Navigating the Rural Health Transformation Program

From federal funding to measurable rural clinical capability

A practical guide for critical access hospitals, rural hospitals, rural health clinics, FQHCs, and health systems preparing to pursue and deploy RHTP funding

An Elsevier educational white paper | April 2026

Executive brief

The Rural Health Transformation Program (RHTP), referred to by the Centers for Medicare & Medicaid Services (CMS) as the Rural Health Transformation (RHT) Program, is a five-year, $50 billion federal investment to help states strengthen rural healthcare access, quality, workforce capacity, technology, and sustainability. CMS has announced awards to all 50 states, with first-year awards averaging about $200 million and ranging from about $147 million to $281 million.

The opportunity for rural providers is practical and immediate. States are translating CMS-approved plans into requests for applications (RFAs), subawards, enterprise procurements, technical assistance programs, and consortium models. Provider organizations should treat RHTP not as a single grant deadline but as a multi-year portfolio of opportunities that will reward readiness, state-plan alignment, measurement discipline, and sustainable implementation.

Why this matters now

The next 12 to 24 months will shape which rural organizations are named in state strategies, invited into regional consortia, included in enterprise procurements, and prepared to respond when RFAs open. The strongest proposals will not simply describe activities; they will connect a rural problem to an evidence-based intervention, a realistic implementation model, baseline metrics, target outcomes, reporting capacity, and a sustainability path.

RHTP is now moving from federal award to state implementation. Rural organizations that can show measurable improvements in access, workforce stability, quality, chronic disease management, and technology adoption will be best positioned to compete for funding and turn awards into durable local capacity.

What you will find in this guide:

- A plain-language overview of RHTP funding mechanics and state implementation
- A step-by-step roadmap for engaging your state agency and pursuing funding
- A clear-eyed look at rural operational challenges and the evidence-based interventions that address them
- Practical next steps, a timeline, and a checklist you can apply this quarter

1. A 90-day action plan for RHTP readiness

Rural leaders who move early can shape state conversations and shorten response time when funding opportunities open. The following plan is designed for a small cross-functional team and should be revisited quarterly.

1.1 A 90-day action plan

Days 1–30: Assess and align

- Identify your state's RHTP lead agency and obtain the publicly available plan or abstract
- Map the state's priority pillars against your organization's most pressing needs (workforce, quality, chronic care, technology, access)
- Assemble a small internal RHTP task force with representation from the CEO, CFO, CMO, CNO, CIO, quality, and grants
- Designate a single executive owner for RHTP engagement

Days 31–60: Prepare

- Register or refresh your organization's SAM.gov profile and state vendor/grantee registration
- Complete or update required assurances: HIPAA safeguards, cybersecurity attestations, financial audits, conflict of interest disclosures
- Inventory existing clinical, workforce, and technology initiatives that can serve as the foundation for RHTP proposals
- Identify measurable baseline metrics (nurse turnover, readmissions, chronic disease control rates, time-to-competency)

Days 61–90: Engage and position

- Request a briefing with your state Office of Rural Health and hospital association to understand solicitation cadence
- Participate in state advisory councils, webinars, and public comment opportunities
- Identify potential partners (academic medical centers, AHECs, neighboring CAHs) for consortium applications
- Draft two or three pre-approved concept papers aligned to the state's priority pillars, ready to tailor when RFAs drop

1.2 Engagement checklist

- [ ] Confirmed state lead agency and primary contact
- [ ] Downloaded and reviewed the state's CMS-approved plan or abstract
- [ ] Subscribed to state procurement bulletins and RHTP distribution lists
- [ ] Established internal RHTP task force with clear executive sponsor
- [ ] Mapped state priorities to organizational needs and current initiatives
- [ ] Verified SAM.gov and state vendor registrations are active
- [ ] Reviewed compliance posture: HIPAA, cybersecurity, Uniform Guidance
- [ ] Identified partner organizations for potential consortium applications
- [ ] Defined outcome metrics and baselines for priority initiatives
- [ ] Drafted concept papers for the state's top two or three priority pillars

1.3 Writing applications that win

States are scoring applications against their transformation plans and against CMS expectations. Proposals that consistently rise to the top share several features:

- **Clear alignment.** Explicit linkage to the state plan's pillars, using the state's own language.
- **Measurable outcomes.** Baseline data, targets, and a measurement plan rather than activity descriptions.
- **Rural specificity.** Evidence that the design fits small-scale, resource-limited settings.
- **Sustainability.** A credible plan for operational continuity after the funding period ends.
- **Equity.** Explicit attention to populations underserved in the service area.
- **Partnership.** Letters of support and named collaborators where appropriate.

