3.20.2026

Rural Health Transformation Program (RHTP)

Disclaimer

This webinar presentation is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $197,271,577.67 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

RHTP Agenda for March RHCC Meeting

Background Recap
RHCC Role
Oregon's Transformation Plan Framework and Initiatives
2026 Implementation Planning
Discussion and Q&A

Background Recap

Background

- H.R. 1, the federal budget reconciliation bill, was signed into law on July 4, 2025, introducing an estimated **$15 billion** to federal funding from Oregon for health insurance coverage, food benefits, and other programs. **Federal funding through RHTP is not intended to offset H.R. 1 Medicaid cuts.**
- H.R. 1 established a **one-time, five-year** Rural Health Transformation Program (**RHT Program or RHTP**), and made 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**.

CMS announced $50B in awards to all 50 states

- On 12/29/25, CMS announced all 50 states will receive awards
- In 2026, first-year awards average $200M, ranging $147-281M
- **Oregon is receiving $197.3M in 2026**
  - OHA submitted a revised budget on January 30, 2026
  - **CMS approved the revised budget on February 18, 2026**, and has partially lifted restrictions on the funds
- If approved for a similar amount in subsequent years, Oregon will receive an estimated $1B over the five-year grant period

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.**

RHCC Role

RHCC Scope and Role, Part 1

- **General Purpose**:
  - Advisory body for RHTP
  - Increase transparency of RHTP planning and implementation through public meetings
  - Rely on rural expertise of RHCC members to inform direction of RHTP
  - Create a pathway for ongoing public engagement
  - Strengthen partnerships (state, local, regional)
  - Utilize existing RHCC to meet CMS requirements

RHCC Scope and Role, Part 2

Discussion questions:

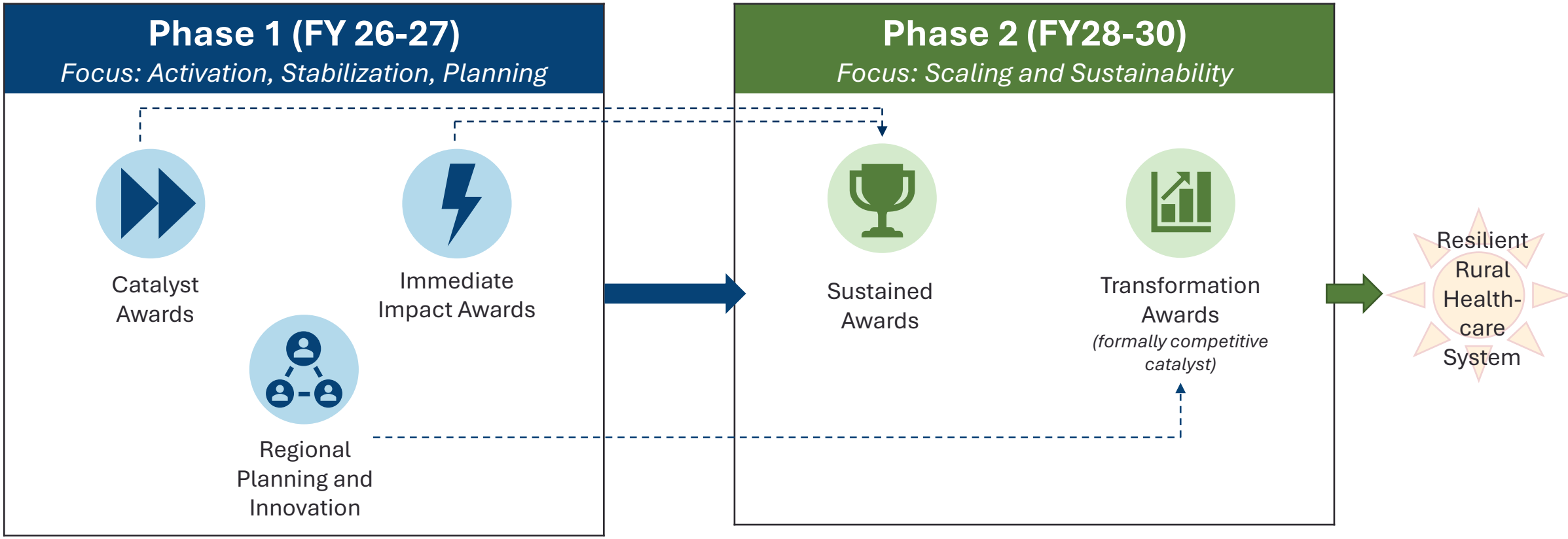
- Do you have any hopes for the role of the RHCC?
- What are you most interested in within RHTP?
  - A specific topic, initiative, project or approach?
  - Technical and operational implementation of the grant?
- What are you most concerned about?

Oregon’s Transformation Plan Framework and Initiatives

Oregon's Five Initiatives

Regional Partnerships & System Transformation	Healthy Communities & Prevention	Workforce Capacity & Resilience	Technology & Data Modernization	Tribal Initiative
Focus on building rural regional networks and shared services to accelerate long-term sustainable strategies	**Focus on scaling successful delivery models and creating new health access points to rural counties**	**Focus on developing a broad workforce from training to professional development programs**	**Focus on expanding and connecting rural health systems to needed technologies and data infrastructure**	**Focus on supporting the Tribes with improving health access and outcomes**
Example Use of Funds: • Regional convenings & collaboratives • Hub-and-spoke models • Investment in Critical Access Hospitals • Learning collaboratives • Shared infrastructure, workforce, data • Maternity care coalitions • EMS modernization • Standby Capacity Payments	**Example Use of Funds:** • Expanding access points • Social health services • Behavioral health integration • Non-traditional models of care (e.g., digital tools and mobile vans) • Chronic disease prevention	**Example Use of Funds:** • Rural residencies and fellowships • Rural k-12 pathway programs • Tele-mentoring and e-consults • Training and certification of non-physician providers • Recruitment incentives and family assistance	**Example Use of Funds**: • Health IT system investments • AI-enabled tech solutions • Community-information exchange & closed-loop referrals • Cybersecurity • Technical assistance for IT implementation	**Example Use of Funds:** • Strengthen Tribal Health Systems • Facility & Infrastructure • Behavioral health expansion • "Grow Your Own" workforce programs • Consumer-facing tech tools for managing chronic disease • IT support and EHR upgrades

