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CMS Releases Rural Health Transformation Funding Opportunity

By Anne Karl, Avi Herring, Liz Osius, and Jacob Rains, Manatt Health

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The Big Picture

On September 15, the Centers for Medicare & Medicaid Services (CMS) released a Notice of Funding Opportunity (NOFO) for states to apply for funds under the $50 billion Rural Health Transformation (RHT) Program, established by H.R.1 (P.L. 119-21). Funding will be distributed over five years beginning in 2026, with $25 billion allocated equally across all states with approved applications ("baseline funding") and $25 billion distributed based on: (1) state rurality factors identified by CMS, (2) a qualitative assessment of state initiatives included in the application, (3) state adoption of or commitment to specific policy actions prioritized by CMS, and (4) other CMS identified priorities (this discretionary portion is referred to as "workload funding").

The NOFO includes considerable detail on the $25 billion in workload funding, which CMS has reframed to align with the Administration's Make America Healthy Again (MAHA) agenda, with a focus on prevention and chronic disease management, access to care, workforce development, innovative care models, and fostering the use of technology. For this portion of funding, CMS developed a detailed scoring methodology that includes 23 factors it will consider in making awards—many of which are not mentioned in H.R.1—ranging from current state policies on Supplemental Nutrition Assistance Program (SNAP), telehealth, scope of practice, and certificate of need (CON) to a state's total square miles. Notably, CMS intends to tie the distribution of workload funding in years two through five to each state's program performance on CMS' score factors, creating additional uncertainty in a state's funding allocations, given that the amount awarded from the $25 billion workload funding pool may fluctuate annually.

Per H.R.1, states must commit to investing in at least three priority areas, such as prevention and chronic disease initiatives, payments to healthcare providers, or clinical workforce recruitment and retention, and submit an RHT strategic plan outlining their vision and goals for rural health transformation. Applications are due November 5, with CMS required by statute to make awards by December 31.

Eligible Applicants

Per H.R.1, only the 50 states[1] are allowed to apply and receive funding from the RHT Program. The NOFO clarifies that states are allowed to involve partners, including universities, local health departments, and provider associations, in designing and implementing planned initiatives and may sub-award or contract with partners to administer initiatives after funding has been awarded.

Allowable Uses of Funding

The NOFO establishes new parameters on permissible uses of funds and adds two new categories beyond those outlined in H.R.1; states must still propose investments in at least three of the following permitted uses:

Permissible Use of Funds	Notable Parameters
Prevention and Chronic Disease: Implementing evidence-based, measurable interventions to improve prevention and chronic disease management.	
Provider Payments: Supporting payments to providers for delivering healthcare services that fill a gap in care coverage (e.g., uncompensated care).	States may not spend more than 15% of the funding they receive on this initiative category in a given budget period.
Consumer Technology Solutions: Expanding consumer-facing, technology-driven tools for chronic disease prevention and management.	
Training and Technical Assistance: Building capacity for adoption of technology-enabled solutions in rural hospitals.	
Workforce: Recruiting and retaining clinicians in rural areas, with a minimum five-year service commitment.	
IT Advances: Upgrading information technology at rural health facilities to improve efficiency and health outcomes.	States may not spend more than 5% of awarded funding in a given budget period on electronic medical record (EMR) upgrades if a previous Health Information Technology for Economic and Clinical Health (HITECH) Act certified EMR system was in place as of September 1, 2025. In addition, state spending on initiatives similar to the "Rural Tech

[1] The District of Columbia and U.S. Territories are not eligible

Permissible Use of Funds	Notable Parameters
	Catalyst Fund Initiative”[2] cannot exceed the lesser of 10% or $20 million per budget period.
Right-Sizing Care Availability: Helping rural communities align healthcare service lines (preventive, ambulatory, emergency, inpatient, post-acute) with community needs.	
Behavioral Health: Expanding access to opioid-use disorder treatment, other substance-use disorder services, and mental healthcare.	
Innovative Care Models: Supporting value-based care, alternative payment models, and other innovative delivery arrangements.	
Capital Expenditures and Infrastructure: Investing in facility upgrades, minor renovations, and equipment to ensure sustainable operations.	States may not spend more than 20% of the funding they receive on this initiative category in a given budget period.
Community Collaboration: Fostering partnerships between rural facilities and other providers to strengthen quality, financial stability, and access.[3]	Initiatives should fund both rural providers and other participating providers (e.g. academic medical centers or other tertiary providers); programs should also avoid models aimed solely at increasing referrals to tertiary providers

