RURAL HEALTH TRANSFORMATION PROGRAM

State Plans Comparison

A Strategic Intelligence Report on State Trends and Emerging Opportunities

SachsMEDIA

INTRODUCTION

The Rural Health Transformation Program (RHTP) represents **one of the most significant federal investments** in rural health infrastructure in decades – and one of the most complex.

Authorized under the One Big Beautiful Bill Act, the program provides **$50 billion nationwide over five years** (2026-2030), with funding flowing to all 50 states beginning in FY 2026. Every state received a substantial first-year award intended to support immediate action, while laying groundwork for longer-term system transformation.

All states received at least $100 million in Year 1, and many will manage awards exceeding $1 billion across the program's five-year life, with particularly large allocations going to states with expansive rural geographies and high unmet need.

The program's structure matters. Year 1 funding is front-loaded, designed to move quickly and demonstrate early progress. Years 2-5 are expected to shift toward fewer, larger, and more durable investments. That will favor initiatives that show **scalability, sustainability, and measurable impact.** Decisions made in the first year could heavily influence which vendors, platforms, and delivery models are positioned to compete successfully in later rounds.

For potential RHTP vendors, this creates both urgency and opportunity.

Most states will open **competitive procurement processes in early 2026**, inviting vendors to apply for funding across a wide range of initiatives, such as telehealth, workforce development, expanded pharmacy practice, preventive care, technology infrastructure, and new care delivery models. For many companies, this will be the first time engaging with certain state agencies, Medicaid offices, public health departments, or procurement authorities. Prior experience in one state won't automatically translate to credibility in another.

Each state has a unique RHTP plan. There is **no single national narrative or one-size-fits-all approach** that will work in every state. Vendors who obtain RHTP funds will provide solutions that address each state's unique needs.

State leaders, agency heads, and procurement professionals want vendors who understand their specific rural realities, policy priorities, and political constraints. Messaging that resonates in one state may fall flat or even raise red flags in another. Vendors who approach RHTP as a purely transactional funding opportunity risk getting outpaced by competitors who invest in understanding how states think, decide, and evaluate partners.

Vendors who can **clearly articulate their value** in language aligned to what state decision-makers are seeking, such as credibility, readiness, risk mitigation, and long-term impact, will be better positioned to win Year 1 awards and remain competitive as the program evolves. That means understanding each state's unique rural health priorities, regulatory environment, and decision-making criteria, then framing your organization accordingly.

Elevating brand visibility, aligning messaging to state-specific priorities, and demonstrating fluency in public-sector expectations are no longer "nice-to-haves." They're increasingly central to success in the RHTP procurement process.

This report examines **how states plan to deploy their RHTP funding, where priorities converge and diverge, and what those differences signal for vendors** navigating this once-in-a-generation opportunity.

WHAT YOU NEED TO KNOW

States will reward vendors that can clearly translate their capabilities into state-specific stories about **credibility**, **readiness**, and **long-term impact**.

Year 1 is all about positioning. Years 2-5 are about growth.

Front-loaded Year 1 funding is designed for quick wins and immediate experimentation across all 50 states. CMS is throwing money at the wall to see what sticks. The program structure favors vendors who demonstrate early results, positioning them for significantly larger awards in subsequent years as funding consolidates around proven models.

Not all states are equal.

Texas received the largest allocation but will likely face the most intense vendor competition during procurement. By contrast, states like Rhode Island, New Jersey, and Delaware received disproportionately large Year 1 allocations relative to their administrative capacity, creating real pressure to identify qualified partners and deploy funds efficiently.

The program wasn't built for the problem it was created to solve.

Lawmakers originally intended for RHTP funding to help offset forthcoming Medicaid cuts to rural providers already hanging on by a thread. The final version became a "transformation" fund focused on innovation. Existing rural providers may receive funding that helps with fiscal sustainability, but some may not receive enough to stay afloat, potentially leading to closures in the years ahead.

There is no national playbook.

Each state submitted a unique plan to CMS, and those plans vary greatly by region. State leaders want vendors who understand their unique rural realities, policy priorities, and political constraints. What works in one state may fall flat in another.

The competitive window is narrow.

Most states will launch procurement and start issuing RFPs in early 2026. Vendors that lack strong visibility, credibility, and relationships in target states need to begin positioning now.

OPPORTUNITY ANALYSIS: WHERE TO COMPETE

Not all state opportunities are created equal.
The strategic question isn't just "how much funding is available?" but "how much is available, relative to how many vendors will compete for it?"

High Allocation, High Competition

Texas received the largest Year 1 allocation, but its market will see the most crowded vendor field. Large health systems, established telehealth platforms, national workforce development firms, technology vendors, and pharmacies will all compete aggressively. The procurement processes will be highly formal and complex. Prior Texas relationships will matter, as will showing extensive experience in the state and within similar rural communities.