Oregon's Rural Health Transformation Journey

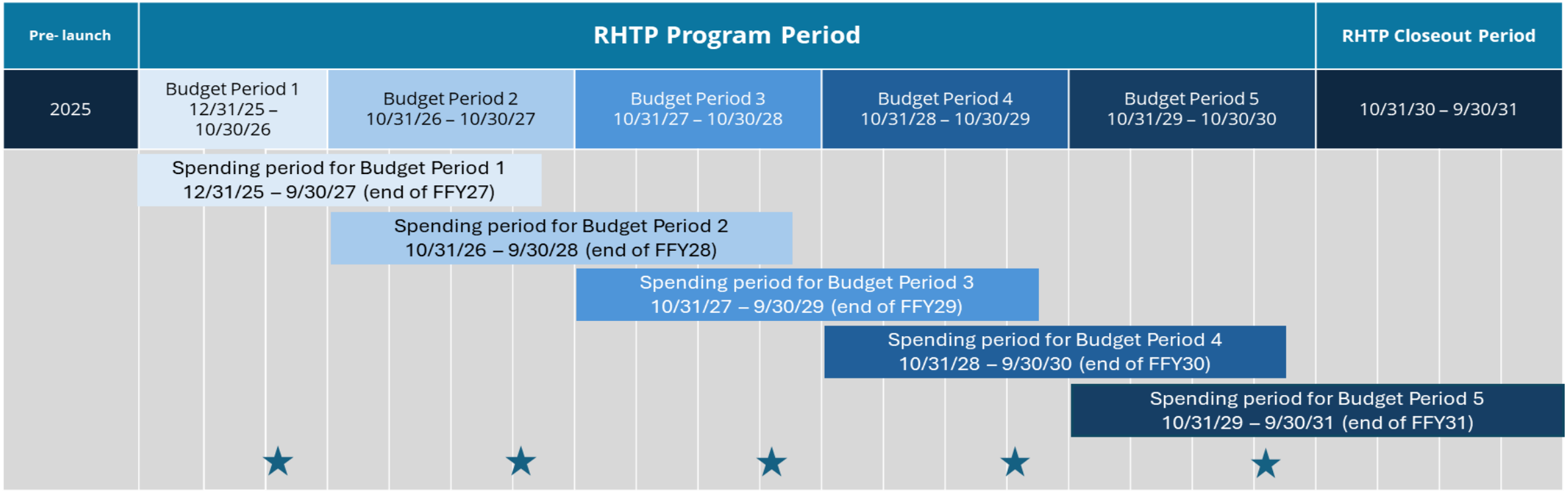


Phase 1 (FY26 – FY27)

Initial phase will focus on three pathways for implementation

1. **Catalyst Awards:** Through a Request-for-Grant-Proposal (RFGP) process, organizations will be expected to apply across initiatives for ready-to-go projects that can be implemented within the first two years of the RHT Program.
2. **Immediate Impact:** Direct awards (non-competitive) for a select set of aligned opportunities identified by the state (not through an application process). Strategic investments will be made to independent rural hospitals, critical access hospitals, and rural health clinics to stabilize essential services and build readiness for Phase 2.
3. **Regional Planning and Innovation:** Partner with the Office of Rural Health to facilitate regional convenings and technical assistance to eligible entities as they form or further develop their regional partnerships, shared infrastructure plans, and build capacity to apply for Phase 2 funding.

RHT Program Spending Timeline



★ Metric milestone/target reporting

Explanation: Funds cannot be carried over from one budget period to another. Subcontractors and subgrantees will have through the following Federal Fiscal Year (FFY) to spend funds awarded for each budget period. Subcontractors and subgrantees can only pay for expenses that have been approved for the budget period. No new activities for the second year can be proposed once the budget period ends, but the subcontractors and subgrantees can still access the funds in the FFY following the budget period to pay for activities approved for that budget period.

Sample Scenario: A state is awarded funding for the budget period of 12/31/25 – 10/30/26 to implement an initiative that will take 18 months to complete. In this scenario, the state would have access to the funding after Budget Period 1 ends to pay the contractor for those services until the end of the next FFY (9/30/27). That means if the contractor did work from January to June 2027, and that work was an approved activity for Budget Period 1, the state could pay for those costs incurred in January – June 2027 from Budget Period 1 funds.

Funding by Initiative

Initiatives	BY1	BY2	BY3	BY4	BY5
1. Regional Partnerships	$39,000,000	$40,000,000	$40,000,000	$40,000,000	$55,000,000
2. Healthy Communities	$75,000,000	$75,000,000	$55,000,000	$50,000,000	$50,000,000
3. Workforce	$37,600,000	$30,000,000	$45,000,000	$35,000,000	$35,000,000
4. Tech/Data	$7,400,000	$15,000,000	$20,000,000	$35,000,000	$20,000,000
5. Tribal	$21,699,874	$21,699,874	$21,699,874	$21,699,874	$21,699,874

Proposed Funding by Pathways

Funding Pathways	Proportion	*Amount budgeted per year under $200 million budget	
1. Phase 1 Catalyst Awards	~40%	~$80 million	
2. Immediate Impact Direct Awards	~20%	~$40 million	
3. Regional Sustainability	~20%	~$40 million	
4. Tribal Set-Aside	10%	~$20 million	[Note: Application does not require details of how funds would be divided between the Tribes]
Administrative Costs, distributed across	<10%	<$20 million	

Note on Admin: OHA personnel staffing estimates for the full pricing are ~$5.5M, with $14.5M being distributed across subcontractors, and 10% of total admin reserved for the Tribal Initiative

Monitoring, Reporting, and Oversight

Outcome/ Metric/Targets	• ≥4 outcomes with metrics & annual targets per initiative

Reporting	• Quarterly and annual reports to CMS
	  • Financial reporting: expenditure by initiative and use of funds category
	  • Progress reporting: progress on project plans and achieving stated outcomes, metrics, and milestones