CMS outlined several funding prohibitions and limitations in the NOFO, including support for new construction and building expansions, clinician salaries or wages at facilities with non-compete agreements, expenditures associated with financing the non-federal share of program costs, replacing payment for clinical services that could be reimbursed by insurance, payments for abortions, and requirements related to documenting citizenship.[4]

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[2] The NOFO’s appendix describes this type of initiative as a process in which the state or its subcontractor solicits competitive proposals from vendors to develop one or more state-defined technological solutions for rural counties, focused on chronic disease prevention and management, among other requirements.

[3] The final two allowable use categories go beyond those defined in H.R.1 as enacted.

[4] Although the NOFO does not address restrictions related to citizenship or immigration status in detail, the NOFO expressly applies citizenship documentation requirements to payments made “with respect to an individual.” This likely impacts RHT funds that go towards health services, and could potentially have implications for certain infrastructure improvements. Further guidance from CMS is needed to determine how states can account for costs to ensure RHT Program funds benefit eligible individuals.

Administrative costs, including direct and indirect, remain capped at 10% of the funding awarded for each state, as set forth in H.R.1.

Notable Application Components

The NOFO offers a detailed description of what states must include in their RHT Program applications including the following key components:

- **RHT Plan**. Each state must submit a transformation plan that outlines how it will improve access to care and health outcomes for rural residents, expand the use of technology that emphasizes prevention and chronic disease management, foster partnerships, expand the clinical workforce in rural areas, implement data-driven solutions, implement strategies that improve the financial solvency of rural health providers, and address the root causes of rural hospitals' risk of closure. States must also include:
    - **Program Objectives.** States must outline what they will achieve by the end of the funding period (Fiscal Year (FY) 2031) with specific and measurable objectives, including both baseline data and targets.
    - **Initiative Profiles.** States are required to detail each proposed initiative, including an implementation plan and timeline, expected outcomes and performance measures, alignment with CMS' strategic goals[5] and key factors in the RHT scoring methodology, and stakeholders involved in the initiative. Performance measures must be described as a part of a detailed metrics and evaluation plan.[6] Initiatives will be evaluated on clarity, completeness, quality of the proposed initiative, direct impact to rural residents and areas and "how transformative the initiative is in relation to the state's baseline." CMS provides several example initiative profiles in the NOFO appendix for states' reference.
    - **Overarching Implementation Plan and Timeline**. In addition to a per initiative implementation plan and timeline, states must also submit an overarching plan associated with general program set-up that describes the governance and project management structure and an approach to coordinating among state health agencies, with CMS noting that frequent communication and a defined decision-making process will be key.

[5] CMS' strategic goals for the RHT program include: (1) make rural America healthy again, (2) ensure sustainable access to care, (3) expand the workforce, (4) expand innovative care models, and (5) foster use of innovative technologies through the RHT Program.

[6] CMS notes that while not required, a formal evaluation plan can strengthen a state's proposal.

   - **Stakeholder Engagement**. States must describe how they have involved and will involve rural stakeholders when planning and carrying out this program.

   - **Policy Landscape.** States must submit descriptions of current state policy—and can be rewarded for committing to future legislative or regulatory action—across a disparate list of policy domains, including state telehealth laws, scope of practice regulations, CON, and efforts to promote integration among individuals eligible for Medicaid and Medicare, among others.

   - **Sustainability Plan.** States must describe how they plan to sustain successful initiatives after the RHT Program funding ends (after FY 31).