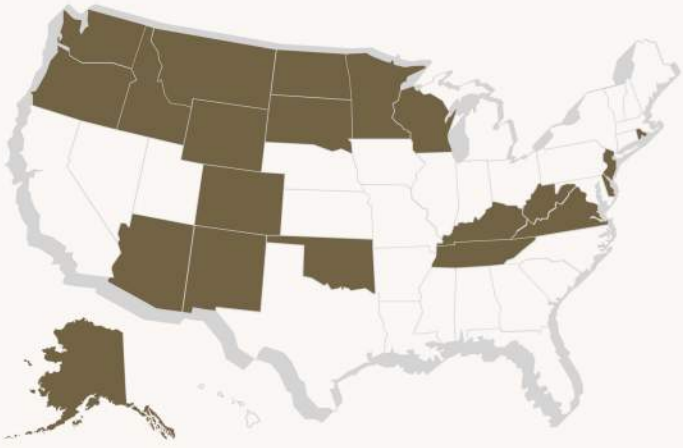
The Sweet Spots: High Allocation, Lower Competition

For Year 1, states concentrated in several regions received disproportionately large allocations relative to their rural populations and likely vendor interest. Vendors may be able to leverage successful track records in neighboring or similar states to position themselves for new opportunities in these respective regions:

Northeast / New England: Rhode Island received $156 million to spread across 18 rural towns, with one rural health clinic and no rural hospitals. New Jersey is mostly urban, but has about 580,000 rural residents, creating an outsized opportunity relative to what its rural footprint might suggest. Delaware has ambitious plans to build a new medical school that could prompt unique partnerships. Expect fewer vendors to target these states, creating opportunities for organizations to demonstrate relevant experience without facing a crowded field.

Upper Midwest: Minnesota, Wisconsin, North Dakota, and South Dakota share similar rural demographics, agricultural economies, and healthcare challenges. Although their rural and overall populations are smaller than those of some other states, they make up for it by covering more expansive geographies, creating opportunities for transportation networks, drone delivery, and remote patient monitoring.

Appalachian Corridor: Kentucky, West Virginia, Virginia, and Tennessee face overlapping challenges: rugged terrain, provider shortages, economic distress, and some of the nation's highest rates of heart disease, diabetes, and opioid use disorder. State plans emphasize workforce pipelines, transportation solutions, maternal health access, and chronic disease prevention.



Mountain West: Montana, Wyoming, Colorado, and Idaho share frontier healthcare challenges: extreme distances, harsh weather, and sparse populations spread across vast terrain. State plans emphasize telehealth, remote monitoring, mobile clinics, and support for Critical Access Hospitals.

Tribal Health Concentration: Alaska, Arizona, New Mexico, Oklahoma, Washington, and South Dakota have significant Native populations, and their RHTP plans include tailored Tribal health initiatives. Washington explicitly sets aside funds for Tribes. Oregon has a dedicated Tribal support initiative.

YEARS 2-5 OUTLOOK

Where the Real Money Is

Year 1 allocations are not predictive of Years 2-5. The RHTP structure expects a funding shift from broad, fairly equitable distribution across all states in the first year to more concentrated investments in proven models with the greatest rural needs in subsequent years.

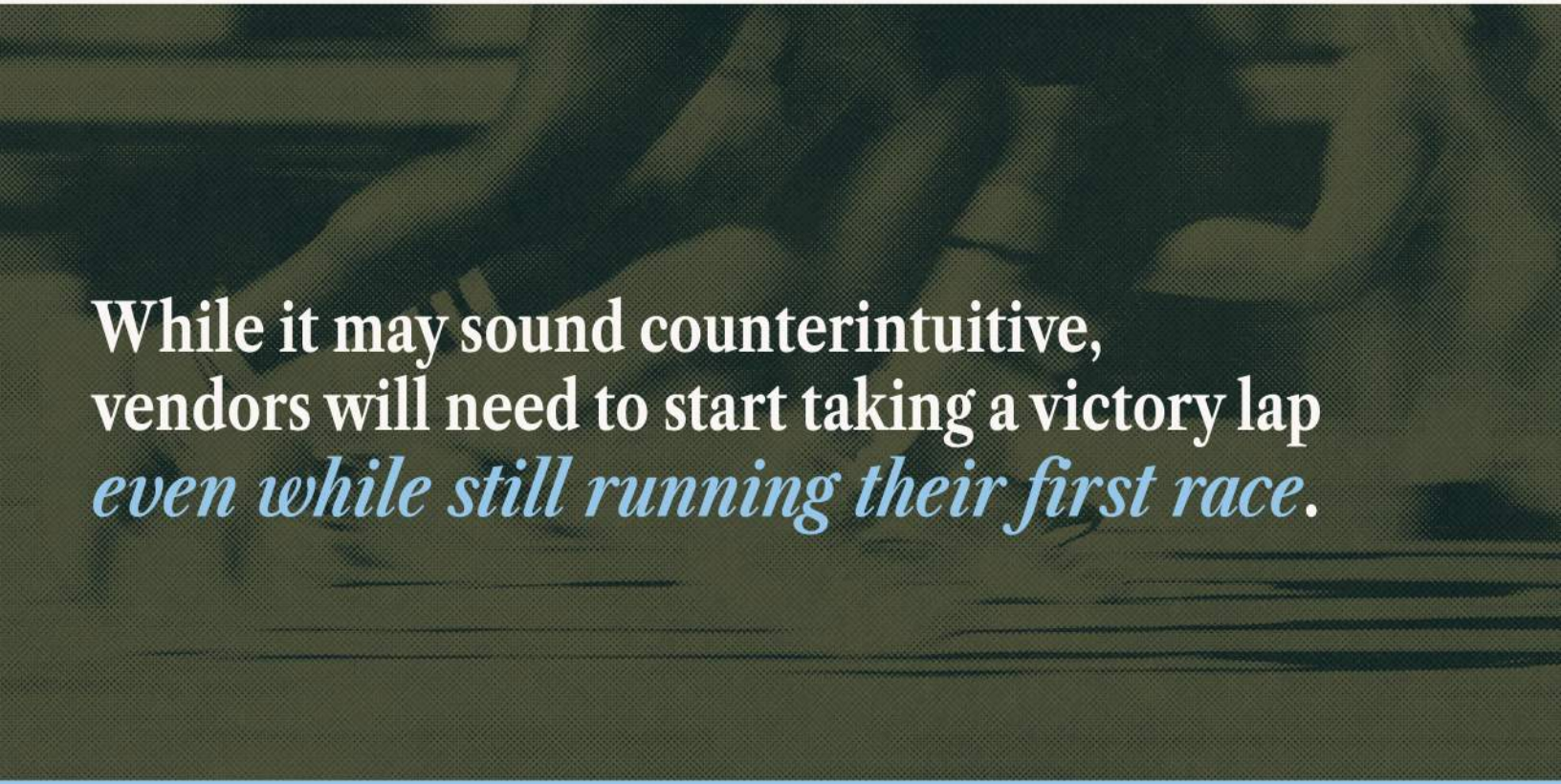
Year 1 Logic

Get money moving quickly. Demonstrate early action and results.
Fund experimentation, funding a wide range of initiatives to see what works.

