

REPORT

Rural health transformation funds: Where they're really going

Rural healthcare providers continue facing acute financial, workforce, and access pressures even as broader hospital finances stabilize. This report examines how states have started deploying funds from the Rural Health Transformation Program — a new federal initiative created to help stabilize and transform rural healthcare delivery following recent federal budget changes — and transform rural healthcare delivery following recent federal budget changes, and highlights early cross-state differences in pace, priorities, and execution that will shape the program's near-term impact on rural capacity and stability.

Published: May 2026

Audience:

- Hospitals and health systems





How the Rural Health Transformation Program is taking shape across states

Rural healthcare providers entered 2026 facing a distinct set of pressures that are more acute — and often more difficult to mitigate — than those confronting their urban counterparts. While hospital finances overall have stabilized, rural providers remain exposed to structural revenue pressures, workforce shortages, and policy shifts. These challenges shaped the creation of the Rural Health Transformation Program (RHTP) and now influence how states are moving to implement it.

SECTION ONE

Where rural healthcare stands today

SECTION TWO

What to know about the Rural Health Transformation Program

SECTION THREE

Early cross-state patterns in RHTP implementation

Where rural healthcare stands today

Persistent revenue pressure tied to payer mix and supplemental funding

Rural hospitals have long operated with an outsized dependence on Medicare and Medicaid, limiting their exposure to higher-margin commercial revenue.¹ Compounding this challenge, rural facilities typically operate at lower patient volumes, leaving little room to absorb revenue shortfalls or cost growth. As a result, even modest disruptions to public coverage or payment policy can have an outsized impact on financial stability — already tenuous, as the average rural hospital margin sits at 2% (compared to an industry average of 8%).¹

To offset this, systems, including rural providers, have leaned increasingly on nonoperating revenue, particularly investment income and state directed Medicaid supplemental payments. While these mechanisms have helped stabilize finances in the near term, they are inherently uncertain as changes in Medicaid eligibility, evolving federal policy, or market volatility can quickly erode revenue sources that rural hospitals rely on to remain solvent.¹

Heightened exposure to looming federal funding changes

Recent and forthcoming policy changes are expected to further strain the rural healthcare safety net. Adjustments to Medicaid eligibility and coverage are likely to increase uninsurance and uncompensated care, while also threatening participation in programs such as 340B that provide critical nonpatient revenue.¹ Because rural hospitals typically operate with thinner financial buffers, these shifts can translate quickly into service reductions or closures.

Nearly 14% of rural hospitals are now considered at immediate risk of closure, a figure that does not account for service line pullbacks, workforce reductions, or reduced hours that often precede full closure.¹ When rural services disappear, demand doesn't vanish — it shifts to nearby providers, increasing capacity strain across broader regional systems.

Population health and access dynamics compound pressure

Rural populations tend to be older, experience higher rates of chronic disease, and face greater barriers to accessing preventive and specialty care.¹ As coverage gaps widen and local access points shrink, rural providers are often left managing more complex patients with fewer resources. These dynamics reinforce financial and workforce challenges, creating a cycle of strain that is difficult to break without external intervention.¹

Against this backdrop, federal policymakers have introduced new funding pathways aimed at stabilizing and transforming rural healthcare delivery.

What to know about the Rural Health Transformation Program

The Rural Health Transformation Program (RHTP) is a federal initiative created under the One Big Beautiful Bill Act (OBBBA) to provide states with multiyear funding to help stabilize and transform rural healthcare delivery. The program functions as a partial stopgap, intended to mitigate the impact of broader federal funding pressures while states pursue longer-term rural health strategies.

States were required to submit applications in November 2025 outlining how they planned to use RHTP funds to address rural health challenges in their markets for 2026. Following approval, federal agencies allocated award amounts to states, which are now responsible for operationalizing those plans. While the program is authorized on a multiyear basis through 2030, funding is awarded year-to-year, and states must demonstrate progress and reapply to continue receiving RHTP support.

Importantly, RHTP funding does not flow directly to providers. Instead, states play a central role in determining how funds are deployed. At a high level, states have several funding mechanisms and structures available to deploy RHTP dollars, including:

- Issuing competitive requests for proposals (RFPs) or notices of funding opportunity (NOFOs)
- Running targeted pilots or demonstration projects
- Funding one-time infrastructure or system-level investments
- Establishing advisory, oversight, or technical assistance functions

As a result, states are now in different phases of turning approved plans into concrete investments, and progress depends heavily on state administrative capacity, policy context, the proposed approach outlined in their applications, and implementation strategy.

The following section examines early RHTP implementation across three dimensions:

- What states are funding first (priority investment areas)
- How states are structuring implementation (funding models and mechanisms)
- When states are deploying funds (speed and sequencing relative to award size)

Together, these dimensions provide a more complete view of how RHTP is taking shape across markets.

What states are funding first

Across states that have moved into awards or open funding opportunities, several funding categories appear repeatedly — though states vary widely in how broadly or narrowly they deploy funds across these areas.

Early RHTP funding focus areas

Funding focus area	Evidence from observed RHTP activity	Illustrative states
Workforce recruitment and retention	Incentives, pipelines, GME expansion, apprenticeships	Iowa, Nevada, Texas, West Virginia
Workforce education and pipelines	Tuition support, career pathways, rural training programs	Hawaii, Georgia, New Hampshire
Access and care delivery expansion	Mobile units, satellite clinics, MIH, hub-and-spoke models	North Carolina, Pennsylvania, Wisconsin
Infrastructure and capital investment	Equipment, facility upgrades, digital health modernization	Iowa, South Dakota, Texas
Technology and data enablement	EHRs, RPM, interoperability, data hubs	Minnesota, South Carolina, Washington
System coordination and technical assistance	Advisory services, revenue cycle management, implementation contractors	Delaware, Montana, Vermont

Note: "Observed activity" reflects publicly documented state actions as of May 7, 2026, including RFAs, awards, legislative activity, and implementation updates.

