Summary: Rural Health Transformation Program *Updated September 18, 2025*

The One Big Beautiful Bill Act (Public Law 119–21) was signed into law on July 4, 2025, and includes a new Rural Health Transformation Program (RHTP). Section 71401 appropriates $50 billion to the Centers for Medicare & Medicaid Services (CMS) to be distributed to states over five years ($10 billion per fiscal year from FY2026 through FY2030) to support the delivery of healthcare in rural areas.

On September 15, CMS opened the application period and published a Notice of Funding Opportunity (NOFO). State applications must be submitted by November 5, 2025.

Funding

Fifty percent of the $50 billion must be divided equally among states with approved applications ($100 million per state per year). CMS will distribute the remaining 50 percent ($5 billion per year) based on factors identified in the NOFO and described below. CMS must ensure that not less than 1/4 of the states with approved applications receive a share of the funds. If a state receives funding under the program, it will receive payments for all five years. States are not required to provide any matching funds as a condition for receiving payments.

Program priorities

CMS identified five strategic goals for RHTP funding:

- **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 individuals trained to help patients navigate the healthcare system.
- **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 Accountable Care Organizations (ACOs) to reduce health care costs, improve quality of care, and shift care to lower cost settings.
- **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.

Application process

To receive funding, a state must submit a one-time application and rural health transformation plan by November 5, 2025. Applications must include a project summary, project narrative – including a description of the state's rural health needs and target population, goals and strategies, proposed initiatives, implementation plan and timeline, stakeholder engagement, evaluation plan, and sustainability plan – and budget narrative.

In FAQs, CMS states that while details in a state's work plan and timelines may change during implementation, the underlying strategy, themes, and general timing for use of funding should not change significantly throughout the five-year program period.

Use of funding

Section 71401 requires states to use program funds to carry out at least three of the following ten activities:

- Promoting evidence-based, measurable interventions to improve prevention and chronic disease management;
- Providing payments to health care providers for the provision of health care items or services;
- Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases;
- Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies;
- Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years;
- Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes;
- Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines;
- Supporting access to opioid use disorder treatment services, other substance use disorder treatment services, and mental health services;
- Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models; and
- Additional uses designed to promote sustainable access to high quality rural health care services.

Application factors and scoring

The NOFO describes workload funding factors that will be used to score state applications and determine funding awards. Rural facility and population score factors (see appendix A) will account for 50 percent of a state's score. The other 50 percent of workload funding (see appendix B) will be determined by a technical score comprised of:

- **Initiative-based factors**: A qualitative assessment of a state's proposed initiatives for use of RHTP funds described in a state's application
- **State policy-based factors**: Current state policy or policy actions a state commits to enacting
- **Data-driven metrics**: Additional data points related to the technical factor

States may receive conditional, partial points for state policy and initiative factors starting in the first budget period followed by full points credit if and when the commitment to change state policy or full implementation of a funding-driven initiative is fulfilled.

Technical score factors address the following topics and are described in more detail in appendix C and D:

- Population health clinical infrastructure
- Health and lifestyle
- SNAP waivers
- Nutrition Continuing Medical Education
- Rural provider strategic partnerships
- EMS
- Certificate of Need
- Talent recruitment
- Licensure compacts
- Scope of practice
- Medicaid provider payment incentives
- Individuals dually eligible for Medicare and Medicaid
- Short-term, limited-duration insurance
- Remote care services
- Data infrastructure
- Consumer-facing tech

Notably, state policy-based factors encourage and reward states for adopting specific state policies. Some of these factors are consistent with AMA policies – such as those that promote coverage for remote care and repeal of certificate of need (CON) laws. However, the AMA has significant concerns about some of the state policy-based factors, including the "scope of practice" factor that promotes expanded scope of practice laws for physician assistants, nurse practitioners, pharmacists, and dental hygienists. Scoring for this factors will be determined based on the AAPA PA State Practice Environment, American Association of Nurse Practitioners State Practice Environment, Cicero Institute 2025 Policy Strategies for Full Practice Authority, and Oral Health Workforce Research Center Variation in Dental Hygiene Scope of Practice by State, respectively. The AMA is also concerned about state policy factors that support mandatory continuing education for physicians on nutrition and short-term, limited-duration insurance plans. State policy-based factors are described more fully in appendix C.

