Black Book
Research Insights

The $50 Billion Rural Health Window

A Guide to State Readiness, Equity, and Digital Transformation Before 2030

Black Book Research Special Report
September 2025

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Introduction

Why This Moment Matters

Rural health in America has been unraveling for decades, but 2025 marks the first time Washington has admitted—publicly and with resources—that patchwork fixes are not enough. The **$50 billion CMS Rural Health Transformation Program** is more than another grant cycle. It is a single, one-time window that could determine whether rural counties regain their footing in health care—or fall further into neglect.

For years, the decline has been visible in headlines and in lived experience. A pregnant mother in Kansas drives 70 miles to deliver because the nearest maternity ward has closed. Families in the Mississippi Delta lose hours each week commuting for dialysis. Broadband black spots across Appalachia mean telehealth visits are a fantasy, not a service. Emergency departments shuttered during the pandemic never reopened, leaving volunteer EMTs as the only lifeline in entire counties.

These stories are not isolated. They are structural. Rural America is older, poorer, and sicker than its urban counterparts. Providers struggle with staff turnover and razor-thin margins. Communities struggle with connectivity that belongs to another century. The result is a widening chasm: in outcomes, in access, in costs.

For the first time, Congress responded at scale. The **One Big Beautiful Bill Act (OBBBA, 2024)** carved out $50 billion—an amount no rural health program has ever touched—and instructed CMS to distribute it not by formula but by competition. States must now write proposals that prove they can not only build new capacity but sustain it into the next decade.

This moment matters because the stakes are asymmetric. States with strong policy teams and vendor partnerships may secure billions. States with the most need, but the least staff capacity, may walk away with little. Hospitals that organize their data and make their needs known may see new broadband towers, telehealth hubs, and workforce programs funded. Hospitals that stay silent will likely be overlooked. Vendors that demonstrate hard ROI may become embedded in multiple state strategies. Those that show up with vague promises will be passed over.

In short: this is the first rural health moonshot of the 21st century. And there will not be another.

At a Glance: Why This Moment Is Different

- **Scale:** $50B—larger than all previous rural health initiatives combined.
- **Structure:** Competitive, not formulaic—states must compete with one another.
- **Scope:** Infrastructure + Workforce + Digital Health, not siloed investments.
- **Longevity:** Projects must demonstrate lasting impact **beyond 2030**.
- **Deadline: November 5, 2025.** No extensions. No second chances.

ACTION ALERT NOW

If this program succeeds, rural communities could leapfrog a decade of decline in just a few years. If it fails—or if the most disadvantaged states cannot mount competitive proposals—the $50 billion will flow disproportionately to places that were already positioned to win. The rural health divide will deepen, and trust in federal promises will erode even further.

Setting the Tone for This Guide

This playbook exists because the opportunity is immense but the rules are unclear. CMS has not published a scoring rubric. That ambiguity is creating paralysis in some states and bold experimentation in others. Hospitals are unsure whether to wait for instructions or push their data forward. Vendors are knocking on statehouse doors, but not all are being invited in.

Black Book Research has built this manual to provide clarity, context, and practical guidance for every stakeholder:

- **State program developers** will find insight into how CMS has scored past initiatives and what constitutes a "credible" proposal.
- **Rural hospital administrators** will see what kind of input matters most, and how to ensure their communities are not invisible.
- **Vendors** will learn how to position their solutions not as products, but as enablers of sustainability and equity.

This is not just background—it is a **roadmap**. The following sections move from history to instructions, from legislative origins to checklists. They tell you what happened, what's happening now, and most importantly, what you must do before the window closes.

Origins of the Program

The Rural Health Transformation Program didn't appear by accident. It was the product of years of frustration, strategic lobbying, and some late-night political dealmaking that transformed rural health from a neglected afterthought into one of the crown jewels of the *One Big Beautiful Bill Act (OBBBA, 2024)*.

Throughout 2022 and 2023, the mood in Congress shifted from resignation to urgency. Rural closures were accelerating; more than a dozen hospitals had shut their doors in 2023 alone. The pandemic had drained reserves and exhausted workforces, and news stories about counties without maternity care or ER coverage made their way into committee hearings. By the time the GAO published its scathing 2022 report on rural disparities, there was broad acknowledgment that **piecemeal solutions were not enough**.

