Rural Health Transformation Program (RHTP) Notice of Funding Opportunity for State Policy Agendas

Background

This document is intended to help navigate potential state policy actions related to Rural Health Transformation opportunities. The policies below are endorsed by the National Rural Health Association membership. If your state is looking for an expanded list of positions, you can find them in our 2025 Policy Agenda. Additionally, NRHA has a series of policy papers that can serve as technical guidance on these issues.

Notice of Funding Opportunity (NOFO) Guidance can be found here. NRHA's summary of the NOFO can be found here.

Key dates

- **Optional letter of intent:** September 30, 2025
- **Application deadline:** November 5, 2025
- **Expected award date:** December 31, 2025

State Policy Actions

CMS will distribute $25 billion of workload funding based on three factors: data-driven metrics, application-based initiatives, state policy actions. The following are NRHA policies recommendations related to state-policy technical score factors listed on page 15 of the NOFO.

B. 2. Health and lifestyle

- Behavioral health:
  - Add language to State Medicaid agencies contracts with managed behavioral health organizations to require contractors to monitor mental health services provided to rural beneficiaries.
  - Ensure that state regulations are not more restrictive than Medicare conditions of participation in order to allow for co-location of mental health and substance use treatment with physical health services at hospitals, clinics, community health agencies, and tribal centers and provide support for interprofessional coordination and collaboration.

B. 3. SNAP waivers

- Develop methods to promote consumption of healthy and nutritious foods among the SNAP recipient population and to encourage farmer participation in accepting SNAP and WIC.

B. 4. Nutrition continuing medical education

- Allow reimbursement under Medicaid to help health care providers become educated on, and provide services for, food insecurity and nutrition screenings.

D. 2. Licensure compacts

- Support policies that facilitate cross-state licensure to expand access to medical providers for rural patients while maintaining local connections through in-person visits as clinically necessary.
- Advance policy solutions for the removal of federal and state licensing, credentialing, and reimbursement restrictions that impede utilization of telemedicine, telehealth, and distance learning services.

D. 3. Scope of practice

- Behavioral Health: Expand scope of practice to allow appropriate use of behavioral health paraprofessionals, including Behavioral Health Aides (BHAs), Peer Support Specialists, and Community Health Workers, to expand available care coordination resources and expand access and affordability, including in telehealth arrangements.
- Community Health Workers: Support creation of state CHW certification and/or licensure. Allocate resources for comprehensive CHW for state certification training programs. Investment in training and professional pathway development for CHWs at the state level.
- Maternal Health: Expand scope of practice and reimbursement for advanced practice providers (e.g., family physicians, nurse practitioners, physician assistants, nurse midwives, certified midwives) and non-traditional providers (e.g., doulas, community health workers) to maintain or improve access to local maternity care for rural women.
- Oral Health: Oral health providers should be encouraged to practice to the top of their licensure to help abate the chronic shortfall of rural oral health providers.

F. 1. Remote care services

- Remove regulatory barriers to enable rural providers and patients to adopt telehealth technologies, including remote patient monitoring. Support adoption through technical assistance, best-practice clinic guidelines, and expanded support for telehealth care.

F. 2. Data infrastructure

- Expand/create incentive payments for implementing EMR to all rural health providers, including home health agencies, hospices, skilled nursing facilities, EMS, and any other providers eligible for Medicare and/or Medicaid payments, to facilitate the seamless exchange of information.
- Promote the allocation of funding and/or create incentives to support resource-poor rural hospitals, community health centers, rural health clinics, behavioral health providers, and other rural health providers for the purpose of upgrading and purchasing infrastructure that allows EMRs to fully utilize API interfaces and participate in interoperable health information exchange.
- Provide funding to establish and train an IT staff member at each regional hospital dedicated to the maintenance and optimization of API and EMR interoperability software.

- Establish regional cybersecurity support centers through collaboration between state and local governments and healthcare providers and technology companies to provide education and training, partnerships, and information sharing.

Initiative-Based Actions

The following are state policies NRHA has identified aligned with initiative-based technical score factors listed on page 15 of the NOFO.

B. 1. Population health clinical infrastructure

- Support All-Payer approaches that aim to curb rising healthcare cost growth, improve population health and health outcomes, and address rural health disparities.
- Collaborate with CMS and other payers to standardize data collection and sharing procedures to allow states to identify the needs of rural beneficiaries.
- Create targeted and directed prevention initiatives to rural populations identified as high risk for chronic illness. Support utilization of locations that are easily accessible, such as schools, churches, workplaces, community centers, and various health care facilities and support programs that recognize the influence of friends and family as participants in an individual's behavior change.
- Maternal Health:
    - Address social determinants of maternal health by prioritizing technology, transportation, and care coordination at to ensuring rural women have access to maternal care, local health department resources, WIC programs, and community health workers, while providing housing and transportation support for those needing care outside their communities.
    - Establish alternative payment models for obstetrics and delivery similar to the NC Pregnancy Medical Home.

