11.17.2025

Rural Health Transformation (RHT) Program

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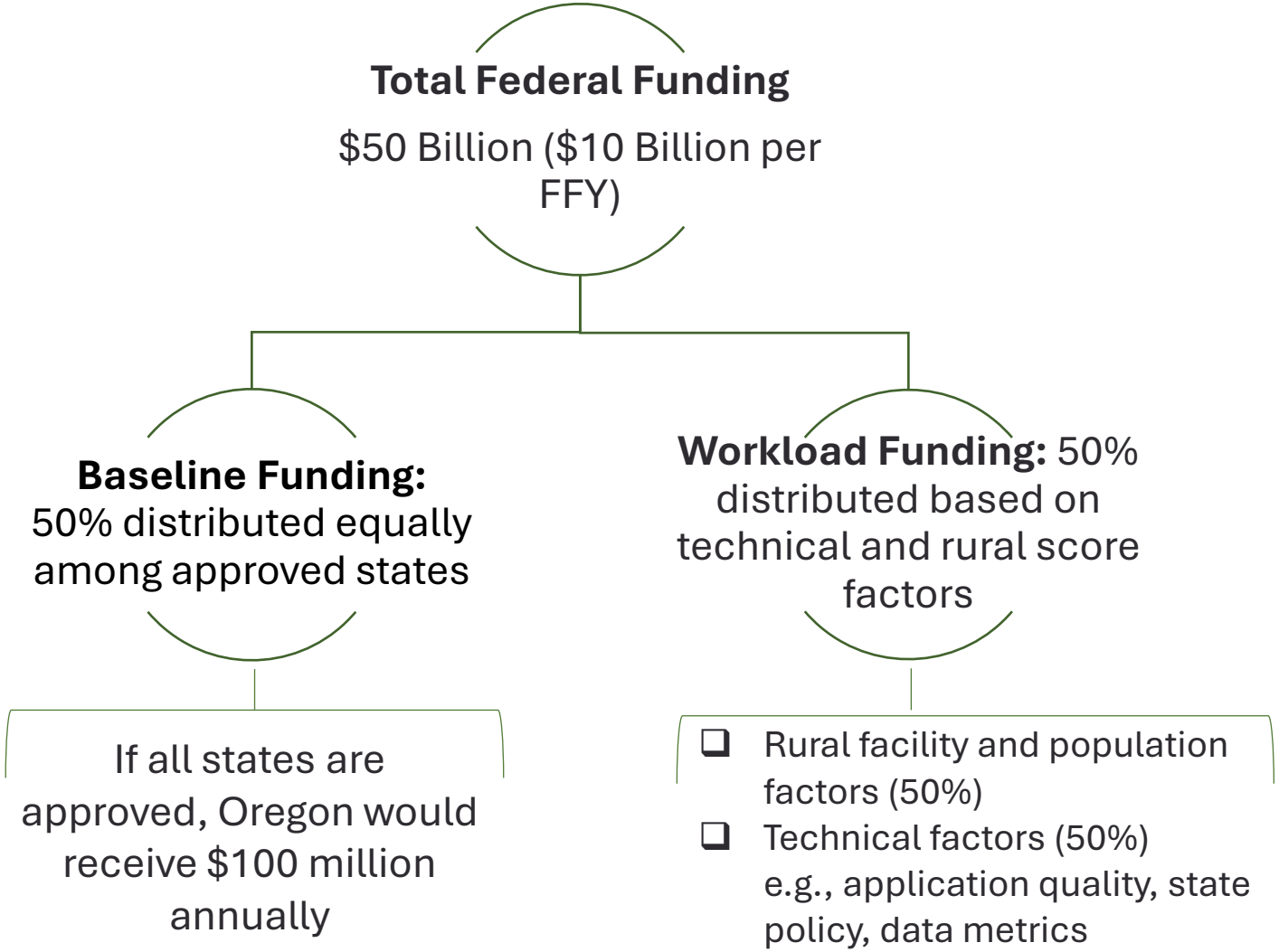
Background

- 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 (RHT Program or 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.
  - CMS released its Notice of Funding Opportunity (NOFO) on September 15, 2025.
- **Federal funding through RHTP is not intended to offset H.R. 1 Medicaid cuts.**

Funding Framework



Public Engagement

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.

