Bipartisan Policy Center

Federal Policy Priorities To Strengthen Rural Health and Maximize Rural Health Transformation Program Investments

JULY 2026

TABLE OF CONTENTS

AUTHORS

Daisy Kim, *Senior Policy Analyst, Health Program*

Maya Sandalow, *Director, Health Program*

ACKNOWLEDGMENTS

The Bipartisan Policy Center would like to thank the Commonwealth Fund and the Helmsley Charitable Trust for their generous support. We would also like to thank Chris Jennings for his continued support and guidance of BPC's Health Program.

HEALTH PROGRAM

BPC's Health Program advances bipartisan policy solutions to build a more cost-effective, evidence-based health care system to improve population health. We work to strengthen and sustain Medicare and Medicaid, accelerate the shift toward value, address inefficiencies and misaligned incentives, and responsibly leverage technology and innovation.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders, board of directors, funders, or advisers.

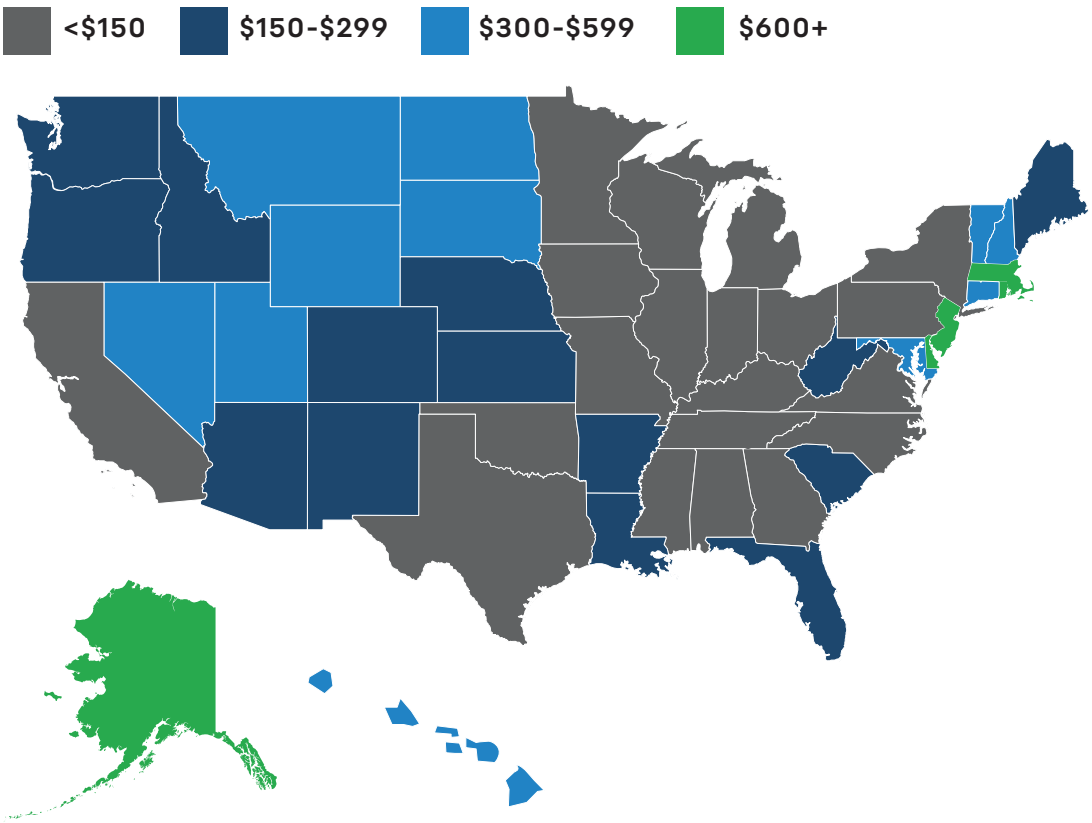
EXECUTIVE SUMMARY

Rural health care in the United States is at an inflection point. The Rural Health Transformation Program (RHTP), enacted as part of H.R. 1, is a $50 billion, five-year investment designed to help states improve access, quality, and outcomes by transforming rural health care delivery. This investment takes place alongside an estimated $137 billion in federal Medicaid cuts to rural communities over the next decade—a gap that RHTP funding alone cannot alleviate.

Against this backdrop, states' RHTP plans reflect the myriad health care challenges rural communities face: provider shortages, aging infrastructure, hospital closures, and limited access to health technologies, to name a few. All 50 states propose initiatives related to technology innovation and workforce development—the two most common investments.

ALL 50 STATES PROPOSE RHTP INITIATIVES RELATED TO TECHNOLOGY INNOVATION AND WORKFORCE DEVELOPMENT—THE TWO MOST COMMON INVESTMENTS.

Year 1 RHTP Award Per Rural Resident



Source: HHS Tracking Accountability in Government Grants System (TAGGS) and the Sheps Center for Health Services Research

RHTP FUNDING ALLOCATION

The Centers for Medicare & Medicaid Services is distributing $10 billion annually for five years, with year-one state awards ranging from $147 million (New Jersey) to $281 million (Texas). Half of the funding is divided equally amongst all approved states, and the other half is allocated based on a point-scoring methodology that accounts for states' rural health factors and proposed initiatives. Because funding is only minimally tied to a state's rural population size, the amount per rural resident varies widely—from less than $150 to greater than $600, with an average of $157 per rural resident. For more information on how some states are deploying RHTP funds and implementing proposed initiatives, listen to ***Rural Health Transformation: Insights from States***.

