Notice of Funding Opportunity

Application due November 5, 2025



Rural Health Transformation Program

Opportunity number: CMS-RHT-26-001



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Before you begin

If you believe you are a good candidate for this funding opportunity, secure your SAM.gov and Grants.gov registrations now. If you are already registered, make sure your registrations are active and up-to-date.

SAM.gov registration (this can take several weeks)

You must have an active account with SAM.gov. This includes having a Unique Entity Identifier (UEI).

See Step 2: Get Ready to Apply

Grants.gov registration (this can take several days)

You must have an active Grants.gov registration. Doing so requires a Login.gov registration as well.

See Step 2: Get Ready to Apply

Apply by the application due date

Applications are due by 11:59 p.m. Eastern Time on November 5, 2025.

To help you find what you need, this NOFO uses internal links. In Adobe Reader, you can go back to where you were by pressing Alt + Left Arrow (Windows) or Command + Left Arrow (Mac) on your keyboard.



Step 1:
Review the Opportunity

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Basic information

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services

Supporting rural communities to improve healthcare access, quality, and outcomes through system transformation.

Summary

The Rural Health Transformation (RHT) Program helps State governments to support rural communities across America in improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem.

The RHT Program focuses on promoting innovation, strategic partnerships, infrastructure development, and workforce investment.

States will help rural communities meet these 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 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

Have questions? See Contacts and Support.

Key facts

Opportunity name: Rural Health Transformation Program

Opportunity number: CMS-RHT-26-001

Assistance listing: 93.798

NOFO version: Original

Key dates

Informational program introduction applicant webinars: September 19 and 25, 2025
To register for the webinars, please visit the program website.

Optional letter of intent deadline:
September 30, 2025

Application submission deadline:
November 5, 2025

Expected award date:
December 31, 2025

Expected earliest start date: December 31, 2025

See other submissions for other time frames that may apply to this NOFO.

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.

Funding details

Funding type: Cooperative agreement, which means that both you and CMS will have roles in the project. Throughout the life of your project, we will be there to help and work with you.

Announcement type: New

Expected total funding for the program: $50 billion over five budget periods

Expected total awards: Up to 50

This is a one-time application opportunity. We will provide funding in five budget periods of 10 months for the first budget period and 12 months for each subsequent budget period. These budget periods align with funding appropriated for this program from fiscal year 2026 through fiscal year 2030. For each budget period, recipients will have until the end of the following fiscal year to spend awarded funding.

We will determine awardees by December 31, 2025. We will determine the four following award amounts by these dates:

- For funding appropriated for fiscal year 2027: October 31, 2026
- For funding appropriated for fiscal year 2028: October 31, 2027
- For funding appropriated for fiscal year 2029: October 31, 2028
- For funding appropriated for fiscal year 2030: October 31, 2029

Eligibility

Eligible applicants

In accordance with the authorizing statute, Section 71401 of Public Law 119-21, only the 50 U.S. States are eligible to receive an RHT Program award; the District of Columbia and U.S. Territories are not eligible.

Local governments, hospitals, universities, nonprofits, federally recognized tribes, individuals, and any other entity besides one of the 50 States of the United States are also ineligible to receive an RHT Program award.

All 50 U.S. States are eligible, even if they do not have a large rural population or any rural hospitals. We encourage every State to focus on how this funding could benefit its rural populations and consider applying.

Other eligibility requirements

To apply for an RHT Program award, each State must submit an official application.

The primary recipient of each award must be a single State. Because each State's funding allotment is distinct, joint or consortium applications involving multiple States are not permitted.

The governor may designate a lead agency or office to develop and submit the application, like the State's department of health, department of human services, or State Medicaid agency.

The application must come from a State government agency or office and include a letter of endorsement signed by the governor. See information on this letter in the Attachments.

Authorized Organizational Representatives

To apply, you need to designate an authorized organizational representative (AOR). This person is the State's designated representative, with the authority to act on behalf of the State to handle grants and cooperative agreements. This person must be an official with the authority to legally bind the State.

The AOR will sign all application forms. This signature means that the State will assume the obligations imposed by the terms and conditions of the award, including federal statutes and regulations and other terms and conditions of the award, if the State and CMS enter into a cooperative agreement.

The State's responsibilities include oversight for using the award funds appropriately and carrying out the project as specified in your approved cooperative agreement.

Partners

Only a State that submits an official application can be the primary recipient of each award under this opportunity. You may consult and involve numerous partners like universities, local health departments, community-based organizations, and provider associations in designing and implementing the planned activities proposed in your application and may sub-award or contract RHT Program funds to such partners for various activities.

You must also consult certain stakeholders during the creation of your application, as described in application contents and format. However, these partners are not co-applicants. The prime awardee responsible to CMS will be the Governor-designated lead agency or office that submitted the application and was awarded funding.

Completeness and responsiveness criteria

We will review your application to make sure it meets the requirements found in Eligibility, Application contents and format, and Application submission and deadlines.

We won't consider an application that:

- Is from an organization that doesn't meet all eligibility criteria.
- Is submitted after the deadline.
- Is not submitted through Grants.gov.
- Does not include all components required in the application checklist.
- Does not use the formatting requirements, including spacing, font size, etc.

We may allow you to correct minor errors if there is time before our decision deadline, but this is not guaranteed.

It is your responsibility to ensure the submission is complete and compliant.

Application limits

A State may submit only one official completed application. We will not review multiple completed applications from the same State. States are expected to coordinate across relevant departments and stakeholders to develop a unified proposal. If more than one completed application is received from a State, the last submitted complete application prior to the submission deadline will be reviewed, and any earlier submissions will be disregarded.

Cost sharing

This program has no cost-sharing requirement, meaning you do not need to contribute to the costs of this project.

Program description

Purpose

The RHT Program will provide funding to support States in enhancing existing activities and implementing activities articulated in the authorizing statute.[1]

Through a cooperative agreement award, funding under the RHT Program will be granted directly to States with approved applications, based on a single application opportunity, for investments that will transform the way care is delivered in rural communities. This funding will drive the following strategic goals, which are aligned with approved use of funds:

- **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.

Background

As part of Public Law 119-21, Congress established the $50 billion RHT Program to help rural communities reimagine their health care delivery systems and improve health outcomes.

Congress authorized the Administrator of CMS to provide funding to States to invest in at least three uses of funds as described in the use of funds section and in statute.

This program addresses longstanding health-care challenges facing rural communities. Therefore, funding will be focused on promoting innovation, strategic partnerships, infrastructure development, and workforce investment to support rural population health care innovations and new access points to promote preventative health and address root causes of disease.

Program requirements and expectations

Use of funds

You may use funds awarded under this opportunity only for the permissible uses specified in the statute and described here. As a condition of approval, your application must reflect that you will use awarded funds to invest in at least three of these permissible uses that are described in Section 71401 of Public Law 119-21:

A. **Prevention and chronic disease:** Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.

B. **Provider payments:** Providing payments to health care providers for the provision of health care items or services, subject to restrictions described in the funding policies and limitations.

C. **Consumer tech solutions:** Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.

D. **Training and technical assistance:** 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.

E. **Workforce:** Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.

F. **IT advances:** Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.

G. **Appropriate care availability:** 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.

H. **Behavioral health:** Supporting access to opioid use disorder treatment services (as defined in section 1861(jjj)(1) of the Social Security Act), other substance use disorder treatment services, and mental health services.

I. **Innovative care:** Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.

Additional uses designed to promote sustainable access to high quality rural health care services, as determined by the Administrator:

J. **Capital expenditures and infrastructure:** Investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume, subject to restrictions in the funding policies and limitations.

K. **Fostering collaboration:** Initiating, fostering, and strengthening local and regional strategic partnerships between rural facilities and other health care providers to promote quality improvement, improve financial stability of rural facilities, and expand access to care.[2]

Collaborators and stakeholders

You may collaborate and share ideas with other States, however, each State must apply separately for its own funding. Your initiatives could include multistate collaborations, such as regional networks or complementary workforce initiatives.

You may consult and involve partners like universities, local health departments, and provider associations when designing and implementing the activities in your project.

You may subaward or subcontract RHT Program funds to such partners for various activities, but you must make your process and criteria for selecting such subawardees and subcontractors clear to CMS. Note that the terms and

conditions of federal awards generally flow down to subawards and subrecipients, as specified in 2 CFR 200.101(b)(1).

See the governor's endorsement section for stakeholders you need to consult when writing your application.

Funds distribution

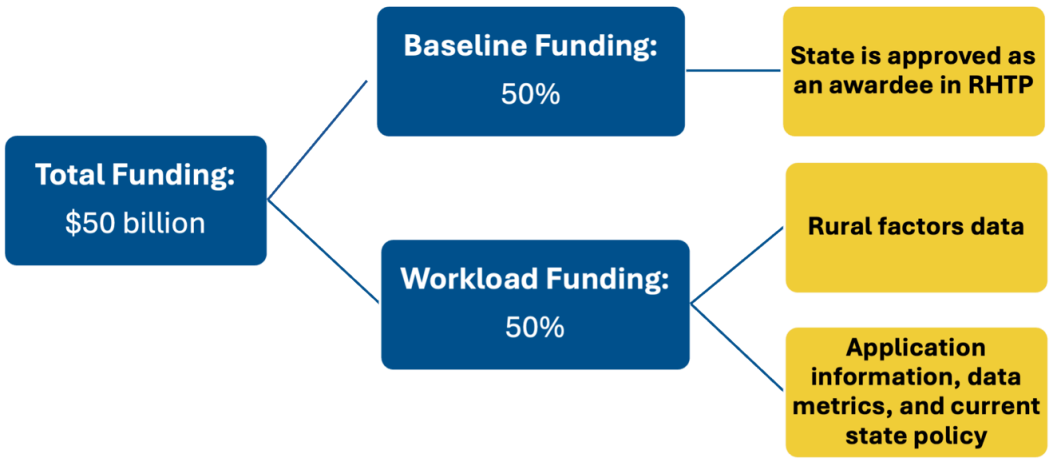
The RHT Program will provide approximately $50 billion to approved States over five budget periods. $10 billion of funding becomes available each budget period, beginning in fiscal year 2026 and ending in fiscal year 2030. The money will be distributed as follows:

- **Baseline funding:** We will distribute $25 billion equally among all approved States, up to a maximum of 50 approved States. Baseline funding will be half of the total funding available each budget period.
    - Baseline funding per approved State = half of the total funding available each budget period / # of approved States
- **Workload funding:** We will distribute the other $25 billion based on the content and quality of your application and rural factors. Workload funding will be half of the total funding available each budget period.

The initial Workload funding amounts will be calculated based on the information you provide CMS in the RHT Program application and government data sets.

The total points score is determined by two sets of factors (see Table 1, and the appendix for detailed definitions and points scoring methodology):

1. Rural facility and population score factors
2. Technical score factors



CMS will re-calculate each approved State's technical score and corresponding Workload funding amount for each subsequent budget period based on the information and data the approved State provides in the required annual reporting each year. In particular, CMS will focus on assessing progress towards the goals and commitments that an approved State makes as documented in its cooperative agreement. The definition and factors for calculating the technical score will remain the same as described in this NOFO. A State's rural facility and population score will not be recalculated every budget period and will only be calculated once, based on data available during your initial application process in calendar year Q4 2025.

Workload funding factors

The workload funding factor types are described here. Refer to the appendix for detailed definitions and points scoring methodology.

- **Data-driven metrics:** Points awarded based on the value of your metrics compared to other States.
- **Initiative-based:** Points are awarded based on a qualitative assessment of the programmatic initiatives you outlined in your application and subsequent follow-through. States should decide what types of initiatives they use funding on and do not have to use funding on all initiative-based factors.
- **State policy actions:** Points are awarded based on current State policy, based on third-party resources accessed by CMS and validated by you attesting to your current policy stance in your application, proposed policy action that you commit to by accepting the award, and subsequent follow-through toward meeting your policy action commitments. We believe these State policy actions, which don't use funding and are optional to pursue, will be complimentary to and greatly enhance the impact of initiative-based investments and their benefits to health care in rural communities. The State policy components of factors B. 2 and B. 4 will not count towards a State's overall score until the budget period beginning after October 31, 2026. States will also have until December 31, 2028 to follow through on meeting their policy commitments for these two factors only.

Table 1: Rural facility and population score and technical score factors

Rural facility and population score factors	Factor type
A. 1. Absolute size of rural population in a State	Data-driven
A. 2. Proportion of Rural Health Facilities in the State	Data-driven
A. 3. Uncompensated care in a State	Data-driven
A. 4. % of State population located in rural areas	Data-driven
A. 5. Metrics that define a State as being frontier	Data-driven
A. 6. Area of a State in total square miles	Data-driven
A. 7. % of hospitals in a State that receive Medicaid DSH payments	Data-driven

Technical score factors	Factor type
B. 1. Population health clinical infrastructure	Initiative-based
B. 2. Health and lifestyle	Initiative-based and State policy actions
B. 3. SNAP waivers	State policy actions
B. 4. Nutrition Continuing Medical Education	State policy actions
C. 1. Rural provider strategic partnerships	Initiative-based
C. 2. EMS	Initiative-based
C. 3. Certificate of Need	State policy actions
D. 1. Talent recruitment	Initiative-based
D. 2. Licensure compacts	State policy actions
D. 3. Scope of practice	State policy actions
E. 1. Medicaid provider payment incentives	Initiative-based
E. 2. Individuals dually eligible for Medicare and Medicaid	Initiative-based and Data-driven
E. 3. Short-term, limited-duration insurance	State policy actions
F. 1. Remote care services	Initiative-based and State policy actions
F. 2. Data infrastructure	Initiative-based and Data-driven
F. 3. Consumer-facing tech	Initiative-based

Funding redistribution

In accordance with 42 U.S.C. 1397ee(h)(1)(B), in either of the following scenarios, unexpended or unobligated funds will be redistributed:

- **Unexpended:** A State does not spend all funds CMS awarded to it by the end of the subsequent fiscal year with respect to each budget period start date. Spending can include expenses paid out on initiatives run at the State level, or funding paid out as subawards, subgrants, or subcontracts to other organizations and entities to execute initiatives, with strong State oversight. Funding earmarked but not paid out for future spending, expenses, or subawards/subgrants/subcontracts are not considered spent.
- **Unobligated:** CMS does not award the full $10 billion available in a given budget period.

If such additional funds become available, we will redistribute them in the nearest following fiscal year possible according to the same structure outlined previously. Any funding that is unexpended or unobligated as of October 1, 2032, shall be returned to the Treasury of the United States.

Cooperative agreement terms

Cooperative agreements require substantial CMS project involvement after an award is made. There are specific roles for both you and CMS as described here. We may be in contact at least once a month, and more frequently when appropriate.

Your responsibilities

- Comply with the terms and conditions of the award.
- Collaborate with CMS staff to implement and monitor the project.
- Submit the performance measures agreed upon in your cooperative agreement, Notice of Award, and subsequent revisions to work plan as approved by us.
- Submit all required performance assessments, evaluations, and financial reports included in the terms and conditions. See the reporting section.
- Attend monthly calls with the CMS project or grants management specialist to discuss your project's progress and challenges. The meetings will include key personnel and the State project officer or project director.
- Participate in any virtual meetings.

CMS responsibilities

- Monitor the project's performance and progress according to the processes outlined in Post-Award Requirements and Administration.
- Collaborate with you and provide substantial project planning and implementation input.
- Provide substantial input in evaluation activities.
- Make recommendations for continuing the project.
- Maintain up-to-date website content to keep you informed.
- Review and approve all key personnel.
- Maintain regular communication with you through at least monthly conference calls along with technical assistance and consultation.
- Review and provide feedback on all required performance assessment reports.
- Review and approve all required submitted data.
- Provide a structured approach to sharing, integrating, and actively applying improvement concepts, tactics, and lessons learned amongst approved award recipients.
- Evaluate changes to proposed activities in your workplan in extenuating circumstances. We will evaluate your State's rural health transformation plan amendments as needed to approve use of funding for alternative activities not originally agreed upon in your application and annual reporting. The intent is not to change a State's allocated funding amount, but to accommodate funding of alternative activities not originally envisioned in rare and extenuating circumstances with existing allocated funding. Extenuating circumstances may include:
  - Drastic changes in the State health care delivery system that would make your original activities not reasonably practicable to implement or not beneficial.
  - Catastrophic events that are not foreseeable when you apply.

Substantial CMS project involvement relates to programmatic involvement, not administrative oversight.

Statutory authority

Public Law 119-21, Section 71401

Funding policies and limitations

Changes in HHS regulations

Awards will be subject to any applicable provisions of 2 CFR Part 200 and 2 CFR Part 300. As of October 1, 2025, HHS will adopt 2 CFR Part 200, with some modifications included in 2 CFR Part 300. These regulations can be found at 89 FR 80055 and replace those in 45 CFR Part 75.

Limitations

We do 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.

For guidance on some types of costs that we restrict or do not allow, see 2 CFR Part 200 Subpart E - General Provisions for Selected Items of Cost.

Program-specific limitations

Unallowable costs

- New construction is unallowable. 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. We will not accept payments to clinical services if they duplicate billable services and/or attempt to change payment amounts of existing fee schedules. If you plan to fund direct health care services, you 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.

Noncompliance

If we determine that you are not using award funds in a manner consistent with the description you provided in your approved application (a "violation of agreement"), we may withhold, reduce, or recover your award payments. Violations of agreement include, but are not limited to:

- Using funds in a manner inconsistent with activities described in a State's application, on activities explicitly limited in the Limitations and Program-specific limitations sections, and/or on activities we have not approved.
- Failure to finalize State policy actions proposed in your application by the end of calendar year 2027. States will have until the end of calendar year 2028 to enact the relevant policies for factors B. 2 and B. 4.
- Not investing funds in a way that broadly affects your State's rural areas and residents in a positive manner.

- Failure to submit required reporting requirements as described in the Reporting section.
- Failure to follow through on other actions in your approved application.
- Violating the terms and conditions of the award.
- Improperly managing or using award funds, including fraud, waste, abuse, and criminal activity.

You must remedy noncompliance within 90 days after we notify you of a violation. Remediation may include submitting a remediation plan. If you do not remedy your noncompliance, we may recover past payments and withhold further payments of both workload and baseline funding. If we withhold or recover funding, we will do so as follows:

- **For violations that affect your technical score:** Proportional to the incremental award funds granted based on the technical score points you were previously awarded.
- **For violations that do not directly affect your technical score:** Assessed on a case-by-case basis. All prior and future payments become eligible for withholding and/or recovery.

