Tandem Research

ADVISORY BRIEF

Rural Health Transformation Program: FY2026 State Award Summary and Cross-State Themes

An analysis of the first $10 billion in federal rural health investments, highlighting award distribution patterns and recurring transformation strategies across all 50 states.

Prepared by Global True North and Tandem Research

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Executive Summary

On December 29, 2025, the Centers for Medicare & Medicaid Services (CMS) announced the first year of awards under the Rural Health Transformation (RHT) Program, a $50 billion federal investment intended to strengthen health care in rural communities nationwide. In FY2026, CMS will distribute $10 billion across all 50 states, with awards ranging from $147.3 million to $281.3 million and averaging almost exactly $200.0 million per state.

$10B	$200M	50
FY2026 TOTAL AWARDS	AVERAGE PER STATE	STATES FUNDED

CMS also released one-page project abstracts from each state describing proposed uses of RHT funds. These abstracts offer a public-facing snapshot of each state's transformation plan. Many display five-year budget figures that CMS has explicitly labeled illustrative and hypothetical rather than final award amounts or approved spending plans.

This brief summarizes the FY2026 award distribution and highlights common strategies that recur across state proposals.

Key Award Distribution Insights

Awards are distributed within a relatively narrow band, reflecting a statutory structure that provides a $100 million base allocation to each state plus additional funds based on rurality, health needs, and anticipated impact.

- **Median award:** $201.1 million
- **Middle 50%:** $189.5M to $211.1M (spread of ~$21.6M)
- **Largest to smallest ratio:** 1.91x (Texas at $281.3M vs. New Jersey at $147.3M)
- **70% of states:** Fall within ±10% of the mean

Eight Recurring Transformation Themes

Despite regional variation, state proposals converge on a recognizable set of strategies:

1. **Prevention and chronic disease management** as an organizing frame
2. **Building and retaining a rural workforce** through pipelines and incentives
3. **Technology modernization, interoperability, and cybersecurity**
4. **New access points** that reduce travel (mobile units, school-based clinics)
5. **Emergency response and right-sized acute care**
6. **Maternal and perinatal services** as a litmus test for rural coordination
7. **Behavioral health integration** and crisis capacity
8. **Payment reform and financial sustainability**

Why This Funding Matters

RHT's five-year, $50 billion commitment represents the largest federal rural health investment in decades. Awards in the $150M-$280M range are large enough to transform underlying infrastructure—including workforce pipelines, shared technology platforms, and regional care coordination—while creating a window to shift from fragile, volume-based models toward more sustainable approaches.

Implementation success will likely turn on governance, interoperability, and sequencing. States that consolidate funds into coherent regional initiatives with shared metrics may achieve more durable gains than those that fragment dollars across disconnected subgrants.

I. Background and Program Context

The RHT Program was authorized in Public Law 119-21 and is structured as a set of cooperative agreements with states. Congress appropriated $10 billion per year for FY2026 through FY2030. States receive yearly allotments, and funds remain available through the end of the following fiscal year, with a later process for redistributing unspent amounts.

CMS has framed RHT around five strategic goals:

- Prevention and chronic disease management
- Sustainable access
- Workforce development
- Innovative care models and payment reform
- Technology that supports secure, interoperable, patient-centered rural care

The Rural Health Landscape

The timing and scale of RHT matter. Depending on definition, rural America includes roughly 46 million to 60 million residents. Many rural communities face overlapping constraints:

- **Workforce shortages:** Clinicians and support staff in short supply
- **Limited service lines:** Many essential services unavailable locally
- **Financial fragility:** Facilities struggle to modernize or maintain operations

> **Since 2010:** More than 150 rural hospitals have closed or converted to models that no longer offer inpatient care.

Rural maternity care has also eroded significantly. A 2024 national report by March of Dimes estimates that more than one-third of U.S. counties are maternity care deserts, meaning no birthing facility and no obstetric clinician.

Strategic Opportunity and Risk

RHT's awards are large enough to finance statewide infrastructure and regional networks, while still being time-limited. That combination puts a premium on sequencing, governance, and sustainability.

States that use the funding to build shared capabilities—such as workforce pipelines, interoperable technology, and coordinated regional models—may be best positioned to convert a five-year infusion into lasting access and outcome gains.