The Centers for Medicare & Medicaid Services' new Office of Rural Health Transformation oversees how states implement these investments. CMS administers RHTP through cooperative agreements, which require communication between states and the federal government and give CMS significant oversight over how funds are used. Between January and May, CMS worked with states to finalize budgets, requiring many to rework their RHTP proposals to align with program requirements. The program includes clawback authority, which allows CMS to recover RHTP funds if states do not use them consistently with their approved applications.

At the state level, administering a program of this scale requires significant staff capacity. Some states and health systems have stood up new RHTP offices by pulling experts from existing rural health programs. Others have hired new staff, leading in some cases to delays and workforce gaps in the offices that have traditionally supported rural health.

As the rural health care landscape shifts, targeted bipartisan reforms can help stabilize rural health infrastructure and ensure that RHTP investments deliver lasting results. In the months ahead, policymakers will face pressure to delay or mitigate Medicaid cuts—debates that will shape the environment in which RHTP operates. Amid those policy discussions, this brief identifies areas of common ground for strengthening rural health.

Drawing on the Bipartisan Policy Center's longstanding focus on rural health and more than 50 interviews with rural stakeholders—including policymakers, researchers, advocacy organizations, industry representatives, and state leaders across the political spectrum—we present two categories of federal policy recommendations: actions specific to RHTP and broader federal reforms needed to support rural communities.

POLICY RECOMMENDATIONS

A. Ensure RHTP Transparency, Elevate Best Practices and Lessons Learned

- CMS should make key information on RHTP implementation—including uses of funds, recipients and subrecipients, and progress reports—publicly available and easily readable. This could be achieved through a public-facing web portal or dashboard with up-to-date information on state initiatives.
- As RHTP implementation progresses, CMS should share promising practices and candid assessments of what is and is not working across states, while providing flexibility for states to adjust their plans as evidence accumulates.

B. Align Federal Policy To Support the Adoption and Maintenance of Health Technology Investments

- Congress should make Medicare telehealth flexibilities permanent, and CMS should establish guardrails—including prepayment review of claims with aberrant billing patterns—to ensure quality and minimize fraud.
- Congress should establish a federal continuity of care policy allowing providers to deliver telehealth across state lines to patients with whom they have an existing provider-patient relationship.
- CMS should ensure Medicare reimbursement policy supports rural adoption of remote patient monitoring by eliminating cost barriers like geographic payment adjustments.
- CMS should build on voluntary health IT initiatives by establishing targeted interoperability requirements; Congress and the Department of Health and Human Services should reduce the administrative burden for rural providers seeking to adopt Certified Electronic Health Record Technology.
- CMS should develop and test financing models that incentivize providers to adopt and sustain health technologies, including telestroke, e-ICU, and Project ECHO.

C. Strengthen Federal Support for the Rural Health Care Workforce

- To increase health worker participation, CMS should consider shortening or allowing flexibilities around the five-year RHTP rural service commitment required of individual RHTP workforce grant recipients.
- Congress should permanently authorize the Health Resources & Services Administration's Teaching Health Center Graduate Medical Education Program and Rural Residency Planning and Development Program.

- Congress should remove barriers and explore financial incentives—such as bonus payments—to attract and retain behavioral health providers in rural areas.

D. Permanently Authorize Medicare Rural Hospital Programs and Update Eligibility

- Congress should permanently authorize the Medicare dependent hospital program, low-volume hospital payment adjustment, sole community hospital payment adjustment, and Rural Community Hospital Demonstration. Congress should also explore pathways to more efficiently direct federal support to the rural hospitals that need it most.
- Congress should remove barriers for rural hospitals to convert to the Rural Emergency Hospital model—such as extending eligibility to facilities closed since January 1, 2014, and permitting REHs to provide limited inpatient and maternal care.
- The secretary of HHS should temporarily reestablish the "necessary provider" designation for critical access hospitals. After three years, the Government Accountability Office should assess the designation's impact on hospital closures, health care access, and Medicare costs, and recommend whether to make it permanent.

POLICY RECOMMENDATIONS TO STRENGTHEN RURAL HEALTH

A. Ensure Transparency, Elevate Best Practices and Lessons Learned

The federal government and states are rapidly implementing RHTP under a constricted timeline. However, the swift pace of implementation should not come at the expense of transparency. Prior federal funding programs offer a cautionary tale: COVID-19 relief programs delivered critical support, but weak upfront oversight and lack of transparency contributed to significant fraud and improper payments. The Medicare Electronic Health Record (EHR) Incentive Program, launched in 2011 to pay hospitals for adopting EHRs, faced similar oversight challenges stemming from weak safeguards around payments. Establishing transparency structures early can help protect RHTP integrity and ensure funds reach the communities they are meant to serve.

RHTP Implementation Timeline, Years 1-2

Date	Action Taken
December 2025	Award decisions made
January - May 2026	State budgets finalized
Summer 2026	States distribute funds
August 2026	Year 1 annual report due
September - October 2026	CMS rescoring
November 2026, March 2027, and May 2027	Quarterly reports due
August 2027	Year 2 annual report due
September 2027	Year 1 spending ends

The recommendations in this section focus on federal actions needed to ensure transparency and best practices in program implementation.

CMS should make key information on RHTP implementation—including uses of funds, recipients, subrecipients, and progress reporting— publicly available and easily readable. This could be achieved through a public-facing web portal or dashboard with up-to-date information on state initiatives.

