Let’s Get Rural!

Rural Health Transformation and Federal Policy Updates

July 30, 2026

Introductions

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Today's Agenda

1. Rural Health Transformation Program

- ✓ Funding
- ✓ State implementation models
- ✓ Examples from the field

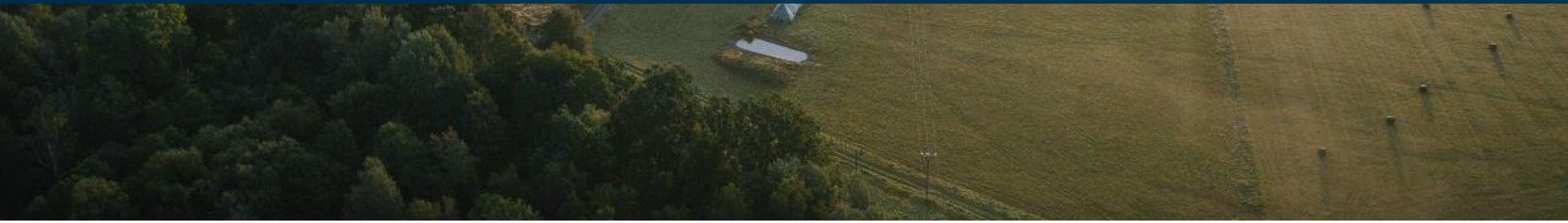
2. Regulatory Updates

- ✓ Provider-based rules
- ✓ CJR-X
- ✓ 340B drug payment
- ✓ Site neutral payment
- ✓ OB billing
- ✓ Rural Health Clinic (RHC) telehealth

3. Legislative Updates

- ✓ Pending price transparency bills
- ✓ Rural-focused USDA and hospital funding legislation

1. Rural Health Transformation Program (RHTP)



What Is RHTP?

$50B
Federal grant program

5 Years
Of funding, beginning FY26

Oct 30, 2026
Year 1 funds must be obligated

- Administered by CMS to improve access, quality, and sustainability in rural healthcare
- States submit a transformation plan for CMS approval (now complete)
- Program structure and eligible activities vary by state
- Future funding allocations for years 2-5 may be adjusted

Areas of State Discretion

- Within the Implementation Plans, states set their own rules across five key areas:

1. Eligible provider types

2. Definition of “rural”

3. Allowable uses of funds

4. Application and selection criteria

5. Reporting and program requirements

CMS Goals of RHTP

Every state is pursuing these five goals, but approaches vary widely

1. Workforce Development

- Recruit and retain rural providers
- Expand roles like community health workers, pharmacists, and care navigators

2. Innovative Care

- Grow new care models and payment approaches that coordinate care and shift it to lower-cost settings

3. Tech Innovation

- Expand remote care, data sharing, cybersecurity, and emerging digital health tools

4. Sustainable Access

- Help rural facilities stay open long-term by coordinating operations, technology, and services regionally

5. Make Rural America Healthy Again

- Fund prevention and new access points targeting chronic disease, behavioral health, and prenatal care

Funding and Implementation

A $50 billion federal grant program administered by CMS through state implementation plans, giving states significant flexibility in program design and provider funding approaches.

Two primary distribution models are emerging

Aggregator Model

CMS → State → **Aggregator** → Providers

Direct Model

CMS → State → **Providers**

CMS Strategic Goals - Eligible activities vary by state

- Workforce Development
- Innovative Care
- Tech Innovation
- Sustainable Access
- Make Rural America Healthy Again

Compliance: Federal grant rules apply, including Uniform Guidance and potential Single Audit requirements.

Key Takeaway: How funding reaches providers will depend largely on each state's implementation model and procurement strategy.

RHTP Implementation Status by State

47 states currently in implementation

Beyond Planning

Most states have advanced beyond planning activities

Rising Procurement

Procurement activity continues to increase nationwide

Examples across the implementation continuum:

In Development

- Massachusetts
- Hawaii
- Virginia

Active RFPs

- Alabama
- California
- Florida
- Maine
- Wyoming

In Process of Awarding Funds

- Oregon
- Kansas
- Michigan
- Indiana
- Georgia
- North Carolina
- Delaware
- New Jersey

Key Takeaway: Funding priorities and implementation approaches remain highly state-specific.

https://www.ruralhealth.us/programs/center-for-rural-health-innovation-and-system-redesign/rural-health-transformation-program/rhtp-resources/state-by-state-funding-opportunities .