2. Overview of the Rural Health Transformation Program

2.1 What RHTP is and why it matters

The Rural Health Transformation Program is the largest federal investment ever directed specifically at rural health delivery. CMS administers the program and distributes funding to states with approved transformation plans. States act as the primary grantees and deploy funds to CAHs, rural hospitals, rural health clinics, Federally Qualified Health Centers, and partner organizations through solicitations, subawards, and procurements.

RHTP is intentionally broad in scope. It reflects a policy recognition that rural health cannot be strengthened through any single lever. Workforce pipelines, technology adoption, care coordination, prevention, and value-based payment readiness must all advance together for rural systems to stabilize and grow.

2.2 Funding mechanics

Element	Detail
Authorizing statute	One Big Beautiful Bill Act (Rural Health Transformation Program)
Administering agency	Centers for Medicare & Medicaid Services
Total appropriation	$50 billion over five federal fiscal years (FY2026–FY2030)
Annual distribution	Approximately $10 billion per year to approved states
Allocation formula	50% equal share across approved states; 50% needs-based, weighted by rural population, facility mix, workforce shortages, and utilization
First-year awards	All 50 states approved; awards averaging approximately $200 million (range ~$147M–$281M)
Period of performance	State funds typically obligated over 3–5 years; provider-level subawards vary

2.3 Program goals

CMS and state plans consistently prioritize six goal areas. Rural providers should anchor their RHTP pursuit strategy to these pillars:

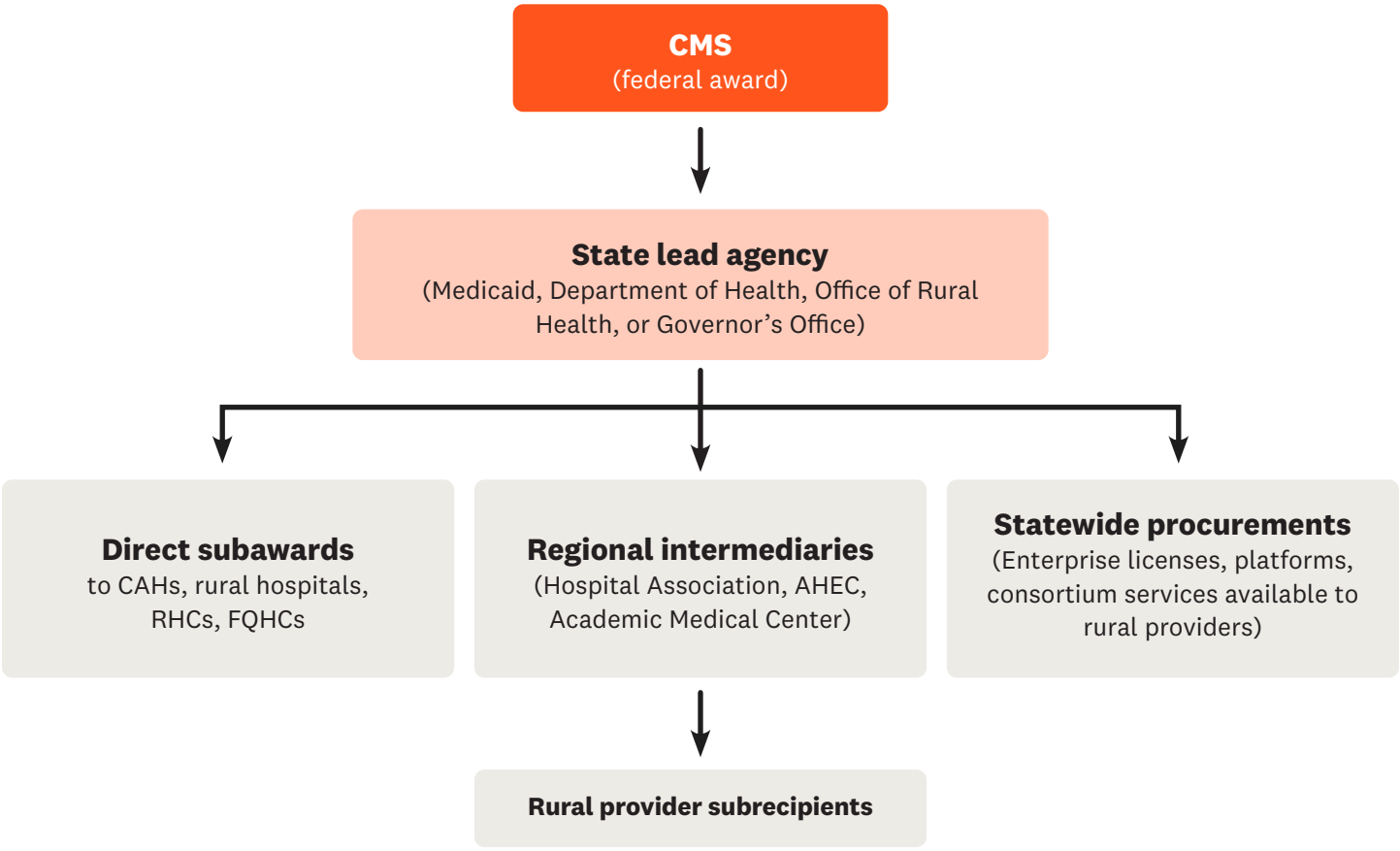
- **Access and infrastructure:** telehealth, facility modernization, and regional care networks
- **Quality and patient safety:** clinical standardization, decision support, and measurement
- **Workforce:** recruitment, retention, training, and residency or transition-to-practice pipelines
- **Technology and innovation:** artificial intelligence, EHR-integrated evidence, and remote monitoring
- **Prevention and chronic disease management:** standardized patient education and population health
- **Value-based and alternative payment models:** data infrastructure and quality reporting readiness