To date, the level of transparency provided by states varies widely, and no standard for disclosure exists. All states have publicly posted at least portions of their initial applications. CMS has publicized state-provided abstracts and state spotlights but not final, approved plans and adjustment decisions.

As of July 2026, many states are working through procurement processes—releasing requests for proposals and making award decisions—and the level of detail states have posted publicly about these decisions varies. Some states are contracting with external entities to rapidly obligate funding. Because such practices can obscure the flow of funds at the subrecipient level, states must exercise careful oversight to prevent waste and fraud.

If transparency gaps persist, they risk carrying into future reporting cycles. As states begin progress reporting in August 2026, the absence of consistent disclosure standards could make it difficult to evaluate progress and ensure funds reach the rural communities they are intended to serve.

RHTP Reporting Requirements

	First Report Due	Reporting Frequency	Reporting Data Required
Annual Reporting	August 30, 2026	Annual: Due 60 days before end of annual budget period	Initiative progress narrative, initiative people served, initiative metrics, initiative checkpoints, state policy action commitments, use of funds, success stories, sustainability planning
Quarterly Reporting	November 29, 2026	Three times a year: Due within 30 days of end of reporting period (*No quarterly report for May 1 - July 31)	Initiative checkpoints, state policy action commitments, use of funds

Source: CMS Office of Rural Health Transformation

As CMS finalizes the reporting template and the web-based reporting tool for RHTP, the agency should prioritize transparency by designing them to collect accurate and precise data in real time. CMS should consider implementing a public-facing web portal that allows users to access easy-to-read information on each state's RHTP initiatives, including the uses of funds, funding recipients and subrecipients, and progress reports. In the agency's Strategic Framework for 2026-2031, CMS frames itself as an "Artificial Intelligence (AI)-first" organization, with initiatives to train thousands of employees on AI. CMS could apply this capacity strategically and use AI to launch and maintain a public-facing RHTP portal, paired with human review processes to ensure data accuracy.

For more information on CMS's strategic plan and HHS AI use, see Four Takeaways from BPC's Event with CMS Leadership *and* Tracking AI in Federal Health Agencies: Key Trends from HHS's FY2025 Inventory.

As RHTP implementation progresses, CMS should share promising practices and candid assessments of what is and is not working across states, while providing flexibility for states to adjust their plans as evidence accumulates.

Since early 2026, the CMS Office of Rural Health Transformation has hired staff to fill about half of the 30 new positions for project officers, who have been providing ongoing technical assistance and conducting site visits. In March 2026, CMS convened the first RHTP summit, bringing together states, federal agencies, and subject matter experts to share early insights and facilitate peer-to-peer learning.

CMS is also working with federal partners—including the Health Resources & Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC)—to elevate existing federal resources and provide technical assistance to states as they implement their RHTP initiatives. Many states have expressed interest in peer networks to share implementation experiences—including among those pursuing similar initiatives, such as the rural technology catalyst fund. CMS is starting to steer states toward outside organizations providing such technical assistance to states, such as the National Academy for State Health Policy.

BACKGROUND ON FEDERAL RURAL HEALTH PARTNERS

HRSA's Federal Office of Rural Health Policy: Established in 1987, FORHP administers a wide range of grant programs designed to build health care capacity, strengthen rural health networks, support rural hospitals, and address workforce shortages. FORHP also funds several policy programs, including providing technical assistance to Rural Health Clinics.

CDC's Office of Rural Health: Created in 2003, ORH coordinates across agency programs and with external partners to ensure that rural public health needs are integrated into CDC programs.

CMS could build on these efforts by implementing an up-to-date repository of best practices and lessons learned from states' RHTP initiatives. For instance, CMS could identify programs that are not working well and encourage states with such programs to adopt other models that have proved successful. RHTP's long-term success will depend in part on whether CMS allows states flexibility to adjust their plans based on early implementation experience. As states enter their second year of funding, the ability to revise activities without significant administrative burden will be critical.

B. Align Federal Policy To Support the Adoption and Maintenance of Health Technology Investments

All 50 states plan to use RHTP dollars to invest in innovative health technologies. States plan to deploy tools like telehealth, remote patient monitoring, and AI to address workforce shortages, increase access to care, and improve care delivery in rural communities. The value of these technology investments depends on how they are deployed and whether providers can afford to adopt them.

THE VALUE OF THESE TECHNOLOGY INVESTMENTS DEPENDS ON HOW THEY ARE DEPLOYED AND WHETHER PROVIDERS CAN AFFORD TO ADOPT THEM.

The following recommendations identify federal actions that can strengthen and sustain rural health technology investments, giving RHTP the foundation it needs to deliver lasting impact.

Congress should make Medicare telehealth flexibilities permanent, and CMS should establish guardrails—including prepayment review of claims with aberrant billing patterns—to ensure quality and minimize fraud.

Telehealth is now a fixture in U.S. health care. Utilization remains lower in rural communities, in part due to broadband inadequacy, lower digital health literacy, and socioeconomic factors. Yet, these areas face greater disease burden and more severe provider shortages. Many states propose to use RHTP funds to expand telehealth access. These investments depend on a stable, sustainable federal policy environment and proper targeting in rural communities.

RHTP TELEHEALTH INVESTMENT EXAMPLES

Arizona, Arkansas, and Maine are establishing telehealth hubs to expand community-based access. Florida and Utah are using telehealth to improve access to specialty care, including behavioral health and obstetrics.