Oregon’s Transformation Plan Framework and Initiatives

Oregon's Initiatives and CMS Strategic Goals

Initiative	Summary	Main Strategic Goal
Regional Partnerships & System Transformation	Focus on building rural regional networks and shared services to accelerate long-term sustainable strategies	Sustainable Access, Innovative Care
Healthy Communities & Prevention	Focus on scaling successful delivery models and creating new health access points to rural counties	Make Rural America Healthy Again, Tech Innovation
Workforce Capacity & Resilience	Focus on developing a broad workforce from training to professional development programs	Workforce Development, Make Rural America Healthy Again, Tech Innovation
Technology & Data Modernization	Focus on expanding and connecting rural health systems to needed technologies and data infrastructure	Tech Innovation, Sustainable Access
Tribal	Focus on supporting the Tribes with improving health access and outcomes	Make Rural America Healthy Again, Workforce Development, Sustainable Access, and Tech Innovation

Note: RHT Funds will target rural and frontier hospitals, health clinics, community health centers, and community-based organizations providing health care services in rural and frontier areas statewide. Rural is defined as any geographic areas in Oregon ten or more miles from the centroid of a population center of 40,000 people or more. Frontier (or "remote") is any county with six or fewer people per square mile.

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	●	●	●	●	●

Monitoring, Reporting, and Oversight

Outcome Metrics/Milestones	• ≥4 outcomes with metrics & FFY milestones per initiative
Reporting	• Quarterly and annual reports to CMS
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

Advisory Body

- The Rural Health Coordinating Council (RHCC), an 18-voting member council statutorily required to advise the Office of Rural Health
  - ❑Consists of healthcare provider organizations, rural consumers, and healthcare leaders.
  - ❑Act as an accountability board; and
  - ❑Advise on matters related to aligning RHT Program activities with the needs of rural and remote communities.

Distribution Plan and Timeline

Phase 1 (FY26 – FY27)

Initial phase will focus on three pathways for fund distribution:

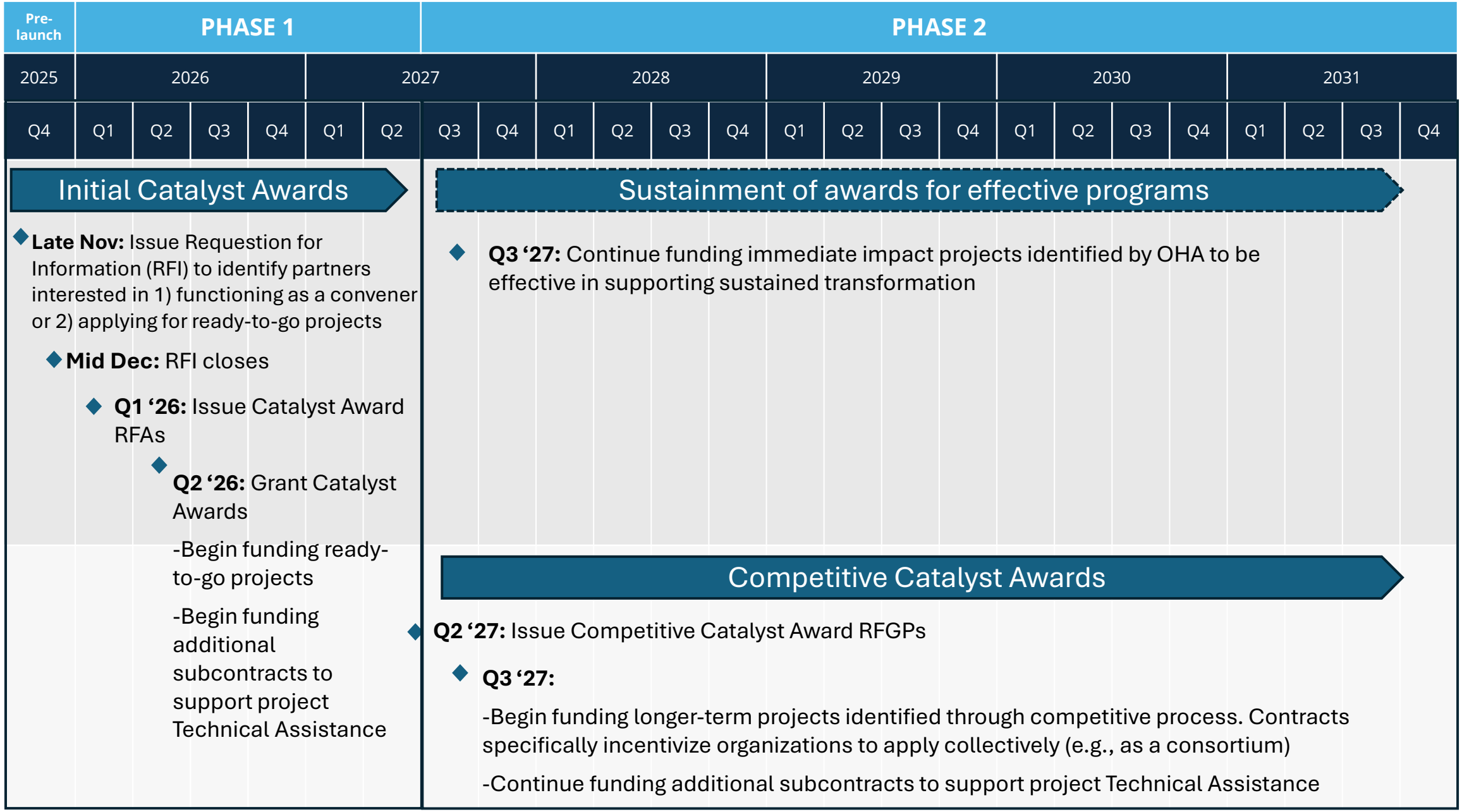
1. **Catalyst Awards:** Through a Request for Application (RFA) process, applicants will be expected to apply across initiatives for ready-to-go projects that can be implemented within the first two years of the RHT Program.
2. **Immediate Impact:** Direct awards for a select set of aligned opportunities identified by the state, such as team-based care PMPMs and funding new residency programs.
2. **Regional Sustainability:** Award a subcontractor(s) to provide facilitation and technical assistance to entities developing rural health networks and regional solutions. Strategic investments will be made to independent rural hospitals and critical access hospitals to stabilize essential services and build readiness for Phase 2.

Phase 2 (FY28 – FY30)

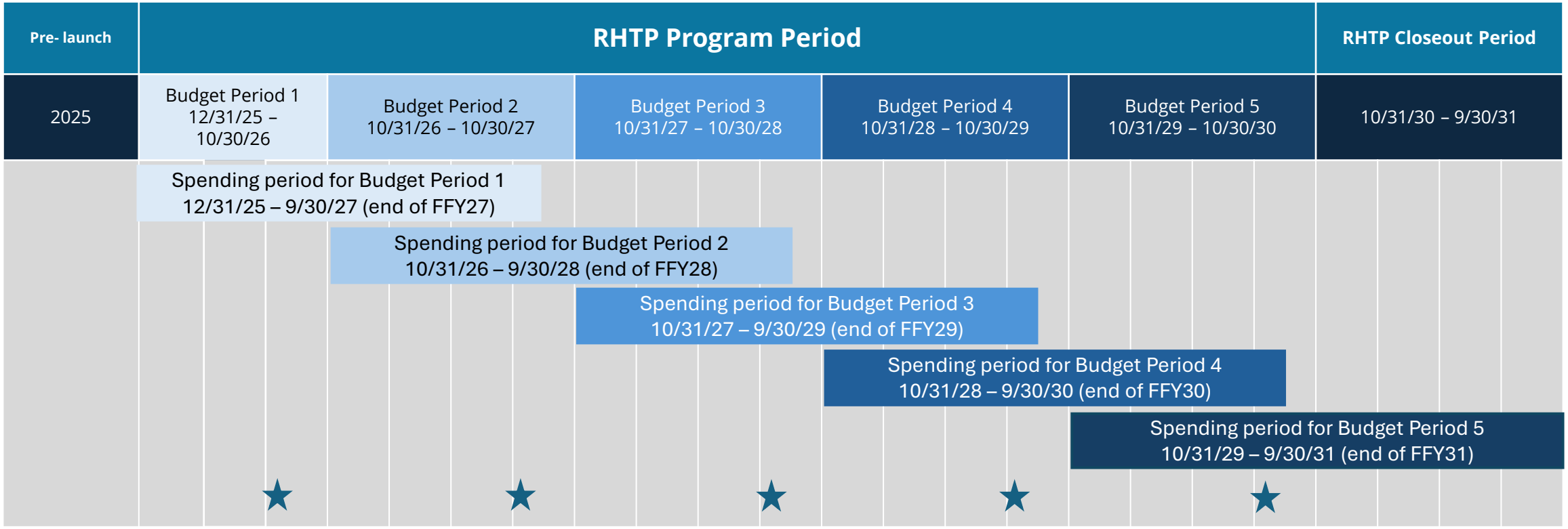
Phase 2 will mirror the initial phase but focus on incentivizing true transformation with increased expectations related to regional alignment and sustainability.

