10.8.2025

Rural Health Transformation Program (RHTP)

Public Forum

Zoom Meeting Tips

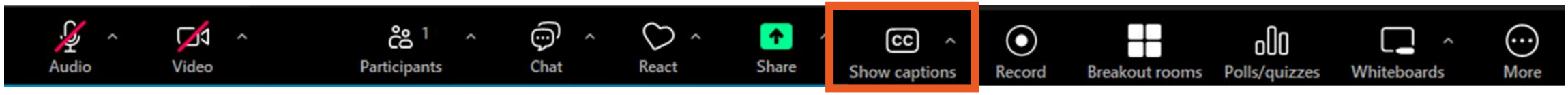
Use chat to ask questions.

- We'd like this session to be interactive, so we'll be saving the chat.
- If you want to ask a question verbally, feel free to raise your hand.

This webinar is being recorded.

- We'll share it with participants after the presentation.

For live captioning, please click on the "cc" button at the bottom of your screen.



RHTP Public Forum Agenda

Time	Agenda Item
6:30 – 6:35	Welcome & housekeeping
6:35 – 6:45	Background and timeline of the RHT Program
6:45 – 6:50	Summary of public comments received in September
6:50 – 7:15	Oregon's transformation plan framework and proposed initiatives
7:15 – end of forum	Discussion and Q&A

Discussion Questions - Preview

Initiatives:

- Are any of these initiatives higher or lower priority for you?
- Are we missing anything you'd expect to see included?

Implementation Design:

- What challenges do you foresee in implementing these potential activities in your local or organizational context?
- Do you have initial reactions as it relates to an RHTP advisory body?
  - Is there an existing body that could take on this role?

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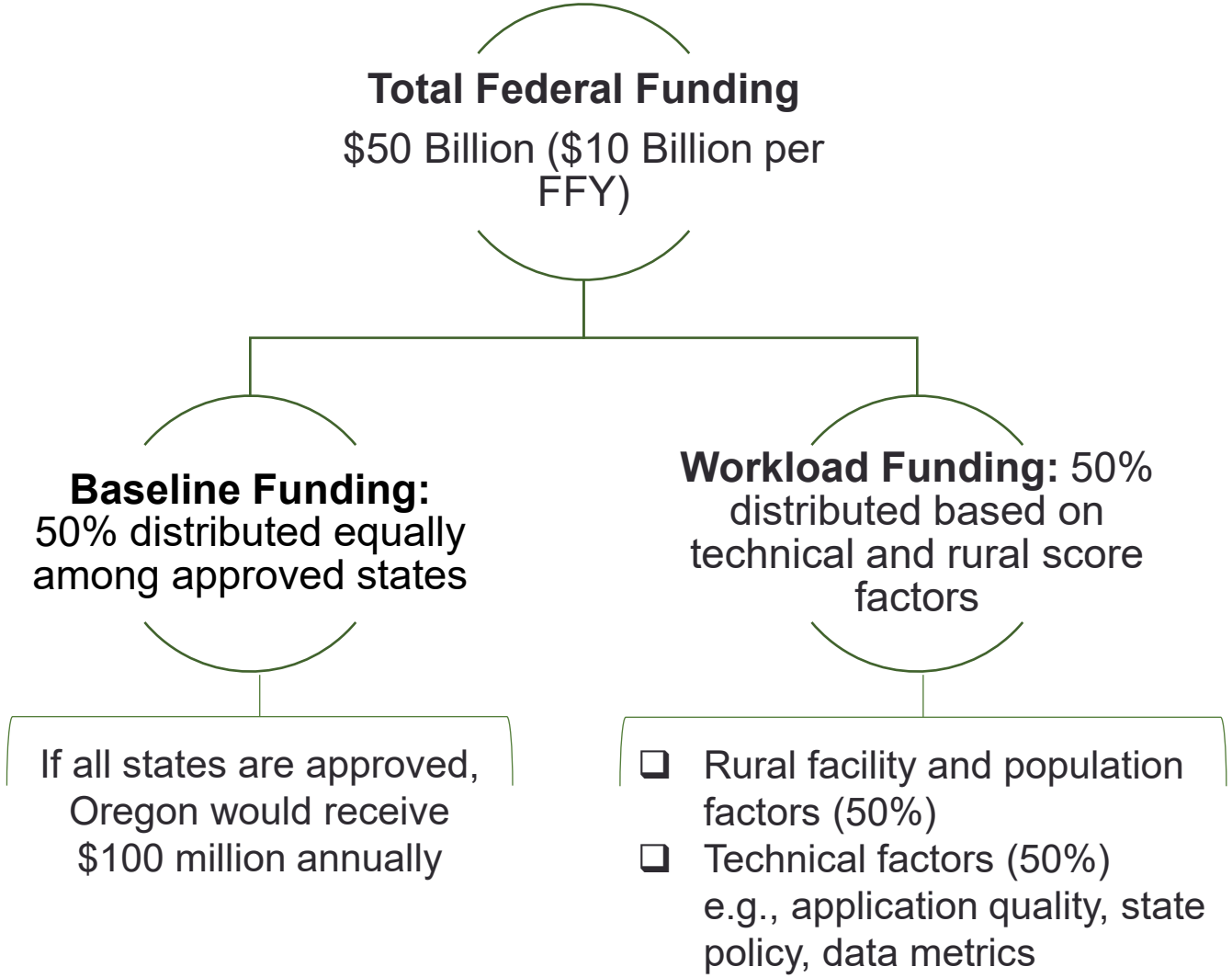
RHTP Background and Timeline