The flip side is implementation risk: large awards can fragment into disconnected subgrants, and technology investments can produce isolated systems if interoperability and governance are weak.

Five-Year Federal Commitment

Fiscal Year	Total Appropriation	Per-State Average	Status
FY2026	$10.0 billion	$200 million	Awarded (Dec 2025)
FY2027	$10.0 billion	$200 million	Planned
FY2028	$10.0 billion	$200 million	Planned
FY2029	$10.0 billion	$200 million	Planned
FY2030	$10.0 billion	$200 million	Planned
TOTAL	**$50.0 billion**	**$1.0 billion**	**5-year program**

II. Why This Funding Matters

RHT is notable not only for its size, but also for what it can realistically buy. An award in the $150 million to $280 million range is too small to rebuild entire rural delivery systems from scratch, yet large enough to change underlying infrastructure.

What RHT Funding Can Finance

At this scale, states can:

- **Shared services:** Interoperable electronic health record (EHR) upgrades, cybersecurity, and statewide analytics
- **Multi-year workforce strategies:** Rural rotations and training capacity that smaller grants rarely sustain
- **New access points:** Telehealth hubs, mobile services, and school or library-based clinics that reduce routine travel burdens
- **Infrastructure modernization:** Technology platforms that enable coordination across distance
- **Regional care models:** Networks that preserve local access while ensuring specialty backup

Compounding Rural Health Constraints

The stakes are high because rural health systems often face compounding constraints:

> **Workforce shortages** limit what clinics can offer. **Financial fragility** makes it difficult to modernize or recruit. When a service line closes, communities can lose not only care but also **referral relationships and workforce stability.**

RHT's five-year horizon creates a window to stabilize core access while investing in models that make rural care less dependent on fragile margins.

Implementation Risk

The flip side is implementation risk. Large awards can fragment into disconnected subgrants, and technology investments can produce isolated systems if interoperability and governance are weak.

Key risk factors include:

- **Fragmentation:** Spreading funds across too many unrelated initiatives
- **Siloed technology:** Investing in systems that don't talk to each other
- **Weak governance:** Lack of regional coordination and shared accountability
- **Sustainability gaps:** Building programs that collapse when federal funding ends
- **Misaligned incentives:** Technology upgrades without payment reform to support new models

The Transformation Window

States have a five-year window to:

1. **Build shared infrastructure** (EHRs, data platforms, workforce pipelines)
2. **Test and scale new models** (mobile care, hospital-at-home, integrated behavioral health)
3. **Shift payment incentives** (from volume to value, with technical assistance for small providers)
4. **Strengthen regional networks** (so rural facilities can function as a coordinated system)

The combination of scale and time-limitation means that **sequencing matters.** States that front-load infrastructure investments and regional governance may be better positioned to sustain gains after federal support tapers.

Conversely, states that treat RHT as a series of short-term pilot projects may struggle to demonstrate lasting impact or build the capabilities needed to participate in value-based payment models.

III. Recurring Themes in State Transformation Proposals

State project abstracts vary in level of detail, but they converge on a recognizable set of approaches. Nearly every proposal combines workforce investments, technology modernization, new access points for preventive and primary care, and at least one lever aimed at long-term financial sustainability.

The following eight themes recur across regions, with illustrative examples from state proposals.

1. Prevention and Chronic Disease Management as an Organizing Frame

Many state plans adopt a "prevention-first" posture that reflects CMS's emphasis on addressing root causes of disease. Rather than treating wellness as an add-on, proposals often tie it to delivery mechanisms such as school-based programs, nutrition supports, and population health infrastructure that can track risk and outcomes.

> **Nebraska:** Centers a "Food as Medicine" initiative that links rural school kitchens, regional food hubs, and nutrition education to obesity and metabolic health goals.

North Dakota pairs nutrition and physical activity campaigns with multipayer payment reforms intended to sustain prevention work over time.

Texas positions wellness and nutrition as one of six flagship initiatives.

A smaller set of states also signal willingness to use policy levers alongside clinical programs, such as **Wyoming's** proposal to restrict certain food assistance purchases.

