GRANT MAKERS IN HEALTH

ISSUE FOCUS

# Rural Health Transformation Program: Opportunities for Philanthropy

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# INTRODUCTION

The Rural Health Transformation (RHT) Program was created as part of H.R.1, a budget reconciliation bill that included significant reductions to federal health care spending. Federal Medicaid spending alone will be reduced by $911 billion over 10 years and, according to the Congressional Budget Office, lead to 10 million more people becoming uninsured by 2034 (Levinson and Neuman 2025).

While these cuts will have significant consequences for millions of people across the country, regardless of geography, particular concerns were raised about the harm to rural hospitals and communities (Rodriguez 2025). Thus, as part of the legislation, $50 billion was appropriated as a Centers for Medicare & Medicaid Services (CMS) administered grant program to provide states with funds to "strengthen rural communities across America by improving health care access, quality, and outcomes by transforming the health care delivery ecosystem" over five years (CMS March 2026).

The following issue brief is a high-level analysis of major themes as identified from initiatives and strategies in state applications, reflecting the primary foci of each state's RHT program. Based on this analysis, we offer several recommendations for grantmaker investment and action in support of RHT initiatives and, ultimately, improving the health and well-being of rural communities. We would like to acknowledge that this issue brief would not have been possible without support from Dogwood Health Trust and the Robert Wood Johnson Foundation.

# OVERVIEW OF THE RHT PROGRAM

The RHT Program has five strategic goals:

1. **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.
2. **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.
3. **Workforce development.** Attract and retain a high-skilled health care workforce by strengthening recruitment and retention of health care 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 health care system.
4. **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 to reduce health care costs, improve quality of care, and shift care to lower cost settings.
5. **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.

These funds, which will be distributed via a CMS cooperative agreement with each state, must be leveraged in at least 3 of 10 approved ways that align with the strategic goals of the program. Each year, 50 percent of $10 billion will be allocated evenly among the 50 states (territories and the District of Columbia are not eligible), while the other 50 percent will be allocated by CMS based on a variety of factors including rural population, the proportion of rural health facilities in the state, the situation of certain hospitals in the state, and other factors (CMS March 2026). The year one awards have been announced by CMS, with states receiving an average of about $200 million. Broken down by population, this generally equates to about $100 to $500 per rural resident (Levinson et al. 2026).

While RHT offers states with a unique opportunity to invest in a variety of innovations, this flexibility comes at a cost. The program's $50 billion investment in rural is just a little over one-third (37 percent) of the estimated loss of federal Medicaid funding in rural areas. Furthermore, RHT is a five-year grant program—the

cuts to Medicaid and other federal health programs will extend far beyond that time horizon (Levinson and Neuman 2025). Concerns have also been raised about whether the lofty goals of RHT can be met with $50 billion over a five-year period. As Katherine Hempstead of the Robert Wood Johnson Foundation put it, "[It] is too upstream, too short term, and too small to meaningfully address the immediate and worsening financial problems of many rural health systems across the country" (Hempstead 2026).

While many of the program's criticisms have validity, many experts do view RHT as an opportunity for meaningful reform and change. Some, like Alan Morgan of the National Rural Health Association, see RHT as a "once-in-a-lifetime opportunity to redesign the healthcare system in rural America with an eye toward sustainability" (JAHF 2026). Along these lines, some see RHT as the federal government's way of catching rural up in adopting value-based payment mechanisms. Regardless of perspective, the fact remains that this federal investment is moving forward, and it is imperative for grantmakers to consider what opportunities may exist to support these initiatives, as they have the potential to provide real benefit to rural communities.

# ANALYSIS OF STATE RHT APPLICATIONS

Every state applied for RHT funding based on their unique needs and CMS-aligned goals. Most (46) have made their applications public, with four (Delaware, Illinois, Mississippi, and New York) having yet to do so or only providing summaries. Each state proposed 5 to 10 initiatives, which are titled programs, including a proposed cost. Initiatives range from expanding the rural health care workforce to programming targeting populations and issue areas.

