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The Rural Health Transformation Program — An Avenue for Promoting Administrative Policies

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Against the backdrop of significant federal cuts to health care spending in the United States, the Rural Health Transformation Program (RHTP) has emerged as an opportunity for states to pursue funding for rural health care, although the program's $50 billion in awards will be insufficient to offset these cuts. Beyond being a rare federal program focused on stabilizing rural health care services, the RHTP represents a vehicle for advancing the Trump administration's priorities related to the Make America Healthy Again (MAHA) movement and for encouraging states to make substantial changes to their health policies on issues such as scope of practice for nonphysician clinicians and access to telehealth services. As the program is rolled out on an ambitious timeline, states, health care organizations, and rural communities are seeking to capitalize on its promise and grappling with risks posed by administrative decisions.

Rural health in the United States is in crisis.[1] Decades of hospital closures, clinician shortages, and losses of essential services have left millions of people without reliable access to care and with worsened health outcomes. These challenges will be compounded by the One Big Beautiful Bill Act (OBBBA), which makes sweeping changes to health programs, including cutting nearly $1 trillion in federal health care funding.[2]

Congress established the RHTP as a partial remedy for those cuts and in recognition that rural communities would need additional health care investments to survive in this new environment.[2] Although this program has been welcomed by states and health care stakeholders, the $50 billion in funding is a one-time allocation and will be insufficient to fill the gaps created by the OBBBA. As a result, states, health care organizations, and other entities, including health technology companies, have been highly motivated to secure a share of the limited funds.

In implementing the program, the Centers for Medicare and Medicaid Services (CMS) complied with an aggressive timeline set by Congress: it issued a notice of funding opportunity (NOFO) on September 15, 2025; state applications were due by November 5; and first-year awards were announced on December 29. Funding will be distributed over the next 5 years.

This timeline presented challenges. In a matter of months, states had to engage with local partners, assess community needs, and design comprehensive plans. Forty-eight states (all except Iowa and Kentucky) took public steps to prepare to apply for funding, including requesting public input.[3] But the compressed schedule most likely limited the ability of some stakeholders, including rural health care organizations and community-based organizations, to share concerns or contribute meaningfully to state planning.

As directed by the OBBBA, 50% of RHTP disbursements, referred to as "baseline funding," will be distributed equally among all states with approved plans. CMS allocated the remaining 50% of funding, or "workload funding," for fiscal year 2026 on the basis of several factors, including rurality, rural health care services, and policy actions. This structure ensures a minimum level of support for every participating state but also provides CMS with substantial discretion to reward states whose policies align with federal priorities.

All 50 states filed applications and received at least some funding for fiscal year 2026; amounts ranged from $147 million for New Jersey to $281 million for Texas. States submitted creative proposals. For example, North Carolina, which was awarded $213 million, will build a system of hubs to link medical, mental health, and social services and establish a fund to help rural health care facilities gain access to artificial intelligence tools, broadband, and other technologies. Alaska will use its $272 million to deploy new mobile dental clinics, offer child care for rural health care workers, and expand medical residency programs, among other uses, and Alabama ($203 million) will explore telerobotic technologies to support rural access to ultrasonography services to improve maternal and fetal health.

CMS went beyond the statutory language in determining how to allocate the discretionary funding. The NOFO outlined five "strategic goals" that reflect the MAHA framework: make rural America healthy again, sustainable access, workforce development, innovative care, and tech innovation. CMS leaders have said they see the RHTP application process as an opportunity to "rebuild and reshape" states' health care systems, not to "backfil … operating budgets."[4] The funding announcement capped the use of program funds for payments to hospitals and other health care organizations at 15% of total funding, adding to competitive pressure and raising concern among rural health care organizations looking to the program for relief.