State Level Projects

North Dakota

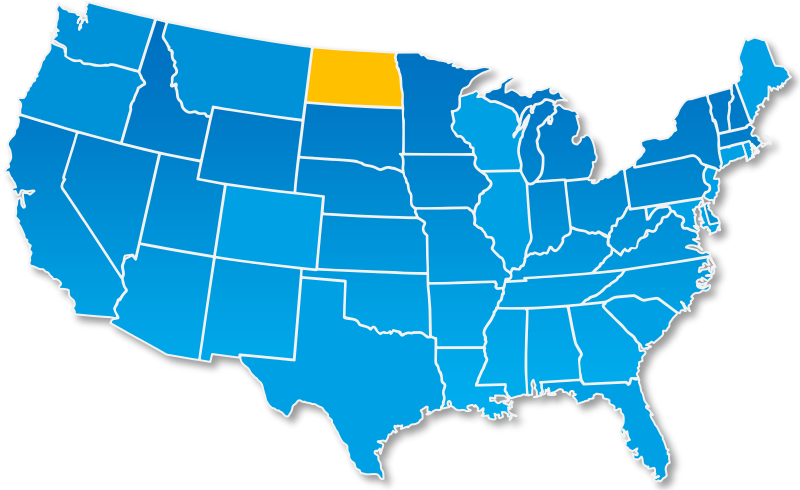
$199M

Received for RHTP Year 1

Distribution Model – Direct

Funds flow from the state directly to providers and other organizations.

CMS → State → **Providers**



Implementation Status:

- 12 of 23 grant opportunities are already closed.

Note: *The majority of North Dakota initiatives are for one year.*

https://www.hhs.nd.gov/news/nd-awarded-199m-rural-health-transformation-program-strengthen-care-rural-communities

State Level Projects

North Dakota

Workforce Development

- Expand Rural Health Care Rotations
  - Expand rural health care rotations to new learner types by facilitating embedding students into rural health care facilities
  - Add additional slots for rural health care rotations
  - Provide short-term housing support for traditional students embedded in rural health care facilities

Rural Health Transformation Application Guidance

State Level Projects

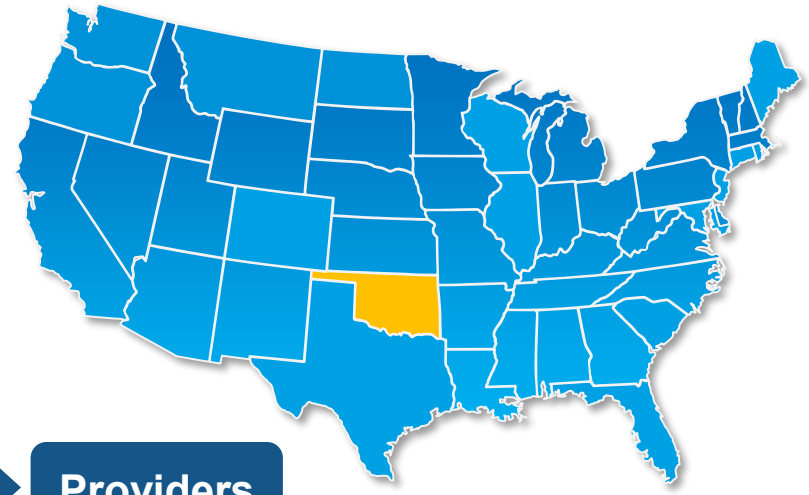
Oklahoma

$223M

Received for RHTP Year 1

Distribution Model – Aggregator

The state routes funds through lead aggregator agencies that distribute to providers.



CMS → State → Aggregator → **Providers**

Implementation Status

- Up to 29 potential grant opportunities are planned.
- Microgrants already issued for Community-Led Wellness Hubs.

