian health systems, community-based organizations, primary care associations, independent physician associations, payers, workforce development and education, county or island representatives, patients and community advocates, health technology and data infrastructure professionals, and representatives from the Office of Rural Health Policy. Many of these stakeholders have been highly engaged in the development of this application.

The Stakeholder Advisory Committee will meet monthly, led by the Oversight Team. The Oversight Team will transmit quarterly reporting from initiatives to the Committee (or allow initiative leaders to present it). Additionally, a member of the Oversight Team (e.g., a Project Advisor) will be tasked with participating in the monthly meetings of SHPDA's Subarea Health Planning Councils (SACs), particularly the rural SACs, to solicit ongoing constituent feedback. Evidence of support from key stakeholders is provided in Appendix E.

6. Metrics and Evaluation Plan

Metrics and targets per initiative are detailed in Table 10. Baseline data is limited because of the lack of access to information, which this funding will correct (e.g., lack of a telehealth network to measure telehealth visits) or as dependent on the particular communities (e.g., the baseline will vary from community to community for community-based care teams). In the absence of baseline data, targets were developed in collaboration with local stakeholders and initiative leaders as ambitious but attainable goals. The targets are interconnected, given the natural overlap of certain initiatives (e.g., RHIN, Pili Ola, RVBI Fund). The key indicator for each initiative is denoted in bold. Community or county-level metrics are underlined.

Table 10. Metrics and Targets per Initiative	
Metrics	**FY 31 Targets *(and Baselines where Available)***
Rural Health Innovation Network (RHIN)	
% rural provider sites using fully interoperable EHRs	**90% of rural provider sites**

% of referrals made in rural counties with closed-loop referral access that are completed and confirmed closed-loop referrals (county-level)	70% of referrals made in rural counties with closed-loop referral access will be completed and confirmed (county-level) *National baseline is around 35%.*[28]
% duals enrolled in integrated plans	20% increase in duals enrolled in integrated plans
% rural PCPs providing telehealth services	50% of rural PCPs providing telehealth services
% rural PCPs or POs in value-based model contracts	50% of rural PCPs or POs in value-based model contracts
Pili Ola Telehealth Network	
% rural patients with at least one telehealth visit, telehealth access, and utilization (county-level)	**20% increase in rural patients with at least one telehealth visit (county-level)**
% number of individuals who manage or prevent chronic diseases using telehealth resources	200% increase in the number of individuals who manage or prevent chronic diseases using telehealth resources
% patient travel for rural OB patients	30% reduction of patient travel for rural OB patients
% of rural behavioral health referrals resulting in a completed telehealth visit	30% increase in rural behavioral health referrals, resulting in a completed telehealth visit *Baseline: FY24 referral → visit completion rates vary by county, averaging <50%.*
Rural Infrastructure for Care Access (RICA)	
% reduction in time of emergency and trauma transfers from dispatch to hospital arrival	**25% reduction in time of emergency and trauma transfers from dispatch to hospital arrival** *Baseline: Air medical transports across Hawai'i average 274 minutes (4.6 hours) from dispatch to hospital arrival.*
% repeat EMS calls among rural residents in served communities (community-level)	25% reduction in repeat EMS calls among rural residents in served community (community-level)
% avoidable ED visits in served communities (community-level)	15% reduction in avoidable ED visits in served community (community-level)
% overall hospital use for recipients in the served community, no matter where the hospitalization occurs (community-level)	10% reduced overall hospital use for recipients in the served community, no matter where the hospitalization occurs (community-level)
HOME RUN	
# new healthcare workers in rural communities	**1,000 new healthcare workers in rural communities**
% healthcare worker vacancy rates in rural healthcare facilities	10% decrease in healthcare worker vacancy rates in rural healthcare facilities *Baseline:18% on neighbor (non-O'ahu) islands.*[29]
# years of cumulative healthcare worker or provider service committed to serving rural communities (provider incentives and scholarships)	2,500 years of healthcare worker or provider service committed to serving rural communities (scholarships and provider incentives)
Neighbor island (non-O'ahu) # of residency programs or rural track (county-level)	At least 1 new neighbor island (non-O'ahu) medical or nursing residency program or rural track in each county (county-specific) *Baseline: 2 medical (1active;1developing); 8 nursing (RN).*
Rural Respite Network (RRN)	

% 30-day hospital readmissions among respite users	**15% reduction in 30-day hospital readmissions among respite users**
% cost savings compared to inpatient alternative (bed-days + uncompensated care)	20% in cost savings compared to the inpatient alternative
% respite clients connected to stable housing or longer-term supportive programs	50% of respite clients connected to stable housing or longer-term supportive programs
# average inpatient length of stay for homeless discharges (baseline vs. post-program) (county-level)	2-3-day reduction in average inpatient length of stay for homeless discharges (county-level)
Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund	
# of rural value-based networks in each county per lead-entity (county-level)	**3 new organized rural provider collaborative value-based networks (county-level; 1 per rural county)** *Baseline: 4 counties with hospital-led ACOs; 2 counties with FQHC-led ACOs.*
% annual per-beneficiary TCOC growth for rural populations	≤3% annual per-beneficiary TCOC growth for rural populations compared to baseline *Baseline:4% (FY25).*
% of rural health providers receiving timely, actionable data to support AHEAD goals	90% rural health providers receiving timely, actionable data to support AHEAD goals *Baseline: 0% (pre-AHEAD implementation).*
% reduction in avoidable hospitalizations in funded communities (community-level)	55 per 1,000 residents reduction in avoidable hospitalizations in funded communities (community-level)

The Oversight Team will verify compliance with stated objectives for each initiative and ensure the initiative leaders have the resources and support needed to deliver and report on each initiative's outcomes. The Oversight Team will closely collaborate with the B&F team on the qualitative and quantitative aspects of grant reports. Initiative leaders will collect and report data on spending, timeline, and progress toward goals in quarterly reports. The Oversight Team will lead on analysis, troubleshooting, and annual reporting to CMS.

7. Sustainability Plan

The sustainability of ongoing RHTP oversight will be two-fold. First, the RHTP Stakeholder Advisory Committee will continue under the oversight of the Office of Rural Health. Second, a new SHPDA Advisory Council will be formed to bring together members of rural county SACs into a single, **Rural Health Coordinating Council**. This latter task will be accomplished by the Oversight Team, building on its involvement with the individual SACs of

rural counties. Combined, these two entities will ensure that the impact of the Rural Health Transformation Plan continues and that rural health retains its focus after federal funds cease.

The RHTP Planning Team has carefully developed the proposed initiatives and overall RHTP to ensure lasting change. The RHIN and RVBI Fund initiatives will directly support Hawai‘i’s participation in the CMS AHEAD model, laying the foundation for AHEAD in rural areas and empowering rural communities to continue their changes afterward. The RVBI Fund will enable rural communities to get a head start on value-based care, innovative preventative health programs, and overall cost savings that will be sustained through AHEAD. The shift in the direction of incentives and settings of care made possible by the RHIN and RVBI Fund initiative will guarantee long-term support for the Pili Ola Telehealth Network, RICA, and RRN initiatives, which would otherwise prove unsustainable under traditional funding models. A core feature of the RHTP is the empowerment of rural communities to address their local needs. An RHTP cooperative agreement will enable Hawai‘i to establish critical digital and human infrastructure in rural areas that will enable and embolden rural communities for decades to come. Specific strategies for sustaining each initiative are described below.

Rural Health Information Network (RHIN): The strategy for sustaining EHR modernization and statewide connectivity beyond FY31 focuses on creating lasting infrastructure. The RHTP funding is designed to lay the foundation for statewide interoperability by addressing the largest and most costly barriers: initial installation, replacement of non-interoperable systems, and broadband connectivity. Once these capital-intensive upgrades are complete, the ongoing costs to maintain and optimize the network will be significantly lower.

Cost savings generated through improved care coordination, reduced duplication of services (e.g., redundant lab tests, imaging, and hospital readmissions), and streamlined

administrative workflows will be reinvested in system upkeep and continuous improvement. For example, reductions in avoidable readmissions and improvements in real-time information exchange will ultimately lower overall healthcare system expenditures, allowing providers and health systems to redirect resources toward sustaining and enhancing their EHR capabilities.

The CQIE will be a fully modernized, statewide exchange connecting rural hospitals, FQHCs, Native Hawaiian Health Centers, and private practices to a single interoperable network. Real-time notifications, longitudinal records, and clinical data aggregation will be integrated into provider workflows, reducing duplication and improving care transitions. Beyond FY31, the CQIE will be sustained through a blended model of provider subscription fees, payer contributions, and Medicaid reimbursement for data exchange services, consistent with CMS guidance. As the AHEAD model takes effect, value-based contracts will require reliable data for quality reporting and cost management, creating ongoing demand and financial incentives for participation. Over time, the CQIE will shift from being a grant-funded infrastructure to becoming Hawai‘i’s permanent backbone for health data exchange.

The C-Hub will establish Hawai‘i’s closed-loop referral infrastructure, with rural primary care providers, hospitals, and community organizations trained, onboarded, and using the system to connect patients to housing, food, transportation, and behavioral health resources. Closed-loop referrals will be embedded into everyday practice operations as a standard element of patient care. After PY5, the C-Hub will be sustained through the AHEAD model’s all-payer framework, with Medicaid managed care, Medicare, and commercial payers incorporating social care referrals into value-based contracts. Financial incentives and contractual requirements will ensure that screening and referrals remain an integral part of care delivery. In this way, the C-Hub transitions from a grant-funded program to a permanent feature of Hawai‘i’s healthcare

delivery system, supporting whole-person care and reducing avoidable uses.

The Analytics and Technical Assistance Hub will integrate clinical and claims data, produce statewide dashboards, and provide actuarial modeling and practice support. Rural providers will receive tailored technical assistance to succeed under value-based care, and state agencies will rely on the Hub's analytics to monitor cost, quality, and health outcomes. After FY31, sustainability will be secured by embedding the Hub's services into SHPDA's statutory evaluation responsibilities, with funding from state appropriations, payer contributions, and Medicaid managed care contracts that require analytic support for performance monitoring. Under the AHEAD model, demand for consistent, statewide evaluation and technical assistance will continue to grow, ensuring that the Hub remains an essential, institutionalized function beyond the life of the grant.

Duals Data Dashboard and Support Hub (DDDASH): The data dashboard will create a sophisticated analytics tool using integrated Medicare–Medicaid data that will provide insights into improvements in care, impacts of different D-SNP benefit designs, and strengthened oversight of D-SNPs for improved care. Once developed, it will be integrated into the existing Health Analytics/All-Payer Claims Database. The insights gained will lead to improved efficiencies and effectiveness of various interventions, which will also enable its continued sustainability. The education and navigation trainings will support enrollment in integrated plans such as FIDE-SNPs, and these will help reduce fragmentation and improve outcomes for dually eligible residents. Once the educational materials and trainings are developed and distributed, Med-QUEST will collaborate with SHIP, the health plans, and D-SNPs to update needed materials as part of their regular education, training, and outreach processes. Also, MQD will continue to require in both the contracts with the Medicaid MCOs and the State Medicaid

Agency Contracts the Medicaid program the state has with the D-SNPs, to continue duals-focused navigation, care coordination, and enrollment supports as contract deliverables. Savings from reduced hospitalizations and readmissions will reinforce the case for continued investment, while CMS's emphasis on integrated care for duals ensures ongoing federal support. Once developed, the AI Data Dashboard and enrollment supports will no longer rely on grant funds but will be embedded as a durable part of Hawai'i's Medicaid and health informatics infrastructure.

Pili Ola Telehealth Network: The Pili Ola Network will sustain beyond FY31 through integration with Hawai'i's Medicaid 1115 waiver, value-based contracts, and alignment with AHEAD global budgets. Workforce training will create a durable pipeline of rural providers, while e-consult and telehealth platforms will become self-funded through shared savings and payer reimbursement. By embedding services in schools, community clinics, and local hospitals, the program will ensure long-term stability through a resilient healthcare system.

RICA: The Rural Infrastructure for Care Access (RICA) initiative will ensure long-term sustainability by optimizing existing expenditures and bending the cost curve through a structural shift toward lower-cost, community-based care. By modernizing Hawai'i's emergency medical infrastructure and integrating preventive, team-based services into rural communities, RICA transforms high-cost, episodic usage into coordinated, value-based care delivery. This approach allows the state to reinvest realized savings in ongoing operations, resulting in both fiscal responsibility and lasting system improvement.

The MEDICOM Center's emergency transfer function represents a strategic, time-limited investment that yields both near-term and long-term returns. Within five years, the MEDICOM Center is projected to generate up to $125 million in avoidable healthcare savings through faster coordination, reduced repeat EMS calls, and fewer preventable transfers, building on comparable

outcomes from the Arkansas Trauma System, which achieved $186 million in savings over three years. These savings will offset operational costs and achieve a positive return on investment by the end of the five-year period while existing state EMS emergency preparedness funding mechanisms provide a stable base for ongoing maintenance and staffing. These savings will directly offset costs to maintain the system and generate a positive ROI by FY31, with continuing economic benefit thereafter.

Cost savings from reduced emergency usage will help sustain community-based preventive and behavioral health services through reinvestment under AHEAD's total cost of care structure. By embedding team-based, community-oriented care into Hawai‘i's AHEAD payment models (i.e., value-based contracts, shared-savings arrangements, and outcome-based payments), leveraging existing Medicaid mechanisms, and building workforce and infrastructure within permanent state and university systems, the MEDICOM coordinated community-based care teams will transition from a grant-funded initiative to a sustainable, reimbursable service model that delivers enduring improvements in rural health access, cost efficiency, and outcomes.

HOME RUN: The HOME RUN initiative is a one-time bulk investment to fill out the vast majority of the rural health ecosystem. At the end of the five years, such large-scale investment will not be needed for another 40 years. The remaining gaps in the healthcare workforce will be addressed through smaller, far more specific investments. Ongoing activities will include in-school career awareness through organizations such as HOSA, AHEC, and industry partners, as well as continuing AHEC's existing one-stop phone line for schools needing speakers and connections to industry. Provider incentives will continue through an existing $1,000,000 budget line in the state budget. Such funds will be devoted to filling remaining and emerging holes in the rural health workforce.

Rural Respite Network: Because medical respite is a billable service under Hawai‘i’s 1115 Medicaid waiver beginning in 2026, providers can secure ongoing reimbursement through Med-QUEST Division and its managed care organizations for certain costs relating to medical respite operations. This creates a durable financing stream for day-to-day clinical operations, but it does not automatically cover all associated costs. Supplemental funding remains essential for start-up expenses, workforce development, and non-billable program operations. Hospitals remain critical partners in this model, though their role is primarily in referral coordination, discharge planning, and data-sharing rather than direct financial contributions. Their incentives remain strong: fewer blocked beds, reduced uncompensated care, and improved patient throughput. Likewise, community-based organizations and FQHCs will continue to provide case management, behavioral health, and housing services that complement billable medical care.

The respite program will also be closely aligned with Hawai‘i’s AHEAD demonstration and the Total Cost of Care (TCOC) model. By reducing avoidable hospitalizations, shortening inpatient stays, and improving chronic disease management, respite services directly contribute to lowering overall healthcare expenditures. These savings can be reinvested in the respite network and rural health infrastructure, further reinforcing long-term financial sustainability. RHTP funding will be strategically focused on start-up costs and program evaluation to demonstrate effectiveness. This targeted use of RHTP support, combined with Medicaid billing and integration into AHEAD/TCOC frameworks, positions medical respite as a sustainable and permanent component of Hawai‘i’s rural health system.

Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund: By FY31, most rural hospitals and primary care practices will be operating under value-based payment and delivery models, APCD participation will be universal, and rural analytics will be

institutionalized. Provider networks will sustain themselves through Medicare, Medicaid, and commercial contracts, while community-driven efficiency projects will be integrated into managed care arrangements. Rather than providing continuation funding for RHTP initiatives, the Fund will create incentive structures and needed infrastructure to ensure their long-term financing. Awards will help projects transition RHTP-seeded initiatives into permanent projects supported by value-based contracts. Examples include matching payer contributions during the first two years of adoption, providing transitional budget allowances for hospitals that integrate new services, and funding assistance for providers to establish value-based contracts. This approach will ensure that RHTP investments mature into a sustainable financial stream rather than remaining dependent on short-term grants.

RHTP-seeded initiatives will not be re-funded directly but instead, supported through incentive structures that transition them into permanent financing streams. Examples include: (1) Step-down payer matches where the Fund covers a share of costs in early years (e.g., 50% Year 1, 25% Year 2, 0% Year 3), ensuring health plans gradually assume full responsibility; (2) Performance-contingent payments where matches or bonuses are released only if initiatives meet measurable TCOC or utilization targets; (3) ROI analysis requirements so all matched projects generate actuarial evidence of cost savings by the time Fund support ends; (4) Regulatory hooks enabling successful initiatives to be written into Medicaid managed care contracts or incorporated into hospital global budgets after the match period; and (5) Alignment with AHEAD TCOC accountability, ensuring that preventive services proven to reduce cost growth become indispensable to meeting state and federal benchmarks.

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Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** CMS RHTP HI Budget Narrative.pdf

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State of Hawai‘i CMS Rural Health Transformation Plan Budget Narrative

Admin Cost Note: The State of Hawai‘i’s Rural Health Transformation Plan (RHTP) is comprised of six initiatives and an overarching Oversight Team. The Oversight Team will be housed in the Executive Office of the State of Hawai‘i, which will also be the primary recipient of RHTP funds. All six RHTP initiatives will be carried out by separate state agencies (including the Department of Health, Department of Human Services, State Health Planning and Development Agency, and the University of Hawai‘i).

We estimate current administrative costs to be around $15 million per year, or roughly 7.5% of each year’s total budget. Given limitations on details for all sub-recipient expenses and the challenge that places on identifying specific administrative costs, the State of Hawai‘i will ensure adherence to the statutory 10% administrative cost limit through clauses in the Memoranda of Agreement (MOAs) executed by the Executive Office with each of the RHTP initiative lead state agencies. The Executive Office budgets to receive 2.5% of the total requested budget for its own administrative purposes ($5 million per year for Oversight Team personnel, fringe, consultants, and indirect costs) and will include a clause stipulating that no subrecipient’s total administrative costs may exceed 7.5% of their total award unless negotiated with another initiative lead state agency to receive a portion of the 7.5% of another. This safeguard ensures that the program’s cumulative administrative expenses remain comfortably below the 10% cap (equivalent to $20 million per year). This structure guarantees that the vast majority of RHTP resources directly support service delivery, infrastructure, and measurable rural health outcomes.

Allowable Uses of Funds Note: Following CMS’s Guidance for Preparing a Budget Request and Narrative, sub-awardee budgets are at the category-level of detail. The State of Hawai‘i and its sub-awardees will cooperate with CMS to provide additional detail upon request (e.g., specific sub-awardee line-items) to enable CMS to confirm that all costs are allowable.

A. Personnel Salaries and Wages*

Oversight Team Personnel Note: Funding for these positions is distributed across the FY in which the funds are awarded and the following FY to ensure that the Oversight Team remains in place through the full duration of the RHTP program into 2031. Hence, each budget period requests 1.2 years’ worth of personnel to sustain the team for six years total.

Initiative Supported				Oversight Team, supporting all initiatives		
Position Title / Time	**Annual Salary**	**Budget Period 1 (BP 1)**	**Budget Period 2 (BP 2)**	**Budget Period 3 (BP 3)**	**Budget Period 4 (BP 4)**	**Budget Period 5 (BP 5)**
Project Director / (FTE) JEREMY LAKIN	$225,000	$270,000 (1.2 years)	$270,000 (1.2 years)	$270,000 (1.2 years)	$270,000 (1.2 years)	$270,000 (1.2 years)
Project Manager / (FTE)	$200,000	$240,000 (1.2 years)	$240,000 (1.2 years)	$240,000 (1.2 years)	$240,000 (1.2 years)	$240,000 (1.2 years)
Project Advisor /	$160,000	$192,000	$192,000	$192,000	$192,000	$192,000

* Amounts listed are the requested maximums of salary ranges, with eventual salaries to be determined post-negotiation with CMS.

(FTE)		(1.2 years)	(1.2 years)	(1.2 years)	(1.2 years)	(1.2 years)
Project Advisor / (FTE)	$160,000	$192,000 (1.2 years)	$192,000 (1.2 years)	$192,000 (1.2 years)	$192,000 (1.2 years)	$192,000 (1.2 years)
Project Advisor / (FTE)	$160,000	$192,000 (1.2 years)	$192,000 (1.2 years)	$192,000 (1.2 years)	$192,000 (1.2 years)	$192,000 (1.2 years)
Project Analyst / (FTE)	$130,000	$156,000 (1.2 years)	$156,000 (1.2 years)	$156,000 (1.2 years)	$156,000 (1.2 years)	$156,000 (1.2 years)
Project Analyst / (FTE)	$130,000	$156,000 (1.2 years)	$156,000 (1.2 years)	$156,000 (1.2 years)	$156,000 (1.2 years)	$156,000 (1.2 years)
Project Analyst / (FTE)	$130,000	$156,000 (1.2 years)	$156,000 (1.2 years)	$156,000 (1.2 years)	$156,000 (1.2 years)	$156,000 (1.2 years)
Project Specialist / (FTE)	$100,000	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)
Project Specialist / (FTE)	$100,000	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)
Project Specialist / (FTE)	$100,000	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)
Project Specialist / (FTE)	$100,000	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)
Project Specialist / (FTE)	$100,000	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)
Project Specialist / (FTE)	$100,000	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)	$120,000 (1.2 years)
Project Assistant / (FTE)	$80,000	$96,000 (1.2 years)	$96,000 (1.2 years)	$96,000 (1.2 years)	$96,000 (1.2 years)	$96,000 (1.2 years)
Project Assistant / (FTE)	$80,000	$96,000 (1.2 years)	$96,000 (1.2 years)	$96,000 (1.2 years)	$96,000 (1.2 years)	$96,000 (1.2 years)
Total	$2,055,000	$2,466,000	$2,466,000	$2,466,000	$2,466,000	$2,466,000
Proportion of Requested Funds		1.23%	1.23%	1.23%	1.23%	1.23%

Justifications:

Project Director [JEREMY LAKIN] - Provides overall leadership and strategic direction for HRHTP, ensuring that all initiatives align with CMS objectives, statutory requirements, and the State's health transformation goals. Oversees interagency coordination, fiscal compliance, and performance monitoring across all subrecipients and contractors.

Project Manager - The Project Manager oversees the day-to-day operations of the Oversight Team and supervises project staff. Duties include developing and monitoring project workplans; coordinating timelines and deliverables; managing inter-agency communications; and ensuring project activities are executed in alignment with RHTP goals.

Project Advisors (1-3) - Project Advisors provide expert consultation and guidance to the Oversight Team across clinical, policy, community, and data domains. Advise initiative leads on implementation strategies, evaluation metrics, and sustainability planning to maximize program impact.

Project Analysts (1-3) - Project Analysts are responsible for gathering, managing, and interpreting project data to assess progress and outcomes to ensure accountability, transparency, and continuous quality improvement in the RHTP. Duties include designing and maintaining data systems, analyzing program metrics, preparing progress reports, performing financial and compliance analyses across different initiatives and reporting requirements, and contributing to evaluation activities.