As required by Public Law 119-21, any amounts withheld or recovered shall be returned to the Treasury of the United States.

General policies

Support beyond the first budget year will depend on:

- Appropriation of funds;
- Satisfactory progress in meeting your project's objectives; and
- A decision that continued funding is in the government's best interest.

Indirect costs

Indirect costs are those shared across multiple projects and not easily separated. Costs included in the indirect cost pool must not be charged as direct costs.

To charge indirect costs you can select one of two methods:

Method 1 — Approved rate. If you currently have an indirect cost rate approved by your Cognizant Federal Agency, you may use that rate.

Method 2 — *De minimis* rate. If you do not have a negotiated indirect cost rate, you may elect to charge a *de minimis* rate (see 2 CFR 200.414(f)).

However, according to Section 71401 of Public Law 119-21, not 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 your entire budget, including indirect and direct costs.

Salary rate limitation

The salary rate limitation in the current appropriations act applies to this program. As of January 2025, the salary rate limitation is $225,700.

Program income

If you earn any money from your award-supported project activities (known as program income), you must use it for the purposes and under the conditions of the award. Find more about program income at 2 CFR 200.307.

Post-award requirements

Before you apply, make sure you understand the requirements that come with an award.

See Step 6: Learn What Happens After Award for information on regulations that apply, reporting, and more.

Step 2:
Get Ready to Apply

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Get registered

SAM.gov

You must have an active account with SAM.gov to apply. SAM.gov registration can take several weeks. Begin that process today.

To register:

- Go to SAM.gov Entity Registration and select Get Started. From the same page, you can also select the Entity Registration Checklist for the information you will need to register.
- You must agree to the financial assistance general certifications and representations specifically. Those for contracts are different.

When you register, you will also receive your required Unique Entity Identifier (UEI).

Once you register:

- You will have to maintain your registration throughout the life of any award.
- If your organization has multiple UEIs, use the one associated with your physical location.

Grants.gov

You must also have an active account with Grants.gov. You can see step-by-step instructions at the Grants.gov Quick Start Guide for Applicants.

Need Help? See Contacts and Support.

Find the application package

The application package has all the forms you need to apply. You can find it at this NOFO's Grants.gov opportunity page.

We recommend that you select the Subscribe button from the View Grant Opportunity page for this NOFO to get updates.

If you can't use Grants.gov to download application materials or have other technical difficulties, including issues with application submission, contact Grants.gov for assistance.



Step 3:
Build Your Application

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Application checklist

Make sure that you have everything you need to apply:

Narratives

Component	How to upload	Page limit
☐ Project summary	Use the Project Abstract Summary Form.	1 page
☐ Project narrative	Use the Project Narrative Attachment form.	60 pages
☐ Budget narrative	Use the Budget Narrative Attachment form.	20 pages

Attachments

Insert each in a single Attachments form.

Component	Page limit
☐ Governor's endorsement	4 pages
☐ Indirect cost rate agreement	None
☐ Business assessment of applicant organization	12 pages
☐ Program duplication assessment	5 pages
☐ Other supporting documentation	35 pages

Other required forms

Complete each required form in Grants.gov.

Component	Page limit
☐ SF-424: Application for Federal Assistance	None
☐ SF-424A: Budget Information for Non-Construction Programs	None
☐ Project/Performance Site Location	None
☐ Disclosure of Lobbying Activities (SF-LLL)	None

Application contents and format

We will provide instructions on how to build your application, including document formats in the following sections. See completeness and responsiveness criteria to understand what may disqualify your application from consideration.

Your organization's authorized organizational representative (AOR) must certify and submit your application.

See requirements for Intergovernmental review, if any.

Project summary

Limit to one page. May be single spaced. Follow other formatting requirements for the project narrative.

Write a one-page summary of your proposed project including its purpose and outcomes. Do not include any proprietary or confidential information. We will use this document for information sharing and public information requests if you get an award. Include:

- The name of your organization.
- The names of any subrecipients or sub-awardee organizations, if applicable.
- Project goals.
- Total budget amount.
- A description of how you will use funds.

Project narrative

The project narrative is the most important part of your application and should clearly describe your proposed project. You must address the proposed goals, measurable objectives, and milestones, following the instructions in this section.

The project narrative should be as specific as possible given space. We encourage you to use tables, bullet points, and headings to improve readability. For example, to convey your plan in a snapshot, you could include a table summarizing your key goals, activities, and timelines.

Define any acronyms or State-specific program names. Remember that reviewers may not be familiar with your specific landscape, so provide any needed explanations.

Avoid overly technical jargon. Keep your narrative clear and focused on what you will do and why it will make a difference for rural health in your State.

Required format for project narrative

Page limit: 60

Endnotes are not included in the page limit.

File name: Project narrative

File format: PDF

Font size: 12-point font, preferably Times New Roman, Arial, or fonts of similar size

Footnotes and text in graphics may be 10-point.

Spacing for main content: Double-spaced

Spacing for project abstract, tables, and footnotes: Single-spaced

Margins: 1-inch

Page size: 8.5 x 11

Include consecutive page numbers throughout.

Use the following headings and format in your project narrative.

Rural health needs and target population

Describe the current rural health landscape in your State and the specific challenges that the RHT Program plan seeks to address. Describe the specific criteria or data that your State uses to identify rural areas in this application. Provide data on:

- Rural demographics, such as: population size and density, income levels, employment sectors, unemployment rates, education attainment, health insurance coverage.
- Health outcomes, such as: rates of chronic conditions, child and maternal health outcomes.
- Healthcare access, such as: average distance to the nearest hospital or primary care clinic, availability of healthcare providers, availability of public transportation, health care facility numbers and distribution.

- Rural facility financial health, such as: number of rural hospital closures, utilization levels and patient volumes of existing rural health facilities.

Identify the target populations and geographic areas in your State that will benefit from the program. For example:

- "Rural residents in 20 high-need counties, including substantial tribal populations."
- "All rural hospitals, rural health clinics, and community health centers in rural areas statewide."

This section sets the context and the case for change. It should establish the need for transformation and help reviewers understand the specific rural health problems your plan will tackle, such as access gaps, quality issues, or unsustainable financing.

Rural health transformation plan: Goals and strategies

This section should include a detailed Rural Health Transformation Plan as required by statute in 42 U.S.C. 1397ee(h)(2)(A)(i). Present your vision, goals, and strategies for transforming rural health in a structured manner. We recommend organizing this section by the objectives or related groupings. For example, you might combine discussion of access and outcomes or technology and data.

Address each element required by statute:

- **Improving access:** What specific actions will you take to improve rural residents' access to hospitals, primary care, specialty care, behavioral health care, and other services, or to health care items?
    - Examples of actions: Establishing telehealth specialty consult programs, keeping emergency departments open, expanding maternal health services.
- **Improving outcomes:** What health care outcomes of rural residents will you target? How will you achieve improvements in these outcomes?
    - Examples of outcomes: Reduction of risk factors associated with increased mortality risk for certain conditions, better chronic disease control.
    - Examples of methods: Care coordination, community health worker programs.
- **Technology use:** How will you use new and emerging technologies that emphasize prevention and chronic disease management? How will you

evaluate the suitability of new technologies for rural providers and patients? How will you plan for long term sustainability of adopted technologies?

  - Examples of emerging technology: Telehealth expansion, remote monitoring for chronic disease, AI diagnostic tools in rural clinics.

- **Partnerships:** How will you foster local and regional strategic partnerships between health care providers and other key stakeholders that promote measurable quality improvement, increase financial stability, maximize economies of scale, and share best practices in rural health care delivery? Describe any networks, consortiums, or affiliations you will create or strengthen among rural providers, federally qualified health centers, and other health care providers, as applicable. Describe their governance structure(s) and how it will reflect the communities they plan to serve. What will those partnerships do? How will they be structured? What improvements will those partnerships promote?
  - Examples of partner activities: Information sharing, joint training, group purchasing.
- **Workforce:** How will you recruit and train more clinicians for rural areas?
  - Examples of methods: New incentive programs, expanded scopes of practice, additional or expanded training programs, telehealth support to extend the reach of specialists.
- **Data-driven solutions:** How will you harness data and technology to furnish high-quality health care services as close to a rural patient's home as possible?
  - Examples of technology and data: Building a rural health data dashboard, connecting rural providers to an electronic health information exchange (HIE), using data to drive quality improvement.
- **Financial solvency strategies:** What reforms or innovations will you make to ensure the financial stability of rural hospitals and other rural providers? If rural hospitals in the State are at risk of financial insolvency, how will the plan stabilize them?
  - Examples of solvency strategies: Transitioning hospitals to new payment models, modifying facility service offerings, right-sizing facilities with low utilization, modifying the number and types of facilities, reducing rural facility bypass, diversifying revenue streams, or changing State policies, such as updating Medicaid payment policies.

- **Cause identification:** Why are standalone rural hospitals at risk of service reduction or closure, and how will your plan address those causes?
    - Examples of causes: Low volume, low quality, bypass of rural providers, payer mix, competition.

You must also address these other required components of the Rural Health Transformation Plan:

- **Program key performance objectives:** Paint a cohesive and comprehensive picture of what your overall program will achieve by the end of the funding period of the cooperative agreement (FY 2031). Include specific and measurable objectives with both baseline data and targets, where possible. Your evaluation outcomes metrics for each initiative, as described in the metrics and evaluation plan, should be consistent with and complementary to the overall program performance objectives.
    - Examples of objectives: "Increase the ratio of rural primary care providers to rural population by X," "reduce 30-day readmissions in rural hospitals by Y%," "ensure that 95% of rural residents have access to broadband-enabled telehealth," "reduce risk factors related to chronic disease by Z%"
- **Strategic goals alignment:** Where relevant, discuss how these elements align with the five strategic goals described in the purpose section.
- **Legislative or regulatory action:** Explicitly mention any commitments you are making to change legislation or regulations. See the technical factors in the program description, with further explanation in the appendix. Describe:
    - Your current policy for each State policy related to the "State policy actions" technical score factors.
    - What legislative or regulatory actions related to the technical score factors you are committed to pursuing.
    - Your timeline for pursuing legislative or regulatory action.
    - How the specific legislative or regulatory action will improve access, quality, and/or cost of care in rural communities.
    - Remember, you will receive technical score credit for commitments made in your application. If you do not finalize legislative or regulatory actions by the end of calendar year 2027 (December 31, 2027), we will recover payments we made to you based on technical score credit received from these commitments (see Table 4). States will have until December 31, 2028 to follow through on meeting their policy commitments for technical score factors B. 2 and B. 4.

- **Other required information:** Information explicitly requested from you as flagged in Table 4 - "Data Source Definition and Source" and as described here.
    - **State policies:** Your current policy for each State policy related to the "State policy actions" technical score factors, as described in Table 4. In the absence of this information on your application, CMS will determine the status of current State policy based on the sources cited in Table 4.
    - **For factor A. 2.:** Report the most current list of Certified Community Behavioral Health Clinic (CCBHC) entities within your State as of September 1, 2025, every active site of care associated with each CCBHC entity, and the address of every active site of care. In the absence of this information on your application, CMS will estimate the number of CCBHCs in your State using the most recent list of CCBHCs as maintained by SAMHSA, the list of CCBHCs supported through the Section 223 CCBHC Medicaid Demonstration and through SAMHSA administered CCBHC Expansion (CCBHC-E) Grants, and State-certified CCBHCs listed on State government websites for States that use other Medicaid authority to designate CCBHCs (such as Medicaid State Plan rehabilitation authority). The addresses of the sites of these CCBHCs, as available, will be compared to rural area designations using the current HRSA definition of rurality to determine whether a CCBHC is in a rural area.
    - **For factor A. 7.:** Report the number of hospitals that received a Medicaid Disproportionate Share Hospital (DSH) payment, consistent with 42 U.S.C. 1396a(a)(13)(A)(iv), from your State for the most recent State plan rate year (SPRY) as defined at 42 CFR 455.301. In the absence of this information in your application, CMS will use data from the latest DSH audit available to CMS.

Proposed initiatives and use of funds

Describe the initiatives (projects or activities) for which you will use the RHT Program funding. For **each initiative**, please include the following information:

- **Initiative:** Provide the name of the initiative in 10 words or less.
- **Description:** Describe what the initiative is, and what specific activities and actions it includes.
- **Main strategic goal:** Describe which strategic goal from the purpose section aligns with this initiative.

- **Use of funds:** Include all uses of funds relevant to this initiative from the eleven categories listed in the program requirements and expectations.
- **Technical score factors:** Include all technical score factors that align with the initiative. We will confirm whether and which technical score factors align with your proposed initiatives.
- **Key stakeholders:** Describe the main types of entities and organizations that will help carry out the initiative. This can be a general description of the entity types, such as FQHCs, primary care clinics, high schools, community-based organizations, rural health clinics, Critical Access Hospitals, State Office of Rural Health, or State Primary Care Association, or can include specific organization names.
- **Outcomes:** Describe the measurable outcomes you will use to assess the impact of this initiative. Include at least four outcomes. One must be at a county or community level of granularity. Include both baseline data and targets for the measurable outcomes where possible. Describe the expected time period to observe changes in measurable outcome data. You may use the same outcome metric across multiple initiatives, but in such cases you must:
  - Explain how the outcome metric is directly related to each initiative.
  - Narratively explain how those initiatives complement each other to achieve the outcome.
  - Commit to a larger outcome improvement than if you had only used the metric for an individual initiative.
- **Impacted counties:** List the counties within the State where you will carry out the initiative and directly affect residents or, if applicable, say that it will impact all counties within your State. Use the Federal Information Processing Series (FIPS) codes to identify counties.
- **Estimated required funding:** Provide an estimated funding range for this initiative. Note: You will provide additional details on funding and budget in the budget narrative section.

We will evaluate the content provided for this subsection based on clarity, completeness of information, quality of the proposed initiatives, direct impact to rural residents and areas, and how transformative the initiative is in relation to the State's current baseline. This will inform the corresponding technical score factors. You must use funding for at least three approved use of funds categories across all your initiatives.

Initiatives may be directly implemented by States or may be implemented by collaborating organizations or entities that have been subawarded or

subcontracted funding, with strong State oversight. If you choose to subaward or subcontract RHTP funds, you must make your process and criteria for selecting such subawardees or subcontractors clear to CMS. Note that the terms and conditions of federal awards generally flow down to subawards and subrecipients, as specified in 2 CFR 200.101(b)(1).

For examples of initiatives that align with the RHT Program strategic goals and approved use of funds, please refer to the example initiatives in the appendix. These examples are provided for reference to help you make decisions, and they are purely optional. Should you choose to use one or more of these example initiatives in your plan, note that they should serve as a starting point rather than a fully developed initiative. You should further tailor, add detail to, and expand upon the example initiative(s) as needed to most effectively serve the unique needs of the rural population in your State and meet the requirements of the application.

Implementation plan and timeline

For each initiative and for activities associated with your general program set-up, provide a timeline of proposed activities for FY26 through FY31. The timeline may be in the form of a narrative with bullet points and/or a Gantt chart. Within each initiative's timeline, include dates and milestones that line up with the following phases:

- **Stage 0** — Project planning is underway, but no work on executing the project plan and implementing the initiative has begun.
- **Stage 1 —** The project plan has been created, and staff have been assigned. Initial work on implementing the initiative has begun.
- **Stage 2 —** The implementation of the project plan and goal achievement are underway. The original project plan has been refined and adjusted.
- **Stage 3 —** The implementation of the project plan and goal achievement are halfway complete and continuously being worked on.
- **Stage 4 —** Deliverables are being finalized, and proposed goals are nearly achieved.
- **Stage 5 —** The initiative is fully implemented, the initiative's goals have been completely achieved, and the initiative is producing measurable outcomes that can be reported on.

Examples of milestones are:

- New initiative launch dates. For example: Telehealth initiative operational by Q4 2026; first cohort of residents start July 2027.

- Major procurements or contracts. For example: Selecting a telehealth vendor by Q2 2026.
- Policy changes. For example: Introduce legislation in 2026 session, aim to pass by 2027 and implement by 2028.
- Reporting intervals.

You should provide your current best estimate on timelines and milestones. You will have the opportunity to update the best estimates on timelines and milestones in your annual reporting.

If applicable, include legislative or regulatory actions that you are committed to enact. Include timelines and milestones to accomplish these actions by the end of calendar year 2027 (December 31, 2027), or by the end of calendar year 2028 (December 31, 2028) for technical score factors B. 2 and B. 4.

Describe your governance and project management structure. The plan should demonstrate that you have a capable management structure.

- Identify the lead agency or interagency team, key personnel by role (such as “Project Director, Rural Health Transformation Program Coordinator”), and any steering committees or advisory groups.
- If you plan to hire new staff or engage external partners to manage parts of the program, indicate this in the timeline (for example, hiring project manager in Q1 2026).
- Describe the headcount and functions of the team overseeing the RHT Program. For example: “We will dedicate X Full Time Employees (FTE) to this program: one program director, two program managers (one focusing on telehealth/technology, one on workforce and hospital projects), and one data analyst.”
- If you plan to use outside project management support or technical assistance providers, describe that plan.

Describe how you will coordinate among State health agencies and with external stakeholders during the program life. Frequent communication and a defined decision-making process will be key, given the scope of changes.

Stakeholder engagement

Describe how you have involved and will involve rural stakeholders when planning and carrying out this program:

- List any stakeholders you have consulted or will consult.
    - Examples: Rural hospital CEOs, primary care providers, community leaders, patients, tribal representatives.

- Include any evidence of support from stakeholders, such as resolutions or letters of support, in your attachments.
- Provide an engagement framework that specifies how the State will have a formal process to engage stakeholders on a regular basis, such as through a stakeholder advisory committee, regular workgroups, or open-door forums for feedback.
- Describe how you will ensure that the project governance reflects the communities you are engaging, including patients as well as providers.
- In your engagement framework, address how you will coordinate regularly with the following entities on deploying funds, tracking milestones, and assessing impact metrics through a new or existing council, workgroup, or structure:
    - State health agency or department of health;
    - State Medicaid agency;
    - State office of rural health;
    - State tribal affairs office or tribal liaison, as applicable; and
    - Indian health care providers, as applicable.

Because transformation can affect many local interests, we value robust stakeholder processes.