Within each initiative there are strategies that provide additional details on specific programmatic and operational activities. While some applications may have made brief reference to many of the themes below as part of a larger initiative or strategy, this analysis does not include such instances as they may not be ultimately undertaken. What follows are some of the most common focuses identified across the applications.

Overall, the major areas states chose to address in their RHT applications are the rural health care workforce shortage, promoting technological innovation, increasing access to primary health care, and improving access to maternal health services (see Table 1). The analysis revealed that many states presented their initiatives and strategies at a high level, with limited details about how their plans will be operationalized and structured. There are many gray areas for how best to capture and categorize the content of the applications. The final cooperative agreements with CMS should provide more clarity, but they may also deviate from what was originally presented in the applications. This will be something for grantmakers and the field to monitor.

### TABLE 1. OVERVIEW OF STATE RHT STRATEGIES AND INITIATIVES

| Themes | Initiatives/Strategies | States |
|---|---|---|
| Increasing Access to Primary Care Services | Regional Care Centers | **20** (AL, CA, FL, GA, HI, ID, IN, IA, KY, MA, MI, MO, NE, NJ, NC, OR, PA, RI, WV, WY) |
| | Expanding Emergency Medical Services (EMS) | **37** (AL, AK, AZ, AR, CO, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MA, MN, MO, MT, NV, NH, NJ, NM, NY, NC, ND, OH, OR, PA, RI, UT, VT, VA, WA, WV, WY) |
| | Expanding Mobile Units | **20** (AL, AK, AZ, CT, DE, GA, ID, KY, ME, MD, NE, NH, ND, SC, TN, UT, VT, VA, WA, WV) |

| Themes | Initiatives/Strategies | States |
| --- | --- | --- |
| Workforce Development | Incentive Programs | **23** (AL, AK, AR, CA, CT, DE, GA, ID, IL, IN, KS, LA, MA, MN, MO, NV, OK, OH, SD, TN, WA, WV, WY) |
| | Continuing Education and Training Programs | **43** (AL, AK, AZ, AR, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, ME, MD, MA, MI, MN, MO, MT, NV, NH, NJ, NM, NY, NC, ND, OH, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY) |
| | Scholarships or Pipeline Programs | **33** (AL, AK, AR, CA, CT, GA, HI, ID, IL, IN, KS, LA, ME, MD, MA, MI, MN, NE, NH, NM, OK, NC, PA, RI, TN, TX, VT, VA, WA, WV, WI, WY) |
| Technological Innovation | Expanding Telehealth Access | **48** (AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, OK, NY, ND, OH, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY) |
| | Electronic Health Records (EHR) and Health Information Exchanges (HIE) | **34** (AL, CA, CT, FL, GA, HI, ID, IL, IA, KS, LA, ME, MD, MA, MO, MT, NH, NJ, NM, OK, ND, OH, OR, RI, SC, SD, TX, UT, VA, WA, WV, WI) |
| Maternal Health | | **35** (AL, AK, AZ, AR, CA, CO, CT, FL, GA, ID, IN, KY, LA, ME, MD, MA, MI, MO, NE, NH, NM, NY, NC, OH, OK, OR, PA, RI, SD, TN, UT, VT, VA, WA, WY) |

## Increasing Access to Primary Care Services

Every state proposed an initiative to expand access to primary care in one form or another; hub-and-spoke models were the most common strategies proposed. Twenty states proposed building new regional care centers. Common state initiatives focused on care coordination and improving communication between primary care centers by improving the state's technology infrastructure. For example, Georgia's "Connecting to Care to Improve Healthcare Access" would create additional telehealth hubs and mobile units. The telehealth hubs would connect universities, rural hospitals, and public health services to improve care at multiple levels. Additionally, the state included strategies to improve transportation infrastructure between regional care centers, EMS networks, and elder care coordination.

