National Rural Health Association

November XX, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: Recommendations for future implementation of the Rural Health Transformation Program

Dear Administrator Oz,

As the first year of the Rural Health Transformation Program (RHTP) closes, the National Rural Health Association (NRHA) writes to share lessons from the rural providers, organizations, and communities working to put this historic investment into practice. NRHA remains strongly supportive of RHTP and its goal of strengthening rural health care through investments in workforce, infrastructure, technology, access, and sustainable models of care. Across the country, rural stakeholders have described RHTP as a rare opportunity to make investments that have been out of reach for years.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

RHTP represents an important step toward the rural health system that NRHA and its partners have long envisioned, one that maintains essential services locally, coordinates care regionally, aligns payment with community needs, develops the rural workforce, and uses technology to extend rather than replace local care. Transformation requires connected investments in providers, people, infrastructure, payment, and community capacity. As Year 1 draws to a close, rural stakeholders see meaningful alignment between that vision and many state RHTP initiatives. States are investing in workforce pipelines, provider stabilization, regional care collaboratives, technology-enabled care, payment reform, infrastructure, and data capacity. These investments suggest that RHTP can help move rural communities toward a more coordinated and sustainable system of care.

At the same time, the experience on the ground shows that the design of an initiative and its practical implementation are not the same. A promising plan cannot improve access until rural providers participate, contracts are executed, funds are available, and projects are operational. Experiences have varied considerably across states. In some places, rural hospitals and providers have benefited from early engagement, experienced rural leadership, accessible grants, and projects that were ready to launch. In other states, rural providers are still awaiting award notices or contracts, navigating changing requirements, or trying to determine when and how funding will reach their communities.

One rural provider summarized the tension: "If this works, it could change the face of rural health care. But small facilities need a realistic pathway to participate." NRHA has drawn the following lessons from feedback shared by rural hospitals, rural health clinics (RHCs), State Rural Health Associations (SRHAs), State Offices of Rural Health (SORHs), clinicians, community organizations, and other stakeholders during Year 1.

RuralHealth.US
50 F. St., N.W., Suite 520
Washington, DC 20001 | 202-639-0550

Lesson 1: The program succeeds when rural expertise helps shape implementation.

The strongest implementation experiences have occurred where state leaders understand rural delivery systems, involve rural stakeholders early, and maintain direct communication throughout the award and implementation process. Rural hospitals and clinics are best positioned to identify the investments that will improve access, strengthen local capacity, and remain useful after the federal funding period ends.

Where rural stakeholder engagement has been limited, providers have reported that opportunities do not always reflect local needs, existing projects, workforce realities, or the administrative capacity of small facilities. Consultation after major program decisions have already been made is not a substitute for meaningful participation.

For future budget periods, NRHA asks CMS to consider:

- Require states to maintain a formal rural advisory process with meaningful representation from partners such as independent rural hospitals, critical access hospitals (CAHs), RHCs, federally qualified health centers (FQHCs), emergency medical services (EMS), SORHs, SRHAs, rural clinicians, tribal health partners where applicable, and rural patients.
- Provide accessible opportunities for rural stakeholders outside formal advisory bodies to submit feedback.
- Hold direct listening sessions with rural providers and community organizations, in addition to CMS engagement with state award recipients.
- Require state investments to include a needs assessment in support of complementing existing services and providers.

Lesson 2: Obligating funds is not the same as delivering resources to rural communities.

Year 1 reporting provides an important picture of state activity, but state-level obligation totals alone do not show whether resources have reached frontline rural providers. Funding may be legally committed through contracts, intergovernmental agreements, or subawards while rural hospitals, clinics, and community partners are still awaiting opportunities, notices, contracts, payments, or implementation authority.

This distinction matters. Rural providers repeatedly expressed concern that they could see significant activity at the state level without knowing how much funding would ultimately support direct care, local infrastructure, or lasting capacity in rural communities. In some communities, small rural providers are being asked to engage in state initiatives without seeing any direct resource being shared. One NRHA rural physician stated "I feel used. Everyone wants me to be part of their proposed activity, but money is going to large systems, and I don't get resources for participating. It's defeating and disheartening."

NRHA asks CMS to consider the following:

- Require each state to establish and publicly report a rural provider investment target.
- Publish recipient-level award and expenditure information, including recipient name, amount, purpose, service area, entity type, and project status.
- Distinguish funds retained by state agencies or routed through contractors and intermediaries from funds delivered to rural providers and locally governed rural organizations.

Lesson 3: Predictability is essential to meaningful rural participation.

One of the clearest lessons from Year 1 is that compressed and uncertain timelines place a disproportionate burden on small rural organizations. Rural hospitals and clinics often do not have dedicated grant-writing, procurement, legal, contracting, or data teams. A short application window can require rural leaders to suspend other responsibilities simply to assemble an application, secure vendor quotes, develop partnerships, and obtain necessary approvals. Providers also described a recurring pattern in which states took months to design or approve opportunities, but rural applicants were given only days or weeks to respond. Subsequent delays in award notices and contracts further compressed the time available for implementation. Further, stakeholders in several states report awards being made for a four-to-five-year period, limiting engagement of rural providers in out years. Finally, small rural providers operating on thin or negative margins lack the financial capacity to repay funds to the state or CMS. Fears of repayment obligations were a factor for some rural providers deterring or delaying their participation even in promising initiatives.