The Political Champions

It was here that three senators—each from deeply rural states—became unlikely architects of the most ambitious rural health program in U.S. history.

- **Sen. Jon Tester (D-MT):** Montana's senior senator, facing reelection in 2024, framed rural health as existential for his state. He returned from town halls with stories of expectant mothers delivering on highways because maternity wards had shuttered. His message to colleagues: *"If we don't act, half my state will have no viable health care left."*
- **Sen. Shelley Moore Capito (R-WV):** With West Virginia consistently ranked near the bottom of broadband and health access metrics, Capito argued that the "digital divide is a health divide." She had already built a reputation as a broadband champion and saw health transformation as a natural extension. She pressed for dedicated funding to tie rural broadband to clinical outcomes.

- **Sen. Jerry Moran (R-KS):** Kansas had lost more rural hospitals than nearly any other state. Moran pushed not just for money but for **sustainability requirements**—workforce pipelines, digital adoption, and financial models that would last beyond construction. His argument was that throwing money at buildings without fixing underlying systems would be "just another bailout."

These three senators—one Democrat, two Republicans—gave the issue credibility across partisan lines. Tester spoke for the Mountain West, Capito for Appalachia, and Moran for the Plains. Their combined constituencies formed the symbolic map of rural distress.

The Negotiations

The *One Big Beautiful Bill Act* was already an omnibus package designed to fund energy, infrastructure, and workforce development. Health was not its central pillar. But in late 2023, as negotiations dragged, the rural coalition made its move.

- They tied rural health investment to **infrastructure votes**, arguing that new roads and clean energy meant little without functioning hospitals and broadband to sustain communities.
- They leveraged **reelection pressure**: Tester's tight 2024 race gave Democrats reason to appease him, while Capito and Moran held sway with Senate Republicans unwilling to cede rural ground.
- They compromised on size: initial drafts floated $75B, but the final language was trimmed to **$50B** in exchange for Republican support on other OBBBA provisions.

The deal was struck in December 2023. When OBBBA passed, it contained an unprecedented directive: CMS would administer a **Rural Health Transformation Fund** that required **competitive state applications** and measurable **impact beyond 2030**. It was not designed to be easy money.