Project Specialists (1-6) - Serve as technical liaisons, facilitators of stakeholder engagement, and/or subject-matter experts for priority focus areas such as telehealth, EMS modernization, behavioral health integration, and data systems. Provide operational support to initiative teams, draft guidance materials, and ensure alignment with federal and state program standards.

Project Assistants (1-2) - Provide comprehensive administrative and logistical support to the Oversight Team, including scheduling, documentation, procurement tracking, and correspondence with CMS and subrecipients. Maintain organized records and facilitate efficient internal operations and communication.

B. Fringe Benefits

Initiative Supported			Oversight Team, supporting all initiatives				
Fringe Benefit	**Rate**	**Total Yearly Salary Requested**	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
Pension Accumulation	22.00%	$2,466,000	$542,520	$542,520	$542,520	$542,520	$542,520
Pension Administration	0.05%	$2,466,000	$1,233	$1,233	$1,233	$1,233	$1,233
Retiree Health Insurance	11.07%	$2,466,000	$272,986	$272,986	$272,986	$272,986	$272,986
Employees' Health Fund	8.59%	$2,466,000	$211,829	$211,829	$211,829	$211,829	$211,829
Workers' Compensation	1.40%	$2,466,000	$34,524	$34,524	$34,524	$34,524	$34,524
Unemployment Compensation	0.07%	$2,466,000	$1,726	$1,726	$1,726	$1,726	$1,726
Social Security	6.20%	$2,466,000	$152,892	$152,892	$152,892	$152,892	$152,892
Medicare	1.45%	$2,466,000	$35,757	$35,757	$35,757	$35,757	$35,757
OPEB	12.45%	$2,466,000	$307,017	$307,017	$307,017	$307,017	$307,017
Total			$1,560,484	$1,560,484	$1,560,484	$1,560,484	$1,560,484
Proportion of Requested Funds			.78%	.78%	.78%	.78%	.78%

The rates for all positions are identical by applying the State of Hawai‘i’s fringe rate.[1]

C. Travel

Initiative Supported				Oversight Team, supporting all initiatives		
Purpose of Travel	**Item**	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
CMS’s Annual RHTP Conference (Washington D.C.)	Airfare	$4,000	$4,000	$4,000	$4,000	$4,000
CMS’s Annual RHTP Conference (Washington D.C.)	Lodging	$4,416	$4,416	$4,416	$4,416	$4,416
CMS’s Annual RHTP Conference (Washington D.C.)	Ground Transportation	$480	$480	$480	$480	$480
CMS’s Annual RHTP Conference (Washington D.C.)	Per Diem / Meals & Incidentals	$1,656	$1,656	$1,656	$1,656	$1,656
Total		$10,552	$10,552	$10,552	$10,552	$10,552
Proportion of Requested Funds		.005%	.005%	.005%	.005%	.005%

Justification: Travel funds are requested to support the RHTP Oversight Team’s participation in the Centers for Medicare & Medicaid Services (CMS) Annual Rural Health Transformation Program (RHTP) Conference in Washington, D.C. each year of the cooperative agreement. Attendance at this meeting is essential to ensure Hawai‘i’s successful implementation of its Rural Health Transformation Plan and continued compliance with CMS guidance. The Oversight Team will send four members to coordinate directly with CMS officials, participate in peer state learning sessions, and present progress on Hawai‘i’s initiatives. Airfare is estimated at $1,000 per person for round-trip economy flights from Honolulu, Hawai‘i, to Washington, D.C., based on recent fare averages and allowing for modest cost variability. Lodging is estimated at $276 per night for 4 nights (FY2026 GSA per-diem rate for Washington, D.C.), totaling $1,104 per traveler. Ground transportation is estimated at $120 per traveler to cover airport transfers, local transit, and ride-share expenses while in D.C. Per Diem (Meals & Incidentals) is estimated at $1,656 for four people across 5 days (FY2026 GSA per-diem rate for Washington, D.C).

D. Equipment: None requested

E. Supplies: None requested

F. Consultant/Subrecipient/Contractual Costs

a. Consultants for the Oversight Team

[1] https://budget.hawaii.gov/wp-content/uploads/2022/06/FM-22-07-Interim-Fringe-Benefit-Rates-for-FY-23.pdf

Initiatives(s) Supported	Supporting the Oversight Team and all Initiatives				
Consultant	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
Consultants	$541,760	$541,760	$541,760	$541,760	$541,760
Total	**$541,760**	**$541,760**	**$541,760**	**$541,760**	**$541,760**
Proportion of Requested Funds	.27%	.27%	.27%	.27%	.27%

Name of Consultant: To be determined. The consultant will be selected based on demonstrated expertise and qualifications relevant to the specific technical or programmatic needs of the RHTP. Qualifications may include advanced subject-matter knowledge, experience in federal or state-level projects, familiarity with rural Hawai‘i, and a proven record of successful project delivery within comparable scope.

Organizational Affiliation: To be determined. The consultant may be an independent contractor or affiliated with a firm, university center, or nonprofit organization that provides specialized expertise relevant to RHTP implementation.

Nature of Services to be Rendered: The consultant will provide specialized technical or programmatic assistance necessary to achieve specific outcomes within the RHTP. The scope of work will include defined tasks and deliverables such as: preparation of technical analyses, facilitation of stakeholder engagement activities, development of implementation frameworks, or other project-specific outputs as detailed in the final statement of work. Deliverables will be outcome-based and tied to measurable project objectives.

Relevance of Service to the Project: The consultants will provide specialized technical, fiscal, and/or analytic expertise essential to achieving the objectives of RHTP. Their work will directly support statewide modernization of health data systems, value-based payment readiness, workforce expansion, and coordinated implementation across multiple agencies and subrecipients. By filling critical short-term capacity gaps or extending Oversight Team expertise in areas such as program evaluation, data analytics, regulatory compliance, and stakeholder engagement, consultants will help ensure that the RHTP achieves measurable outcomes, including improved access to care, increased interoperability, and strengthened rural service delivery.

Number of Days of Consultation: This budget may cover 350–400 total consultant days per year across multiple specialized consultants, including necessary expenses.

Expected Rate of Compensation: Consultants will be compensated at standard market rates ranging between $900–$1,500 per day, not to exceed $558,720 annually in aggregate across all consultant contracts.

Justification of expected compensation rates: The rate is consistent with prevailing market rates for senior consultants providing specialized technical assistance to federally funded state health

programs. Comparable rates for subject-matter experts and program advisors in Hawai‘i and nationally range between $900–$1,500 per day, depending on expertise and scope.

Method of Oversight: The consultant's work will be overseen by the RHTP Project Director or the RHTP Project Director's designee, in coordination with the relevant Project Advisor. Oversight will include review of interim and final deliverables, periodic progress meetings, and milestone-based payment approval. All work products will be reviewed for quality, completeness, and alignment with RHTP objectives before final acceptance.

b. Subrecipient Awardees (Initiatives)

Initiative 1: Rural Health Information Network (RHIN)

Name of Subrecipient: State Health Planning and Development Agency (SHPDA)

Period of Performance: FY26 – FY31

Scope of Work: SHPDA will lead the establishment and statewide rollout of the Rural Health Information Network (RHIN) initiative, which modernizes Hawai‘i's rural health data infrastructure, in coordination with the State's Medicaid office (Med-QUEST Division). SHPDA will procure and manage contracts for electronic health record (EHR) onboarding, in-facility network installations, and interoperability integration for statewide health information exchange. Deliverables include implementation of four RHIN sub-hubs: the Care Quality Information Exchange (CQIE), Community Care Coordination Hub (C-Hub), Analytics & Technical Assistance Hub, and Duals Data Dashboard & Support Hub (DDDASH). Outcomes will include increased data interoperability, expanded closed-loop referrals, and measurable improvements in dual eligible integration, telehealth usage among providers, and value-based readiness.

Method of Oversight: The RHTP Project Director and Oversight Team will oversee SHPDA's implementation of the initiative. RHIN initiative leaders will meet with the RHTP Project Director and relevant members of the Oversight Team monthly. The lead agency (SHPDA) will provide quarterly progress reports and expenditure documentation. RHIN initiative leaders (or their designated representative) will participate in monthly RHTP Stakeholder Advisory Committee meetings, ensuring coordination among initiatives and community leaders, transparency in conduct, and real-time stakeholder feedback on implementation.

Itemized Budget and Justification:

Initiative	**Rural Health Information Network (RHIN)**				
Category	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
A. Personnel	$249,696	$249,696	$249,696	$249,696	$249,696
B. Fringe	$159,954	$159,954	$159,954	$159,954	$159,954
C. Travel	$3,250	$3,250	$3,250	$3,250	$3,250

D. Equipment					
E. Supplies	$7,860	$3,360	$3,360	$3,360	$3,360
F. Consultant/ Subrecipient/Contractual	$45,000,000	$45,000,000	$45,000,000	$45,000,000	$45,000,000
G. Construction					
H. Other	$2,160	$2,160	$2,160	$2,160	$2,160
I. Total Direct	$45,422,920	$45,418,420	$45,418,420	$45,418,420	$45,418,420
J. Indirect Costs	$24,969	$24,969	$24,969	$24,969	$24,969
Total Request	$45,447,889	$45,443,389	$45,443,389	$45,443,389	$45,443,389
Proportion of Requested Funds	23.3%	23.3%	23.3%	23.3%	23.3%

A. Personnel: Personnel funds support three full-time positions (two in SHPDA, one in MQD) for direct RHIN program oversight. These positions ensure SHPDA and MQD maintain full internal capacity to manage procurement, compliance, and technical deliverables under the RHIN initiative.

B. Fringe: Fringe benefits apply at SHPDA's approved composite rate and cover retirement, health insurance, and other employee obligations associated with these positions.

C. Travel: Travel supports SHPDA and MQD staff travel for site visits and oversight on neighbor islands. Activities include monitoring implementation progress, meeting with participating clinics, and verifying technology installations. Travel provides continuous performance verification across dispersed island sites.

E. Supplies: Supplies support administrative and technical operations including telecommunications, office equipment, and IT tools necessary for project management.

F. Subrecipient/Contractual: Contractual costs represent the core RHIN implementation of work conducted via competitive procurements. Each contract supports a discrete pillar of the RHIN architecture. Funds will be executed through competitive contracts to build and support the operation of RHIN's statewide digital infrastructure. Major components include: EHR replacement/upgrade (no more than $10M of which will go toward replacing HITECH Certified EHRs), on-premise-facility network deployment, Care Quality Information Exchange (CQIE), Community Care Coordination Hub (C-Hub), Analytics & Technical Assistance Hub, Duals Data Dashboard and Support Hub (DDDASH).

H. Other: Other costs sustain internet services and secure communications necessary for continuous system oversight.

J. Indirect Cost: A 10% indirect cost rate is applied to cover SHPDA administrative overhead.

Initiative 2: Pili Ola Telehealth Network

Name of Subrecipient: University of Hawai‘i at Mānoa, Social Science Research Institute (SSRI), Telecommunication and Social Informatics Program (TASI)

Period of Performance: FY26 - FY31

Scope of Work: TASI, in the SSRI and with the UH Pacific Basin Telehealth Resource Center (PBTRC), will implement the statewide Pili Ola Telehealth Network initiative to connect rural communities to care through telehealth access points, navigators, and data-driven training and evaluation. TASI will coordinate community telehealth sites, develop training materials, operate the Telehealth Analytics Coordinating Center (TACC), deploy consumer-facing technologies, and expand access to primary, behavioral, and maternal health services through partnerships. Deliverables include operational telehealth access points, a functioning TACC dashboard, and telehealth data integration with the RHIN. Outcomes include increased rural telehealth utilization and reduced travel burden for rural patients.

Method of Oversight: The RHTP Project Director and Oversight Team will oversee TASI's implementation of the initiative. Dr. Christina Higa, Pili Ola initiative leader and director of TASI, will meet with the RHTP Project Director and relevant members of the Oversight Team monthly. The lead agency (TASI) will provide quarterly progress reports and expenditure documentation. Pili Ola initiative leaders (or their designated representatives) will participate in monthly RHTP Stakeholder Advisory Committee meetings, ensuring coordination among initiatives and community leaders, transparency in conduct, and real-time stakeholder feedback on implementation. Oversight will also be managed through the UH Office of Research Services (ORS), which provides centralized review, approval, and monitoring of extramural awards. ORS ensures compliance with federal, state, and institutional requirements through its myGRANT system, fiscal and subrecipient monitoring, and internal controls.

Itemized Budget and Justification:

Initiative	**Pili Ola Telehealth Network**				
Category	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
A. Personnel	$2,500,972	$2,949,414	$3,097,617	$3,250,415	$3,410,486
B. Fringe	$1,459,451	$1,724,247	$1,811,519	$1,901,199	$1,995,472
C. Travel	$69,228	$72,220	$72,476	$72,480	$72,732
D. Equipment					

E. Supplies	$149,762	$65,705	$65,745	$87,790	$65,835
F. Consultant/ Subrecipient/Contractual	$7,945,383	$8,980,075	$9,311,849	$9,666,671	$10,067,388
G. Construction					
H. Other	$100,450	$100,450	$70,450	$10,450	$10,450
I. Total Direct	$12,225,246	$13,892,111	$14,429,656	$14,989,005	$15,622,363
J. Indirect Costs	$275,930	$302,585	$313,432	$324,301	$336,540
Total Request	**$12,501,176**	**$14,194,696**	**$14,743,088**	**$15,313,306**	**$15,958,903**
Proportion of Requested Funds	6.4%	7.3%	7.6%	7.9%	8.2%

A. Personnel: The core team of the Pili Ola Telehealth Network is responsible for statewide coordination, implementation, and oversight of Hawai‘i’s Telehealth Initiative. Key staff include leadership (Principal Investigator and Program Director), telehealth coordinators and navigators, program support, and data analytics personnel. Most personnel directly carry out program activities, and therefore are not administrative. Core responsibilities include convening the Pili Ola Coordinating Council and working groups; developing training for providers, families, and workforce programs; developing telehealth access points; expanding the rural Telehealth Safety Network (maternal, pediatric, behavioral health, chronic disease, and primary care services); implementing shared referral and scheduling systems; unifying statewide telehealth evaluation; advancing performance monitoring and outcome reporting; overseeing tele-ultrasound implementation; and disseminating information about the work under the Telehealth Initiative.

B. Fringe: Fringe costs are calculated using UH’s federally approved rate of 59.5%.[2]

C. Travel: Travel enables project leaders to conduct on-site training, inter-island coordination, and national dissemination of lessons learned.

E. Supplies: Office supplies (paper, toner, outreach materials) for daily operations, training, and reporting; and laptop computers for new and replacement staff to enable telehealth coordination, data collection, analytics, and training activities.

F. Subrecipient/Contractual: The Contractual and Subrecipient component of the Pili Ola Telehealth Network supports the full range of specialized partnerships, vendors, and implementation partners required to establish, operate, and sustain a comprehensive statewide telehealth ecosystem. Contractual services will provide the technical foundation for Hawai‘i’s rural telehealth expansion, encompassing web platform design, program support and evaluation,

[2] https://research.hawaii.edu/ors/resources/rates/

training support, and the development of secure, interoperable systems that link patients, providers, and data networks across all islands. Technical contractors will design and deploy telehealth and remote-patient-monitoring platforms; build and manage the program's central website and public dashboard; and create the analytics and reporting tools needed to evaluate utilization, quality, and outcomes. Specialized consultants will lead system architecture, AI-assisted data management, and customer relationship management (CRM) tools to streamline provider engagement, track training participation, and coordinate telehealth site performance. Training contractors will develop and deliver curriculum for rural healthcare workers, digital navigators, and telehealth coordinators, ensuring providers and patients alike are equipped to use emerging technologies effectively. Subrecipients—including hospitals, Federally Qualified Health Centers, rural clinics, and community organizations—will implement telehealth access points, maternal and behavioral-health telehealth programs, and remote-monitoring services for chronic-disease management. These partnerships will provide essential infrastructure, clinical staffing, and outreach capacity to extend care to isolated areas. Collectively, these contractual and subrecipient relationships will operationalize the Pili Ola Telehealth Network's core goals: expanding equitable access to virtual care, strengthening Hawai‘i's digital health infrastructure, integrating data into the Rural Health Information Network (RHIN), and building the statewide capacity necessary to sustain telehealth as a permanent component of the rural healthcare delivery system. Contracts and Subrecipient awards will be engaged following State procurement law and applicable regulations.

H. Other: Includes essential tools and minimal operational costs to support communication, outreach, and training statewide. Funds cover limited conference space rental for stakeholder engagement and dissemination, software and collaboration platforms (Microsoft Teams, Zoom licenses) for secure coordination and virtual meetings, and a Learning Management System to host telehealth training and track participation.

J. Indirect Cost: A 5% indirect rate supports UH's oversight, compliance, and fiscal management.

Initiative 3: Rural Infrastructure for Care Access (RICA)

Name of Subrecipient: Hawai‘i State Department of Health (DOH)

Period of Performance: FY26–FY31

Scope of Work: Through the Rural Infrastructure for Care Access (RICA) initiative, DOH will modernize Hawai‘i's emergency and trauma coordination systems through the establishment of the MEDICOM Center and deploy preventive, behavioral, and chronic-disease care into rural communities. The subrecipient will implement EMS fleet modernization, upgrade communication and data systems, deploy community paramedicine, mobile clinics, and/or behavioral health outreach teams, and improve preventative facilities. Deliverables include operationalization of the MEDICOM hub, fleet replacement, and measurable reductions in transfer times, repeat EMS calls, and avoidable ED visits.

Method of Oversight: The RHTP Project Director and Oversight Team will oversee DOH's implementation of the initiative. RICA initiative leaders will meet with the RHTP Project Director and relevant members of the Oversight Team monthly. The lead agency (DOH) will provide quarterly progress reports and expenditure documentation. RICA initiative leaders (or their designated representative) will participate in monthly RHTP Stakeholder Advisory Committee meetings, ensuring coordination among initiatives and community leaders, transparency in conduct, and real-time stakeholder feedback on implementation.

Itemized Budget and Justification:

Initiative	**Rural Infrastructure for Care Access (RICA)**				
Category	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
A. Personnel	$7,272,000	$7,278,900	$7,648,528	$7,868,505	$8,099,482
B. Fringe	$4,326,840	$4,330,946	$4,550,874	$4,681,760	$4,819,192
C. Travel	$50,000	$50,000	$50,000	$50,000	$40,000
D. Equipment	$19,428,000	$13,848,500	$6,928,500	$4,481,000	$2,161,000
E. Supplies	$95,000	$87,000	$87,000	$87,000	$87,000
F. Consultant/ Subrecipient/Contractual	$24,886,903	$23,862,077	$29,214,651	$30,723,527	$31,046,600
G. Construction	-	-	-	-	-
H. Other	$7,165,000	$7,095,000	$8,095,000	$8,095,000	$9,070,000
I. Total Direct	$63,223,743	$56,552,423	$56,574,553	$55,986,792	$55,323,274
J. Indirect Costs	$587,192	$587,342	$616,820	$634,363	$652,284
Total Request	**$63,810,935**	**$57,139,765**	**$57,191,373**	**$56,621,155**	**$55,975,558**
Proportion of Requested Funds	32.7%	29.3%	29.3%	29.0%	28.7%

A. Personnel: Personnel costs fund the Department of Health (DOH) and county-based teams implementing the Hawai‘i Medical Communications (MEDICOM) Center, EMS modernization, and community-based care delivery. Positions include program directors, operations managers, EMS regional coordinators, clinical advisors, data and logistics specialists, and administrative support staff, as well as frontline service providers such as community paramedics, community health workers (CHWs), behavioral-health clinicians, pharmacists, and outreach team members. Most personnel directly carry out program activities, and therefore are not administrative. These staff ensure the coordinated operation of the MEDICOM Center, oversight of fleet assets, and management of rural mobile clinics and home-based services. The inclusion of community paramedicine and outreach personnel directly supports RICA’s second strategic prong: expanding preventive and chronic-disease care in community settings to reduce unnecessary 911 calls, emergency department visits, and inter-island transfers. All positions are essential to operating, maintaining, and evaluating the statewide emergency-to-community care continuum.

B. Fringe: Fringe benefits are calculated at an average rate of 59.5%, consistent with DOH policy.

C. Travel: Travel funds support inter-island and rural site operations, including MEDICOM system installation, fleet inspections, staff training, and community-care coordination. Travel is required for EMS modernization workshops, preventive-care team deployments, and stakeholder meetings on Hawai‘i, Maui, Kaua‘i, Moloka‘i, and O‘ahu. Costs cover airfare, ground transportation, and lodging consistent with State policy. Travel ensures access to oversight, training, and services for all rural counties.

D. Equipment: Equipment purchases represent one-time investments to modernize Hawai‘i’s emergency and community-care infrastructure to enable real-time coordination, faster transfer decisions, and seamless data flow between rural providers, hospitals, and public-safety networks. Major procurements include: (1) Fleet modernization: replacement of aging ambulances, rapid-response vehicles, and mobile medical units with tech-enabled units that meet federal safety standards and include telehealth, GPS, and bi-directional data-exchange capabilities**;** (2) Communications infrastructure: CAD-to-CAD interoperability systems, MEDICOM servers, dispatch consoles, hospital-capacity dashboards, and rural-facility communications upgrades; and (3) Connectivity hardware: Starlink satellite systems and signal boosters for continuous communication among rural ambulances, mobile clinics, and the MEDICOM hub.

E. Supplies: Supplies include clinical and operational materials required to support the mobile and community-based workforce. Examples include basic medical consumables, diagnostic kits, PPE, and patient-education materials for mobile and in-home visits. Administrative and training supplies cover printed protocols, outreach materials, and workshop resources for EMS and community-health personnel. Software licenses and maintenance costs under $10,000 per item are also charged here.

F. Subrecipient/Contractual: This category funds competitively procured contracts and subawards to implement RICA’s statewide system, including the following. (1) County EMS agencies: fleet operations, vehicle maintenance, and MEDICOM system integration. (2) Hospitals, FQHCs, and behavioral-health providers: facility improvements for preventive care and operation of community-paramedicine programs, mobile clinics, and crisis-response teams. (3) Technology: CAD-system integration, Starlink connectivity, and cybersecurity support. (4) Consultant experts: population-health analytics, performance monitoring, and technical assistance. Awards will be performance-based, with measurable deliverables tied to outcomes such as reduced transfer times, decreased repeat 911 calls, increased preventive-care utilization, and improved chronic-disease control.

H. Other: Other direct costs include minor renovations and retrofitting necessary for MEDICOM command-center operations, EMS station improvements, mobile-clinic housing, and small behavioral-health facility updates such as dispatch offices, charging bays, and crisis-stabilization rooms. These improvements are limited, incidental, and essential to program performance rather than stand-alone construction projects. Additional costs include training and certification for EMS personnel, community health workers, pharmacists, and behavioral-health staff; community education and public-awareness campaigns promoting preventive care and appropriate 911 use; and software and data-sharing licenses, maintenance, and subscriptions supporting MEDICOM and interoperability platforms. Funds also support evaluation, communications, and annual

reporting activities used to track outcomes and keep stakeholders informed. Together, these costs ensure that RICA's statewide emergency-to-community health infrastructure functions safely, efficiently, and sustainably.