Medicare is a primary payer for most rural providers. Without policy permanence, the business case for sustained infrastructure investment weakens. Congress should make Medicare telehealth flexibilities permanent; these include including removing geographic and originating site restrictions, authorizing Federally Qualified Health Centers and Rural Health Clinics to serve as telehealth site providers, and repealing in-person visit requirements for telemental health services. Congress should retain CMS's ability to set telehealth payment rates based on emerging data on provider costs, utilization, and quality over time.

POLICY BACKGROUND

Since 2020, Congress has repeatedly waived statutory Medicare telehealth restrictions. In 2021, Congress passed permanent policy for telebehavioral health. Most recently, the 2026 Consolidated Appropriations Act authorized an extension of many Medicare telehealth flexibilities through December 31, 2027, at a Congressional Budget Office-scored cost of $3.8 billion from 2026 to 2028. CBO has not yet scored the cost of recent legislative proposals, such as the CONNECT for Health Act of 2025, that would implement these flexibilities on a permanent basis.

Policymakers should pair permanency with guardrails to ensure telehealth remains high quality and sustainable. The HHS Office of Inspector General has documented recurring fraud schemes in which telehealth companies bill medically unnecessary items, including durable medical equipment and laboratory tests. Congress should require CMS to use its existing authority to conduct prepayment review of claims with aberrant billing patterns and to mandate an in-person visit within a reasonable timeframe before certain high-cost items are ordered. This is consistent with recommendations from the Medicare Payment Advisory Commission and bipartisan proposals such as the Telehealth Extension Act of 2021. Providers participating in alternative payment models with two-sided risk should be exempt.

CMS should also ensure that RHTP telehealth investments reach rural communities that lack access. Expanding telehealth coverage does not automatically translate into improved rural access; for example, the large shift to mental health telemedicine in recent years largely reflects utilization from existing patients relocating rather than new rural patients gaining access through telehealth. CMS should work with states to demonstrate how their telehealth investments will reach rural communities—such as through dedicated referral pathways—and ensure telehealth initiatives support continuity of care and complement rather than displace local care delivery. As states contract with various IT vendors to expand telehealth services, CMS should help states coordinate their procurement to avoid duplicating standard IT functionalities other states have already funded and instead pay for services that provide value by increasing access.

For more information, see BPC's brief Positioning Telehealth Policy to Ensure High-Quality, Cost-Effective Care.

Congress should establish a federal continuity of care policy allowing providers to deliver telehealth across state lines to patients with whom they have an existing provider-patient relationship.

Rural patients often travel across state lines to receive care, yet interstate licensure barriers can make it difficult for providers to follow those patients virtually. Licensure compacts aim to simplify multistate licensing, and RHTP incentivizes compact participation through a tiered scoring system, with states eligible for increased funding if they commit to join by 2027.

RHTP INTERSTATE LICENSURE COMPACT EXAMPLES

In February 2026, Maine passed legislation to expand scope of practice for physician assistants, and New Mexico passed legislation to join several interstate licensure compacts, including the Psychology Interjurisdictional Compact.

However, licensure compacts are not a complete solution. Even in participating states, provider enrollment is low. Fees and lengthy application processing times often disincentivize enrollment. A federal licensure exception for established patient-provider relationships would ensure that fewer patients lose access to care. This continuity of care policy would complement state compact efforts by allowing providers to deliver telehealth services across state lines to patients with whom they have an existing provider-patient relationship, for a defined time period.

Congress has precedent for federal licensure exemptions. It has removed state licensure requirements for Veterans Affairs-affiliated telehealth providers, allowed sports medicine providers to treat athletes across state lines, and established TRICARE provider licensing based on the provider's license and location rather than the patient's.

Bills to establish additional exemptions to state licensure have been introduced in the House, including the TELE-MED Act of 2013 to implement reciprocity in Medicare and the TREAT Act, which was introduced in 2023, to allow telemental health services to be provided across state lines during public health emergencies. The Federation of State Medical Boards has recognized similar exceptions in its model policy.

Congress would need to make clear determinations about how to oversee care delivery, especially regarding prescribing, across state lines. Grievances could be filed in the state where the patient-provider relationship was established. Congress could also outline in-person visit requirements for interstate provider-patient relationships.

For more information, see BPC's report Redesigning the Health Care Delivery System to Better Meet the Needs of Youth.

CMS should ensure Medicare reimbursement policy supports rural adoption of remote patient monitoring (RPM) by eliminating cost barriers like geographic payment adjustments.

RPM—which uses devices like blood pressure cuffs, heart monitors, and mental health apps to transmit patient data to providers—is particularly effective for patients with severe disease, poor treatment adherence, and limited provider access. This describes many rural residents, who face higher rates of chronic conditions like diabetes, heart failure, and behavioral health disorders, and often travel twice as far as their urban counterparts to see a provider.

While RPM use has expanded rapidly in recent years, growth is largely concentrated among a small number of primary care providers, and there is lower use in rural areas. Many states propose using RHTP funds to expand access to RPM.

RHTP REMOTE PATIENT MONITORING INVESTMENT EXAMPLES

Delaware, Kansas, Maryland, and South Carolina are investing in expanded uses of RPM and patient-facing health technologies—including apps, wearables, and AI-enabled tools—in rural areas. South Carolina will purchase standards-based RPM equipment and monitoring infrastructure for diabetes, hypertension, chronic obstructive pulmonary disease, and heart disease patients.