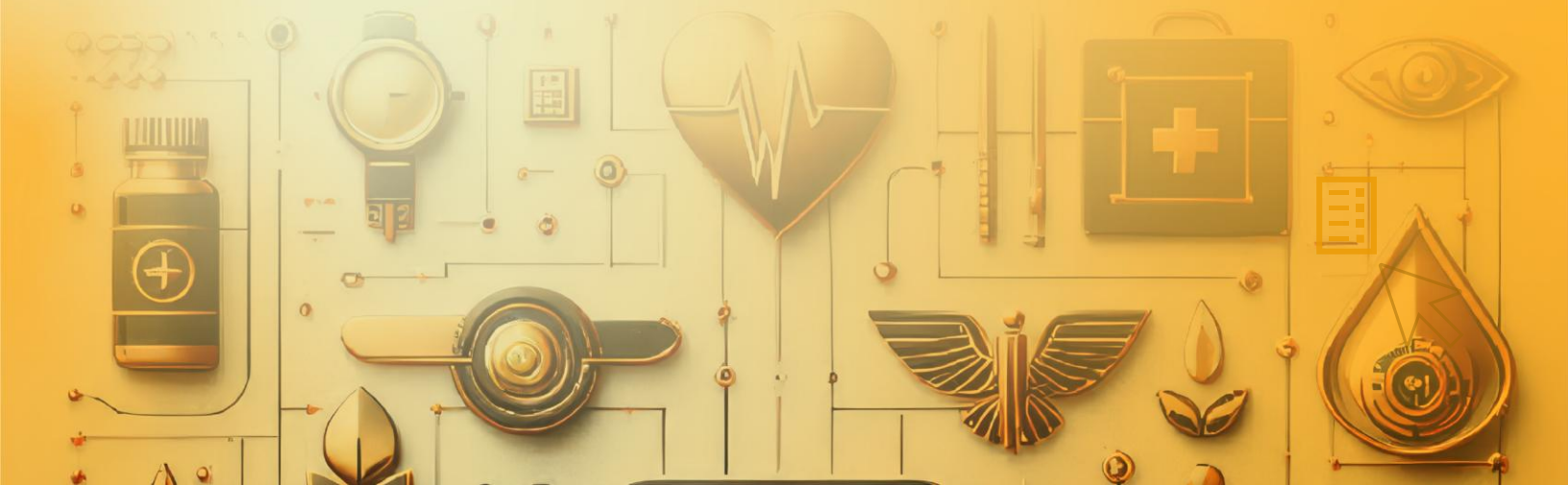
Key Outcomes of the Origins

- **Bipartisan Coalition:** Tester (D-MT), Capito (R-WV), Moran (R-KS) were the pivotal champions.
- **Legislative Leverage:** They tied rural health to infrastructure and broadband votes.
- **Funding Secured:** $50B allocated—largest single rural health commitment in U.S. history.
- **Built-in Strings:** Competitive process, sustainability requirement, CMS administration.

ACTION ALERT NOW

The program was born from negotiation, not inevitability. The $50B figure was a compromise, and it came with conditions designed to weed out weak plans. That means the very states with the greatest need—but the least staff or analytic capacity—may find themselves least able to compete. The political victory that birthed the program also planted the seeds of uneven outcomes.

The July 2025 Announcement and Rollout



The moment the $50B program officially left the pages of legislation and entered reality came on a steamy July morning in Washington. On **July 8, 2025**, CMS Administrator **Chiquita Brooks-LaSure** stood before reporters at a packed press briefing, flanked by Senators Jon Tester, Shelley Moore Capito, and Jerry Moran—the same bipartisan coalition that had pried this funding out of the *One Big Beautiful Bill Act*. Cameras rolled as she declared:

> "This is the most significant rural health investment since Medicare's founding. But it will not be given. It must be earned."

Her words set the tone. This was not a block grant or a handout. It was a contest. States had 120 days to prove they could reimagine rural health, with **proposals due November 5, 2025**. There would be no extensions, no do-overs, and no promise that every state would get a slice.

How States Were Notified

The rollout was orchestrated through official CMS channels, but the effect varied dramatically depending on each state's capacity and readiness.

- **Formal Notification:** The same afternoon, CMS issued a **Dear State Medicaid Director Letter (SMDL)** to all 50 states, D.C., and U.S. territories. It outlined the basics: funding size, pillars (infrastructure, workforce, digital health), and the deadline.
- **National Webinar:** Two weeks later, CMS hosted a stakeholder webinar that drew more than 700 attendees—state agency staff, hospital leaders, association representatives, and vendors. Questions poured in: *What counts as lasting impact? Can broadband-only projects qualify? How will digital health be weighed against brick-and-mortar facilities?* CMS officials responded carefully but vaguely, declining to offer a scoring rubric.

- **Regional Outreach:** CMS regional offices were tasked with follow-up calls to states. In practice, the quality and frequency of these conversations varied. Some states described near-daily contact with responsive CMS liaisons. Others reported waiting weeks for clarification emails, leaving their staff stalled.

Unequal Beginnings

Although every state technically received the same letter, the reality of the rollout quickly diverged.

In **Minnesota**, state officials convened their first **task force** within 10 days of the announcement, inviting rural hospital CEOs, digital health vendors, and broadband agencies to the table. Draft subcommittees were formed to address each pillar. By early August, they had a working outline.

In **North Carolina**, the Office of Rural Health moved swiftly to integrate the new program with existing Medicaid expansion efforts. Their strategy emphasized telehealth hubs and workforce apprenticeships, and they began actively recruiting vendor partners.

Meanwhile, in **Mississippi**, the Office of Rural Health—staffed by just three analysts—struggled to even interpret the SMDL. “We’re still waiting on answers from CMS before we can start,” one staffer admitted in a call with Black Book. By late August, they had no task force and only a preliminary list of priorities.

In **West Virginia**, despite Senator Capito’s role as a program champion, the state health department admitted it had “limited internal capacity to design competitive proposals.” Without technical assistance or vendor partnerships, officials warned they might miss the deadline or submit a weak plan.

Key Features of the Rollout

- **Simultaneous start, uneven pace:** All states got the same SMDL, but responses ranged from immediate mobilization to weeks of paralysis.
- **Early Leaders:** Minnesota, North Carolina, Washington, Pennsylvania.
- **At Risk:** Mississippi, Arkansas, West Virginia, Montana.
- **Vendor scramble:** Companies began cold-calling state health agencies within 48 hours of the announcement, positioning their products as “proposal-ready solutions.”

