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State Strategies for the Rural Health Transformation Program (RHTP)

A Milbank State Leadership Network Convening Recap

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EXECUTIVE SUMMARY

The Milbank State Leadership Network (MSLN) hosted two virtual sessions for state-to-state discussion on opportunities and strategies related to the federal Rural Health Transformation (RHT) Program, recently launched by the Centers for Medicare & Medicaid Services (CMS). Representatives from 24 states participated in the two-day convening, which consisted of five one-hour breakout sessions focused on each of the program's strategic funding pillars: 1) Make Rural America Healthy Again, 2) Workforce Development, 3) Sustainable Access, 4) Innovative Care, and 5) Technology Innovation. Session themes and strategies are summarized below. Official responses on allowable costs, scoring, and other grant specific questions should be posed to CMS. While state names are not listed below for confidentiality, please contact Milbank to be connected to those pursuing specific strategies.

Key themes

Across all sessions, panelists and participants identified the following areas for priority action:

- **Ongoing Rural Community Engagement**: States have been rapidly collecting community and stakeholder input through surveys, local convenings, and requests for information to guide grant applications and ensure alignment with community needs. Given the five-year implementation timeline, states shared how they will receive continuous feedback through grantee meetings, task forces, community health assessments, and standing advisory groups to public health and Medicaid agencies.
- **Shovel-Ready Projects:** Due to grant timelines and the possibility that unspent funds could be redistributed at the end of each grant period, states are prioritizing projects that can launch quickly, enhance existing systems and contracts, purchase needed equipment and technology, and demonstrate measurable early outcomes.
- **Legislative and Local Collaboration:** While some states' legislatures are minimally involved, others are holding weekly oversight meetings for the RHTP planning process. All participants emphasized the value of early coordination between legislators, counties, and state agencies to align policies, funding, and implementation priorities and expectations.

Framing Resources

- NCSL: RHTP State Legislative Resources
- NRHA: RHTP Opportunity for State Policy Agendas
- ASTHO: Understanding and Applying for the Rural Health Transformation Program
- State Health and Value Strategies: Rural Health Transformation Program: State Strategies for Lasting Impact
- Paragon Report: RHTF Offers States a Way to Improve Rural Health Care Access

MAKE RURAL AMERICA HEALTHY AGAIN

This pillar focuses on prevention, primary care, behavioral health, chronic disease management, prenatal care and expanded access to coordinated care in rural communities. States are integrating clinical services, such as primary care, behavioral, maternal, and oral health, and strengthening emergency medical services (EMS) and public health capacity to reduce preventable illness and improve community wellness. Public health has had a long history of engaging with rural communities and deploying grants and resources to meet needs identified by communities via county health councils, county health assessments, and other structures. Likewise, states have been investing in certified diabetes prevention programs, certified community behavioral health clinics, and access to/incentives for physical activity and nutritious food that they plan to expand.

Implementation Timelines

States emphasized the importance of creating clear timelines in the proposals to balance early implementation with long-term transformation. Short-term projects build momentum and demonstrate readiness, while later phases focus on integration and sustainability across systems. The five-year grant structure allows states to plan in stages, with an evaluation after the first year to assess progress, document early outcomes, and inform subsequent implementation phases.

Examples:

- Immediate (Year 1)**:** Direct investments in ambulance and EMS systems, including new ambulance equipment and EMT/non-delivery hospital training for perinatal and maternal care. Training and technical assistance for clinical care integration.
- Medium-term: Align RHTP with the AHEAD model to increase investment in rural primary and preventive care and incentivize care integration. Use existing regional hubs as hub-and-spoke networks to coordinate maternal, dental, and behavioral health. Invest in telehealth, expand nurse home visiting, and support school-based prevention programs.
- Long-term: Coordinate services and share data by building consortia that link federally qualified health centers, hospitals, community organizations, and health departments.

Operational Collaboration

Counties (either government entities or via ongoing county health councils that may be partnered with a fiduciary entity) emerged as key operational partners in RHTP planning and implementation. Local public health and health delivery are engaged with local government, which can serve as sub-recipients or managing entities for rural health transformation efforts.

Approaches:

- Use local public health departments or health councils as primary delivery channels for engagement, integration and prevention work.
- Create memorandums of understanding (MOUs) between states and counties to clarify roles and funding responsibilities.
- Repurpose staff funded by the American Rescue Plan Act to support RHTP management, maintaining capacity and expertise without expanding government structures or staffing.

