

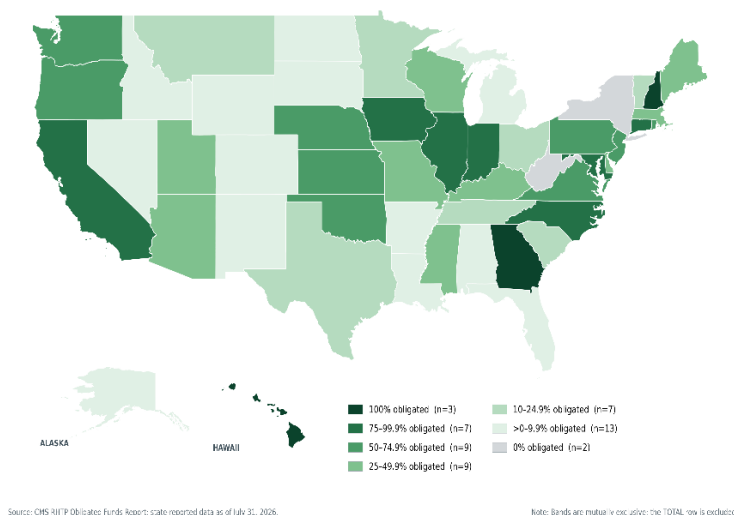
A Review of the Rural Health Transformation Program Year 1 Obligated Funds

The Rural Health Transformation Program (RHTP) is a federally funded, state-led initiative designed to strengthen rural health care systems through investments in workforce, infrastructure, innovation, and sustainable models of care. As of July 31, 2026, states had committed (obligated)¹ about 40%, or \$4.0 billion, of the \$10.0 billion of first year RHTP awards.² Funding distribution varied, with three states fully obligating dollars, two reporting no obligated dollars, and median state obligation at approximately 40%.

- Fully obligated (100%): Georgia, Hawaii, and New Hampshire.
- More than 75% obligated (10 states): Maryland (99.4%), Connecticut (98.4%), Indiana (97.9%), California (93.8%), Iowa (91.7%), Illinois (85.4%), North Carolina (78.7%).
- Less than 10% obligated (15 states): (2.7%), Arkansas (2.9%), Alaska (4.2%), Nevada (1.3%), Wyoming (0.9%), Florida (0.9%), New Mexico (0.4%), Idaho (0.2%).
- None obligated (0%): New York and West Virginia.

RHTP Year 1 Funds Obligated by State as of July 31, 2026

Share of each state's Period 1 award reported as obligated



The dispersion of funding demonstrates states' operational readiness and award mechanics. States that leaned on expanding existing programs, intergovernmental agreements, or large single awards (e.g., Georgia's AHEAD contract) could obligate fast. States running competitive RFP cycles were still mid-procurement at the cutoff. The program's structure rewards early commitment as unobligated Year 1 funds are subject to recoupment and redistribution to other states under 42 U.S.C. 1397ee(h)(1)(B).

¹ Obligated means the state has legally committed the funds via sub-awards, contracts, or agreements. It is not the same as spent. States have until Sept 30, 2027, to spend Year 1 dollars. These amounts reflect funds obligated as of July 31, 2026, and are not a complete view of state progress. A significant amount of sub-award activity happened in August–October 2026.

² Centers for Medicare & Medicaid Services. *Rural Health Transformation Program: Obligated Funds*. Published October 14, 2026. Accessed October 26, 2026. <https://www.medicare.gov/resources-for-states/rural-health/rhtp-resources/RHTP-Obligated-Funds-20261014.pdf>