ACTION ALERT NOW

The **120-day clock is merciless**. By mid-September, frontrunner states had draft outlines, while laggards were still forming committees. Vendors report that most states will **lock proposals by mid-October**, leaving latecomers effectively excluded. Unless low-capacity states secure outside help, the November 5 deadline will cement a two-tier system: well-staffed states with billion-dollar proposals, and neediest states submitting thin, underdeveloped plans.

Program at a Glance

When CMS unveiled the Rural Health Transformation Program, many state officials expected the familiar: a formula grant, or at worst a block grant with allocations based on population or poverty levels. Instead, they were told to sharpen their pencils. The $50 billion fund would be awarded competitively, with **states judged against each other** on the quality and sustainability of their proposals.

This competitive structure startled some, but it was deliberate. Congressional sponsors had pushed for it, insisting that money could not simply be handed out; it had to catalyze transformation. Too often in the past, rural funds disappeared into one-off capital projects—new roofs, new scanners—that never solved systemic weaknesses. CMS wanted states to think bigger: to prove they could build systems that would endure beyond the life of the grant.

The Three Pillars

Every proposal must touch the three pillars CMS has emphasized:

- **Infrastructure:** bricks and mortar matter, but only when tied to new models of access. That could mean reopening a shuttered ER, but paired with digital monitoring to extend its reach. It might mean broadband towers, but linked directly to telehealth and electronic health records.
- **Workforce:** no facility survives without clinicians. CMS wants states to propose pipelines: training programs, apprenticeships, retention incentives, even immigration strategies for specialists. A new clinic built in 2026 is useless if it is staffed by traveling nurses who leave in 2027.
- **Digital Health:** the most forward-looking pillar. Telehealth, remote monitoring, cloud-based EHRs, interoperability platforms, and cybersecurity are not optional add-ons but central to proposals. CMS signaled this by naming **lasting impact beyond 2030** as a non-negotiable requirement. Digital health is the only pillar with inherent durability.

By tying these three together, CMS is forcing states to design **ecosystems, not projects**. A plan that includes only one or two pillars will almost certainly fail.

Why the Competitive Design Matters

- **Winners and losers:** There is no guarantee every state gets money. Some may walk away empty-handed.
- **Evidence over anecdotes:** CMS wants **data, ROI, and measurable outcomes**, not stories alone.
- **Integration rewarded:** States that weave infrastructure, workforce, and digital health into a single plan will stand out.
- **Sustainability enforced:** The 2030+ rule ensures that proposals are judged on their ability to last beyond the funding window.

What This Means for Key Stakeholders

The $50 billion Rural Health Transformation Program is not abstract money in Washington—it is a once-in-a-generation test for the people who deliver, design, and enable rural health care. Every stakeholder has a role to play, and failure by one group risks sinking the entire state's proposal.

For Rural Hospital Administrators

In rural counties, the stakes are personal. Consider a critical access hospital in western Kansas that lost its maternity ward in 2021. Patients now drive 90 miles to deliver. The CFO is juggling staff shortages, high travel nurse costs, and a crumbling IT system. When the CMS letter arrived in July, the instinct was to wait for the state to reach out. But by September, neighboring hospitals were already meeting with their health department, feeding in data, and shaping the state's proposal. Silence here would mean invisibility.

Administrators must understand: **if your needs are not in writing, they will not be funded.** CMS expects states to demonstrate community-level impact, and that evidence comes from you.

- Submit **needs assessments now**—even rough versions with basic data on closures, transfers, or staffing shortages.
- Partner with vendors you already work with; ask them to package ROI evidence that ties to your story.
- Don't assume the state will call first. Pick up the phone and make yourself visible.

ACTION ALERT NOW

Hospitals that wait for the state to initiate will be left out. Administrators must act now to avoid being erased from proposals.

For State Program Developers

For Medicaid directors, health secretaries, and rural health offices, this is both a political opportunity and an administrative minefield. You are writing the proposals, but CMS has given you no rubric. That vacuum forces you to read history and improvise.

Past federal pilots suggest the scoring will favor **integration**. CMS will not look kindly on fragmented proposals—one section for infrastructure, one for workforce, one for digital health—without a unifying strategy. The early leaders are already acting on this insight. In North Carolina, the Office of Rural Health convened hospitals, broadband officials, and digital vendors into one task force. By August, they had a draft showing how telehealth hubs, nursing apprenticeships, and broadband expansion knit together into a single ecosystem.