Years 2-5 Logic

Double down on what's working. Consolidate around scalable, sustainable models.
Favor vendors and initiatives that show measurable results.

This means Year 1 vendors who deliver strong outcomes will have significant advantages in subsequent rounds. It also means some Year 1 awards may not be extended.
To continue receiving RHTP funding, vendors will need to make sure state health departments, elected officials, and public health leaders recognize and value their Year 1 successes.



While it may sound counterintuitive, vendors will need to start taking a victory lap *even while still running their first race*.

FORECASTING FUNDING IN YEARS 2-5

While exact Years 2-5 allocations are not yet determined, the program's authorizing framework suggests that **funding will be weighted toward states with larger rural populations and more extensive rural geography**.

For example, Texas received the largest Year 1 award at about $281 million. While that may sound like a big victory, the state is also home to more than 4.7 million rural residents, over a million more than any other state. This means Texas will receive only $59 per rural resident, the lowest of any state.

Texas is home to more than 7% of the nation's rural population. If the state received a proportional share of funding during Years 2-5, it could be awarded over $700 million per year, roughly $3 billion over a four-year period.

North Carolina, home to nearly 3.5 million rural residents, could also see a significant funding increase if awards are distributed proportionally during Years 2-5. In particular, the Western North Carolina rural region, devastated by Hurricane Helene in 2024, may be well positioned to nearly double its Year 1 award of $213 million.

Similar changes could happen across dozens of states, though the actual approach used to calculate awards in Years 2-5 will likely include several factors, not just rural population, so storytelling may play an even more important part throughout this process.

Organizations that position themselves now, even with modest initial contracts, could stand to gain even larger Years 2-5 awards.

Of course, that goes both ways, with smaller states with relatively fewer rural residents likely to see their Years 2-5 awards less than where they start in 2026.

These state-federal dynamics will create additional needs for state governments and state-based associations focused on rural health, hospitals, community health centers, pharmacies, etc., to tell the macro-level story that helps their respective state maximize its awards for 2027 onward.

COMMON THEMES

Across most states, several trends and priorities emerge

Expanding Access Points

Virtually all states plan to bring care closer to home for rural residents. This includes deploying mobile clinics or units, establishing regional hub-and-spoke networks, using pharmacies as accessible local care providers, and expanding telehealth infrastructure and remote care. Many states target maternal and primary care deserts by expanding access through obstetric telecarts and local birthing centers.

Workforce Development

Every state highlights strengthening the rural health workforce through incentives, training pipelines, or educational partnerships. Examples include Delaware's new medical school, North Dakota's "grow-your-own" programs (Scrubs Camps), and loan repayment or residency expansions. Recruitment and retention of clinicians (doctors, nurses, behavioral health providers) in rural communities is a unifying theme.

Telehealth & Technology

Modernizing rural health infrastructure is a core focus. Most plans invest in telehealth or telepharmacy expansion, broadband connectivity, RPM enrollment, and health IT upgrades. States like North Carolina, Pennsylvania, and Oregon are creating data exchanges or using AI for analytics. Several plans also mention cybersecurity and interoperability. Innovative tech appears in some outliers, such as Alaska and North Dakota using drones, and Washington and Texas implementing AI tools for population health.

Preventive Health and MAHA

Almost all states echo the "Make Rural America Healthy Again" (MAHA) preventive care ethos promoted by CMS. This translates to programs for nutrition, exercise, chronic disease self-management, and addressing social determinants. For instance, many states are pursuing "food as medicine" initiatives, and others plan to reduce obesity and tobacco use. Behavioral health and substance use disorder (SUD) treatment expansion in rural areas is another widespread goal. The emphasis is on keeping rural populations healthy rather than just reactive sick care.

Financial & Structural Reform

Several states are experimenting with new payment models or policy reforms to ensure sustainability. For example, Pennsylvania's value-based payment grants, South Dakota's rural ACO model, and global budgeting in some hospital support plans. About half of the states pledge to repeal or modify certificate of need (CON) restrictions. Additionally, some states are seeking structural changes to keep rural systems viable, such as Wyoming incentivizing essential services at Critical Access Hospitals (CAHs) and Texas investing in after-hours clinics.

NOTABLE OUTLIERS

While goals are largely aligned, some states' plans feature outliers that address state-specific challenges with creative solutions. Unique initiatives that stand out include:

New Medical School

Delaware is the only state to use RHTP funds to launch a new medical school, reflecting a bold workforce strategy not seen elsewhere.

Drone Delivery

Alaska and North Dakota plan to use drones to deliver medical supplies, labs, and medicine to remote areas, a novel approach to frontier healthcare. A handful of innovative companies have emerged in this space, such as Zipline, which pioneered vaccine delivery to remote areas of Africa, and Matternet, which recently announced a medical partnership with UPS.

Farmer Mental Health

Wisconsin's Farmer Wellness hotline and vouchers specifically tackle agricultural mental health, a targeted program unique to a state with high farm suicide rates.