- **Budget Narrative.** CMS is instructing states to develop a budget narrative as a part of their application for illustrative purposes, budgeting $200 million per year over five years across the states' proposed initiatives. These budgets should reflect “best estimates” of the cost to operate each proposed initiative, and states will have the opportunity to revise them in their annual reports to CMS. Actual award amounts may be larger or smaller than $200 million per year based on CMS’ review of applications.

- **Governor’s Endorsement.** All applications must include a letter from the state’s governor endorsing the RHT application, certifying that the application was developed in consultation with certain state agencies, and committing to state-level changes to ensure the success of the state’s transformation plan including state-level legislative or regulatory changes.

Distribution and Scoring Methodology

While the NOFO reiterated that half of the $50 billion will be distributed equally across all states with complete[7] and approved applications (“baseline funding”), it provided extensive new detail on what factors will be taken into account for the remaining discretionary funds (the “workload funding”). The “workload funding” will be awarded based on two equally weighted criteria: (1) Rural Facility and Population Factors, and (2) Technical Score Factors, which reflect a grab bag of Administration priorities. States will need to navigate this broad set of factors as they develop their applications but are not required to propose initiatives that address them all. For each factor, CMS has outlined what type of information will be considered in its evaluation (a state’s *data*, description of *initiatives*, and/or state *policies*) and a specific scoring approach.[8] Each state will submit information to CMS on these factors to inform their score.

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[7] CMS emphasizes the importance of ensuring an application is complete and responsive to all eligibility criteria, noting that CMS may allow for the correction of minor errors if time allows but that this opportunity is not guaranteed.

[8] CMS intends to use a variety of approaches when ranking states for scoring purposes. For example, for the absolute size of a rural population in a state, CMS will establish a percentile ranking for each state and divide it by

Specifically, CMS will weight the scoring factors as follows:

Factor	Weight	Factor Type
Rural Facility and Population Score Factors (50% of Score)		
Absolute size of rural population in a state	10%	Data
Proportion of rural health facilities in the state	10%	Data
Uncompensated care in a state	10%	Data
Percentage of state population located in rural areas	6%	Data
Metrics that define a state as being frontier	6%	Data
Area of a state in total square miles	5%	Data
Percentage of hospitals in a state that receive Medicaid Disproportionate Share Hospital (DSH) payments	3%	Data
Technical Score Factors (50% of Score)		
Population health clinical infrastructure	3.75%	Initiative
Health and lifestyle	3.75%	Initiative, Policy
SNAP waivers	3.75%	Policy
Nutrition Continuing Medical Education	1.75%	Policy
Rural provider strategic partnerships	3.75%	Initiative
Emergency Medical Services (EMS)	3.75%	Initiative
CON	1.75%	Policy
Talent recruitment	3.75%	Initiative
Licensure compacts	1.75%	Policy
Scope of practice	1.75%	Policy
Medicaid provider payment incentives	3.75%	Initiative
Individuals dually eligible for Medicare and Medicaid	3.75%	Initiative, Data
Short-term, limited-duration insurance (STLDI)	1.75%	Policy
Remote care services	3.75%	Initiative, Policy
Data infrastructure	3.75%	Initiative, Data
Consumer-facing technology	3.75%	Initiative

Notably, there is considerable variation in how states rank across the rural facility and population score factors. For example, according to U.S. Census Bureau data, Texas, North Carolina, and Pennsylvania have the highest number of rural residents, while Vermont, Maine, and West Virginia rank highest on the percentage of state population located in rural areas.[9] Other factors, such as the percentage of hospitals in a state that receive DSH payments, may

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the sum of all percentile rankings with that value multiplied by 100. For the Nutrition Continuing Medical Education factor, CMS will multiply 100 points by a state's 0 to 100 point score and divide that value by the sum of all states' 0 to 100 point scores.