Contrast that with Arkansas, where officials admitted they had not yet convened rural providers. Their draft outline still read like three disconnected grant applications stitched together.

For state developers, the **task is clear**:

- Form a multi-stakeholder task force immediately, if you haven't already.
- Blend infrastructure, workforce, and digital health into a single cohesive plan.
- Frame sustainability not as "buildings that last" but as systems that endure—from apprenticeship pipelines to cybersecurity frameworks.
- Recognize that politics matters: this is a chance for governors to claim a legacy win.

ACTION ALERT NOW

States waiting until October to engage stakeholders will submit hollow, low-scoring proposals. The competitive process leaves no margin for late starts.

For Digital Health Vendors

Vendors are not applicants, but they may be the make-or-break partners that elevate a state's proposal from average to award-winning. Already, within 48 hours of the CMS announcement, telehealth firms, cloud EHR providers, and cybersecurity companies were calling state offices to position themselves as "proposal-ready."

But there is a difference between noise and credibility. States will not gamble their $50B shot on vendors who bring only slide decks. They need partners with hard **ROI evidence**—reduced readmissions, improved chronic disease management, better workforce efficiency, and clear pathways to interoperability.

One vendor told Black Book that a Great Plains state had asked for **data packages** they could drop directly into their proposal: 10-year cost savings, reduced patient travel times, and security certifications. Those vendors are likely to be embedded. Others reported sending marketing brochures to state health departments—and getting no call back.

For vendors, the playbook is simple but urgent:

- **Approach both states and providers simultaneously.** Hospitals can validate your impact; states can embed your solution.
- Deliver **case studies with metrics**, not promises: ER utilization drops, chronic disease outcomes, workforce cost savings.
- Emphasize **interoperability and cybersecurity**—two vulnerabilities CMS is sensitive to.
- Position yourself not as a product seller but as a **long-term enabler of sustainability beyond 2030.**

ACTION ALERT NOW

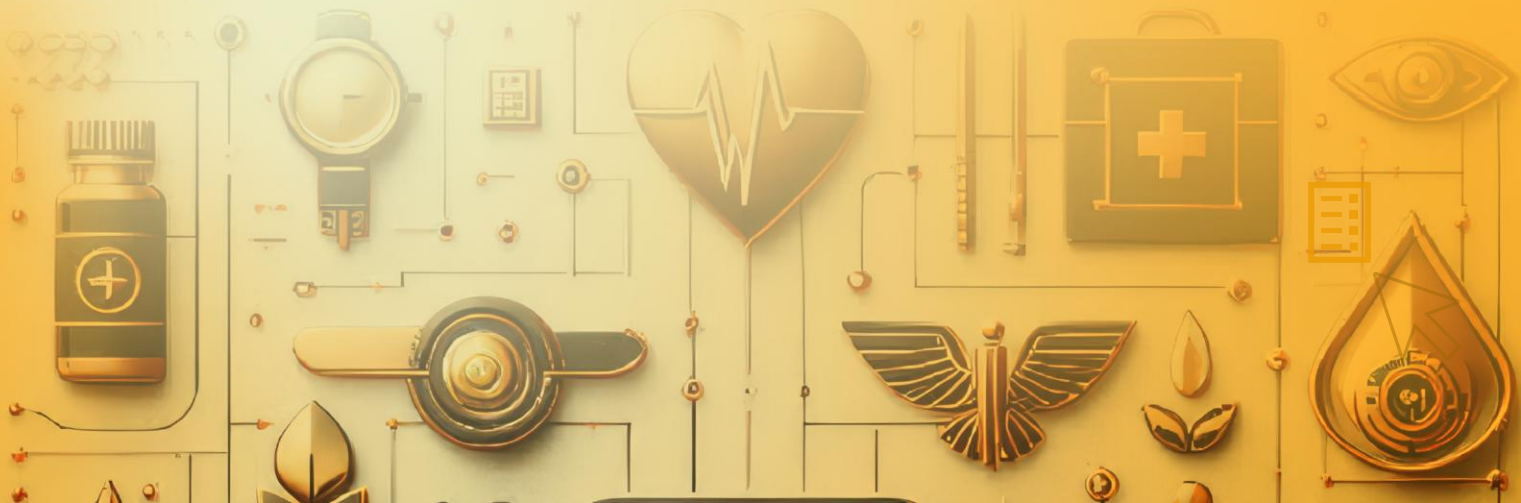
By mid-October, most states will lock their drafts. Vendors who have not secured a seat at the table by then will be shut out for the duration of the program.