CMS's funding announcement outlined detailed scoring methods for determining award amounts. The 23 factors it used included some that conform to statutory provisions, such as "rural facility and population score factors," and others that go beyond the statutory purpose. Applications that proposed advancing state policy in various areas not mentioned in the authorizing legislation but prioritized by CMS and the Department of Health and Human Services were given additional points during scoring, and those states saw a boost in overall award amounts. Although some of these factors are directly related to rural health, others are not.

States will continue to face pressure to implement reforms that align with these policies in order to compete for the scarce health care funding available in a post-OBBBA world. Some of the administration's preferred policies may be welcomed across the political spectrum, such as including nutrition training in continuing medical education (see table). Other policies may be more controversial, such as placing no restrictions on short-term, limited-duration insurance plans beyond the latest federal guidance. Evidence suggests that these plans don't offer sufficiently comprehensive coverage to meet the needs of many patients.[5]

Some policies could affect the practice of medicine. For example, states with no certificate-of-need requirements for health care facilities or those that grant pharmacists full authority to administer drugs, order laboratory analyses, and practice independently get extra points on their applications.

It is important for health care leaders to understand the range of policies that CMS is seeking to influence with this process. Many states included elements listed in the NOFO in their applications; for example, Alaska proposed implementing the Presidential Fitness Test.

In its effort to advance the administration's priority policies, the program introduces risks for states related to access to future funding. CMS made clear in its announcement that distribution of workload funding after the first year will be tied to a state's performance on the measures scored by CMS, including the adoption of priority policies. States will need to spend the full amount of

Selected Policies and Associated Point Values for State RHTP Applications.*

Policy	Points Awarded
Nutrition training included in continuing medical education	100 points if fully implemented 25 or 75 points if a policy to establish training is in progress
No restriction on short-term, limited-duration insurance plans	100 points if no restrictions on plans exist, beyond federal guidance
Presidential Fitness Test	100 points if reestablished
Food-restriction waivers on non-nutritious foods in the Supplemental Nutrition Assistance Program	100 points if there is a USDA-approved waiver 75 points if a waiver has been submitted to the USDA but not yet approved 25 or 50 points if a policy to submit a waiver to the USDA is in progress
Lack of certificate-of-need requirements	Up to 100 points, depending on evaluation by the Cicero Institute
Participation in licensure compacts	Up to 100 points, depending on the extent of a state's participation in the Interstate Medical Licensure Compact, the Nurse Licensure Compact, the Emergency Medical Services Compact, the Psychology Interjurisdictional Compact, and the Physician Assistant Compact
Scope-of-practice expansion	Up to 100 points, depending on scope-of-practice policies for nurse practitioners, physician assistants, and dental hygienists and authority for pharmacists
Improved access to telehealth and remote-care services	Up to 100 points, depending on Medicaid reimbursement of live-video services, Medicaid payments for store-and-forward services, Medicaid coverage of remote patient monitoring, exceptions to in-state licensing requirements, and telehealth license and registration pathways

* RHTP denotes Rural Health Transformation Program, and USDA U.S. Department of Agriculture.

awards by the end of the following year, a challenge that will be exacerbated by the typically slow contracting processes states use to implement projects. If states don't adopt the policies promised in their applications — for example, if a state legislature doesn't pass legislation authorizing a particular policy — future funding may be jeopardized. The same would be true if states don't meet new criteria that the administration may impose in subsequent funding years.

The RHTP presents an opportunity to mitigate some of the harm that will be caused by looming funding cuts. Its success, however, will depend on the ability of states to craft thoughtful, locally informed plans on tight timelines, CMS's willingness to prioritize meaningful investments in care transformation, and states' capacity to follow through on plans, now that initial awards have been announced. Physicians and health care leaders should be aware that the RHTP is a vehicle for pushing states to rapidly modify their health care policies. If implemented effectively, the program could lay the groundwork for sustainable improvements in access to health care, workforce stability, and community well-being. But if the process is dominated by political interests or driven by unrelated policy priorities, this opportunity will be lost.

An audio interview with Carmel Shachar is available at NEJM.org

Disclosure forms provided by the authors are available at NEJM.org.

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