Most states are relying on EMS and mobile units to act as the "spokes" to expand their network of care. Thirty-seven states included strategies to improve or expand their EMS services. Strategies included workforce incentive programs, modernizing data sharing between EMS and providers, and equipment investments (e.g., vehicles, medical equipment, and medical supplies). For example, Illinois proposed a designated EMS

initiative that emphasizes the need for expanding mobile health care units to lessen the burden on EMS for routine medical care. Their proposal focuses on using "Treat-In-Place" and "Treat-and-Refer" models, all with the goal of decreasing the burden on smaller EMS systems.

Twenty states requested funding to strengthen and broaden the reach of their mobile health care programs, many with the stated purpose of investing in preventative mobile health care to lessen the burden on their EMS systems. These units range from oral health care, chronic disease management, behavioral health services, OBGYN services, and simulation labs for workforce development. For example, West Virginia proposed its "Rural Health Link" program, which would unify communications between all health transport units and triage incoming calls based on severity.

A notable area where applications lacked attention is to Tribal health. Despite geographic overlap and significant health disparities found in Tribal populations, only seven states (Alaska, Idaho, Kansas, New Mexico, Oregon, Washington, and Wisconsin) prioritized strategies to improve Tribal health care. Oregon and Washington are the only states that proposed full, standalone Tribal health care initiatives.

## Workforce Development

Initiatives to expand, train, and retain the rural workforce were the largest category across proposals, with every state requesting funding. Twenty-three of these states focused on incentive programs, and 43 states proposed continuing education programs to attract existing clinicians. A common incentive was states paying for the clinician's relocation or housing costs. Multiple states plan to fund "grow your own" pipeline workforce efforts through early exposure for high school students, expanding community college rural health care programs, and adding rural rotations to state medical schools. For example, Michigan's "High School to Health Care Pipeline" program would provide scholarships and employment opportunities for high school students interested in health care in rural areas. The pipeline also proposes continuing education opportunities for EMS, behavioral health, community health, and maternal health workers.

## Technological Innovation

Modernizing rural health technology infrastructure and increasing access to telehealth services was the second largest initiative addressed with 48 states requesting funding. Thirty-four states addressed Electronic Health Records (EHR) and Health Information Exchanges were the most common areas cited to streamline patient data access across health systems. A few states proposed updating their clinician-to-pharmacist EHR. While every state proposed increasing access to telehealth services, only a handful of states mentioned increasing broadband access. For example, Arizona proposed its "Making Rural Healthcare Accessible" initiative, a comprehensive effort that would improve access to preventative care, integrate telehealth services, expand EMS, provide for broadband updates, and update digital access points across the state. Oklahoma proposed a dual approach to strengthen regional partnerships and leverage the data-sharing infrastructure to reduce the administrative burden on smaller health care centers.

## Expanding Access to Maternal Health Services

Many states (35) proposed expanding access to maternal health services through birthing centers and mobile clinics (Hasan et al. 2026). Others proposed initiatives like maternal behavioral health clinics and increasing access to prenatal chronic disease screening. States also proposed technical assistance initiatives, including maternal workforce development and technology infrastructure advancements. For example, Alabama's "Maternal and Fetal Health Initiative" proposes to implement telerobotic ultrasound technology at regional hubs, adding labor and delivery carts to emergency rooms without those services, and workforce programs for midwives.