The Shared Reality

Each group has different responsibilities, but their fates are tied together. A hospital that produces data but has no vendor partner may not make the cut. A vendor with ROI metrics but no local provider story will look opportunistic. A state with a bold vision but no grassroots engagement risks CMS labeling the proposal as top-down.

The program's design is intentional: **states, providers, and vendors must align—or they will fail together.**

Equity and Sustainability



The Rural Health Transformation Program was never meant to be a temporary bandage. From the moment Congress wrote the language into the *One Big Beautiful Bill Act*, lawmakers demanded that any investments funded through CMS must endure beyond 2030. That single requirement—the **longevity clause**—changes everything about how states must design their proposals.

Equity as a Core Expectation

Though CMS has not published a scoring rubric, its officials have spoken often enough in public briefings to make one priority unmistakable: equity. Proposals will be judged not only on their ambition but also on their ability to **close the rural divide** across geography, race, income, and connectivity.

- In Mississippi and Alabama, where Black rural communities report higher rates of diabetes and maternal mortality, CMS expects targeted strategies, not generic statewide averages.
- In Appalachia, where broadband deserts block telehealth, proposals that simply add new clinics without digital connectivity will appear incomplete.
- In Native American reservations, CMS is looking closely at how states are partnering with tribal health authorities, not bypassing them.

The implication is clear: states that ignore their most disadvantaged populations may struggle to win, no matter how polished their overall submission.

Why Sustainability Matters

Congressional champions like Senator Jerry Moran were adamant: this funding could not dissolve into short-lived projects. A new ER built in 2026 but staffed entirely by temporary nurses who leave in 2027 will not pass muster. Sustainability, in CMS's eyes, means designing **systems that last**.

- **Workforce pipelines:** Apprenticeship programs with community colleges, retention bonuses, rural residency slots.
- **Digital infrastructure:** Interoperable records, robust cybersecurity, broadband that connects homes and clinics.
- **Financial models:** Proposals showing how new facilities will generate ongoing revenue or tie into Medicaid innovation waivers.

The 2030+ requirement forces states to move beyond "shiny objects" and confront structural issues that have hollowed out rural health for decades.

How States Can Frame Equity and Sustainability

- **Disparity Data:** Document baseline gaps by county or population group and tie proposed investments directly to those gaps.
- **Targeted Solutions:** Design initiatives that explicitly serve hardest-hit communities (maternal health in the Delta, broadband in Appalachia, oncology in tribal areas).
- **Durability Plans:** Show how investments continue producing outcomes in 2031 and beyond—through permanent pipelines, interoperable systems, or self-sustaining business models.
- **Partnership Evidence:** Demonstrate collaboration with local providers, tribal councils, and nonprofits. CMS will favor inclusive design over top-down mandates.

Narrative Example

Take two contrasting states. **State X** proposes reopening a shuttered rural hospital and expanding ER capacity. The plan includes capital costs, staffing contracts, and some broadband wiring. But when asked how those changes endure beyond 2030, the state offers no pipeline for nurses, no sustainable funding model, and no plan to connect patients digitally.

State Y also proposes reopening a hospital, but ties it to a nursing apprenticeship program with the local community college, a telehealth hub that integrates into statewide Medicaid programs, and a cybersecurity upgrade ensuring continuity of care. State Y's plan is not just a project—it is a system.

In a competitive framework, State Y will almost certainly score higher, even if its raw need is no greater than State X's.

ACTION ALERT NOW

Equity and sustainability are not optional add-ons. They are the hidden gatekeepers of the entire $50B program. Proposals that ignore disparities or fail to prove endurance past 2030 will likely collapse under review. The tragedy is that many of the states with the greatest needs are also the least equipped to produce sophisticated equity analyses or long-term models—putting them at risk of losing the very funding designed to save them.