Background

- H.R. 1, the Trump Administration's federal budget reconciliation bill, was signed into law on July 4, 2025, introducing an estimated $15 billion in cuts to federal funding from Oregon for health insurance coverage, food benefits, and other programs.
- H.R. 1 establishes a one-time, five-year Rural Health Transformation Program (RHTP), which makes funding available to states for health-related activities supporting rural communities and rural health system transformation.
- The Centers for Medicare & Medicaid Services (CMS) is charged with administering the program as a cooperative agreement.
- **Federal funding through RHTP is not intended to offset H.R. 1 Medicaid cuts.**

Funding Framework

- A total of $50 billion made available to awarded states from federal fiscal year (FFY) 2026 through FFY 2030
  - $10 billion distributed per FFY
- Approved states may use up to 10% of funds for administrative expenses
- Each FFY's funds are available through the following FFY



CMS RHTP Strategic Goals

Make Rural America Healthy Again	• Support rural health innovation and new access points to promote disease prevention, chronic disease management, behavioral health, and prenatal care.
Sustainable Access	• Improve efficiency and sustainability of long-term access points through high-quality regional systems and coordinated operations, technology, primary and specialty care, and emergency services.
Workforce Development	• Attract and retain a high-skilled workforce with a broader set of health care providers who are supported in practicing at the top of their license.
Innovative Care	• Spark the growth of innovative care models and develop and implement payment mechanisms to improve quality, outcomes, and care coordination, and shift care to lower cost settings.
Tech Innovation	• Foster investment and use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools for rural facilities, providers, and patients.

RHTP Application Components

Rural Health Transformation Plan	Project Narrative and Proposed Initiatives	Budget Narrative
Detailed plan that presents Oregon's vision, goals, and strategies for transforming rural health.	Key components include alignment with CMS' strategic goals and permissible uses of funds, clear performance and outcome metrics, strong partnership engagement, and detailed plans for sustainability and implementation.	Detailed description for costs linked to each activity and explanation for dividing expenses between lead agency and subcontracted partners.

Uses of Funds

States must commit to using funds for three or more of the health-related activities below:

1. Promote chronic disease management
2. Pay health care providers
3. Promote consumer-facing tech for chronic disease management
4. Train and assist rural hospitals in adopting technology-enabled solutions
5. Recruit and retain clinical workforce in rural areas with 5-year service commitments
6. Provide IT support to improve efficiency, cybersecurity, and patient outcomes
7. Help rural communities right-size delivery systems
8. Expand access to opioid, substance use, and mental health treatment
9. Develop innovative care models, including value-based and alternative payment models
10. Invest in rural health care facility infrastructure
11. Foster and strengthen strategic partnerships between local and regional partners

Aug-Sep Public Comment Learnings

Public Comment Themes

OHA sought public comment in August and September 2025 via structured survey. We received over 240 responses to questions addressing areas of unmet need, ready-to-launch projects, regionally coordinated partnerships and strategies, and evidence-based initiatives to strengthen care delivery.

