1/14/26

House Interim Committee on Health Care

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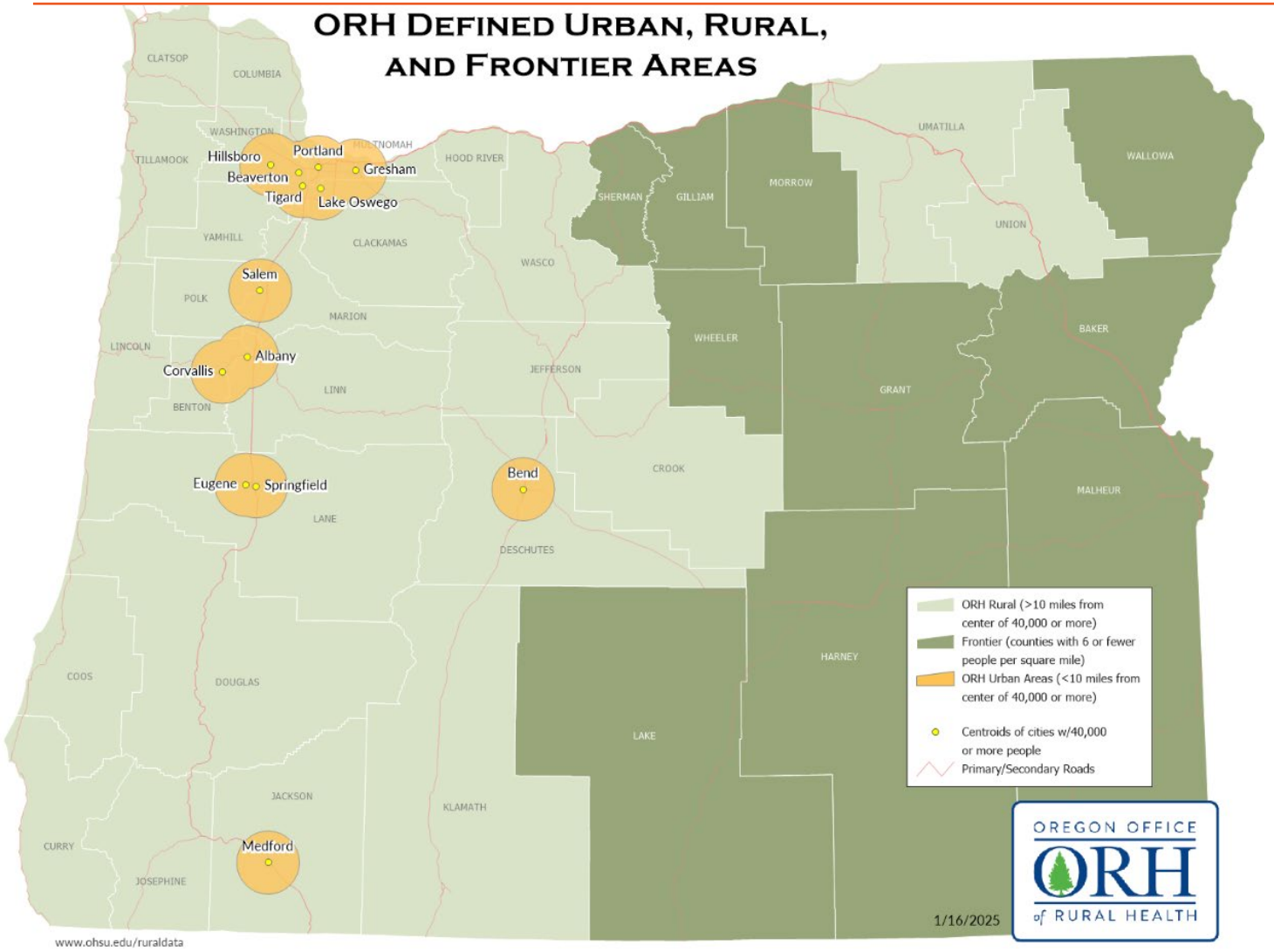
OREGON HEALTH AUTHORITY

Rural Health Transformation Program

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 set to receive $197.3M in 2026**
  - Funds are frozen until the budget is finalized and approved by CMS in January 2026
- If approved for a similar amount in subsequent years, Oregon will receive an estimated $1B over the five-year grant period

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).