Risks of Failure

Every major federal initiative carries the risk of uneven implementation. The **Rural Health Transformation Program** is no exception—but here the stakes are higher because the program is **one-time-only**. There will be no second window, no renewal cycle, no opportunity to try again in 2026. A weak proposal submitted now could mean an entire state's rural communities miss out for a generation.

What Failure Looks Like

Failure is not just the absence of success. It will appear in specific, painful ways:

- **Funds consolidating in a handful of states:** Early leaders like Minnesota, North Carolina, and Washington may capture outsized shares of the $50B, while neediest states like Mississippi, West Virginia, and Montana struggle to secure even modest awards.
- **Hospitals excluded:** Rural facilities that fail to provide input now may see their state's proposal omit their communities altogether. When the funds flow, they will watch upgrades go elsewhere.
- **Vendors sidelined:** Digital health companies that do not embed themselves in proposals by October will miss the opportunity to expand in rural markets for the next decade.
- **CMS scrutiny and clawbacks:** Proposals that exaggerate capacity or promise unsustainable results could face audits, clawbacks, or public embarrassment if they collapse within a few years.

The Political Fallout

Congressional champions promised transformation. If the program results in billions going to already-advantaged states, expect sharp criticism. Senators Tester, Capito, and Moran took political risks to push this through. Their constituents will notice if local hospitals remain shuttered while better-resourced states build broadband towers and telehealth hubs.

The risk extends to CMS itself. An uneven rollout could fuel skepticism about whether federal agencies can administer competitive health equity programs without widening divides. That skepticism may chill future attempts to address rural health at scale.

Specific Failure Scenarios

- **The "Shiny Object" Trap:** A state builds new facilities but has no workforce pipeline. By 2028, the buildings are underutilized or closed.
- **The "Equity Blind Spot":** A state submits a proposal that raises statewide averages but ignores its poorest counties. CMS reviewers notice, and funding is slashed.
- **The "Late Start":** States that don't mobilize task forces until October submit thin proposals with little provider or vendor input. They lose out to states with polished, integrated plans.
- **The "Vendor Void":** Rural providers in high-need states have no vendor partnerships to demonstrate ROI. CMS reviewers find the proposals unconvincing.