Metrics and evaluation plan

Outline the performance measures and outcomes you will track to evaluate success for each initiative. Identify at least four quantifiable metrics for each initiative described in your proposed initiatives and use of funds section. At least one of the four should allow you to demonstrate how the impact is distributed in different parts of the State — that is, the metric should provide data on at least a county or community level of granularity. You may use one outcome to measure multiple initiatives, but in such cases you must:

- Explain how the outcome metric is directly related to each initiative.
- Narratively explain how those initiatives complement each other to achieve the outcome.
- Commit to a larger outcome improvement than if you had only used the metric for an individual initiative.

Here are some illustrative examples and a non-exhaustive list of types of metrics. You should decide on appropriate, specific, and measurable metrics relevant to your own initiatives.

- **Access metrics:** Number of primary care visits in rural clinics, travel time for patients to nearest hospital, specialist appointment wait times in rural areas.
- **Quality and health outcomes:** Rural hospital readmission rates, rates of diabetes or hypertension in rural areas, infant/maternal health indicators in rural populations, rural opioid overdose death rates.
- **Financial metrics:** Operating margin of rural hospitals in aggregate, reduction in uncompensated care at rural hospitals, number of rural hospitals that become financially sustainable.
- **Workforce metrics:** Ratio of physicians to residents in rural areas, clinician vacancy rates in rural areas, new providers recruited to deliver telehealth in rural areas through affiliation agreements.
- **Technology use:** Percentage of rural patients with access to telehealth, electronic health record (EHR) interoperability scores for stakeholders in rural areas.
- **Program implementation:** Counts of new programs launched, rural populations served by new services (telehealth encounters delivered, patients in chronic disease programs), training sessions held.

Specify milestones or targets for these metrics if possible. Describe the data sources for these metrics, timing of data updates, and your ability to collect and analyze them. Provide baseline data for these metrics if available. Mention whether you will require participating providers to submit data or if you will use State health data systems. You will be required to report on performance metric progress during annual reporting. Examples of milestones or targets could include:

- "By Year 2, train 100 EMTs in treat-and-release protocols."
- "By Year 3, increase target facilities' utilization rate to 70%."

Describe any plans for program evaluation. Will you conduct your own evaluation or partner with an academic institution to study the impact of the program? A formal evaluation is not required, but it can strengthen your proposal. You must at least confirm that you will cooperate with any CMS-led evaluation or monitoring. CMS and/or third-party evaluators may assess outcomes across States.

Sustainability plan

Describe how you plan to sustain successful initiatives after the RHT Program funding ends (after FY31). What is your strategy to ensure lasting change vs. temporary infusions of funding? For instance:

- If you have helped create rural affiliation models, used funding for IT infrastructure development, or expanded rural workforce development programs, how will those persist and be maintained beyond the RHT funding period?
- If new telehealth programs prove effective, will you try to make them part of the permanent Medicaid benefit or pursue legislative appropriations to continue them?
- Will the partnerships and models you launch be self-sustaining? For example, how will accountable care organizations (bearing two-sided risk) or alternative payment models that generate savings continue operations?
- What sources of funding will you use to maintain all programs, services, and initiatives beyond the RHT funding period?

Address how you will integrate the lessons from this program into your ongoing policy. For example, you might incorporate rural health transformation goals into your Health Improvement Plan or Medicaid managed care contracting. If you have been using certain Medicaid financing mechanisms that are being phased out by federal law, explain how this program will help you transition away from those financing mechanisms sustainably. The sustainability discussion will assure us that our investment will have lasting benefits, and States are strongly discouraged from using funds for projects that will not be sustainable after the program ends.

Budget narrative

The budget narrative supports the information you provide in Standard Form 424-A. See other required forms.

It includes added detail and justifies the costs you ask for. As you develop your budget, consider:

- If the costs are reasonable and consistent with your project's purpose and activities.
- The restrictions on spending funds. See funding policies and limitations.
- HHS now uses the definitions for equipment and supplies in 2 CFR 200.1. The new definitions change the threshold for equipment to the lesser of the recipient's capitalization level or $10,000 and the threshold for supplies to below that amount.

To create your budget narrative, see detailed instructions and a template on our website.

In your budget narrative, you will:

- Identify a principal investigator or program director (PI/PD) who will dedicate sufficient time and effort to manage and provide oversight of the grant program.
- Include a yearly breakdown of costs for each line item in your SF-424A.
- Describe the proposed costs for each activity or cost within the line item.
- Define the proportion of the requested funding designated for each activity.
- Justify the costs, including how you calculated them.
- Explain how you separate costs and funding administered directly by you as the lead agency, from funding you subcontract to other partners.
- Be clear about how costs link to each activity and the goals of this program.

Program-specific guidance

For this program, keep the following requirements and considerations in mind:

- We request that everyone use one standard figure for ease of budgeting, with the understanding that initiatives may have to be scaled and re-budgeted to align with the final funding awards. Use the purely hypothetical and illustrative award amount of $200 million each budget period to formulate your budget. Your actual award may be larger or smaller than this amount following our review of applications and the budget negotiation process.
- For each cost category's budget table, breakdown your estimated budgeted spending on an annual basis from federal FY26 to federal FY31.
- Include an extra column in every budget table to indicate which initiative, as described in your proposed initiatives and use of funds section, each budget line item supports.
- Provide a narrative rationale for any anticipated or planned funding allocations like subawards, subgrants, or subcontracts to specific provider groups, health care systems, hospitals, health care facilities, organizations, or other entities.
    - Clearly outline your methodology, process, and specific criteria for selection of who receives these allocations.
    - For example, you might select specific facility sites for funding via a competitive application process assessed by the population served and financial need.

- You may not use more than 10% of funds for administrative expenses. Explicitly show that your administrative expenses are less than or equal to 10%. Identify which line items count as administrative expenses (such as salaries of program management and contracts for administrative support) and show that their sum is 10% or less of the total.
    - Note that this portion includes any indirect costs used for administrative expenses.
- For each budget period, recipients will have until the end of the following fiscal year to spend awarded funding. Because of this, you might plan to spend part of the funds awarded for one budget period across the fiscal year in which it's awarded and the remainder across the next fiscal year. Keep this in mind as you budget your overall expected spending from federal FY26 to federal FY31.
- Wherever possible, tie budget items to activities in the project narrative.
    - For example: "As described in the plan under Telehealth Expansion, we will invest $X in telehealth equipment — this is reflected under Equipment."
- We encourage you to note any funding from other sources that complement RHT Program funding, if relevant.
    - For example: "In addition to the federal $50 million per year, the State will apply $5 million per year of State funds to support the rural telehealth access initiative."

You should provide your current best estimates for the budget narrative. You will have the opportunity to update the best estimates on budget in your annual non-competing continuation application and annual progress report.

Required format for budget narrative

Page limit: 20

File name: Budget Narrative

File format: PDF

Font size: 12-point font, preferably Times New Roman, Arial, or fonts of similar size

Footnotes and text in graphics may be 10-point.

Margins: 1-inch

Spacing: Single spaced

Page Size: 8.5 x 11

Include consecutive page numbers throughout.

Attachments

You will upload attachments in Grants.gov using the Other Attachments form.

Governor's endorsement

Maximum 4 pages.

You must submit a letter from the governor of the State expressing the governor's support for your proposed RHT Plan. Address the letter to the CMS Administrator. The letter should:

- Express the governor's support for and commitment to the proposed Rural Health Transformation plan.
- Notify us of the lead agency or office responsible for this program.
- Certify that you developed the application in collaboration with the State health agency/department of health; State Medicaid agency; the State office of rural health; the State's tribal affairs office or tribal liaison, as applicable; Indian health care providers, as applicable; and any other key stakeholders identified in the planning process. Include an explanation of how the State will account for input from these stakeholders in its decision-making process throughout the development and implementation of the program.
- Describe how the lead agency or office engaged key stakeholders throughout the development of the State's application and how it will continue that engagement through implementation.

- Commit to any State-level actions needed to ensure success. This could include collaboration across agencies or pursuit of legislation or regulatory changes.
- Certify that the State will not spend any award funds on activities prohibited under 42 U.S.C. 1397ee(h)(2)(A)(ii). See the funding policies and limitations.
- Briefly describe how the State plans to ensure that the funding will benefit rural residents across the entire State.

If you do not include the governor's letter of endorsement, your application may be considered nonresponsive (see completeness and responsiveness criteria) unless you provide a valid reason. This could include, for example, a governor transition in progress. In such cases, you can provide the incoming governor's intent to endorse, along with an explanation.

If the responsibility for signing the letter has been delegated to someone other than the governor, such as a cabinet official, attach evidence of that delegation.

Indirect cost agreement

If you include indirect costs in your budget using an approved rate or cost allocation plan, include a copy of your current agreement approved by your Cognizant Federal Agency for indirect costs.

According to Section 71401 of Public Law 119-21, not 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 all of your budget, including indirect and direct costs.

Business assessment of applicant organization

Maximum 12 pages, single-spaced.

We must assess your organization's risk before we can make an award. This analysis includes your organization's:

- Financial stability.
- Quality of management systems.
- Internal controls.
- Ability to meet the management standards in 2 CFR Part 200.

For us to complete your assessment, you must review, answer, and attach the completed business assessment questions found in the Business Assessment of Applicant Organization section on our website.

Program duplication assessment

Maximum 5 pages.

The U.S. Government Accountability Office (GAO) defines program duplication as two or more agencies or programs engaged in the same activities or providing the same services to the same beneficiaries. You may not use Rural Health Transformation Program funding to replace or duplicate current funding activities. For example, this means you may not use funding to reimburse providers for services already funded by Medicaid, CHIP, Medicare, or the Health Resources Services Administration. In this attachment, you will need to explain your understanding of program duplication risk and your plan for avoiding program duplication.

Conduct a budget analysis to identify current funding streams you propose to apply to State activities (if any). As part of this analysis, identify new and distinct activities toward which you could apply Rural Health Transformation Program cooperative agreement funding.

During application review, we will consider your understanding of program duplication risks as well as the thoroughness of your plan to avoid program duplication.

In this attachment, you must:

- Confirm your responsibility to avoid program duplication.
- Confirm that you will ensure RHT Program award funds are not used to duplicate or supplant current federal, State, or local funding, or be used for the nonfederal share of Medicaid payments.
    - Sample question to consider: Is this expense paid for by another federal, State or local program, such as Medicaid, Medicare, Title V block grant funds, the local health department, or another innovation model?
    - Sample question to consider: Is the activity a service already provided directly to an attributed beneficiary, such as under current Medicaid benefits?
- Explain how this funding builds upon current State and Federal programs and initiatives, if applicable, while avoiding duplication.
- Summarize your standard operating procedures and best practices for avoiding program duplication. If available, please include these standards in this attachment.

Other supporting materials

Maximum 35 pages.

You may include additional materials that support your application, such as:

- Detailed work plan and timeline charts;
- Organizational charts for the project governance;
- More extensive data tables on rural health status; or
- Letters of support.

Do not include materials that are not directly relevant, like full CVs of staff or lengthy reports.

If you include resumes for key project personnel, limit to two pages each and only include resumes for key personnel.

If you include any documentation of past performance, like summaries of previous rural initiatives you have completed, keep it brief.

Other required forms

You will need to complete some other required forms. Submit the following required forms through Grants.gov. You can find them in the NOFO application package or review them and their instructions at Grants.gov Forms.

Form	Submission requirement
Application for Federal Assistance (SF-424)	With the application. See extra instructions in the next section.
Budget Information for Non-Construction Programs (SF-424A)	With the application.
Disclosure of Lobbying Activities (SF-LLL)	With the application.
Project/Performance Site Location(s) Form	With the application.

Extra instructions for SF-424: Application for Federal Assistance

Special instructions include:

- Check No to item 19c. State review under Executive Order 12372 does not apply.
- Your authorized organizational representative (AOR) must electronically sign this form. The AOR is the person who can make legally binding commitments for your organization. When the AOR authorizes an application, they agree to assume all award obligations.

Important: public information

When filling out your SF-424 form, pay attention to Box 15: Descriptive Title of Applicant's Project.

We share what you put there with USAspending. This is where the public goes to learn how the federal government spends their money.

Instead of just a title, insert a short description of your project and what it will do.

See instructions and examples. You can also see Writing a Strong Descriptive Title on our website.



Step 4: Understand Review, Selection, and Award

In this step

Application review 47
Award notices 54

Application review

Initial review

We review each application to make sure it meets basic requirements.

We will review your application to make sure that it meets the completeness and responsiveness criteria. If your application does not meet these criteria, we will not move it to the merit review phase.

We will not review any pages that exceed the page limit.

Merit review

A merit review panel reviews all applications that pass the initial completeness and responsiveness review. The members use the following criteria. For more information, see Merit Review and Selection Process.

State application review

Applications will be scored to determine if a State is eligible to receive an RHT Program award. To be considered for funding, the application must:

- Fulfill the completeness and responsiveness criteria.
- Include all required documents and content (as described in Step 3) by the application deadline. We will not approve your applications if you send it in late or do not meet the eligibility requirements. We may allow you to correct minor errors if there is time before our decision deadline, but this is not guaranteed. It is your responsibility to ensure the submission is complete and compliant.
- Show, through description of planned initiatives, how you will use funding to address at least three of the approved use of funds categories, as described in use of funds.
- Show that you will not use funds for unacceptable spending categories, as described in funding policies and limitations.

State workload funding amount

This section describes how workload funding is calculated. The general distribution methodology for State funds is described in the funds distribution section. The elements of the technical score as described there and in the appendix lay out areas of funding-driven initiatives (“initiative-based” factors) and State health policy (“State policy action” factors) that will support the goals of the program.

For both types of factors:

- You can choose which technical score factors to pursue. You do not have to use funding to address all initiative-based factors and you do not have to pursue State policy actions.
- You can receive conditional, partial points in the application 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.

The conditional points framework is described here. States are highly encouraged to read the appendix for a detailed walkthrough of how State funding amounts are assessed.

For changes to State policy (i.e., "State Policy Actions" Category, as described in Table 1 and in the appendix):

See a detailed walkthrough example in the appendix

You can achieve high or maximum points for each factor either by having an existing policy or by committing to make policy changes by the end of calendar year 2027 (or calendar year 2028 for factors B. 2 and B. 4) that align with the policy described in the technical score factors. Points will be awarded on a scale of 0 to 100 based on current policies and/or your commitment to changing your policies.

If you are committing in your application to make changes to State policies, you will receive conditional, partial points for that factor starting in the first budget period (except for factors B. 2 and B. 4, which won't count to points score until after the first budget period). When you have fulfilled your commitment to changing policy, you can achieve full points. If you don't fulfill your commitment, we will recover points and funds in later years of the program.

We believe these State policy actions, which don't use funding and are optional to pursue, will be complementary to and greatly enhance the impact of initiative-based investments and their benefits to health care in rural communities. Note that there are restrictions to federal funds being used for lobbying, including under 2 CFR 200.450.

Here are details on how we allot points.

- In the first budget period: You receive 50% of the full credit for proposed changes to policy described in your application.
- For future budget periods:

- If you fulfill the commitment in Year 1 or 2: Your points will increase to the full credit as you enact the policy.
- If you do not fulfill the commitment by the end of calendar year 2027 (or 2028 for factors B. 2 and B. 4): Your points will decrease to zero for the related factor, and we will recover funds we previously awarded based on the factor.

For Funding-Driven Initiatives (i.e., "Initiative-Based" Category, as described in Table 1 and in the appendix):

See a detailed walkthrough example in the appendix

We will score each initiative-based factor that aligns with initiatives (projects and activities) that you choose to pursue using an incremental approach that assesses your progress in milestones for each initiative.

Unlike the "State Policy Actions" factors of the Technical Score, you cannot automatically qualify for maximum points score at the time of the application for Initiative-Based factors. This is because Initiative-Based funding allocation is inherently conditional on your success in completing the initiative.

Merit reviewers will evaluate the transformative possibilities of each of your initiatives, as described in the matrix here. They will come up with a "full score potential," which will be between 0 and 100 points. Full score potential is measured for each State relative to your own baseline, not in comparison to other State's existing initiatives or programs. Each initiative-based factor that you choose to spend funding on, as outlined in your application's project and budget narratives, will be assessed as follows. The specific type of content we will be looking for in a high-quality initiative for each initiative-based factor is described in Table 4.

Table 2: Initiative-based factor scoring matrix

Category	0 to 4 points	5 to 9 points	10 to 14 points	15 to 20 points
Strategy **(Maximum points: 20)**	Investments would lead to small, incremental changes to existing rural health care delivery system and facilities.	Investments would modestly support measurable changes to rural health care delivery.	Major investments with significant transformative potential for rural health care delivery.	Robust investment plan to structurally transform rural health care delivery.

Category	0 to 4 points	5 to 9 points	10 to 14 points	15 to 20 points
Workplan and monitoring **(Maximum points: 20)**	Timeline, milestones, and budget breakdown are not clear, feasible, or directly linked to initiative. Explanation of stakeholder engagement and initiative oversight is unclear.	Detailed workplan that reflects serious thought about obstacles and potential delays. Explanation of stakeholder engagement and initiative oversight is provided but does not have details.	Workplan reflects a considered, thoughtful operating and strategic framework with clear and feasible timelines, milestones, and budget breakdown. Explanation of stakeholder engagement and initiative oversight is clear and implementable.	In addition to prior points categories, workplan includes creative and clear approaches to maximizing the immediate impact of the five-year additional federal funds. Explanation of stakeholder engagement and initiative oversight is detailed, implementable, and thoughtful.
Outcomes **(Maximum points: 20)**	Outcomes to be tracked are vague, cannot be readily measured, and/or do not support improvement of patient outcomes, access to care, and/or reduction of healthcare costs.	Outcomes are reasonable and specific, can be reliably measured, and/or support improvement of patient outcomes, access to care, and/or reduction of healthcare costs.	Outcomes are well-supported by credible literature, are specific, and can be reliably measured. They directly relate to improvement of patient outcomes, access to care, and/or reduction of healthcare costs.	Outcomes are ambitious, well-supported by credible literature, and specific. They can be reliably measured. They directly relate to a variety of improvements in patient outcomes, access to care, and/or reduction of healthcare costs.
Projected impact	Impact on rural residents is limited. Unclear how initiative	Impact on rural residents is fair. Feasible how initiative and	Impact on rural residents is significant. Clear explanation on	Impact on rural residents is structurally transformative.