J. Indirect Cost: A 10% indirect rate supports administrative overhead and cross-departmental coordination.

Initiative 4: HOME RUN (Hawaii Outreach for Medical Education in Rural Under-resourced Neighborhoods)

Name of Subrecipient: University of Hawai'i John A. Burns School of Medicine (JABSOM)

Period of Performance: FY26–FY31

Scope of Work: UH JABSOM will administer the HOME RUN initiative to expand Hawai'i's rural health workforce through introducing new rural high school health certificate training and mentoring programs, developing new residency training opportunities, and expanding provider wellness and mentoring programs to promote retention. HOME RUN will introduce new scholarships and a provider incentive program which require a 5-year commitment to working in rural Hawai'i. Outcomes include five new rural residency training programs, a 10% decrease in healthcare worker vacancy rates, the placement of at least 1,000 new rural healthcare workers, and cumulative working years of healthcare worker or provider service committed to serving rural communities.

Method of Oversight: The RHTP Project Director and Oversight Team will oversee UH JABSOM's implementation of the HOME RUN initiative. HOME RUN initiative leaders, Dr. Kelley Withy and Dr. Lee Buenconsejo-Lum, will meet with the RHTP Project Director and relevant members of the Oversight Team monthly. The lead agency (UH JABSOM) will provide quarterly progress reports and expenditure documentation. HOME RUN initiative leaders (or their designated representatives) will participate in monthly RHTP Stakeholder Advisory Committee meetings, ensuring coordination among initiatives and community leaders, transparency in conduct, and real-time stakeholder feedback on implementation.

Itemized Budget and Justification:

Initiative	**HOME RUN**				
Category	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
A. Personnel	$1,015,666	$1,413,806	$1,630,875	$1,666,925	$1,522,013
B. Fringe	$604,321	$841,215	$970,371	$991,821	$905,597
C. Travel	$65,000	$65,000	$65,000	$65,000	$65,000

D. Equipment					
E. Supplies	$ 44,000	$ 44,000	$ 44,000	$ 44,000	$ 44,000
F. Consultant/ Subrecipient/Contractual	$23,167,063	$22,517,778	$22,154,242	$22,093,867	$22,336,560
G. Construction					
H. Other	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000
I. Total Direct	$44,896,050	$44,881,799	$44,864,488	$44,861,613	$44,873,170
J. Total Indirect	$103,950	$118,201	$135,512	$138,387	$126,830
Total Request	**$45,000,000**	**$45,000,000**	**$45,000,000**	**$45,000,000**	**$45,000,000**
Proportion of Requested Funds	23.1%	23.1%	23.1%	23.1%	23.1%

A. Personnel: Personnel funds support UH JABSOM staff coordinating and operating high school health programs, residencies, and workforce retention initiatives statewide. Most personnel directly carry out program activities, and therefore are not administrative.

B. Fringe: Fringe costs use UH's Fringe rate of 59.5%.

C. Travel: Travel expenses support inter-island and neighbor-island coordination efforts, including participation in training sessions, outreach activities at rural schools and hospitals, and attendance at workforce development summits.

E. Supplies: Supplies include healthcare guidebooks, educational materials, and resources for workshops and clinical training.

F. Subrecipient/Contractual: Contractual funds under the HOME RUN initiative support a portfolio of competitively procured and subawarded projects administered by the University of Hawai'i John A. Burns School of Medicine (JABSOM) to expand Hawai'i's rural health workforce pipeline from high school through residency and professional practice. These contracts fund the development of 20 new rural high school health-certificate and vocational programs; support teacher training, travel, and substitute coverage; and enable schools to establish or strengthen Health Occupations Students of America (HOSA) chapters. Additional agreements provide ECHO (Extension for Community Healthcare Outcomes) tele-mentoring sessions, wellness campaigns, and community meetings that improve professional skills and workforce resilience in isolated communities. Subrecipient awards to rural hospitals, university-affiliated clinical sites, and health systems support the creation of at least five new rural residency programs and multiple rural training tracks, including one new primary-care residency on a neighbor island. Other contracts provide scholarships and incentive payments for rural-

serving providers and students who commit to at least five years of rural service, as well as temporary housing and start-up support for new hires, residents, and trainees. Each contract includes defined deliverables—such as numbers of programs created, residents trained, scholarships awarded, and providers retained—and will be performance-monitored through quarterly reports to JABSOM's HOME RUN Steering Committee and the statewide RHTP Oversight Team. These subrecipient and contractual funds are essential to achieving measurable workforce outcomes: the training of 1,000 new rural healthcare workers, 2,500 years of committed rural service, and a 10% reduction in healthcare-worker vacancy rates across Hawai'i by FY31.

UH JABSOM will create a HOME RUN Steering Committee to oversee the entire HOME RUN initiative, develop the criteria for scholarships and incentives, and review/approve the scholarship and incentive awards. JABSOM will also hold quarterly HOME RUN key partner meetings, comprised of the leads of each subaward, and establish a written quarterly reporting structure to ensure all activities and initiatives are aligned to meet HOME RUN and larger RHTP outcomes.

H. Other: Scholarships for future healthcare workers who commit to serving rural communities, including the following tracks: nursing, nurse practitioner, medical or licensed clinical social workers, psychologists or other behavioral therapists; physician assistant (future), physical therapist (future), numerous allied health professions (e.g., community health workers, medical laboratory technicians, medical technologists, dental assistants, radiology technicians, respiratory therapists, pharmacy technicians, EMT, MICT, occupational therapy assistants, physical therapy assistants, speech-language pathologists) and physicians.

J. Indirect Cost: A 5% indirect rate supports UH's oversight, compliance, and fiscal management.

Note: funds from the other initiatives unable to be expended in a timely fashion will be reallocated into rural workforce incentive payments to further remedy the state's rural healthcare workforce shortage.

Initiative 5: Rural Respite Network (RRN)

Name of Subrecipient: Department of Human Services

Period of Performance: FY26–FY31

Scope of Work: As the lead subrecipient, the Department of Human Services (DHS) will establish and oversee a statewide network of rural medical respite sites that provide short-term residential care for individuals recovering from hospitalization who lack stable housing or sufficient home supports. DHS will contract with rural hospitals, FQHCs, and community partners to operate these programs, ensuring that each site delivers integrated medical, behavioral health, and case management services that support recovery and stability. The department will align respite operations with Medicaid and housing programs, link sites to the Rural Health Information Network (RHIN) for data sharing and referrals, and track key outcomes such as hospital readmissions, emergency department utilization, and successful discharge to permanent

housing. Through these coordinated efforts, DHS will strengthen the continuum between health care and housing, reduce avoidable hospital use, and improve health and social outcomes for vulnerable rural residents.

Method of Oversight: The RHTP Project Director and Oversight Team will oversee DHS's implementation of the Rural Respite Network (RRN) initiative. RRN initiative leader, Joseph Campos (Deputy Director of the Department of Human Services), will meet with the RHTP Project Director and relevant members of the Oversight Team monthly. The lead agency (DHS) will provide quarterly progress reports and expenditure documentation. RRN initiative leaders (or their designated representatives) will participate in monthly RHTP Stakeholder Advisory Committee meetings, ensuring coordination among initiatives and community leaders, transparency in conduct, and real-time stakeholder feedback on implementation.

Itemized Budget and Justification:

Initiative	**Rural Respite Network (RRN)**				
Category	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
A. Personnel					
B. Fringe					
C. Travel					
D. Equipment					
E. Supplies					
F. Consultant/ Subrecipient/Contractual	$3,235,000	$8,209,650	$7,609,650	$7,609,650	$7,609,650
G. Construction					
H. Other					
I. Total Direct	$3,235,000	$8,209,650	$7,609,650	$7,609,650	$7,609,650
J. Total Indirect	$5,000	$12,500	$12,500	$12,500	$12,500
Total Request	**$3,240,000**	**$8,222,150**	**$7,622,150**	**$7,622,150**	**$7,622,150**
Proportion of Requested Funds	1.7%	4.2%	3.9%	3.9%	3.9%

F. Subrecipient/Contractual: Contractual funds under the Rural Respite Network (RRN) will support the Hawai'i Department of Human Services (DHS) in executing competitively procured

subawards with qualified nonprofit and healthcare provider organizations experienced in delivering medical respite and supportive housing services in each county.[3] Each contract will be awarded to an organization that demonstrates the capacity to operate licensed, medically supervised respite facilities with integrated clinical and case management functions. Contracts will span the full RHTP period of performance, beginning in FY26 and continuing beyond FY30, with site-specific durations based on readiness and capacity: Hawai‘i County (40-bed site), Kaua‘i County (30-bed site), Maui County (50-bed site), Wai‘anae (40-bed site), and a second Hawai‘i County expansion site (50 beds). Each facility requires a $200,000 start-up cost. Service costs average $8,500–$10,000 per month, per bed. Respites are anticipated to average 87% occupation, and 75% of users will be reimbursed by Medicaid after the beginning of its 1115 Waiver in Q1 2026. Hence, Medicaid is anticipated to reimburse 65.25% of costs.

Each contracted organization will establish and operate a 24/7 medical respite facility that provides comprehensive, wraparound services for medically fragile or unhoused individuals who are stable for discharge but lack a safe recovery environment. Clinical components will include on-site nursing supervision, wound care, medication management, behavioral health support, and medication-assisted treatment (MAT), while case management services will encompass housing navigation, benefits enrollment, and coordination with primary care and chronic disease management providers.

All contractors will report monthly financial and performance data to the RRN initiative lead or initiative lead designee, including patient admissions, demographics, services rendered, and linkage outcomes, and will participate in integration with the Rural Health Information Network (RHIN) to ensure referrals and outcomes are tracked electronically in real time. Deliverables include fully operational respite facilities with the designated bed capacities, quarterly financial and performance reports to the RHTP Oversight Team, and annual evaluations demonstrating cost savings, reduced hospital readmissions, decreased inpatient length of stay, and successful housing placements. Oversight will be performed by DHS through site visits and progress reviews.

J. Indirect Cost: A 10% indirect rate, up to the MTDC base, supports DHS oversight, contract administration, and performance monitoring.

Initiative 6: Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund

Name of Subrecipient: State Health Planning and Development Agency (SHPDA).

Period of Performance: FY26–FY31

Scope of Work: John Lewin, SHPDA Administrator, will administer the Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund with other members of the Rural Innovation Council: Judy Mohr Peterson, Hawai‘i Med-QUEST Division Administrator (MQD), Roger Scott Daniels, Department of Health’s Office of Rural Health, and Jeremy Lakin, RHTP Project Director. The Rural Innovation Council will also seek the advice of the AHEAD Steering Committee in reviewing applications and progress. The initiative will support the development

[3] No funds awarded by this contract or any other can replace payment for clinical services that could be reimbursed by insurance.

of rural provider networks and transitions to value-based payment models. The subrecipient will issue competitive subawards to rural providers for payment model redesign, data integration, and population health management projects. Deliverables include three county-level rural provider collaboratives, shared analytics tools, and documented reductions in per-beneficiary cost growth and avoidable hospitalizations.

Method of Oversight: The RHTP Project Director and Oversight Team will oversee SHPDA and the Rural Innovation Council's execution of the RVBI fund. Members of the Rural Innovation Council will meet with the RHTP Project Director and relevant members of the Oversight Team monthly. The lead agency (SHPDA) will provide quarterly progress reports and expenditure documentation. RVBI initiative leaders (or their designated representatives) will participate in monthly RHTP Stakeholder Advisory Committee meetings, ensuring coordination among initiatives and community leaders, transparency in conduct, and real-time stakeholder feedback on implementation.

Itemized Budget and Justification:

Initiative	**Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund**				
Category	**BP 1**	**BP 2**	**BP 3**	**BP 4**	**BP 5**
A. Personnel					
B. Fringe					
C. Travel					
D. Equipment					
E. Supplies					
F. Consultant /Subrecipient/Contractual	$25,000,000	$25,000,000	$25,000,000	$25,000,000	$25,000,000
G. Construction					
H. Other					
I. Total Direct	$25,000,000	$25,000,000	$25,000,000	$25,000,000	$25,000,000
Proportion of Requested Funds	12.8%	12.8%	12.8%	12.8%	12.8%

F. Subrecipient/Contractual: This category constitutes the full cost of the RVBI & AHEAD Readiness Fund, which will issue competitive subawards to rural providers, hospitals, payers, and community organizations implementing projects that accelerate the transition to value-based

care. SHPDA will procure Requests for Applications each year. All applications must include a TCOC and Population Health Impact Statement, demonstrate alignment with at least two AHEAD areas of focus, demonstrate fiscal responsibility, and include a sustainability plan. Applications will be competitively scored on AHEAD alignment, TCOC/population-health impact, sustainability, fiscal soundness, and feasibility. See the Project Narrative for examples of allowable uses. The Fund will prioritize payment mechanisms incentivizing providers or ACOs to reduce health care costs, improve quality of care, and shift care to lower-cost settings and value-based programs that have a pathway to include two-sided risk and are supported by evidence to suggest programs will change patient and provider behavior. The Rural Innovation Council will cross-check all applications against existing RHTP-funded and AHEAD-funded initiatives and reject proposals that duplicate already-funded projects. The Rural Innovation Council will observe a minimum rural allocation rule whereby ≥70% of awards must flow to neighbor island counties. All subrecipient awards will include clear deliverables and performance metrics tied to cost containment, quality improvement, and population-health outcomes. Fund recipients will be required to submit detailed work plans, performance baselines, and quarterly progress reports to SHPDA demonstrating measurable outcomes such as reductions in per-beneficiary cost growth, improved quality performance, and decreased preventable hospitalizations. SHPDA will conduct mid-year and annual reviews. Closeout oversight includes final performance reports, fiscal reconciliations, and evidence of sustainability, such as payer match adoption and Medicaid contract inclusion.

F. **Construction**: None requested

H. **Other**: None requested

I. **Total Direct Costs**

Category	BP 1	BP 2	BP 3	BP 4	BP 5
A. Personnel	$2,466,000	$2,466,000	$2,466,000	$2,466,000	$2,466,000
B. Fringe	$1,560,484	$1,560,484	$1,560,484	$1,560,484	$1,560,484
C. Travel	$10,552	$10,552	$10,552	$10,552	$10,552
D. Equipment					
E. Supplies					
F. Consultant/ Subrecipient/Contractual	$195,541,760	$195,541,760	$195,541,760	$195,541,760	$195,541,760
G. Construction					
H. Other					

Total	**$199,578,796**	**$199,578,796**	**$199,578,796**	**$199,578,796**	**$199,578,796**

J. Indirect Costs

The rate is 10% and is computed on the following direct cost base of $4,212,036.

Category	BP 1	BP 2	BP 3	BP 4	BP 5
A. Personnel	$2,466,000	$2,466,000	$2,466,000	$2,466,000	$2,466,000
B. Fringe	$1,560,484	$1,560,484	$1,560,484	$1,560,484	$1,560,484
C. Travel	$10,552	$10,552	$10,552	$10,552	$10,552
F. Consultant/ Subrecipient/Contractual	$175,000	$175,000	$175,000	$175,000	$175,000
Total Indirect Costs	**$421,204**	**$421,204**	**$421,204**	**$421,204**	**$421,204**

Total Request

Category	BP 1	BP 2	BP 3	BP 4	BP 5
A. Personnel	$2,466,000	$2,466,000	$2,466,000	$2,466,000	$2,466,000
B. Fringe	$1,560,484	$1,560,484	$1,560,484	$1,560,484	$1,560,484
C. Travel	$10,552	$10,552	$10,552	$10,552	$10,552
D. Equipment					
E. Supplies					
F. Consultant/ Subrecipient/Contractual	$195,541,760	$195,541,760	$195,541,760	$195,541,760	$195,541,760
G. Construction					
H. Other					
I. Total Direct	$199,578,796	$199,578,796	$199,578,796	$199,578,796	$199,578,796
J. Total Indirect	$421,204	$421,204	$421,204	$421,204	$421,204
Total Request	**$200,000,000**	**$200,000,000**	**$200,000,000**	**$200,000,000**	**$200,000,000**

5-Year Total Request: $1 billion

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

OMB Number: 4040-0013
Expiration Date: 06/30/2028

1. * Type of Federal Action:

- [ ] a. contract
- [ ] b. grant
- [x] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:

- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:

- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name:* Executive Office of the State of Hawaii

** Street 1:* 415 S Beretania St Fl 5 *Street 2:* Fl 5

** City:* Honolulu *State:* HI: Hawaii *Zip:* 96813-2407

Congressional District, if known: HI-001

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

DHHS, CMS

7. * Federal Program Name/Description:

Rural Health Transformation Program

Assistance Listing Number, *if applicable:* 93.798

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: ** First Name:* Non-Applicable *Middle Name:*

** Last Name:* Non-Applicable *Suffix:*

** Street 1:* Non-Applicable *Street 2:*

** City:* Non-Applicable *State:* *Zip:*

b. Individual Performing Services (including address if different from No. 10a)

Prefix: ** First Name:* Non-Applicable *Middle Name:*

** Last Name:* Non-Applicable *Suffix:*

** Street 1:* Non-Applicable *Street 2:*

** City:* Non-Applicable *State:* *Zip:*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix:* ** First Name:* Mark *Middle Name:*

** Last Name:* Anderson *Suffix:*

Title: **Telephone No.:** [redacted] **Date:** Completed on submission to Grants.gov

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Project/Performance Site Location(s)

Project/Performance Site Primary Location

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Executive Office of the State of Hawaii

UEI: L1SGJ7LKJKT3

* Street1: 415 S Beretania St

Street2: Fl 5

* City: Honolulu

County:

* State: HI: Hawaii

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 96813-2407

* Project/ Performance Site Congressional District: HI-001

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Hawaii State Health Planning and Development Agency

UEI:

* Street1: 1177 Alakea St

Street2: #402

* City: Honolulu

County:

* State: HI: Hawaii

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 96813-2800

* Project/ Performance Site Congressional District: HI-001

Project/Performance Site Location 2

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: University of Hawaii at Manoa, TASI

UEI:

* Street1: 2424 Maile Way

Street2: Saunders Hall 704

* City: Honolulu

County:

* State: HI: Hawaii

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 96822-2223

* Project/ Performance Site Congressional District: HI-001

Project/Performance Site Location(s)

Project/Performance Site Location 3

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Hawaii State Department of Health

UEI:

* Street1: 1250 Punchbowl St

Street2:

* City: Honolulu County:

* State: HI: Hawaii

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 96813-2416 * Project/ Performance Site Congressional District: HI-001

Project/Performance Site Location 4

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: University of Hawaii John A. Burns School of Medicine

UEI:

* Street1: 651 Ilalo St

Street2:

* City: Honolulu County:

* State: HI: Hawaii

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 96813-5525 * Project/ Performance Site Congressional District: HI-001

Project/Performance Site Location 5

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Hawaii State Department of Human Services

UEI:

* Street1: 1390 Miller St

Street2: Room 209

* City: Honolulu County:

* State: HI: Hawaii

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 96813-2403 * Project/ Performance Site Congressional District: HI-001

Additional Location(s) Add Attachment Delete Attachment View Attachment

Other Attachment File(s)

*** Mandatory Other Attachment Filename:** SF-424a Sheet 2.pdf

Add Mandatory Other Attachment | Delete Mandatory Other Attachment | View Mandatory Other Attachment

To add more "Other Attachment" attachments, please use the attachment buttons below.

Add Optional Other Attachment | Delete Optional Other Attachment | View Optional Other Attachment

BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 06/30/2028

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Assistance Listing Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Opportunity No. CMS-RHT-26-001 (Year 5)	93.798	$	$	$ 200,000,000.00	$	$ 200,000,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 200,000,000.00	$	$ 200,000,000.00

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SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1)	(2)	(3)	(4)	(5)
	Opportunity No. CMS-RHT-26-001 (Year 5)				
a. Personnel	$ 2,466,000.00	$	$	$	$ 2,466,000.00
b. Fringe Benefits	1,560,484.00				1,560,484.00
c. Travel	10,552.00				10,552.00
d. Equipment					
e. Supplies					
f. Contractual	195,541,760.00				195,541,760.00
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a-6h)	199,578,796.00				$ 199,578,796.00
j. Indirect Charges	421,204.00				$ 421,204.00
k. TOTALS (sum of 6i and 6j)	$ 200,000,000.00	$	$	$	$ 200,000,000.00
7. Program Income	$	$	$	$	$

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SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Opportunity No. CMS-RHT-26-001 (Year 5)	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Opportunity No. CMS-RHT-26-001 (Year 5)	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges: 10% rate, calculated on MTDC of base $4,212,036

23. Remarks:

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CMS Business Assessment of Applicant Organization

Applicants review and answer the business assessment questions outlined below. There are eleven (11) topic areas labeled A-K, with a varying number of questions within each topic area. **Applicants MUST provide a brief substantive answer to each question (and supporting documentation, as applicable. Singular web links are not acceptable.)** If the answer to any question is not-applicable, please provide an explanation.

Please note: If CMS cannot complete its review without contacting the applicant for additional clarification, the applicant risks selection for award.

The Executive Office of the State of Hawai‘i is a unit of the Hawai‘i State Government and, as such, is subject to the rules and regulations of the State. Our answers below will reference these relevant and applicable State laws and regulations.

A. General Information

1. Provide organization's:
   a. Legal name: Executive Office of the State of Hawai‘i
   b. EIN (include PMS prefix and suffix, if applicable-ex. **1**-12356789-**A1)**: 990275730
   c. Organizational type: State government

2. What percentage of your organization's capital is from Federal funding? (percentage = total Federal funding received in previous fiscal year/organization's total gross revenue in previous fiscal year).
   According to the State of Hawai‘i, The Fiscal Biennium 2025-2027, Budget in Brief, 2024, p.4 (or p.31 of 171 in pdf), 20.6% of the State of Hawai‘i's operating budget for State FY 2026 is from federal funds.

3. Does/did your organization receive additional oversight (examples include: Correction Action Plan, Responsibility and Qualification (R/Q) findings, reimbursement payments for enforcement actions) from a Federal agency within the past 3 years due to past performance or other programmatic or financial concerns with the organization?
   a. If yes, please provide the following information: Name of the Federal agency and the reason for the additional oversight as explained by the Federal agency
   b. If resolved, please indicate how the issue was resolved with the Federal agency.
   The Executive Office of the State of Hawai‘i has not received additional oversight from a Federal agency within the past 3 years due to past performance or other programmatic or financial concerns.

4. Does your organization currently manage grants with other U.S. Department of Health and Human Services components or other Federal agencies?
   Yes, the Executive Office of the State of Hawai‘i currently manages grants with other Federal agencies. These include $80,184,413.30 for Emergency Rental Assistance #2 (completed); $1,641,602,609.60 for Coronavirus State & Local

Fiscal Recovery Funds (active); $149,484,493.57 for Broadband Equity, Access and Deployment (active); $115,475,318.00 for Capital Projects Fund (active); and $50,000,000.00 for Homeowners Assistance Funds (active). The Executive Office has also previously managed other such grants that have since been closed, such as $125,432,511.11 for Emergency Rental Assistance #1.