Resources Shared

- National Grocery Association State SNAP Restriction Waiver Tracker/Explainer
- Integration of Health Care, Public Health and Communities: A New Model for Rural Public Health (*AJPH* Article, Maine experience)
- Available upon request from TN: Rural Health Care Resiliency Grant Program scoring rubric based on Community Need (35 points), Quality of Approach (35), Sustainability (10), Evaluation plan (10), and Budget (10) (jw.randolph@tn.gov)

Cross-Branch Engagement

Legislative and cross-agency collaboration is critical for sustainability. State agencies are involving legislators early in planning, through briefings and advisory councils, to align program goals and strengthen policy continuity. In many states, legislators must approve key budget items, so active engagement throughout the process helps build shared ownership and ensures that supportive legislation creates the policy framework needed for programs to succeed.

Examples of legislation that results in RHTP scoring advantages are below.

- Offer or require continuing medical education (CME) credits in nutrition for rural clinicians and all health care trainees.
- Collaborate with education agency on expanding school-based physical fitness programs.
- Review scope of practice, competencies, and Medicaid reimbursement for pharmacists and doulas to strengthen access to maternal and preventive care as a means of extending teams and integrating services into places (pharmacies) that are already in rural communities.

Although the first two policies were new to most states, they were more likely to consider them accomplishable. However, states were less willing to gamble a potential funding claw-back on legislative changes to scope of practice.

TECHNOLOGY INNOVATION

This pillar includes technology to enhance care coordination, strengthen cybersecurity, and expand digital access in rural areas. In addition to data system improvements, states aim to support telehealth, e-consults, and build digital-literacy programs to ensure residents and providers can use tools effectively. These strategies aim to reduce fragmentation and build long-term, sustainable infrastructure for connected care.

Digital System Integration & Access

States emphasized connecting existing technology systems rather than building new platforms. Expanding e-consults and health information exchanges allows providers to collaborate more efficiently and coordinate patient care.

Examples:

- Develop regional data-sharing frameworks connecting hospitals, FQHCs, and community partners, including libraries and food pantries.
- Consolidate health information exchanges (HIEs) across public agencies and health care systems to reduce costs and improve efficiency.
- Expand digital literacy and navigation programs by training community-based digital navigators to help residents access telehealth and health technology tools.

"We are not building new platforms; we are connecting what already exists." — [Participant]

Resources Shared

- RHI HUB: Barriers to Telehealth Access in Rural Areas
- Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review of Evidence
- NRHA: Expansion of EHR Interoperability Software to Rural Health Care Systems
- Washington: RHTP Priorities, Inputs and Resources

Innovation through Vendor Partnerships

Technical capacity remains a major challenge. States are engaging vendors early to ensure timely implementation and translate strategic goals into effective technical solutions.

Examples:

- Expand electronic medical record (EMR) and e-consult capacity to enable provider-to-provider consultations to improve access to specialty care and reduce referral delay.
- Integrate AI to link clinical and community data, automate directory updates, and support coordinated population health strategies through community information exchanges (CIE).
- Expand Project ECHO from provider education to direct care delivery and use the existing program structure to train providers on digital tools.

Sustainability & Support

Sustainable technology strategies require collaboration among payers, workforce systems, and data-governance entities. States aim to align policies, training, and reimbursement models to sustain digital tools and ensure interoperability across rural and urban settings.

Examples:

- Partner with the legislature to align technology investments with service coverage and reimbursement for digital care.
- Use interstate telehealth compacts to expand workforce and increase access to care.
- Engage payers beyond Medicaid to develop multi-payer reimbursement models that sustain telehealth, e-consult, and digital infrastructure after RHTP funding ends.

BUILDING AND SUSTAINING THE RURAL HEALTH WORKFORCE

Participants discussed strategies to sustain access to care and strengthen the rural health workforce pipeline. States emphasized locally tailored workforce solutions, cross-sector partnerships, and policies that align short-term grant opportunities with long-term sustainability.

Engaging Communities and Building Health Hubs

One approach to addressing workforce shortages is the regional "health hub" model that brings together regional public health centers with local health care providers and social-service partners to improve access and connect residents to care and services. This has been noted as a strategy to reduce burnout and retain current workforce and also to address patient needs efficiently.