Tribal Health Focus

States with significant Native populations **(AK, AZ, NM, OK, WA, etc.)** include tailored Tribal health initiatives in their plans. Washington sets aside RHTP funds for Tribes, and other states, like Oregon, have Tribal support initiatives that highlight equity considerations.

Transportation Innovations

A few states prioritize transportation solutions. **Tennessee's** high-tech Non-Emergency Medical Transportation (NEMT) coordination system and **West Virginia's** health mobility platform for NEMT are cutting-edge responses to rural transit barriers. These present opportunities for large mobility networks like Uber Health and Lyft Healthcare, as well as specialty transportation providers.

STATE-BY-STATE COMPARISON

Summarizing each state's announced plans for using its RHTP funds

State	Planned Use of RHTP Funds (Goals/Initiatives)
Alabama	**Expanding maternal care and preventive services:** 11 initiatives, including digital obstetric care, cancer prevention, integrated behavioral health, and building a local health workforce pipeline. Focus on reducing maternal mortality and the burden of chronic disease in rural communities.
Alaska	**Serving vulnerable, remote populations:** Rightsizing primary care delivery in frontier areas and expanding obstetric care access for high-risk patients. Alaska will also pilot emerging technologies to overcome geographic barriers, such as remote pharmacy kiosks and drone-delivered medications. Workforce upskilling (e.g., training local health workers and EMS techs) is another key component.
Arizona	**Workforce and mobile care expansion:** Addressing needs in all 15 rural counties via new rural clinical rotations/residencies and recruitment incentives for home-grown providers. Arizona is also deploying telehealth hubs and mobile clinics to bring care closer to remote communities, alongside digital infrastructure upgrades (electronic health records, telehealth equipment) to modernize rural care.
Arkansas	**Prevention, networks, and telehealth:** Tackling the nation's 3rd highest heart disease rate and high rural hospital closures through chronic disease prevention programs, integrated care networks, rural workforce expansion, and broad telehealth/telepharmacy implementation across all 63 rural counties. Emphasis on keeping rural hospitals open and improving cardiac health outcomes.
California	**Statewide infrastructure & workforce plan:** With 82% of California's land area rural, the state plan targets persistent access and workforce stability issues. California is focusing on strengthening Medical Service Study Areas (underserved rural regions) by modernizing facilities/equipment, expanding telehealth, and stabilizing the rural health workforce. Efforts include regional centers of excellence and investments in clinic infrastructure to bridge urban-rural care gaps.
Colorado	**Overcoming geography and weather barriers:** In rugged frontier areas, Colorado's plan centers on innovative ways to deliver specialty and primary care during winter isolation. Strategies include expanded telehealth and remote monitoring to reach communities cut off by terrain or snow, as well as mobile clinics and improvements to emergency care to ensure year-round access.

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Connecticut	**Care coordination & population health:** 31 planned initiatives centered on maternal and child health, bolstering community-based services, and shifting to value-based care. Connecticut aims to integrate providers through strategic partnerships to improve care coordination and to use data-driven population health management to improve outcomes in its rural areas.
Delaware	**Workforce development and new services:** Investing in its first four-year medical school (with a rural primary care track) to grow the provider pipeline, plus deploying mobile health units and establishing "Hope Centers" to integrate housing, primary care, and behavioral health for unhoused and rural populations. These moves address Delaware's last-place ranking in primary care access by training more doctors and bringing services directly to underserved communities.
Florida	**Broad care delivery innovations:** A large rural population (1.8 million) drives Florida's plan to create new care delivery models and partnerships. Initiatives include regional resource-sharing collaboratives among rural providers, expanded remote patient monitoring programs, and community paramedicine to treat patients in place. Florida's approach spans primary care, emergency response, pharmacy, paramedicine, and technology upgrades to link rural clinics and hospitals.
Georgia	**Maternal health and telemedicine focus:** Addressing glaring gaps (82 rural counties with no OB-GYN), Georgia will deploy mobile "obstetrical unit" carts to rural hospitals and adopt the AHEAD model (a value-based rural primary care model). Additional initiatives include mobile health units and a major expansion of telehealth infrastructure to bring prenatal, primary, and specialty care to counties without hospitals.
Hawaii	**Islands' infrastructure & workforce:** Confronting archipelago geography, Hawaii will bolster rural healthcare infrastructure (upgrading clinics on outer islands) and invest in workforce training/retention. The state will support rural providers in transitioning to value-based care, recognizing unique challenges of inter-island patient transport and provider shortages. Telehealth and inter-island specialty rotations are key tools in Hawaii's plan.
Idaho	**Workforce growth and access improvement:** Idaho outlines five initiatives that prioritize rural healthcare workforce development, improve access to care in isolated communities, and prevent chronic disease. Plans include incentives for rural practice, telehealth expansion in sparsely populated areas, and community wellness programs to address diabetes and other chronic conditions in frontier regions.