2.4 Current status

As of April 2026, every state has received a first-year award and is operationalizing its plan. Implementation pace varies: some states have opened initial Requests for Applications (RFAs) and procurements; others are convening advisory councils and finalizing governance. The practical implication is that rural providers should treat RHTP not as a single deadline but as a multi-year portfolio of opportunities, with substantial activity expected between Q2 2026 and Q4 2028.

3. How funding flows: From CMS to states to providers

3.1 The pathway at a glance



3.2 Step-by-step flow

Step 1 — CMS cooperative agreement. CMS obligates each state's annual award under a cooperative agreement tied to the state's approved transformation plan.

Step 2 — State implementation plan. The state lead agency operationalizes the plan, establishes governance, and defines priority investment areas for the fiscal year.

Step 3 — State solicitations. The state issues RFAs, grants, and procurements. Solicitation types typically include:

- Competitive grants to individual providers or consortia
- Workforce pipeline subawards (residencies, transition to practice, continuing education)
- Technology and quality enterprise procurements (clinical decision support, telehealth, education platforms)
- Technical assistance contracts for hospital associations, AHECs, and academic partners

Step 4 — Provider application and selection. Eligible providers submit applications. States score against transformation-plan criteria, including outcome measurability, equity impact, and sustainability.

Step 5 — Subaward execution. Selected providers execute subaward agreements with the state or intermediary. Providers accept reporting, compliance, and performance obligations under 2 CFR Part 200 and state law.

Step 6 — Deployment and reporting. Providers implement funded activities and submit quarterly financial and performance reports. States aggregate results for CMS reporting.

3.3 Who is eligible

Eligibility is set by each state within federal guidance. The most commonly eligible entities include:

- Critical Access Hospitals and Rural Emergency Hospitals
- Sole community hospitals, Medicare Dependent Hospitals, and other rural PPS hospitals
- Rural Health Clinics and Federally Qualified Health Centers
- Rural-serving health systems and integrated delivery networks
- State Offices of Rural Health, hospital associations, AHECs, and academic medical centers (often as intermediaries)
- Consortia and collaboratives that include the above entities