Note: *Many grants begin as pilot projects, with full realization in years 4 and 5.*

State Level Projects

Oklahoma

Innovative Care – Innovating the Care Model

- Maternal-Fetal Medicine (MFM) Telehealth Expansion
  - $6.6M one time funding
  - University of Oklahoma and Oklahoma State University are lead agencies
  - Funding will cover startup equipment and software

1) RHTP_InitiativeFundingSummary.pdf

State Level Projects

Tennessee

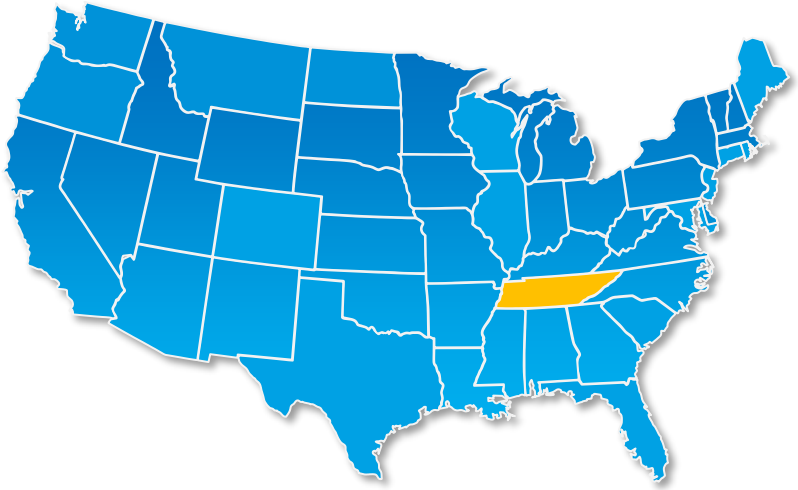
$206M

Received for RHTP Year 1

Distribution Model – Direct

Funds flow from the state directly to providers and other organizations.

CMS → State → **Providers**



Implementation Status

- 9 Request for Applications (RFAs) released; awardees are currently being notified.
- 6 RFPs scheduled for release in the third quarter of 2026.

Note: *All RFAs have had a 30-day turnaround for proposals.*

State Level Projects

Tennessee

- Tech innovation
  - For short-range and long-range projects, priorities include:

Telehealth and virtual care expansion

Remote patient monitoring

Artificial intelligence and clinical decision support tools

Health information exchange and interoperability

[Tennessee Department of Health Rural Health Access for Tennessee's Future]

State Level Projects

Kansas

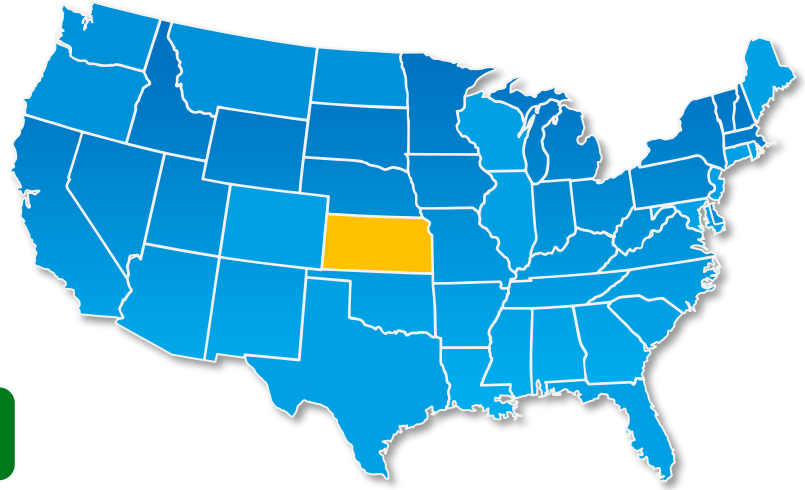
$221M

Received for RHTP Year 1

Distribution Model — Direct

Funds flow from the state directly to providers and other organizations.

CMS → State → **Providers**



Implementation Status

- $79.1 million already awarded to 39 organizations.
- Administrative contracts in place for implementation support.

