Rural Health Transformation Program

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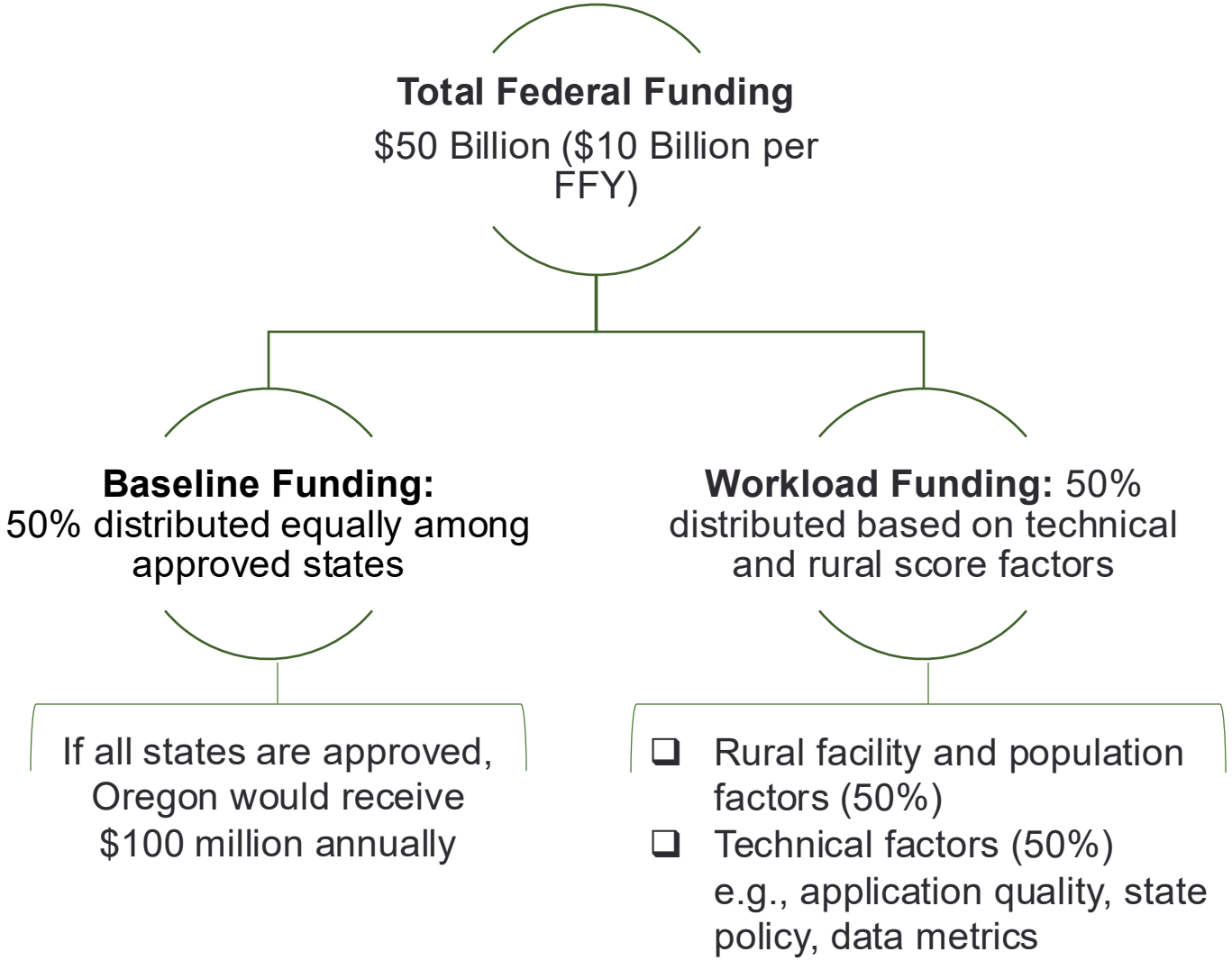
Rural Health Transformation Program

Background

- H.R. 1, the Trump Administration's federal budget reconciliation bill, was signed into law on July 4, 2025, introducing an estimated $15 billion in cuts to federal funding from Oregon for health insurance coverage, food benefits, and other programs.
- H.R. 1 establishes a one-time, five-year Rural Health Transformation Program (RHTP), which makes funding available to states for health-related activities supporting rural communities and rural health system transformation.
- The Centers for Medicare & Medicaid Services (CMS) is charged with administering the program as a cooperative agreement.
- **Federal funding through RHTP is not intended to offset H.R. 1 Medicaid cuts.**