2. Building and Retaining a Rural Workforce

Every state plan treats workforce as a core constraint on rural access. The dominant approach is a portfolio that blends training pipelines, rural rotations, recruitment incentives, and supports that help clinicians practice at the top of their license.

Many states emphasize expanded roles for **community health workers, peers, pharmacists, and other allied professionals** as practical capacity multipliers.

> **Delaware:** Proposes creating the state's first medical school with a primary care rural health track and education awards aimed at retaining graduates in rural counties.

Alaska pairs pipeline strategies with wraparound housing and childcare supports to improve retention in remote communities.

Georgia emphasizes scholarships and graduate medical education expansion.

California proposes a statewide workforce mapping and planning tool to align training investments with regional needs.

3. Technology Modernization, Interoperability, and Cybersecurity

Technology appears in every state plan, often framed as the backbone that allows small rural providers to function as a coordinated system. Common investments include EHR modernization, connectivity upgrades, shared data platforms, and cybersecurity, along with technical assistance that can help smaller facilities adopt tools they could not procure alone.

Alabama proposes regional shared service hubs for EHR integration and cybersecurity compliance.

Rhode Island proposes a state-sponsored EHR and rural health information technology grants, paired with rural data and workforce tracking.

Louisiana describes combining a state-managed, CMS-aligned EHR approach with a "tech catalyst fund" for digital tools.

A smaller set of states explicitly reference **artificial intelligence,** usually as workflow or decision support, such as Alaska's plans for "appropriate AI use" alongside wearables and North Dakota's focus on remote monitoring and AI-assisted care.

4. New Access Points That Reduce Travel

Many states treat geography as a modifiable barrier. Telehealth is the most common tool, but it is frequently paired with physical access points that make virtual care usable for people without reliable broadband, devices, or private space.

Mobile units and community-based sites appear in many proposals as a way to bring preventive and routine care closer to home.

> **Delaware:** Proposes mobile health units, school-based health centers, and library-based health services.

Rhode Island proposes mobile services and telehealth sites in schools and community learning centers as part of a "community-integrated rural health model."

Ohio's plan includes school-based health centers that also serve as rural clinical training sites, plus a mobile vision, hearing, and dental program built on an earlier pilot.

5. Strengthening Emergency Response and Right-Sized Acute Care

Emergency response is a recurring priority, reflecting the reality that in many rural places, the emergency department and the ambulance service function as the safety net.

States describe investments in EMS training pipelines, routing protocols, communications upgrades, and models that allow clinicians and paramedics to treat patients in place when safe.

Alabama highlights statewide trauma and stroke routing improvements.

Rhode Island proposes a statewide EMS academy and a mobile integrated health/community paramedicine model.

Ohio plans to scale a "treat-in-place" or "alternate destination" pilot so EMS can reduce avoidable emergency department use.

Several states also link emergency care to hospital-at-home and post-acute strategies, with Rhode Island proposing hospital-at-home capacity supported by remote monitoring and EMS partnerships.

6. Maternal and Perinatal Services as a Litmus Test

Rural maternal health appears in many plans as both a high-stakes access issue and an indicator of whether a rural system can coordinate across distance.

Proposals describe maternity care deserts, shortages of obstetric clinicians, and the need for regional models that preserve local prenatal and postpartum care while ensuring safe delivery options.

> **Alabama:** Proposes digital obstetric regionalization and telerobotic ultrasound.

California includes "OB Nest"-style prenatal care with remote patient self-monitoring and nursing support, paired with perinatal psychiatry access and e-consults.

Ohio notes that multiple counties are maternity care deserts and proposes policy and delivery reforms, including legislative changes to enable low-risk birthing centers in rural hospitals.

7. Behavioral Health Integration and Crisis Capacity

Behavioral health is among the most consistently cited needs in state plans. Proposals describe limited rural access to psychiatry and counseling, substance use disorder burdens, and gaps in crisis response.

Many states propose integrated models that embed behavioral health in primary care and extend access through telebehavioral services.

> **Alabama:** Proposes converting community mental health centers into certified community behavioral health clinics.

Rhode Island plans to expand behavioral health through a 24/7 crisis stabilization center, recovery community centers, and peer navigators.