Redetermination of Funding	• CMS uses reports to evaluate compliance and determine funding for subsequent budget period
State Program Oversight	• Emphasize strong oversight, data collection, and technical assistance

Reporting Periods

Type of Report	Reporting period start date	Reporting period end date	Due to CMS from OHA
Annual #1	December 29, 2025	July 31, 2026	August 30, 2026
Quarterly #1	August 1, 2026	October 30, 2026	November 29, 2026
Quarterly #2	October 31, 2026	January 30, 2027	March 1, 2027
Quarterly #3	January 31, 2027	April 30, 2027	May 30, 2027
Annual #2	August 1, 2026	July 31, 2027	August 30, 2027
Quarterly #4	August 1, 2027	October 30, 2027	November 29, 2027
Quarterly #5	October 31, 2027	January 30, 2028	February 29, 2028
Quarterly #6	January 31, 2028	April 30, 2028	May 30, 2028
Annual #3	August 1, 2027	July 31, 2028	August 30, 2028
Quarterly #7	August 1, 2028	October 30, 2028	November 29, 2028
Quarterly #8	October 31, 2028	January 30, 2029	March 1, 2029
Quarterly #9	January 31, 2029	April 30, 2029	May 30, 2029
Annual #4	August 1, 2028	July 31, 2029	August 30, 2029
Quarterly #10	August 1, 2029	October 30, 2029	November 29, 2029
Quarterly #11	October 31, 2029	January 30, 2030	March 1, 2030
Quarterly #12	January 31, 2030	April 30, 2030	May 30, 2030
Annual #5	August 1, 2029	July 31, 2030	August 30, 2030
Quarterly #13	August 1, 2030	October 30, 2030	November 29, 2030
Final Report	December 29, 2025	October 30, 2030	February 27, 2031

2026 planning and updates

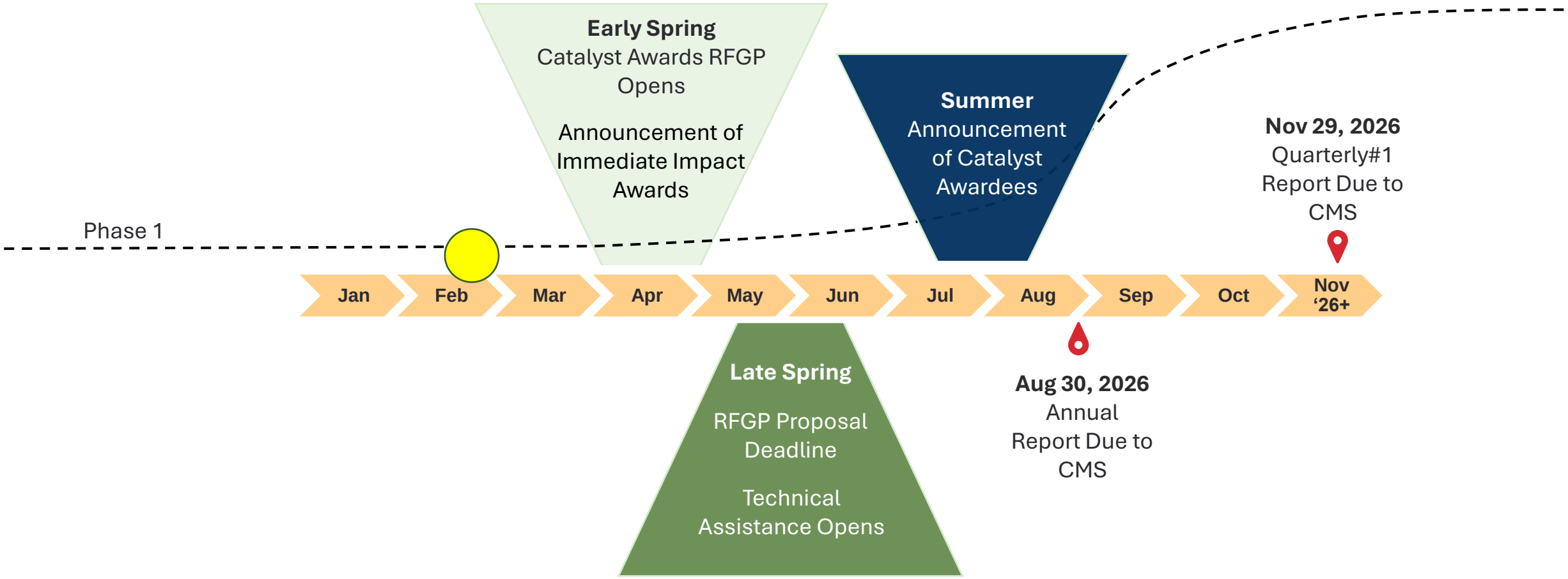
2026 Work-to-Date

- CMS budget resubmission
- Program Design
- Operations Development
- Internal and external engagement with partners

CMS updates

- Rural Health Transformation Program Summit in Baltimore – recap
- Actual budget approval last night – acceptable to now draw down funds; still need to have each contract and grant approved
- Different states are experiencing different direction and interpretation from Project Officers and Budget Managers

2026 Roadmap



*All dates are proposed and contingent on CMS prior approval and release of funds decisions.