Rural Health Transformation Program: Funding Framework

- A total of $50 billion made available to awarded states from federal fiscal year (FFY) 2026 through FFY 2030
  - $10 billion distributed per FFY
- Approved states may use up to 10% of funds for administrative expenses
- Each FFY's funds are available through the following FFY



CMS RHTP Strategic Goals

Make Rural America Healthy Again	• Support rural health innovation and new access points to promote disease prevention, chronic disease management, behavioral health, and prenatal care.
Sustainable Access	• Improve efficiency and sustainability of long-term access points through high-quality regional systems and coordinated operations, technology, primary and specialty care, and emergency services.
Workforce Development	• Attract and retain a high-skilled workforce with a broader set of health care providers who are supported in practicing at the top of their license.
Innovative Care	• Spark the growth of innovative care models and develop and implement payment mechanisms to improve quality, outcomes, and care coordination, and shift care to lower cost settings.
Tech Innovation	• Foster investment and use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools for rural facilities, providers, and patients.

RHTP Application Components

Rural Health Transformation Plan

Detailed plan that presents Oregon's vision, goals, and strategies for transforming rural health

Project Narrative and Proposed Initiatives

- Alignment with CMS' strategic goals and permissible uses of funds
- Performance measures and outcome metrics
- Any commitments to state policy changes
- Partner engagement
- Sustainability Plan
- Implementation Plan and Timeline

Budget Narrative

Describe and justify the costs linked to each activity and explain how costs are divided between lead agency and subcontracted partners

Transformation Plan and Uses of Funds

States must commit to using funds for three or more of the health-related activities below:

1. Promote chronic disease management
2. Pay health care providers
3. Promote consumer-facing tech for chronic disease management
4. Train and assist rural hospitals in adopting technology-enabled solutions
5. Recruit and retain clinical workforce in rural areas with 5-year service commitments
6. Provide IT support to improve efficiency, cybersecurity, and patient outcomes
7. Help rural communities right-size delivery systems
8. Expand access to opioid, substance use, and mental health treatment
9. Develop innovative care models, including value-based and alternative payment models
10. Invest in rural health care facility infrastructure
11. Foster and strengthen strategic partnerships between local and regional partners

*highlighted = Oregon's initial priority areas

Public Comment Themes

OHA sought public comment in August and September 2025 via structured survey. We received over 240 responses to questions addressing areas of unmet need, ready-to-launch projects, regionally coordinated partnerships and strategies, and evidence-based initiatives to strengthen care delivery.

Top Challenges Identified:

1. **Workforce Development** – Lack of robust training programs, recruitment & retention difficulties, housing shortages, and insufficient professional development and support across all provider types.
2. **Access to Care** – Service gaps all around, including dental, mental health, pharmacy, and specialty care. Limited transportation and long travel distances. EMS shortages and unstable workforce.
3. **Chronic Disease Management and Prevention** – Higher rates of preventable diseases. Limited prevention programs and access to specialists. Need for more community-based solutions, care coordination, and CHW-led programs.
4. **Telehealth & Technology**– Insufficient investment in digital infrastructure, technologies, and telehealth services for patient access and provider efficiency.
5. **Behavioral Health & SUD** – Severe shortages in behavioral health services, including addiction treatment. Need for more integration with primary care and outpatient services, especially for youth.
6. **Financial Instability** – Insufficient reimbursement rates and concerns about Medicaid cuts. Rural hospitals and clinics operating at a loss.
7. **Maternal & Child Health** – Maternity deserts, closures of L&D units, and lack of alternative perinatal care and early childhood interventions.
8. **Data & Quality Infrastructure** – Lack of capital to update HIT systems with improved EHRs, real-time analytics, and shared platforms.