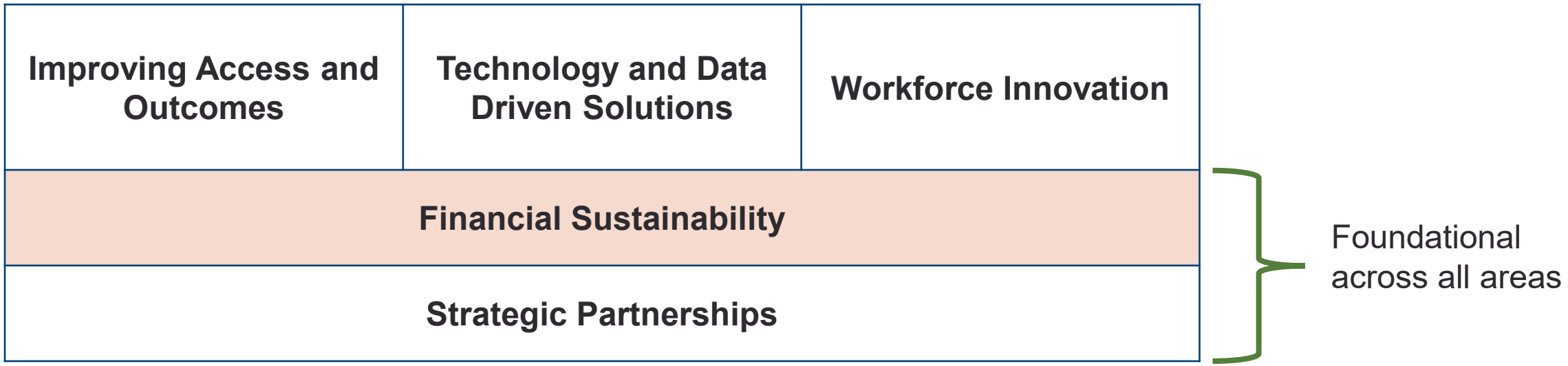
Top Challenges Identified:

1. **Workforce Development** – Lack of robust training programs, recruitment & retention difficulties, housing shortages, and insufficient professional development and support across all provider types.
2. **Access to Care** – Service gaps all around, including dental, mental health, pharmacy, and specialty care. Limited transportation and long travel distances. EMS shortages and unstable workforce.
3. **Chronic Disease Management and Prevention** – Higher rates of preventable diseases. Limited prevention programs and access to specialists. Need for more community-based solutions, care coordination, and CHW-led programs.
4. **Telehealth & Technology**– Insufficient investment in digital infrastructure, technologies, and telehealth services for patient access and provider efficiency.
5. **Behavioral Health & SUD** – Severe shortages in behavioral health services, including addiction treatment. Need for more integration with primary care and outpatient services, especially for youth.
6. **Financial Instability** – Insufficient reimbursement rates and concerns about Medicaid cuts. Rural hospitals and clinics operating at a loss.
7. **Maternal & Child Health** – Maternity deserts, closures of L&D units, and lack of alternative perinatal care and early childhood interventions.
8. **Data & Quality Infrastructure** – Lack of capital to update HIT systems with improved EHRs, real-time analytics, and shared platforms.

Oregon's Transformation Plan Framework and Proposed Initiatives

Oregon's RHTP Transformation Plan

- **Goal:** Ensuring all people and communities in rural Oregon can achieve optimum physical, mental, and social well-being at every life stage. This will be achieved through strong partnerships, innovation, prevention, and access to quality, affordable health care.
- **Strategies:** Oregon's rural health transformation will be anchored in the following focus areas:

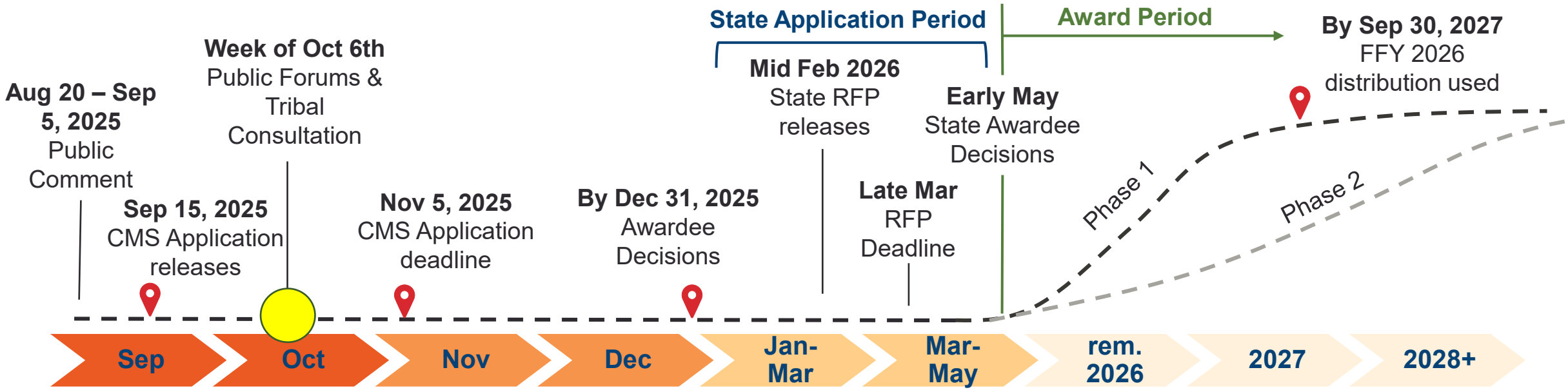


Framing the Initiatives

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

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

Funding Distribution Timeline and Phases



Application Development

Intragovernmental coordination and external engagement to develop rural health strategy

Program Design

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

Program Preparation

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

Phase 1: Fast-Track Deployment (FFY 2026 Focus)

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

Phase 2: Sustain and Grow (FFY 2027+)

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

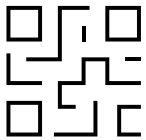
*All dates are proposed and contingent on CMS award decisions.

Proposed Initiatives

Healthy Communities & Prevention

Regional Partnerships and Systems Coordination

Workforce Capacity & Resilience



Technology & Data Modernization

1. Healthy Communities & Prevention

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

Future vision:

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

1. Healthy Communities & Prevention

Proposed Use of Funds	Proposed Disbursement Plan
• Targeted investments in stabilizing services lines that are most strained or under-resourced in rural communities, including primary care, BH services and EMS services • Innovative access points (e.g., schools, mobile clinics, remote pharmaceutical dispensing) • Consumer-facing technology and AI-enabled tools for chronic disease management • Community-based programs to promote healthy behaviors (e.g., nutrition education, chronic disease self-management programs) • Expand maternal health care team (e.g., doulas, lactation consultants, and CHWs) • Risk-appropriate Labor & Delivery coordination and services (e.g., free-standing birth center) • Community-based services that support families through residential treatment programs • Care navigation connecting members to mental health and SUD resources	• RFP to small rural facilities, clinics, counties, etc. • RFP for statewide coordinated case management • Direct funding or wrap-around payments

2. Regional Partnerships and Systems Coordination

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

Future vision:

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

2. Regional Partnerships and Systems Coordination

Proposed Use of Funds	Proposed Disbursement Plan
Phase 1 • Start-up funding to support regional planning efforts (e.g., developing shared resources, shared workforce, and targeted service line expansion) • Assistance in setting up organization frameworks (e.g., clinically integrated networks) • Investments in care coordination models supporting integration of primary care, behavioral health, and social health services **Phase 2** • Implementation of shared/distributed network services, such as telehealth services, network-wide staff recruitment and retention, billing and coding support for providers • Implementation of regional solutions that build in efficiencies in the delivery of care that can improve financial status and enhance sustainability while providing a pathway to value-based care	• RFP to hospitals or regional collaboratives

3. Workforce Capacity & Resilience

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

Future vision:

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

3. Workforce Capacity & Resilience

Proposed Use of Funds	Proposed Disbursement Plan
• Rural physician, nursing, and advanced practice provider residency programs in high-need specialties, including family medicine, obstetrics/maternity care, and psychiatry • Rural behavioral health fellowships and clinical apprenticeship programs • Tele-mentoring training for rural providers • Mobile simulation trainings for rural hospitals and ERs • Training programs for Community Health Workers, school-based mental health service providers, palliative care doulas, etc. • Rural preceptor recruitment and training models for programs including pharmacy and nursing • Programs to support rural students interested in pursuing health careers • Supporting and funding housing solutions and incentivizing collaboration between local employer and private sector	• RFP to hospitals, medical schools, and clinical training or placement sites • State-distribution (RFA) for new medical residency programs