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Illinois	**Regional partnerships for care:** Illinois expects to benefit ~1.6 million rural residents and emphasizes regional partnerships between healthcare providers and community organizations. By creating collaborative networks (for example, linking rural hospitals with larger systems and local nonprofits), Illinois plans to expand services, share resources (like specialists via telemedicine), and address social determinants of health in rural western and southern Illinois.
Indiana	**Preventive care & sustainability:** Facing provider shortages and struggling rural hospitals, Indiana has 12 initiatives focused on "Making Rural America Healthy Again" (preventive health and wellness) and on sustaining rural healthcare services. This includes chronic disease prevention programs, efforts to improve rural hospital finances, and expanding transit options for patients (addressing transportation barriers to care) in Indiana's rural communities.
Iowa	**Addressing farm-community needs and cancer:** Iowa is targeting significant geographic/transportation barriers for its agricultural communities, with an innovative focus on skin cancer prevention (skin cancer is the state's second leading cause of death). Plans include deploying tele-dermatology and providing dermatoscopes to rural clinics for early melanoma detection, along with mobile integrated health units and health education to improve access in farm regions.
Kansas	**Stabilizing hospitals and incentivizing providers:** Kansas proposes initiatives to support rural hospital finances (possibly through small hospital subsidies or global budgeting), offer new workforce incentives (scholarships, loan repayment) to attract providers, expand PACE (Program of All-Inclusive Care for the Elderly) into rural areas, and enhance value-based care participation. These efforts aim to counter provider shortages and limited preventive services in Kansas's rural counties.
Kentucky	**Holistic quality improvement:** Kentucky addresses its Appalachian rural health challenges through four "dimensions" of health quality: Engagement, Access, Prevention, and Delivery. In practice, this means community engagement in health programs, improving access to basic and specialty care (e.g., mobile clinics in mountain areas), expanding preventive services (like substance abuse and diabetes programs), and optimizing care delivery systems for rural patients.

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Louisiana	**Digital infrastructure & prevention:** Ranked last in health outcomes, rural Louisiana suffers high chronic disease, maternal mortality, and behavioral health burdens. The state is directing funds to improve digital infrastructure in rural clinics (e.g., broadband, telehealth), to aggressively recruit and incentivize healthcare workers in underserved parishes, and to close gaps in community-based prevention services (such as maternal health programs and mental health outreach).
Maine	**Integrating fragmented systems:** Maine's rural landscape is marked by fragmented care (disconnected hospitals, EMS, behavioral health, etc.), so the state will establish a rural provider partnership hub model to link these entities and improve care coordination. Maine is also incorporating innovative AI tools and payment reform to increase efficiency – for example, a statewide health information exchange and value-based payments. Other plans include alternative care sites (like school-based mental health centers) and an EMS "community paramedicine" model to reduce inefficiencies.
Maryland	**Targeted chronic disease initiatives:** About 30% of Maryland's population is rural (with an older demographic), facing higher rates of diabetes, heart disease, and mental health issues. Maryland's plan has three strategic aims: improving rural workforce access (e.g., incentives for clinicians in Eastern Shore and Western MD), enhancing care delivery (through telehealth and the expansion of rural clinics), and strengthening the rural food system to improve nutrition. For example, the state will invest in "food as medicine" programs and mobile farmers' markets alongside traditional health services.
Massachusetts	**Multi-faceted recovery plan:** After three rural hospital closures, Massachusetts is addressing rural gaps through six domains and 20 activities emphasizing health IT and innovative care delivery. Key efforts include: improving information exchange between rural providers, deploying remote patient monitoring and mobile health units to cover large catchment areas, providing in-home visits for seniors, and modernizing payment systems to sustain rural healthcare. The plan also strengthens behavioral health and chronic disease management in rural western Massachusetts.

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Michigan	**Technology and tribal outreach:** Michigan's 75 rural counties (including many Tribal communities) face clinician shortages and limited broadband. Michigan will use funds to support telehealth infrastructure (expanding broadband and virtual care in remote areas) and bolster the rural health workforce (through training programs and incentives to practice in underserved Upper Peninsula and northern counties). Special emphasis is on aging populations and Tribal health – for example, partnering with Tribal clinics to improve elders' access to care.
Minnesota	**Cardiometabolic health & workforce:** Minnesota's rural population (including 11 Tribal nations) struggles with high rates of diabetes and heart disease, as well as provider shortages. The state's plan targets cardiometabolic health outcomes (through nutrition and exercise programs and better chronic disease management), invests in workforce development pipelines for rural clinics, improves access via telehealth, and strengthens partnerships among rural hospitals and Tribal health systems to enhance care continuity. Provider stability (financial and operational) is another focus to keep rural facilities open.
Mississippi	**Maternal health and infrastructure:** Facing the nation's highest maternal mortality and poverty rates, Mississippi will invest heavily in maternal health services for rural women (e.g., supporting OB units and prenatal care in underserved counties). The plan also addresses emergency care by improving EMS coordination statewide and upgrading outdated health IT infrastructure in rural hospitals. Additionally, Mississippi is focusing on telehealth and remote monitoring to reach patients in impoverished and isolated areas, and tackling workforce training to alleviate provider shortages.
Missouri	**Regional hub-and-spoke collaboration:** With 1.9 million rural Missourians across 104 counties, Missouri is building a hub-and-spoke model to foster regional and local cooperation between hospitals, pharmacies, and clinics. These regional hubs will coordinate specialty care outreach, telemedicine/telepharmacy networks, and shared services (e.g., bulk purchasing and lab resources) to help rural providers remain sustainable. The goal is to improve access and operational efficiency (e.g., by having small clinics refer patients to regional centers of excellence while keeping patients local when possible).