To facilitate RPM access in rural areas, CMS should eliminate geographic payment adjustments when RPM is used in rural areas. These adjustments are inappropriate for RPM: Deployment costs generally do not vary by location, and they disincentivize companies from offering remote monitoring in rural areas. In the absence of CMS action, Congress could ensure that RPM services are adequately reimbursed by Medicare in rural areas. For example, the bipartisan, bicameral Rural Remote Patient Monitoring (RPM) Access Act, or S. 1535, would set a geographic payment floor for RPM at the national average.

For more information, see Maximizing the Value of Remote Patient Monitoring.

CMS should build on voluntary health IT initiatives by establishing targeted interoperability requirements; Congress and HHS should reduce administrative burden for rural providers seeking to adopt Certified Electronic Health Record Technology (CEHRT) by consolidating grant programs.

Modern health IT is foundational to coordinated, high-quality care, but many rural facilities have been left behind. Tight budgets make upgrades difficult, leaving rural providers with aging systems, limited interoperability, and fragmented data that hinder care delivery. Administrative complexity further deters adoption of tools like electronic health records (EHRs).

Health IT infrastructure is a necessary foundation for rural areas to be able to adopt innovative technologies and value-based payment, two goals of RHTP. As such, states propose to use RHTP funds to invest in IT infrastructure, including EHR upgrades.

RHTP EHR INVESTMENT EXAMPLES

Indiana and Missouri plan to modernize EHR systems by expanding integration with the state Health Information Exchange and adopting international standards for electronically exchanging health care information. Oklahoma plans to purchase and deploy EHR hardware and software, subsidize subscriptions, and provide technical assistance for providers.

Notably, CMS caps RHTP spending on replacing Health Information Technology for Economic and Clinical Health certified EHRs at 5% of the annual award, so state investments tend to focus on targeted enhancements rather than full system replacements.

CMS has taken important steps to advance health IT infrastructure. The Health Technology Ecosystem initiative encourages voluntary industry alignment around a shared data exchange framework. The CMS Interoperability Framework calls on participants to pledge to meet several criteria, including EHR connection to CMS Aligned Networks. CMS has also proposed to adopt the Fast Healthcare Interoperability Resources standard for prior authorization-related transactions, further ensuring compliance with the data exchange framework.

To build on this work, CMS should require EHRs in alternative payment models (APMs) to be compliant with data exchange framework criteria by a target date. A target deadline would ensure that APM participants can achieve consistent access to clinical data across payers, providers, and care settings.

Congress and HHS should also simplify and consolidate similar federal grant programs and support the adoption of certified EHR technology among small and rural clinicians. Consolidation should not lead to reductions in total grant amounts. Small rural providers often lack the resources and support to keep pace with federal reforms. HRSA currently funds at least six grant programs that provide data, evaluation, and technical assistance to rural providers. Consolidating such programs can help to avoid duplication and inefficiencies while supporting CEHRT uptake.

For more information, see Strengthening Primary Care: Medicare Physician Payment and Related Reforms *and* Recommendations to Modernize Medicare Part B Physician Payment and Related Reforms.

CMS should develop and test financing models that incentivize providers to adopt and sustain evidence-based health technologies such as telestroke, e-ICU, and Project ECHO.

Telestroke, e-ICU, and Project ECHO are evidence-based programs that have proven particularly valuable in rural settings.

- **Telestroke** connects emergency physicians at rural hospitals with off-site stroke specialists for real-time assessment and treatment—critical for a condition in which every minute counts.
- **Tele-ICU** allows remote intensivists to monitor critically ill patients at rural facilities, guiding local staff through acute events using audio, video, and real-time data.
- **Project ECHO** is a distance-learning, telementoring model designed to help primary care clinicians and other community providers deliver care to patients where they live.

Many states plan to invest RHTP funds in these programs, yet they lack sustainable federal financing pathways. Reimbursement pathways for telestroke and tele-ICU exist, but complex Medicare billing rules create confusion and deter providers, particularly at small rural facilities without dedicated coding staff. Project ECHO has no federal billing mechanism, though some states have explored financing models through state Medicaid.

RHTP HEALTH TECHNOLOGY INVESTMENT EXAMPLES

Florida's Hub-and-Spoke Telestroke initiative connects rural emergency departments with stroke specialists via secure, real-time video for immediate assessment and treatment. Tennessee proposes expansion in e-ICU as part of a statewide digital modernization strategy. Washington proposes using RHTP funds to expand existing ECHO programs in clinics and facilities and implement new ECHO programs.

Congress and CMS should explore policy options to give states a pathway to sustain these technology investments beyond 2030. Key opportunities include testing a monthly or annual payment for rural hospitals to maintain telestroke and tele-ICU capacity; adding Project ECHO to the Medicare Physician Fee Schedule; and simplifying telestroke and tele-ICU billing rules to reduce coding errors and underbilling.

For a full suite of policy options, see BPC's report Leveraging Digital Technology To Enable a More Equitable Distribution of the Health Care Workforce.

C. Strengthen Federal Support for the Rural Health Care Workforce

Given that 60% of Health Professional Shortage Areas (HPSAs) across primary care, dental and behavioral health are rural, every state proposes to use some of their RHTP funding for workforce priorities. Provider shortages are especially dire for specific clinical specialties. For example, as of March 2026, there were nearly 7,000 behavioral health HPSAs.

60% of Health Professional Shortage Areas (HPSAs) across primary care, dental and behavioral health are rural.