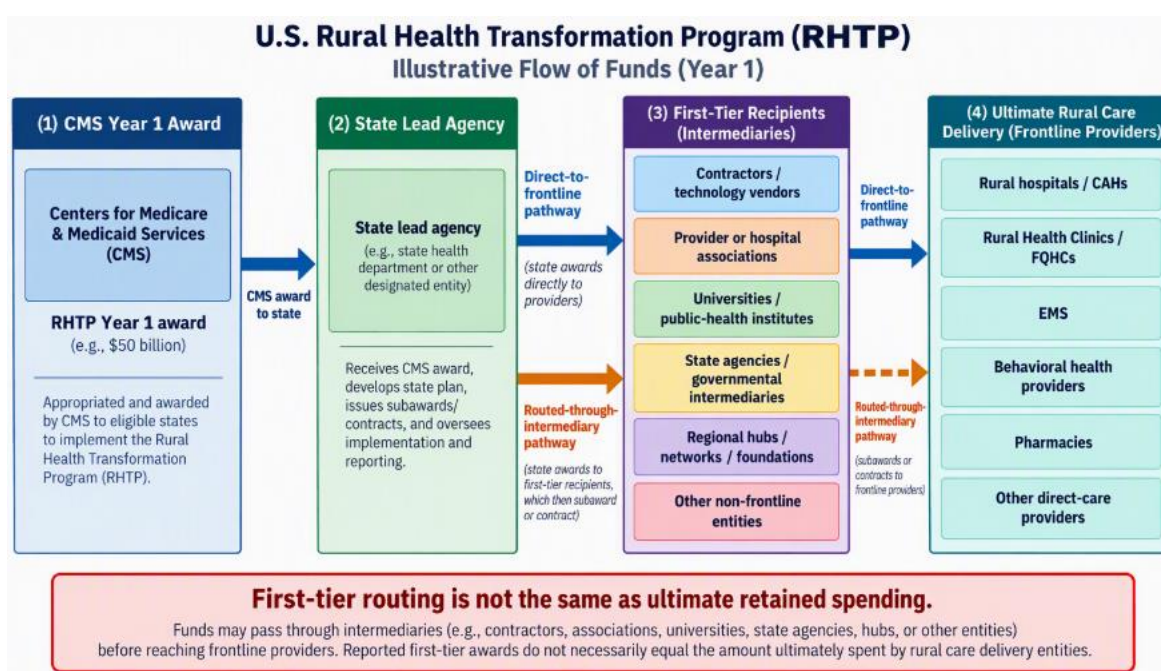
Who is receiving the funding?

CMS pays each state's governor-designated lead agency through a cooperative agreement therefore everything below that is a sub-award, contract, or agreement. Initial sub-award dissemination was overwhelmingly to state government intermediaries including contractors, vendors, and community partners, with hospitals and clinics receiving a smaller portion. CMS published obligation totals by state and initiative, not a national total by recipient type. Only a few states disclosed additional clarity on how funds were allocated by recipient.

Table A: RHTP Awardee Types

Recipient type (as reported to CMS)	Direct or downstream	What the data shows
State government (lead agency)	Direct awardee	The only entity CMS pays. Receives the full Year 1 allotment.
State agencies (Dept of Health, Medicaid, Higher Education)	Downstream	Common early recipients via intergovernmental agreements (e.g., Idaho State Board of Education \$8.0M for GME).
Contractors & Vendors (consultants, tech/IT, grants managers)	Downstream	Present in nearly every state (e.g. Guidehouse, Deloitte, Access Health, Oklahoma's OSU tech co-op).
Community Partners (CBOs, universities, etc.)	Downstream	Universities and CHW alliances recur (Michigan CHW Alliance; NC hub model via Duke/Trillium).
Hospitals & Facilities (CAHs, clinics, FQHCs, EMS)	Downstream	Lead where states route "infrastructure/stabilization" dollars (Idaho hospitals; Montana's 79 EMS agencies).
Other awardees	Downstream	Catch-all (tribal governments, school systems, military division for NG-911).

Rural stakeholders are concerned that without a rural set-aside, dollars may concentrate in state agencies, intermediaries, and vendors better positioned to win and administer grants, rather than in rural hospitals and clinics. It is also anticipated that funds may continue to flow from intermediaries to direct care providers in the field through further sub-award arrangements. Future analysis will be needed to obtain a national recipient analysis, as CMS quarterly and annual reporting requires states to show spending by recipient name.



What initiatives are being funded?

CMS's Office of Rural Health Transformation groups state initiatives under eight categories: *Accessible Care, Population Health, Workforce, Payment and Service Models, Health System Innovation, Technology, Disease Prevention and Care, Health Promotion*.

Preliminary obligation of funding by states focused on keeping facilities open (*Health System Innovation*), staffing, (*Workforce*), connecting them (*Technology*), and paying differently (*Payment & Service Models*). A few states made a significant effort towards disease prevention and care, such as Iowa's cancer program. Health Promotion and Population Health investments were present but more diffuse. Because states initiative categories vary by state, it is not possible to do an analysis of funding amount by category.