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Montana	**Workforce & technology expansion:** In a state where nearly all counties are rural, Montana is prioritizing strengthening its healthcare workforce (through new training programs and securing financial solvency for rural providers), embedding prevention and community health at the core of care, and expanding technology use. This includes telehealth services for remote ranching communities, better health data sharing, and potentially piloting remote monitoring for chronic conditions. Montana also aims to stabilize rural hospitals' finances to prevent closures.
Nebraska	**Food-as-medicine and system reform:** With high obesity rates and "maternity desert" areas, Nebraska's plan includes food-as-medicine programs to improve nutrition in rural communities and reduce chronic disease. Other initiatives focus on developing the rural health workforce, investing in technology (telehealth and health information systems), and "right-sizing" the healthcare delivery system (aligning resources to community needs). For example, Nebraska will support small hospitals in shifting to outpatient and telehealth models where appropriate and expand maternal care access in counties lacking birthing facilities.
Nevada	**Four major initiatives:** Nevada's rural areas have severe chronic disease and access issues, so the state outlined four initiatives: a Make Rural Nevada Healthy Again public health push; improved funding to stabilize rural hospitals; establishing a Workforce Recruitment and Rural Access Program (with incentives for providers to live and practice in rural Nevada); and upgrading technology infrastructure statewide (telehealth, health IT). These aim to increase local healthcare capacity (including adding mobile clinics and telemedicine mentorship) and reduce the miles patients must travel for care.
New Hampshire	**Prevention-first approach:** New Hampshire is advancing a prevention-oriented strategy across behavioral health, perinatal and maternal care, chronic disease management, oral health, and school-based wellness. A "primary care and prevention first" model underpins the plan – for example, expanding community-based preventive services (like dental hygienists in schools, AI tools for early risk detection) and strengthening primary care practices to catch health issues early, thereby improving health outcomes in its ~575,000 rural residents.

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New Jersey	**Flexible care systems and community input:** New Jersey (with ~580,000 rural residents) is focusing on improving healthcare availability via more primary and specialty providers (including mobile and telehealth services). The state will make investments responsive to community input – for instance, competitive grants for local innovations – and foster a flexible healthcare system that can rapidly adapt to changing rural needs. Telehealth training and a Healthcare Innovation Engine are planned to drive the adoption of new technologies in rural parts of the state.
New Mexico	**Statewide access & chronic care:** With rural needs in every county (⅓ of residents live in rural areas), New Mexico has 5 initiatives to transform access and quality of care. Key focuses include expanding specialty care access in remote areas (e.g., tele-specialty clinics and mobile screening programs) and strengthening chronic disease management on both the provider and patient sides. One initiative ("Healthy Horizons") will extend chronic care and nutrition support into rural communities, and another ("Rooted in New Mexico: Building Tomorrow's Workforce") will invest in local healthcare workforce recruitment and training pipelines.
New York	**Preventive care and medical homes:** New York's plan targets fragmented rural care by focusing on Make Rural America Healthy Again preventive health initiatives and strengthening primary care. This includes building out patient-centered medical homes (PCMHs) in rural areas, creating partnership networks among hospitals, Federally Qualified Health Centers (FQHCs), and community groups, and school-based health programs. New York also plans sustainable tech investments to reduce provider burden (e.g., implementing an eConsult platform for specialist access) and to support workforce development at all levels.
North Carolina	**Innovative models and ROOTS hubs:** North Carolina defined three goals: catalyze innovative care models, transform the rural care experience, and create a sustainable rural delivery system. A key feature is establishing community care network hubs ("ROOTS Hubs") – up to six regional hubs that coordinate resources and IT infrastructure for local partners. The state will also expand behavioral health and SUD treatment via standardized Certified Community Behavioral Health Clinics and mobile opioid treatment units. Overall, the state emphasizes coordinated, value-based models and improved care navigation in its rural areas.

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North Dakota	**Tech and "grow-your-own" workforce:** With nearly half of residents living in rural areas and 30% in frontier areas, North Dakota is focusing on rural workforce development (e.g., new residency slots, "grow-your-own" programs like Scrubs Camps for K-12 students) and deploying innovative consumer-facing technologies. Plans include automated pharmacy kiosks, at-home lab testing kits, health apps, and even drones for rapid medical deliveries in remote areas. The state is also launching wellness initiatives (Eat Well ND, ND Moves Together) to combat chronic disease, under the broader MAHA (Make Rural America Healthy Again) umbrella.
Ohio	**Clinically integrated networks & tech:** Ohio (2.8 million rural residents) is improving access by building clinically integrated networks (CINs) that connect rural hospitals, clinics, and social services. The state will expand chronic disease self-management programs and remote monitoring to improve outcomes (e.g., with diabetes and hypertension). It's also investing in telehealth and electronic health records upgrades for pharmacists and providers, to bridge distances and enhance care coordination. These efforts aim to reduce ER use for chronic conditions, strengthen local care capacity, and expand access points.
Oklahoma	**Connected care and wellness hubs:** Largely rural Oklahoma (with a 16% Indigenous population) seeks to ensure that every community has high-quality local care. Plans include building a digitally connected provider network with flexible care delivery across regions, designing data-driven solutions tailored to rural needs, and advancing whole-person health pathways for behavioral health, chronic disease, maternal health, and social needs. Oklahoma is also launching community-led Wellness Hubs, which are competitive microgrants for each rural county (up to $50k) to fund local wellness projects in response to community needs.
Oregon	**Behavioral health and Tribal support:** Oregon's rural communities face behavioral health challenges, an aging population, and OB/GYN unit closures. The state has four initiatives to address mental health, elder care, and obstetric access, plus a fifth initiative specifically supporting Tribal health. Key strategies include workforce capacity & resilience programs (grow-your-own provider training and an "exchange" program to bring specialists to rural areas), and Healthy Communities prevention efforts (integrated primary care and social services, pharmacy telehealth lockers, etc.) to improve wellness.