Note: *Grants are being distributed directly to providers and other community organizations.*

State Level Projects

Kansas

Sustainable Access

- Secure Local Access to Primary Care
  - Revenue Improvement Program
    - Statewide rural commercial rate analysis
    - Revenue Cycle Support and Credentialing Organization
    - Direct-to-employer contracts

Rural Health Transformation Program | KDHE, KS

State Level Projects

Arkansas

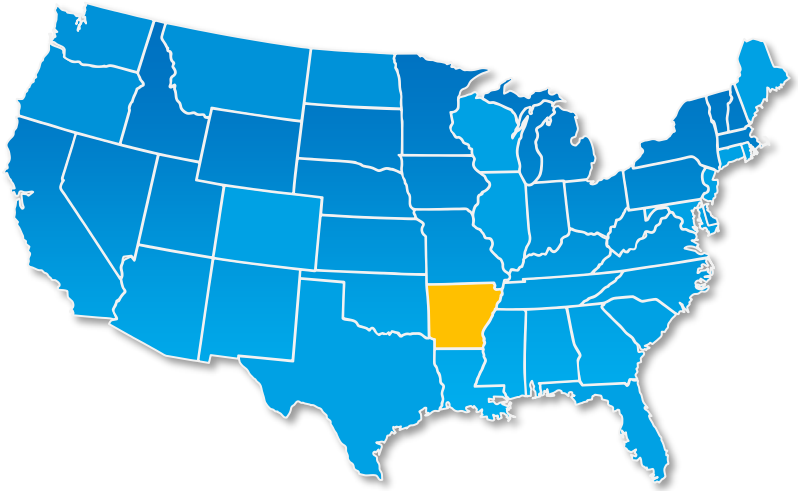
$208M

Received for RHTP Year 1

Distribution Model — Direct

Funds flow from the state directly to providers and other organizations.

CMS → State → **Providers**



Implementation Status

- Four major initiatives are underway.
- All Notice of Funding Opportunities (NOFOs) released; final applications due July 31st.

Note: *Applications for the final funding opportunities close at the end of July.*

State Level Projects

Arkansas

Make Rural America Healthy Again

- **Arkansas HEART** (Healthy Eating, Active Recreation & Transformation)
- **GROW kids** (Growing Resilient, Optimally Well Kids)
- **FARM** (Food Access & Regional Markets)
- **MOVE** (Mobilizing Opportunities for Vital Exercise)
- **FAITH** (Faith-based Access, Interventions, Transportation, and Health)
- **HEAL** (Healthcare Education and Advancement for Leadership)
- **IMPACT** (Integrated Models for Prevention, Access, Care, and Transformation)

Next Steps

Practical actions to position your organization for RHTP funding — **start now.**

1. **Confirm your state's model:** Identify whether your state uses an aggregator, direct, or hybrid approach, and where your organization fits. — **Now**
2. **Monitor state sources:** Track your state Medicaid agency and rural health office for deadlines, eligibility criteria, and approved plans. — **Ongoing**
3. **Engage in listening sessions:** Join stakeholder meetings to learn how your state is interpreting requirements and where guidance is heading. — **Ongoing**
4. **Review funding applications:** Even opportunities that seem like an imperfect fit reveal eligibility, covered activities, and budget parameters. — **Before applying**
5. **Build audit-ready processes:** Document decisions in real time and prepare for Single Audit obligations from day one. — **Day one**

Compliance and Audit Readiness

RHTP is **federal financial assistance** — accepting it triggers federal grant compliance obligations.

The Single Audit trigger

$1M

in federal awards expended in a fiscal year

triggers a mandatory Single Audit under Uniform Guidance (2 CFR §200.501).

Subrecipients included

2–3 years: typical lag before an audit reviews how funds were spent.

- ✓ **Uniform Guidance applies:** RHTP funds fall under 2 CFR Part 200, including Single Audit testing of internal controls, allowable costs, and reporting.
- ✓ **Document in real time:** Capture spending decisions, approvals, and the guidance relied upon as they happen, not years later.
- ✓ **Learn from the Provider Relief Fund:** Pandemic-era findings stemmed from incomplete documentation, not intentional misuse.
- ✓ **Build audit-ready records:** Clear records show why costs were allowable and how each decision advanced program objectives.

Source: 2 CFR Part 200, Subpart F (Uniform Guidance)

Bennett-Collins-Padilla-Hickenlooper Letter

Support: Bipartisan backing for successful RHTP implementation.

Concern: Smaller rural providers may face barriers accessing funding opportunities.

