National Rural Health Association

Rural Health Transformation Program Summary

Background: The One Big Beautiful Bill Act, enacted into law on July 4, 2025, created a $50 billion fund, called the Rural Health Transformation Program, in an attempt to offset losses that rural health providers will experience associated with other health provisions in the legislation.

Amount and Distribution of Funds: The $50 billion will be **distributed to all states between fiscal years (FYs) 2026 – 2030.** $10 billion will be distributed each fiscal year.

Half of the $50 billion will be allocated equally among all states with an application approved by CMS (more information below). The other 50% of funds will be distributed to states with an approved application in an amount determined by the CMS Administrator.

The CMS Administrator will consider the following in determining allotments to each state:

- The percentage of the state's population that is located in a rural census tract of a metropolitan statistical area (MSA);
- The proportion of rural health facilities (defined below) in the state relative to the number of rural health facilities nationwide;
- The situation of hospitals in the state; and
- Any other factors that the CMS Administrator finds appropriate.

Application: Many aspects of the application process are left up to CMS and will be announced by CMS at a later date. This includes the application submission period, due date, state entity that must submit the application, and the form and manner of the application.

Each state must apply for funds, and it is **a one-time application** for the whole 5-year program. Applications will be made to CMS. **CMS must approve or deny all applications by December 31, 2025.**

Applications must include the following:

- **A detailed rural health transformation plan.** The plan must outline how the state will:
  - Improve access to hospitals and other providers for rural residents;
  - Improve health care outcomes of rural residents;
  - Prioritize use of new and emerging technologies that emphasize prevention and chronic disease management;
  - Initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other providers to promote quality improvement, increase financial stability, maximize economies of scale, and share best practices;
  - Recruit and retain clinicians;
  - Prioritize data and technology driven solutions that help rural providers furnish health care services as close to the patient's home as possible;
  - Outline strategies to manage long-term financial solvency and operating models of rural hospitals; and
  - Identify specific causes that are driving standalone rural hospitals to close, convert, or reduce service lines.
- Certification that funds will not be used for intergovernmental transfers, certified public expenditures, or any other expenditure that finances the non-federal Medicaid share.
- Any other information that the CMS Administrator may require.

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Allowable Uses of Funds and Conditions: The bill lists several allowable uses of Rural Health Transformation Program funds.

- Promoting evidence-based interventions to improve prevention/chronic disease mgmt.
- Payments to providers
- Promoting technology driven solutions for prevention and mgmt.
- Training/TA for developing and adopting technology-enabled solutions that improve care delivery in rural hospitals
- Recruiting and retaining clinical staff to rural areas with 5-year obligation to stay
- TA, software, hardware for significant tech advances to improve efficiency, cybersecurity, patient outcomes
- Assisting rural communities to right size health care delivery by identifying needed services, facilities, etc.
- Supporting access to OUD/SUD treatment
- Projects that support value-based care
- Additional uses "designed to promote sustainable access to high quality rural health care services" as determined by CMS Administrator

As a condition of receiving funds, states must submit to the CMS Administrator a plan to use the funds to carry out at least 3 of the activities listed above and annual reports on use of funds. Annual reports may include information to be determined by the CMS Administrator.

Funds must be used by the end of the fiscal year following the fiscal year in which the funds were allotted. For example, funds distributed in FY 2026 must be used by the end of FY 2027. By March 31, 2028 CMS will annually determine the amount of funds that are unused by states and redistribute such funds. Any unused funds left as of October 1, 2032 will be returned to the Treasury.

If CMS determines that a state has misused funds, it may withhold payments, reduce payments, or recover payments from the state.

Additionally, no more than 10% of funds can be used for state administrative expenses.

Rural Health Facilities: The bill defines rural health facilities as the following:

- Hospitals:
    - Located in a rural area (which is defined as outside of a Metropolitan Statistical Area per 42 U.S.C. § 1395ww(d)(2)(D))
    - Treated as being located in a rural area
        - *This captures many large, urban hospitals that have "reclassified" to rural for inpatient prospective payment system purposes, i.e. urban located rural reclassified hospitals.*
    - Located in a rural census tract of an MSA
- Critical access hospitals
- Sole community hospitals
- Medicare-dependent hospitals
- Low-volume hospitals
- Rural emergency hospitals
- Rural health clinics

- Federally qualified health centers (FQHCs) and health centers receiving Section 330 grants
- Community mental health centers (CMHCs)
- Opioid treatment programs located in a rural census tract of an MSA
- Certified community behavioral health clinics located in rural census tract of an MSA

Note that some providers listed above as "rural health facilities," such as CMHCs and FQHCs/community health centers do NOT have to be located in a rural area.