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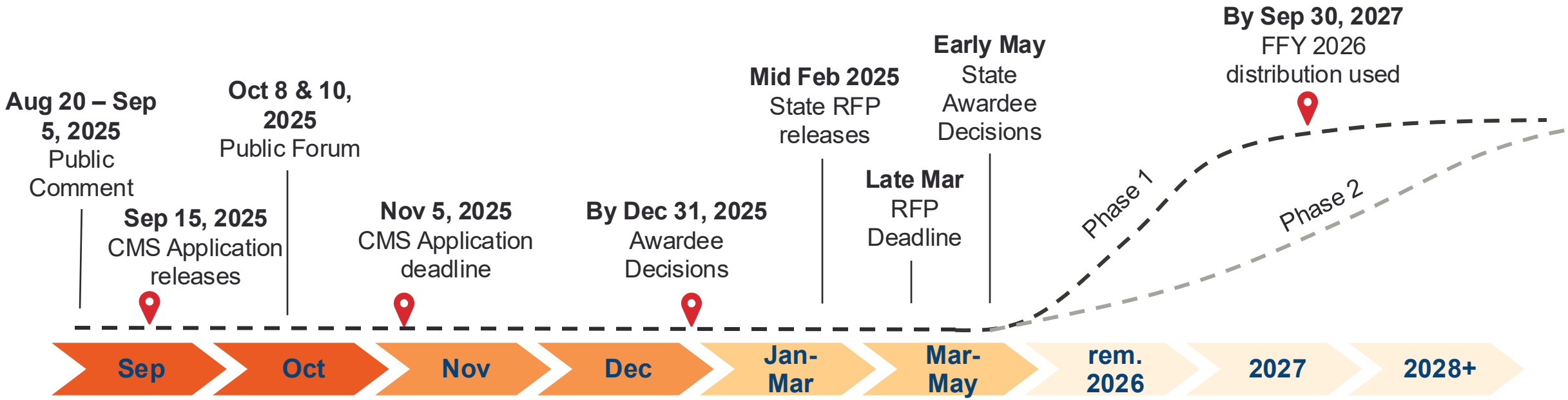
Top Areas of Action Identified (non-exhaustive list of projects and strategies):

- **Primary Care Access and Outcomes** – new pharmacy access points, mobile clinics, CHW-led home visits, school-based health, nutrition classes
- **Behavioral Health** – fellowships and apprenticeships, youth residential treatment programs, integrated BH in outpatient settings
- **Technology and Data-driven Care** – digital health tools, e-consults, virtual psychiatry, and closed-loop referral systems
- **Workforce Development** – rural residency programs, loan forgiveness, telementoring and upskilling opportunities
- **Maternal and Child Health** – perinatal coordination, caregiver support systems, OB training programs for family physicians
- **Capital investments and infrastructure** – facility upgrades, equipment investments, short-term housing for staff
- **Emergency Services** – EMS system improvements, EMS buprenorphine train-the-trainer program, community paramedicine
- **Regional Partnerships and System Transformation** – cross-sector planning and forming of structured partnerships including clinically integrated networks (CIN), learning collaboratives, health information exchanges

Discussion Questions

- Which unmet challenges, areas of action, and/or activities resonated most with you?
- Are there any key issues or perspectives you feel are missing?
- What challenges do you foresee in implementing these potential activities in your local or organizational context?
- Additional comments/questions?

RHTP Roadmap



Application Development

Intragovernmental coordination and external engagement to develop rural health strategy

Program Design

Operational planning, resource alignment, and ongoing external engagement

Program Preparation

Undergo RFP for state applicants and build core operational infrastructure and process for state program

Phase 1: Fast-Track Deployment (FFY 2026 Focus)

- Support ready-to-launch projects for immediate impact and timely funding

Phase 2: Sustain and Grow (FFY 2027+)

- Invest in longer-term, regionally-driven efforts for sustainable transformation

*All dates are proposed and contingent on CMS award decisions.

Public Forum Details

Please join us at one of the following public forums to learn more about Oregon's application to the Rural Health Transformation (RHT) Program. We will discuss:

- Background and timeline of the RHT Program
- Summary of public comment received in September
- Oregon's proposed initiatives

Note: The forums will be the same and will repeat the information at a different day/time for your convenience.

Option 1: Wednesday, October 8th from 11:00 a.m. to 12:30 p.m.
REGISTER HERE: https://www.zoomgov.com/meeting/register/X_JVkeh0SWyTq9_gq05DMQ

Option 2: Thursday, October 9th from 6:30 p.m. to 8:00 p.m.
REGISTER HERE: https://www.zoomgov.com/meeting/register/BIIdEFJFRHuAybxOw6E8_w

If you need accommodations or have any questions, please contact: RHTP@oha.oregon.gov

Thank You

Appendix

Other Considerations

- H.R. 1 does not place limitations on types of entities that can receive funding through RHTP; only the discretionary portion (50%) requires CMS to consider rural representation.
  - States decide which entities receive funding. Oregon intends to direct this funding to high-need health care services for rural communities.
- RHTP is structured as a “Cooperative Agreement,” so states should expect more involvement, including detailed reporting and technical assistance, from CMS than typical grant programs would necessitate.