Table B: Obligations by CMS Category

CMS Category	Representative Activities	Year 1 intensity	Illustrative Obligated Efforts
Workforce	Grow-your-own pipelines, rural residency/GME, CHWs, recruitment and retention (5-year service commitment)	Dominant	Mississippi Workforce Expansion ~\$19.3M; Idaho GME \$8.0M
Health System Innovation	Hospital financial stability, operational efficiency, EMS modernization, regional networks	Dominant	Idaho Healthcare Infrastructure \$101.5M; Maine Rural Hospital Efficiency \$30M; Montana EMS \$8.7M
Technology	Telehealth, remote patient monitoring, interoperability and HIE, cybersecurity, AI, data hubs	Strong	Michigan "Interoperability in Action" \$48.8M; Maine EMR \$30M; Utah SPRINT tech \$20.9M; Indiana HIE (450 facilities)
Payment & Service Models	Alternative payment models, hub-and-spoke, clinically integrated networks, Medicaid innovation	Strong	Georgia AHEAD \$61.0M; Maine APM transition \$28.5M; Louisiana APM \$30M
Disease Prevention & Care	Chronic disease, cancer, behavioral health/SUD, maternal-fetal	Strong	Iowa cancer \$93M; Mississippi EmPATH psychiatric \$13.3M
Accessible Care	Mobile health, transportation, primary care access, dental, EMS access	Moderate	Colorado whole-blood access \$5M; Alaska mobile frontier access \$99M
Population Health	Upstream drivers, maternal/peds, tribal engagement, place-based, school-based	Moderate	Colorado maternal/peds \$4.2M; Alaska Healthy Beginnings maternal \$22M; tribal set-asides in MI \$8.7M and OR \$22M
Health Promotion	Healthy eating/farming, physical activity, food is medicine, nutrition	Emerging	Texas \$51M (68 rural hospital districts) for chronic disease and nutrition; Louisiana Food is Medicine \$2.7M

APPENDIX:

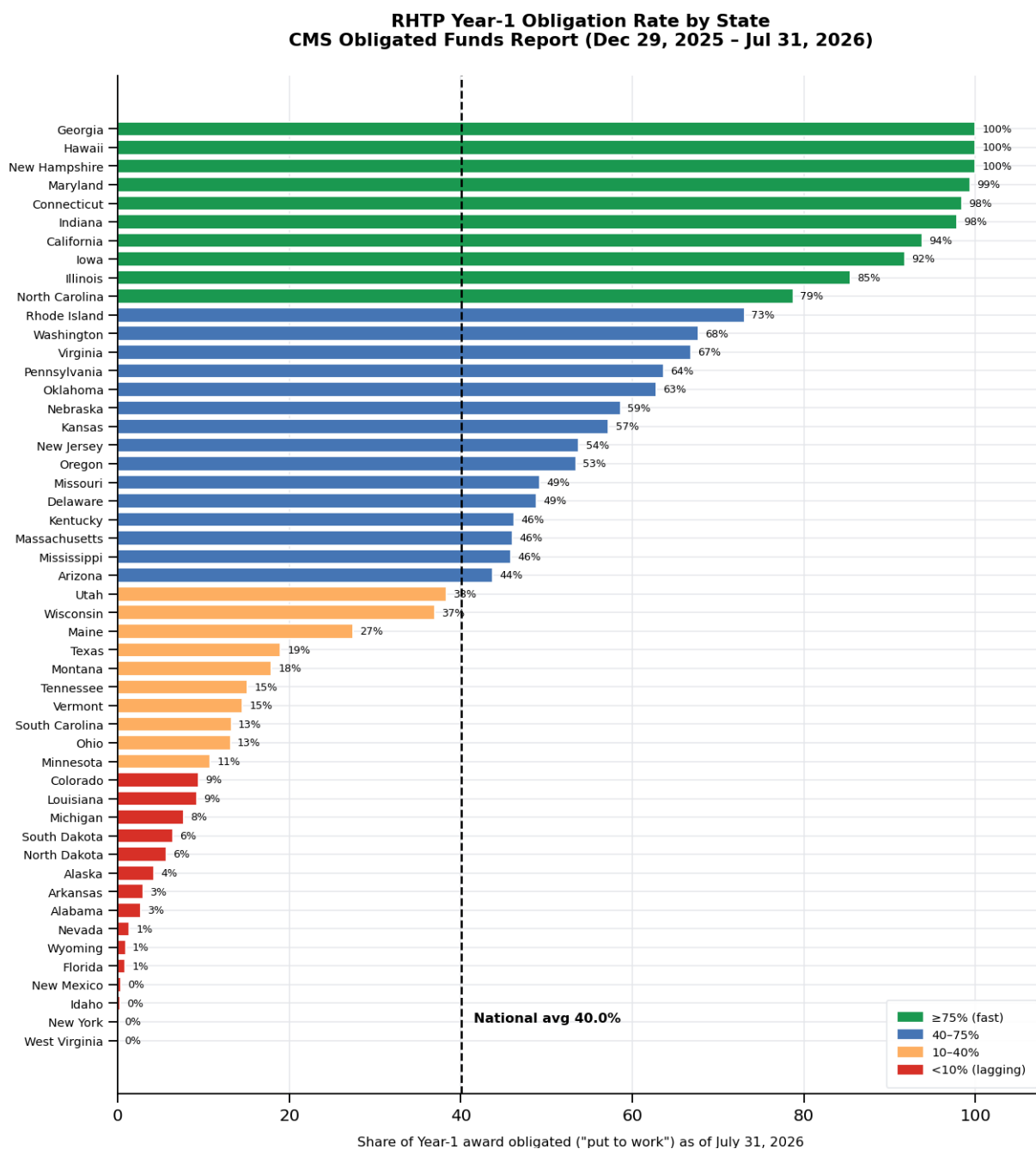


Figure 1: Year-1 obligation rate by state as of July 31, 2026. Computed from the CMS state-level table.

Award Size vs. Obligation Pace — the biggest awards moved slowest

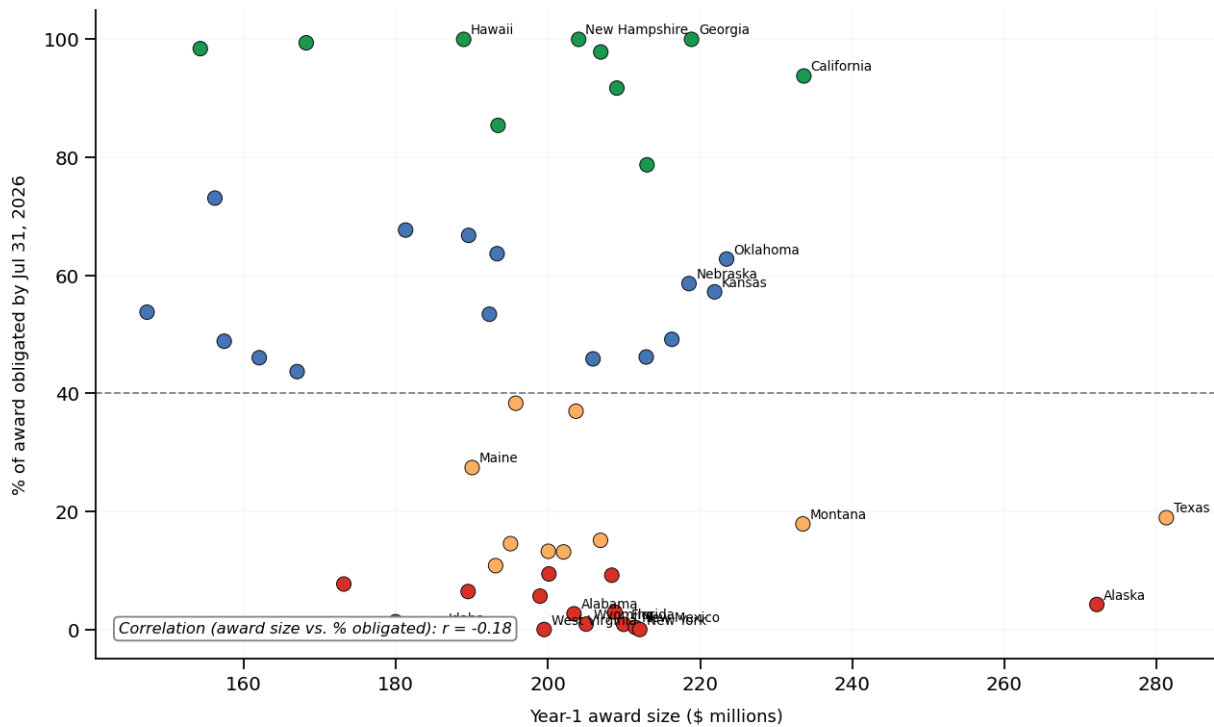


Figure 2: Award size vs. obligation pace. Large allotments did not translate into fast commitment.