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Pennsylvania	**Sustainable access & technology:** Pennsylvania's rural provider network lacks capital and tech infrastructure. The plan promotes sustainable access by integrating and expanding service delivery (addressing gaps in maternity care, behavioral health, dental, and aging services), leveraging technology and interoperability (e.g., patient-facing apps, health information exchange), and developing the rural workforce at all levels. A regional hub model will be used, where hubs (health systems or HIEs) provide direct technical support to local hospitals for workflow redesign, staff training, and telehealth implementation. Pennsylvania will also offer competitive grants to foster rural value-based care, building on its prior Rural Health Model.
Rhode Island	**Workforce, tech, and access:** America's smallest state has distinct rural issues (ferry-dependent island communities, no rural maternity ward, one rural hospital in deficit). Rhode Island's plan focuses on strengthening the rural workforce (incentivizing clinical placements and top-of-license practice), leveraging technology (a state-sponsored EHR platform for small practices, grants for telehealth, and remote monitoring tools), and promoting sustainable access to care. For example, the state will provide low-cost EHR and telehealth platforms to solo rural providers and expand home-based care programs to keep healthcare local.
South Carolina	**Digital literacy and innovation:** Rural South Carolina (1.75 million residents) will improve access and quality of care for chronic disease management by expanding digital infrastructure and telehealth capacity. The "Connections to Care" initiative will improve digital health literacy, enabling more residents to use telehealth services. South Carolina is also creating a Tech Catalyst Fund to invest in rural health technology startups and community innovations that drive long-term improvements. Workforce development and provider training are also featured, building on existing state efforts to reduce disparities in rural health outcomes.

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State	Planned Use of RHTP Funds (Goals/Initiatives)
South Dakota	**Direct investment & local innovation:** With almost all of South Dakota rural and 9 Native American Tribes), the state is prioritizing direct investments in provider capacity rather than new programs. The plan provides flexible funding and tools to local providers to deliver high-quality care efficiently (trusting they know community needs best). South Dakota will fund essential tech and equipment (for data infrastructure, telehealth, etc.), develop the rural workforce, enhance chronic disease management, and improve behavioral health and EMS services. Notably, it will establish Regional Maternal and Infant Health Hubs to reduce deficient outcomes in rural and Tribal areas by coordinating OB care through hub-and-spoke networks. Payment reform (e.g., a Medicaid Primary ACO model) will also be piloted to promote cost accountability in rural clinics.
Tennessee	**High-need patients and NEMT solutions:** Tennessee (ranked 44th in health) is focusing on patients with the highest disease burdens (e.g., dementia) and on unique solutions for Non-Emergency Medical Transportation (NEMT) in rural areas. Planned initiatives include a Memory Care Assessment Network (a hub-and-spoke model linking rural memory clinics with urban neuropsychiatry centers) and a Rural Healthcare Resiliency Program to overhaul NEMT via a tech-enabled coordination system. Tennessee is also investing broadly in technology infrastructure and workforce development, and aims to eliminate all rural maternity care deserts and improve preventive care utilization with these funds.
Texas	**Technology and networks at scale:** Texas's rural health challenges span 80% of counties. The state is leveraging statewide technology initiatives (such as the Lone Star AI Health Network to connect fragmented telehealth services) and supporting rural clinical workforce development. Plans also include establishing clinically integrated networks (CINs) for rural providers, modernizing equipment and facilities, and empowering patients in disease prevention (e.g., expanding nutrition and fitness programs). For example, Texas will fund community wellness centers offering chronic disease screenings and diet/exercise classes, and set up after-hours rural clinics to reduce non-emergency ER use.

STATE-BY-STATE COMPARISON

Summarizing each state's announced plans for using its RHTP funds

State	Planned Use of RHTP Funds (Goals/Initiatives)
Utah	**Wellness and provider access:** Utah has the nation's lowest per-capita primary care supply. To serve far-flung rural residents, Utah is focusing on wellness and nutrition initiatives, such as the "Making Rural Utahns Healthy" PATH program, which promotes exercise, nutrition, and preventive care. The state also wants to boost the rural clinical workforce (training and incentive programs), leverage technology (EHR upgrades, interoperability, AI tools to cut provider burden), and improve access to care (e.g., telehealth and remote clinics). A Shared Utilities/Technology SUPPORT program will help rural providers share digital resources and improve efficiency.
Vermont	**Primary care, tech & workforce:** Vermont is addressing geographic dispersion and an aging rural populace by improving primary care and long-term support through tech-enabled networks and workforce initiatives. The plan will build robust rural care networks (with better bed-tracking, transfer systems, and community paramedicine), lower costs via shared technology infrastructure (telehealth, telepharmacy, remote monitoring, AI scribes) to boost efficiency, and strengthen the rural workforce through housing support, training, and financial incentives for medical professionals. Vermont is even exploring new insurance models, modified certificate of need (CON) rules, and cost-tracking tools to make healthcare more affordable.
Virginia	**Patient empowerment & prevention:** Rural Virginians face poor outcomes and long travel times for care. Virginia's plan centers on empowering patients and emphasizing prevention, with particular focus on expanding access to care, deploying new technology, and workforce development. Initiatives include "Food as Medicine" programs (funding food pharmacy services with medically tailored meals for chronically ill patients) and innovative maternal care models ("Connected Care, Closer to Home") that expand prenatal/postpartum services via community hubs, mobile units, and telehealth for maternity care deserts. The state also aims to build a pipeline of rural health workers and modernize operations with health IT tools to improve efficiency.