Examples:

- Develop regional health hubs that provide immediate access to primary care and then deploy community health workers (CHWs) to link residents to primary care, behavioral health, and wraparound services.
- Use state data systems (such as updated licensure systems, linked claims data that gives visibility on site of service delivery, and public health scorecards) to identify regions with workforce gaps and align hub resources accordingly.

Innovation and Local Capacity

States are balancing the need for innovation with the realities of short grant timelines and limited administrative capacity. Some states are considering requesting a short-term period that encourages local experimentation while maintaining accountability. Participants noted that metrics for workforce success, such as pipeline development and retention, are evolving and should be tied to final program goals rather than short-term outputs.

Examples:

- Establish a state-led "sandbox", or testing environment, that allows regional partners to pilot new workforce approaches within defined parameters.
- Focus on "grow-your-own" workforce strategies, recruiting and training local residents for health care careers through partnerships with community colleges, tribal organizations, and regional health systems. Individuals from rural communities are much more likely to stay and work in rural communities.

Expanding Training and Tribal Workforce Pathways

Sustaining a rural health workforce requires targeted investments in education and training. States are prioritizing both clinical training programs and workforce development.

Examples:

- Expand medical residency slots dedicated to training and retaining providers in rural communities through partnerships with medical schools and academic health centers.
- Provide incentives to draw residency program directors to rural areas or train physicians to become teachers in rural areas.
- Create tribal workforce set-asides to ensure Native communities have dedicated funding and culturally competent providers.
- Invest in career ladders to retain the rural health workforce through career advancement opportunities.

Resources Shared

- Louisiana State Health Improvement Plan
- Health Report Card | Louisiana Department of Health
- Targeting Rural Health Care Workforce Investments by Tracking the Local Distribution of Medicaid Primary Care Providers (Milbank)
- IMPaCT: Model Language for Integrating Proven Community Health Worker Programs into RHTP Applications
- GW State Tracker for Medicaid Primary Care Workforce
- State Strategies for Engaging CHWs Amid Federal Policy Shifts (Milbank)
- Investing in Primary Care: The Nurse Practitioner Will See You Now (Milbank
- Lessons Learned from State-Based Efforts to Leverage Medicaid Funds for Graduate Medical Education (SME interviews from 10 states)
- Can Interstate Licensure Compacts Enhance the Health Care Workforce? (Milbank)

ADVANCING INNOVATIVE CARE MODELS

State leaders discussed strategies for designing and implementing innovative care models. The conversation focused on building upon existing programs and aligning Medicaid and public health priorities, leveraging federal funding to advance value-based care, and ensuring that models are sustainable and responsive to rural community needs.

Innovative Financing

States discussed building off existing initiatives that advance innovative care through financing models.

Examples:

- Expanding value-based purchasing (VBP) beyond prospective payment system hospitals to include critical access hospitals and rural health clinics.
- Encouraging more critical access hospitals to convert to rural emergency hospitals.
- Exploring alternative payment models (APMs) that reward quality and sustainability.
- Encouraging multi-payer alignment on goals and outcomes to reduce administrative burden and improve consistency for providers.
- Funding cooperative purchasing agreements (e.g. Rough Rider High Value Network) that help rural hospitals procure services and reduce costs.
- Creating regional subgrants that would allow flexibility in selecting locally relevant metrics aligned with overarching statewide outcomes.

Wrap Around Services and Care Coordination

States also discussed adding new service lines in regional hubs to address the root causes of illness, investing in technology to reduce reliance on limited workforce capacity (from "floor-mopping robots" to telehealth systems), and expanding mobile clinics to reach remote populations.

Examples:

- Filling safety-net service gaps, e.g. establishing medical detox units.
- Creating a billing app for non-emergency medical transportation to help providers better coordinate rides for patients in rural regions.
- Developing closed-loop referral systems that integrate with electronic health records (EHR) to connect medical and social service providers.