Category	0 to 4 points	5 to 9 points	10 to 14 points	15 to 20 points
(Maximum points: 20)	and outcomes impact rural residents.	outcomes impact rural residents, but the explanation is not substantiated or clear.	how initiative and outcomes directly impact rural residents.	Clear explanation on how initiative and outcomes directly impact rural residents across the State, and how scale of impact is transformative.
Sustainability of initiative beyond RHT program funding period **(Maximum points: 20)**	Sustainability is not sufficiently supported or plausible.	Sustainability is somewhat plausible but without a detailed plan.	Sustainability is clearly plausible but without a detailed plan.	Sustainability is planned in detail or is not needed given the nature of the initiative.

In the first budget period, because you have proposed the initiatives but have not yet started implementing them, you can receive up to half of your full score potential.

In the following budget periods, you can receive greater percentages of your full score potential based on how well you've implemented your initiatives. This means you will receive more funding as you make progress in your initiative goals. We will send you more information about future-year funding after award.

For Data-Driven Metrics (i.e., "Data-driven" Category, as described in Table 1 and in the appendix):

Your score is directly tied to the value of your State's metric in comparison to other approved States. See Table 4 for details related to specific scoring metrics.

Total points score methodology:

Each factor A. 1. through F. 3. has a total points score of 100 across all 50 States. Your total points score for each budget period is the weighted sum of the points score of each factor. While Technical Score Factors are re-calculated each year based on the same methodology as outlined in this NOFO, Rural Facility and Population Score Factors points are assessed once

during Q4 2025. The total funding you will receive each budget period is equal to:

Total Available Workload Funding in a Budget Period * Your Total Points Score for a Budget Period / Sum of All Approved States' Total Points Score for a Budget Period

The relative weighting of each factor is outlined here. The relative weighting of factors will not change over the duration of the program. The relative total weighting of technical score factors reflects the importance in the quality of your proposed initiatives and subsequent follow-through on appropriate use of funds.

Table 3: Weighting of Factors in Points System

Rural facility and population score factors	% weight
A. 1. Absolute size of rural population in a State	10.00%
A. 2. Proportion of Rural Health Facilities in the State	10.00%
A. 3. Uncompensated care in a State	10.00%
A. 4. % of State population located in rural areas	6.00%
A. 5. Metrics that define a State as being frontier	6.00%
A. 6. Area of a State in total square miles	5.00%
A. 7. % of hospitals in a State that receive Medicaid DSH payments	3.00%

Technical score factors	% weight
B. 1. Population health clinical infrastructure	3.75%
B. 2. Health and lifestyle	3.75%
B. 3. SNAP waivers	3.75%
B. 4. Nutrition Continuing Medical Education	1.75%
C. 1. Rural provider strategic partnerships	3.75%
C. 2. EMS	3.75%
C. 3. Certificate of Need	1.75%
D. 1. Talent recruitment	3.75%
D. 2. Licensure compacts	1.75%

Technical score factors	% weight
D. 3. Scope of practice	1.75%
E. 1. Medicaid provider payment incentives	3.75%
E. 2. Individuals dually eligible for Medicare and Medicaid	3.75%
E. 3. Short-term, limited-duration insurance	1.75%
F. 1. Remote care services	3.75%
F. 2. Data infrastructure	3.75%
F. 3. Consumer-facing tech	3.75%

Risk review

Before making an award, we review the risk that you will mismanage federal funds or fail to complete the project objectives. We need to make sure you've handled any past federal awards well and demonstrated sound business practices.

We use SAM.gov Responsibility/Qualification to check this history for all awards likely to be over $250,000. We also check Exclusions.

If we find a significant risk, we may choose not to fund your application or to place specific conditions on the award.

You can see more details about risk review at 2 CFR 200.206.

Selection and allotment process

CMS selects recipients at our sole discretion unless the authorizing statute says otherwise.

When making funding decisions, we consider:

- Review results. These are key in making decisions but are not the only factor.
- The past performance of the applicant. We may choose not to fund applicants with management or financial problems.

We may:

- Fund applications in whole or in part.
- Fund applications at a lower amount than requested.

- Decide not to allow a prime recipient to subaward if they may not be able to monitor and manage subrecipients properly.
- Choose to fund no applications under this NOFO.

Per 42 U.S.C. 1397ee(h)(8)'s preclusion of review (section 2105(h)(8) of the Social Security Act), there shall be no administrative or judicial review under section 1116 or otherwise of amounts allotted or redistributed to States, payments to States withheld or reduced, or previous payments recovered from States.

Award notices

If you are successful, your authorized organizational representative (AOR) will receive an email notification from GrantSolutions. You can then retrieve your Notice of Award (NoA). We will email you if your application is incomplete or unresponsive.

The NoA is the only official award document. The NoA tells you about the amount of the award, important dates, and the terms and conditions you need to follow. Until you receive the NoA, you don't have permission to start work.

By drawing down funds, you accept the terms and conditions of the award. The NoA incorporates the requirements of the program and funding authorities, the grant regulations, the HHS Grants Policy Statement (GPS) , and the NOFO.

If you want to know more about NoA contents, go to Notice of Award on our website.



Step 5: Submit Your Application

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Application submission and deadlines

See Find the Application Package to make sure you have everything you need.

Make sure you are current with SAM.gov and UEI requirements. See get registered. You will have to maintain your registration throughout the life of any award.

Optional letter of intent

Due by September 30, 2025, no later than 11:59 p.m. ET.

You should let us know if you plan to apply for this opportunity. We use this information to determine the amount of funding available to each recipient and guage interest in the program. The letter of intent is non-binding.

Please email the letter to MAHARural@cms.hhs.gov.

In your email, include:

- The funding opportunity number and title.
- Name of the State.
- Name of the State agency or office designated to submit the application.
- Confirmation that you plan to apply.
- A contact name, title, phone number, and email address.

Application

Due by November 5, 2025, no later than 11:59 p.m. ET.

Grants.gov creates a date and time record when it receives the application. If you submit the same application more than once, we will accept the last on-time submission.

The grants management officer may extend an application due date based on emergency situations such as documented natural disasters or a verifiable widespread disruption of electric or mail service.

Grants.gov submissions

You must submit your application through Grants.gov unless we give you an exemption for a paper submission. See get registered.

For instructions on how to submit in Grants.gov, see the Quick Start Guide for Applicants. Make sure your application passes the Grants.gov validation checks. Do not encrypt, zip, or password protect any files.

Intergovernmental review

Executive Order 12372, Intergovernmental Review of Federal Programs does not apply to this. You do not need to take any action other than checking “No” on the SF-424 box 19c.



Step 6: Learn What Happens After Award

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Post-award requirements and administration

Administrative and national policy requirements

There are important rules you need to know if you get an award. You must follow:

- All terms and conditions in the Notice of Award. We incorporate this NOFO by reference.
- The rules listed in 2 CFR Part 200 and applicable provisions in 2 CFR Part 300, Uniform Administrative Requirements, Cost Principles, and Audit Requirements. As of October 1, 2025, HHS will adopt 2 CFR Part 200, with some modifications included in 2 CFR Part 300. These regulations replace those in 45 CFR Part 75.
- The HHS Grants Policy Statement (GPS). This document has terms and conditions tied to your award. If there are any exceptions to the GPS, they'll be listed in your Notice of Award.
- All federal statutes and regulations relevant to federal financial assistance, including those highlighted in the HHS Administrative and National Policy Requirements [PDF].
- All antidiscrimination laws: By applying for or accepting federal funds from HHS, recipients certify compliance with all federal antidiscrimination laws and these requirements and that complying with those laws is a material condition of receiving federal funding streams.
- The authorizing statute, Section 71401 of Public Law 119-21.
- Recipients are responsible for ensuring subrecipients, contractors, and partners also comply with all administrative and national policy requirements.

Reporting

If you are successful, you will have to submit financial and performance reports. Reporting requirements include:

- Progress reports.
- Federal Financial Report (FFR).
- Federal Funding Accountability and Transparency Act (FFATA).

- SAM.gov Responsibility/Qualification records.
- Payment Management System (PMS).
- Audit reporting (Federal Audit Clearinghouse).
- Workplan updates.
- Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification.

For more information on reporting, see Post-Award Reporting Requirements on our website.

Continued eligibility

Once we have approved your application and awarded your funds, your State is eligible for all five years of funding as long as you follow program requirements.

Continued funding depends on the availability of funds, program authority, satisfactory performance, and compliance with the terms and conditions of the Federal award.

For us to issue you continuation funding, you must demonstrate satisfactory progress.

At any time, we could decrease funding or terminate your award if you fail to follow the requirements of the award. Awards will be subject to the termination provisions at 2 CFR 200.340.

If you have performance issues, we could suspend or terminate the award. Performance issues might include misusing funds or not carrying out the activities you described in your approved application. Remedies may include suspension or termination of the award, which could render you ineligible for further funds until you resolve this noncompliance.

Non-competing continuation application

You will be required to submit annual non-competing continuation (NCC) applications to receive funding for each subsequent budget period. You may use the NCC to adjust your budget or make other administrative changes. You may revise your project goals based on any reductions in funding.

NOTE: You will be required to submit your progress reports along with your non-competing continuation applications. This ensures CMS has the relevant

data to make funding decisions for subsequent budget periods. The NCC is due approximately 60 days before the end of each budget period end date.

Cybersecurity requirements

You must create a cybersecurity plan if your project involves both of the following conditions:

- You have ongoing access to HHS information or technology systems.
- You handle personal identifiable information (PII) or personal health information (PHI) from HHS.

See the HHS Administrative and National Policy Requirements [PDF] for full information.



Contacts and Support

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Agency contacts

Program and eligibility

MAHARural@cms.hhs.gov

Financial and budget

Grants@cms.hhs.gov

Review process and application status

Grants@cms.hhs.gov

Help with systems

Grants.gov

Grants.gov provides 24/7 support. Hold on to your ticket number.

- Phone: 1-800-518-4726
- Email: support@grants.gov

SAM.gov

If you need help, you can:

- Call 866-606-8220.
- Live chat with the Federal Service Desk.

Reference websites

- U.S. Department of Health and Human Services (HHS)
- CMS Grants and Cooperative Agreements
- Grants.gov Accessibility Information
- Code of Federal Regulations (CFR)
- United States Code (U.S.C.)

Appendix

Points scoring details

Table 4: Points scoring methodology, definitions, and data sources for rural facility and population score factors and technical score factors

Rural facility and population score factors	Points scoring methodology	Data source definition and source
A. 1. Absolute size of rural population in a State	• 100 Points * Percentile ranking of the size of a State's rural population / Sum of all States' percentile rankings	• The number of people in the State located in a rural area is based on the most recent version of the rural definition maintained by HRSA. • Census tract population and land area are from the U.S. Bureau of the Census, Department of Commerce, 2020 Census of Population and Housing. • Includes the percentage of the State population that is located outside Metropolitan Statistical Areas plus the population located in a rural census tract of a Metropolitan Statistical Area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 FR 6725).
A. 2. Proportion of Rural Health Facilities in the State	• 100 Points * Percentile ranking of a State's blended % of total rural health facility count / Sum of all States' percentile rankings	• Critical access hospitals are defined as all active facilities identified as a Critical Access Hospital (GNRL_FAC_TYPE_CD = 11)

Rural facility and population score factors	Points scoring methodology	Data source definition and source
	• A State's blended % of total rural health facility count is 50% percent of hospital rural health facilities and 50% percent of other rural health facility types: ◦ Percent of hospital rural health facilities: Sum of Critical Access Hospitals, Sole Community Hospitals, Medicare Dependent Hospitals, Low Volume Hospitals, Rural Emergency Hospitals, and other rural hospitals in a State divided by the sum across all States ◦ Percent of other rural health facility types: Sum of Rural Health Clinics, Federally Qualified Health Centers or PHS Act Section 330 Grantees or Look-Alikes, Community Mental Health Centers, Opioid Treatment Facilities, and Certified Community Behavioral Health Centers located in a rural area based on the most recent version of the rural definition maintained by HRSA in a State divided by the sum across all States • Each individual facility has only been counted in one category to not duplicate count. When a facility could	in the most recent CMS Provider of Services file (Q2 2025). • Sole Community Hospitals are defined as all hospitals with an SCH or SCH and Rural Referral Center (RRC) payment designation in the 2023 CMS Hospital Cost Reports (HCRS). Must also appear and be active in the most recent CMS Provider of Services file (Q2 2025). • Medicare Dependent Hospitals (MDH) are defined as all hospitals with an MDH or MDH and RRC payment designation in the 2023 CMS Hospital Cost Reports (HCRS). Must also appear and be active in the most recent CMS Provider of Services file (Q2 2025). • Low Volume Hospitals (LVH) are defined as all hospitals with a LVH payment adjustment in the 2023 CMS Hospital Cost Reports (HCRS). Must also appear and be active in the most recent CMS Provider of Services file (Q2 2025). • Rural Emergency Hospitals are defined as all active facilities identified as a Rural Emergency Hospital (PRVDR_CTGRY = 1 and PRVDR_CTGRY_SBTYP = 28) in the most recent CMS Provider of Services file (Q2 2025).

Rural facility and population score factors	Points scoring methodology	Data source definition and source
	be assigned to multiple categories, CMS assigned the facility one category tag based on a rank order. • Rural facilities are defined as any of the following: ◦ Critical Access Hospital ◦ Sole Community Hospital (SCH) ◦ Medicare Dependent Hospitals (MDH) ◦ Low Volume Hospital ◦ Rural Emergency Hospital ◦ Rural Health Clinic ◦ Federally Qualified Health Center or PHS Act Section 330 Grantee or Look-Alike (single category) ◦ Community Mental Health Center ◦ Opioid Treatment Facility ◦ Certified Community Behavioral Health Clinic located in rural areas. Rural areas are defined using the current HRSA definition of rurality, to include clinics located in non-metro areas or rural census tracts of metro areas. • Any other hospital that does not fall into one of the previously listed categories and is either geographically located in a rural area or reclassified as rural.	• Rural Health Clinics are defined as all active facilities identified as a Rural Health Clinic (PRVDR_CTGRY = 12 and PRVDR_CTGRY_SBTYP = 1) in the most recent CMS Provider of Services file (Q2 2025). • Federally Qualified Health Centers and Section 330 Grantees (combined category) are defined as all Service Delivery and Service Delivery/ Administrative sites listed in the most recent list of HRSA Health Centers and Look-Alikes. • Community Mental Health Center are defined as all active facilities identified as a Community Mental Health Center (PRVDR_CTGRY = 19 and PRVDR_CTGRY_SBTYP = 1) in the most recent CMS Provider of Services file (Q2 2025). • Opioid Treatment Facilities are defined in the most recent list of OTPs identified by SAMHSA, and located in rural areas. Rural areas are defined using the current HRSA definition of rurality, to include facilities located in non-metro areas or rural census tracts of metro areas. Geocoding of facilities was performed by HRSA.

Rural facility and population score factors	Points scoring methodology	Data source definition and source
		• The most recent list of Certified Community Behavioral Health Clinics (CCBHCs) as maintained by SAMHSA, CCBHCs supported through the Section 223 CCBHC Medicaid Demonstration and through SAMHSA administered CCBHC Expansion (CCBHC-E) Grants, and State-certified CCBHCs listed on State government websites for States that use other Medicaid authority to designate CCBHCs (such as Medicaid State Plan rehabilitation authority). The addresses of the sites of these CCBHCs, as available, are compared to rural area designations using the current HRSA definition of rurality to determine whether a CCBHC is in a rural area. • To confirm the CCBHC count, States are requested to submit the most current list of CCBHC entities within their State as of September 1, 2025; every active site of care associated with each CCBHC entity; and the address of every active site of care. • Other rural hospitals are defined as all active hospitals identified in the most recent CMS Provider

Rural facility and population score factors	Points scoring methodology	Data source definition and source
		of Services file (Q2 2025) that do not fall into one of the previously listed categories, and that are either identified by HRSA as rural or have been reclassified as rural by the most recent CMS IPPS release (IPPS FY2026 Final Rule). This category also excludes specialty hospitals (psychiatric, children's, cancer, rehabilitation, and long-term care).
A. 3. Uncompensated care in a State	• 100 Points * Percentile ranking of the % of hospital uncompensated care as a share of hospital operating expenses in a State / Sum of all States' percentile rankings	• Uncompensated care as a share of hospital operating expenses uses the same methodology as described in MACPAC's latest published "Annual Analysis of Medicaid Disproportionate Share Hospital Allotments to States" report as of September 1, 2025. • Uncompensated care defined as charity care and bad debt from the Medicare cost report. • Hospital operating expenses are from the Medicare cost report.
A. 4. % of State population located in rural areas	• 100 Points * Percentile ranking of % of State population that is located in a rural area / Sum of all States' percentile rankings	• The number of people in the State located in a rural area based on the most recent version of the rural area definition maintained by the Health Resources and Services Administration

Rural facility and population score factors	Points scoring methodology	Data source definition and source
		(HRSA) Federal Office of Rural Health Policy. • Census tract population and land area are from the U.S. Bureau of the Census, Department of Commerce, 2020 Census of Population and Housing. • Includes the percentage of the State population that is located outside Metropolitan Statistical Areas plus the population located in a rural census tract of a Metropolitan Statistical Area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 FR 6725)).
A. 5. Metrics that define a State as being frontier	• 100 Points * Percentile ranking of % of State population located in a FAR level 2 zip code / Sum of all States' percentile rankings	• State's population located in a zip code designated as a Frontier and Remote (FAR) Area Code level 2 by the USDA based on data from the 2010 decennial census. • FAR designations identify areas with low populations that are particularly geographically isolated from population centers based on travel distance thresholds. It is a subset of rural areas as defined by HRSA, which includes a broader definition of non-metropolitan counties.