Limitations on funding use

States are not limited to distributing funds to facilities defined as "rural health facilities" in the legislation (e.g., rural hospitals). However, funds may not be used to pay for clinical services already reimbursed by another source (i.e., insurance, Medicaid, CHIP, Medicare, or HRSA) and may not be used to change payment amounts of existing fee schedules. Additionally, funding for provider payments cannot exceed 15% of the total funding award in a given budget period. States may not spend more than 10 percent of the funding on administrative expenses.

States must spend funds by end of the fiscal year following the fiscal year in which such amounts are allotted. For example, funds allotted in FY2026 will be available only through the end of FY2027. Unspent funds will be redistributed and returned to the Treasury after October 1, 2032.

States must participate in ongoing monitoring and submit an annual report to CMS on the use of the funds. CMS may recoup funds it determines have been misused.

Additional limitations are described in the NOFO beginning on page 18.

Funding award decisions

CMS will announce funding awards by December 31, 2025.

The amount of funding allotted to a state per budget period will be calculated as: Total Available Workload Funding in a Budget Period * State's Total Points Score for a Budget Period / Sum of All Approved States' Total Points Score for a Budget Period

However, funding under the RHTP is not guaranteed and CMS retains sole discretion to make funding decisions. The NOFO states that CMS will base funding decisions on its review of state applications and data but cautions that

the application will not be the sole factor of consideration. CMS will also consider the past performance of applicants, and may choose not to fund applicants with management or financial problems.

Additionally, Section 71401 of the authorizing legislation bars administrative or judicial review of “amounts allotted or redistributed to States, payments to States withheld or reduced, or previous payments recovered from States.”

The AMA will continue to monitor and keep Federation partners apprised of any relevant updates. For questions about the Rural Health Transformation Program in your state, please contact Annalia Michelman, JD, MPP, Senior Attorney, AMA Advocacy Resource Center, at annalia.michelman@ama-assn.org or (312) 464-4788.

Appendix A: Rural facility and population score factors and weights

Rural facility and population score factors	% weight
Absolute size of rural population in a State	10.00%
Proportion of Rural Health Facilities in the State	10.00%
Uncompensated care in a State	10.00%
% of State population located in rural areas	6.00%
Metrics that define a State as being frontier	6.00%
Area of a State in total square miles	5.00%
% of hospitals in a State that receive Medicaid DSH payments	3.00%

Appendix B: Technical score factors and weights

Technical score factors	% weight	Type of factor
Population health clinical infrastructure	3.75%	Initiative-based factor
Health and lifestyle	3.75% (2.8125% initiative-based factors, .9375% state policy-based factors)	Initiative-based and state policy-based factor
SNAP waivers	3.75%	State policy-based factor
Nutrition Continuing Medical Education	1.75%	State policy-based factor
Rural provider strategic partnerships	3.75%	Initiative-based factor
EMS	3.75%	Initiative-based factor
Certificate of Need	1.75%	State policy-based factor
Talent recruitment	3.75%	Initiative-based factor
Licensure compacts	1.75%	State policy-based factor
Scope of practice	1.75%	State policy-based factor
Medicaid provider payment incentives	3.75%	Initiative-based factor
Individuals dually eligible for Medicare and Medicaid	3.75% (1.875% initiative-based factors, 1.875% data-driven factors)	Initiative-based and data-driven factor
Short-term, limited-duration insurance	1.75%	State policy-based factor
Remote care services	3.75% (1.875% initiative-based factors, 1.875% state policy-based factors)	Initiative-based and state policy-based factor
Data infrastructure	3.75% (2.8125% initiative-based factors, .9375% data-driven factors)	Initiative-based and data-driven factor
Consumer-facing tech	3.75%	Initiative-based factor

*score will be based on both state policy factors and initiative-based factors

Appendix C: State policy-based factors

State policy-based factor	Details
Health and Lifestyle*	Whether a state requires schools to reestablish the Presidential Fitness Test
SNAP Waivers	Whether a state has a USDA SNAP Food Restriction Waiver that prohibits the purchase of non-nutritious items
Nutrition Continuing Medical Education	Whether a state has a requirement for nutrition to be a component of continuing medical education
Certificate of Need (CON)	Based on a state's ranking in the Cicero Institute report, A Policymaking Playbook for Certificate of Need Repeal: Ranking Certificate of Needs Laws in All 50 States