(2026) Year 1, Phase 1 Considerations

- **Goals**:
  - Support ready-to-launch projects for timely impact and funding
  - Stabilize critical services and meet year 1 targets through direct awards
  - Support regional convenings to propel planning and innovation
- **Receiving any RHTP award or Technical Assistance does not prevent you from applying for other RHTP awards, including Phase 2 Transformation Awards.**

Catalyst Awards – Request for Grant Proposals (RFGP)

- **Opening:** Spring 2026 (Target: Early April 2026)
- **Goals:** Support “ready-to-launch” projects for timely impact and effectively utilize available funding
- **Award Details:** Limited number of *grant* awards will be available (50-100 range)
- **Eligibility (non-exhaustive):**
  - Serve rural community members
  - Provide services in alignment with one of our four initiatives and CMS’s use of funds category
  - Demonstrate connection to an initiative outcome, metric, and target
  - Represent new or expanded work (not currently reimbursable activities)
  - *The types of eligible entities are currently being finalized and will be shared soon*
- **Proposal Requirement:** All proposers must submit an RFGP to be considered for funding, regardless of involvement in past Intent to Apply or other public surveys.
  - Collaborative proposals are welcomed but one eligible entity needs to be the lead proposer/fiduciary
- **Next Update:** Webinar focused on preparing for Catalyst Awards on March 25

Phase 1 Immediate Impact Awards

- **Award Details:** Direct Awards – there is no application process
- **Goals:**
  - Stabilize critical services through direct investments in qualifying rural hospitals and rural health clinics
  - Secure subsequent year funding by meeting Year 1 CMS targets
  - Distribute funding primarily through existing agreements that align with public input
- **Project Selection:** Projects identified from public comments and partner engagements
  - Candidates demonstrate broad impact across Oregon while addressing specialized gaps and niche services
  - Clear connection and ability to achieve Year 1 CMS targets
  - OHA is already in touch with organizations under consideration
- **Next Update:** Announcement of Immediate Impact Awards expected mid-Spring 2026

Regional Planning and Innovation

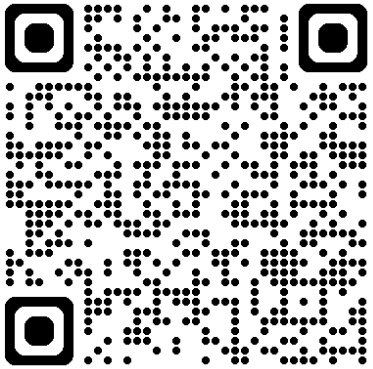
- **Partner** with the Office of Rural Health
- **Activities:**
  - Facilitated regional convenings
  - Technical assistance across community-identified issue areas
- **Goal:**
  - Develop or advance regional partnerships
  - Create shared infrastructure plans
  - Build capacity for Phase 2 funding – help organizations without ready-to-launch projects prepare and plan to apply in Phase 2
- **Upcoming Event:**
  - Vendor Roadshow in October 2026 in conjunction with Rural Health Conference
  - Vendor Interest Form – link to form

RHTP Vendor Interest Form

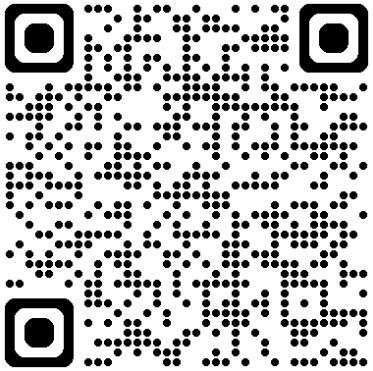
Discussion and Q&A

Communication

Newsletter



- Visit our home page: https://www.oregon.gov/oha/hpa/hp/pages/rural-health-transformation.aspx



- Sign up for bimonthly newsletter: https://public.govdelivery.com/accounts/ORHA/subscriber/new?topic_id=ORHA_209

Next Communications

- Details on the Catalyst Awards RFGP will be shared via home page updates, newsletter announcement, and a dedicated webinar
- **Webinar Date:**
  - Date: March 25, 2026
  - Link: click here to register for the webinar or scan the QR code →
  - Purpose: Walk through steps you can take to prepare for the RFGP
- **Office Hour:** Planned for Spring 2026 to support interested proposers
- Look out for upcoming communication on the home page and in the newsletter for webinar and office hour schedules

OREGON HEALTH AUTHORITY

Thank You

Website: https://www.oregon.gov/oha/HPA/HP/Pages/rural-health-transformation.aspx?
Email: rhtp@oha.oregon.gov

Appendix

Metrics and Outcomes: Healthy Communities & Prevention

Initiative: Healthy Communities & Prevention

Outcome 1: Universal access to home visiting services
Metric: Number of families receiving home visits.
Data Source & Timing: County-specific, Oregon Family Care Connects data, annual

Outcome 2: Increase availability of mental health and substance use disorder treatment.
Metric: Follow up after ED visit for MH & SUD (7-day and 30-day rates)
Data Source & Timing: State-specific, Oregon Medicaid data for CMS Core (NCQA), annual

Outcome 3: Increase patient engagement with new preventative health and/or self-management programs.
Metric: Number of new preventative health or self-management programs in rural Oregon.
Data Source & Timing: State-specific, participant-reported, annual

Outcome 4: Increase rural populations served by new health care and social health services (i.e. health services)
Metric: Number of new access points to care
Data Source & Timing: State-specific, participant-reported, annual

Outcome 5: Expanded access to health care services, including chronic disease management, through increase availability of telehealth.
Metric: Increase proportion of telehealth encounters
Data Source & Timing: County-specific, claims and encounter data, annual

Metrics and Outcomes: Workforce Capacity & Resilience

Initiative: Workforce Capacity & Resilience
Outcome 1: Increase number of rural providers/partner organizations participating in workforce training programs. **Metric:** Number of provider trainings held. **Data Source & Timing:** State-specific, participant-reported, annual
Outcome 2: Increase number of providers recruited to deliver health care in rural areas through local partnerships and relocation and retention incentives. **Metric:** Provider-to-population ratio (direct patient care FTE per 100,000 population) in rural areas. **Data Source & Timing:** County-specific, Oregon Health Care Workforce Reporting Program data, annual
Outcome 3: Increase health care career pathway programs in rural K-12 schools. **Metric:** Number of K-12 health career pathway programs launched. **Data Source & Timing:** State-specific, participant-reported, annual
Outcome 4: Increased hiring, training, and use of non-physician, non-hospital, and allied health professionals. **Metric:** Number of non-physician, non-hospital, and allied health professionals recruited to rural areas. **Data Source & Timing:** State-Specific, participant-reported, annual