These RHTP investments take place against a changing federal backdrop. H.R. 1 made changes to the student loan landscape—including new caps on borrowing—that will affect access to graduate and professional education. This could compound existing workforce shortages, particularly for students from rural communities who face limited access to health care education and training.

The following recommendations identify federal policy levers to bolster state workforce efforts.

CMS should consider shortening or allowing flexibilities around the five-year RHTP rural service commitment required of individual RHTP workforce grant recipients to increase health worker participation.

A major strategic goal of the RHTP workforce initiative is to build a sustainable pipeline of local talent in rural communities. States can use funding to recruit and retain clinical workers through training and development, residency programs, and financial incentives.

Awards that are specific to an individual and lead to credentialing or a degree—such as salaries or stipends for residents and fellows during training—are tied to a requirement that recipients practice in a rural area within the same state for five years.

RHTP INVESTMENTS TIED TO FIVE-YEAR SERVICE COMMITMENT

Kansas proposes short-term housing in rural communities for up to 100 medical students, while Nevada proposes financial assistance for housing, relocation costs, signing bonuses, and continuing medical education stipends.

Rural workforce experts and state leaders have expressed concern that this service commitment of five years can limit the ability of rural areas—especially in states that are more remote, such as Alaska—to recruit and retain providers, including behavioral health peer support specialists, community health workers, and paraprofessionals. A study of Indian Health Service program participants found that retention in the same training site drops by half after more than three years of service completion.

To ensure that states successfully meet the goals of their workforce initiatives, CMS should consider shortening the service commitment or allowing flexibilities around the requirement. For example, rural workforce experts said the program could better meet its goals if recipients were allowed to move to a rural area in a different state after serving for three years, provided they continue serving a rural community for the remainder of their service commitment. Another option could be to narrow the criteria for what counts toward the requirement so that the service commitment does not deter health worker participation. For example, trainees who receive only relocation incentives could be exempt from the requirement.

Congress should permanently authorize HRSA's Teaching Health Center Graduate Medical Education Program and Rural Residency Planning and Development Program.

Physician shortages in rural areas begin with the training pipeline. Several states are investing RHTP funds to expand Graduate Medical Education (GME) and create new residency programs.

RHTP WORKFORCE INVESTMENT EXAMPLES

Hawaii is proposing to use RHTP funds to establish a new residency program based on the success of a pilot residency program funded by HRSA. Arkansas and Georgia seek to expand GME slots.

Medicare GME is the primary federal funding source for physician residency training, but rural facilities face significant barriers to accessing it—including an outdated funding formula, structural funding inequities, and high administrative costs. Two HRSA-administered programs have helped fill this gap: the Teaching Health Center Graduate Medical Education (THCGME) and the Rural Residency Planning and Development Program (RRPD).[1] For more information on THCGME and RRPD, see **Appendix A.**

Despite their strong track record, neither program has permanent authorization. Congress most recently extended THCGME through fiscal year 2029 under the 2026 Consolidated

[1] Growing evidence suggests these programs have strengthened the rural workforce. The Teaching Health Centers model has been found to help produce physicians who are dedicated to caring for underserved populations and practicing in settings of need. Physician training in rural and Federally Qualified Health Center settings more than doubled between 2008 and 2024, with RRPD programs accounting for 22% of all rural residencies.

Appropriations Act, and RRPD continues to rely on discretionary appropriations. In April 2026, HHS announced more than $11 million in funding for RRPD grants to support new residency programs in high-need specialties, committing to 15 grants of up to $750,000 over three years. However, the continued lack of permanence creates operational and financial instabilities and challenges long-term planning. At minimum, Congress should pass the bipartisan RRPD Act of 2025, which would authorize $12.7 million annually through 2030.

For more information on federal rural workforce programs, see Achieving Behavioral Health Care Integration in Rural America.

Congress should remove barriers to behavioral health access and explore financial incentives—such as bonus payments—to attract and retain behavioral health providers in rural areas.

Rural areas face severe behavioral health workforce shortages due to ongoing challenges to attract and retain behavioral health providers. Many states are using RHTP funds to build behavioral health workforce pipelines and integrate behavioral health into primary care settings.

RHTP BEHAVIORAL HEALTH INVESTMENT EXAMPLES

California is integrating behavioral health into primary and maternal care through clinician training. Indiana is building rural behavioral health workforce pipelines through career pathway programming.

More than 5,400 Rural Health Clinics provide primary care to rural residents—often as the only health care option available—making them critical access points for behavioral health services. Yet, the Rural Health Clinic Services Act limits Rural Health Clinics to dedicating only 50% of their operating hours to behavioral health treatment. This restricts Rural Health Clinics' ability to meet rural behavioral health needs and recruit behavioral health providers, leading to poorer health outcomes.

Congress should reverse the provisions in the Rural Health Clinic Services Act that limit the ability of Rural Health Clinics to provide behavioral health treatment. Bipartisan legislation, such as the Rural Health Clinic Burden Reduction Act, would also help rectify this issue by revising the provision specifically for Rural Health Clinics located in behavioral health HPSAs.

Additionally, financial incentives play an important role in attracting behavioral health providers to rural areas. Yet, a lack of financial incentive for behavioral health providers who are not psychiatrists serves as a barrier for alleviating behavioral health provider shortages.

MEDICARE HPSA BONUS PROGRAM

Established in 1987, Medicare's HPSA bonus program pays a 10% quarterly bonus when physicians deliver Medicare services within a primary care HPSA. While psychiatrists qualify for this bonus, no other behavioral health providers—including psychologists, clinical social workers, and marriage and family therapists—are eligible.