RHT Program Use of Funds Requirements

Approved states may use funds awarded by CMS to invest in at least three of the permissible uses below:

- **Prevention and chronic disease**
- **Provider payments** (no more than 15% of total funds)
- **Consumer tech solutions**
- **Training and technical assistance**
- **Workforce** (commitment to serve rural communities for 5 years)
- **Information technology advances** (subject to restrictions)
- **Appropriate care availability**
- **Mental health (MH) and substance use disorder (SUD)**
- **Innovative care**

Additional uses, as determined by the Administrator:

- **Capital expenditures and infrastructure** (including minor building alterations or renovations and equipment upgrades, subject to restrictions; no more than 20% of total funds)
- **Fostering collaboration** (strengthening local and regional partnerships; both rural and other participating providers)

Note: No more than 10% of the amount allotted to a state for a budget period may be used by the state for administrative expenses. This 10% limit applies to administrative costs for the entire budget, including indirect and direct costs. See appendix for more information unallowable costs.

Funding Policies and Limitations

CMS will not allow the following costs:

- **Pre-award costs.**
- **Meeting matching requirements for any other federal funds or local entities.**
- **Services, equipment, or supports that are the legal responsibility of another party** under federal, State, or tribal law, such as vocational rehabilitation or education services.
- **Services, equipment, or supports that are the legal responsibility of another party under any civil rights law**, such as modifying a workplace or providing accommodations that are obligations under law.
- **Goods or services not allocable to the project.**
- **Supplanting existing State, local, tribal, or private funding** of infrastructure or services, such as staff salaries.
- **Construction or building expansion,** purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increases the value of the capital or useful life as a direct cost.
- **The cost of independent research and development**, including their proportionate share of indirect costs. See 2 CFR 300.477.
- **Funds related to any activity designed to influence** the enactment of legislation, appropriations, regulation, administrative action, or executive order.
- **Purchase of covered telecommunications and video surveillance equipment** (See 2 CFR 200.216) as well as financial assistance to households for installation and monthly broadband internet costs.
- **Meals**, unless in limited circumstances such as:
  - Subjects and patients under study.
  - Where specifically approved as part of the project or program activity, such as in programs providing children's services.
  - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.
- **Activities prohibited under 2 CFR 200.450 and the HHS Grants Policy Statement**, including but not limited to: Paying the salary or expenses of any grant recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any State government, State legislature, or local legislature or legislative body.
- **Lobbying**, but awardees can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying.

RHT Program Specific Limitations

CMS will also not allow the following RHT-specific costs:

- **New construction.** Supplanting funding for in-process or planned construction projects or directing funding towards new construction builds is unallowable. Renovations or alterations, as described in category J of the program requirements and expectations use of funds section, are allowed if they are clearly linked to program goals.
  - **Category J funding cannot exceed 20% of the total funding** CMS awards states in a given budget period.
- **To replace payment for clinical services that could be reimbursed by insurance. CMS will not accept payments to clinical services if they duplicate billable services and/or attempt to change payment amounts of existing fee schedules.** (If a state plans to fund direct health care services, the state must justify why they are not already reimbursable, how the payment will fill a gap in care coverage (such as uncompensated care or services not covered by insurance), and/or how they transform the current care delivery model.)
  - **Funding for provider payments**, as described in category B of the program requirements and expectations use of funds section, **cannot exceed 15% of the total funding** CMS awards states in a given budget period.
  - **Funding cannot be used for initiatives that fund certain cosmetic and experimental procedures** that fall within the definition of a specified **sex-trait modification procedure** at 45 CFR 156.400 because that is beyond the scope of this program.
- **No more than 5% of total funding CMS awards to a state in a given budget period can support funding the replacement of an EMR system** if a previous HITECH certified EMR system is already in place as of September 1, 2025.
- **Funding towards initiatives similar to the "Rural Tech Catalyst Fund Initiative"** (as described in the appendix) cannot exceed the lesser of (1) 10% of total funding awarded to a State in a given budget period or (2) $20M of total funding awarded to a State in a given budget period, and funding is subject to all restrictions and requirements described in the example initiative
- **Clinician salaries or wage supports** for facilities that subject clinicians to **non-compete contractual limitations**.
- **None of the funding shall be used by the state for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law.**
- SSA Section 2105(c), paragraphs (1), (7), and (9) apply as funding limitations. These limitations are related to general limitations, limitations on **payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.**