## Other Notable Trends

- Thirty-two states proposed initiatives to expand long-term care systems for older adults and 19 of those initiatives focused on nursing homes. Twenty-five states proposed reforms to care and coordination for individuals with dual eligibility in Medicaid and Medicare. Seventeen states proposed initiatives relating to aging in place and healthy aging. Ten states proposed initiatives to create or strengthen their Program for All-Inclusive Care for the Elderly programs, which focuses on care for older adults living at home or retirement community (Taggart 2026).
- Twenty-seven states proposed an initiative relating to behavioral health services. Strategies included: integrating primary and behavioral health care and increasing workforce development (Galbreath 2026). Twelve states proposed creating or improving Certified Community Behavioral Health Clinics.
- Twenty-five states proposed strategies to expand oral health care, and workforce and mobile unit initiatives were the most common approaches (D'Alessandro 2026). One example is Kentucky's rural dentist initiative, which proposed increasing dental hygiene training programs and expanding preventative treatment using mobile units and clinics.
- Twenty-three states, such as Indiana, proposed some type of regranting program with states pushing funds to the county level.
- Twenty-one states proposed adopting some form of Value-Based Care payment reform, such as Per-member-per-month, Shared Savings, and Achieving Healthcare Efficiency through Accountable Design.
- Seventeen states proposed initiatives to expand food access and healthy eating active living programs. Seven states proposed Food is Medicine programs to increase access to whole foods and decrease chronic diseases.
- Five states (Florida, Georgia, Hawaii, South Dakota, and Virginia) included strategies to educate people on Medicare and Medicaid eligibility and streamline the user experience.

# LEAD STATE IMPLEMENTATION AGENCIES

Each state has identified a lead implementation agency that will coordinate the release and expenditure of their RHT award dollars. In most cases, either the state department of health and/or the state Medicaid office are the leads for RHT implementation. They serve as an important point of entry and contact regarding all RHT-related activities. Depending on which agency or agencies are leading the effort, there are significant implications for decisionmaking and strategy.

**TABLE 2. OVERVIEW OF STATE LEAD IMPLEMENTATION AGENCIES**

| Lead State Implementation Agency | States |
| --- | --- |
| Department of Health | **19** (AK, CA, LA, MD, ME, MI, MN, MT, NC, NE, ND, NY, OH, OK, SD, TN, WI, WV, WY) |
| Medicaid | **15** (AZ, CA, CO, FL, IL, MA, MO, NM, NV, PA, RI, SC, TX, VA, WA) |
| Medicaid and Department of Health | **9** (DE, IA, ID, IN, KS, NJ, OR, UT, VT) |
| Central Administrative/Executive Agency | **4** (AL, AR, GA, HI) |
| Governor's Office | **2** (MS, NH) |
| Department of Public Health | **1** (KY) |

Source: Lopez et al. 2026

# WHAT'S NEXT FOR THE RHT PROGRAM

With awards decided and announced in December 2025, CMS will be engaged in continuous monitoring and support with the states for the rest of the calendar year through 2030. So far this has included the 2026 Rural Health Transformation Summit, which was hosted by CMS on March 18th.

As of April 2026, CMS is still in the process of negotiating and finalizing many state cooperative agreements. Those states which have completed their negotiations with CMS, or soon will, are focused on quickly and efficiently distributing federal funds to stay on track with CMS reporting and oversight requirements to maintain their annual awards. Reporting templates will be released later this year, but states will be required to report progress at the initiative-level using the Checkpoint Model, which focuses on the completion of milestones, metric reporting, and post-program planning. Early indications are that federal technical assistance funds to support the states may not be available until the end of 2026.

# OPPORTUNITIES FOR GRANTMAKERS

The RHT Program presents many opportunities for grantmakers; perhaps most importantly, a chance to better direct resources into rural communities. A forthcoming Grantmakers In Health (GIH) survey of over 200 grantmaking organizations confirms new and existing research on the lack of philanthropic resources reaching rural communities. As a recent U.S. Department of Agriculture Rural Development Innovation Center report found, only three percent of total funding from grantmaking organizations is going to rural (USDA 2026). According to the GIH survey, only about one-in-five (18 percent) of funders allocate 50 percent or more of their health grant dollars to rural communities, with about a third (32.6 percent) of funders allocating between 10 and 49 percent. Furthermore, only around a quarter (26.2 percent) of funders said they were increasing funding or changing funding tactics over the next 1–2 years. Nearly half (49 percent) said they were not changing their approach to funding in rural and a quarter (24.8 percent) were unsure of any changes (GIH 2026).