How states are structuring implementation

As of May 7, 2026, five cross-state patterns have emerged in how states are translating approved plans into action. These themes reflect differences in implementation sequencing, funding strategy, and administrative readiness — often independent of total award size.

Early implementation models (nonlinear approaches)

Note: States are not following a single progression. Instead, these models reflect different strategic starting points and implementation choices rather than a fixed sequence.

Implementation model	Evidence from observed RHTP activity	Illustrative states
Targeted early deployment	Large or high-visibility awards issued early; limited number of initiatives	Iowa, Hawaii
Competitive multi-RFA rollout	Multiple RFAs/NOFOs released across workforce, access, infrastructure	Delaware, Nevada, South Carolina
Infrastructure-first build-out	Early focus on contractors, TA, IT, or governance before provider awards	Minnesota, Montana, Washington
Sequenced planning and governance	Advisory councils, legislation, or staffing precede funding release	Michigan, Maryland, Massachusetts
Bundled or track-based RFAs	Multiple priorities combined into fewer, larger solicitations	Florida, Texas

Speed, scale, and award size: Not a linear relationship

Early RHTP activity suggests that how quickly states move from approval to awards depends more on administrative readiness and implementation choices than on total funding levels.

Award size vs. early activity

Pattern observed	Evidence from observed RHTP activity	Illustrative state(s)
Large awards, fast deployment	Significant awards or RFAs issued soon after approval	Iowa
Mid-range awards, fast deployment	Targeted high-impact or workforce-focused awards	Hawaii
Similar award size, slower rollout	Ongoing governance and planning activity	Michigan, Maryland
Very large awards, bundled rollout	Few large RFAs spanning multiple priorities	Texas, Florida

In the near term, RHTP will produce uneven benefits across markets. Providers in states moving quickly into awards — particularly those prioritizing workforce, capital, and access — are more likely to experience visible short-term relief.

At the same time, leaders should remain cautious about expectations. In many states, early activity remains focused on planning, governance, or system enablement rather than direct provider funding. Over time, differences in deployment strategy may shape which organizations benefit first, how broadly funds are distributed, and whether RHTP meaningfully closes existing gaps in rural capacity.

Related content

Advisory Board resources



EXPERT INSIGHT

Making waves in rural health:
Lessons from Sanford Health CEO
Bill Gassen

[Read now](#)



EXPERT INSIGHT

One Big Beautiful Bill Act:
Understanding the healthcare impacts

[Read now](#)



EXPERT INSIGHT

What health plan leaders need to
know about OBBBA

[Read now](#)

Hands-on support to help deliver the results you need

Optum consulting has a team of thousands of industry professionals with expertise earned from years in our fields. We're here to work side-by-side with you to build organizations that last.

Get in touch at advisory.com/optum-support.

Endnote

1. Advisory Board State of the Industry 2026

Project director

Ben Palmer

palmerbe@advisory.com

Contributing research team

Natalie Trebes

Abby Burns

Max Hakanson

Executive leadership

Ashley Ford

Contributors

Tim Prinz

Director, Strategy and implementation

Optum Advisory

LEGAL CAVEAT

Advisory Board has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and Advisory Board cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, Advisory Board is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member's situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither Advisory Board nor its officers, directors, trustees, employees, and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by Advisory Board or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by Advisory Board, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

Advisory Board and the "A" logo are registered trademarks of The Advisory Board Company in the United States and other countries. Members are not permitted to use these trademarks, or any other trademark, product name, service name, trade name, and logo of Advisory Board without prior written consent of Advisory Board. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names, and logos or images of the same does not necessarily constitute (a) an endorsement by such company of Advisory Board and its products and services, or (b) an endorsement of the company or its products or services by Advisory Board. Advisory Board is not affiliated with any such company.

IMPORTANT: Please read the following.

Advisory Board has prepared this report for the exclusive use of its members. Each member acknowledges and agrees that this report and the information contained herein (collectively, the "Report") are confidential and proprietary to Advisory Board. By accepting delivery of this Report, each member agrees to abide by the terms as stated herein, including the following:

1. Advisory Board owns all right, title, and interest in and to this Report. Except as stated herein, no right, license, permission, or interest of any kind in this Report is intended to be given, transferred to, or acquired by a member. Each member is authorized to use this Report only to the extent expressly authorized herein.
2. Each member shall not sell, license, republish, or post online or otherwise this Report, in part or in whole. Each member shall not disseminate or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of, this Report by (a) any of its employees and agents (except as stated below), or (b) any third party.
3. Each member may make this Report available solely to those of its employees and agents who (a) are registered for the workshop or membership program of which this Report is a part, (b) require access to this Report in order to learn from the information described herein, and (c) agree not to disclose this Report to other employees or agents or any third party. Each member shall use, and shall ensure that its employees and agents use, this Report for its internal use only. Each member may make a limited number of copies, solely as adequate for use by its employees and agents in accordance with the terms herein.
4. Each member shall not remove from this Report any confidential markings, copyright notices, and/or other similar indicia herein.
5. Each member is responsible for any breach of its obligations as stated herein by any of its employees or agents.
6. If a member is unwilling to abide by any of the foregoing obligations, then such member shall promptly return this Report and all copies thereof to Advisory Board.