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

CMS - 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

Advisory Body

- The Rural Health Coordinating Council (RHCC), an 18-voting member council statutorily required to advise the Office of Rural Health, will serve as the advisory body for the state RHT Program.
  - ❑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.

Public Engagement

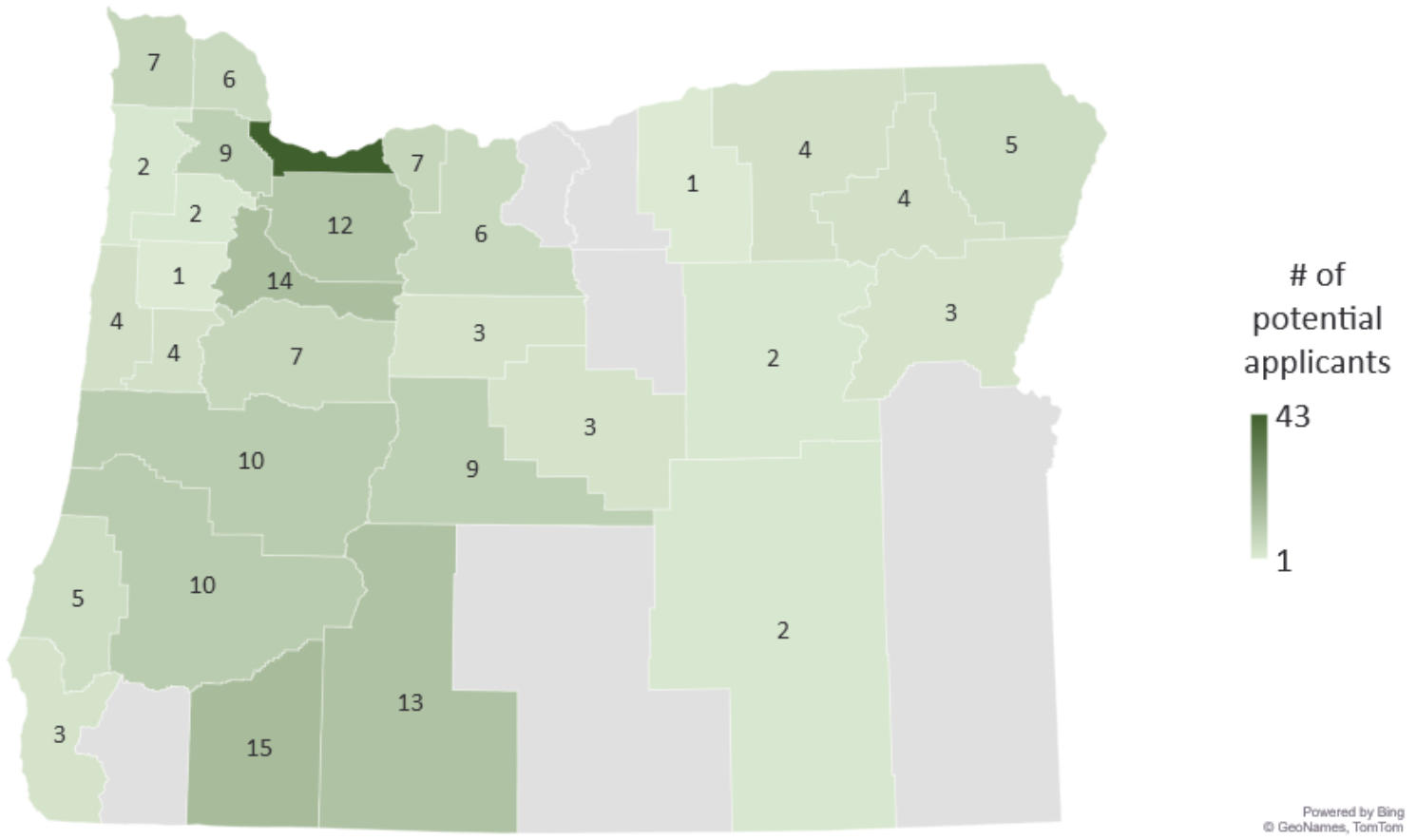
Public Engagement History

- 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.
- "Intent to Apply" Survey fielded 11/25 to 12/29
  - 255 responses were collected. 384 projects were proposed.