Metrics and Outcomes: Technology & Data Modernization

Initiative: Technology & Data Modernization
Outcome 1: Robust engagement in IT technical assistance **Metric:** Percent of organizations requesting health IT technical assistance that complete health IT and cybersecurity self-assessment **Data Source & Timing:** State-specific, participant-reported, annual
Outcome 2: Increase health IT adoption and interoperability **Metric:** Number of tools/capabilities adopted by awardees **Data Source & Timing:** County-specific, participant-reported, annual **Note:** Tools/capabilities are counted at the organization level
Outcome 3: Reduce administrative burden on providers **Metric:** Percent of organization adopting a new health IT tool/capability that self **Data Source & Timing:** State-specific, participant-reported, annual
Outcome 4: Improve organizational cybersecurity practices **Metric:** Percent of organizations completing a cybersecurity self-assessment implementing measures to improve cybersecurity. **Data Source & Timing:** State-specific, participant-reported, annual
Outcome 5: Increased use of remote care services and remote patient monitoring to prevent and manage chronic disease and reduce hospital **Metric:** Percent increase in providers using remote patient monitoring. **Data Source & Timing:** State specific, claims data, annual

Metrics and Outcomes: Regional Partnerships & Systems Transformation

Initiative: Regional Partnerships & Systems Transformation
Outcome 1: Reduce operating costs for rural health organizations through shared infrastructure according to regional/local needs. **Metric:** Operating margins for CAHs **Data Source & Timing:** State-specific, Oregon Hospital Financial and Utilization Data, quarterly
Outcome 2: Increase access to high need or at-risk service lines, such as maternity care **Metric:** Number of patients receiving care from shared resources for at-risk service **Data Source & Timing:** State-specific, participant-reported, annual
Outcome 3: Increase regional planning efforts focused on shared governance models, including CINs and consortiums **Metric:** Number of organizations participating in regional partnerships **Data Source & Timing:** State-specific, participant-reported, annual
Outcome 4: Increase participation in value-based care models **Metric:** Number of organizations participating in value-based care models **Data Source & Timing:** State-specific, participant-reported, annual

Example Outcome, Metric, and Targets: Workforce Capacity & Resilience

Initiative: Workforce Capacity & Resilience

Outcome 1: Increase # of rural providers/partner organizations participating in workforce training programs.
Metric: # of Provider Trainings held
Data Source & Timing: State Specific, participant-reported, annual

Targets:

YR1: By September 30, 2026, conduct 15 simulation trainings for at least two specialties; launch one new project ECHO or comparable education programs designed for rural providers; establish one additional peer-to-peer e-consultation line for rural providers.

YR2: By September 30, 2027, conduct 20 simulation trainings for at least two specialties; launch three new project ECHO or comparable education program for rural providers; expand hours of access to peer-to-peer e-consultation line for rural providers and promote consult line to increase access and availability of resource.

YR3: By September 30, 2028, maintain at least 20 simulation trainings across two specialties; add additional consultation capacity and incorporate more regional expertise.

YR4: By September 30, 2029, maintain at least 20 simulation trainings across two specialties; begin transitioning non RHT Program funding for sustainability of provider consultation service.

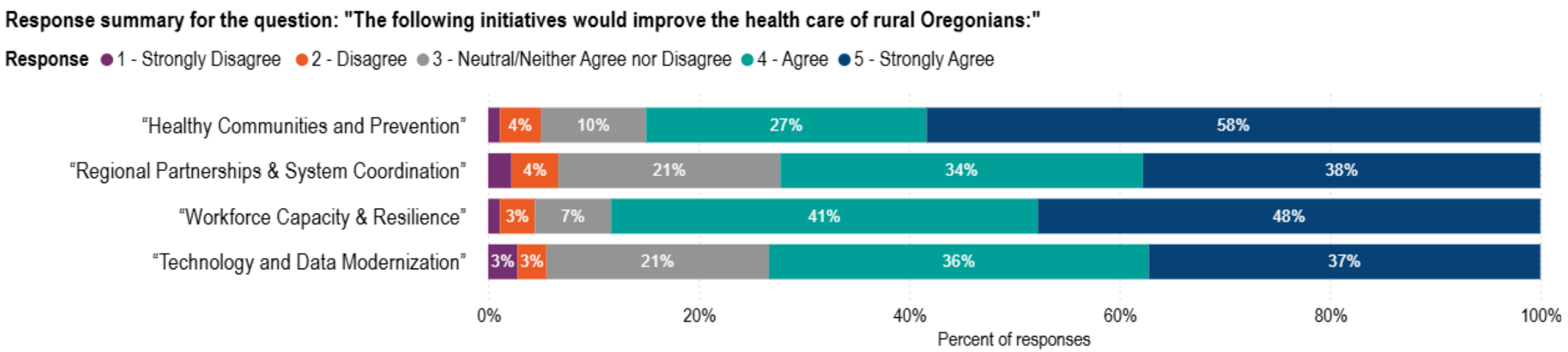
YR5: By September 30, 2030, secure sustainable funding to maintain and expand workforce training programs as needed by communities.

Public Engagement History

Public Engagement History

- Initial public comment period ran from 8/20 to 9/12
  - 240 responses were collected.
  - Results informed OHA's scoping of the proposed initiatives and related activities.
- October's public survey was open from 10/8 to 10/15, following two public forums.
  - 180 responses were collected.
  - Results validated the direction of the State's proposed initiatives and informed the budget plan.
- "Intent to Apply" Survey fielded 11/25 to 12/29
  - 255 responses were collected. 384 projects were proposed.