Supports Recent Flexibility

- Workforce recruitment and retention
- Infrastructure investments
- Technical assistance
- Alternative payment model participation

Requests Additional Flexibility

- Capital improvements
- Direct provider payments
- EHR and health IT investments
- Enhance reimbursements
- Offset uncompensated care costs

Emphasis: *Support for independent providers and rural hospitals serving underserved communities.*

Interpretation: *Congress supports RHTP but is urging CMS to provide greater flexibility and ensure funding reaches frontline rural providers.*

Source: https://www.collins.senate.gov/imo/media/doc/cms-rhtp-bennet-collins-padilla-hickenlooper-061826.pdf

2. Regulatory Updates

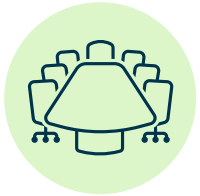
Provider-Based Departments

- Requirements of the Consolidated Appropriations Act, 2026, Section 6225
  - Requirement that hospitals submit a provider-based status attestation for all off-campus outpatient "departments"
    - CMS will develop standardized attestation form to replace the current MAC-specific templates
      - **DRAFT AVAILABLE:** https://www.cms.gov/files/document/proposed-section-6225-attestation-format.pdf
    - All off-campus HOPDs providing services on or before January 1, 2028, would be required to submit an attestation between January 1, 2026, and December 31, 2027
    - New departments after January 1, 2028, must submit during the two years prior to when billed services are delivered
    - Recurring attestations not to exceed every 5 years
  - Requirement for all off-campus outpatient "departments" to obtain a National Provider Identifier (NPI) that is separate from the hospital's main NPI
    - Proposed rule also requires an update to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

Provider-Based Requirements in General

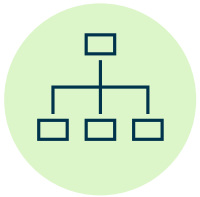
- Provider-based “facility” and main provider must operate under the same license (unless the applicable state requires a separate license)
- Clinical services integration
  - Staff privileges, monitoring and oversight, medical records integration, etc.
- Financial integration
  - Shared income and expenses
- Public awareness
  - Held out to the public as part of the hospital
- Compliance with hospital rules

Off-Campus Provider-Based Requirements



Operates under the ownership and control of the main provider

- Business enterprise that constitutes the facility/organization is wholly owned by the main provider
- Same governing body and organizational documents
- Main provider has final responsibility for administrative decisions, contracts with outside parties, personnel actions, medical staff appointments



Administration and supervision

- Under the direct supervision of the main provider and operated the same as any other department of the main provider

Location

- Located within a 35-mile radius of the campus of the main provider (exceptions exist: refer to 42 CFR 413.65(e)(3))
- Off-campus status identified using the correct modifier (PO vs. PN)

Obligation to deliver written notice to beneficiaries regarding coinsurance obligation for both the facility and the physician service

Mandatory Comprehensive Care for Joint Replacement Model – CJR-X

- **Nationwide expansion effective 10/1/27**
  - Hospitals required to take financial accountability for hip, knee, and ankle replacements
    - Original CJR model found to have generated an estimated $112.7 million in savings from 2021-2023
  - Episode of care covers initial surgery, hospital stay, and first 90 days of recovery/therapy

- **Applies to all acute care hospitals paid under both IPPS and OPPS**
  - Exclusions:
    - TEAM hospitals until 2031
      - Reminder for TEAM hospitals: downside risk begins in 2027 – MAKE SURE YOU ARE READY!
    - Hospitals in Maryland
    - Hospitals with fewer than 31 lower extremity joint replacement (LEJR) episodes in the baseline period

CJR-X Episodes of Care

MS-DRG 469

Major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)

MS-DRG 470

Major joint replacement or reattachment of lower extremity without MCC

MS-DRG 521

Hip replacement with principal diagnosis of hip fracture with MCC

MS-DRG 522

Hip replacement with principal diagnosis of hip fracture without MCC

HCPCS 27447

Total knee arthroplasty (TKA)

HCPCS 27130

Total hip arthroplasty (THA)

Calculating the Benchmark

- Three years of baseline data: October 1, 2023, through September 30, 2026, trended forward
- Benchmark prices calculated at the MS-DRG/HCPCS code level
- Proposed discount factor of 2% reflective of Medicare's portion of potential savings from each episode
- Would apply a 20% stop-gain/stop-loss limit for most providers
  - Limited to 5% for safety net, rural hospitals, Medicare Dependent Hospitals (MDH) and sole community hospitals (SCH)
  - Quality measures determine whether a hospital earns financial bonuses or faces penalties
    - Hospitals are scored across five clinical and experience metrics to calculate a Composite Quality Score (CQS)
    - The CQS dictates a hospital's effective discount factor - poor outcomes can forfeit all savings or require larger repayments to Medicare
- Concern that CAHs with swing beds could see reduced volume when focus is on savings