5. Explain your organization's process to ensure annual renewal in SAM.gov, including R/Q and Reps and Certs.

   The Executive Office of the State of Hawai'i currently has three individuals assigned the "Entity Administrator" role. These three individuals receive a reminder email from donotreply@sam.gov sixty (60) days before the expiration of the Executive Office of the State of Hawai'i's entity registration in SAM.gov. Once this email is received, one of the entity administrators is internally assigned to renew the registration. They begin a request to renew the registration in SAM.gov and receive a confirmation email from donotreply@sam.gov when it has been submitted. The request remains in "submitted" status until all external validations are completed. All three entity administrators receive emails from donotreply@sam.gov when (a) the external validations are successful and (b) the renewed registration is activated. The next annual renewal date for the Executive Office of the State of Hawai'i is August 12, 2026.

6. Explain your organization's process to comply with (a) 2 CFR 200.113 "Mandatory Disclosures" and (b) your organization's process to comply with FFATA requirements.

   Under 2 CFR § 200.113, "mandatory disclosures" require applicants, recipients, and subrecipients of a federal award to report credible evidence of certain violations to the awarding agency in a timely, written manner. To meet the requirements of 2 CFR § 200.113, the Executive Office of the State of Hawai'i will:

   1. Include the "mandatory disclosure requirement" in all agreements for subrecipients and contracts;
   2. Work with the Department of Attorney General and the State Ethics Commission, who currently and will continue to maintain an email and phone hotline to allow individuals to report waste, fraud, and abuse. Detailed information on how to use the hotlines is available to all employees.

   The Executive Office of the State of Hawai'i also has established controls and procedures to ensure that FFATA requirements are met. When a subaward amount is equal to or exceeds $30,000, a FFATA subaward report is filed on SAM.gov no later than the end of the month following the month in which the subaward agreement is fully executed. If the initial subaward amount is less than $30,000, a FFATA subaward amount is not filed until the cumulative subaward amount is equal to or exceeds $30,000. Information contained in the executed subaward agreement is used to file the report. For more detailed information, see the FFATA Sub-award Reporting Requirements for Prime Awardees (May 25, 2012).

7. Do you have conflict of interest policies? Does your organization or any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds? If yes, please explain and provide a mitigation plan.

   Every Hawai‘i state employee is subject to the state ethics code, which prohibits employees from taking any official action directly affecting a business in which the employee either has a financial interest or is engaged in some agency capacity. Employees are also prohibited from developing new financial interests in any business that may be affected by their official actions (HRS § 84-14). We are not aware of any employee who will be working on this grant who has a conflict of interest related to these funds. If one does, they would be required under the ethics code to report it, and we would then bring that to the attention of relevant state officials and CMS for resolution.

8. Does your organization currently, or in the past, have delinquent Federal debt in the last 3 years? If yes, please explain.

   No, we do not and have not in the past.

9. Have you filed bankruptcy or entered into proceedings for bankruptcy, whether voluntarily or involuntarily?

   No, we have not.

10. Has your organization obtained fidelity bond insurance coverage for responsible officials and employees of the organization in amounts required by statute or organization policy? What is that amount?

    This is not applicable. No statute or organizational policy dictates the purchase of fidelity bonds, to our knowledge. However, if obtaining a fidelity bond is a requirement of the grant, we will work with the Hawai‘i State Department of Accounting and General Services (DAGS) Risk Management Office (RMO) to do so. DAGS RMO manages the statewide risk management program to minimize state government losses. Established under Chapter 41D of the Hawai‘i Revised Statutes, its functions include risk identification, insurance procurement, managing self-insurance programs (automobiles, liability, property), processing informal claims (under $25,000), advising state departments on loss prevention, and coordinating disaster claims with property insurance carriers. The program assesses negligence when claims are filed, uses the state Risk Management Revolving Fund for self-insured programs, claims, and commercial insurance, and requires state departments to report incidents using forms like the “Supervisor’s Report of Loss or Damage to State Property.”

11. Do you have (and briefly describe) policies and procedures in place to meet the requirements below? If not, explain your plan and estimated timeline for establishing these policies and procedures if selected for award.
    a. Determinations between subrecipients versus contracts in accordance with 2 CFR 200.331?
    b. Compliance with 2 CFR 200.332 “Requirements for pass-through entities?”

c. Manage, assess risk, review audits, and monitor the subrecipients as necessary to ensure that subawards are used for authorized purposes in compliance with laws, regulations, and terms and conditions of the award and that established subaward performance goals are achieved (2 CFR 200.331-200.333)?

Upon receiving a federal award notice, the Department of Budget and Finance, Office of Federal Awards Management (OFAM), will implement written procedures to ensure compliance with 2 CFR 200.331, 2 CFR 200.332, and 2 CFR 200.333. This approach aligns with OFAM's previous actions for other significant awards granted to the Executive Office of the State of Hawai‘i. These procedures will, at a minimum, cover the following areas:

Subaward Issuance and Setup

- **Verification of Eligibility:** Before issuing a subaward, the pass-through entity (the Executive Office of the State of Hawai‘i) must confirm the subrecipient is not excluded or disqualified from receiving federal funds. This involves checking the System for Awards Management (SAM.gov).
- **Risk Assessment:** Pass-through entities are required to assess each subrecipient's risk of noncompliance with federal statutes, regulations, and award terms. Key factors include the subrecipient's past experience, previous audit findings, and any changes in personnel or systems.
- **Specific Conditions:** Based on the risk assessment, the Executive Office of the State of Hawai‘i may impose specific subaward conditions, such as more frequent financial reporting, on-site reviews, or enhanced monitoring.
- **Subaward Information:** The subaward agreement will clearly identify the award as a subaward and include all necessary federal award details, including the federal award identification number, CFDA number, total award amount, and indirect cost rate.

Financial Management and Procurement

- **Procurement Standards:** Subrecipients must use their own documented procurement procedures for purchasing goods and services. However, these procedures must comply with federal procurement standards (2 CFR §200.317–327) or be at least as restrictive. If the subrecipient's policies are less stringent, federal rules must be followed. For this award, we anticipate that all subrecipients will be Hawai‘i State agencies. These all follow the Hawai‘i State Procurement Code, which complies with federal standards.
- **Cost Principles:** Subrecipients must adhere to federal cost principles, ensuring all costs charged to the award are allowable, allocable, and reasonable.
- **Tax Clearances:** In Hawai‘i, non-state subrecipients receiving subawards of $25,000 or more must provide a current tax clearance from both the Hawai‘i Department of Taxation and the Internal Revenue Service. Exemptions apply to government agencies and subawards below this threshold.

Monitoring and Reporting

- **Continuous Monitoring:** The Executive Office of the State of Hawai‘i will continuously monitor subrecipients’ programmatic and financial activities to ensure compliance and progress toward performance goals.
- **Reporting Requirements:** Subrecipients will be required to submit financial and performance reports to the Executive Office of the State of Hawai‘i within a specified timeframe. These reports enable the pass-through entity to monitor progress and confirm appropriate use of funds.
- **Federal Funding Accountability and Transparency Act (FFATA):** For subawards exceeding $30,000, pass-through entities must report required information through the FFATA Subaward Reporting System (FSRS).

Auditing and Closeout

- **Single Audit Requirements:** Subrecipients spending $1,000,000 or more in federal funds during their fiscal year will be required to undergo a single audit or a program-specific audit.
- **Audit Resolution:** If a subrecipient receives an audit finding, the Executive Office of the State of Hawai‘i will be responsible for issuing a management decision and ensuring the subrecipient takes timely corrective action.
- **Subaward Closeout:** At the conclusion of the subaward period, the Executive Office of the State of Hawai‘i will initiate closeout procedures, requiring the subrecipient to submit final financial and performance reports. All administrative closeout actions must be completed promptly.

B. Accounting System

1. Does your organization have updated (last two years) written accounting policies and procedures to manage Federal awards in accordance with 2 CFR 200?
   a. If not, please provide a brief explanation of why not.
   b. Describe the management of Federal funds and how funds are separated (not co-mingling) from other organizational funds.

   Yes, the State of Hawai‘i has written accounting policies and procedures to manage federal awards in accordance with 2 CFR 200 which are updated regularly. Details can be found in the Department of Accounting and General Services’ Accounting Manual and Comptroller’s Memoranda, as well as in the Office of Federal Awards Management’s guidelines for State management of federal awards. Additionally, on May 16, 2013, the State Director of Finance issued Finance Memorandum (FM) No. 13-05, which requires that for each federal award (identified by its unique identifier federal award ID), a separate state appropriation account be established. This prevents award funds from co-mingling with other funds.

2. Briefly describe budgetary controls in effect to preclude incurring obligations in excess of:
   a. Total funds available for an award.

   We have an appropriation allotment control system in place that will only provide an allotment that is less than or equal to the award amount.

b. Total funds available for a budget cost category.
Each department within the State of Hawai‘i is responsible for maintaining a budget worksheet that separates its expenses by budget cost category. Departments may also make use of object codes in the state accounting system to accomplish this. These same controls apply to budget costs for all federal awards.

3. Has any government agency rendered an official written opinion within the last 3 years concerning the adequacy of the organization’s accounting system for the collection, identification, and allocation of costs under Federal awards?
   a. If yes, please provide the name and address of the agency that performed the review.
   b. Provide a summary of the opinion.
   c. How did your organization resolve any concerns?

   No, we are not aware of an official written opinion within the last 3 years.

4. How does the accounting system provide for recording the non-Federal share and in-kind contributions (if applicable)?

   In the Federal Awards Management Systems (FAMS), federal award recipients provide information on the state match requirement (including the state appropriation account that is the source of the non-Federal share), and any in-kind contributions (including funding amounts and sources).

5. Does the organization's accounting system provide identification for award funding by Federal agency, pass-through entity, Assistance Listing (CFDA), award number, and period of funding?
   a. If yes, how does your organization identify awards?

   Each Federal award is identified by its unique Federal Award Identification Number (FAIN). After receiving an award, the recipient must create a FAMS record in the State’s DataMart accounting system. Each record involves several data fields, including assistance listing number, federal awarding agency, performance period and other relevant dates, and information on the pass-through entity or subrecipients, if relevant.

   b. If not, please explain why not.

C. Budgetary Controls

1. What are your organization’s controls used to ensure that the Authorized Organizational Representative (AOR), as identified on the SF-424, approves all budget changes for the Federal award?

   Should we receive the award, we will have written procedures on how budget changes are to be made for the award.

2. Describe your organization’s procedures for minimizing the time between transfer of funds from the U.S. Treasury (e.g., Payment Management System) and disbursement for grant activities (See 2 CFR 200.305, “Federal Payment.”)

These procedures are described in detail in the State of Hawai‘i’s 2025 Cash Management Improvement Act (CMIA) Treasury State Agreement. In general, the State operates on a reimbursement basis.

D. Personnel

1. Does your organization have a current organizational chart or similar document establishing clear lines of responsibility and authority?
   a. If yes, please provide a copy.
   b. If not, how are lines of responsibility and authority determined?

   Yes, there is an organizational chart for the full State Government of Hawai‘i, as well as one for the Department of Budget & Finance. The organizational chart for the State Government of Hawai‘i can be found in the FB 2025-2027 State Plan of Organization. The organizational chart for the Department of Budget and Finance can be found on page 2 of 79 of the FB 2025-2027 Operating and Capital Budget of the Department of Budget and Finance.

2. Does your organization have updated (last two years) written Personnel and/or Human Resource policies and procedures? If not, provide a brief explanation.

   Yes, we have updated written Human Resource policies and procedures, maintained by the State’s Department of Human Resources and Development. The policies can be found in detail on their website.

3. Does your organization pay compensation to Board Members?

   This is not applicable, as the Executive Office of the State of Hawai‘i does not have boards attached to the office.

4. Are staff responsible for fiscal and administrative oversight of HHS awards (Grants Manager, CEO, Financial Officer) familiar with Federal rules and regulations applicable to grants and cooperative agreements (e.g., 2 CFR 200)?

   Yes, they are.

5. Please describe how the payroll distribution system accounts for, tracks, and verifies the total effort (100%) to determine employee compensation.

   Payroll for State employees is tracked and managed through the Hawai‘i Information Portal (HIP) system, which allows managers to charge time to individual funding sources by their Uniform Accounting Code (UAC), including federal and non-federal sources. The “Earnings Distribution” and “Percent of Distribution” fields in HIP determine how the pay will be distributed when a salary needs to be charged to multiple UACs. These are then reviewed and approved by supervisors.

E. Payroll

In preparation of payroll is there a segregation of duties for the staff who prepare the payroll and those that sign the checks, have custody of cash funds, and maintain accounting records? Please describe.

Yes, there is such segregation of duties in payroll preparation, and it plays an integral role in the State’s internal controls. Different steps in the payroll

preparation process are conducted by different departments within the state. The originating department approves payroll records for its employees, the Department of Accounting and General Services (DAGS) signs checks and maintains accounting records, and the Department of Budget & Finance maintains custody of cash funds.

F. Consultants

1. Are there written policies or consistently followed procedures regarding the use of consultants that detail the following (include an explanation for each question below):
    a. Briefly describe your organization's method or policy for ensuring consultant costs and fees are allowable, allocable, necessary, and reasonable.

    The Executive Office of the State of Hawai'i is subject to the Hawai'i Public Procurement Code, which is maintained by the State Procurement Office. Detailed information on the procurement code can be found here. In general, the state official managing the consultant contract(s) is required to ensure that all consultant costs and fees are allowable, allocable, necessary, and reasonable under the code's regulations.

    b. Briefly describe your organization's method or policy to ensure prospective consultants prohibited from receiving Federal funds are not selected.

    Hawai'i Administrative Rules § 3-122-133 prohibits the use of any contract that would jeopardize the receipt or limit the amount of federal assistance monies. Before selecting consultants and other contractors, they are reviewed to ensure that they are not excluded or disqualified from receiving federal funds, including by checking the System for Awards Management (SAM.gov).

G. Property Management

1. Briefly describe the system for property management (tangible or intangible) utilized for maintaining property records consistent with 2 CFR 200.313. Refer to (2 CFR 200) for definitions of property to include personal property, equipment, and supplies.

    The Hawai'i State Department of Accounting and General Services maintains the Fixed Asset Inventory System (FAIS). Each department is responsible for updating its inventory records in FAIS. The SPO Form 17-A is used to report all transactions (additions, deletions, removals, transfers, losses, and changes). Newly acquired property must be recorded in FAIS in the quarter of the fiscal year the department receives the property or when the department assumes responsibility for maintaining the property. Supplies should be recorded in the department's internal control listing. The following categories and dollar thresholds are required to be reported in FAIS:

    1. State property (regardless of cost or expected life): Land and interest in land, weapons, works of art, and historical treasures.
    2. Non-expendable state property having a unit cost of $1,000 or more and a useful life of more than one year: Land improvements, buildings and building improvements, motorized vehicles, equipment (machinery, tools, furnishing, software, books, etc.), and infrastructure.
    3. Theft-sensitive property having a unit cost of $250.00 through $999.99

with a useful life of more than one year: Including personal computer equipment, photographic equipment, television sets, video equipment, and communication equipment.

More information on inventory reporting requirements and FAIS can be found in the Inventory System User Manual.

2. Does your organization have adequate insurance to protect the Federal interest in equipment and real property (see 2 CFR 200.310 "Insurance coverage")? How does the organization calculate the amount of insurance?

Yes. The Executive Office of the State of Hawai‘i has adequate insurance to protect the federal interest in equipment and real property. The DAGS Risk Management Office (RMO) conducts an annual actuarial study on probable losses and purchases insurance based on risk and what can be afforded by the amount of funds appropriated to the office. If additional insurance is required, the Executive Office of the State of Hawai‘i will work with the DAGS RMO to obtain the necessary insurance. More information on DAGS RMO is provided in question A10’s response.

H. Property Standards

Describe the organization’s property standards in accordance 2 CFR 200.310-327 “Procurement Standards”)? If there are no procurement procedures, briefly describe how your organization handles purchasing activities.

a. Include individuals responsible and their roles
b. Describe the competitive bid process for procurement purchases of equipment, rentals, or service agreements that are over certain dollar amounts.

The Executive Office of the State of Hawai‘i has property standards that are in accordance with 2 CFR 200.310-327. As part of the State of Hawai‘i, the Executive Office is subject to the Hawai‘i Procurement Code (the Code), maintained by the State Procurement Office. Established by Hawaii Revised Statutes Chapter 103D, the Code is a comprehensive set of statutes and administrative rules governing how the State of Hawai‘i purchases goods, services, and construction. The Code was modeled after the American Bar Association's Model Procurement Code, and aims to ensure efficiency, promote broad-based and fair competition, maintain a high-quality and ethical procurement system, and foster public confidence in government purchasing. Key aspects include requiring public employees to act as fiduciaries, avoiding conflicts of interest, and ensuring equal opportunity for potential suppliers in a fair and open environment.

I. Transportation Costs

1. Describe your organization’s written travel policy. Ensure, at minimum, that:
   a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates (see 2 CFR 200.474, “Transportation costs”).
   b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred.
   c. Subsistence and lodging rates are equal to or less than current Federal per diem and mileage rates.

d. Commercial transportation costs incurred at coach fares unless adequately justified. Lodging costs do not exceed the GSA rate unless adequately justified (e.g., conference hotel).
e. Travel expense reports show purpose and date of trip.
f. Travel costs are approved by organizational official(s) and funding agency prior to travel.

The State of Hawai‘i’s travel policy is outlined in detail in Hawai‘i Administrative Rules 3-10, and travel procedures are maintained by the State Procurement Office. Briefly, the policy dictates that:

- A department head must give approval for all out-of-state and intrastate travel, and a written travel plan with itemized costs must be submitted and approved before travel.
- Travel must use the most direct and economical routes, as well as the most economical means consistent with time availability and the urgency of the trip, unless otherwise justified by the Governor.
- Funds for travel expenses, including per diem allowances and reimbursable expenditures, may be secured by way of cash advance or by way of reimbursement upon the trip’s completion. Advances are limited to the costs on the pre-approved travel plan and other determinable anticipated requests. For reimbursements, a statement must be submitted that includes expenditure details and receipts.
- The State of Hawai‘i’s current per diem rate for overnight travel is $99 per 24 hours for intra-state travel and $145 per 24 hours for out-of-state travel. The GSA does not set per diem rates for Hawai‘i.

J. Internal Controls

1. Provide a brief description of your organization’s internal controls that will provide reasonable assurance that the organization will manage award funds properly. (See 2 CFR 200.303, “Internal controls.”)

   The State of Hawai‘i maintains internal budgetary controls that provide reasonable assurance that: transactions are executed in accordance with management’s authorization, transactions are recorded as necessary to permit preparation of financial statements in conformity with the Generally Accepted Accounting Principles (GAAP) and to maintain accountability risks for assets, and that access to assets is only permitted in accordance with management’s authorization. To accomplish this, the State utilizes an allotment system and encumbrance accounting for budgetary control purposes, and obligations in the form of purchase orders or contracts are recorded as encumbrances when they are awarded and executed. Departments are responsible for maintaining budgetary controls at the program level, and the State Comptroller conducts periodic investigations and audits to ensure the internal control systems are functioning correctly. State departments, such as the Executive Office of the State of Hawai‘i, are also subject to an annual single audit, which assesses the State’s internal budgetary controls.

2. What is your organization’s policy on separation of duties as well as responsibility for receipt, payment, and recording of cash transactions?

The State of Hawai‘i separates these duties between different departments. Each State agency requests drawdowns of its funds, the Department of Budget & Finance records the receipt of funds through a Treasury Deposit Receipt, and the Department of Accounting and General Services facilitates these payments.

3. Does your organization have internal audit or legal staff? If not, how do you ensure compliance with the award? Please describe.

   The State of Hawai‘i has legal staff with the Department of the Attorney General, and the Executive Office is subject to a single audit each year. The Department of Accounting and General Services has an Audit Division, which conducts internal audits of State agencies. The Audit Division also conducts investigations to ensure that State agencies maintain adequate internal control systems that function as designed.

4. If your organization has a petty cash fund, how is it monitored?

   We do not have a petty cash fund.

5. Who in the organization reconciles bank accounts? Is this person familiar with the organization’s financial activities? Does your organization authorize this person to sign checks or handle cash?

   The State of Hawai‘i has a Financial Administration Division that maintains custody of state funds. The check-writing function of the State lies separately with the Department of Accounting and General Services.

6. Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?

   No, they are not.

K. Audit

1. What is your organization’s fiscal year?

   The Hawai‘i State fiscal year runs from July 1st to June 30th.

2. Did your organization expend $1,000,000 or more in Federal awards from **all** sources during its most recent fiscal year?

   Yes, both the full State of Hawai‘i and the Executive Office did.

3. Has your organization submitted:

   (a) An audit report to the Federal Audit Clearing House (FAC) in accordance with the Single Audit Act in the last 3 years? (see 2 CFR 200.501, “Audit requirements” and 2 CFR 300.218 “Special Provisions for Awards to for-profit organization as recipients.”) **or**

   (b) An independent, external audit? If no, briefly explain. If yes, address the following:

   a. The date of the most recently submitted audit report.

   The State of Hawai‘i conducts an independent annual single audit of the federal programs of 13 of the State’s agencies, including the Executive Office (referred to as the Governor’s Office in the report). The most recent audit was conducted for the State fiscal year ending on June 30, 2024.

b. The auditor's opinion on the financial statement.

The auditors reviewed the State's major federal programs and offered opinions on State agencies' compliance with "the types of compliance requirements identified as subject to audit in the U.S. Office of Management and Budget (OMB) *Compliance Supplement* that could have a direct and material effect on each of the State's major federal programs." As it relates to the Executive Office of the State of Hawai'i, the auditors found that "the State complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect" on the relevant major federal programs.

c. If applicable, indicate if your organization has findings in the following areas:

- internal controls
- questioned or unallowable costs
- procurement/suspension and debarment
- cash management of award funds, and
- subrecipient *monitoring*.

The Executive Office of the State of Hawai'i did not receive findings in the most recent single audit.

d. Include (if applicable):

- a description of each finding classified as Material Weakness.
- a description of each finding classified as Significant Deficiency.

Not applicable, as there were no findings identified for the Executive Office of the State of Hawai'i.

4. Has your organization had corrective actions in the past 2 years for the findings identified above (3(iii))? If yes, describe the status (closed or open) and progress made on those corrective actions.

No findings were identified for the Executive Office of the State of Hawai'i in the past two years; thus, no corrective actions were taken.

Program Duplication Assessment

For this application, the State of Hawai‘i defines program duplication in a manner consistent with the U.S. Government Accountability Office (GAO) definition: “Duplication occurs when two or more agencies or programs are engaged in the same activities or provide the same services to the same beneficiaries” (April 2017, *2017 ANNUAL REPORT: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*). The following assessment demonstrates our awareness of the risks of program duplication and the steps we will take throughout the implementation of the State of Hawai‘i’s Rural Health Transformation Plan (RHTP) to avoid any potential duplication, should we be awarded this funding. We will also detail here the steps we will take to avoid supplanting existing funds and issuing duplicative payments for the same program expense.

Program Duplication

Program duplication can result in inefficient resource allocation, diminished effectiveness, and unnecessary complexity. As such, the State of Hawai‘i acknowledges its responsibility as a grantee to prevent program duplication. In developing program plans for this application, we reviewed our existing State and Federal programs to avoid duplicating any existing programs and to identify new and distinct activities that would be applicable to this award.