1. **Competitive Catalyst awards:** Through a competitive Request for Grant Proposal (RFGP), organizations will be incentivized to apply collectively (e.g., as a consortium, part of a formal agreement, a CIN) or demonstrate significant alignment with regional priorities and needs.
2. **Sustained awards:** Fund some Phase 1 projects that have demonstrated significant success and valuable impact but require additional years of investment to ensure completion.

RHT Program Distribution Timeline



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.

Proposed Funding by Initiative

Initiatives	BY1	BY2	BY3	BY4	BY5
1. Regional Partnerships	$40,000,000	$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	$20,000,000	$20,000,000	$20,000,000	$20,000,000	$20,000,000

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

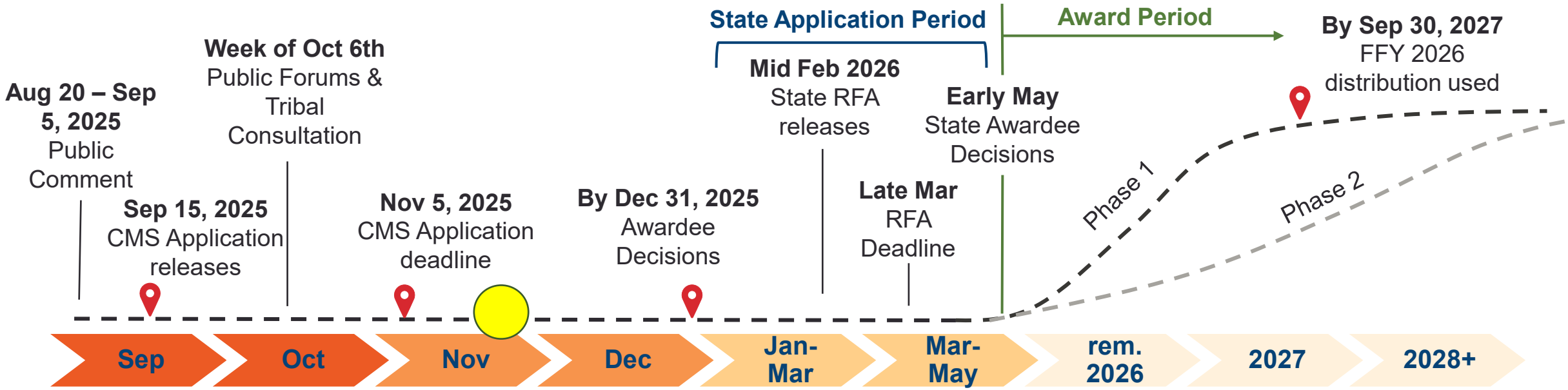
OREGON HEALTH AUTHORITY

Thank You

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

Appendix

Funding Distribution Timeline and Phases



Application Development

Intragovernmental coordination and external engagement to develop rural health strategy

Program Design

Operational planning, resource alignment, and ongoing external engagement to prepare applicants for RFPs