Licensure Compacts	Whether and to what extent a state has adopted the Interstate Medical Licensure Compact, NLC Nurse Licensure Compact, EMS Compact, Psychology Interjurisdictional Compact, and/or Physician Assistants (PA) Compact
Scope of Practice	Based on practice environments for Physician Assistants, Nurse Practitioners, Pharmacists, and Dental Hygienists according to the AAPA PA State Practice Environment, American Association of Nurse Practitioners State Practice Environment, Cicero Institute 2025 Policy Strategies for Full Practice Authority, and Oral Health Workforce Research Center Variation in Dental Hygiene Scope of Practice by State, respectively
Short-term, Limited-Duration Insurance	Whether STLDI plans are restricted in the state beyond the latest federal guidance
Remote Care Services*	Based on Medicaid payment for live video, store and forward, and remote patient monitoring, whether there are any exceptions to the in-state licensing requirement, and whether the state has a telehealth license/registration process

*Score will be based on both state policy factors and initiative-based factors.

Appendix D: Initiative-based factors

Initiative-based factors will be scored based on the quality of details in the application addressing the following elements, as well as feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics.

Initiative-based factor	Details
Population health clinical infrastructure	• Enhancement of and/or creation of community-based care initiatives. • How to strengthen the whole rural health care ecosystem at the community level through technological innovation, a focus on primary care, a focus on behavioral health, and expanded scope of practice for mid-level practitioners and pharmacists. • How to coordinate amongst existing rural community providers, community-based facilities, and other stakeholders to enhance access to preventative care, long-term care, behavior health, and other social health services.
Health and lifestyle*	• Novel prevention-focused models emphasizing lifestyle changes, around physical activity and / or proper nutrition, that are evidence-based with potential for clear and measurable health outcome improvements. • Engagement of a variety of stakeholders and community resources within the geographic area of the initiative to successfully execute vision. • Clear, concise, and implementable goals focused on root causes of public health tailored to the needs of local rural communities.
Rural provider strategic partnerships	• Arrangements that include an exchange of best practices and coordination of care, partially facilitated through remote care services. • Arrangements will expand access to specialty services in a financially sustainable manner. • Arrangements centralize and/or streamline back-office functions and resources to create cost savings for participants. • Arrangements improve financial viability of rural providers, preserve independence of rural providers where appropriate, and strive to keep care local where appropriate.
EMS	• State policies and infrastructure that will support coordination between EMS and other provider types as well as EMS integration with other parts of the healthcare delivery systems. Examples include collaboration with primary care providers and expanding models like community paramedicine where appropriate. • Infrastructure that will support alternative site of care treatment (e.g. treat “in place” as part of an emergency call).

	• Other investments to improve speed, access, and cost to deliver emergency medical services.
Talent recruitment	• Supporting health care career education infrastructure in rural communities, like health care career pathway programs in high schools. • Funding new residency training programs, fellowships, or combined programs in rural communities, tied to at least 5 years of service spent in rural areas. • Relocation grants for clinicians moving to rural communities for at least 5 years of service. Investment in health care talent recruitment related to Indian Health Services, as relevant for a State. • A focus on supporting pathways for non-physician health care providers, non-hospital-based providers, and allied health professionals in rural areas.
Medicaid provider payment incentives**	• Development and implementation of payment mechanisms incentivizing providers or ACOs to reduce health care costs, improve quality of care, and shift care to lower cost settings. • Development and implementation of value-based programs that have a pathway to include two-sided risk and are supported by evidence to suggest programs will change patient and provider behavior.
Individuals dually eligible for Medicare and Medicaid	• Ways that time-limited investments can support dual eligible enrollment in integrated plans, such as investments to promote data integration, technical assistance to improve duals support and resources, and enrollment support.
Remote care services*	• Enhancement of remote care services infrastructure within a State.
Data infrastructure**	• Enhancement of data infrastructure within a State, such as • investments in EHR, clinical support, and operational software infrastructure upgrades that enable participation in data exchange and interoperability. These enhancements should be aligned with CMS's Health Technology Ecosystem criteria and ASTP/ONC criteria, as applicable. • Investments should only be considered if they have specific rural benefits. • For technology that has a cloud-based alternative compared to on-premises technology, preference for cloud-based, multi-tenant architecture when feasible.
Consumer-facing tech	• Support the development, appropriate usage and/or deployment of various consumer-facing health technology tools for the prevention and management of chronic diseases. • Health technology tools supported should be aligned with CMS's Health Technology Ecosystem criteria for patient-facing apps, as applicable.

*Score will be based on both state policy factors and initiative-based factors.
*Score will be based on both initiative-based factors and data-driven factors.