Intent to Apply Survey Results

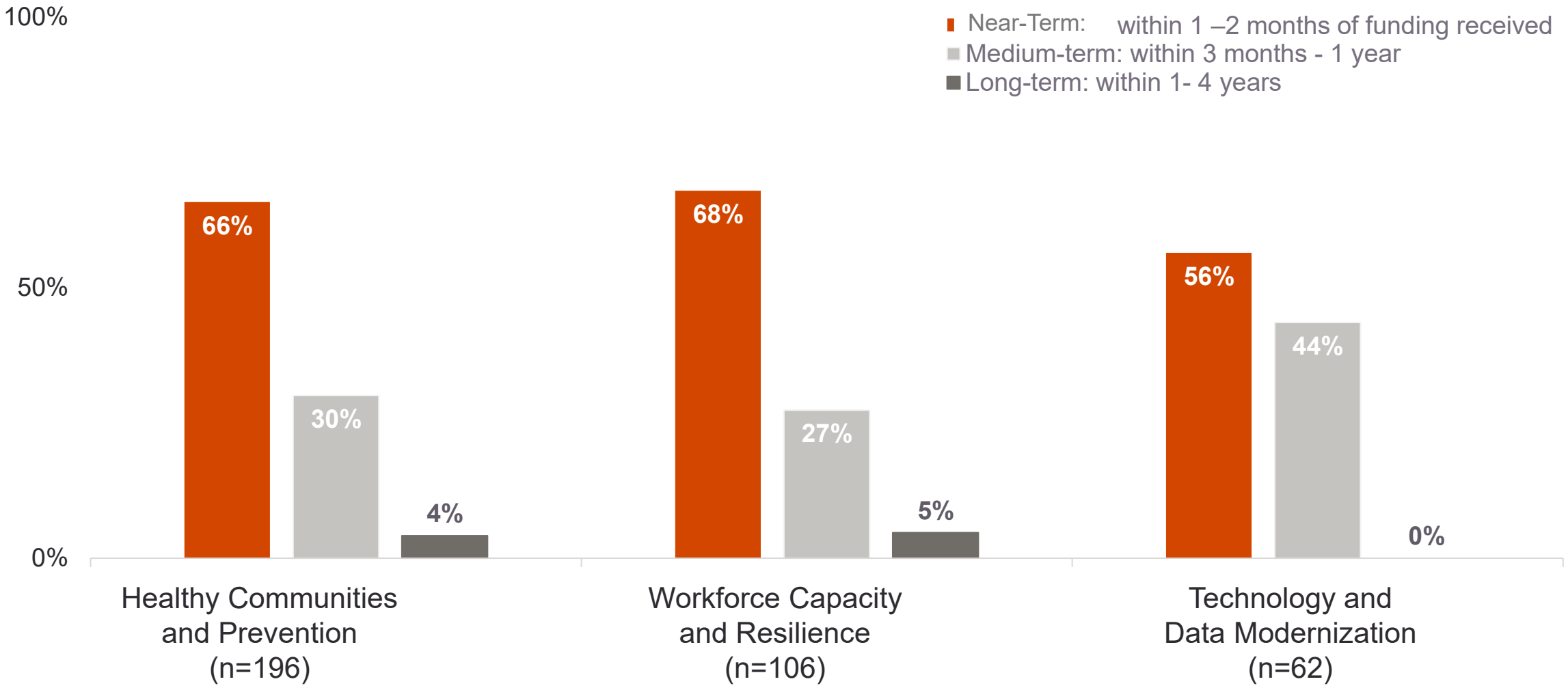
General Information

- 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 fast-tracked projects: $256,290,781

Fund Distribution Timeline and Plan

Phase 1 (FY26 – FY27)

Initial phase will focus on three pathways for fund distribution:

1. **Catalyst Awards:** Through a grant application 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-compete) for a select set of aligned opportunities identified by the state (not through an application process).
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 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.