4. Common challenges in rural settings and how evidence-based solutions accelerate success

4.1 Five operational realities that shape rural transformation

1. **Workforce fragility.** High turnover among new nurses and difficulty recruiting specialists leave rural teams stretched thin. First-year nurse turnover and physician recruitment gaps are the single largest drivers of rural service reductions.
2. **Variation in clinical practice.** Without ready access to current evidence and decision support, variation in diagnosis and treatment drives both cost and outcome disparities.
3. **Technology debt.** Many rural facilities run lean IT environments with limited integration capacity, making sophisticated tools hard to adopt.
4. **Chronic disease burden.** Rural populations experience higher rates of diabetes, cardiovascular disease, and behavioral health comorbidities, yet have fewer resources for structured self-management education.
5. **Quality reporting and value-based readiness.** Smaller teams struggle to meet growing measurement requirements, limiting participation in alternative payment models.

4.2 How evidence-based solutions move the needle

Rural challenge	Evidence-based response	Expected RHTP outcome
First-year nurse turnover	Structured transition-to-practice with competency tracking and peer mentoring	Improved retention; reduced orientation time
Clinical variation	Point-of-care evidence and decision support integrated into the EHR	Reduced variation; improved quality measures
Specialist scarcity	AI-enabled clinical decision support for common diagnostic and therapeutic decisions	Faster, more consistent care; reduced transfers
Chronic disease burden	Standardized, plain-language patient education and self-management tools	Improved adherence; reduced avoidable utilization
Reporting burden	Structured content and documentation that aligns with quality measures	More reliable reporting; APM readiness

Elsevier's clinical solutions, including ClinicalKey, ClinicalKey AI, ClinicalKey Nursing and ClinicalKey Nursing AI, Clinical Skills, Transition to Practice, Patient Education, and Clinical Pharmacology, are designed to operate in resource-limited environments and to integrate with existing EHR and learning systems. They are developed from peer-reviewed evidence and editorial governance that rural clinicians and regulators recognize.

4.3 Illustrative outcomes

The following examples are anonymized composites drawn from rural and community hospital deployments and are offered for educational context only. Specific results vary by setting and implementation design.

- A regional health system with several CAH affiliates reduced first-year nurse turnover after implementing a structured transition-to-practice program with integrated clinical reference and skills competency tracking
- A rural hospital standardized its stroke and sepsis pathways using point-of-care clinical decision support, improving adherence to evidence-based bundles and supporting quality reporting
- A rural primary care network improved A1c control in its diabetes population after adopting standardized, plain-language patient education materials distributed through the patient portal

5. How Elsevier can partner as your consultant and solution provider

Elsevier's role in the rural health community is to put trusted, current evidence in the hands of clinicians and patients, and to help health systems translate that evidence into measurable outcomes. In the context of RHTP, we partner with rural leaders in four ways.

5.1 Evidence and content that fits rural practice

Our clinical content is developed by editors and clinician reviewers, refreshed continuously, and designed for point-of-care use. Rural providers use it to reduce variation, support new hires, and meet quality standards without expanding local infrastructure.

5.2 AI-enabled clinical decision support

ClinicalKey AI and ClinicalKey Nursing AI deliver answer-grade clinical guidance grounded in Elsevier's curated evidence base. Guardrails, traceable sources, and editorial governance are designed to support safe adoption in settings that cannot absorb the risk of unconstrained generative AI.

5.3 Integration and implementation expertise

We support integration with leading EHR platforms, learning management systems, and patient portals. In rural settings, this matters because implementation capacity is the scarcest resource. We plan deployments to minimize IT burden, accelerate clinician adoption, and preserve local workflows.

5.4 Consultative guidance for RHTP-aligned initiatives

Our teams collaborate with health systems, State Offices of Rural Health, hospital associations, and academic partners to design programs that align with RHTP pillars and state plans. This includes outcome frameworks, measurement design, consortium models for CAH access, and content licensing structures suited to rural budgets.

5.5 A clear invitation

We recognize that RHTP planning is unfolding under real-time pressure. If you would find it helpful, we welcome the opportunity to share relevant research, implementation frameworks, and anonymized outcome examples with your team, with no expectation of commercial discussion. Our goal is to support the rural health community and to be a useful resource as you translate RHTP funding into durable local capacity.