Results for Question 1-4



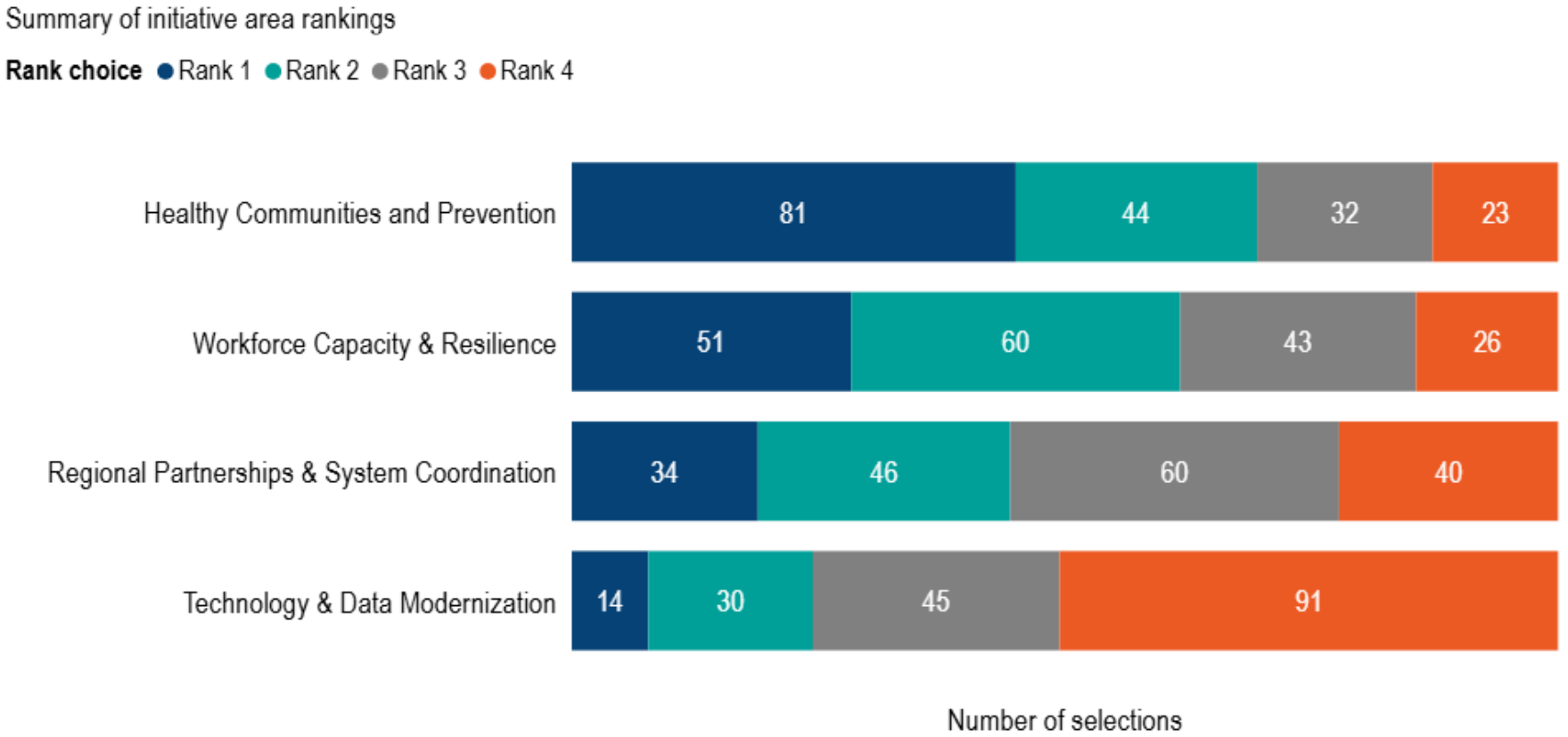
Initiative	5 - Strongly Agree	4 - Agree	3 - Neutral/Neither Agree nor Disagree	2 - Disagree	1 - Strongly Disagree
"Healthy Communities and Prevention"	105	48	18	7	2
"Regional Partnerships & System Coordination"	68	62	38	8	4
"Workforce Capacity & Resilience"	86	73	13	6	2
"Technology and Data Modernization"	67	65	38	5	5

Question 5: Ranking on Priority

Ranking of all the initiatives

We want to know which initiatives you think would have the greatest impact on improving health care in rural communities. Please rank the initiatives from 1 (highest impact) to 4 (lowest impact)