When queried about involvement in the RHT, the survey found only about one-in-five (21 percent) funders are or are planning to become involved in RHT activities, with another one-in-five (18 percent) unsure about their organization's plans. This leaves over 60 percent of funders firmly on the sidelines of a major federal investment in rural (GIH 2026). There are likely a myriad of reasons for individual grantmakers opting out of engaging, but it does raise concerns that philanthropy is opting to be absent.

With these concerns in mind, there are many potential roles for health philanthropy in RHT implementation. Funders have been critical leaders and partners in many similar efforts, and there is still time to become involved. The following are recommendations for philanthropic action and investment based on our analysis of RHT applications and feedback from key stakeholders in rural health and philanthropy.

## **Recommendation 1:** *Provide matching, supplemental, and flexible funds.*

There may be opportunities for philanthropy to enter public-private partnerships with state agencies around specific projects and initiatives. While much will depend on the final cooperative agreements and guidance from CMS, there is likely to be a need for additional support vital to the program that cannot be funded by federal funds. This could include providing technical assistance or core support grants, providing matching grant dollars to help offset costs, or collaborating with state agencies to identify and fill gaps (e.g., public communication and outreach).

Supplemental or matching funds for specific initiatives could be critical to the initial success of state RHT programs. There is general concern across sectors regarding the uncertainty of year-to-year federal funding; CMS has been clear that it is not guaranteed. If philanthropy is at the table and partnering with states, this could provide some feeling of security that initiatives will not be fully beholden to federal investment in the short- and long-term.

Flexible funding in support of RHT initiatives will be especially important, as indications are CMS will be placing significant restrictions on how state award dollars can be allocated for various activities. Workforce initiatives in particular may be an area where philanthropy can make a significant impact. Provider payments have been capped by CMS at 15 percent of the state's award (Searing 2025). States have also raised concerns that, due to time and budgetary constraints, large pre-existing provider contracts could be prioritized over smaller providers who are more likely based in rural communities.

Another example of a philanthropic opportunity in workforce is around provider certification and commitments. Several state RHT applications have focused on developing courses and certifications that, due to CMS regulations, would include an automatic five-year rural service commitment. For providers such as community health workers, such a long commitment may be deterrent and at a significant overall cost. If funders were to support the cost of certifications, for example, this would bypass the required five-year period and provide more flexibility for providers and lower costs overall.

## **Recommendation 2:** *Convene relevant stakeholders.*

A critical aspect of the RHT program is receiving input from communities and stakeholders that will be engaged in or impacted by these initiatives. One of philanthropy's greatest strengths is as a neutral convener that can reach not only into community but across sectors. Some important sectors that will be critical partners in RHT implementation that grantmakers may have that state health agencies often do not are education (school-based health) and transportation (mobile health integration). As each state begins the implementation process, it will not only be critical for states to have a platform to engage with key stakeholders but also to receive input as plans are formulated.

Some grantmaking organizations, like the Mat-Su Health Foundation, have hosted listening sessions that helped inform state applications and early planning. The foundation is now an official regional convener for the state of Alaska and will continue to be a key partner. Other foundations, such as The John A. Hartford Foundation, have focused on providing nonpartisan outreach and informational calls to better inform and engage stakeholders and communities around RHT (JAHF 2026).

Convening stakeholders around the RHT Program also offers an important opportunity to bring people together around larger rural health transformation efforts. As has been consistently emphasized, RHT is only a five-year investment, and true systems change will require a longer time horizon. Funders have a unique window of opportunity to use RHT as a catalyst for longer and broader dialogues around what is needed in each state to complete the process.

## **Recommendation 3:** *Provide state agencies and rural organizations with strategic technical assistance and guidance.*

Given philanthropy's grantmaking and programmatic expertise, funders have an opportunity to engage as direct implementation partners, including as grantmaking intermediaries, with states. This role is especially important as states are feeling pressure to distribute funds as quickly and efficiently as possible. For example, the Virginia Health Care Foundation is serving as a key partner in Virginia Rural Vitality, the

Commonwealth's multi-year Rural Health Transformation initiative. In this role, the foundation is acting as an intermediary, managing funding opportunities to support rural providers in implementing interoperability and productivity solutions (VHCF 2026).