Congress should allow additional types of behavioral health providers to receive bonuses when they practice in mental health HPSAs. This expansion would strengthen financial incentives for these providers to practice in underserved rural areas and help sustain states' RHTP investments in behavioral health.

For more information, see BPC's report Achieving Behavioral Health Care Integration in Rural America.

D. Permanently Authorize Medicare Rural Hospital Programs and Update Eligibility

Sustainable access to care, a central goal for RHTP, is under threat across rural communities. More than 40% of rural hospitals are operating at a loss, and roughly 20% of all rural hospitals are vulnerable to closure. The financial outlook over the next decade is even worse, with rural hospitals projected to face an $87 billion decline in revenue following H.R. 1.

The following recommendations identify federal policy priorities to sustain Medicare rural hospital programs, including updated eligibility criteria.

Congress should permanently authorize the Medicare dependent hospital program, low-volume hospital payment adjustment, sole community hospital payment adjustment, and the Rural Community Hospital Demonstration. Congress should also explore pathways to more efficiently direct federal support to rural hospitals that need it most.

Medicare is the largest payer and primary funding source for rural hospitals. Medicare's rural hospital programs provide crucial financial support to rural, geographically isolated, and low-volume facilities. For descriptions of each Medicare rural hospital designation and payment adjustment, see **Appendix B.**

Several of these programs lack permanent authorization. Medicare dependent hospitals and the low-volume hospital payment adjustment were extended only through the end of 2026, under the 2026 Consolidated Appropriations Act, while the sole community hospital payment adjustment is considered annually as part of the Medicare regulatory process. Periodic extensions contribute to financial instability and complicate long-term planning for participating facilities.

The Medicare Rural Community Hospital Demonstration—which provides financial support to hospitals that are too large to qualify for the Critical Access Hospital (CAH) designation but are less financially viable under the Medicare Inpatient Prospective Payment System (IPPS)—has improved hospital finances and prevented closures. Congress has extended the program multiple times in five-year increments, and its current authority expires June 30, 2028.

RURAL COMMUNITY HOSPITAL DEMONSTRATION

Initially, the five-year program was implemented in the 10 least populated states, with a maximum of 15 hospital participants. Since then, the program has expanded to include all states, with priority to the 20 least densely populated and capped at 30 hospital participants. In April 2025, 10 new participants joined the 20 hospitals already participating, and hospitals not selected were placed on a waitlist.

Given the program's positive outcomes, Congress should permanently authorize the Rural Community Hospital Demonstration. In the absence of permanent authorization, Congress should pass the Rural Community Hospital Demonstration Program Reauthorization Act to extend the demonstration for five years. For hospital agreements slated to end in 2026, CMS has indicated it may not renew hospital participation until they know Congress plans to extend authority beyond 2028.

For more information, see Sustaining Rural Hospital Access: Adjustments to Medicare Rural Hospital Designations.

Congress should remove barriers for rural hospitals to convert to the Rural Emergency Hospital (REH) model—such as extending eligibility to facilities closed since January 1, 2014, and permitting REHs to provide limited inpatient and maternal care.

Congress created the REH model in the 2021 Consolidated Appropriations Act to give struggling rural facilities a viable alternative to closure. REHs can provide emergency department services, observation care, and additional outpatient services not exceeding a 24-hour stay, but may not provide inpatient services or maintain swing beds. As of June 2026, 50 hospitals operate as REHs. For details on REH qualification and payment, see **Appendix B.**

Some states are using RHTP funds to support facilities converting to the REH model. Early evaluations suggest the REH model has provided a viable option for financially struggling rural facilities, but two federal policy barriers limit its reach.

Kansas is proposing a REH Conversion/Transformative Capital Investment Grant Program, which will use RHTP funds for minor facility renovations and other capital investments for hospitals converting to REH.

Some hospitals that could benefit are not eligible because they closed before December 2020. Extending eligibility to facilities that closed before 2020—a provision included in the House-passed version of H.R. 1 but not included in the final bill—would allow more communities to reopen hospitals as REHs without needing to construct a new facility. CBO determined that this provision would increase federal spending by $806 million from 2025 to 2034.

Additionally, some facilities are reluctant to convert to the REH model because doing so requires eliminating inpatient and swing beds, significantly reducing access to inpatient care in the community. Many are also hesitant to shut down their inpatient labor and delivery care and lose the ability to treat maternal complications—a particularly acute concern since more than half of rural counties have no hospital-based obstetric care.

Congress should remove barriers for rural hospitals to convert to the REH model—such as extending eligibility to facilities closed since January 1, 2014, and permitting REHs to provide limited inpatient and maternal care. Congress should address these barriers by allowing REHs to offer swing bed services and inpatient maternal care, as proposed in the Rural Emergency Hospital Designation Improvement Act.

For more information, see The Rural Emergency Hospital Model: Year Two Progress Report.

HHS should temporarily reestablish the "necessary provider" designation for critical access hospitals (CAHs). After three years, the Government Accountability Office should assess the designation's impact on hospital closures, health care access, and Medicare costs, and recommend whether to make it permanent.

To qualify as a CAH, a facility must be located more than 35 miles from the nearest full-service hospital, or more than 15 miles in mountainous terrains, and have 25 or fewer inpatient hospital beds. CAHs are paid 101% of reasonable costs for most inpatient and outpatient services. As of April 2026, 1,383 hospitals operate as CAHs.