Across proposals, behavioral health investments are often linked to EMS and emergency department flow so that rural hospitals are not the default crisis setting.

8. Payment Reform and Financial Sustainability

Many states connect RHT investments to payment reform, arguing that rural providers cannot modernize if reimbursement remains tethered to volume and unstable utilization.

Proposals highlight value-based care readiness, multipayer alignment, and technical assistance to help small hospitals and clinics participate in alternative payment models.

Georgia's plan emphasizes aligning rural facilities with the CMS AHEAD model and related primary care reforms through readiness assessments and technical assistance.

Alaska names "Pay for Value" as a major initiative intended to shift from volume-based reimbursement toward models that reward coordination and outcomes.

Rhode Island proposes incentives and technical assistance to help hospitals and practices transition to value-based payment, while **North Carolina** and **Louisiana** similarly describe building capabilities needed to participate in value-based arrangements.

Summary of Eight Themes

Theme	Key Elements
1. Prevention Focus	Food as medicine, school programs, population health infrastructure
2. Workforce	Training pipelines, rural rotations, housing supports, scope expansion
3. Technology	EHR modernization, interoperability, cybersecurity, AI tools
4. Access Points	Mobile units, school clinics, library sites, telehealth hubs
5. Emergency Care	EMS upgrades, treat-in-place, trauma routing, hospital-at-home
6. Maternal Health	OB regionalization, telehealth, policy reforms for birthing centers
7. Behavioral Health	Primary care integration, crisis centers, peer support, telebehavioral
8. Payment Reform	Value-based care readiness, multipayer alignment, technical assistance

IV. Early Implications and Questions to Watch

RHT's award distribution suggests that CMS is using the program to create a national baseline of rural investment while still recognizing variation in rurality and need. Because most states are funded at roughly comparable levels, the program may also produce unusually useful lessons about which combinations of workforce, technology, and delivery reforms translate into measurable gains.

Governance and Implementation Will Be Decisive

Implementation will likely turn on governance and interoperability choices. State plans that consolidate funds into a small number of coherent initiatives, with clear regional partners and shared metrics, may achieve more durable change than plans that fragment dollars across many unrelated subgrants.

> **Key Success Factors:** Consolidated governance, regional coordination, shared metrics, interoperable technology platforms, and clear sustainability strategies.

Technology investments, in particular, will need common standards and ongoing operational models so that rural providers are not left with disconnected systems when time-limited funding ends.

Critical Questions for Years 2-5

As the program unfolds through FY2030, several questions will shape whether RHT produces lasting transformation:

Sustainability and Payment Reform

- Will states successfully transition rural providers to value-based payment models that can sustain new services after federal funding tapers?
- Can multipayer alignment be achieved at state and regional levels?
- Will technical assistance be sufficient for small, resource-constrained providers to participate in alternative payment models?

Workforce Pipeline and Retention

- Will training investments and rural rotations actually produce net increases in rural workforce, or will they simply redistribute existing clinicians?
- Can non-traditional supports (housing, childcare, loan forgiveness) meaningfully improve retention in the most remote communities?
- Will scope-of-practice expansions for allied professionals be implemented effectively and accepted by rural communities?

Technology Interoperability

- Will state-level EHR modernization efforts produce truly interoperable systems, or will they create new silos?
- Can rural providers meaningfully participate in health information exchanges and regional data platforms?
- Will cybersecurity investments be sustained beyond the five-year window?

Access and Service Line Viability

- Can new access points (mobile units, school clinics, telehealth hubs) be maintained after RHT funding ends?
- Will maternal health investments reverse the trend toward maternity care deserts, or merely slow the decline?
- Can emergency care innovations (treat-in-place, hospital-at-home) scale while maintaining quality and safety?

Opportunities for Cross-State Learning

Because RHT provides comparable funding levels to most states, the program creates natural experiments. States taking different approaches to similar challenges—such as workforce retention, maternity care deserts, or behavioral health integration—will generate valuable comparative evidence.

CMS and independent evaluators should prioritize:

- Standardized outcome metrics across states
- Rapid learning networks to share promising practices
- Transparent reporting of implementation challenges and failures
- Rigorous evaluation of which governance models produce the most durable results

Appendix A. FY2026 RHT Award Amounts by State

The following table lists the FY2026 Rural Health Transformation Program award amounts for all 50 states, as announced by CMS on December 29, 2025.