6. Next steps and resources

6.1 A practical timeline for 2026

Period	Priority actions
Q2 2026	Form internal RHTP task force; map state plan; refresh registrations and assurances
Q3 2026	Engage state Office of Rural Health and hospital association; draft priority concept papers; identify partners
Q4 2026	Respond to initial RFAs and procurements; establish baseline metrics; finalize partner agreements
2027	Execute funded initiatives; begin quarterly performance reporting; pursue follow-on solicitations
2028-2030	Sustain programs; expand successful pilots; position for value-based and APM transitions

6.2 Key contacts to identify in your state

- State lead agency director (Medicaid, Department of Health, or Office of Rural Health)
- State RHTP program manager or transformation lead
- Governor's rural health advisor or rural affairs office
- State hospital association rural council
- State Office of Rural Health director
- Academic medical center rural health program leadership
- CMS regional office liaison

6.3 Provider checklist

- [ ] Executive sponsor identified and RHTP task force convened
- [ ] State plan obtained, summarized, and circulated internally
- [ ] Gap analysis completed against state priority pillars
- [ ] Baseline metrics defined for priority initiatives
- [ ] Concept papers drafted for top two or three opportunities
- [ ] Partners identified and letters of support requested
- [ ] Registrations, assurances, and compliance documents current
- [ ] Application calendar built from state procurement bulletins
- [ ] Measurement and reporting plan drafted
- [ ] Sustainability plan beyond the funding period defined

6.4 Connect with Elsevier

Elsevier's role in rural transformation is to put trusted, current evidence in the hands of clinicians and patients, while helping leaders turn that evidence into measurable outcomes. In RHTP-funded work, that means supporting practical, measurable improvements in clinical practice, workforce readiness, patient engagement, medication safety, and reporting. Elsevier helps rural organizations move from funding to measurable clinical capability by combining trusted evidence, AI-enabled clinical guidance, workforce development, patient education, and workflow integration in a way that fits resource-constrained rural care settings.

7. References and appendix

7.1 Primary federal sources

- Centers for Medicare & Medicaid Services. Rural Health Transformation Program Overview. cms.gov/priorities/rural-health-transformation-rht-program/overview
- Centers for Medicare & Medicaid Services. Rural Health Transformation Program State-Provided Abstracts. cms.gov/files/document/rht-program-state-provided-abstracts.pdf
- Rural Health Information Hub. Rural Health Transformation Program Resources. ruralhealthinfo.org/resources/lists/rhtp
- Rural Health Information Hub. Critical Access Hospitals Topic Guide. ruralhealthinfo.org/topics/critical-access-hospitals
- Rural Health Information Hub. Healthcare Access in Rural Communities. ruralhealthinfo.org/topics/healthcare-access
- U.S. Office of Management and Budget. Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, 2 CFR Part 200.
- U.S. Department of Health and Human Services. HIPAA Privacy, Security, and Breach Notification Rules, 45 CFR Parts 160 and 164.

7.2 Elsevier resources

- Elsevier. Clinician of the Future 2025 Report
- Elsevier Health Solutions for Nurses: elsevier.com/health/nurse
- Elsevier Health Solutions for Physicians: elsevier.com/health/physician
- ClinicalKey, ClinicalKey AI, ClinicalKey Nursing, ClinicalKey Nursing AI, Clinical Skills, Transition to Practice, Patient Education, Clinical Pharmacology

7.3 Key facts at a glance

- **Total RHTP appropriation:** $50 billion over FY2026–FY2030
- **Annual distribution:** Approximately $10 billion per year to approved states
- **Allocation formula:** 50% equal share; 50% needs-based
- **First-year awards:** All 50 states approved; awards averaging approximately $200 million
- **Administering agency:** Centers for Medicare & Medicaid Services
- **Eligible providers (typical):** Critical Access Hospitals, Rural Emergency Hospitals, other rural hospitals, Rural Health Clinics, FQHCs, and rural health systems, often through state or intermediary pathways

7.4 Disclaimer

This guide is an educational resource prepared for the rural health community. It summarizes publicly available federal and state information as of April 2026 and is not legal, procurement, or investment advice. Rural providers should confirm state-specific rules, eligibility, and timelines with the appropriate agencies, and consult legal, financial, and compliance counsel as appropriate.

Prepared by Elsevier Health Sciences in support of rural providers advancing the goals of the Rural Health Transformation Program.

For more information, contact your Elsevier representative or visit elsevier.com/health