Our review also considered and identified ways in which this funding could be used to complement or build on existing programs without duplicating their efforts. One such existing program is Broadband Equity Access and Deployment (BEAD), which is working to provide broadband infrastructure to rural areas. The Rural Health Information Network (RHIN) initiative within Hawai‘i’s RHTP will expand these efforts by creating the necessary on-site connections to allow rural healthcare facilities to access and use this broadband network. In developing this plan, we collaborated with members of our BEAD implementation team to ensure that the RHIN will complement the BEAD program without duplicating their existing or future efforts.

Similarly, we developed our plan for the Rural Value-Based Innovation (RVBI) and AHEAD Readiness Fund initiative within Hawai‘i’s RHTP to complement the Achieving Healthcare Efficiency Through Accountable Design (AHEAD) model. Hawai‘i is part of the 2nd Cohort implementing the AHEAD model, which aims to reduce growth in health care costs and thus increase statewide access to quality health care. Many rural providers, however, face unique challenges in adopting alternative payment models like AHEAD. The RVBI initiative aims to finance local innovation in developing ways to overcome these challenges, helping rural providers transition to payment models under AHEAD. These efforts will help rural communities best utilize AHEAD, without duplicating it.

In addition to Federal programs, we also considered existing State programs that this funding could complement, such as Hawai‘i’s Healthcare Education Loan Repayment Program (HELP). While loan repayment is not an allowable cost under the Rural Health Transformation Program, the Hawai‘i Outreach for Medical Education in Rural Under-resourced Neighborhoods (HOME

RUN) initiative within Hawai‘i’s RHTP will develop other methods to recruit and retain healthcare workers in Hawai‘i. These methods will complement the existing loan repayment program, which serves the same goal.

Should we be granted this award, we will use the State's established structure to mitigate program duplication throughout the program’s development and implementation phases. This strategy involves the following steps:

1. **Application of the State of Hawai‘i’s Program Structure Methodology:**
   We will apply the State of Hawai‘i’s established program structure methodology to each initiative submitted within our application.

   The State of Hawai‘i's program structure is a hierarchical, objective-oriented system that organizes all state programs into 11 major functional areas. This system is an integral component of the Planning, Programming, and Budgeting System (PPBS) used by the state's executive branch for managing its biennial budget.

   At its highest level, the structure is organized into 11 major areas, designated as "Level I programs," which correspond to the primary objectives of the state government:
   - **Economic Development:** Programs designed to foster economic growth, tourism, and business.
   - **Employment:** Programs pertaining to labor, workforce development, and unemployment.
   - **Transportation Facilities and Services:** Programs encompassing airports, harbors, and highways.
   - **Environmental Protection:** Programs dedicated to the preservation of natural resources and the environment.
   - **Health:** Programs addressing public health, behavioral health, and medical care.
   - **Social Services:** Programs supporting human services, social welfare, and housing assistance.
   - **Formal Education:** The statewide public school system, including the Department of Education and the University of Hawai‘i.
   - **Culture and Recreation:** Programs for parks, libraries, and cultural arts.
   - **Public Safety:** Programs related to law enforcement, emergency management, and corrections.
   - **Individual Rights:** Programs designed to protect and uphold citizens’ rights.
   - **Government-Wide Support:** Programs that underpin the overall operations of state government.

   Within each of the 11 major program areas, a further hierarchical breakdown exists, extending to up to five levels of subordinate programs. This design aims to comprehensively categorize all state programs and inform resource allocation decisions effectively. Each program within this structure is assigned a unique identifier:
   - **Two-digit number:** Identifies the Level I program area.

- **Three-letter departmental code:** Designates the specific state department responsible for administering the program, such as "HTH" for the Department of Health.
- **Three-digit program code:** Uniquely identifies the lowest-level program within its respective department.

For additional information regarding the Program Structure for the State of Hawai‘i, please refer to: https://budget.hawaii.gov/budget/programstructure/

2. **Identification of Duplicative Programs:**
   After each initiative has been classified, we will review our state system to identify any existing programs that are similarly classified and defined. If any such program exists, we will conduct a more in-depth review of it and the relevant initiative to identify potential sources of duplication.

3. **Consultation with Federal Funding Officer:**
   Should any program be identified as duplicative, we will contact our federal funding officer to review our findings and discuss appropriate next steps, such as modifying the initiative.

4. **Departmental Certification and Subrecipient Agreement Language:**
   We will require department heads leading an initiative to certify, following an internal review, that the initiative is not duplicative. Furthermore, we will incorporate language concerning program duplication into our subrecipient agreements.

We anticipate that, in the period after an award is made but before the commencement of program activities, we will engage in extensive discussions with our assigned federal program officer to identify, document, and implement any additional controls deemed necessary to reduce the risk of program duplication. These controls will be integrated into a grant manual specifically developed for the Rural Health Transformation Program.

Maintenance of Effort / Supplanting Funds

The State of Hawai‘i confirms that Rural Health Transformation (RHT) Program award funds will not be used to supplant existing federal, state, or local funding, nor will they be used for the non-federal share of Medicaid payments.

In instances where an initiative constitutes an expansion of an existing project currently undertaken with non-RHT Program award funds, the State will identify the current federal, state, or local funding for the past three years. Federal funding will be identified by its specific source.

The State of Hawai‘i will prohibit the use of RHT program funds for the non-federal share of Medicaid payments, and this provision will be enforced through its inclusion in all subrecipient agreements. The Office of Federal Awards Management (OFAM) will monitor this provision via the state’s financial accounting system, FAMIS.

While the specific maintenance-of-effort (MOE) standard to be employed by CMS for this grant is currently unclear, the State of Hawai‘i will, before commencing program activities and in collaboration with our assigned federal program officer, identify, document, and implement any additional controls or reporting mechanisms deemed necessary to demonstrate that current federal, state, or local funding is not supplanted and that expenses generated from our program activities do not duplicate other federal, state, or local funding.

Avoiding Duplication of Payment

The state maintains budgetary and accounting controls designed to mitigate the risk of making duplicate payments for the same expense.

The state mandates that departments receiving a federal award (or subaward) draw down and expend award proceeds from a single state appropriation account.

All initiatives proposed in the Hawai‘i RHTP plan are led by a state department (e.g., Department of Health or Department of Human Services). As such, all departments leading an initiative will utilize the Federal Awards Management System (FAMS) as a centralized database and portal for tracking and overseeing federal funds.

Integrated into the state's broader DATAMART financial application, FAMS serves as a secure, master database for all federal awards received by state executive departments and agencies. FAMS also provides and features in key aspects of the State’s budgetary controls for federal awards, such as:

1. **Centralized Record Keeping:** Within 14 calendar days of receiving a federal award notice, departments are required to create a record in FAMS. This record includes details about the prime recipient, federal award information from the notice, state project details, and any subrecipient information.

2. **Mandatory Document Management:** FAMS is used to upload and attach supporting documents in PDF format to each award record, including the federal award notice itself. Departments must also maintain a separate physical or electronic file for each award, containing a copy of the notice and other key correspondence.

3. **Budget Execution and Approval:** The system facilitates the budget request process by allowing departments to use FAMS to prepare and submit the "Form FF" budget worksheet. FAMS is integrated into the workflow for submitting "Form E-1" (Request to Increase Federal Funds), with the FAMS ID required on the form.

4. **Monitoring Award Status:** OFAM employs FAMS to monitor the lifecycle of awards, particularly when their performance period has concluded. OFAM issues memoranda requiring departments to close or update FAMS records with expired performance or liquidation dates. For transparency and accountability, OFAM also maintains and updates public reports on federal funds using information managed in FAMS, including those

related to COVID-19 relief, the Infrastructure Investment and Jobs Act (IIJA), and the Inflation Reduction Act (IRA).

5. **Role-Based User Access:** FAMS is accessible exclusively through a DATAMART account, with different user groups assigned varying levels of privileges. User groups are structured based on organizational hierarchy (e.g., department, division, program) and the user's role (e.g., viewer, editor).

6. **Comprehensive Reporting:** FAMS provides basic querying and reporting functionalities to offer a snapshot of federal awards held by state entities. This database is crucial for compiling the state's Schedule of Expenditures of Federal Awards (SEFA) for the annual single audit.

For further information on FAMS, please refer to: https://federalawards.hawaii.gov/sga/

FAMS and FAMIS will enable the State to monitor expenditures and identify any duplicate expenditures by date, vendor, or invoice amount.

We anticipate that, in the period after an award is made but before the commencement of program activities, we will engage in extensive discussions with our assigned federal program officer to identify, document, and implement any additional controls deemed necessary to reduce the risk of duplicate payments. One such control might include steps to mitigate the risk of duplicative payments between State and Federal funding streams, which the State cannot entirely account for without collaboration with CMS. These controls will be integrated into a grant manual specifically developed for the Rural Health Transformation Program.

EXECUTIVE CHAMBERS
KE KE‘ENA O KE KIA‘ĀINA

JOSH GREEN, M.D.
GOVERNOR
KE KIA‘ĀINA

November 3, 2025

VIA GRANTS.GOV
U.S. Department of Health and Human Services
U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Honorable Dr. Mehmet Oz,

I am pleased to present the State of Hawai‘i’s Rural Health Transformation Plan (RHTP) for your consideration. This plan—developed through extensive collaboration among state agencies, healthcare providers, and community partners—has my full support and will remain under my direct oversight. The RHTP represents a bold and necessary step to modernize our rural health infrastructure, expand access to essential primary and behavioral health services, and bolster Hawai‘i’s rural and neighbor island healthcare workforce.

As a physician and emergency room doctor who served the rural community of Ka‘ū on Hawai‘i Island for over two decades, I have seen firsthand the disparities that too often define rural healthcare in our islands. Many of our residents face substantial and disproportionate barriers to care, resulting in higher rates of avoidable emergency room visits, preventable hospitalizations, and unmanaged chronic conditions.

These disparities are caused by long-standing, large-scale challenges. Rural providers struggle with workforce shortages driven by limited training opportunities, low patient volumes, and high rates of uncompensated care. Additionally, healthcare providers in rural areas frequently rely on outdated, non-interoperable data systems. These limitations hinder effective referrals, telehealth monitoring, and participation in value-based care models, ultimately preventing the delivery of coordinated, preventive, and efficient care. And for too many on our neighboring islands, basic access to specialty services is severely deficient. Many patients must travel long distances, often inter-island, to receive essential services such as behavioral health care, trauma treatment, and chronic disease management, thereby increasing both the cost and complexity of care for rural residents.

Beyond medical access, our rural families also face broader social challenges—housing instability, food insecurity, and unreliable transportation—that compound health risk and strain limited local resources.

Addressing these intertwined challenges has been the central motivation of my public service. During my fourteen years in the Hawai‘i State Legislature, including as Chair of the Health and Human Services Committee, I advanced reforms to strengthen trauma systems, expand insurance coverage, and invest in rural and general healthcare infrastructure. As Lieutenant Governor and now as Governor, I have continued to pursue solutions that improve care coordination, expand access, and increase the resilience of our healthcare system in the face of crises from the COVID-19 pandemic to the Lahaina wildfires, both of which deeply affected healthcare systems, especially in rural and underserved areas.

The RHTP builds upon this legacy of innovation and collaboration to take advantage of a unique and timely opportunity to strengthen and reimagine rural healthcare across our state. Developed through extensive engagement with community members, stakeholders, and county and state agencies, the RHTP is built around six interlocking initiatives:

1. Rural Health Information Network (RHIN) establishes the state's health data backbone.
2. Pili Ola Telehealth Network expands virtual access to care.
3. Rural Infrastructure for Care Access (RICA) ensures physical and emergency access to medical and behavioral services.
4. HOME RUN strengthens our rural health workforce pipeline.
5. Rural Respite Network (RRN) provides short-term, transitional care for patients who would otherwise cycle through hospitals.
6. Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund invests in grassroots efforts for innovative care.

Our rural communities must have access to the same high-quality healthcare as the rest of our state. To that end, this proposal addresses the distinct challenges faced by our rural communities and leverages the unique strengths of our islands to ensure healthier futures for all rural Hawai‘i residents.

The lead agency responsible for this program is the Executive Office of the State of Hawai‘i (UEI: L1SGJ7LKJKT3), and the contact person for this award is:

Department of Budget and Finance
Mark K. Anderson, Administrator
Email: [redacted]@hawaii.gov
Phone: [redacted]

Please note that this contact person differs from the one listed in the State of Hawai‘i's non-binding letter of intent to apply, dated September 23, 2025. We have already communicated this to the Rural Health Transformation Program Team and received confirmation of the change.

I certify that this application was developed collaboratively with the Hawai‘i State Department of Health (including the Office of Primary Care and Rural Health), the Med-QUEST Division of the Hawai‘i State Department of Human Services (the State Medicaid agency), other key federal, state, and county government entities, and relevant non-profit agencies. Hawai‘i residents were also invited to collaborate on the development of this plan by sharing information on community health needs and ideas for potential projects through the State’s public engagement hub.

In addition to this collaboration during the program’s development phase, we plan to continue engaging and collaborating with these and other relevant stakeholders throughout the implementation phase. An RHTP Oversight Team will be established at the Office of the Governor to facilitate coordination of grant implementation actions among all stakeholders, and to provide oversight across all aspects of the program. The oversight team, led by Project Director Jeremy Lakin, will maintain close communication and direct coordination with each of the teams implementing the program’s six initiatives; the project director will be a cabinet-level position, reflecting the position’s authority and the importance of this effort to my administration. This will help ensure that program plans are implemented in a way that best serves Hawai‘i’s rural communities, with the full support, input, and participation of the relevant agencies and organizations.

To complement the program initiatives involved in this plan, I will continue to work with the Hawai‘i State Legislature to support the introduction and passage of several measures that will help transform rural healthcare. I will also work with the relevant State agencies to ensure that any legislative changes can be implemented smoothly and efficiently.

As part of this legislative effort, we intend to introduce a bill in the upcoming legislative session that would require the Hawai‘i State Department of Education to establish the Presidential Fitness Test in all public schools, in alignment with federal guidance. We plan to also introduce a measure that would include nutrition education as part of the State’s requirements for Continuing Medical Education for physicians. Nutrition and fitness are key aspects of improving one’s health and preventing the development of serious medical conditions, and I believe these changes would greatly benefit all of Hawai‘i’s residents. They would particularly well serve our rural communities, however, which are often disproportionately impacted by chronic health issues.

In addition to these measures, our legislative effort will also work to include Hawai‘i in several licensure compacts, which increase access to healthcare by making it easier for medical professionals to practice across state lines. Hawai‘i is currently listed as a member state of the Interstate Medical Licensure Compact (IMLC) as a non-State of Principal License (SPL), but State legislation passed in 2025 allowed the Hawai‘i Medical Board to make changes necessary to be in full compliance with the IMLC and serve as an SPL member state. We will continue to introduce legislation that will enter Hawai‘i into clinical licensure compacts, including legislation to become a Nurse Licensure Compact (NLC) member state, a

Psychology Interjurisdictional Compact (PSYPACT) participant, and a Physician's Assistant (PA) compact member. Participation in these licensure compacts may incentivize more medical professionals to relocate to Hawai‘i, while also allowing for providers in other states to provide telehealth care to Hawai‘i residents. This would be especially beneficial for rural communities that lack easy physical access to health care.

The State has also submitted a waiver request to the U.S. Department of Agriculture (USDA) seeking authorization to restrict the purchase of carbonated sugary and artificially sweetened beverages (sodas and energy drinks) under the Supplemental Nutrition Assistance Program (SNAP). This waiver will help ensure that public nutrition benefits directly support better health outcomes by encouraging the purchase of wholesome, locally produced, and nutrient-rich beverages.

Finally, I certify that the State will use the proceeds in accordance with the guidelines issued by the U.S. Department of Health and Human Services and will not spend any award funds on activities prohibited under 42 U.S.C. 1397ee(h)(2)(A)(ii).

I am excited about the potential of this program to significantly improve the quality of and access to rural health care in Hawai‘i. Let us work together for a better future for Hawai‘i's people.

Mahalo,

Josh Green M.D.

Josh Green, M.D.
Governor, State of Hawai‘i

The following attachment is not included in the view since it is not a read-only PDF file.

Upon submission, this file will be transmitted to the Grantor without any data loss.

Indirect Cost Agreement.pdf

Appendix A – Summary of Initiatives

Rural Health Information Network (RHIN): A statewide digital backbone connecting rural hospitals, clinics, and health centers to the rest of the state through interoperable EHRs, wireless networks, and integrated data hubs.				
Strategic Goals	**Use of Funds**	**Technical Score Factors**	**Key Stakeholders**	**Outcomes/ Metrics**
Tech Innovation	D, F, I, K	B.1, B.2, C.1, E.2, C.2, E.1, F.2	State Health Planning and Development Agency (SHPDA) and Med-QUEST Division (MQD) in coordination with providers, payers, contractors, and the University of Hawai‘i (UH)	• **90% of rural provider sites using fully interoperable EHRs** • 70% of referrals made in rural counties with closed-loop referral access completed and confirmed (county-level) • 20% increase in duals enrolled in integrated plans • 50% of rural PCPs providing telehealth services • 50% of rural PCPs or POs in value-based model contracts
Pili Ola Telehealth Network: A statewide telehealth network connecting rural communities to providers, integrating digital health access, virtual care, and telehealth training.				
Strategic Goals	**Use of Funds**	**Technical Score Factors**	**Key Stakeholders**	**Outcomes/ Metrics**
Tech Innovation Sustainable Access	A, B, C, D, F, G, H, K	B.1, C.1, C.2, D.1, F.1, F.2, F.3	UH Social Science Research Institute (SSRI), Telecommunication and Social Informatics (TASI), and Pacific Basin Telehealth Resource Center (PBTRC), in coordination with the UH John A. Burns School of Medicine (JABSOM), University Health Partners, UH School of Nursing and Dental Hygiene, UH Health Policy Initiative, health systems and facilities, and health plans (AlohaCare and Med-QUEST)	• **20% increase in rural patients with at least one telehealth visit (county-level)** • 200% increase in the number of individuals who manage or prevent chronic diseases using telehealth resources • 30% reduction in patient travel for rural OB patients • 30% increase in rural behavioral health referrals resulting in a completed telehealth visit

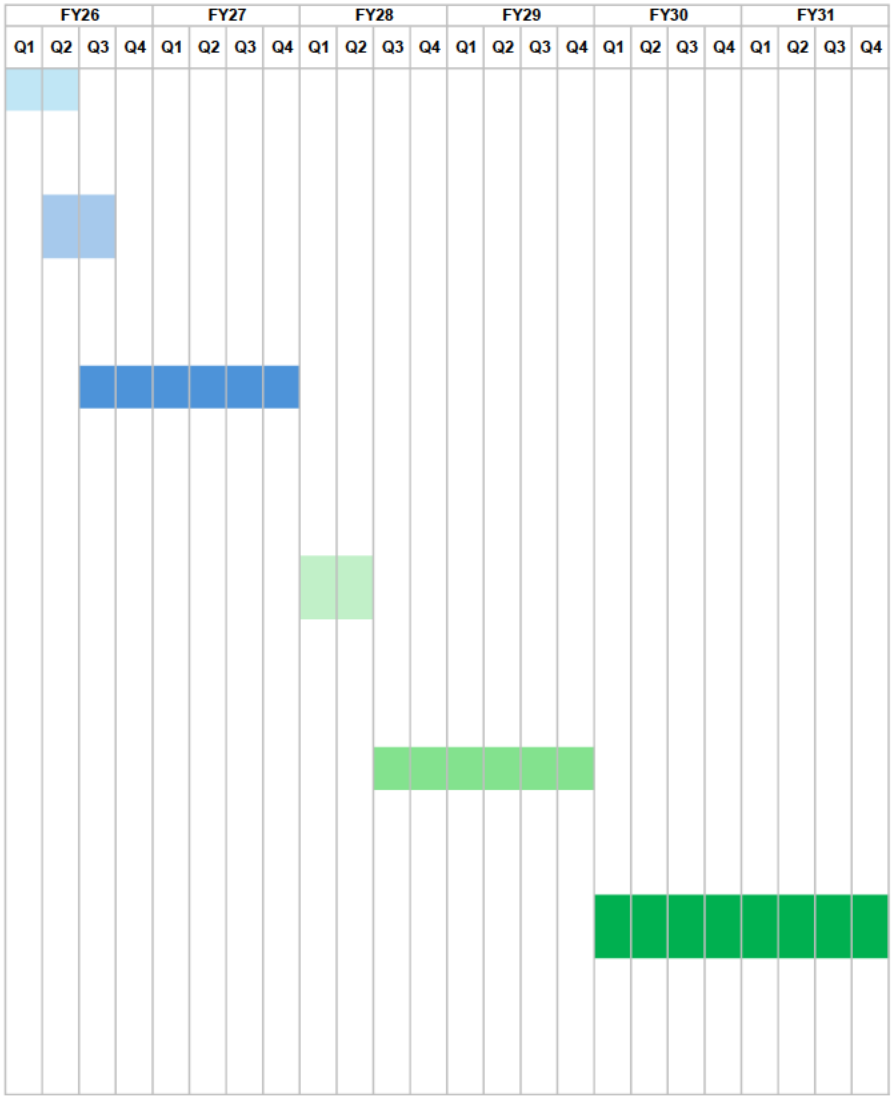
Rural Infrastructure for Care Access (RICA): A physical access initiative expanding emergency medical services, community care, and behavioral health infrastructure in rural communities.				
Strategic Goals	**Use of Funds**	**Technical Score Factors**	**Key Stakeholders**	• **Outcomes/ Metrics**
Make Rural America Healthy Again Sustainable Access	A, B, D, E, F, G, H, J, K	B.1, B.2, C.1, C.2, D.1, F.1, F.2, F.3	Hawai‘i Dept. of Health (DOH) in coordination with Hawai‘i Emergency Management Agency (HI-EMA) and Hawai‘i Fire Departments and EMS Agencies	• **25% reduction in time of emergency and trauma transfers from dispatch to hospital arrival** • 25% reduction in repeat EMS calls among rural residents in the served community (community-level) • 15% reduction in avoidable ED visits in the served community (community-level) • 10% reduced overall hospital use for recipients in the served community, no matter where the hospitalization occurs (community-level)
Hawai‘i Outreach for Medical Education in Rural Under-resourced Neighborhoods (HOME RUN): A pipeline initiative expanding education, recruitment, and retention of healthcare workers across rural Hawai‘i through certificate programs, residencies, incentives, and mentoring.				
Strategic Goals	**Use of Funds**	**Technical Score Factors**	**Key Stakeholders**	**Outcomes/ Metrics**
Workforce development	E, K	C.1, D.1	UH JABSOM, in collaboration with CHCs, practices, hospitals, Healthcare Association of Hawai‘i, Dept. of Education, Dept. of Labor and Industrial Relations, Hawaii Pacific Health, high schools, healthcare workers	• **1,000 new healthcare workers in rural communities** • 10% decrease in healthcare worker vacancy rates in rural healthcare facilities • 2,500 years of healthcare worker or provider service committed to serving rural communities (scholarships and provider incentives) • 1 new neighbor island (non-O‘ahu) residency program or rural track in each county (county-specific)