Rural facility and population score factors	Points scoring methodology	Data source definition and source
		Residents in frontier areas face unique health care access challenges, such as lack of access to timely emergency services, greater distances to travel for health care services, fewer healthcare providers per capita, and limited infrastructure like paved roads that make traveling to health care resources difficult.
A. 6. Area of a State in total square miles	• 100 Points * Percentile ranking of the % of land area in a State compared to all 50 States / Sum of all States' percentile rankings, with both numerator and denominator subject to a State's percent of land area being greater than or equal to the 90th percentile	• Total Area of a State in square miles as defined by the U.S. Bureau of the Census's Master Address File/Topologically Integrated Geographic Encoding and Referencing (MAF/TIGER®) database as of January 1, 2010 (most recent data). • The total area of a State is an important metric that highlights challenges in the sheer scale of infrastructure and isolation of service areas that are not captured by other rural metrics. A large total area of a State can result in significant travel distances to healthcare facilities, particularly in States with rugged terrain or extreme weather, complicating timely access to care. Large State areas introduce additional logistical hurdles that aren't captured in other

Rural facility and population score factors	Points scoring methodology	Data source definition and source
		rural definitions like transportation scarcity and dispersed service networks. For example, in extremely expansive States, pockets of "non-rural" areas still face extreme isolation from other pockets of residents due to sheer size of the State, introducing unique challenges in emergency response time, specialty care access, and multiple transfers to receive care.
A. 7. % of hospitals in a State that receive Medicaid DSH payments	• 100 Points * Percentile ranking of the % of State hospitals that receive Medicaid DSH payments / Sum of all States' percentile rankings	• Medicaid Disproportionate Share Hospital (DSH) Payments are statutorily required payments intended to offset hospitals' uncompensated care costs to improve access for Medicaid and uninsured patients as well as the financial stability of safety-net hospitals. • The situation of hospitals receiving Medicaid DSH payments is required for consideration under the authorizing statute of the Rural Health Transformation Program. • The percent of State hospitals that receive Medicaid DSH payments is equal to the number of hospitals within a State receiving Medicaid DSH payments divided by the

Rural facility and population score factors	Points scoring methodology	Data source definition and source
		total number of hospitals within a State. • States must report in their applications the number of hospitals that received a Medicaid DSH payment, consistent with 42 U.S.C. 1396a(a)(13)(A)(iv), from that State for the most recent State plan rate year (SPRY) as defined at 42 CFR 455.301. In the absence of this information in your application, CMS will use data from the latest DSH audit available to CMS. • The total number of hospitals within a State is based on the count of hospitals that have filed a Medicare cost report, for each hospital's most recent cost reporting period, in the Healthcare Cost Report Information System (HCRIS) using the same counting methodology described in the "Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule" published on February 23, 2024. These counts include: ◦ Acute care hospitals paid under the inpatient prospective payment system (IPPS) ◦ Critical access hospitals

Rural facility and population score factors	Points scoring methodology	Data source definition and source
		◦ Inpatient rehabilitation facilities ◦ Inpatient psychiatric facilities

Technical score factors	Points scoring methodology	Data source definition and source
B. 1. Population health clinical infrastructure Four of the five leading causes of death in rural areas are associated with chronic disease. This situation is exacerbated by gaps in access to primary care and mental health services. Integrated care models may increase access to services in rural communities, as it is an effective strategy to maximize the use of scare rural health resources. Rural communities can benefit from integrated care models focused on preventative care, long-term care, behavior health, and other social health services through coordination amongst existing community stakeholders. **Sources:** RHI Hub – Rural Health Disparities RHI Hub – Mental Health Integration	• 100 Points * a State's 0-100 Point Score depending on quality of details in application / Sum of all States' 0-100 Point Scores for this factor • Quality of details in application on the initiative addressing: ◦ 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	• Initiative-Based Factor: Based on information provided in State's application.

Technical score factors	Points scoring methodology	Data source definition and source
	other social health services. ◦ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application. • For 2028-2030: Strength of a rural health care ecosystem measured by access to care (in particular, preventative and behavioral health), patient health outcomes, and/or reduction in total cost of care.	
B. 2. Health and lifestyle Prevention-focused initiatives based on nutrition, diet, and exercise are relevant to rural health needs because they address prevalent health disparities and unique socioeconomic challenges in rural areas. Rural populations are disproportionately impacted by chronic diseases like obesity, diabetes, and heart disease, with one of the drivers being food and diet. Rural communities can benefit from initiatives promoting prevention through physical activity and proper nutrition, which can reduce overall cost of care burden and improve health outcomes.	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • Two factors contribute to the 0-100 Points score: (1) Initiatives-Based qualitative assessment (75% weight), (2) State Policy Actions assessment (25% weight) • For Initiative-Based Factor: ◦ 0-100 Point Score depending on quality of details in application ◦ Quality of details in application on the initiative addressing: ▪ Novel prevention-focused models emphasizing lifestyle changes, around physical activity and /	• Initiative-Based Factor and State Policy Actions Factor • Initiative-Based Factor: Based on information provided in State's application. • For State Policy Action Factor, factor captures whether a State requires schools to reestablish the Presidential Fitness Test. The Presidential Fitness Test must be reinstated in a way that is aligned with any announced federal guidance associated with Executive Order 14327. This factor will not contribute to a State's overall points score until the budget period beginning after October 31, 2026. States will have until December 31,

Technical score factors	Points scoring methodology	Data source definition and source
Sources: Quantifying the Food and Physical Activity Environments in Rural, High Obesity Communities Rural Healthy People 2030—Nutrition and Healthy Eating and Obesity and Physical Activity in Rural Settings	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. ▪ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application. • For 2028-2030: Initiatives have produced measurable benefits in access to care, patient health outcomes (such as clinical indicators and biomarker improvements that are associated with long-term disease risk), and/or reduction in total cost of care.	2028 to enact this policy change.

Technical score factors	Points scoring methodology	Data source definition and source
	• For State Policy Actions Factor: ◦ 0–100 Points based on the following: ▪ 0 Points: A State does not require schools to reestablish the Presidential Fitness Test ▪ 100 Points: A State requires schools to reestablish the Presidential Fitness Test that is aligned with federal guidance associated with Executive Order 14327	
B. 3. SNAP waivers Rural populations are disproportionately impacted by chronic diseases like obesity, diabetes, and heart disease, with one of the drivers being food and diet. In addition, rural areas have higher rates of poverty and higher participation in SNAP benefits than urban areas. Restricting the use of SNAP benefits on non-nutritious foods can help improve dietary intake and clinical indicators associated with long-term disease in rural populations. **Sources:** Rural Health Disparities, CDC	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • 0-100 Points allotted to each State based on waivers in place and plans to submit a waiver ◦ 0 Points: State has no pending or approved USDA SNAP food restriction waiver prohibiting the purchase of non-nutritious items or no pending State bill requiring a food restriction waiver be submitted to USDA ◦ 25 Points: State with active bill in the State legislative process	• State Policy Actions Factor • Sources: USDA Food and Nutrition Service. (2025). SNAP Food Restriction Waivers. Available at the USDA SNAP Food Restriction Waivers page and individual State legislature sites. • State to include in application whether a State has USDA SNAP Food Restriction Waiver that prohibits the purchase of non-nutritious items, to include one or more of soda (including sweetened drinks), candy, energy drinks, fruit and vegetable drinks with less than 50% natural juice, and prepared desserts.

Technical score factors	Points scoring methodology	Data source definition and source
Rural SNAP Participants and Food Insecurity	◦ 50 Points: State bill was passed to submit a USDA food restriction waiver ◦ 75 Points: State submitted a waiver prohibiting the purchase of non-nutritious items in SNAP and waiver is in processing with USDA ◦ 100 Points: USDA approved State waiver prohibiting the purchase of non-nutritious items in SNAP	
B. 4. Nutrition Continuing Medical Education Research has revealed physicians in the United States widely lack sufficient education in nutrition, despite the demonstrable links between proper nutrition and improved health outcomes. One area in which nutrition education can be improved for physicians is within state continuing medical education (CME) requirements. Given the disproportionate impact of chronic disease on rural America, improved nutrition education among physicians through CME requirements can directly contribute to improving the health of Americans who live in rural areas.	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • 0-100 Points allotted to each State based on requirements in place and plans to implement requirements. ◦ 0 Points: States that have no requirement for nutrition to be included in continuing medical education (CME) for physicians as well as no pending State bill requiring nutrition to be included in CME for physicians ◦ 25 Points: States with an active bill in the State legislative process or regulation proposed	• State Policy Actions Factor • State to include in application whether a State has a requirement for nutrition to be a component of continuing medical education (CME). This factor will not contribute to a State's overall points score until the budget period beginning after October 31, 2026. States will have until December 31, 2028 to enact this policy change. • Example of qualifying state policies: Louisiana Senate Bill 14, Texas Senate Bill 25

Technical score factors	Points scoring methodology	Data source definition and source
Sources: Rural Health Disparities, CDC Addressing the Urgent Need for Clinical Nutrition Education in Postgraduate Medical Training: New Programs and Credentialing, Advances in Nutrition	◦ 75 Points: State bill requiring nutrition to be included in CME for physicians was passed or regulation finalized but not yet implemented or enforced ◦ 100 Points: Requirement for nutrition to be included in CME for physicians is currently in place and enforced	
C. 1. Rural provider strategic partnerships Rural facilities face several challenges, including low patient volume and high fixed costs that lead to financial strain and workforce shortages that drive up labor costs and limit local resident access to primary and specialty providers. Rural health care facilities may choose to join clinically integrated networks with other rural facilities or partner with larger health care systems to share resources and improve access to services in their communities. These partnerships can improve the financial viability of rural providers through shared infrastructure and operations resources. Collaborations with a larger healthcare system may increase access to specialty services and promote sharing	• 100 Points * a State's 0-100 Point Score depending on quality of details in application / Sum of all States' 0-100 Point Scores for this factor • Quality of details in application on the initiative addressing: ◦ 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.	• Initiative-Based Factor: Based on information provided in State's application.

Technical score factors	Points scoring methodology	Data source definition and source
of best practices and training resources. **Sources:** Introduction to Rural Clinically Integrated Networks [PDF] Healthcare Access in Rural Communities Overview - Rural Health Information Hub	◦ Arrangements improve financial viability of rural providers, preserve independence of rural providers where appropriate, and strive to keep care local where appropriate. ◦ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application. • For final allocations in 2028-2030: Arrangements have produced measurable benefits in: access to care, patient health outcomes, decrease in health care costs, and/or increase in rural facility financial sustainability.	
C. 2. EMS Access to EMS is critical for providing emergency medical care but it can be difficult to provide in rural areas. One reason is rural EMS serve a geographically large and sparsely populated area, and EMS providers need to travel farther or navigate difficult terrain when responding to a call or transporting a patient to a hospital. This can result in longer average response times and delays in care. Another	• 100 Points * a State's 0-100 Point Score depending on quality of details in application / Sum of all States' 0-100 Point Scores for this factor • Quality of details in application on the initiative addressing: ◦ State policies and infrastructure that will support coordination between EMS and other provider types as well as EMS integration with	• Initiative-Based Factor: Based on information provided in State's application.

Technical score factors	Points scoring methodology	Data source definition and source
reason is a shortage of rural EMS workforce and reliance on volunteers, who may have lower training levels and higher turnover than non-rural counterparts. Rural areas can strongly benefit from more seamless integration of EMS services with the healthcare ecosystem and increased efficiency in delivering services. **Sources:** RHI Hub - EMS	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. ◦ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application. • For final allocations in 2028-2030: Arrangements have produced measurable benefits in: timely access to emergency services and/or reduction in total cost from emergency care.	
C. 3. Certificate of Need (CON) Certificate of Need is an additional expense and burden on rural facilities. In addition to increasing cost and decreasing choice and competition, CON	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • Total State CON score as defined in the Cicero report	• State Policy Actions Factor • Source: Cicero Institute. (2024). A Policymaking Playbook for Certificate of Need Repeal: Ranking

Technical score factors	Points scoring methodology	Data source definition and source
laws tend to favor established providers, creating a barrier to new entrants, thus preventing innovation and growth in rural settings. Eliminating or loosening CON laws allows providers to establish new facilities in underserved rural regions without increased burden, addressing the scarcity of local care options. **Sources:** Certificate of Need Laws in Health Care: Past, Present, and Future. Certificate-of-Need Laws: How They Affect Healthcare Access, Quality, and Cost.	converted to a 100-Point Score: ◦ 0 Points: 100 score from Cicero report for States with universal CONs for all facility categories. ◦ 25 Points: 80-99 score from Cicero report for States with stringent CONs across facility categories. ◦ 50 Points: 45-79 score from the Cicero report for States with moderate CONs across facility categories. ◦ 75 Points: 1-44 score from Cicero report for States with limited CONs across facility categories. ◦ 100 Points: 0 score from Cicero report for States with no CONs across facility categories.	Certificate of Needs Laws in All 50 States [PDF]. • The report was created by Cicero Institute reviewing all relevant statutes in all 50 States as of January 1, 2024. • Report ranks each State CON laws from least to most restrictive, categorizing by nine facility types with CON restrictions: medical inpatient, medical outpatient, behavioral inpatient, behavioral outpatient, long-term care facilities, day services, ancillaries, imaging, and other. Report assigned points pursuant to each CON or CON-equivalent barrier present across facility types in that State's statutes on a 100-point basis. The most restrictive States are burdened with 100 points, reflecting CON barriers in every category measured. Meanwhile, the States with 0 points do not have any CON or CON-equivalent statutes limiting market entry in the measured categories.
D. 1. Talent recruitment Rural areas often face challenges in maintaining an adequate health workforce. The patient-to-primary care physician and patient-to-	• 100 Points * a State's 0-100 Point Score depending on quality of details in application / Sum of all States' 0-100 Point Scores for this factor	• Initiative-Based Factor: Based on information provided in State's application.

Technical score factors	Points scoring methodology	Data source definition and source
specialist ratios in urban areas are 1.3x and 8.8x, respectively, the coverage in rural areas. Workforce shortages in rural areas can lead to delays in patient care and limit access to high quality care. Building a strong local health care workforce is critical to improving access and quality of care. **Sources:** About Rural Health Care - NRHA RHI Hub - Rural Healthcare Workforce RHI Hub - Recruitment and Retention for Rural Health Facilities Building a Sustainable Rural Health Workforce for the 21st Century: A Report of the 2024 Rural Health Workforce Summit	• Quality of details in application on the initiative addressing: ◦ 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. ◦ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as	

Technical score factors	Points scoring methodology	Data source definition and source
	described in the application. • For 2028-2030: Strength of the rural health care ecosystem measured by increase in provider to patient coverage ratio and/ or patient access to and cost of care.	
D. 2. Licensure compacts Compared to non-rural areas, rural areas have more limited access to health care professionals. As mentioned previously, the per capita supply of health professionals is lower in rural areas compared to urban areas. By providing clinicians with the opportunity to serve patients across State borders, licensure compacts increase the supply of accessible rural health providers. This also increases the reach and effectiveness of telehealth in enhancing rural access. **Sources:** RHI Hub - Telehealth and Health Information Technology in Rural Healthcare Addressing Rural Health Challenges Head On NRHA's Rural Health Voices Blog | National Rural Health Association - NRHA - NRHA	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • 0-100 Points based on average of Physician Score, Nurse Score, EMS Score, Psychology Score, and Physician Assistant Score • For Physician Score: ◦ 0 Points: Not a Member State ◦ 50 Points: Interstate Medical Licensure Compact (IMLC) member State issuing non-State of Principal Licensure (SPL) licenses only OR compact legislation introduced (towards serving as SPL) ◦ 75 Points: IMLC passed; implementation phase ◦ 100 Points: IMLC Member State serving as SPL (State of principal license) • For Nurse Score:	• State Policy Actions Factor • For Physician Score: State participation in the Medical Licensure Compact, which covers physicians who hold an MD (Doctor of Medicine) or DO (Doctor of Osteopathic Medicine) degree (Source: Interstate Medical Licensure Compact. (2025). U.S. State Participation in the Compact. Available at Interstate Medical Licensure Compact (includes links to primary State legislative sources)). ◦ The Interstate Medical Licensure Compact is an agreement among 40 participating U.S. States, the District of Columbia and the Territory of Guam to work together to significantly streamline the licensing process for physicians who want to practice in multiple States. The Interstate Medical Licensure Commission

Technical score factors	Points scoring methodology	Data source definition and source
	◦ 0 Points: Not a Member State ◦ 50 Points: Pending NLC legislation ◦ 75 Points: NLC legislation enacted; implementation phase ◦ 100 Points: NLC state • For EMS Score: ◦ 0 Points: Not a Member State ◦ 100 Points: is-a-licensure compact member of the EMS Compact • For Psychology Score: ◦ 0 Points: non-PSYPACT participating ◦ 50 Points: PSYPACT legislation introduced ◦ 75 Points: enacted PSYPACT legislation-practice; implementation phase ◦ 100 Points: PSYPACT participating • For Physician Assistant Score: ◦ 0 Points: No active legislation to become a PA Compact member ◦ 50 Points: Legislation filed to become a PA Compact member ◦ 100 Points: Legislation enacted to become a PA Compact member – State is a compact member	serves as an independent coordinating organization that administers the Compact on the States' behalf. The Commission is made up of representatives from each participating Compact State. Last updated July 2025. • For Nurse Score: State participation in the Nurse Licensure Compact (Source: National Council of State Boards of Nursing (NCSBN). (2025). NLC Nurse Licensure Compact. ◦ The Interstate Commission of Nurse Licensure Compact Administrators (ICNLCA) facilitates cross-border nursing practice through the implementation of the nationally recognized multistate license via the Nurse Licensure Compact (NLC). The NLC enables registered nurses (RNs) and licensed practical/ vocational nurses (LPN/ VNs) to hold one multistate license, with the authority to practice in person or via telehealth in both their home State and other NLC states. In FY24, 42

Technical score factors	Points scoring methodology	Data source definition and source
		jurisdictions were members of the NLC. • For EMS Score: Compact Member States that have legislatively unified: EMS Personnel Licensure Standards, Background Checks, and Public Protection and Investigation Standards under the EMS Compact (Source: The EMS Compact. (2025). The United States Emergency Medical Services Compact. ◦ The EMS Compact is a State law that functions as a contractual agreement between States and State law. It is a legal agreement enacted by State legislation in 25 States. The Compact is governed by the Interstate Commission for EMS Personnel Practice, a governmental body established under the model legislation enacted by each member State. Website updated 2025. • For Psychology Score: States participating in the Psychology Interjurisdictional Compact (PSYPACT), States with enacted PSYPACT legislation, States with PSYPACT legislation introduced, and Non-

Technical score factors	Points scoring methodology	Data source definition and source
		PSYPACT States/States with no active legislation. (Source: PSYPACT. (2025). PSYPACT Map. (Includes list of primary State sources.)). ◦ The Psychology Interjurisdictional Compact (PSYPACT®) is an interstate compact designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across State boundaries. The PSYPACT Commission is the governing body of PSYPACT responsible for creating and finalizing the Bylaws and Rules and Regulations. The Commission is also responsible for granting psychologists the authority to practice telepsychology and temporary in-person, face-to-face practice of psychology across State boundaries. Data updated in 2025. • For Physician Assistant Score: States participating as members in the Physician Assistants (PA) Compact, States with legislation filed to become members, and non-member States with no active legislation. (Source:

Technical score factors	Points scoring methodology	Data source definition and source
		PA Compact. (2025). PA Licensure Compact. ◦ The Physician Assistants Compact is an interstate occupational licensure compact for physician assistants (PAs). The compact facilitates multistate practice for PAs, improves health care access for patients, and enhances public protection. Data updated in 2025.
D. 3. Scope of practice There are less physicians in rural areas, creating barriers to access for rural patients. These physician supply challenges could be mitigated, especially in the context of primary care, by expanding the scope of practice of other clinicians such as nurse practitioners and physician assistants who have training and competency in caring for many of the cases currently limited to physician care. By allowing clinicians to practice at the top of their license, States can increase health service supply. Rural populations will benefit from the preventive health impact of increased primary care options as well as decreased time to wait for appointments. **Sources:**	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • 0-100 Points based on average of PA Score, NP Score, Pharmacist Score, and Dental Hygienists Score • PA Score: ◦ 0 Points: Reduced Scope of Practice ◦ 50 Points: Moderate Scope of Practice ◦ 75 Points: Advanced Scope of Practice ◦ 100 Points: Optimal Scope of Practice • NP Score: ◦ 0 Points: Restricted Scope of Practice	• State Policy Actions Factor • For PAs: The State scope of practice environments for PAs on a scale from Optimal, to Advanced, to Moderate, to Reduced (Source: American Academy of Physician Associates (AAPA). (2025). PA State Practice Environment.) Data updated as of July 2025. • For NPs: The State scope of practice environments for NP licensure ranging from full practice, to reduced practice, to restricted practice (Source: American Association of Nurse Practitioners (AANP). (2024). State Practice Environment). Data updated as of October 2024. • For Pharmacists: Variation in pharmacist scope of practice and ability to operate independently by

Technical score factors	Points scoring methodology	Data source definition and source
Reforming America's Healthcare System Through Choice and Competition — Section 3: Government Healthcare Policies and Their Effect on Competition	◦ 50 Points: Reduced Scope of Practice ◦ 100 Points: Full Scope of Practice • Pharmacist Score: ◦ 0 Points: 0-3 score from Cicero report for States with restricted authority ◦ 50 Points: 4-7 score from Cicero report for States with Formulary-Based Authority ◦ 100 Points: 8-10 score from Cicero report for States with full authority • Dental Hygienists Score: ◦ Restriction categories are based on the number of types of tasks dental hygienists can do ◦ 0 Points: Restricted Scope of Practice (0-2 types tasks) ◦ 50 Points: Semi-Restricted Scope of Practice (3-5 types tasks) ◦ 100 Points: Unrestricted Scope of Practice (6-8 types tasks)	State, scored by classifying State laws based on authority to administer drugs, order and perform laboratory testing, and prescribe drugs or devices as described in the Cicero report (Source: Cicero Institute. (2025). 2025 Policy Strategies for Full Practice Authority). The report was created by Cicero Institute reviewing all relevant statutes in all 50 States as of August 2025. • For Dental Hygienists: Variation in Dental Hygiene Scope of Practice by State, categorized by several allowable tasks (Source: Oral Health Workforce Research Center (OHWRC). (2024). Variation in Dental Hygiene Scope of Practice by State). Data updated as of November 2024.
E. 1. Medicaid provider payment incentives Since its establishment in 2010, the CMS Innovation Center has been testing value-based care via its models. Outside of the Innovation Center, the concept	• 100 Points * a State's 0-100 Point Score depending on quality of details in application / Sum of all States' 0-100 Point Scores for this factor	• Initiative-Based Factor: Based on information provided in State's application.

Technical score factors	Points scoring methodology	Data source definition and source
of value-based care has existed since the late 1960's. The concept rewards increases in quality and reductions in cost. Compared to urban residents, rural residents have a 44% higher rate of preventable ED visits and a 13% higher rate of preventable hospitalizations. Rural communities can benefit from participating in thoughtfully designed value-based programs focused on value over volume. States can consider leveraging learnings from the Innovation Center in designing these programs. **Sources:** Comparing Preventable Acute Care Use of Rural Versus Urban Americans	• Quality of details in application on the initiative addressing: ◦ 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. ◦ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application. • States can use the Health Care Payment Learning and Action Network (LAN) framework for reference on payment model frameworks that focus on quality and reducing total cost of care. • For 2028-2030: Strength of the rural health care ecosystem measured by access to care, patient	

Technical score factors	Points scoring methodology	Data source definition and source
	health outcomes, and/or reduction in total cost of care.	
E. 2. Individuals dually eligible for Medicare and Medicaid A larger share of Medicare beneficiaries in rural areas are covered by both Medicare and Medicaid than beneficiaries in urban areas. Although studies have found that beneficiaries enrolled in integrated care models have lower rates of hospitalization and readmissions than those who are not enrolled, a minority of dually eligible beneficiaries are now enrolled in integrated care, and there are fewer integrated care options available for dual eligible beneficiaries in rural areas. Dual-eligible beneficiaries in rural areas can benefit from more intentionally coordinated care for improved health outcomes and reduced total cost of care. **Sources:** MACPAC Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid Care Coordination Quality Measure for Primary Care (CCQM-PC)	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • Two factors contribute to the 0-100 Points score (both 50%): (1) Initiatives-Based qualitative assessment, (2) Data-Driven factors assessment • For Initiative-Based Factor: ◦ 0-100 Point Score depending on quality of details in application ◦ Quality of details in application on the initiative addressing: ▪ 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. ▪ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application.	• Initiative-Based Factor and Data-Driven Factor • For Initiative-Based Factor: Based on information provided in State's application. • For Data-driven factor: ◦ Medicare-Medicaid dual enrollees include both full- and partial-duals identified by reviewing the most recent release of Medicare Monthly Enrollment Data (May 2025) on data.cms.gov. ◦ Individuals enrolled in any of the following integrated plans: Programs of All-Inclusive Care for the Elderly (PACE), Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), Highly Integrated D-SNPs (HIDE SNPs), Coordination-Only Dual Eligible Special Needs Plans (CO SNPs), Dual Eligible Special Needs Plans (D-SNPs), Medicare-Medicaid Plans (MMPs) offered under the Financial Alignment Initiative model (Note: The model demonstrations are slated to conclude by

Technical score factors	Points scoring methodology	Data source definition and source
	• For 2028-2030: Initiatives have produced measurable benefits in patient health outcomes and/or reduction in total cost of care, as well as measurable benefits in care coordination. • For Data-Driven Factor: ◦ 0-100 Points based on the average of the following: ▪ Duals Contact at the State: 100 Points for having at least one individual identified as a dual contact by MMCO. 0 Points otherwise. ▪ Integrated Plan Availability: 100 Points for having at least one integrated plan (PACE, MMP, AIP D-SNP) available in the State as indicated by whether a State has at least one enrollee in such plan. 0 Points otherwise. ▪ % of Duals Enrolled in an Integrated Plan: 100 Points * Percentile Ranking of the proportion of dual enrollees that are enrolled in an integrated plan in a State, compared to all other State proportions.	December 31, 2025 with MMP enrollees transitioning to other integrated plans), as identified by the Integrated Care Resource Center (ICRC) (CMS/MMCO Contract) (*Note: The ICRC document includes FIDE SNPs, HIDE SNPs, and CO D-SNPs under Applicable Integrated Plans (AIPs)*). ◦ Integrated plan enrollment is calculated as of the month of the most recent duals enrollment data release in the Medicare Monthly Enrollment Data (May 2025). ◦ State integrated plan availability is a binary indicator, which describes whether a State has at least one individual enrolled in PACE, PACE, FIDE-SNP, HIDE SNP, D-SNP or MMP. ◦ State dual contact is a binary indicator, which describes whether a State has at least one staff member identified as a contact for issues related to individuals dually enrolled in Medicare-Medicaid (as identified by MMCO).

Technical score factors	Points scoring methodology	Data source definition and source
E. 3. Short-term, limited-duration insurance (STLDI) Rural populations consistently have higher uninsurance rates than their urban counterparts. Approximately 18% of adults living in nonmetropolitan counties are uninsured, leading to higher costs for patients. Rural adults are also more likely than urban adults to report delayed care due to cost and issues paying medical bills. STLDI plans may offer some rural individuals lower cost short-term coverage options to help address issues associated with being uninsured. **Sources:** RHI Hub – Healthcare Access in Rural Communities Geographic Variation in Health Insurance Coverage: United States, 2020	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • 0-100 Points scale based on the following: ◦ 0 Points: STLDI plans are restricted in the State beyond the latest federal guidance. ◦ 100 Points: STLDI plans are not restricted in the State beyond the latest federal guidance.	• State Policy Actions Factor • STLDI as defined in 45 CFR 144, and any latest federal guidance or regulation updates to STLDI definition • States must report in their applications any state-level policies on STLDI, including: ◦ Whether there are any State restrictions in place that limit STLDI plans beyond latest federal guidance; ◦ What the State's maximum allowable initial contract term for STLDI is; and ◦ What the State's maximum allowable total coverage period for STLDI is.
F. 1. Remote care services Rural areas often lack access to medical care due in part to distance from care and workforce shortages. Remote care services can help expand access to care by allowing clinicians of any type to provide rural residents with care from another location via telehealth, remote patient monitoring, or other modalities. While these services can be useful for rural residents, lack of Medicaid coverage for remote care	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • Two factors contribute to the 0-100 Points score (both 50%): (1) Initiatives-Based qualitative assessment, (2) State Policy Actions assessment • For Initiative-Based Factor: ◦ 0-100 Point Score depending on quality of details in application	• Initiative-Based Factor and State Policy Actions Factor • For Initiative-Based Factor: Based on information provided in State's application. • For State Policy Action Factor, metrics capture whether a State has broadly supportive State policies towards access to remote care and telehealth services.

Technical score factors	Points scoring methodology	Data source definition and source
services, lack of in-State providers, and limited infrastructure can all be limiting factors in providing remote care access for rural residents. **Sources:** RHI Hub – Healthcare Access in Rural Communities RHI Hub – Barriers to Telehealth in Rural Areas Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review	◦ Quality of details in application on the initiative addressing: ▪ Enhancement of remote care services infrastructure within a State. ▪ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application. • For 2028-2030: Initiatives have produced measurable benefits in access to care, patient health outcomes, and/or reduction in total cost of care. • For State Policy Actions Factor: ◦ 0–100 Points based on the average of the following categories: ▪ Medicaid payment for at least one form of live video: 100 Points if reimbursed. 0 Points if no payment. ▪ Medicaid payment for Store and Forward: 100 Points if reimbursed. 50 Points if only reimbursing Communication Technology Based Services (CTBS). 0 Points if no payment.	• Based on categories of State Telehealth Laws and Reimbursement Policies (Source: Center for Connected Health Policy (CCHP). (2024, November). State Telehealth Laws and Reimbursement Policies Report, Fall 2024.

Technical score factors	Points scoring methodology	Data source definition and source
	▪ Medicaid payment for Remote Patient Monitoring (RPM): 100 Points if reimbursed. 0 Points if no payment. ▪ In-State licensing requirement exception: 100 Points if any exceptions are in place. 0 Points if not. ▪ Telehealth License/ Registration Process (including special licenses): 100 Points if a registration process is in place. 0 Points if not.	
F. 2. Data infrastructure Rural geography and healthcare facility distribution often necessitate rural residents receiving care from providers and specialists outside of their community at different health systems. High-quality data infrastructure facilitating interoperability is vital for continuity of care. Data infrastructure can also improve rural health outcomes at a larger scale. IT software, for example, can allow hospitals to analyze their patient and outcome data on an aggregate level and make targeted improvements and clinical decisions. Similarly, high-quality T-MSIS data can help	• 100 Points * a State's 0-100 Point Score as described below / Sum of all States' 0-100 Point Scores • Two factors contribute to the 0-100 Points score: (1) Initiatives-Based qualitative assessment (75% weight), (2) Data-Driven factors assessment (25% weight) • For Initiative-Based Factor: ◦ 0-100 Point Score depending on quality of details in application ◦ Quality of details in application on the initiative addressing: ▪ Enhancement of data infrastructure within a State, such as	• Initiative-Based Factor and Data-Driven Factor • For Initiative-Based Factor: Based on information provided in State's application. • For Data-driven factor, measures quality of State's reporting of full T-MSIS data as defined by CMS's latest Outcomes Based Assessment methodology. Refer to the most recent Outcome-Based Assessments methodology posted on Transformed Medicaid Statistical Information System (T-MSIS).

Technical score factors	Points scoring methodology	Data source definition and source
State and federal governments make informed decisions about rural healthcare needs. Despite their importance, rural hospitals have upgraded data infrastructure and facilitated patient access to health information at lower rates than other hospitals due to financial and human resources restrictions. **Sources:** CMS Health Technology Ecosystem – Interoperability Framework Prioritizing the Expansion of Electronic Medical Record Interoperability Software to Rural Health Care Systems RHI Hub - Making the EHR Work: Rural Healthcare Organizations Use Data Extraction to Improve Patient Care Transformed Medicaid Statistical Information System (T-MSIS)	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. ▪ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application. • For 2028-2030: Initiatives have produced measurable benefits in patient and provider access of health data as well as improved	• State grades are assigned based on the most recent OBA data available at time of assessment. • T-MSIS is housed within CMS. T-MSIS collects Medicaid and Children's Health Insurance Program (CHIP) data from U.S. states, territories, and the District of Columbia into the largest national resource of beneficiary information. This data is crucial for research and policy on Medicaid and CHIP and helping the Centers for Medicare and Medicaid Services (CMS) conduct program oversight, administration, and integrity.

Technical score factors	Points scoring methodology	Data source definition and source
	access to, quality of, and cost of care. • For Data-Driven Factor: ◦ States receive 100 Points for reaching the target on Critical Priority, High Priority, and Expenditure T-MSIS Outcome-Based Assessments (OBA). States deducted 1/3 of total 100 points for each target not reached on any of Critical Priority, High Priority, and Expenditure T-MSIS OBAs.	
F. 3. Consumer-facing technology Consumer-facing health technology, such as symptom checkers and AI chatbots, are new developments which can help address critical rural healthcare access barriers like geographic isolation, high costs, and provider shortages. Tools like symptom checkers and virtual consultations enable rural patients to access care without traveling long distances by providing personalized health education and decision support. Providers can also leverage digital health tools to work more efficiently, lowering costs and mitigating provider shortages. **Sources:**	• 100 Points * a State's 0-100 Point Score depending on quality of details in application / Sum of all States' 0-100 Point Scores for this factor • Quality of details in application on the initiative addressing: ◦ 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	• Initiative-Based Factor: Based on information provided in State's application.

Technical score factors	Points scoring methodology	Data source definition and source
RHI Hub - Healthcare Access in Rural Communities	patient-facing apps, as applicable. ◦ Feasibility, long-term financial self-sustainability, and robustness of suggested evaluation metrics as described in the application. • For 2028-2030: Initiatives have produced measurable benefits in access to care, patient health outcomes, and/or reduction in total cost of care.	

Example initiatives

The following are examples of initiatives that align with the RHT Program strategic goals and approved use of funds and may be used as references when you are forming the proposed initiatives and use of funds section of your application. These examples are provided for reference to support your decision making, and they are purely optional. Should you choose to use one or more of these example initiatives in your plan, note that they should serve as a starting point rather than a fully developed initiative. You should further tailor, add detail to, and expand upon the example initiative(s) as needed to most effectively serve the unique needs of the rural population in your State and meet the requirements of the application.

Initiatives may be directly implemented by States or may be implemented by collaborating organizations or entities that have been subawarded or subcontracted funding, with strong State oversight. If you choose to subaward or subcontract RHTP funds, you must make your process and criteria for selecting such subawardees or subcontractors clear to CMS. Note that the terms and conditions of federal awards generally flow down to subawards and subrecipients, as specified in 2 CFR 200.101(b)(1). You should structure initiatives and initiative governance to meet community needs with consideration for local contexts.

Population health infrastructure initiative

Description

Facilitate rural beneficiary access to primary care, behavioral health, and other preventative care community-based services. Ensure rural beneficiaries can access the health system in an easy and expedient way in community settings by supporting infrastructure and outreach capabilities of provider and facility types such as:

- Pharmacists and pharmacies.
- Primary care clinics.
- Rural health clinics.
- Community health centers.
- Behavioral health clinics and providers.
- Emergency medical services.
- Other community-based organizations offering support.

Establish a facilitator, such as a rural health clinic or other central health care hub and bring together partners to implement strategies that address health needs, increase the use of preventive care, provide care in lower-cost settings such as homes, and reduce preventable hospital admissions and emergency room visits. The initiative aims to enhance population health within the served community by focusing on preventive care, behavioral health, addressing root causes of diseases, and facilitating health care access.

Projects could use community health workers, community paramedicine providers, and other ancillary staff to improve rural residents' health by leveraging technology-enabled prevention, wellness and chronic care management strategies through a health navigator approach. The community health navigators can work directly with patients and use the data from appropriate technology-enabled tools to support patients managing their own health. This can align with larger efforts in value-based care models focused on prevention and case management in support of the Make America Healthy Again framework.

Potential use of funds could include:

- Technical assistance to assess community needs, develop community infrastructure, and plan for sustainability.
- Developing a hub and spoke model to place a community health center, rural health clinic, rural hospital, or other community-based organization at the center of care to integrate physical health, behavioral health, long term care, and social health services more formally.

- Targeted technical assistance and training to help clinicians, medical coders, and other personnel better understand and use existing payment mechanisms already in place for care coordination services via Medicare and Medicaid or other payers. Providers often underuse payment mechanisms for care coordination services due to lack of awareness or capacity in coding and billing and coordination with billing eligible clinicians to deliver and bill for these services. Collecting this additional revenue could help offset the costs of the community health providers and sustain these projects.
- Creating, implementing, or enhancing IT systems, software, or data sharing infrastructure to streamline population health management and care coordination by sharing resources, making referrals, and ensuring the completion of the referral process that help with coordinating amongst stakeholders and/or population health management. Promoting community engagement, awareness of programs, and community input on program development, structure, and oversight.
- Training and integrating community health workers, care coordinators, peer support specialists, community paramedics, other auxiliary personnel, and behavioral health specialists into the care delivery system. Such personnel can then launch and support targeted outreach programs to engage and educate rural populations.
- Developing multidisciplinary frameworks to formally integrate non-physician providers such as paramedics, community paramedics, emergency medical technicians, community health workers, and pharmacists into care teams, in collaboration with rural health care facilities.
- Developing community-based programs to promote health literacy and healthy behaviors within a population, such as tobacco cessation programs, diabetes management education, or nutrition education.
- Improving access to primary care and preventative services in innovative sites of care, such as schools, retail centers, public libraries, and home-based visits, and/or via mobile care delivery, such as use of mobile screening vans, community paramedicine, and mobile clinics.