Results for Question 5



Number of responses

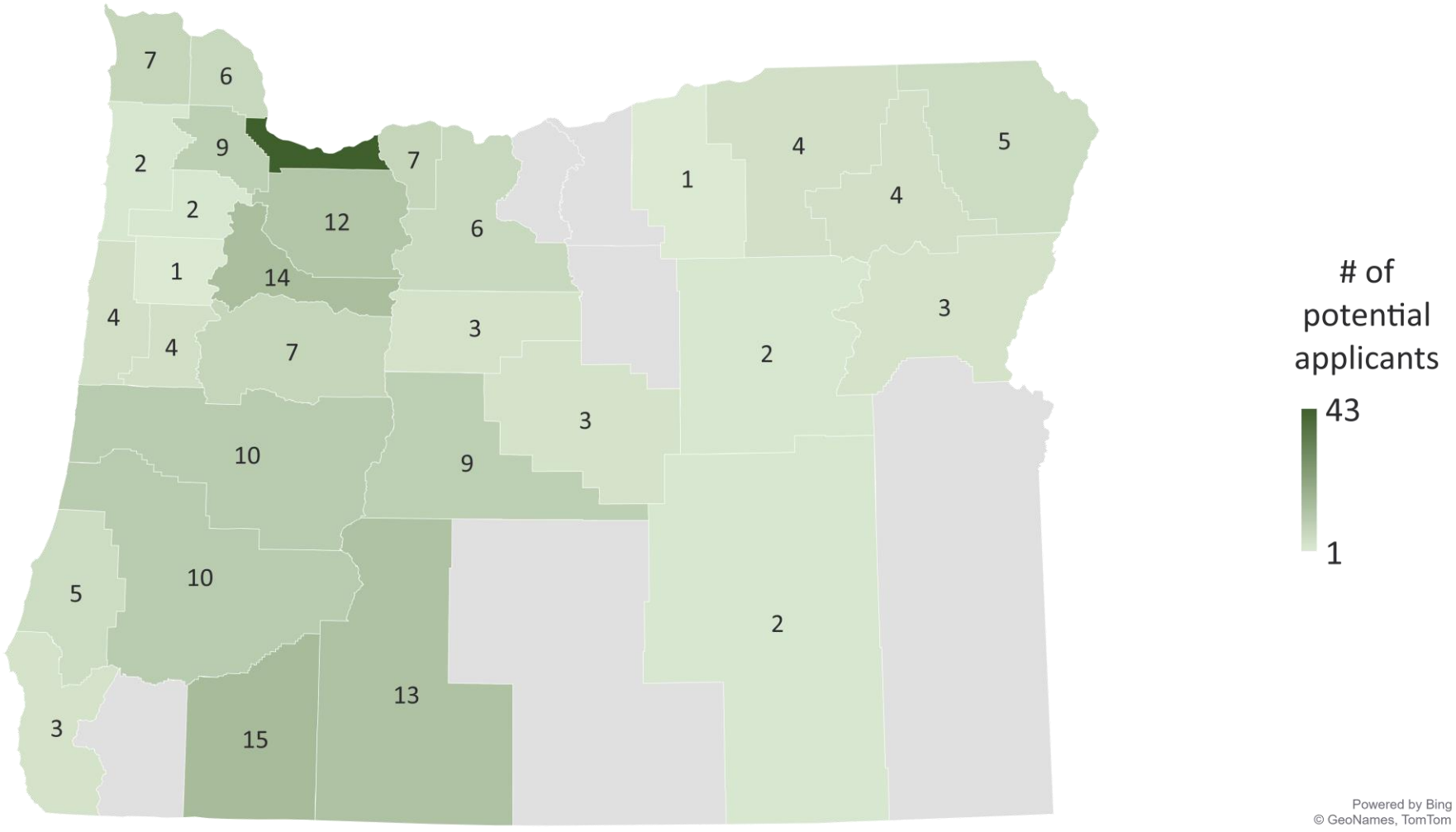
180

Area	Overall Rank
Healthy Communities and Prevention	543
Workforce Capacity & Resilience	496
Regional Partnerships & System Coordination	434
Technology & Data Modernization	327

Intent to Apply Survey Results

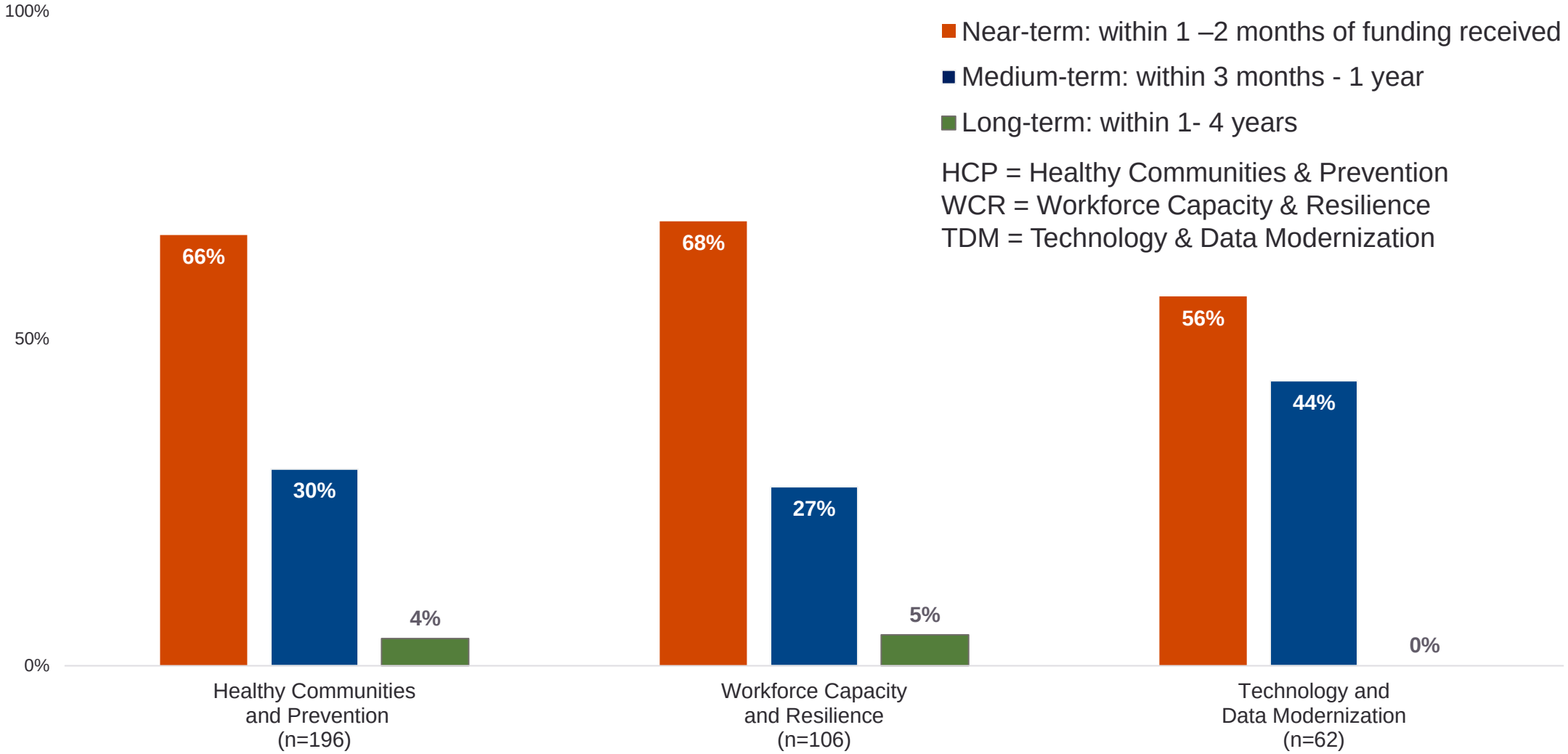
General Information

- Applicants could submit multiple projects
- Non-binding
- Not required
- 255 responses
  - 217 within Oregon
- 384 projects proposed



Intent to Apply Survey Results

Percentage of projects proposed within each initiative by timeframe



Intent to Apply Survey Results

Estimated annual funds that will be requested for near-term projects

- “Near-term" means projects that applicants said could be implemented "immediately, within 1-2 months of funding received"
- These amounts reflect responses to the survey, not actual funding amount available nor any funding decisions