While it remains unclear, there could also be opportunities to assist states with creating sustainability plans. While CMS has denied states the ability to use funds to create "an endowment, capital fund, or other vehicle resembling an investment fund with the purpose of generating income," Wyoming is still waiting to hear whether its Rural Health Transformation Perpetuity Fund will be approved (Zionts 2026). If it is, it could open an innovative avenue for sustaining RHT initiatives where grantmakers could be critical advisors or partners. If not, and in most cases, philanthropy can help states think through sustainability strategies to ensure the work continues beyond the RHT Program.

There are also ways grantmakers can engage and support RHT efforts without directly investing. Early analysis and conversations with states indicate a wide disparity in how federal funds will be leveraged, and there is concern that some states may not be taking a systems level approach. Philanthropy has an important wealth of experience in not only funding systems change but also being connected with critical change agents who are often grantees. Funders should engage their state's lead implementation agency in an advisory capacity to help guide these funds to places that will be transformational rather than short-term investments.

The Foundation for Opioid Response Efforts, for example, released an issue brief to share lessons learned from 10 grantees with the goal of informing states' implementation plans by sharing "innovative models for expanding access to prevention, treatment, and recovery supports in rural and frontier areas" (FORE 2026). Grantmakers have extensive networks of grantees, community partners, collaboratives, and coalitions that can be partners that both inform the implementation process and aid the initiative directly. Funders can not only help connect lead implementation agencies with these potential partners but also help to share their stories and work.

Rural communities and organizations will also need direct technical assistance. Many do not have the capacity or experience applying for large federal programs such as RHT and could easily find themselves discouraged from or at a great disadvantage when applying for funds. Grantmakers can provide vital support and resources to ensure these critical partners and stakeholders are not left out of the program.

## **Recommendation 4:** *Support data collection and monitoring efforts.*

Tracking the impact of the RHT Program in and of itself can provide invaluable insights into innovations that improve rural health. This could prove especially important in identifying which initiatives and interventions to scale following the five years of the RHT Program.

But there are also more practical reasons for working with the state on data collection and monitoring. The RHT Program is a cooperative agreement between the state and CMS; as such, grant funds are not guaranteed across all five years. CMS has stated that continued funding is contingent upon, among others, satisfactory performance (CMS Feb 2026). Thus, data collection and analysis will be critical. States have varying capacities for such efforts, and they may be under additional strain given state budget crises. Thus, support for data collection that demonstrates progress will be critical.

## Recommendation 5: *Support peer learning and feedback networks.*

There is a significant need to connect states with one another as the planning and implementation process unfolds. This will not only allow for shared learning but, if properly organized, can provide CMS and other relevant federal offices with important, real-time feedback over the course of RHT. There are federal technical assistance funds at CMS to support state RHT efforts, but when and how they will be released is still unclear. Supplemental or bridge funding may be essential to successful RHT launches.

While the National Academy for State Health Policy and the National Organization of State Offices of Rural Health (NOSORH) are among seven national technical assistance organizations convening and supporting state officials and agencies through the application process and beyond, theirs and similar efforts would greatly benefit from philanthropic support. The W.K. Kellogg Foundation, for example, provided NOSORH with support for a National Information Hub that connected states to rural-focused expertise as they prepared their RHT applications (NOSORH 2026).

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The RHT Program offers an important opportunity for implementing new health innovations, expanding existing programs, and catalyzing systems-level health efforts in rural communities. Given the limitations and conditions of the CMS funds, there are numerous opportunities for funders to get involved. Regardless of approach, funders should contact their state lead implementation agencies to better understand their state's application and connect on what role they can take to best support RHT implementation.

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