Other considerations:

- Funds must be used to develop the population health infrastructure (such as setting up a school-based clinic and supporting start-up costs), as opposed to ongoing service delivery in schools (which is already funded by Medicaid).

- Funding and activities must be clearly linked to supporting local rural health systems and improving health outcomes in the served communities.
- Funding for provider payments is subject to restrictions described in funding policies and limitations
- Funding for capital expenditures and infrastructure is subject to restrictions described in funding policies and limitations

Main strategic goal: Make Rural America Healthy Again

Uses of funds: A, B, C, E, F, G, H, I, J, K (non-exhaustive)

Technical score factors: B.1, B.2, C.1, C.2, E.1, F.1, F.2, F.3 (non-exhaustive)

Key stakeholders: Rural Health Clinics, Rural Hospitals, Primary Care Clinics, Community Health Centers, Pharmacies, Emergency Medical Services, Community-Based Organizations, Indian Health Care Providers

Outcomes (examples, non-exhaustive):

- Decreased rates of avoidable hospitalizations and readmissions.
- Decreased rates of avoidable emergency department use.
- Reduced overall hospital use for recipients in the served community, no matter where the hospitalization occurs.
- Reduced total cost of care for the target population.
- Improved clinical indicators associated with long-term disease risk (such as blood pressure or hemoglobin A1c) for the target population.
- Increased hiring, training, and use of non-traditional provider types such as community health workers.

Examples:

- Missouri Transformation of Rural Community Health (ToRCH)
- Healthy Connections, Inc. Health Families Arkansas
- Scenic Bluffs Community Health Centers Help Team
- Rural Project Examples: Community health workers – Rural Health Information Hub
- Rural Project Examples: Community paramedicine

Rural health network initiative

Description

Help rural providers form or expand integrated health networks to improve health care delivery, coordination, and outcomes in rural communities. Integrated networks allow providers to coordinate resources to provide operational efficiencies. These efficiencies can improve financial status and enhance sustainability while providing a pathway to value-based care. Networks may have significant up-front onetime costs for legal services, recruiting stakeholders, and developing services.

Rural health networks use a formal shared governance model that allows them to act collectively while maintaining local autonomy. Integrated networks may develop shared or distributed network services to improve operations and reduce costs for participating healthcare organizations. These network services could include:

- Health information technology
- Staffing
- Data analytics
- Payor contract negotiation
- Consolidated billing services
- Consolidated human resources
- Population health tools
- Other IT investments such as strategies to share resources to protect against cyber-attacks and implement AI and other technologies to extend the clinical and/or administrative workforce

Networks can also coordinate activities to support and expand the health care workforce in both clinical and non-clinical roles.

Many rural hospitals and other rural health care organizations struggle with low service volume which impacts their financial solvency, leading to high fixed costs to maintain local services. Through an integrated rural health network model, health care service lines can be strategically planned to meet community health needs, achieve community-appropriate volume, and develop long-term sustainability. This could include non-traditional care models such as mobile clinics, home visits, or telehealth that can increase access to services for rural patients. Networks may assist participating members with information, feasibility assessments, and best practices to implement targeted service line expansions linked to local need. For

organizations with limited cash flow, service expansions may require start-up funding to cover initial staffing and equipment until patient volumes grow to sustainable levels.

Network strategies may also include restoring, leveraging, or expanding services in rural hospitals and clinics based on strategic implementation and operational synergies with other inpatient and ambulatory services and collaboration among network members.

For example, networks can establish originating sites for telehealth services in rural maternity care shortage areas that connect patients to obstetricians and specialists for routine and specialist prenatal and postpartum visits to reduce travel time to a clinic or hospital. During these virtual visits, nurses, or community health workers (CHWs) can collect essential data such as weight, screen for issues such as gestational diabetes and depression, and identify upstream drivers of health. This expanded team can also refer patients to network partners offering community-based resources and support services. By incorporating CHWs into the expanded maternal health care team, the clinical care team is able to work at the top of their licenses, the quality of maternity care can be improved, and critical upstream drivers of health can be addressed.

Potential uses of funds could include:

- Assistance in setting up the legal and organizational framework to create and operate the network including, but not limited to, articles of incorporation, network operating practices, dues structure, and network decision making procedures.
- Technical assistance to organizations developing or enhancing integrated rural health networks.
- Technical assistance with restarting closed service lines, such as with recruitment, compliance, or infrastructure.
- Technical assistance on legal and regulatory issues (such as antitrust navigation and contracting and data sharing between members).
- Needs assessments for rural communities related to strategic planning of services, including maternity care.
- Investing in the development of shared/distributed network services, such as telehealth services, network-wide staff recruitment and retention, billing and coding support for providers, and quality and financial management capacity to enable network members to take part in value-based health care models.

- IT systems, software, or data sharing infrastructure, such as health information exchanges or frameworks like The Trusted Exchange Framework and Common Agreement (TEFCA), that help with coordinating amongst providers and supporting population health management.
- Infrastructure upgrades to expand or modify services, such as through mobile health units for general health purposes or specialties like maternal health.
- Technical assistance and facilitation on access to capital and engaging with State bonding agencies, Community Development Financial Institutions, and capital programs from the Departments of Agriculture and Housing and Urban Development.
- Investments in technologies to extend the workforce.
- Start-up funding to cover providers' initial staffing and equipment to support strategically targeted service line expansion linked to local need until enough volume develops to reach sustainability.
- Renovations or retrofitting to convert underutilized cost-intensive spaces within existing health care facilities to clinic or community-based treatment spaces (e.g., converting a hospital space to be a standalone ER + OB and NICU ward with retrofitting remaining space to serve as telehealth or primary care).

Other considerations:

- Funding for provider payments is subject to restrictions described in funding policies and limitations
- Funding for capital expenditures and infrastructure is subject to restrictions described in funding policies and limitations

Main strategic goal: Sustainable access

Uses of funds: D, E, F, G, H, I, J, K (non-exhaustive)

Technical score factors: C.1, C.2, E.1, F.1, F.2, F.3 (non-exhaustive)

Key stakeholders: Hospitals, Critical Access Hospitals, Rural Emergency Hospitals, Rural Health Clinics, Federally Qualified Health Centers, IHS/Tribal Facilities, Certified Community Behavioral Health Clinics, Opioid Treatment Centers, and Nonprofit healthcare organizations.

Outcomes (examples, non-exhaustive):

- Increase access to primary care.
- Increase access to specialty care, for example maternal fetal medicine providers.

- Reduce travel burden for rural patients.
- Reduce avoidable hospitalizations.
- Increase referrals to support services.
- Increase preventive care, including prenatal and postpartum visits.
- Reduce rates of severe pregnancy complications.
- Reduce operating costs for rural health care organizations.
- Increased participation in value-based care models.

Examples:

- Illinois Critical Access Hospital Network
- Indiana Statewide Rural Health Network
- Rough Rider Network
- Western Healthcare Alliance
- Southeast Rural Physician Alliance
- Montana Health Network
- Texas Organization of Rural and Community Hospitals Clinically Integrated Network
- Introduction to Rural Clinically Integrated Networks

Rural health regional excellence initiative

Description

Support rural providers in forming arrangements and affiliations with high-quality regional health systems (such as academic medical centers and tertiary hospitals) and perinatal quality collaboratives with the aim of:

- Sharing best practices.
- Sharing talent/training/knowledge.
- Improving quality of care.
- Improving referral processes.
- Supplementing access to specialty services that may not be available locally as part of a long-term strategy for collaboration that strengthens rural hospitals and clinics.

These arrangements should include funding that directly supports rural community partners in addition to their upstream tertiary partners. These models should avoid traditional approaches of a top-down strategy focused only on increasing referrals to the tertiary partner by placing the focus on how to empower care in rural communities to expand specialty services and help

rural hospitals and clinics retain patients locally at an appropriate level of care. At a minimum, affiliation should include a referral system and the coordination of specialty provider services either in-person or virtually and include on-site specialty services at local rural hospitals and clinics when feasible.

Strategies should focus on using the arrangement to increase new patients and retain existing patients receiving care locally in rural communities with consultations and referrals to regional specialty services when needed. This may include strategies such as leveraging swing beds at Critical Access Hospitals for post-acute skilled care in patients' local community. This would have the benefits of relieving pressure on upstream facilities facing difficulties placing discharged patients in skilled nursing beds and keeping patients close to home.

These collaborative efforts can facilitate two-way communication and follow-up monitoring following major procedures in coordination with local rural primary care to reduce patient travel burden and improve timeliness and consistency of care. These arrangements can assist rural primary care providers with delivering coordinated, longitudinal care for complex patients and managing chronic disease locally with support from urban specialists. These models often include having specialists from regional health systems offer regular clinics in rural communities, helping to co-locate services and reduce travel burdens on patients while reducing bypass of patients from their local healthcare providers. This can also include a virtual component with e-consults for providers in rural areas to connect with specialists at regional health systems. Specific examples of collaborative efforts may include establishing telehealth networks for prenatal and postpartum routine and specialty care as well as for maternal health training. These arrangements also facilitate having specialists from regional health systems run simulation training and tele-simulations for providers in rural areas to manage high-acuity, low-occurrence (HALO) events to prepare for emergencies in areas such as obstetrics.

Potential uses of funds could include:

- Technical assistance on forming arrangements/affiliations that lead to new service lines and retention of patients in rural communities to increase rural volume, revenue, and efficiency.
- Needs assessments for rural communities related to strategic planning of services.
- Shared infrastructure, such as patient referral systems, telehealth platforms, population health tools, and other IT investments.

- Investing in AI and other technologies to extend the workforce to improve access for patient population.
- Developing shared regional resources such as affiliation development assistance, training and workforce development, care coordination, and post-discharge placement planning.
- Supporting training for rural clinicians at urban partners for high-intensity, low-volume cases (such as obstetric care or trauma care) to maintain skill levels that ensure continuity of services in rural settings.
- Infrastructure upgrades in order to expand or modify services.
- Use of telementoring for rural providers enabling collaboration and training for managing complex cases and improving quality of services.

Other considerations:

- Funding for provider payments is subject to restrictions described in funding policies and limitations.
- Funding for capital expenditures and infrastructure is subject to restrictions described in funding policies and limitations.
- Limit direct payments to individual providers or facilities without alignment to regional excellence model.
- Arrangements/affiliations should not be contingent on or influence ownership and/or independence of participating providers.

Main strategic goal: Sustainable access

Uses of funds: D, E, F, G, H, I, J, K (non-exhaustive)

Technical score factors: C.1, C.2, E.1, F.1, F.2, F.3 (non-exhaustive)

Key stakeholders: Urban Tertiary Hospitals and Health Systems, Academic Medical Centers, Rural Hospitals, Critical Access Hospitals, Rural Emergency Hospitals, Rural Health Clinics, Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, IHS/Tribal Facilities, Clinicians.

Outcomes (examples, non-exhaustive):

- Increase access to primary care.
- Increase access to specialty care.
- Reduce travel burden for rural patients.
- Improve financial stability of rural hospitals and clinics.
- Increased utilization and patient volumes of rural hospitals and clinics.
- Reduce avoidable transfers of patients from rural to non-rural areas.
- Increase retention of rural clinicians.

- Improve quality of care measures reported by participating rural providers.
- Reduce rates of severe pregnancy complications.

Examples:

- Auburn University Rural Health Initiative
- Project ECHO New Mexico
- Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder
- Kentucky Cancer Program
- UAMS IDHI High-Risk Pregnancy Program
- Illinois Perinatal Quality Collaborative: Reducing Pregnancy Complications from High Blood Pressure

Rural talent recruitment initiative

Description

Help develop, recruit, and retain individuals to support health care services in rural communities. Focus on building a long-term local workforce and supporting pathways for non-physician providers of health care and allied health professionals in rural areas, such as:

- Social workers
- Pharmacists
- Therapists
- Paramedics
- Nurse practitioners
- Certified nurse assistants
- Patient navigators
- Midwives
- Community health workers
- Support staff for rural providers, such as:
  - Lab techs
  - Health IT technicians
  - Cybersecurity experts
  - Billing and coding personnel

For a specific example, maternity care training would support the rural maternity workforce with the necessary skills for pregnancy, labor and delivery, including managing high-risk events. This training may involve

regular virtual and/or in-person sessions as well as access to simulation-based training to address healthcare system deficiencies in rural areas. Provider training should include enhancing telemedicine capabilities which allows the maternal workforce to utilize remote consultation and monitoring technologies effectively. Training for rural maternity care could include a broad spectrum of professionals, from OB-GYNs and midwives to perinatal community health workers.

Potential use of funds could include:

- Development or expansion of non-physician provider and allied health education programs based at or rotating in rural facilities, such as nursing schools, social work programs, licensed practical nurse (LPN) programs, physician assistant rotations, or nurse practitioner residencies.
- Support for the development of rural physician residency programs in high demand rural specialties, such as family medicine, psychiatry, obstetrics, internal medicine, and general surgery, tied to at least 5 years of service spent in rural areas. Similarly, support for the development of residency training programs in community-based outpatient settings in rural communities, tied to at least 5 years of service spent in rural areas.
- Training opportunities for high school students in rural hospitals, such as paramedic or certified nursing assistant courses.
- Programs to support rural students interested in pursuing health careers, such as distance learning options so students may stay in rural areas while studying, support with school applications to pursue health care careers, tutoring, and career coaching.
- Use of telementoring for rural providers enabling continuing education, collaboration, and improving quality and scope of services.
- Activities that support resilience and address burnout amongst healthcare providers to improve retention.
- Local training in rural areas for positions such as community health workers, digital health navigators, care navigators, care coordinators, social workers, behavioral health specialists, and midwives.
- Training for health IT and cybersecurity positions that help with implementing IT systems and health information interoperability.
- Professional advancement such as continued medical education, and support with licensure and clinical supervision in rural areas for positions including clinical social workers, mental health professionals, nurses, and physicians.
- Workforce development and training in rural areas, including upskilling of existing staff, for administrative professionals such as billing and coding,

medical records management, medical receptionist, clinic manager, and schedulers.

- Local housing for students or trainees in rural areas, limited to short-term (less than 6 months) housing for rotations.
- Technical assistance for communities developing health care provider and allied health professional training programs in rural areas.

Other considerations:

- Financial incentives should include a requirement for the provider or healthcare worker to commit at least five years of service in a rural community to receive the benefits.

Main strategic goal: Workforce development

Uses of funds: E, G, H (non-exhaustive)

Technical score factors: B.1, B.2, C.1, D.1 (non-exhaustive)

Key stakeholders: Community Colleges, Universities, Medical Schools, Hospitals, High Schools, Libraries, Community Centers, IHS/Tribal Facilities

Outcomes (examples, non-exhaustive)

- For training programs:
  - Increase in number of students trained annually in rural areas.
  - Total number of training program graduates working in rural areas.
  - Percent of program graduates practicing in a rural area.
  - Increase in rural students in health care professions.
- Retention rates of rural medical professionals.
- Retention rates for health IT staff in rural healthcare facilities.
- Reductions in rural healthcare facility vacancies in health IT and other support staff positions.

Examples:

- HRSA Teaching Health Center Graduate Medical Education
- HRSA Rural Residency Planning and Development
- HRSA Nurse Practitioner Residencies
- HRSA Workforce Training Network Program
- FORWARD NM Pathways to Health Careers
- University of Wisconsin-Madison Rural OBGYN Residency Track
- Rural Hospital and High School Nursing Assistant Partnership

- Simulation in Motion-South Dakota (SIM-SD) EMS Educational Outreach Program
- Advanced EMT Classes in Rural High Schools in Idaho
- Structured Training for Rural Enhancement of Community Health in Obstetrics (STRETCH)
- Area Health Education Centers

Value-based care initiative

Description

Help rural providers, especially those inexperienced with value-based care, participate in value-based care models and position them to deliver proactive, preventive care that is coordinated across the spectrum of health care providers that treat patients.

A State-based or private entity could lead efforts to engage a variety of stakeholders, with the expectation that the value-based arrangement would become self-sustaining over time.

Develop and implement payment mechanisms incentivizing providers, networks, or two-sided risk accountable care organizations (ACOs) to reduce costs by improving care efficiency such as through reducing unnecessary hospital utilization and shifting care to lower cost settings.

Consider empowering providers to participate in CMS Innovation Center models and other established Medicaid and private payer (e.g., Medicaid managed care or Medicare Advantage) value-based payment arrangements (with two-sided risk and evidence-based outcomes improvement) as appropriate.

Potential use of funds could include:

- Technical assistance to help rural providers participate in value-based care, including enhancing their ability to correctly code patients' health status, analyze clinical quality data, implement quality improvement activities, address upstream drivers of health, and utilize appropriate health information technology systems.
- Establish value-based Medicaid payment methodologies, include for specific services such as maternal health and behavioral health. This may include payment incentives for reporting quality metrics and improving quality of care.

- Start-up funding to cover providers' initial costs such as infrastructure, staffing, and equipment to build capacity to participate in advanced payment models and accept two-sided risk.

Other Considerations:

- Funding for provider payments is subject to restrictions described in funding policies and limitations

Main strategic goal: Innovative care

Uses of funds: A, B, D, F, G, H, I, J, K (non-exhaustive)

Technical score factors: B.1, B.2, C.1, E.1, E.2, F.1, F.2 (non-exhaustive)

Key stakeholders: Hospitals, clinicians, Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), State Primary Care Associations, IHS/Tribal Facilities, other rural health care provider types and facilities

Outcomes (examples, non-exhaustive):

- Decreased rates of avoidable hospitalizations and readmissions.
- Decreased rates of avoidable emergency department use.
- Improve management of chronic conditions, such as diabetes and high blood pressure.
- Increase access to specialty care.
- Increase utilization of preventive care, including wellness visits.
- Reduction in the total cost of care for the target population.

Examples:

- Colorado Hospital Transformation Program
- Community Care Partnership of Maine Accountable Care Organization
- Profiles of Value Based Care in Action

Remote care services initiative

Description

Help rural providers in use of remote care services and modern digital solutions to improve the scale, quality, and outcomes of patient engagement to prevent and manage chronic disease.

Provide technical assistance and initial start-up funding. Facilitate rural knowledge sharing to understand emerging technologies and digital tools and how to sustainably and robustly integrate those tools with rural clinical practice and care delivery workflows.