NRHA asks CMS to consider the following:

- Establish a reasonable minimum application period, with documented exceptions when an urgent circumstance requires a shorter timeline.
- Require prompt notice when award, contracting, or payment milestones are delayed.
- Permit reasonable project modifications when implementation experience shows that an approved approach is no longer workable or is less effective than an alternative.
- Ensure Years 2 and beyond offer additional opportunities for rural providers to engage in initiatives.
- Provide clear, upfront guidance and reasonable protections against claw backs when rural providers act in good faith but projects do not achieve expected results or funding changes in later years.

Lesson 4: Administrative requirements must reflect rural capacity.

Rural stakeholders understand the need for accountability and responsible stewardship of federal funding. However, Year 1 has shown that administrative requirements can become a barrier when they are not proportionate to the size, risk, or complexity of an award. Given the limited administrative capacity and economies of scale in rural settings, many rural stakeholders find restrictions on administrative overhead infeasible, particularly when allowable funding is further reduced below the 10% permitted at the state award level. Some rural organizations have devoted substantial staff time to collaboration, applications, procurement, contracting, reporting preparation, and technical questions without reimbursement or assurance of an award. Others have struggled to participate because they cannot finance projects from limited operating cash while waiting for reimbursement.

NRHA asks CMS to consider:

- Encourage advance or milestone-based payments when legally permissible, rather than relying exclusively on reimbursement after costs are incurred.
- Allow reasonable planning, grant-development, procurement, legal, data, fiscal, and project-management costs when necessary to implement an approved initiative.
- Support shared grant-writing, fiscal, legal, procurement, and data assistance through trusted rural intermediaries, including SORHs, SRHAs, and rural hospital networks.

Lesson 5: Rural providers should not be penalized for state-level process.

Rural providers are concerned that state administrative process, contracting challenges, or implementation problems could affect future funding even when rural projects are ready to proceed.

CMS oversight should distinguish between a lack of rural demand or readiness and delays created by state procurement, staffing, approval, or contracting processes.

NRHA asks CMS to consider:

- Provide corrective action and technical assistance opportunities to states before reducing funds that would otherwise support viable rural projects.
- Protect or redirect funding for approved rural projects when state-level administrative delays are the primary barrier.
- Publish the factors CMS uses to evaluate state performance and explain how circumstances outside a rural subawardee's control will be treated.
- Establish a confidential channel through which rural providers and associations can report systemic implementation problems.
- Provide rapid technical assistance on contracting, procurement, payment, reporting, and stakeholder-engagement barriers including the resources for the aforementioned planning, grant-development, procurement, legal, data, auditing, and project-management costs necessary to engage rural providers in an approved initiative.

Lesson 6: Year 2 and beyond should incorporate structured learning from Year 1.

Variation among states has produced an important body of implementation experience. CMS now has an opportunity to identify which approaches moved funding efficiently, encouraged rural participation, reduced administrative burden, and produced investments likely to outlast the federal award period. Rural stakeholders do not expect every state to use an identical model. They do expect CMS to identify common standards and facilitate learning across state lines.

CMS should continue transparency of RHTP implementation that supports public transparency. A commitment by CMS for public access to data would allow rural residents to understand how their State is progressing, encourage cross-State learning and innovation, and strengthen trust in federal rural health initiatives. Further, public release of data would enable researchers to evaluate program effectiveness and support stakeholders and policymakers in identifying best practices.

NRHA asks CMS to consider:

- Make implementation and performance data publicly available in a timely, usable, and exportable format through public dashboards, downloadable datasets, or annual public reports.
- Identify early promising practices with a focus on sustainability ensuring those investments produce long term delivery system change—not simply short-term projects—for rural providers and the patients they serve.

In summary

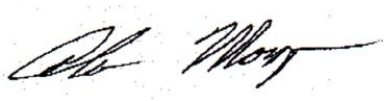
RHTP remains an opportunity to move rural health care toward a system that maintains essential services close to home, connects rural patients to regional care, supports a stable workforce, modernizes infrastructure, and transitions toward sustainable models of payment and care delivery. That transition will take more than one year. The message from Year 1 is not that CMS should reduce the program's ambition or its accountability. It is that the path toward transformation must be transparent, predictable, locally informed, and workable for the rural organizations responsible for delivering results. One rural stakeholder captured the broader sentiment: "Keep the investment and keep the ambition but make the process work for the people who are trying to deliver care."

NRHA urges CMS to use its oversight and technical assistance authority to ensure that funding reaches frontline rural providers, reduce avoidable administrative and cash-flow barriers, improve

visibility into awards and contracts, protect ready rural projects from state-level delays, and require meaningful rural participation throughout implementation.

Thank you for the opportunity to share these lessons. NRHA looks forward to continuing to work with CMS toward our mutual goal of improving health care and access for rural Americans. If you have any questions or would like to discuss these recommendations further, please contact NRHA's Chief Policy Officer, Carrie Cochran-McClain, at ccochran@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

CC: Office of Rural Health Transformation

RuralHealth.US
50 F. St., N.W., Suite 520
Washington, DC 20001 | 202-639-0550