Program Preparation

Undergo RFA 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

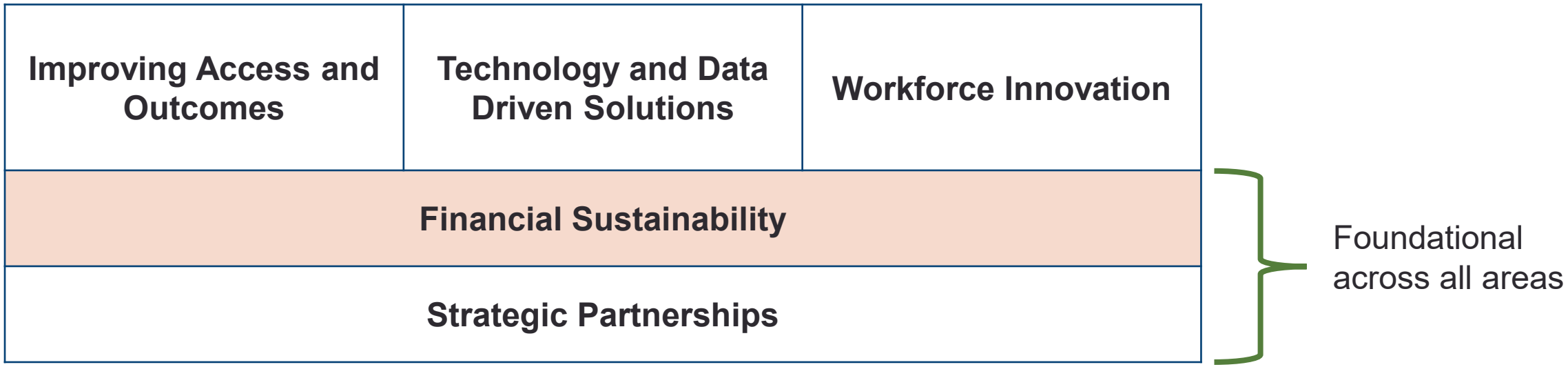
Phase 2: Sustain and Grow (FFY 2027+)

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

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

Oregon's RHTP Transformation Plan

- **Goal:** We envision healthy rural communities where people, partners, and technology come together to build thriving communities of care – rooted in prevention, strengthened by regional collaboration, sustained by a resilient workforce, and guided by smart data for better health and well-being.
- **Anchor Strategies:** Oregon's rural health transformation will be anchored in the following focus areas:



Framing the Initiatives

- **Align with CMS Strategic Goals:** Each initiative is mapped to one or more CMS strategic goals (e.g., MAHA, sustainable access, workforce development, innovative care, and tech innovation) to ensure federal alignment and maximize scoring potential.
- **Integrate Public Comment Ideas:** Initiatives include for consideration projects submitted during public comment, ensuring responsiveness to community-identified needs and alignment with ongoing efforts.
- **Elevate What's Already Working:** Models and programs that have demonstrated success and clear timelines will be strongly considered as initiative projects, allowing for replication and scaling.
- **Invest in Sustainable Transformation:** Support ready-to-launch projects for immediate impact and longer-term, regionally-driven efforts for sustainable transformation.

This approach allows for local solutions and innovation while maintaining state-level oversight and adaptability, ensuring funds are used effectively and within required timelines.

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

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

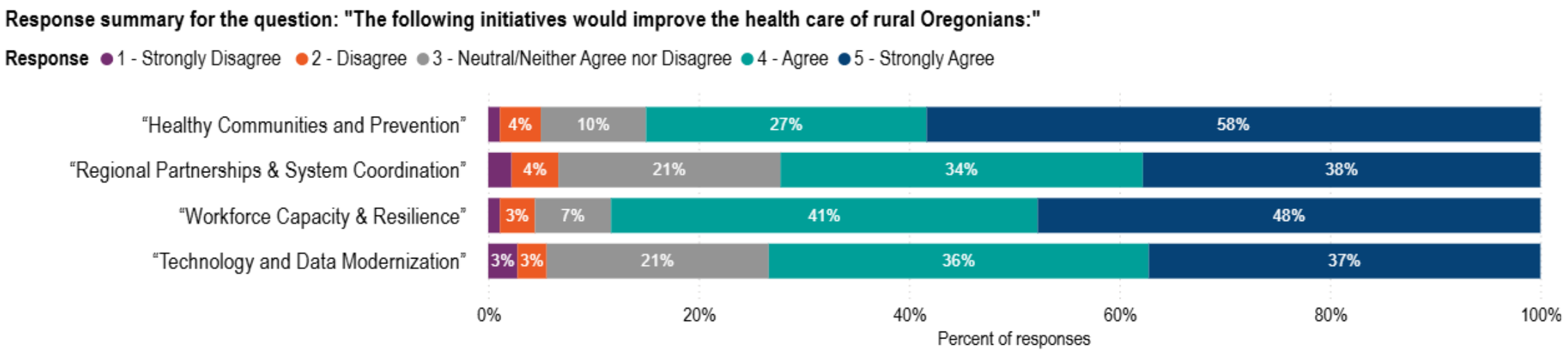
Public Comment Themes: Challenges

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:

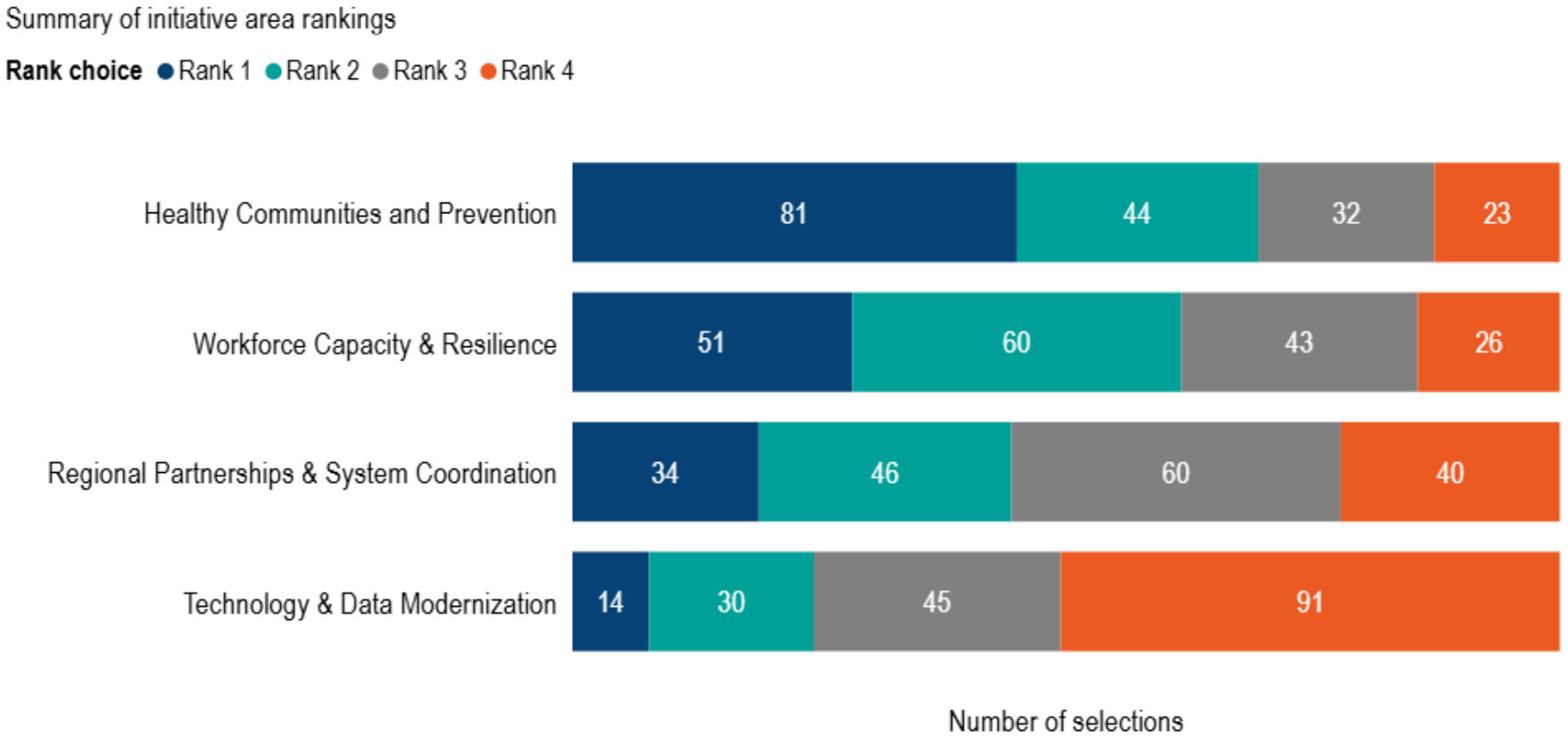
1. **Workforce Development** – Lack of robust training programs, recruitment & retention difficulties, housing shortages, and insufficient professional development and support across all provider types.
2. **Access to Care** – Service gaps all around, including dental, mental health, pharmacy, and specialty 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.