Rural Respite Network (RRN): A rural expansion of medical respite programs to reduce preventable hospital use among unhoused or post-acute patients with low medical acuity.				
Strategic Goals	**Use of Funds**	**Technical Score Factors**	**Key Stakeholders**	**Outcomes/ Metrics**
Sustainable access	A, B, G, H, J, K	B.1, B.2, C.1	Hawai‘i Dept. of Human Services in coordination with the Statewide Office on Homelessness and Housing Solutions, DOH Behavioral Health Services Administration, Med-QUEST Division, rural health facilities, and community-based organizations	• **15% reduction in 30-day hospital readmissions among respite users** • 20% in cost savings compared to the inpatient alternative • 50% of respite clients connected to stable housing or longer-term supportive programs • 2-3 day reduction in average inpatient length of stay for homeless discharges (county-level)
Rural Value-Based Innovation (RVBI) & AHEAD Readiness Fund: A competitive fund enabling rural providers to adopt innovative care models and succeed under the AHEAD model by financing local value-based innovations.				
Strategic Goals	**Use of Funds**	**Technical Score Factors**	**Key Stakeholders**	**Outcomes/ Metrics**
Innovative care	A, B, D, F, G, I, K	B.1, B.2, C.1, E.1	State Health Planning and Development Agency (SHPDA), the Med-QUEST Division (MQD), the DOH Office of Rural Health, and the RHTP Oversight Team.	• **3 new organized rural provider collaborative value-based networks (county-level; 1 per rural county)** • ≤3% annual per-beneficiary TCOC growth for rural populations compared to baseline • 90% rural health providers receive timely, actionable data to support AHEAD goals • 55 per 1,000 residents reduction in avoidable hospitalizations in funded communities (community-level)

Appendix B: Gantt Charts for each initiative, the oversight team, and state policy

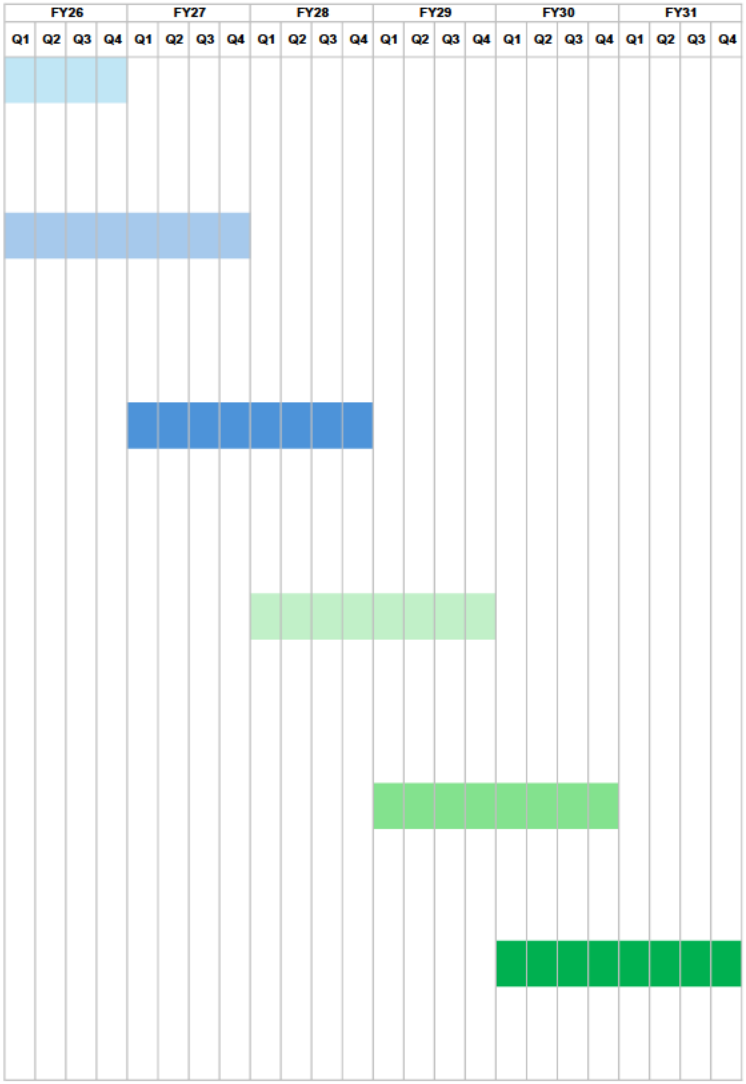
Initiative: Rural Respite Network

Stage/Milestone	Start	End	Responsible Party
Stage 0: Project Planning - Planning, site selection, partner MOUs	**Q1 FY26**	**Q2 FY26**	**DHS**
Finalize site selection in Kaua'i, Maui, Kona, Hilo, and Wai'anae.			
Negotiate MOUs with hospital partners, FQHCs, and behavioral health agencies.			
Establish steering committee and governance protocols.			
Develop data-sharing agreements with hospitals and Medicaid.			
Stage 1: Staff Assignment & Initial Set-up - Modular procurement, site infrastructure groundwork	**Q2 FY26**	**Q3 FY26**	**DHS**
Execute necessary capital improvements on two pilot sites. (No RHTP funds will go towards constructing the facilities.)			
Procure medical respite site operators.			
Launch inter-island training and workforce development partnerships with UH.			
Stand up structure for limited referral pathways with hospitals for early admissions.			
Stage 2: Implementation Begins - Pilot sites in two rural designated locations	**Q3 FY26**	**Q4 FY27**	**DHS**
Execute necessary capital improvements to remaining three sites.			
Medical respite site provider implements intake, discharge, and case management protocols.			
Open two initial sites, one in Kauai County and one in Hawaii County.			
Begin telehealth integration for behavioral health and chronic disease.			
Track first-year outcome metrics (readmissions, ER utilization, housing linkage).			
Adjust staffing ratios and operational processes based on early data.			
Begin Medicaid billing for respite stays as soon as pilot sites open.			
Stage 3: Midpoint Review - Evaluate pilots, adjust staffing, expand to full capacity at each site	**Q1 FY28**	**Q2 FY28**	**DHS**
Expand to three additional respite sites.			
Standardize care model across counties.			
Conduct midpoint evaluation comparing baseline vs. 2-year outcomes.			
Standardize billing practices across all five sites; integrate respite outcomes into AHEAD/TCOC performance metrics.			
Build out chronic disease and behavioral health integration.			
Stage 4: Finalization of Deliverables - Five sites operating at full scale	**Q3 FY28**	**Q4 FY29**	**DHS**
All five sites operating at full scale.			
Strengthen case management pipelines into kauhale villages and HUD housing.			
Expand telehealth specialist access statewide.			
Establish workforce pipeline (nursing, medical, social work rotations).			
Publish progress reports to CMS and state stakeholders.			
Stage 5: Full Implementation & Reporting - Transition to steady-state operations, performance evaluation	**Q1 FY30**	**Q4 FY31**	**DHS**
Respite billing fully integrated into Medicaid managed care; AHEAD/TCOC shared savings mechanisms used to reinvest in network expansion and chronic disease supports.			
Conduct independent evaluation of program impacts and cost savings.			
Institutionalize respite beds into state Medicaid plan as a covered service.			
Steering Committee evolves into permanent advisory board under DOH/DHS.			
Program becomes a core component of Hawai'i's rural health and homelessness response system.			



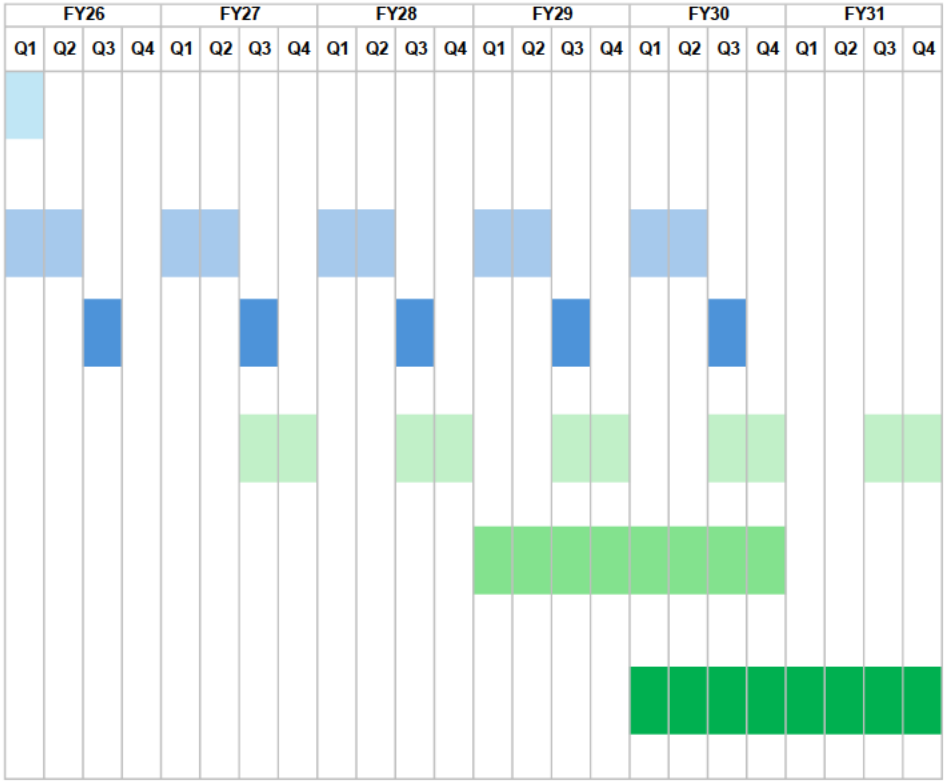
Initiative: Rural Infrastructure for Care Access (RICA)

Stage/Milestone	Start	End	Responsible Party
Stage 0: Project Planning	**FY26**	**FY26**	**DOH**
Hire staffing for program and recruit local candidates.			
Certify CCBHCs and a third PSAP.			
Develop statewide protocols, policies, and standard operating procedures (SOPs) for medical transfers, teleconsults, and communication escalation.			
Conduct a needs assessment to identify high-need communities and gaps in care access, and engage key stakeholders.			
Stage 1: Staff Assignment & Initial Set-up	**FY26**	**FY27**	**DOH**
Begin procurement for health platforms, system integration tools, and mobile clinics.			
Develop and integrate cross disciplinary training programs for team-based care models, home-based care, and telehealth tools.			
Begin statewide network buildout and integration with Pili Ola Telehealth Network.			
Establish CCBHCs on Kaua'i, Big Island, and rural Oahu and launch behavioral health teams.			
Launch 24/7 MEDICOM operations at PSAP and expand mobile crisis van services across Neighbor Islands and rural O'ahu.			
Stage 2: Implementation Begins	**FY27**	**FY28**	**DOH**
Deploy statewide CAD platform for EMS, Fire, and Air Medical.			
Link medical systems to MEDICOM via Starlink.			
Expand teleconsult capacity for critical care through MEDICOM and Pili Ola Telehealth.			
Pilot and expand youth-focused prevention and support services and identify potential community center sites for future youth-specific programs.			
Establish collaborative care frameworks that integrate clinical specialists and community health workers into primary care and public health teams.			
Implement scheduled in-home visits by community paramedicine teams.			
Stage 3: Midpoint Review	**FY28**	**FY29**	**DOH**
Achieve full interoperability between CAD, Starlink-enabled EMS EHRs, and hospital EHR systems statewide, and conduct systemwide training.			
Expand youth prevention and support services in high-need rural communities.			
Establish dashboards for time-to-definitive-care, utilization rates, and transfer efficiency.			
Begin independent evaluation of outcomes.			
Scale mobile van coverage to include all areas of Maui, Moloka'i, and Lāna'i.			
Deploy and expand care-teams across rural communities and supportive infrastructure to enable successful integration and service delivery.			
Stage 4: Finalization of Deliverables	**FY29**	**FY30**	**DOH**
Expand MEDICOM capabilities for scheduling and tracking.			
Achieve full statewide telehealth connectivity across behavioral health care providers and crisis response systems.			
Conduct mid-cycle ROI analysis to measure cost avoidance.			
Evaluate performance metrics related to health outcomes, service utilization, and team effectiveness.			
Stage 5: Full Implementation & Reporting	**FY30**	**FY31**	**DOH**
Begin a collaborative network between UH, state and community colleges, and State DOE to develop a pipeline of mental health workers across all areas.			
Establish an investment program for residents in training to receive financial support.			
Publish final statewide evaluation of RHTP-funded initiatives, highlighting cost savings, improved outcomes, and sustainability strategies.			



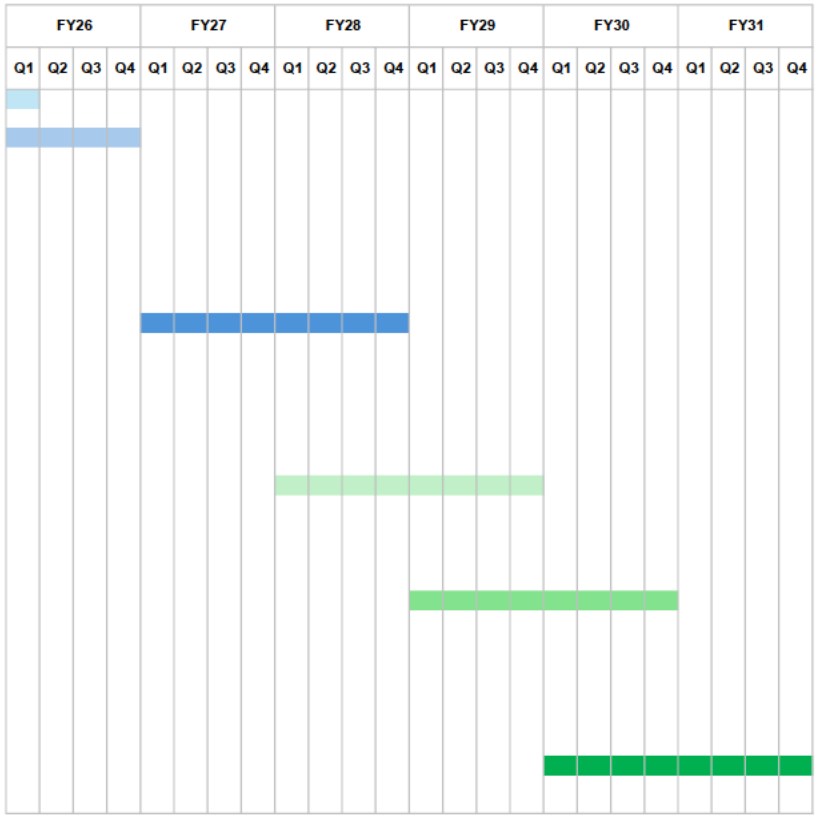
Initiative: Rural Value-Based Innovation (RVBI) and AHEAD Readiness Fund

Stage/Milestone	Start	End	Responsible Party
Stage 0: Project Planning	**Q1 FY26**	**Q1 FY26**	**Rural Innovation Council**
Establish the Rural Innovation Council (initiated by SHPDA) consisting of leadership from SHPDA, MQD, DOH (Office of Rural Health), the RHTP Oversight Team, the AHEAD Steering Committee, and rural stakeholders.			
Stage 1: Staff Assignment & Initial Set-up	**Q1 FY26**	**Q2 FY26**	**Rural Innovation Council**
Procure, review, and decide on requests for proposals.			
Stage 2: Implementation Begins	**Q3 FY26**	**Q3 FY26**	**Rural Innovation Council**
Disburse funds (yearly thereafter), offer oversight, and connect to the Analytics and Technical Assistance Hub established by the RHIN initiative.			
Stage 3: Midpoint Review	**Q3 FY27**	**Q4 FY27**	**Rural Innovation Council**
Rural Innovation Council reviews condition of funded projects (yearly thereafter).			
Report findings from Rural Innovation Council review.			
Stage 4: Finalization of Deliverables	**Q1 FY29**	**Q4 FY30**	**Rural Innovation Council**
Rural Innovation Council reviews success of funded projects and provides directional oversight to meet initiative goals.			
Report findings from Rural Innovation Council Review.			
Stage 5: Full Implementation & Reporting	**Q1 FY30**	**Q4 FY31**	**Rural Innovation Council**
Rural Innovation Council advises funded projects on means to sustain innovative models after			
Report findings from Rural Innovation Council Review.			



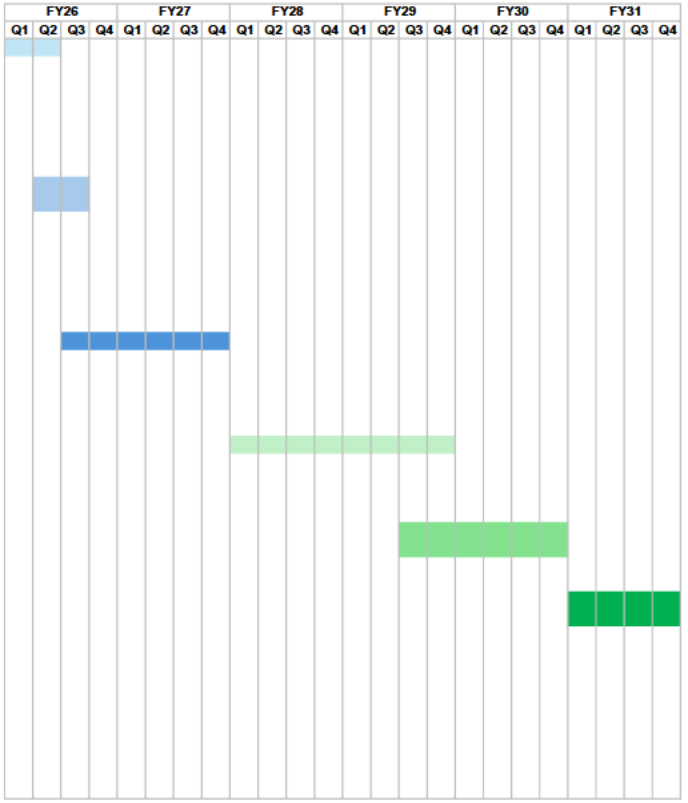
Initiative: Rural Health Information Network (RHIN)

Stage/Milestone	Start	End	Responsible Party
Stage 0: Project Planning	**Q1 FY26**	**Q1 FY26**	**SHPDA**
Assign lead State agencies for each program.			
Stage 1: Staff Assignment & Initial Set-up	**FY26**	**FY26**	**SHPDA/ MQD**
Conduct statewide needs assessments of EHR systems, broadband capacity, and HIE capabilities; establish baseline metrics for ED visits, provider readiness, and system capacity.			
Begin planning and buildout for EHR integration, broadband expansion, and data systems for improved connectivity and care coordination.			
Develop RFPs across service domains with stakeholder input and award key contracts by the end of FY26 to support program implementation.			
Initiate C-Hub, DISH, and the Technical Assistance Hub with project leadership in place and alignment across governance structures to support coordinated statewide implementation.			
Stage 2: Implementation Begins	**FY27**	**FY28**	**SHPDA/ MQD**
Begin onboarding priority sites and deploy wireless infrastructure to support clinical data exchange and system access.			
Stand up statewide platforms for data aggregation, real-time clinical event notifications, and system integration across major health and rural networks.			
Build secure data systems and launch initial dashboards.			
Continue expanding platform adoption among healthcare and community-based organizations.			
Begin tracking newly available outcomes such as access and referrals, launch enrollment campaigns, establish Medicare–Medicaid data linkages, and align efforts with broader system reforms.			
Stage 3: Midpoint Review	**FY28**	**FY29**	**SHPDA/ MQD**
Enhance connectivity between rural providers and networks/programs: EHR and wireless networks.			
Receive real-time connectivity and longitudinal care coordination.			
Expand program's public and network outreach through modeling and program analytics.			
Strengthen closed-loop referral processes and embed them into routine practice to improve service access.			
Expand integrated plan availability to all rural counties; scale enrollment hub statewide.			
Stage 4: Finalization of Deliverables	**FY29**	**FY30**	**SHPDA/ MQD**
Improve data platforms and analytics capabilities to support priority areas such as workforce, maternal health, chronic disease, and kupuna care.			
Scale systems to reach high provider participation, improve referral completion rates, reduce avoidable ED visits, and identify service gaps.			
Align key initiatives with Hawai'i's AHEAD model through all-payer strategies and value-based payment contracts to ensure long-term impact.			
Develop and implement financing plans to secure ongoing support for digital health infrastructure and services.			
Stage 5: Full Implementation & Reporting	**FY30**	**FY31**	**SHPDA/ MQD**
Complete EHR conversions.			
Transition all programs to non-RHTP sustained models.			