4. Technology and Data Modernization

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

Future vision:

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

4. Technology and Data Modernization

Proposed Use of Funds	Proposed Disbursement Plan
• Population health software and clinical support tools • AI-enabled tools and other technologies to extend the workforce and decrease administrative burden • Electronic Health Records (EHR) modernization • Interoperable technology systems across CBOs, hospitals, health centers, local health departments, clinics, behavioral health, and other social supports	• RFP for organizations to allow for independent and regional solutions and purchases

State Policy and Program Alignment

Proposed Initiatives	Alignment Opportunities
Healthy Communities & Prevention	Aligns with existing state-led efforts, such as public health grants, enhanced maternity payments, home visiting programs, and allied health professional training programs.
Regional Partnerships and Systems Coordination	May leverage existing partnerships and infrastructure to provide targeted technical assistance, peer learning opportunities, and support the convening of experts and partners focused on developing short and long-term solutions to regionally specific challenges and at-risk services, such as maternity care.
Workforce Capacity & Resilience	Opportunities to leverage the Health Care Provider Incentive Program to reach more individuals and a broader range of provider types while ensuring alignment with RHTP goals and needs.
Technology and Data Modernization	May support existing and future Health Information Exchange and Community Information Exchange efforts by offering technical assistance and support for projects that complement RHTP investments among all providers types.

Tribal Initiative/Tribal Set-Aside

- OHA has received requests for inclusion of Tribes & NARA in the RHTP.
- The CMS definition of FQHC used in HR1 includes any Tribal 638 and Urban Indian Health Programs.
- Following our policy, a “Dear Tribal Leader Letter” has been sent and a collective Nine Tribes Consultation/Confer is scheduled for 10/10. Individual consultations will be scheduled as requested.

Initiatives and Uses of Funds Crosswalk

	Healthy Communities and Prevention	Regional Partnerships and Systems Coordination	Rural Workforce Capacity & Resilience	Technology and Data Modernization	*Tribal Set-aside
Prevention & chronic disease management	●	●		●	
Provider payments (with restrictions)	●		●		
Consumer tech solutions	●			●	
Training & technical assistance	●			●	
Workforce recruitment & retention		●	●		*Types of permissible projects to be determined at Tribal Consultation
IT advances & cybersecurity	●	●		●	
Right-sizing care availability		●	●		
Behavioral health & substance use disorder services	●		●		
Innovative care/value-based models	●		●		
Capital expenditures (≤20%)				●	
Partnership-building		●		●	

Advisory body

Some states are considering an advisory committee for their RHTP implementation.

Oregon is considering an external advisory committee for 2026 to support planning and launch of RHTP.

- **Pros:** Connects State with external partners to ensure collaboration; strengthens alignment with other activities; provides enhanced transparency
- **Cons**: Admin dollars from RHTP funds will be needed to staff and support this committee; time commitment may be burdensome; wary of potential conflicts of interest; timelines will be very rapid and could require a lot of coordination

Discussion

Initiatives:

- Are any of these initiatives higher or lower priority for you?
- Are we missing anything you'd expect to see included?

Implementation Design:

- What challenges do you foresee in implementing these potential activities in your local or organizational context?
- Do you have initial reactions as it relates to an RHTP advisory body?
  - Is there an existing body that could provide this?

Public Survey on Proposed Initiatives

- OHA is seeking feedback from the public on the proposed initiative areas through a short survey available from **October 8 to October 15, 2025, 11:59 PM.**
  - **Links to OHA RHTP webpage and survey**
- Respondents are asked to share their opinion on whether each of the proposed initiatives would improve health care for rural Oregonians and to rank the potential initiatives by impact.
- Survey responses will be considered for revisions to the current proposed RHTP framework and initiatives; however, responses will not be considered an application, nor weighed in any subsequent application process, for individual program funding.

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Thank You

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

Appendix

Other Considerations

- H.R. 1 does not place limitations on types of entities that can receive funding through RHTP; only the discretionary portion (50%) requires CMS to consider rural representation.
  - States decide which entities receive funding. Oregon intends to direct this funding to high-need health care services for rural communities.
- RHTP is structured as a “Cooperative Agreement,” so states should expect more involvement, including detailed reporting and technical assistance, from CMS than typical grant programs would necessitate.