STATE-BY-STATE COMPARISON

Summarizing each state's announced plans for using its RHTP funds

State	Planned Use of RHTP Funds (Goals/Initiatives)
Washington	**Five key strategies:** Washington identified numerous issues (high rural SUD rates, clinician turnover, ER strain) and devised a plan with five strategies: (1) improve rural health outcomes for substance use disorder and other challenges; (2) create opportunities for health in rural communities (e.g. wellness programs); (3) foster partnerships across the rural delivery system; (4) grow the rural health workforce; and (5) deploy technology and data solutions for efficiency and connectivity. Notably, Washington will "Ignite Innovation in Rural Hospitals" by investing in sustainable financial models and health IT to prevent further obstetric unit closures, and "Invest in the Health of Native Families" by dedicating funds to the Tribal healthcare workforce and data-sharing initiatives.
West Virginia	**Workforce, tech, sustainability:** West Virginia's mountainous rural areas have travel and broadband issues and low workforce participation. The state proposes a three-pronged approach to improve the rural health workforce, leverage technology, and enhance the sustainability of the healthcare system. One element is a "Flywheel" plan to improve population health, which, in turn, boosts workforce participation and economic growth (by increasing employer-sponsored insurance rates). West Virginia's initiatives include Rural Health Link (a mobility platform for dispatching non-emergency transport and expanding EMS capacity) and Mountain State Care Force (building local provider pipelines via co-funded faculty positions, rotational staffing pools, etc.) to increase provider capacity in rural areas.

STATE-BY-STATE COMPARISON

Summarizing each state's announced plans for using its RHTP funds

State	Planned Use of RHTP Funds (Goals/Initiatives)
Wisconsin	**Care coordination and farmer mental health:** Wisconsin's rural communities (many in agriculture) face unique challenges – agriculture accounts for 10% of jobs, and farm suicide rates are 180% above average. Wisconsin's plan focuses on care coordination (simplifying access to behavioral health programs and improving health information exchange for dual-eligibles) and expanding mental health support for farm families. For example, an Interoperability Infrastructure initiative will fund rural dental clinics to adopt health IT and extend Medicaid dental services. A Public Navigation Transformation: Farmer Wellness Program will offer a 24/7 farmer mental health hotline, free counseling vouchers (telehealth or in-person), and monthly peer support groups to address farm stress and suicide. Workforce development and leveraging technology are also prominent to ensure "the right providers, with the right technology and networks" transform rural health.
Wyoming	**Right-sizing care and workforce pipeline:** Wyoming's rural population skews older and relatively affluent, with high Medicare and IHS utilization, but a shortage of providers makes basic care hard to access. Wyoming plans initiatives to boost its rural clinical workforce through enhanced pipeline programs and new incentives, by leveraging technology (e.g., competitive grants for telehealth and telepharmacy adoption, a new statewide tele-specialist platform, a non-emergency transport coordination system), and "right-sizing" the delivery system to local needs. One spotlight is the Critical Access Hospital – Basic Incentive Program, which will incentivize CAHs to provide essential services (ER, OB, ambulance, pharmacy), while limiting less-needed services, in exchange for tiered state funding. These efforts aim to improve access to specialty services (e.g., adding labor/delivery in frontier areas) and reduce negative health indicators, such as rural suicide rates.

Sources: *Official CMS RHTP state summaries and state announcements/news releases as cited above. Each state's plan is derived from its RHTP application and public statements in early 2026.*

STATE-BY-STATE COMPARISON

Summarizing each state's announced plans for using its RHTP funds

State	Access points (mobile/hub-spoke/etc.)	Workforce development	Telehealth / Tech & Health IT	Prevention / MAHA	Behavioral health / SUD	Maternal / Perinatal	Care coord. & networks	Financial / Payment reform	Facilities / Equipment	EMS / Emergency
Alabama		✓	✓	✓	✓	✓				
Alaska		✓	✓			✓				✓
Arizona	✓	✓	✓				✓		✓	
Arkansas		✓	✓	✓				✓		
California		✓	✓					✓	✓	
Colorado	✓		✓							✓
Connecticut						✓	✓	✓		
Delaware	✓	✓			✓					
Florida	✓		✓				✓		✓	✓
Georgia	✓		✓			✓		✓		
Hawaii		✓	✓					✓	✓	
Idaho		✓	✓	✓						
Illinois			✓				✓			
Indiana				✓				✓		
Iowa	✓		✓	✓						
Kansas		✓		✓				✓		
Kentucky	✓			✓						
Louisiana		✓	✓	✓	✓	✓				
Maine	✓		✓		✓		✓	✓		✓
Maryland	✓	✓	✓	✓	✓					
Massachusetts	✓		✓	✓			✓	✓	✓	
Michigan		✓	✓							
Minnesota		✓	✓	✓			✓	✓	✓	
Mississippi		✓	✓			✓			✓	✓
Missouri	✓		✓				✓	✓		
Montana		✓	✓	✓				✓		
Nebraska	✓	✓	✓	✓		✓			✓	
Nevada	✓	✓	✓	✓				✓	✓	
New Hampshire	✓		✓	✓	✓	✓				
New Jersey	✓	✓	✓							
New Mexico	✓	✓	✓	✓						
New York	✓	✓	✓	✓			✓	✓		
North Carolina	✓				✓		✓	✓		
North Dakota		✓	✓	✓						
Ohio			✓	✓			✓		✓	
Oklahoma				✓	✓	✓	✓			
Oregon		✓	✓	✓	✓	✓				
Pennsylvania		✓	✓		✓	✓	✓	✓	✓	
Rhode Island	✓	✓	✓			✓		✓		
South Carolina		✓	✓	✓						
South Dakota		✓	✓	✓	✓	✓	✓	✓	✓	✓
Tennessee	✓	✓	✓	✓		✓	✓			✓
Texas	✓	✓	✓	✓			✓		✓	✓
Utah	✓	✓	✓	✓					✓	
Vermont		✓	✓				✓	✓		
Virginia	✓	✓	✓	✓		✓	✓		✓	
Washington		✓	✓	✓	✓	✓	✓	✓		
West Virginia		✓	✓					✓		✓
Wisconsin		✓	✓	✓	✓		✓			
Wyoming		✓	✓					✓		✓

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