[9] CMS will score each state's performance on these factors using the Health Resources and Services Administration (HRSA) rural definition (HRSA, 2025); 50-state information based on this definition is not available.

disadvantage states that rely heavily on Medicaid state directed payments (SDPs) and as a result make DSH payments to fewer hospitals.[10]

Technical factors that will be scored in part or in whole based on whether a state's policies align with the Administration's priorities are also worth highlighting for their mixture of focus areas. For some factors, states will earn credit based on current practice, though more often states will receive increasing points over time for planning to and then implementing these policy changes. Factors that will be scored based on a state policy component are:

- **Health and lifestyle:** Beginning in year two, a state's score for this factor will, in part, be calculated based on whether a state requires schools to reestablish the Presidential Fitness Test.[11]
- **SNAP waivers:** States will be scored for this factor based on whether they have a pending or approved SNAP waiver that prohibits the purchase of non-nutritious foods.
- **Nutrition Continuing Medical Education (CME):** States beginning in year two will be scored for this factor based on whether they require nutrition to be a component of CME.
- **CON:** States will receive higher scores if they do not have CON restrictions across nine facility types (e.g., inpatient services, outpatient services, long-term care) **as of January 1, 2024.**
- **Licensure compacts:** States will receive higher scores if they participate or plan to participate in compacts for physicians, physician assistants, nurses, EMS, and psychologists.
- **Scope of practice:** States with less restrictive scope of practice regulations for physician assistants, nurse practitioners, pharmacists, and dental hygienists will receive higher scores.
- **STLDI:** States with restrictions on STDLI that are more restrictive than the latest federal guidance or regulation will receive lower scores.
- **Remote care services:** States that have Medicaid payment policies in place for multiple types of telehealth (e.g., live video, store and forward), remote patient monitoring,

[10] Hospitals in states with large SDP programs often have less room under the hospital-specific DSH limit to receive DSH payments.
[11] On July 31, 2025, President Trump signed an executive order reestablishing the Presidential Fitness Test, a physical fitness test completed by middle and high school students in public schools from the 1950s until 2013.

along with policies that promote streamlined licensing for clinicians delivering telehealth services, will receive higher scores.

CMS will rely on an array of data sources to evaluate state applications, including government data (e.g., data from U.S. Census Bureau), data from industry groups (e.g., American Association of Nurse Practitioners), and think tanks (e.g., Cicero Institute).

While the rural facility and population factors will be assessed just once in the fourth quarter of 2025, the technical score factors will be re-assessed annually to measure progress over time toward the objectives each state identifies for its initiatives. As a result, the distribution of workload funding in years two through five will partly depend on each state's program performance, creating additional uncertainty in a state's funding allocation given the amount awarded from the $25 billion workload funding pool may fluctuate annually.

Post-Award Expenditure of Funds

Funds will be awarded annually by CMS for five years. States will have two years from the time each annual allotment of funds is made to expend funds. Unused funds must be returned to the federal government, and CMS can decrease a state's funding or terminate its award entirely if the state fails to meet RHT program requirements. If states receive funds based on a commitment to change state policy that is not effectuated, the Administration can recoup the associated points and funds during later years of the program.

Application Timeline

States will need to work quickly to build out applications to CMS in advance of the November 5 application deadline. CMS will hold two webinars in the coming weeks to educate states on the funding opportunity and answer questions. As a part of the application process, states have the option to submit a non-binding letter of intent by September 30, informing CMS of their plan to submit an application. CMS expects to notify states and make awards by December 31.

Looking Ahead

States have approximately seven weeks to prepare their RHT Program applications. Each state's governor, as a part of this process, is required to designate a lead agency responsible for application development, for example, the state's Department of Health and Human Services or Medicaid agency. States in developing their applications will need to consult with key stakeholders, including the state health agency, state office of rural health, state Medicaid agency, the state's tribal affairs office or liaison, and Indian healthcare providers. Many states have already released requests for information to gather ideas for initiatives from stakeholders, and now will look to sharpen those proposals to align with the allowable uses of funding and scoring criteria outlined by CMS. Stakeholders should look out for additional opportunities to engage with states as they develop their applications in the coming weeks.

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