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

Program Launch

Some key guiding principles for launch

- Focus on self-identified health care needs in rural communities
- Quickly and effectively distribute funds
- Ensure projects are aligned with outcome metrics to strengthen likelihood of future funding
- Strength in partnerships

Q1-Q2 2026: Next steps (non-comprehensive…)

- Begin shifting from a temporary “transition team” to a more established and longer-term project team
- Negotiate and finalize award with CMS
- Establish necessary and urgent subcontracts
- Activate initial immediate impact awards (direct grant awards)
- Design, open and announce Catalyst Award applications

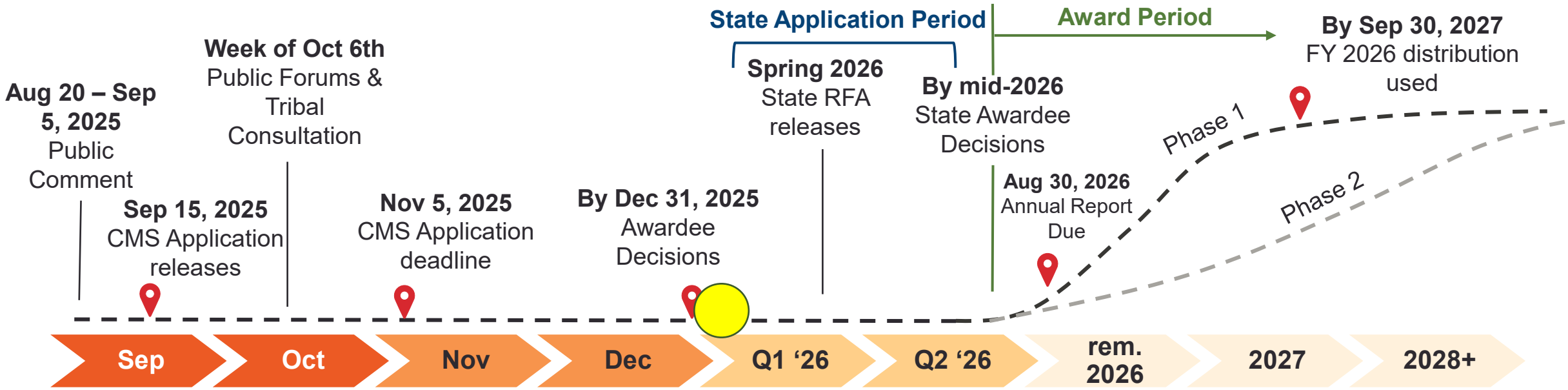
OREGON HEALTH AUTHORITY

Thank You

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

Appendix

Oregon RHT Program 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 RFAs

Program Preparation

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

Phase 1: Fast-Track Deployment (FY 2026-7 Focus)