Initiative (n=223)	Min	Max	Mean	Median
Healthy Communities & Prevention	$3,000	$7,800,000	$1,313,320	$575,000
Workforce Capacity & Resilience	$5,000	$5,000,000	$1,083,882	$500,000
Technology and Data Modernization	$7,010	$3,750,000	$664,932	$426,126

Total expected to be requested across near-term projects: $256,290,781

Oregon’s Transformation Plan Framework and Initiatives

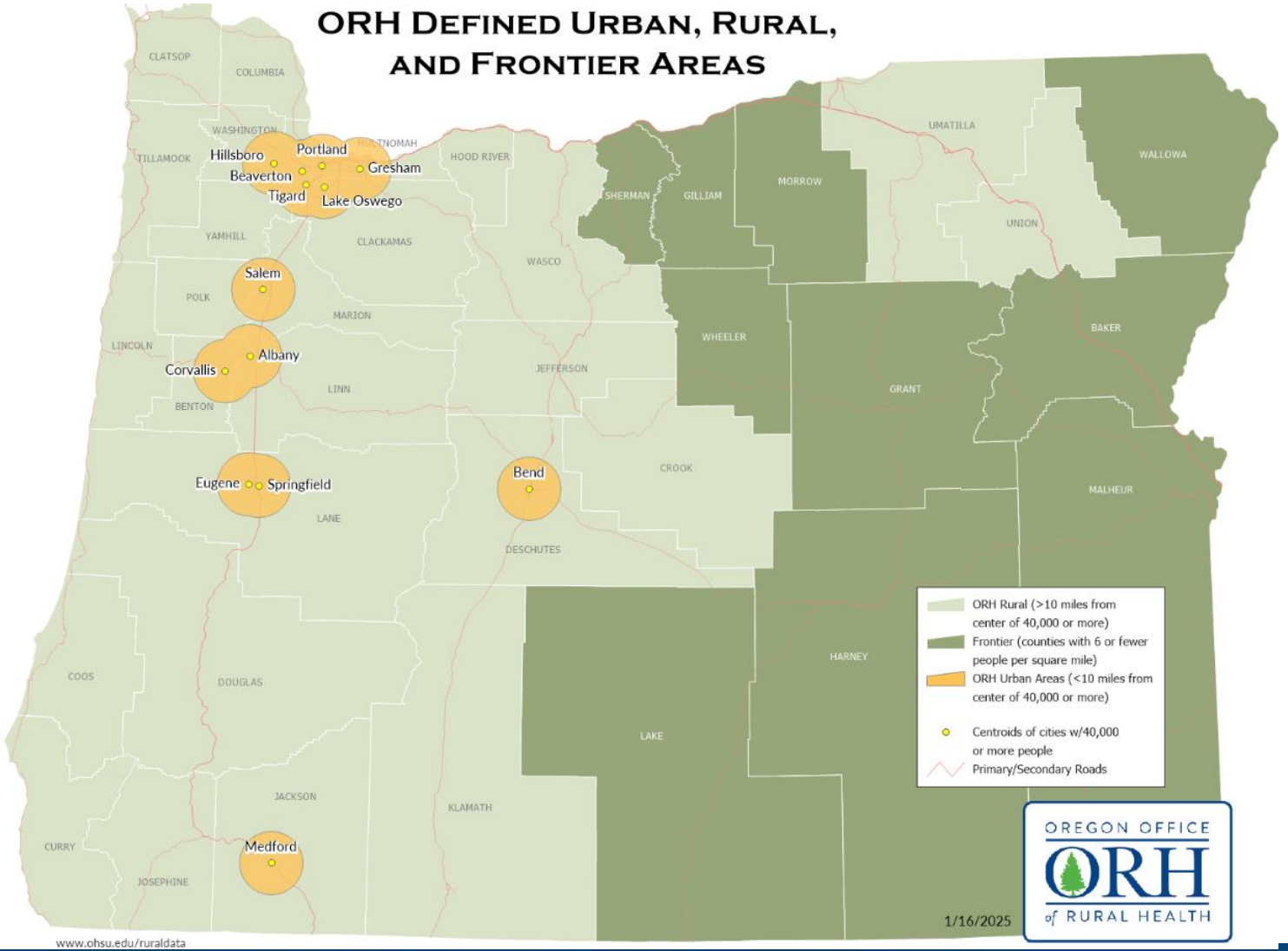
Initiatives and Uses of Funds Crosswalk

	Regional Partnerships & Systems Coordination	Healthy Communities & Prevention	Workforce Capacity & Resilience	Technology & Data Modernization	Tribal Initiative/ Set-aside
Prevention & chronic disease management	●	●			●
Provider payments (with restrictions)	●	●			●
Consumer tech solutions		●			●
Training & technical assistance on tech solutions				●	●
Workforce recruitment & retention			●		●
IT advances & cybersecurity	●			●	●
Right-sizing care availability	●	●	●	●	●
Behavioral health & substance use disorder services	●		●		●
Innovative care/value-based models	●				
Capital expenditures (≤20%)		●			●
Partnership-building	●	●	●	●	●

Initiatives and Technical Factors Crosswalk

	Regional Partnerships & Systems Coordination	Healthy Communities & Prevention	Workforce Capacity & Resilience	Technology & Data Modernization	Tribal Initiative/ Set-aside
B.1 Population health clinical infrastructure	●	●	●		●
B.2 Health and lifestyle		●			
C.1 Rural provider strategic partnerships	●		●		●
C.2 Emergency Medical Services	●	●	●		
D.1 Talent recruitment			●		●
E.1 Medicaid provider payment incentives	●				
E.2 DNSP enrollment support		●			
F.1 Remote care services		●		●	●
F.2 Data infrastructure	●			●	●
F.3 Consumer-facing tech		●			●

How is Oregon defining “rural” communities?



- Oregon is using the definition of “rural” used by the Oregon Office of Rural Health, which is defined as areas greater than 10 miles away from a population center of 40,000 or more people.

- All funds will be directed to rural and remote/frontier areas, with specific exceptions for only if funds will specifically advance rural health transformation (e.g., new medical residency programs).

Public Comment Themes: Challenges

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.

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 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