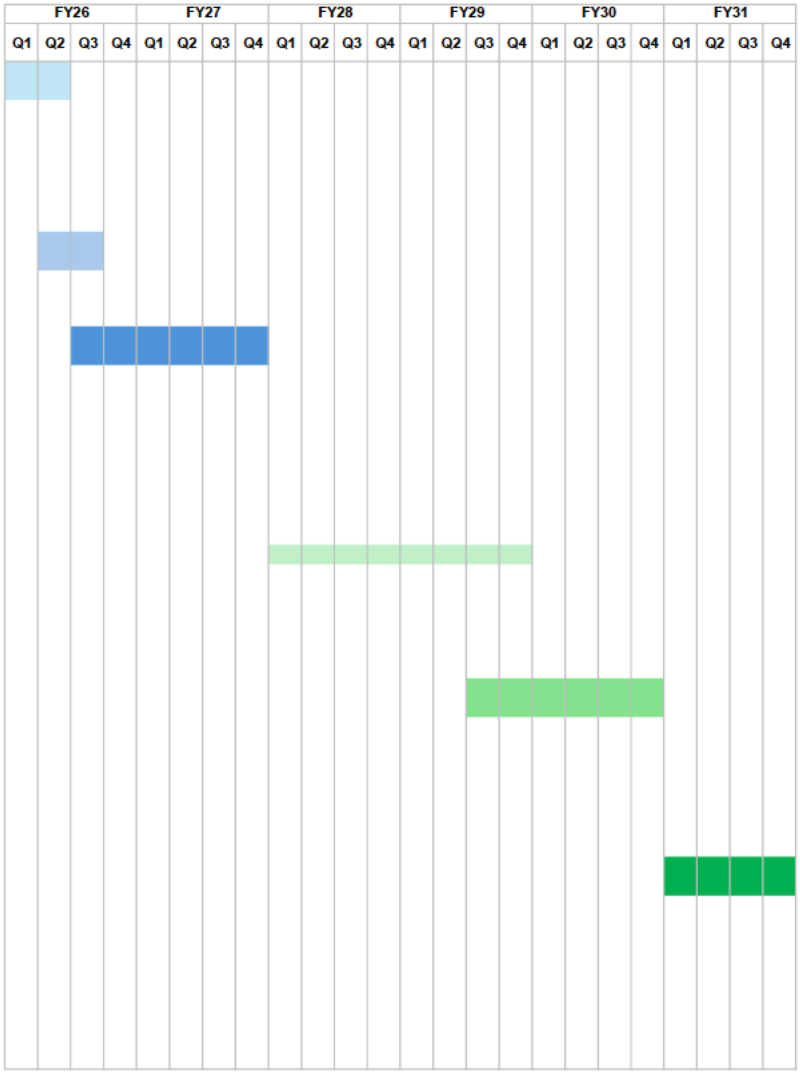
Initiative: HOME RUN (Workforce Development)

Stage/Milestone	Start	End	Responsible Party
Stage 0: Project Planning	**Q1 FY26**	**Q2 FY26**	
Execute subawards.			UH JABSOM/ Co-PIs; Core team
Establish overall HOME RUN steering committee, governance, operational structures within JABSOM AHEC and ADAA.			
Conduct stakeholder meetings with the core groups for each activity.			
Develop reporting protocols (quarterly or semi-annual reporting), detailed metrics for each activity, and structure for overall			
Hire and assign key staff for HOME RUN core functions and activities.			
Establish criteria and contracts for the HOME RUN loan repayment program.			
Integrate policy and legislative strategy into project planning and establish pathways for inclusion in state budget and/or			
Stage 1: Staff Assignment & Initial Set-up	**Q2 FY26**	**Q3 FY26**	
Finalize the detailed timelines, processes, and operational structure (if needed) for each activity (i.e., annual workplan for each			Core team; Co-PIs with Subrecipients
Identify and prioritize high schools to start Activity 1 (CTE certificates, HOSA).			Core team; Subrecipient
Assign staff to the HOME RUN loan repayment and scholarship components.			Core team
Assign staff lead to facilitate rural clinical training opportunities (connecting learner to the subrecipient).			Co-PIs; Subrecipient; Lead points of contact for existing UH health professions programs
Hire staff to coordinate Activity 2b (GME expansion) if not previously done.			JABSOM ADAA
Stage 2: Implementation Begins	**Q3 FY26**	**Q4 FY27**	
Deploy HOME RUN Loan Repayment and Scholarship website, programs, and applications.			Core team
Initiate mentoring and implement additional education programs.			Core team
Subrecipients begin implementation according to the workplans developed in Stage 0 and 1: Activities 1, 1b, 2a, 2b, 3b, 4a,b,d,e.			Subrecipients with oversight by the Co-PIs (lead PI differs by activity)
Review progress reports.			HOME RUN Steering Committee
Stage 3: Midpoint Review	**Q1 FY28**	**Q4 FY29**	
Mid-point review of all activities, make any necessary adjustments, including any adjustments in the proportion of loan			HOME RUN Steering Committee
Expand activities according to the updated annual workplans.			Core team; Subrecipients
Determine readiness for additional rural GME tracks.			GME Core team; JABSOM ADAA
In conjunction with the state RHTP and other efforts, start policy advocacy efforts impacting healthcare provider recruitment			Co-PIs
Stage 4: Finalization of Deliverables	**Q3 FY29**	**Q4 FY30**	
Begin garnering state and private resources to sustain the core infrastructure for CTE, HOSA, mentoring, core faculty positions			Co-PIs with key stakeholders
Expand activities in accordance with the annual workplans.			
Stage 5: Full Implementation & Reporting	**Q1 FY31**	**Q4 FY31**	
Fully established mechanism for tracking and supporting retention of loan and scholarship recipients in rural locations.			Core AHEC
Stabilized funding for HOSA activities in each rural high school.			Core AHEC
Statewide (UH, DOE) and private support (i.e., health systems, insurers) to maintain CTE programs in high schools.			Core AHEC
Additional state support for neighbor island clinical rotations.			Core AHEC; ADAA
Organized coalitions for each county working synergistically with statewide policy and programmatic efforts to address health			All Hawaii AHECs and partners
Fully operational and embedded educational, local (rural hospital) and telehealth infrastructure for virtual neonatal support			UH TASI; Subrecipient
One additional accredited rural primary care residency program (funded by a mix of state, health system, DGME and IME			JABSOM ADAA/ GME Office
At least two additional rural residency training tracks (funded by a mix of state, health system, DGME and IME support).			JABSOM ADAA/ GME Office
At least one additional rural residency track application submitted.			JABSOM ADAA/ GME Office
Demonstrate measurable system-wide impacts including increased numbers and types of healthcare workers, ratio of rural			Core team



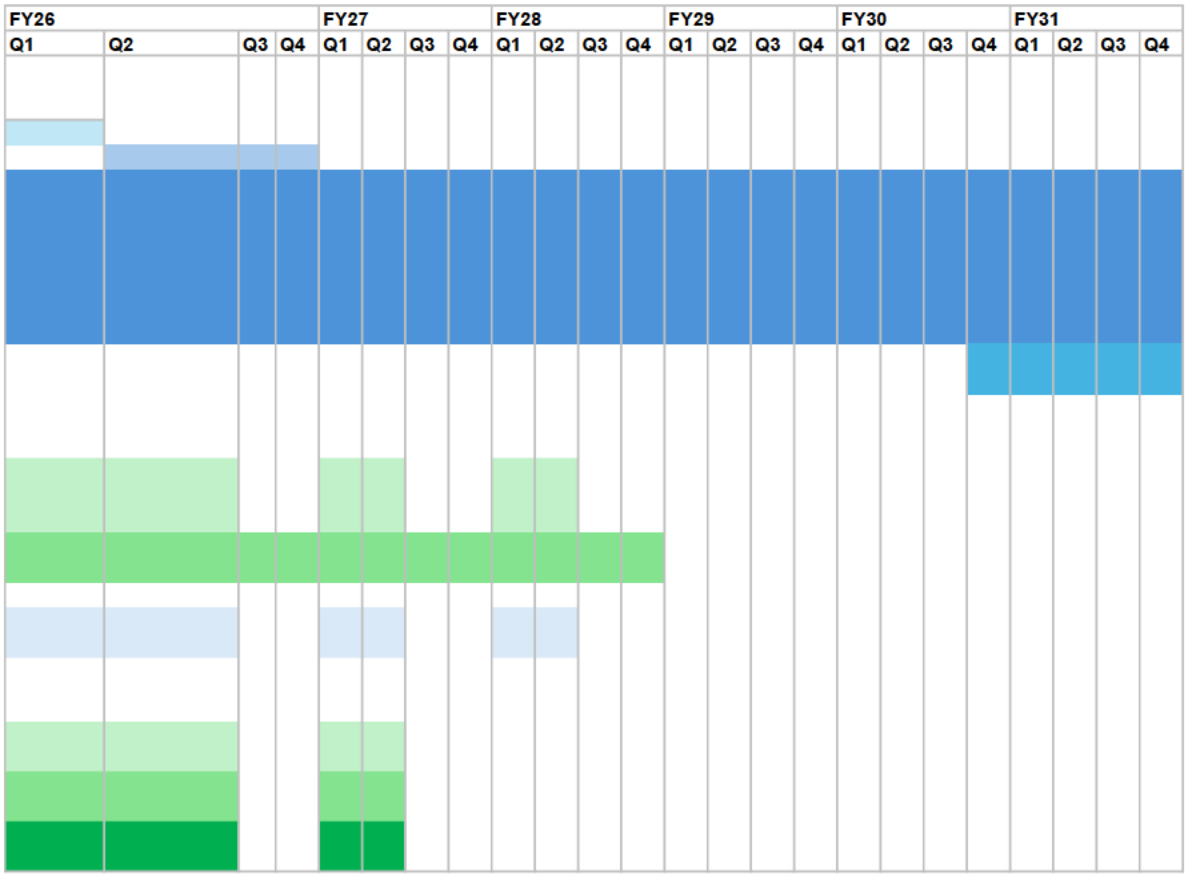
Initiative: Telehealth

Stage/Milestone	Start	End	Responsible Party
Stage 0: Project Planning - Planning, readiness, and coordination framework	**Q1 FY26**	**Q2 FY26**	
Establish Pili Ola Telehealth Coordinating Council and Working Groups (Policy, Technology/AI,			TASI
Conduct statewide needs and readiness assessments for access points, workforce, and data			Contractors
Finalize project management structure at UH–TASI.			TASI
Develop baseline data collection plan and reporting framework for all telehealth programs.			TASI; TACC
Hire and assign key staff for Pili Ola backbone functions.			TASI
Disseminate information to share as the program evolves.			TASI
Integrate policy and legislative strategy into project planning and establish pathways for inclusion			TASI
Stage 1: Staff Assignment & Initial Set-up - Workforce activation and data architecture	**Q2 FY26**	**Q3 FY26**	
Begin Navigator and Facilitator recruitment and training.			TASI
Launch contracts and procurement for initial Safety Net specialties, workforce, TAPs, (as awarded			TASI
Begin design and procurement of subrecipients agreements and contracts for all projects under			TASI
Stage 2: Implementation Begins - Early delivery across multiple settings	**Q3 FY26**	**Q4 FY27**	
Pilot access points across schools, libraries, community sites, and state agencies to test models of delivery in different rural settings.			TASI; Contractors; Subrecipients
Deploy initial cohort of trained Navigators beginning in Hawai'i County and Maui County,			TASI
Identify additional Safety Net specialty services needed in rural communities.			TASI
Launch pilot referral and scheduling platform, integrating with early adopter sites to test			TASI
Refine strategies and implementation plan based on Coordinating Council and community			TASI
Implement virtual chronic-disease management, e-consult, teleinfectious disease, maternal health and behavioral-health/kiosk pilots to test integrated workflows.			TASI; Contractors; Subrecipients
Quarterly reports towards milestones developed, followed by yearly progress status reports and			TASI; TACC
Stage 3: Midpoint Review - Network growth, analytics, and evaluation	**Q1 FY28**	**Q4 FY29**	
Expand access points across rural counties, focusing on sustainable models of care through schools, libraries, FQHCs, RHCs, employers, and community-based organizations.			TASI; Contractors; Subrecipients
Scale Navigator and workforce training to reach a statewide cohort and meet program benchmark,			TASI
Broaden Safety Net specialty services based on program plans and the gaps identified by the			TASI
Strengthen referral and scheduling systems to integrate clinical and social service partners into a			TASI
Conduct mid-point evaluation to assess reach, impact, and equity of access; refine strategies to			TASI; TACC
Stage 4: Finalization of Deliverables - Statewide Telehealth Expansion	**Q3 FY29**	**Q4 FY30**	
Expand and stabilize statewide access points with consistent systems for tracking and evaluation.			TASI
Operationalize the full Safety Net portfolio across all five counties, ensuring specialty care is accessible through multiple community entry points.			TASI; Contractors; Subrecipients
Embed a robust workforce of Navigators and Facilitators across partner organizations, supported by shared accountability and retention agreements.			TASI; Statewide Organizations; State & County Government
Achieve consistent statewide referral logging through the scheduling platform, building toward			TASI
Stage 5: Full Implementation & Reporting - Full operation, reporting, and long-term sustainability	**Q1 FY31**	**Q4 FY31**	
Fully coordinate statewide access points under Pili Ola, creating a cohesive network across			TASI
Ensure Safety Net services are fully operational, with priority specialties available across all counties.			TASI; Contractors; Subrecipients
Sustain and embed the Navigator, Facilitator, and CHW workforce across community sites, with structures for long-term integration and quality improvement.			TASI; Statewide Organizations; State & County Government
Scale referral and scheduling system adoption, capturing the majority of referrals and follow-up			TASI
Operate fully integrated statewide telehealth system spanning maternal, behavioral, chronic-care, and specialty domains.			TASI; Contractors; Subrecipients

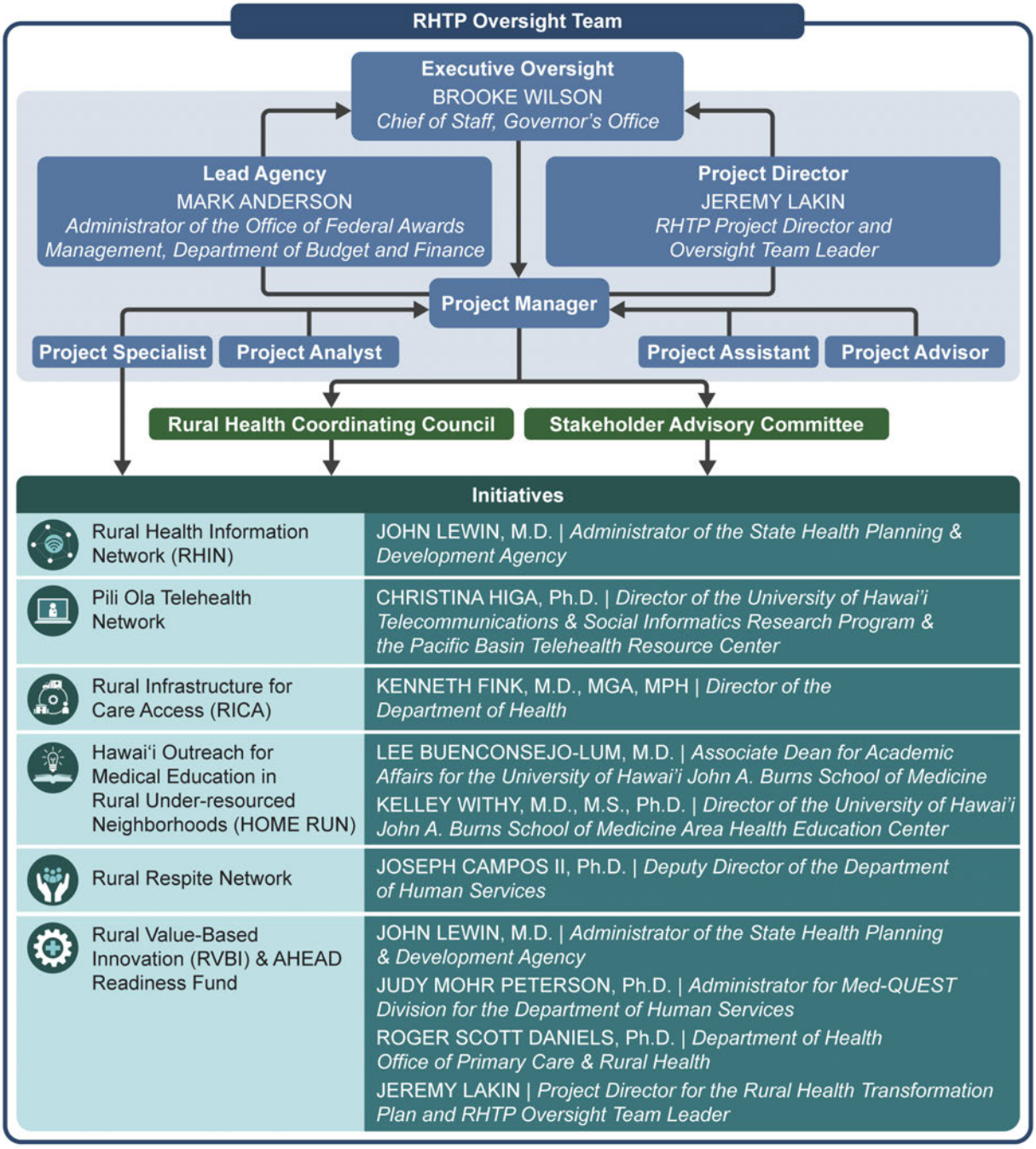


Oversight Team and State Policy

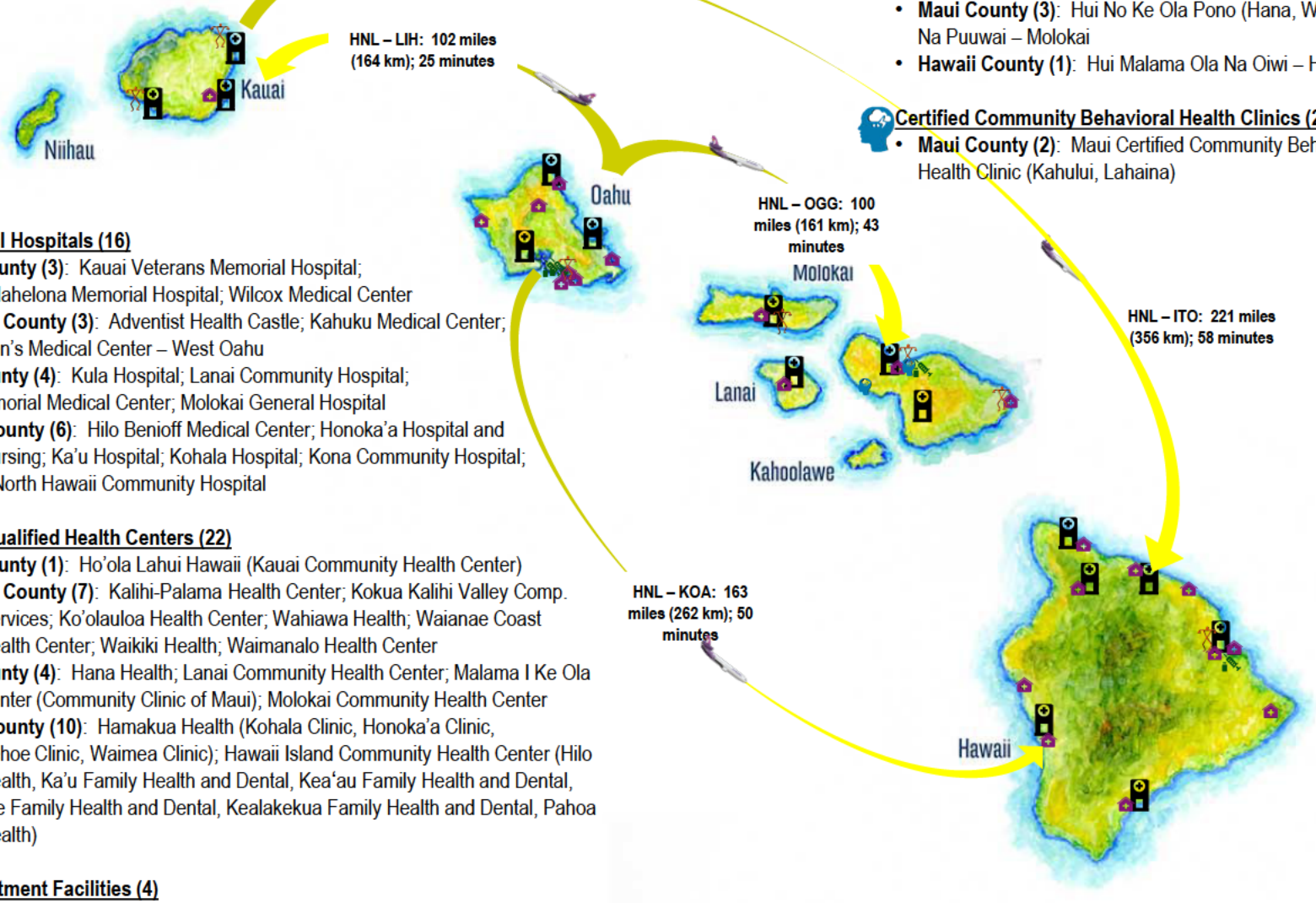
Oversight Team or State Policy
Oversight Team
Hire Project Director and essential staff
Complete hirings of the Oversight Team
Oversight team activitites, including: facilitate monthly Stakeholder Advisory Committees and engage with constituents; receive and interpret quarterly reports from initaitive leaders; collaborate with initiaitve leaders and ensure cooperation among initatiives; coordinate with CMS and provide annual reviews
Transition ongoing and succssful initiatives to sustainable models
Presidential Fitness Test
Introduce legislation to require public schools to establish the Presidential Fitness Test. Introduce until passing or end of 2028.
Administratively pursue requiring the test in public schools. Pursue until success or end of 2028.
Nutrition CME
Introduce legislation to include nutrition in CME. Introduce until passing or end of 2028.
Compacts
Introduce legislation to become a PA Compact state. Introduce until passing or end of 2027.
Introduce legislation to become a PSYPACT state. Introduce until passing or end of 2027.
Introduce legislation to become an NLC state. Introduce until passing or end of 2027.



Appendix C: Hawai‘i RHTP Organizational Chart



D. Map of Key Facilities & Flight Times



Hawaii Rural Hospitals (16)

- **Kauai County (3)**: Kauai Veterans Memorial Hospital;
- Samuel Mahelona Memorial Hospital; Wilcox Medical Center
- **Honolulu County (3)**: Adventist Health Castle; Kahuku Medical Center;
- The Queen's Medical Center – West Oahu
- **Maui County (4)**: Kula Hospital; Lanai Community Hospital; Maui Memorial Medical Center; Molokai General Hospital
- **Hawaii County (6)**: Hilo Benioff Medical Center; Honoka'a Hospital and
- Skilled Nursing; Ka'u Hospital; Kohala Hospital; Kona Community Hospital; Queen's North Hawaii Community Hospital

Federally Qualified Health Centers (22)

- **Kauai County (1)**: Ho'ola Lahui Hawaii (Kauai Community Health Center)
  Honolulu County (7): Kalihi-Palama Health Center; Kokua Kalihi Valley Comp. Family Services; Ko'olauloa Health Center; Wahiawa Health; Waianae Coast Comp. Health Center; Waikiki Health; Waimanalo Health Center
  Maui County (4): Hana Health; Lanai Community Health Center; Malama I Ke Ola Health Center (Community Clinic of Maui); Molokai Community Health Center
  Hawaii County (10): Hamakua Health (Kohala Clinic, Honoka'a Clinic, Laupahoehoe Clinic, Waimea Clinic); Hawaii Island Community Health Center (Hilo Family Health, Ka'u Family Health and Dental, Kea'au Family Health and Dental, Kealakehe Family Health and Dental, Kealakekua Family Health and Dental, Pahoa Family Health)

Opioid Treatment Facilities (4)

- **Honolulu County (2)**: Comprehensive Health and Attitude Management Program; Ku Aloha Ola Mau
- **Maui County (1)**: Comprehensive Health and Attitude Management Program Clinic of Maui
- **Hawaii County (1)**: Ku Aloha Ola Mau

Native Hawaiian Health Systems (7)

- **Kauai County (2)**: Ho'ola Lahui Hawaii (Kapaa, Waimea)
- **Honolulu County (1)**: Ke Ola Mamo
- **Maui County (3)**: Hui No Ke Ola Pono (Hana, Wailuku); Na Puuwai – Molokai
- **Hawaii County (1)**: Hui Malama Ola Na Oiwi – Hilo

Certified Community Behavioral Health Clinics (2)

- **Maui County (2)**: Maui Certified Community Behavior Health Clinic (Kahului, Lahaina)

The following attachment is not included in the view since it is not a read-only PDF file.

Upon submission, this file will be transmitted to the Grantor without any data loss.