Several states include critical access hospitals (CAHs) as potential funding recipients that can support RHTP initiatives. For example, as part of its obstetric digital regionalization initiative, Alabama will provide funding for CAHs—among other health care facilities—to connect with regional referral hubs. Tennessee is launching a competitive grant program allowing hospitals, including CAHs, to apply for funding to implement or expand transportation programs.

Until 2006, states could designate rural hospitals as CAHs under a necessary provider designation, even if the facility did not meet all eligibility criteria. As the risk of rural hospital closures has increased, state hospital associations and individual rural hospitals have called for the reinstatement of states' authority to issue necessary provider designations—and the bipartisan Rural Hospital Closure Relief Act of 2025 would do so.

HHS should temporarily reestablish the necessary provider designation process for three years, after which GAO should evaluate the program's impact on patient access to rural hospital care, rural hospital closures, and Medicare spending. GAO should then recommend whether to make the necessary provider designation permanent.

For more information, see Sustaining Rural Hospital Access: Adjustments to Medicare Rural Hospital Designations.

CONCLUSION

The Rural Health Transformation Program is the largest federal investment in rural health care in more than two decades. It arrives as states and rural communities face mounting financial pressure and a growing uninsured population. State RHTP initiatives reflect both the severity of the challenges faced by rural communities and the commitment of states to address them. This report identifies opportunities for bipartisan actions for Congress and CMS to bolster rural health and ensure RHTP investments are transparent, durable, and effective. As states approach the second year of implementation while navigating the impacts of broader federal Medicaid cuts, BPC will continue to monitor the program's rollout and develop solutions to strengthen rural health.

APPENDIX A

Medicare Graduate Medical Education (GME)	Medicare is the primary federal funding source for physician residency training in the United States. It distributes GME payments to teaching hospitals to cover both the direct cost of operating training programs (i.e., Direct GME) and the indirect cost of caring for patients with complex needs (i.e., Indirect Medical Education, or IME).
Teaching Health Center Graduate Medical Education (THCGME)	Established by the Patient Protection and Affordable Care Act in 2010, THCGME funds primary care residency training in community-based settings—such as Federally Qualified Health Centers and Rural Health Clinics—that are not eligible for Medicare GME funding. In academic year 2024-2025, THCGME supported 1,254 primary care residents, 22% of whom came from a rural background.
Rural Residency Planning and Development (RRPD)	This program provides start-up grants to help rural communities launch new residency programs. As of August 2025, total RRPD awards have created 752 new residency positions in rural areas and enrolled more than 660 resident physicians to train in rural settings.

APPENDIX B

Rural Hospital Designations, 2025

Designation	Requirements	Payment Mechanism	Number (as of January 2025)
Critical Access Hospital	Rural hospitals with ≤ 25 acute care beds located 35 miles from the nearest hospital	Reimbursed 101% based on Medicare allowable costs for each service	1325
Sole Community Hospital	Hospitals that are ≥ 35 miles from similar hospitals; rural hospitals ≤ 35 miles from another hospital may qualify based on how accessible the other hospital is.	Paid under IPPS, with option for a payment adjustment as volume decreases	355
Medicare Dependent Hospital	Rural hospitals with ≤ 100 beds where Medicare patients make up at least 60% of inpatient days; hospitals designated a sole community hospital do not qualify	Paid under IPPS at the higher of either the federal rate or the federal rate + 75% of the difference between the hospital and federal rate	141
Rural Emergency Hospital	CAHs and rural hospitals with ≤ 50 beds; no inpatient beds except those that are licensed as a skilled nursing facility	Paid under OPPS + 5% and additional monthly facility payment	35
Low-Volume Hospital	Hospitals with ≤ 3,800 discharges in the previous year and ≥ 15 miles from the nearest inpatient prospective payment system hospital	Paid under IPPS, with payments adjusted up to 25% per Medicare discharge	Not available*
Rural Community Hospital (Demonstration)	Small rural hospitals with fewer than 51 beds that do not qualify as CAHs but face low or negative Medicare inpatient margins and are participating in the demonstration	Paid for inpatient hospital services provided to Medicare beneficiaries, excludes services furnished in psychiatric or rehabilitation units that are distinct part of the hospital	24**

*Adapted from Kevin Bennett et al., "Why Rural Hospitals Are Facing a Funding Crisis — and How It Could Get Worse" (explainer), Commonwealth Fund, Feb. 9, 2026. * In 2023, rural referral centers and low-volume hospitals made up 9% of rural hospital designations. ** Number as of June 2026*

Source: The Cecil G. Sheps Center for Health Services Research

Bipartisan Policy Center
1225 Eye St. NW
Suite 1000
Washington, DC 20005
bipartisanpolicy.org
202 - 204 - 2400

Policy Areas

Economics

Energy

Human Capital

Housing

Health

Governance

The Bipartisan Policy Center and its advocacy affiliate, Bipartisan Policy Center Action (BPC Action), are unique in their approach to addressing the nation's most pressing issues. As the only organization working across the full political spectrum on domestic issues, BPC brings together diverse perspectives to craft data-driven, pragmatic policy solutions. BPC Action then works directly with legislators and other policymakers to turn those solutions into real change.

@BPC_Bipartisan
facebook.com/BipartisanPolicyCenter
instagram.com/BPC_Bipartisan
linkedin.com/company/bipartisan-policy-center