Integrating Value-Based Care and Technical Assistance

States participating in the AHEAD discussed aligning RHT strategies with the model by building technical assistance (TA) resources for hospitals and rural providers preparing to transition to VBP. Other TA strategies included:

Resources Shared

- Colorado Hospital Collaborative Agreements (legislation and implementation)
- Mississippi Rural Health Transformation Program Stakeholder Survey
- Mississippi: Information and Recommendations
- Transforming Rural Health Care Through Medicaid Innovation (CHCS)
- Rural Health Value: Introduction to Clinical Integrated Networks

- Drawing from HRSA's Delta Region TA model, which offered fiscal and operational guidance to hospitals pursuing APMs.
- Learning lessons from the four states who worked on the CMS Community Health Access and Rural Transformation (CHART) program.
- Upgrading data systems and providing TA for smaller hospitals and primary care practices, enabling their participation in global budgets and capitated programs.

SUSTAINABLE ACCESS

This pillar focuses on helping rural providers become long-term access points for care by improving efficiency, coordination, and financial sustainability. States are aligning workforce, infrastructure, and data systems so that small and rural facilities can remain viable while meeting community needs.

Coordinating Systems and Using Data for Access Planning

States are integrating planning across Medicaid, behavioral health, and public health agencies to align priorities and prevent duplication. Community engagement and local data analysis help states determine where care should be delivered and how rural facilities can collaborate to ensure reliable access.

Examples:

- Establish cross-agency coordination teams that align RHTP planning and implementation across public health, behavioral health, and Medicaid agencies.
- Use data mapping and capacity analyses to identify service gaps and structure regional coordination for primary, maternal, and behavioral health care.
- Conduct community listening sessions and advisory councils to ensure that access strategies reflect local needs and build trust in public health planning.

Regional Collaboration and Service Coordination

States are pursuing regional partnerships that allow rural hospitals and clinics to share staff, technology, and administrative systems. This approach preserves access while preventing duplication and helping smaller facilities remain sustainable within broader service networks.

Examples:

- Develop regional hospital consortiums to share administrative services, health information systems, and clinical staff. This has required enabling legislation in some states. In others, it has required clarification of anti-competitive practices.
- Offer planning assistance for needed service lines so facilities can focus on services that match local demand, such as emergency or maternal care.
- Offer incentives such as electronic medical record upgrades for facilities that transition to rural emergency hospitals or outpatient entities to appropriately match population needs.
- Create transportation coordination systems that connect residents in remote areas with nearby facilities, expanding access to specialty or inpatient care.

Resources Shared

- Washington Certificate of Need Modernization study including impact from actions in other states
- NRHA Policy Brief: Obstetric Readiness in Rural Communities Lacking Hospital Labor and Delivery Units
- Building Bridges to Value: Infrastructure Essentials for Community Health Centers (Milbank report)
- Comparing Preventable Acute Care Use of Rural vs Urban Americans
- Community Health Access and Rural Transformation (CHART) Model

Strengthening Financial Sustainability and Operational Innovation

Financial stability underpins sustainable access. States are supporting hospitals and health systems in improving cost management, operational efficiency, and innovation in care delivery to ensure resources are used effectively over the long term.

Examples:

- Provide technical assistance and management support to strengthen financial operations and strategic planning for rural hospitals through statewide rural centers of excellence.
- Support operational innovations such as shared staffing pools, cooperative purchasing agreements, or centralized billing systems to improve efficiency.
- Foster multi-agency collaboration to align funding sources, leverage federal programs, and coordinate investments that stabilize rural service networks.

DISCUSSION: ADDRESSING COMMON CHALLENGES ACROSS STATES

States highlighted enduring challenges in rural health transformation that may impact the implementation of sustainable programs including fee-for-service payment models, telehealth restrictions, transportation barriers, and limited broadband access.

In addition to these challenges, states expressed uncertainty about how applications will be scored, particularly when committing to policy changes that require legislative approval — such as expanding scope of practice or creating new licensure compacts. Given potential leadership changes and the risk of federal fund rescission, many states are considering prioritizing administrative action over legislative proposals.

States emphasized the importance of alignment and accountability across agencies to ensure the Rural Health Transformation Program achieves lasting impact. Many are forming cross-agency groups that include Medicaid, public health, technology vendors, and higher education representatives to coordinate implementation and maintain oversight during the five-year grant period. Because many program budgets require legislative approval, close coordination across branches of government is also essential to sustain funding and policy continuity.

States noted that territorialism can emerge in rural health systems where providers are competing for limited patient populations and reimbursement. Participants described building communication mechanisms and on-the-ground relationship management to foster trust and collaboration across institutions to sustain transformation.