Appendix E Letters.pdf

Appendix F. State of Hawai‘i Data for CMS RHTP Rural Facility and Population Score Factors and Technical Score Factors

Rural Facility and Population Score Factors	State of Hawai‘i	Data Source
A.1. Absolute size of rural population in a State	The absolute size of the rural population in Hawai‘i is 593,603.	Source: Decennial Census 2020: DEC Demographic Profile
A.2. Proportion of Rural Health Facilities in the State	Hospital Rural Health Facilities = 64% Other rural health facility types = 55%	Sources listed in the detailed data below.
A.3. Uncompensated care in a State	1.1% is the % of Hospital Care as a Share of Operating Expenses Charity Care and Bad Debt = $49,895,544 Operating Expenses = $4,728,437,972	Source: MACPAC's latest published "Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States" report as of September 1, 2025 [WS S-10, line 30] and Medicare cost report [WS G-3, line 4].
A.4. % of the State population located in rural areas	13.9% of the population of HI is in rural areas	Source: Decennial Census 2020: DEC Demographic Profile;
A.5. Metrics that define a State as being a frontier	7.4% of Hawai‘i's population (98,845 people) is in FAR Level 2 areas. 35% of the land area (2,304 square miles) is classified as frontier and remote.	Source: 2010 decennial census Decennial Census 2020: DEC Demographic Profile
A.6. Area of a State in total square miles	10,932 square miles (land plus water)	Census Bureau's MAF/TIGER® database. The boundaries of the states and equivalent areas are as of January 1, 2010.
A.7. % of hospitals in a State that receive Medicaid DSH payments	87.5% of (21 of 24) hospitals in Hawaii receive Medicaid DSH payments.	Federal FY 2024 DSH payment schedule produced by Myers & Stauffer and the Healthcare Association of Hawai‘i

Technical Score Factors	State of Hawai‘i
B.3. SNAP waivers	***State policy actions factor: 75 points currently:*** The State's USDA SNAP waiver, submitted by the Department of Human Services on October 1, 2025, seeks to ban purchases of non-nutritious items.
B.4. Nutrition Continuing Medical Education	***State policy actions factor: 0 points currently; 25 points when legislation proposed.*** Nutrition is not currently required in physicians' continuing medical education, and no legislation is pending on this matter. The State RHTP Oversight Team plans to propose a bill before the 2026 legislative session.
C.3. Certificate of Need (CON)	***State policy actions factor: 65 points.*** The State has moderate CONs across facility categories, total score of 65 per the Cicero ranking system, resulting in 50 points. Source: 50-State-CON-Rankings-Report-12-5-2024.pdf Medical Inpatient = 10 Medical Outpatient = 15 Behavioral Inpatient = 15 Behavioral Outpatient = 0 Long-term Care Facilities = 5 Day Services = 0 Ancillaries = 5 Imaging = 15 Other =0

D.2. Licensure compacts	***State policy actions factor: 40 points based on the average of all scores.*** • Physician Score = 100 • Act 163, SLH 2025 passed legislation to allow the Hawai‘i Medical Board to perform criminal history checks, allowing for full compliance with the Interstate Medical Licensure Compact (IMLC) as a State of Principal License. Nurse Score = 50 [Hawai‘i is not a NLC member state. And Hawai‘i has a 2025 bill that will carry over to 2026.] • EMS Score = 0 [Hawai‘i is not a part of the EMS compact.] • Psychology Score = 50 [Hawai‘i is non-PSYPACT participating. And Hawai‘i has a 2025 bill that will carry over to 2026.] • Physician Assistant Score = 0 [Hawai‘i is not a part of the PA Compact. And no active legislation found.]

D.3. Scope of practice
 	
State policy actions factor:
50 points based on the average of all scores.
	• PA score = 0
	  ○ Reduced scope
	  ○ HRS 475 Under Hawai‘i’s scope-of-practice policy, PAs must be supervised by a physician. The supervising physician determines the PA’s scope of practice in a written agreement at the practice site.
	• NP score = 100
	  ○ Full scope
	  ○ HRS§ 457-8.6, the Board of Nursing grants prescriptive authority to qualified APRNs. This includes over-the-counter (OTC) drugs, legend drugs, and controlled substances (subject to restrictions), as well as ordering, prescribing, and dispensing medical devices and equipment within their specialty.
	• Pharmacist score = 50
	  ○ Hawai‘i has a score of 4
	  ○ HRS 461, “practice of pharmacy” includes compounding, dispensing, labeling, selecting and reviewing prescriptions, and providing consultation and advice on therapeutics.
	  ○ HB659: Pharmacists are authorized to order, perform, or report CLIA-waived tests (e.g., point-of-care assays) and certain diagnostic tests, under new or clarifying legislation (e.g., HB 659).
	  ○ Admin Rules § 16-95-80, a registered pharmacist must be physically present in the prescription area during hours of operation, except in emergencies.
	• Dental Hygienist score = 50 [Hawai‘i has 4 types of tasks]

E.3. Short-term, limited-duration insurance	***State policy actions factor: 0 points.*** N/A. Hawai‘i is the only state with pre-paid healthcare (PrePaid Healthcare Act)
F.1. Remote care services	***State policy actions factor: 80 points based on the average of state policy actions.*** The State Medicaid plan currently covers live video, Store and Forward, and Remote Patient Monitoring in full. No policy changes or additions are proposed. State Policy Actions assessment

	• Medicaid payment for at least one form of live video = 100 • Medicaid payment for Store and Forward = 100 • Medicaid payment for Remote Patient Monitoring = 100 • In-State licensing requirement exception = 100 (some exceptions) • Telehealth License/ Registration Process (including special licenses) = 0
F.2. Data infrastructure	***Data-driven factor: 67 points*** Quality of State's reporting of full T-MSIS data: Hawai'i passed all Outcomes-Based Assessment metrics for Transformed Medicaid Statistical Information System (T-MSIS).

SUPPORTING DATA

A.2. Detailed data for Proportion of Rural Health Facilities in the State with Source

Category	Total	Rural	Source
Critical access hospitals	9	8	CMS Provider of Services file (Q2 2025)
Sole Community Hospitals	5	1	CMS Provider of Services file (Q2 2025)
Medicare Dependent Hospitals (MDH)	0	0	CMS Provider of Services file (Q2 2025)
Low Volume Hospitals (LVH)	3	0	CMS Provider of Services file (Q2 2025)
Rural Emergency Hospitals	0	0	CMS Provider of Services file (Q2 2025)
Other rural hospitals	5	5	CMS Provider of Services file (Q2 2025)
Subtotal of Hospital Rural Health Facilities	***22***	***14***	***64% RURAL***
Rural Health Clinics (RHC)	25	25	CMS Provider of Services file (Q2 2025)
Federally Qualified Health Centers (FQHC)	128	65	Most recent list of HRSA Health Centers and Look-Alikes
FQHC Look-Alikes	7	0	Most recent list of HRSA Health Centers and Look-Alikes
Community Mental Health Centers (CMHC)	18	10	CMS Provider of Services file (Q2 2025)
Opioid Treatment Facilities (OTF)	4	1	Designated by SAMHSA
Certified Community Behavioral Health Clinics	2	1	Current list of CCBHC entities within the State as of 9/1/25
SUBTOTAL of other rural health facility types:	***184***	***102***	***55% RURAL***

Critical access hospitals:

Kaua'i Veterans Memorial Hospital (rural)	Ka'u Hospital (rural)	Kohala Hospital (rural)
Molokai General Hospital (rural)	Kahuku Medical Center (rural)	Lanai Community Hospital (rural)
Samuel Mahelona Memorial Hospital (rural)	Hale Ho'ola Hamakua	Kula Hospital (rural)

Sole Community Hospitals:

Hospital	[redacted]	Sole Community	Rural
Hilo Benioff Medical Center		Yes	Yes
Kona Community Hospital		Yes	Yes
Maui Memorial Medical Center		Yes	No

North Hawai‘i Community Hospital	[redacted]	Yes	Yes
Wilcox Memorial Hospital	[redacted]	Yes	Yes

Medicare Dependent Hospitals (MDH): **None.**

Low Volume Hospitals (LVH):

Hospital	[redacted]	Low volume	Located in rural areas per HRSA
Kona Community Hospital	[redacted]	Yes	Yes
North Hawai‘i Community Hospital	[redacted]	Yes	Yes
Wilcox Memorial Hospital	[redacted]	Yes	Yes

Rural Emergency Hospitals: **None**

Rural Health Clinics (RHC):

Molokai Rural Health Clinic	Hamakua Health Center Inc	Five Mountains Hawai‘i, Inc
Lahaina Clinic	Kihei Clinic	Kahuku Clinic
Molokai Rural Health Clinic	Ka‘u Hospital Rural Health Clinic	Molokai General Hospital
Castle Health Clinic of Laie	Puna Community Medical Center	The Clinic at Kahuku Medical Center
Women's Center	Primary Care Clinic	East Hawaii Health Clinic At 1190 Waianuenue
East Hawai‘i Health Clinic at Pu‘uhonu Way	HHSC-Kaua‘i Region Clinics The Clinic At Lihue	HHSC-Kaua‘i Region Clinics The Clinic At Kalaheo
HHSC-Kaua‘i Region Clinics Specialty Clinic Kalaheo	HHSC-Kaua‘i Region Clinics The Clinic At Kapaa	HHSC-Kaua‘i Region Clinics The Clinic At Port Allen
HHSC-Kaua‘i Region Clinics The Clinic At Waimea	East Hawaii Health Clinic At Kea‘au	HHSC-Kaua‘i Region Clinics Urgent Care At Poipu
KMC Haleiwa		

Federally Qualified Health Centers (FQHC) and Section 330 Grantees (combined category): Just over half (51%, or 65 of 128 FQHCs) are rural. 0 FQHC Look-alikes are rural, as detailed in the following table.

Federally Qualified Health Centers (FQHC) and Section 330 Grantees (combined category)	Total	Rural	Total MUA/P	Total Dental Health HPSA	Total Mental Health HPSA	Total Primary Care HPSA
Federally Qualified Health Center (FQHC)	128	65	108	85	128	77
Federally Qualified Health Center (FQHC) Look-Alike	7		7	0	7	7
Total	**135**	**65**	**115**	**85**	**135**	**84**

Community Mental Health Centers (CMHC): List includes State of Hawai‘i Adult Mental Health Division Clinics, all actively participating in Medicare & Medicaid. In Sept 2025, the State asked CMS why these clinics are missing from Provider of Services file

Clinic	Location	[redacted]	Rural
Central-Leeward O‘ahu CMHC	860 Fourth Street, Pearl City, HI 96782	[redacted]	No

	Wahiawa Satellite, 860 Fourth Street, Pearl City, HI 96782 Makaha Satellite, 84-1170 Farrington Highway, Waiʻanae, HI 96792	[redacted]	No No
East Honolulu CMHC	3627 Kilauea Avenue #408, Honolulu, HI 96816		No
West Honolulu/Kalihi-Palama CMHC	1700 Lanakila Avenue, Honolulu, HI 96817		No
Windward Oʻahu CMHC	45-691 Keaʻahala Road, Kaneohe, HI 96744		No
Kauaʻi CMHC	4370 Kukui Grove Street, Suite 3-211, Lihue, HI 96766		Yes
Wailuku CMHC	121 Mahalani Street, Wailuku, HI 96793 Lanai Satellite, 430 Lanai Avenue, #6, Lanai City, HI 96763 Molokai Satellite, 65 Makaena Street, #107, Kaunakakai, HI 96768		No Yes Yes
Kahului CCBHC (not State Certified)	53 S. Puunene, Suite 105, Kahului, HI 96732		No
Lahaina CCBHC (not State Certified)	1830 Honoapiilani Hwy, Lahaina, HI 96761		Yes
Hilo CMHC	355 Kinoʻole Street, Hilo, HI 96720 Honokaa Satellite 45-3380 Mamane Street, Honokaa, HI 96727 Pahoa Satellite, 15-2866 Pahoa Village Road, Pahoa, HI 96778 Waimea Satellite 67-5189 Kamamalu Street, Kamuela, HI 96743		Yes Yes Yes Yes
Kona CMHC	79-1020 Haukapila Street, Kealakekua, HI 96750 Kaʻu Satellite, 219-B Ka Alaiki Road, Naalehu, HI 96772		Yes Yes

Opioid Treatment Facilities (OTF):

OTF Name	Address	Certification
Ku Aloha Ola Mau-East Hawaiʻi Treatment Clinic	900 Leilani St. Hilo, HI 96720 ***Rural***	7/21/2006
Comprehensive Health and Attitude Management Program	173 South Kukui St., Honolulu, HI 96813	7/10/2006
Ku Aloha Ola Mau	1130 North Nimitz Hwy., C-302 Honolulu, HI 96817	7/21/2006
CHAMP Clinic of Maui (Comp. Health & Attitude Mgmt. Program)	270 Waiehu Beach Rd, #115 Wailuku, Maui, HI 96793	11/1/2004

Other rural hospitals:

Castle Medical Center;Kaiser Foundation Hospital; Pali Momi Medical Center; Straub Clinic & Hospital; The Queen's Medical Center

A.3. Uncompensated care in a State. Source: Medicaid and CHIP Payment and Access Commission (MAPAC)

Uncompensated Care in Hawaiʻi, 2020-2023		
Year-end	**Charity Care and Bad Debt**	**Share of Operating Expenses**
2020	$56,000,000	1.5%
2021	$44,000,000	1.1%
2022	$39,901,546	0.9%
2023	$35,518,206	0.8%
2024	$49,895,544	1.1%

Technical Score Factors

Technical Score Factors	State of Hawai‘i
B.1. Population health clinical infrastructure ***Initiative-based factor. Quality of details in the application addressing*:**	**<u>Enhancement of and/or creation of community-based care initiatives.</u>** RRN: Creates transitional, community-based step-down care. RICA: Expands mobile, pharmacist, and community paramedicine services to operate in communities. Pili Ola: Brings telehealth to schools, libraries, and workplaces. RVBI Fund: Supports community-led innovation pilots. **<u>Strengthen the whole rural health care ecosystem</u>** Technology: RHIN + Pili Ola expand broadband, EHR, and telehealth. Primary Care: HOME RUN and RICA expand residencies and rural practices. Behavioral Health: RICA and RRN strengthen crisis and step-down care. **<u>Coordinate rural providers/stakeholders to ↑ access to preventative, long-term, behavioral, and social health services</u>** RHIN: Links hospitals, clinics, and social-service agencies. RICA: Integrates EMS, hospitals, and behavioral networks. RRN: Coordinates discharges with housing and social supports. RVBI: Incentivizes joint projects across provider networks. Pili Ola: Uses local navigators and access points to connect remote care across the state. **<u>Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics: see narrative</u>**
B.2. Health and lifestyle ***Initiative-based factor. Quality of details in the application addressing:***	**<u>Novel prevention-focused models</u>** Pili Ola: Promote preventive telehealth, remote monitoring, lifestyle coaching for nutrition, activity, and chronic-disease control. HOME RUN: Embeds wellness, nutrition, and fitness education into rural workforce and school pipelines. RICA: Community paramedicine and pharmacist-led chronic-care management for prevention over emergency response. RHIN: Develops a statewide closed-loop referral system, thereby enabling prevention-focused care by ensuring referrals are tracked to completion, closing feedback loops that turn early risk detection into timely, coordinated intervention. RVBI Fund: Finances local pilots that test innovative, evidence-based prevention models with measurable outcomes. **<u>Engagement of stakeholders and community resources within the geographic area to successfully execute the vision.</u>** All Initiatives: Co-designed with DOH, MQD, UH, FQHCs, and rural hospitals under the RHTP Oversight Team. Oversight Team: sustain dialogue with local stakeholders and connect them to relevant initiatives. Stakeholder Advisory Committee: continued collaboration and coordination among initiative leaders and the oversight team with rural healthcare stakeholders. Rural Health Coordinating Council: a committee of rural constituents with a direct line to the RHTP Oversight Team. **<u>Clear, concise, and implementable goals focused on the root causes of public health for the needs of local rural communities.</u>**

	RICA: Addresses geographic isolation, delayed emergency response, fragmented behavioral care, and limited access to pharmacy and primary services. HOME RUN: Addresses provider shortages and access to education. RRN: Targets rural housing instability and connects users to housing and other social services. Pili Ola: Overcomes geographic isolation through digital access and connectivity. RHIN: Tackles fragmentation with shared data and coordinated value-based metrics. **Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics: see narrative.**
C.1. Rural provider strategic partnerships ***Initiative-based factors***	**Arrangements, including exchange of best practices and coordination of care, facilitated through remote care services.** RHIN: Creates shared analytics and EHR integration to enable statewide best-practice exchange. RICA: Standardizes protocols between EMS and hospitals to improve transfers and continuity. RVBI Fund: Enables multi-partner learning networks and care coordination projects. HOME RUN: Establishes UH-led rural training consortia for cross-site education and mentorship. **Arrangements will expand access to specialty services in a financially sustainable manner.** Pili Ola: Leverages tele-specialty partnerships (e.g., behavioral, maternal, chronic care) with shared savings models. RICA: Integrates pharmacists and behavioral specialists into local care at a lower cost. RICA: Cuts down rural emergency and trauma patient transfer times and saves funds. RVBI: Supports creation of regional specialty networks. **Arrangements centralize and/or streamline back-office functions and resources, creating cost savings for participants.** RHIN: Provides shared data infrastructure, analytics, and reporting tools to cut administrative costs. RVBI: Offers TA and shared services for value-based contracting and compliance. RICA: Standardizes EMS operations and dispatch systems, reducing overhead and inefficiency. **Arrangements improve the financial viability of rural providers, preserve the independence of rural providers where appropriate, and strive to keep care local, where appropriate.** RHIN: Enables data-driven performance payments, sustaining small rural systems. RICA: Builds durable local infrastructure (e.g., modern EMS, behavioral stabilization)to prevent costly off-island transfers, and offers care in lower-costs settings. HOME RUN: Reduces rural staffing churn and recruitment costs through local pipelines. RRN: Cuts avoidable readmissions and uncompensated care costs, improving hospital margins. RVBI: Transitions rural providers to value-based, risk-sharing arrangements that reward efficiency. **Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics. See narrative.**
C.2. EMS ***Initiative-based factor. Quality of***	**State policies and infrastructure that will support coordination between EMS and other provider types; EMS integration with different parts of the healthcare delivery systems.** RICA: Establishes the MEDICOM Center as a statewide coordination hub linking EMS, hospitals, primary care, and telehealth; expands community paramedicine and pharmacist-assisted home visits. RHIN: Connects EMS data to hospital EHRs and analytics dashboards for real-time coordination. **Infrastructure that will support alternative site of care treatment (e.g., treat "in place" as part of an emergency call).**

details in the application:	RICA: Equips advanced ambulances and mobile medical units with telehealth and remote monitoring for on-site triage & care. Pili Ola: Develops virtual physician support for paramedics and rural clinics to manage cases locally. RHIN: Supplies interoperable data flow so "treat-in-place" encounters are documented and potentially reimbursable. **Other investments to improve speed, access, and the cost of delivering emergency medical services.** RICA: Modernizes EMS fleet, dispatch, and communications, reducing response times and costly transfers. RHIN: Enables predictive analytics and shared situational awareness for faster deployment. RVBI: Supports sustainability planning and shared service models to lower per-mile and per-response costs. **Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics. See narrative.**
D.1. Talent recruitment ***Initiative-based factor. Quality of details in the application:***	**Supporting healthcare career education infrastructure in rural communities.** HOME RUN: Expands high-school health career pathway programs and HOSA chapters across rural islands. **Funding new residency training programs, fellowships, or combined programs in rural communities, tied to at least 5 years of service spent in rural areas.** HOME RUN: Establishes new residencies on neighbor islands with 5-year rural service ties. **Relocation grants for clinicians moving to rural communities for at least 5 years of service.** HOME RUN: Offers relocation and retention incentives for providers who commit to multi-year rural practice. **Investment in health care talent recruitment related to the Indian Health Services, as relevant for a State.** N/A. **Supporting pathways for non-physician health care providers, non-hospital-based providers, and allied health professionals in rural areas.** HOME RUN: Trains CHWs, NPs, PAs, pharmacists, EMTs, and behavioral-health aides. RICA: Creates pathways for pharmacist-led chronic care, community paramedicine, and behavioral health providers. RRN: Employs non-physician clinicians for transitional and social-health coordination. Pili Ola: Uses telehealth navigators and digital health workers to broaden participation beyond hospital-based care. **Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics. See narrative.**
E.1. Medicaid provider payment incentives **Initiative-based factor. Quality of details in the application:**	**Development and implementation of payment mechanisms incentivizing providers or ACOs to reduce health care costs, improve quality of care, and shift care to lower-cost settings.** RVBI Fund: Finances the development of alternative payment models such as risk-bearing ACOs, shared-savings initiatives, and global-budget models for rural providers to improve quality of care and lower costs (e.g., by shifting to lower-cost settings). RHIN: Provides interoperable data for measuring cost, quality, utilization, supporting precise risk adjustment, and shared-savings distribution. Helps Medicaid and Medicare providers, especially in rural areas, transition to value-based payment models focused on population health. **Development and implementation of value-based programs that have a pathway to include two-sided risk and are supported by evidence to suggest that programs will change patient and provider behavior.** RVBI Fund: Establishes a clear on-ramp to two-sided risk; funds readiness activities such as data analytics, governance formation, and payment reform design.

	RHIN: Embeds value-based reporting and analytics capacity statewide, supporting provider and practice change through transparency and performance feedback. **Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics. See narrative.**
E.2. Individuals dually eligible for Medicare and Medicaid	**Investments can support dual-eligible enrollment in integrated plans** RHIN: Provides data, training, and navigation infrastructure to integrate Medicare–Medicaid services and boost rural dual-eligible enrollment in FIDE plans through its DDDASH. **Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics. See narrative.**
F.1. Remote care services	**Enhancement of remote care services infrastructure within a State.** Pili Ola: Develops the state's first remote care network. Builds a statewide network with digital access points in rural schools, libraries, workplaces, and community centers. Establishes a "Telehealth Safety Net" offering remote maternal, pediatric, behavioral, and chronic care services, and a Telehealth Analytics Coordinating Center to support all telehealth projects. RHIN: Expands wired and wireless connectivity for rural clinics and hospitals, enabling full EHR and telehealth functionality. Integrates statewide data systems to support telehealth utilization and performance monitoring. RICA: Equips ambulances and mobile medical units with telehealth and remote-monitoring technology to connect directly with hospitals and specialists in real time. Integration Across Systems: RHIN and Pili Ola work together to create an interoperable telehealth and data backbone, linking providers, patients, and EMS systems across islands to ensure reliable, continuous virtual care. **Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics. See narrative.**
F.2. Data infrastructure Quality of the State's reporting of full T-MSIS data	**Enhancement of data infrastructure within a State** RHIN: Serves as the backbone of Hawai'i's rural health data ecosystem, funding EHR onboarding, network upgrades, and full interoperability with CMS and ONC standards. Supports clinical, operational, and analytic integration through the Care Quality Information Exchange (CQIE) and statewide Analytics Hub. Pili Ola: Integrates telehealth platforms into RHIN's data framework to ensure virtual encounters and remote monitoring data feed into shared patient records and quality dashboards. **Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics. See narrative.**
F.3. Consumer-facing technology ***Initiative-based factor. Quality of details in the application***	**Support the development, appropriate usage and/or deployment of various consumer-facing health technology tools for the prevention and management of chronic diseases.** Pili Ola: Broadens patient app and remote monitoring to manage hypertension and diabetes. Connects these tools to the statewide telehealth network so patient data updates EHRs and analytics for real-time support. RHIN: Provides the interoperability layer for secure, CMS-aligned integration of wearable devices, mobile health applications, and remote monitoring platforms. Oversight Team: Ensures compliance with federal Health Technology Ecosystem and ONC standards for patient access and data exchange. **Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics. See narrative.**

Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
Maui Certified Community Behavior Health Clinic – Lahaina	1830 Honoapiilani Hwy	Lahaina	HI	96761	Maui Certified Community Behavior Health Clinic	Y			Y
Maui Certified Community Behavior Health Clinic – Kahului	53 S. Puunene, Suite 105	Kahului	HI	96732	Maui Certified Community Behavior Health Clinic	Y			N