C. 1. Rural provider strategic partnerships

- Test opportunities to improve regional and local health planning to improve distribution of essential services and improve community support for rural health services. Special attention should be given to the health care delivery sector in regionally appropriate planning.
- Behavioral Health: Expand telepsychiatry services and developing partnerships with local rural hospitals.
- Emergency Preparedness: Designate a health care point of contact to establish regional partnerships for preparedness and response inclusive of rural areas. Create data exchange for consistent information sharing from federal, state, and/or local resources to address lack of current consistency across counties.
- Maternal Health:
    - Create regional, multidisciplinary emergency obstetric quality improvement teams.
    - Support local perinatal regionalization and access to OB care policies by establishing centers of excellence and regional care models inclusive of prenatal and postpartum

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care through use of expand telehealth and technology, local health departments, and case managers/care coordinators.
  - Encourage formal relationships between rural emergency department providers and regional specialists for telemedicine consultations and opportunities to rotate to higher-volume facilities for exposure.
  - Incentivize the integration of rural EMS programs, community health workers, other non-traditional providers specializing in maternal care (e.g. doulas), and hospitals to support maternity care in maternal health professional shortage areas.
  - Use telehealth and other technologies to facilitate the delivery of maternity and pediatric services so that women can receive prenatal, postpartum, and low-risk obstetric care in facilities within their own community. Encourage hospitals, as funding and collaborating network provisions allow, to stock maternal monitoring equipment and technology for antepartum surveillance.

C. 2. EMS

- Support state funding to strengthen and integrate emergency medical services with rural health care services and providers, including innovative paramedicine demonstrations, improved training, research, telehealth, preventive health and personnel recruitment.
- Incentivize health care systems to use the Informed Community Self Determination process to drive the development of rural emergency care.
- Provide support for the rising cost and decreasing availability of general and property (including vehicle) insurance for EMS services.
- Provide guidance to private insurers on paying for treat-and-discharge EMS care and community paramedicine.
- Support alternate funding models for EMS and emergency care delivery in rural areas such that payments are not contingent on transporting a patient.

D. 1. Talent recruitment

- Attract more health care providers to rural areas, including behavioral health and oral health, through use of financial incentives, such as student loan forgiveness, equipment purchasing grants and loans, relocation support, and programs providing specialized training. Funding should be contingent on the providers serving a minimum percentage of Medicaid beneficiaries and uninsured patients.
- Require outcome data for all Medicaid GME funding that identifies rural community practice as an intended outcome.
- Support rural family practice physicians in providing maternity services, including developing and supporting rural-specific obstetrics-focused residency and fellowship programs.
- Launch a state campaign to encourage rural health professionals to prioritize their mental health and to use available mental and behavioral health services.
- Invest in sufficient childcare options, employment opportunities for providers' spouses, and affordable housing options available to support rural health workforce needs.

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- Support efforts to encourage rural students to seek health careers through mentoring programs, pre-health professions rural interest groups and support for math and science competencies in primary and secondary schools.

E. 1. Medicaid provider payment incentives

- Implement innovative value-based payment reform that promotes preventive care and enhances chronic disease management.
- To the extent it is not reimbursed in your state, create reimbursement for CHW services at the state level to ensure financial stability; collaborate with local governments, non-profits, and private entities to provide resources and sustain CHW programs and facilitate innovative solutions tailored to specific community needs.
- Promote the provision of incentives (e.g., financial) for agencies that hire CHWs (e.g., rural county health departments, state departments of rural health) in rural settings.
- Maternal Health:
    - Create value-based care Medicaid payment arrangements to allow for rural hospitals and regional obstetrical consultants for telehealth visits and consultations.
    - Use flexibilities in the Medicaid program to address barriers to rural practice of OB services including: protections for low volume providers; incentives to address a decreased focus of OB care within primary care practice; and resources to support C-sections including an OB-GYN, surgeon, and/or anesthesiologist.
    - Address the high costs of OB malpractice insurance to make it more economically viable for family practice physicians to continue providing obstetrics care in rural areas through state-supported insurance programs, practice-based incentives, Tort Reforms, and geographic adjustments.