State	FY2026 Award	State	FY2026 Award
Alabama	$203,404,327	Montana	$233,509,359
Alaska	$272,174,856	Nebraska	$218,529,075
Arizona	$166,988,956	Nevada	$179,931,608
Arkansas	$208,779,396	New Hampshire	$204,016,550
California	$233,639,308	New Jersey	$147,250,806
Colorado	$200,105,604	New Mexico	$211,484,741
Connecticut	$154,249,106	New York	$212,058,208
Delaware	$157,394,964	North Carolina	$213,008,356
Florida	$209,938,195	North Dakota	$198,936,970
Georgia	$218,862,170	Ohio	$202,030,262
Hawaii	$188,892,440	Oklahoma	$223,476,949
Idaho	$185,974,368	Oregon	$197,271,578
Illinois	$193,418,216	Pennsylvania	$193,294,054
Indiana	$206,927,897	Rhode Island	$156,169,931
Iowa	$209,040,064	South Carolina	$200,030,252
Kansas	$221,898,008	South Dakota	$189,477,607
Kentucky	$212,905,591	Tennessee	$206,888,882
Louisiana	$208,374,448	Texas	$281,319,361
Maine	$190,008,051	Utah	$195,743,566
Maryland	$168,180,838	Vermont	$195,053,740
Massachusetts	$162,005,238	Virginia	$189,544,888
Michigan	$173,128,201	Washington	$181,257,515
Minnesota	$193,090,618	West Virginia	$199,476,099
Mississippi	$205,907,220	Wisconsin	$203,670,005
Missouri	$216,276,818	Wyoming	$205,004,743

Source: CMS press release, December 29, 2025

Notes and Methodology

Data Sources

Award amounts come from the Centers for Medicare & Medicaid Services (CMS) press release dated December 29, 2025, announcing the first year of Rural Health Transformation (RHT) Program awards.

State project descriptions and proposed uses come from CMS's compilation of state-provided project abstracts, released in December 2025. These one-page abstracts offer a public-facing snapshot of each state's transformation plan.

> **Important Note:** CMS explicitly labels the five-year budget figures shown in many state abstracts as "illustrative and hypothetical," not final award amounts or approved spending plans. States have flexibility to modify their approaches as implementation proceeds.

Background Context

Background information on rural health challenges draws from:

- **UNC Sheps Center Rural Hospital Closures dataset:** Tracking of rural hospital closures and conversions since 2010
- **March of Dimes 2024 Maternity Care Deserts Report:** Analysis of counties lacking birthing facilities and obstetric clinicians
- **Public Law 119-21:** Authorizing legislation for the RHT Program
- **CMS strategic goals:** As outlined in program guidance and cooperative agreement terms

Allocation Formula

The RHT Program uses a two-part allocation formula:

1. **Base allocation (50%):** Distributed equally across all states, resulting in $100 million per state in FY2026
2. **Need-based allocation (50%):** Distributed based on CMS scoring factors including:
    - Measures of rurality (population density, frontier designation)
    - Rural health needs (closure risk, service gaps, health outcomes)
    - Anticipated impact (state capacity, regional coordination potential)

Analysis Approach

This brief analyzes FY2026 award distribution patterns and identifies recurring themes across state proposals. The analysis is descriptive and based on publicly available state abstracts. It does not evaluate state plans or predict implementation outcomes.

Recurring themes were identified by systematic review of all 50 state project abstracts, noting strategies that appeared in multiple proposals across different regions. Examples are illustrative, not exhaustive.

Limitations

- State abstracts vary in specificity. Some provide detailed implementation plans while others offer high-level summaries.
- Five-year budget projections in state abstracts are illustrative and subject to change.
- This analysis captures state *proposals*, not implementation outcomes or effectiveness.
- Regional variation and state-specific context are necessarily simplified in a cross-state thematic analysis.

About This Brief

This advisory brief was prepared by **Global True North and Tandem Research** to synthesize publicly available information about the Rural Health Transformation Program's first year of awards and to highlight patterns in state transformation strategies.

For questions or additional analysis, please contact the research team.