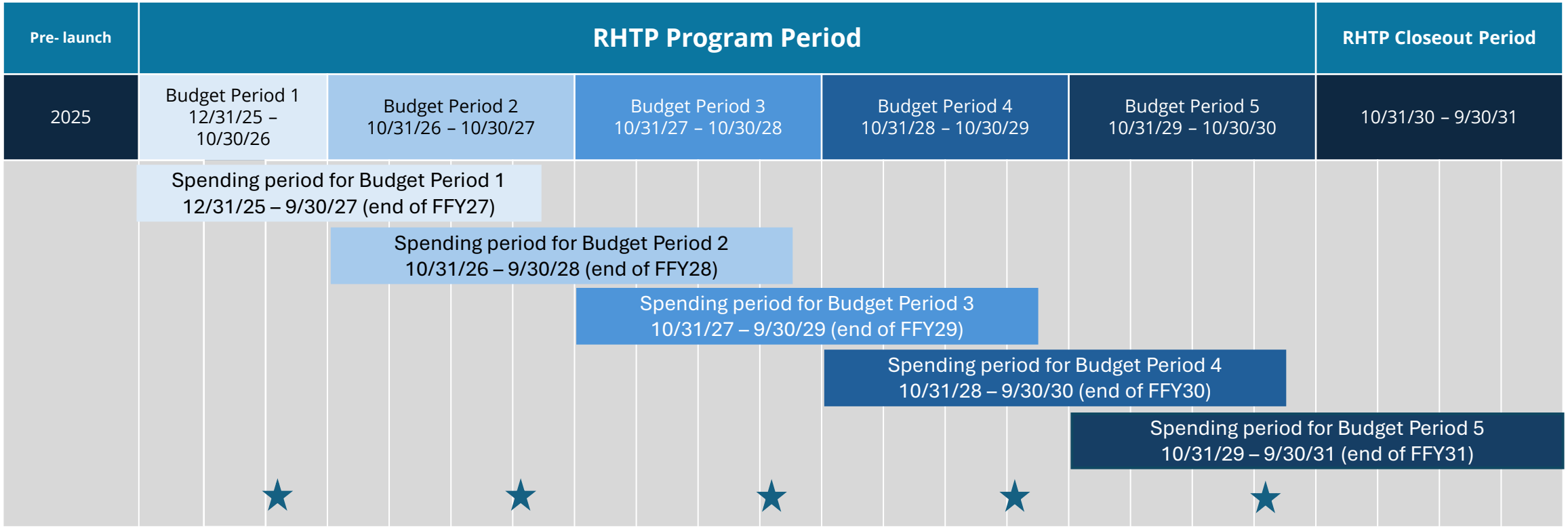
- Support ready-to-launch projects for immediate impact and timely funding

Phase 2: Sustain and Grow (FY 2028+)

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

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

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 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 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

Metrics and Outcomes: Healthy Communities & Prevention

Initiative: Healthy Communities & Prevention
Outcome 1: Universal access to home visiting services Metric: # of families receiving home visits Data Source and 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 and 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: # of new preventative health or self-management programs in rural Oregon Data Source and 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: # of new access points to care Data Source and Timing: State-specific, participant-reported, annual
Outcome 5: Expanded access to health care services, including chronic disease management, through increased availability of telehealth Metric: Increased proportion of telehealth encounters Data Source and Timing: County-specific, Claims and encounter data, annual

Metrics and Outcomes: 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 and Timing: State-specific, participant-reported, annual
Outcome 2: Increase # 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 and 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: # of K-12 health career pathway programs launched Data Source and Timing: State-specific, participant-reported, annual
Outcome 4: Increased hiring, training, and use of non-physician, non-hospital, and allied health professionals Metric: # of non-physician, non-hospital and allied health professionals recruited to rural areas Data Source and 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: % organizations requesting health IT technical assistance that complete health IT and cybersecurity self-assessment Data Source and Timing: State-specific, participant-reported, annual
Outcome 2: Increase health IT adoption and interoperability Metric: # of tools/capabilities adopted by awardees Data Source and Timing: County-specific, participant-reported, annual Note: Tools/capabilities are counted at the organization level
Outcome 3: Reduce administrative burden on providers Metric: % of organizations adopting a new health IT tool/capability that self Data Source and Timing: State-specific, participant-reported, annual
Outcome 4: Improve organizational cybersecurity practices Metric: % of organizations completing a cybersecurity self-assessment implementing measures to improve cybersecurity Data Source and 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 admittance Metric: % increase in providers using remote patient monitoring Data Source and 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 and 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: # of patients receiving care from shared resources for at-risk service Data Source and Timing: State-specific, participant-reported, annual
Outcome 3: Increase regional planning efforts focused on shared governance models, including CINs and consortiums Metric: # of organizations participating in regional partnerships Data Source and Timing: State-specific, participant-reported, annual
Outcome 4: Increase participation in value-based care models Metric: # of organizations participating in value-based care models Data Source and Timing: State-specific, participant-reported, annual

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