Payment for 340B Drugs

- **Use of 340B Drug Cost Acquisition Survey**
  - Approximately 43.6% of eligible hospitals responded to the survey
    - 29.8% submitted usable acquisition cost information
  - Survey results
    - Hospitals acquired non-340B drugs at approximately 2.7 to 2.8% above Average Sales Price (ASP)
    - Hospitals acquired 340B drugs at approximately 33.4% below ASP

- **CY 2027 OPPS proposed rule**
  - Proposes to pay most 340B-acquired drugs at ASP minus 33.4%
    - Non-340B drugs would continue to be paid at ASP plus 6%
  - CMS intends to conduct survey every 4 years
  - Exempts:
    - ✓ Rural SCHs
    - ✓ Children's hospitals
    - ✓ PPS-exempt cancer hospitals

Payment for 340B Drugs

Will require use of modifiers on all drug claims:

-JG: 340B-acquired drug subject to payment reduction

-TB: exempt 340B drug that continues to receive ASP + 6%

"-XX": placeholder to identify all separately payment non-340B drugs

Resulting budget neutrality necessitates an increase in OPPS payments for non-drug services by an estimated 8.44% in non-drug payments

Payment for 340B Drugs

"The Secretary…shall conduct periodic…surveys to determine the hospital acquisition cost for each specified covered outpatient drug for use in setting the payment rates…to generate a statistically significant estimate of the average hospital acquisition cost for each specified covered outpatient drug."

Section 1833(t)(14)(D)(ii) and (iii) of the Social Security Act

"We seek comment on our proposal to apply a single discount factor to the ASP for 340B-acquired drugs in lieu of calculating individual acquisition cost amounts for 340B-acquired drugs."

CMS OPPS Proposed Rule (page 41,889)

Site Neutral Payments

- Applicable to hospitals paid under outpatient PPS
- Imaging services without contrast in exempted (grandfathered) off-campus provider-based departments (PBDs)
  - Will be paid at 40% of OPPS rate to equate to physician fee schedule rate
  - Applies to:
    - **APCs 5521-5524:** imaging without contrast
    - **APC 8004:** ultrasound composite
    - **APC 8005:** CT/CTA without contrast composite
    - **APC 8007:** MRI/MRA without contrast composite
  - Does not apply to rural SCHs
  - Will not be budget neutral

2027 Changes to OB Billing

- **Effective January 1, 2027**
  - AMA to replace single-payment global billing model with itemized, phase-based reporting
  - Providers would bill separately for each encounter related to prenatal and postpartum care
  - For more information on coding https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes

- **To prepare:**
  - ✓ Identify charges for the various encounter codes
  - ✓ Review payer contracts to address needed reimbursement changes
  - ✓ Educate patients regarding encounter-specific billing and co-pays
  - ✓ Initiate detailed encounter-specific documentation
  - ✓ Need to address “straddle” patients
  - ✓ Evaluate compensation structure of employed (affected) providers

Telehealth Changes for RHCs

- **Effective October 1, 2026**
  - RHCs must report individual CPT or HCPCS codes with modifiers instead of the generic code G2025 for non-behavioral health telehealth
  - Claims must include specific modifiers to designate the type of telehealth service:
    - **Modifier 95:** For real-time interactive audio-visual communication
    - **Modifier 93:** For encounters conducted via synchronous audio-only technology
  - Review CMS specific coding instructions and timeline: https://www.cms.gov/files/document/mm14468-rural-health-clinics-federally-qualified-health-centers-billing-distant-site-telehealth.pdf
  - Review CMS telehealth services list: https://www.cms.gov/medicare/coverage/telehealth/list-services

3. Legislative Updates

Of Concern: Pending Legislation

- **Tax-Exempt Hospital Transparency Act (H.R. 9504)**
  - Increases reporting requirements for Form 990, Schedule H
    - How are hospitals responding to items identified in their community health needs assessment?
    - If there are needs not being addressed, why?
    - Dollar value of financial assistance
    - Number of financial assistance applications received, approved, and denied
    - Calculation of the amount of federal income tax that would be due if not tax-exempt
  - Additional requirements for larger hospitals (more than 100 staffed beds) and those with net patient revenue greater than $100 million per year