Results for Likert Scale Questions



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

Results for Ranking Question



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

Oregon's Initiatives and CMS Strategic Goals

	Healthy Communities & Prevention	Regional Partnerships and Systems Coordination	Rural Workforce Capacity & Resilience	Technology and Data Modernization
Oregon's Initiatives	People in rural Oregon can easily and affordably access the essential care they need through innovative, community-driven solutions that provide choice, including a variety of provider types, care delivery approaches (e.g., telehealth, home visits, mobile clinics), and tools to support personal health care management at all stages of life from prenatal to end-of-life care.	Oregon's rural health care system is organized in a way that enables regionally driven approaches to meet the unique and evolving needs of communities by sharing resources, providers, and technology.	Oregon is able to meet the health care needs of rural communities through innovative workforce solutions that expand capacity and utilize creative approaches, including enhanced recruitment and retention efforts, new residency and training programs specifically focused on rural and maternity care, supporting "grow-your-own" efforts, new staffing models, and a broader array of provider types.	Oregon's rural communities are supported through enhanced technological approaches and solutions to ensure digital access, secure information-sharing, reduced administrative complexity, and better communication across providers, patients and systems.
CMS Strategic Goals	**Make rural America healthy again:** Support rural health innovations and new access points to promote preventative health and address root causes of diseases. Projects will use evidence-based, outcomes-driven interventions to improve disease prevention, chronic disease management, behavioral health, and prenatal care.	**Sustainable access:** Help rural providers become long-term access points for care by improving efficiency and sustainability. With RHT Program support, rural facilities work together—or with high-quality regional systems—to share or coordinate operations, technology, primary and specialty care, and emergency services.	**Workforce development:** Attract and retain a high-skilled health care workforce by strengthening recruitment and retention of healthcare providers in rural communities. Help rural providers practice at the top of their license and develop a broader set of providers to serve a rural community's needs, such as community health workers, pharmacists, and patient navigators.	**Tech innovation:** Foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients. Projects support access to remote care, improve data sharing, strengthen cybersecurity, and invest in emerging technologies.

Innovative care: Spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements. Develop and implement payment mechanisms incentivizing providers or ACOs to reduce health care costs, improve quality of care, and shift care to lower cost settings). CMS's fifth strategic goal has relevance across multiple initiatives. And because financial sustainability is foundational to achieving our Oregon's transformation goal for the program, this strategy will not be treated as standalone and, instead, integrated throughout.

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.**

1. Healthy Communities & Prevention

Focus: Primary care (for physical, behavioral, and oral health needs) and chronic disease management, maternal and child health, and population health infrastructure

Future vision:

People in rural Oregon can easily and affordably access the essential care they need through innovative, community-driven solutions that provide choice, including a variety of provider types, care delivery approaches (e.g., telehealth, home visits, mobile clinics), and tools to support personal health care management at all stages of life from prenatal to end-of-life care.

2. Regional Partnerships and Systems Coordination

Focus: Shared infrastructure, regional planning, cross-sector collaboration

Future vision:

Oregon’s rural health care system is organized in a way that enables regionally driven approaches to meet the unique and evolving needs of communities by sharing resources, providers, and technology.

3. Workforce Capacity & Resilience

Focus: Recruitment, training, retention, and wellness of rural health providers

Future vision:

Oregon is able to meet the health care needs of rural communities through innovative workforce solutions that expand capacity and utilize creative approaches, including enhanced recruitment and retention efforts, new residency and training programs specifically focused on rural and maternity care, supporting “grow-your-own” efforts, new staffing models, and a broader array of provider types.

4. Technology and Data Modernization

Focus: Health information technology (HIT) infrastructure, data exchange, cybersecurity, and provider-facing technology

Future vision:

Oregon's rural communities are supported through enhanced technological approaches and solutions to ensure digital access, secure information-sharing, reduced administrative complexity, and better communication across providers, patients and systems.