One example target population could include rural patients with pregnancy-related co-morbidities who could benefit from remote patient monitoring to manage conditions that put them at risk for severe maternal morbidity (SMM) and mortality. Such pregnancy-related comorbidities include:

- Hypertension
- Gestational diabetes
- Existing chronic conditions that put them at high risk for complications or adverse outcomes, such as:
  - Diabetes
  - Hypertension
  - Obesity
  - Sickle-cell anemia

In this example, funds could be used for start-up costs for a tech-enabled care program that allows community health workers to help providers collect essential data on pregnant patients by enabling remote patient monitoring. Patients would be given appropriate durable medical equipment to use as part of remote patient monitoring.

Potential use of funds could include:

- Development of a standards-based platform that integrates and stores patient health data from remote monitoring devices and existing health records, enabling seamless exchange, real-time monitoring, and actionable patient and provider alerts.
- Technical assistance to educate and support rural providers on the options and strategies to incorporate and maintain digital solutions.
- Technical assistance for understanding offerings and selecting vendors.
- Technical assistance to help patients by developing digital literacy tools.
- Training for staff using remote care services to ensure compatibility and as a retention strategy to maintain continuity of skills and patient care.
- Software infrastructure for digital health solutions like telehealth and patient engagement tools.
- Training for digital health navigators, nurses, and/or community health workers to help patients learn to use new technologies.
- Hardware capabilities for remote medical screening or interventions.
- Digital health products for preventing and managing chronic disease.
- Digital care navigation tools and infrastructure, such as symptom checking, triage, care guidance and scheduling assistance.

- Assessments and enhancements of technology infrastructure needs.
- Technical assistance on legal and regulatory issues, contracting, and billing and coding support for providers participating in remote care services.
- Mobile health units, vehicles, telehealth equipment, or other remote care services equipment.

Other considerations:

- Funding for provider payments is subject to restrictions described in funding policies and limitations

Main strategic goals: Tech innovation

Uses of funds: A, C, D, F (non-exhaustive)

Technical score factors: B.1, C.1, C.2, E.1, F.1, F.2, F.3 (non-exhaustive)

Key stakeholders: Hospitals, Rural Health Clinics, State Office of Rural Health, Primary Care Associations, Community Colleges, Universities, Medical Schools, IHS/Tribal Facilities.

Outcomes (examples, non-exhaustive):

- Decreased rates of avoidable hospitalizations and readmissions.
- Decreased rates of avoidable emergency department use.
- Increased access to primary care.
- Increased access to specialty care, for example maternal fetal medicine providers.
- Improved management of chronic conditions, such as diabetes and high blood pressure.
- Reduce chronic disease progression in older adults.
- Increase patient satisfaction.
- Increase provider and patient digital literacy.

Examples:

- HRSA Evidence Based Telehealth Network Program
- HRSA Telehealth Resource Center Program
- Digital Therapeutics for Management and Treatment in Behavioral Health
- Rural OB Access and Maternal Services (ROAMS)
- Rural Project Examples: Telehealth

Interoperability infrastructure initiative

Description

Help rural providers invest in technology infrastructure to improve data liquidity and availability between patients, digital health products, and providers. This initiative focuses on goals for enhancing interoperability in the community by creating a long-term sustainable health IT system and workforce. Provide technical assistance to providers and patients to maximize value of their EHRs.

Potential use of funds could include:

- IT and/or technology technical assistance expertise in support of rural providers advancing and maintaining their technology infrastructure.
- Technical assistance with recruiting and training specialized staff.
- Training for providers and IT specialists on cybersecurity and interoperability systems.
- Assessments of the Health IT environment, including cybersecurity assessments.
- EHR, clinical support, and operational software infrastructure investments that enable participation in data exchange and that are also aligned with CMS's Health Technology Ecosystem criteria and ASTP/ONC criteria, as applicable.
- Implementation of patient or provider identity verification solutions that enable secure data exchange.
- Integration of State managed data systems to inform data-driven population health insights and initiatives.
- Enhancements to streamline EHR workflows to fit rural communities.
- Support for cybersecurity and assistance to rural health facilities to achieve HHS' Cybersecurity Performance Goals.
- Assessment of technology infrastructure needs and enhancement of technology infrastructure.

Other Considerations:

- State should consider sustainability plan addressing long term maintenance and upgrade costs to maintain utility of information exchange systems over time.

Main strategic goal: Tech Innovation

Uses of funds: C, D, F (non-exhaustive)

Technical score factors: B.1, C.1, C.2, E.1, F.2 (non-exhaustive)

Key stakeholders: Hospitals, Rural Health Clinics, Primary Care Associations, Community Centers, IHS/Tribal Facilities

Outcomes (examples, non-exhaustive):

- Reduce burden on providers for sharing medical records.
- Reduce clinical errors with improved patient data accuracy and data availability during transfers and referrals.
- More rapid diagnosis and treatment of serious medical conditions.
- Improve metrics on health care data interoperability within a State.
- Increase EHR data exchange compatibility among health care networks.
- Enhance cybersecurity practices and systems in rural health care organizations.

Examples:

- CMS Health Technology Ecosystem – Interoperability Framework
- ONC/ASTP The Trusted Exchange Framework and Common Agreement
- HRSA Telehealth Resource Center Program

Rural tech catalyst fund initiative

Description

As technology continues to progress at a rapid pace, health tech solutions that leverage next generation technology developed with a focus on the unique challenges of rural communities have the potential to accelerate improved quality, expanded access, and reduced cost of care for rural residents. Historically, rural populations have had less focus from health tech startups and from venture capital sourcesfocused on rural solutions. Rural residents also have a slower uptake in digital health adoption.[3],[4] States can encourage the development and adoption of emerging health tech innovation focused on rural populations that improve quality, expand access, and reduce cost of care. This initiative should focus on promoting consumer-facing, technology-driven solutions (including those that support evidence-based, measurable interventions) for prevention and management of chronic diseases, for which traditional government funding sources and private commercial incentives have proven inadequate or insufficient to drive development and innovation.

Potential use of funds could include:

- States provide funds to be managed by an office with deep health care expertise, health care company operating experience, and experience assessing early-stage health care companies, which may not charge fees to the State for activities in connection with this initiative. This deep expertise and infrastructure should either already exist at the State level (e.g. an existing State-run startup funding vehicle) or be delegated from the State to a sophisticated strategic-aligned group (e.g. local health system startup incubator or payor startup incubator).
- This office will solicit and vet competitive proposals from vendors to develop one or more State-defined technological solutions that meet the requirements of this initiative. This initiative must comport with federal regulations on intangible property in 2 CFR 200.315, including, without limitation, that CMS reserves (and the State must ensure that reserved to CMS is) a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use a copyrighted work developed with RHT Program funds for federal purposes, and to authorize others to do so. The State and subrecipients are subject to applicable regulations governing patents and inventions, including those in 37 CFR Part 401. The vendor may own the product developed, including associated intellectual property, and may commercialize it, to the extent consistent with these and all other applicable federal requirements.
- This initiative also must comport (along with all other applicable federal regulations) with the federal regulations at 2 CFR 200.307 and 2 CFR 300.218 (eff. Oct. 1, 2025; 2 CFR 300.218 not yet in the Code of Federal Regulations (CFR), text available at 89 FR 80055), including without limitation, regarding program income and profit.

Other considerations:

- The State's proposal for a rural tech catalyst fund initiative must specifically describe the products or services that the State believes are currently unavailable and not likely to be obtainable through traditional government funding structures or private market incentives. The proposal must describe how the State will provide adequate oversight, including ensuring that all initiative funds are:
    - Paid to the end product developer no later than the end of the fiscal period for which the funds are available; and
    - Used for CMS-approved purposes.

- No more than (1) 10% of funding allocated to a State in a budget period or (2) $20M of total funding awarded to a State in a budget period, whichever is less, may be used to support this initiative.
- Funds must go to support innovations that:
  - Serve rural communities, with a focus on or special consideration for their particular needs and challenges;
  - Benefit Medicaid, low-income, and/or vulnerable rural consumers;
  - Focus on prevention and management of chronic diseases;
  - Are significantly different from or fulfil an unmet need compared to the existing landscape of products and solutions; and
  - Increase quality, affordability, and access to care.
- Company profiles must be:
  - Preference for funding of companies that directly deliver or enable care
  - Less than 10 years since founding and with less than $50M prior funding raised
  - Must be U.S.-based and U.S.-owned businesses, with preference for companies that will perform the RHT Program-supported work in the U.S. with U.S. employees and, if applicable, contractors
- Total funding awards to any one Company:
  - Cannot be more than $3M of non-dilutive funding (funding that does not require the recipient to give up equity or ownership)
  - Must be contingent such that it is earned through clear interim milestones and measurable benchmarks for technical progress and outcomes, defined by the entity managing the funding and approved by the State and CMS
  - Must be contingent on data-sharing and reporting with the State and product accessibility requirements. The specific requirements will be specified by the State with input from the entity managing the funding, and approved by CMS.
  - Must be awarded to companies subject to a competitive process with clear qualification criteria and requirements for preventing conflicts of interest. The process, criteria, and requirements must be approved by CMS
  - Must come with some degree of collaboration with and oversight by the State

- If funding decision making is delegated to a non-State entity (a sophisticated strategic-aligned group such as a local health system startup incubator or payor startup incubator):
  - The non-State entity should be selected via a transparent process that avoids conflicts of interest, with the process approved by CMS
  - The non-State entity should be associated with a strategic-aligned healthcare organization (e.g. health system, payor, academic institution, etc.)
  - The non-State entity may not charge fees to the State for activities in connection with this initiative
  - The non-State entity may co-invest funding from separate funding vehicles in the same company
- All federal legal requirements applicable to the State's proposed initiative must be satisfied.

Main strategic goal: Tech innovation

Uses of funds: A, C (non-exhaustive)

Technical score factors: F.3

Key stakeholders: Health Systems, Payors, Academic Institutions, Providers, Patients and Consumers, Private Investors and Venture Capital Firms, Tech Industry, State Government Entities

Outcomes (examples, non-exhaustive):

- Number of Medicaid beneficiaries and/or low-income patients served in rural areas through the funded innovations
- Improved patient outcomes from funded innovations, with a focus on chronic disease management
- Robust user engagement metrics

Examples:

- The Digital Health Sandbox Program
- Launch Minnesota

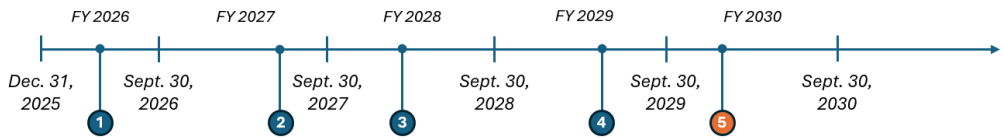
Examples of State funding amount assessment

For initiative-based factors

This example is for illustrative purposes only.

1. During application process

State writes an application, which includes detailed information on various initiatives/projects that it plans to use funding for within its Project Narrative and Budget Narrative sections. Each initiative/project includes a timeline with major milestones, as described in the Project Narrative section. For *purely hypothetical and illustrative purposes*, a State describes one of its initiatives as aligning to "C. 1. Rural provider strategic partnerships", and generally describes the timeline and milestones as follows:



Based on State's description of each Milestone within its application:

- Milestone 1: Reflects ~15% completion of this initiative
- Milestone 2: Reflects ~30% completion of this initiative
- Milestone 3: Reflects ~50% completion of this initiative
- Milestone 4: Reflects ~75% completion of this initiative
- Milestone 5: Reflects ~100% completion of this initiative – initiative has reached its goal and is producing measurable outcomes

2. During application assessment process

- Merit review panel assesses the quality of the initiatives in the State's application using information from the project narrative and budget narrative sections.
- The panel decides on a full score potential (FSP) between 0 and 20 points for each scoring category (adding up to 0 to 100 points total for each initiative-based factor).
- The panel uses Table 2 in the Merit review section to decide on the FSP.

3. Points scoring impacting funding

For budget period 1 funding:

- State receives 50% credit of FSP based on merit review panel assessment of initiative:

Point Score for C. 1. Rural provider strategic partnerships Influencing Year 1 Funding = 50% * FSP = **Base Credit**

For budget period 2 funding:

- Based on information from regular correspondence with CMS program officers and annual reporting in 2026, CMS assesses that this initiative has reached Milestone 1 (~15% total initiative completion). The State has earned corresponding incremental points credit above the Base Credit

Point Score for C. 1. Rural provider strategic partnerships Influencing Year 2 Funding = Base Credit + 15% * 50% * FSP

For budget period 3 funding:

- Based on information from regular correspondence with CMS program officers and annual reporting in 2027, CMS assesses that this initiative has reached approximately half-way between Milestones 2 and Milestones 3 (~40% total initiative completion). The State has earned corresponding incremental points credit above the Base Credit

Point Score for C. 1. Rural provider strategic partnerships Influencing Year 3 Funding = Base Credit + 40% * 50% * FSP

For budget period 4 funding:

- Based on information from regular correspondence with CMS program officers and annual reporting in 2028, CMS assesses that this initiative has reached approximately 80% between Milestones 3 and Milestones 4 (~70% total initiative completion). The State has earned corresponding incremental points credit above the Base Credit

Point Score for C. 1. Rural provider strategic partnerships Influencing Year 4 Funding = Base Credit + 70% * 50% * FSP

For budget period 5 funding:

- Based on information from regular correspondence with CMS program officers and annual reporting in 2029, CMS assesses that

this initiative has reached Milestone 5 (~100% total initiative completion). The State has reached the initiative goal and has been reporting on outcomes metrics. The State has earned the full score potential

Point Score for C. 1. Rural provider strategic partnerships Influencing Year 5 Funding = **FSP**

For state policy action factors

This example is for illustrative purposes only.

1. ### Current state policy

   This example will be based on D. 2. Licensure compacts.

   A State's current licensure compact policies are as follows:

   - Interstate Medical Licensure Compact (Physician LC): IMLC Member State non-SPL issuing licenses ONLY
   - Nurse Licensure Compact (Nurse LC): No licensure compact in place
   - Emergency Medical Services Compact (EMS LC): Member State
   - Psychology Interjurisdictional Compact (Psychology LC): No licensure compact in place
   - Physician Assistant Compact (PA LC): No licensure compact in place

2. ### During application assessment process

   - Based on a State's current State policy, CMS assesses a **Current Credit**
   - In its application, a State commits to State policy actions to:
     - Physician LC: Upgrade to IMLC Member State serving as State of Principal License (SPL) processing applications and issuing licenses (i.e., a higher commitment for a Member State)
     - Nurse LC: Join the Nurse Licensure Compact
   - For Current Credit: States receive full credit based on where its State policy is currently at
   - For additional credit for application commitments: States receive 50% of full credit, where full credit reflects if the commitment was an enacted State policy
   - A State can assess its Point Score credit for its Current Credit and commitments in the appendix. The appendix describes "full credit" for enacted State policies

To calculate the **Current Credit** (current score), multiply the point values for each LC by 20%. Add the sum of these values together.

Current Physician LC = 20% * 50 points

Current Nurse LC = 20% * 0 points

Current EMS LC = 20% * 100 points

Current Psychology LC = 20% * 0 points

Current PA LC = 20% * 0 points

In this example, the **Current Credit** is 30.0 points.

3. Points scoring impacting funding

For budget period 1 funding:

- State received Current Credit and 50% of incremental points to full credit for policy action commitments in its application

Points for D. 2. Licensure Compact Influencing Year 1 Funding =

Current Credit + Incremental Physician LC + Incremental Nurse LC + Incremental EMS LC + Incremental Psychology LC + Incremental PA LC =

30.0 Points + (100 – 50) * 50% * 20% + (100 – 0) * 50% * 20% + 0 + 0 + 0 = 45.00 Points

For budget period 2 funding:

- State is in process of enacting Physician LC and Nurse LC State policy changes committed to in its application

Points for D. 2. Licensure Compact Influencing Year 2 Funding =

Current Credit + Incremental Physician LC + Incremental Nurse LC + Incremental EMS LC + Incremental Psychology LC + Incremental PA LC =

30.0 Points + (100 – 50) * 50% * 20% + (100 – 0) * 50% * 20% + 0 + 0 + 0 = 45.00 Points

For budget period 3 funding:

- State is in process of enacting Physician LC and Nurse LC State policy changes committed to in its application

Points for D. 2. Licensure Compact Influencing Year 3 Funding =

Current Credit + Incremental Physician LC + Incremental Nurse LC + Incremental EMS LC + Incremental Psychology LC + Incremental PA LC =

30.0 Points + (100 – 50) * 50% * 20% + (100 – 0) * 50% * 20% + 0 + 0 + 0 = 45.00 Points

For budget period 4 funding:

Scenario A

- State successfully enacts Physician LC and Nurse LC State policy changes committed to in its application by the end of calendar year 2027

Points for D. 2. Licensure Compact Influencing Year 4 Funding =

Current Credit + Incremental Physician LC + Incremental Nurse LC + Incremental EMS LC + Incremental Psychology LC + Incremental PA LC =

30.0 Points + (100 – 50) * 100% * 20% + (100 – 0) * 100% * 20% + 0 + 0 + 0 = 60 Points

Scenario B

- State does not successfully enact Physician LC and Nurse LC State policy changes committed to in its application by the end of calendar year 2027

Points for D. 2. Licensure Compact Influencing Year 4 Funding =

Current Credit + Incremental Physician LC + Incremental Nurse LC + Incremental EMS LC + Incremental Psychology LC + Incremental PA LC =

30.0 Points + 0 + 0 + 0 + 0 + 0 = 30.0 Points

- In addition, funding will be recovered for Budget Period 1, Budget Period 2, and Budget Period 3 payments. The amount of funding recovered is the amount attributed to the **incremental** 15.00 Points earned each budget period

For budget period 5 funding:

Scenario A

- State continues to receive same points score as the prior year.

Points for D. 2. Licensure Compact Influencing Year 5 Funding = 60 Points

Scenario B

- State continues to receive same points score as the prior year.

Points for D. 2. Licensure Compact Influencing Year 5 Funding = 30 Points

Endnotes

1. Pub. L. No. 119-21, § 71401 (July 4, 2025) (codified at 42 U.S.C. § 1397ee(h)) (“Rural Health Transformation Program”). ↑
2. Formation of strategic partnerships should not be contingent on or influence ownership and/or independence of participating providers. ↑
3. https://rockhealth.com/insights/startup-innovation-for-underserved-groups-2021-digital-health-consumer-adoption-insights/ ↑
4. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/nacrhhs-oct-2024-tech-brief.pdf ↑