RHT Program Use of Funds Requirements

Approved states may use funds awarded by CMS to invest in at least three of the permissible uses below:

- **Prevention and chronic disease**
- **Provider payments** (no more than 15% of total funds)
- **Consumer tech solutions**
- **Training and technical assistance**
- **Workforce** (commitment to serve rural communities for 5 years)
- **Information technology advances** (subject to restrictions)
- **Appropriate care availability**
- **Mental health (MH) and substance use disorder (SUD)**
- **Innovative care**

Additional uses, as determined by the Administrator:

- **Capital expenditures and infrastructure** (including minor building alterations or renovations and equipment upgrades, subject to restrictions; no more than 20% of total funds)
- **Fostering collaboration** (strengthening local and regional partnerships; both rural and other participating providers)

Note: No more than 10% of the amount allotted to a state for a budget period may be used by the state for administrative expenses. This 10% limit applies to administrative costs for the entire budget, including indirect and direct costs. See appendix for more information unallowable costs.

Funding Policies and Limitations

CMS will not allow the following costs:

- **Pre-award costs.**
- **Meeting matching requirements for any other federal funds or local entities.**
- **Services, equipment, or supports that are the legal responsibility of another party** under federal, State, or tribal law, such as vocational rehabilitation or education services.
- **Services, equipment, or supports that are the legal responsibility of another party under any civil rights law**, such as modifying a workplace or providing accommodations that are obligations under law.
- **Goods or services not allocable to the project.**
- **Supplanting existing State, local, tribal, or private funding** of infrastructure or services, such as staff salaries.
- **Construction or building expansion,** purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increases the value of the capital or useful life as a direct cost.
- **The cost of independent research and development**, including their proportionate share of indirect costs. See 2 CFR 300.477.
- **Funds related to any activity designed to influence** the enactment of legislation, appropriations, regulation, administrative action, or executive order.
- **Purchase of covered telecommunications and video surveillance equipment** (See 2 CFR 200.216) as well as financial assistance to households for installation and monthly broadband internet costs.
- **Meals**, unless in limited circumstances such as:
  - Subjects and patients under study.
  - Where specifically approved as part of the project or program activity, such as in programs providing children's services.
  - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.
- **Activities prohibited under 2 CFR 200.450 and the HHS Grants Policy Statement**, including but not limited to: Paying the salary or expenses of any grant recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any State government, State legislature, or local legislature or legislative body.
- **Lobbying**, but awardees can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying.

RHT Program Specific Limitations

CMS will also not allow the following RHT-specific costs:

- **New construction.** Supplanting funding for in-process or planned construction projects or directing funding towards new construction builds is unallowable. Renovations or alterations, as described in category J of the program requirements and expectations use of funds section, are allowed if they are clearly linked to program goals.
  - **Category J funding cannot exceed 20% of the total funding** CMS awards states in a given budget period.
- **To replace payment for clinical services that could be reimbursed by insurance. CMS will not accept payments to clinical services if they duplicate billable services and/or attempt to change payment amounts of existing fee schedules.** (If a state plans to fund direct health care services, the state must justify why they are not already reimbursable, how the payment will fill a gap in care coverage (such as uncompensated care or services not covered by insurance), and/or how they transform the current care delivery model.)
  - **Funding for provider payments**, as described in category B of the program requirements and expectations use of funds section, **cannot exceed 15% of the total funding** CMS awards states in a given budget period.
  - **Funding cannot be used for initiatives that fund certain cosmetic and experimental procedures** that fall within the definition of a specified **sex-trait modification procedure** at 45 CFR 156.400 because that is beyond the scope of this program.
- **No more than 5% of total funding CMS awards to a state in a given budget period can support funding the replacement of an EMR system** if a previous HITECH certified EMR system is already in place as of September 1, 2025.
- **Funding towards initiatives similar to the "Rural Tech Catalyst Fund Initiative"** (as described in the appendix) cannot exceed the lesser of (1) 10% of total funding awarded to a State in a given budget period or (2) $20M of total funding awarded to a State in a given budget period, and funding is subject to all restrictions and requirements described in the example initiative
- **Clinician salaries or wage supports** for facilities that subject clinicians to **non-compete contractual limitations**.
- **None of the funding shall be used by the state for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law.**
- SSA Section 2105(c), paragraphs (1), (7), and (9) apply as funding limitations. These limitations are related to general limitations, limitations on **payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.**