Of Concern: Pending Legislation

- **Lower Costs, More Transparency Act of 2026 (H.R. 9393)**
  - Expands current transparency requirements to ASCs, laboratories, imaging providers, and pharmacy benefit managers
  - Codifies transparency requirements for above, as well as hospitals and group health plans/issuers
  - Requires plans to provide cost-sharing information through real-time self-service tools

- **Prices on the Wall Act of 2026 (H.R. 9390)**
  - Beginning January 1, 2028
    - Requires hospitals to post discounted cash prices for all CMS-specified shoppable services in clearly visible areas
    - Requires ASCs to post prices for shoppable services in clearly visible areas
    - Requires laboratories to post prices for specified clinical laboratory tests
    - Requires imaging providers to post prices for imaging services in clearly visible areas

Of Concern: Pending Legislation

- **Patients Deserve Price Tags Act (S.2355/H.R.5582)**
  - Codifies transparency requirements, including exact prices rather than estimates
  - Requires monthly updates to both MRF and shoppable services (currently annual)
  - Expands posting of shoppable services from 300 to all shoppable services
  - Expands posting requirements to clinical diagnostic labs, imaging services, and hospital-owned/controlled ASCs
  - Patients legally protected from owing more than the amount calculated by their health plan's estimator tool
  - Providers restricted from taking collection action on amounts exceeding calculated amounts

S. 3637 Agriculture Act of 2026 (Farm Bill)

Proposed Farm Bill legislation adds new rural healthcare provisions through **USDA programs**

Establishes a New Program

Creates a Rural Health Care Facility Technical Assistance Program

Facility-Level Focus

Supports individual rural healthcare facilities, rather than state-level transformation programs

Targets Core Needs

Provides technical assistance and training to eligible facilities

Broad Eligibility

Applies to:

- ✓ Hospitals
- ✓ CAHs
- ✓ REHs
- ✓ RHCs
- ✓ Community health centers

https://www.congress.gov/bill/119th-congress/house-bill/7567/text

S. 3637 Agriculture Act of 2026 (Farm Bill)

The **Rural Health Technical Assistance Program**

1

Program goals

- Improve operational efficiency and financial stability, prevent facility closures, strengthen rural healthcare delivery, and connect facilities to USDA loan and grant opportunities.

2

Potential assistance areas

- Planning for construction, expansion, renovation, and modernization of facilities; telehealth development; EHR and health information system upgrades; and long-term financial planning.

3

Funding

- Up to $2 million per year for the entire program, not per applicant (FY2027–FY2031).

4

Eligible uses

- Financial and operational planning, telehealth and EHR planning, facility modernization planning, and help accessing USDA loans and grants.
- This program does not include funding for construction or implementation projects. It is for planning and technical assistance only.

https://www.congress.gov/bill/119th-congress/house-bill/7567/text

S.4141 Rural Hospital Revitalization Act of 2026

What it offers

- Temporary **0%** USDA Community Facilities loans for construction, replacement, renovation, and modernization
- Optional five-year extension under certain circumstances
- No specific loan funding amount named in the legislation
- Potential new capital financing option for facility modernization

Who qualifies?

- County population under 20,000
- More than 35 miles from nearest hospital (*15 miles in areas with challenging terrain*)
- Long-standing rural hospital presence (> 30 years)
- Geographic isolation and access considerations
- Financial stability requirements

Applies to:

CAHs **REHs**

Definitions: *CAH and REH follow their Social Security Act definitions; the hospital-campus test is set by 42 CFR 413.65, and a facility must have been continuously licensed as a hospital for 30+ years.*

https://www.congress.gov/119/bills/s4141/BILLS-119s4141is.pdf

Our Upcoming Webinars:

Wednesday, August 12; 11 am – 12 pm ET

CY 2027 Medicare Physician Fee Schedule (MPFS) Proposed Rule: Key Changes and Strategic Implications

Wednesday, August 26; 11 am – 12 pm ET

CY 2027 Inpatient Prospective Payment System (IPPS), Psychiatric, Rehabilitation, Skilled Nursing Facility, and Hospice Final Rules

Please leave a comment regarding topics for future webinars!

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