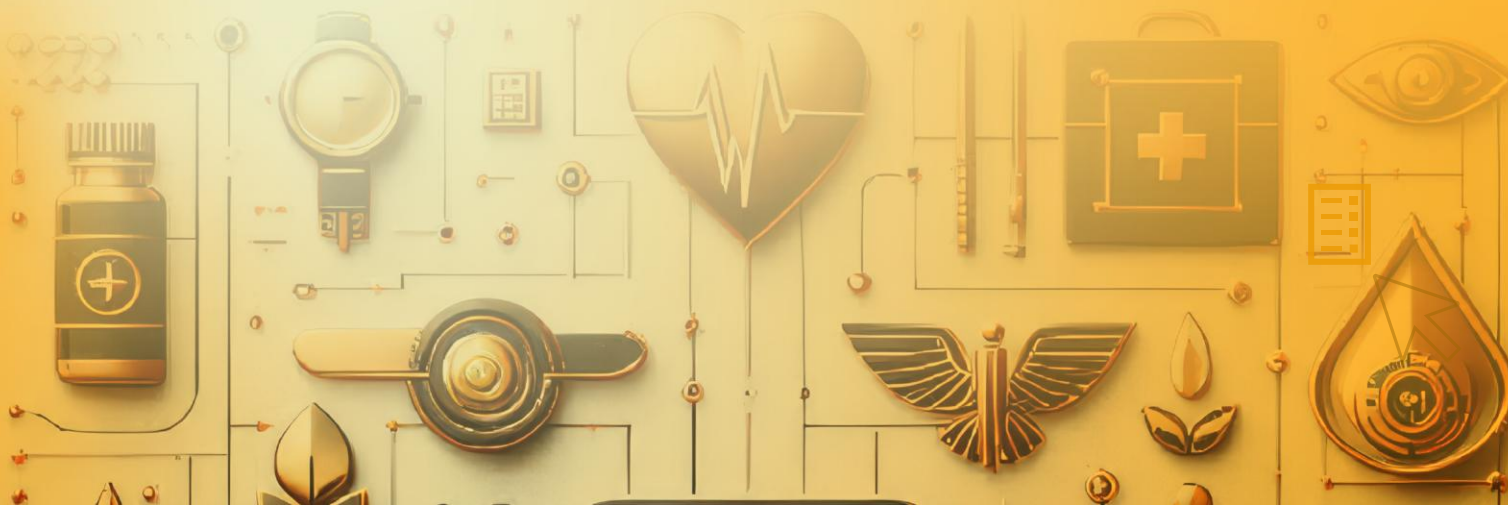
Narrative Example

Imagine two neighbors: North Carolina and West Virginia. North Carolina convenes a task force in July, integrates digital health vendors, collects data from every rural hospital, and drafts a sustainability plan. West Virginia, by contrast, waits until September to organize. By October, its staff are scrambling, proposals are half-baked, and vendors are missing. When awards are announced, North Carolina secures billions. West Virginia gets crumbs. The political fallout at home is fierce: rural communities who heard promises of "transformation" see no change.

ACTION ALERT NOW

The greatest risk is that the $50B will not flow where it is needed most. Without urgent mobilization, the program could entrench the rural divide it was designed to close. Neediest communities—those with the weakest proposals—will lose, while better-prepared states gain. This outcome would deepen distrust in federal commitments and harden rural America's sense of abandonment.

Use of Funds: Illustrative Scenarios



The **Rural Health Transformation Program** was intentionally left broad to allow states flexibility, but the lack of specificity has left many wondering: *what exactly can these funds build?* While CMS has not issued a strict menu, conversations with policymakers, providers, and vendors suggest a range of investments that could define winning proposals.

These scenarios are not hypothetical wish lists—they are grounded in what rural communities are already discussing and what CMS officials have informally nodded toward in stakeholder briefings.

Broadband Expansion in Appalachia

In southern West Virginia, broadband deserts remain so wide that families must drive to fast-food parking lots for reliable Wi-Fi. Telehealth, remote monitoring, and digital records are impossible without connectivity. A state proposal here could dedicate funds to:

- Laying **fiber optic lines** and erecting **broadband towers** in the hardest-hit counties.
- Bundling broadband with **telehealth hub programs** at local FQHCs, ensuring connectivity is immediately tied to clinical care.
- Training **community digital navigators** to help patients use new tools, so infrastructure translates into real health access.

Why it matters: Broadband-only proposals may look incomplete. But broadband tied to care delivery is transformation.

Tele-ER Hubs in the Great Plains

In Kansas, ER closures have left some counties with no acute care. A transformation plan here might fund:

- **Regional tele-ER hubs** staffed by emergency physicians in larger hospitals, connected to local clinics via high-speed broadband.
- **Mobile tele-ER units** that bring virtual emergency expertise into ambulances.
- Integration with **state EMS systems**, reducing transfer times and improving outcomes for trauma and stroke patients.

Why it matters: This addresses the “90-minute problem”—the deadly lag between emergencies and treatment in rural regions.

Cybersecurity Upgrades in the Midwest

Rural hospitals are among the most vulnerable to ransomware. In 2023, an attack on a small Iowa hospital knocked out operations for weeks. A Midwestern state could propose:

- Funding **enterprise-grade cybersecurity systems** across all rural hospitals and clinics.
- Establishing a **statewide rural health cyber center** that provides monitoring and rapid response.
- Training **local IT staff** in cyber hygiene and system defense.

Why it matters: CMS is deeply sensitive to security. A cybersecurity focus demonstrates sustainability—protecting systems beyond 2030.

Maternal Health Networks in the Mississippi Delta

The Delta has some of the highest maternal mortality rates in the nation. A state plan could include:

- Funding **tele-maternity programs** to connect local clinics with urban specialists.
- Creating **mobile OB units** staffed with rotating nurse practitioners and midwives.
- Embedding **remote monitoring for high-risk pregnancies**, ensuring real-time alerts for complications.

Why it matters: This ties equity directly into measurable outcomes, addressing racial and geographic disparities CMS has flagged.

Workforce Apprenticeships in Appalachia and the Midwest

Recruiting doctors to rural areas is difficult. Keeping them is harder. A forward-looking proposal might:

- Establish nurse and physician assistant apprenticeships with local community colleges.
- Create loan repayment programs tied to multi-year service commitments in rural counties.
- Fund rural residency slots that integrate telehealth into training, preparing clinicians for hybrid practice.

Why it matters: Sustainability requires workforce pipelines that replenish themselves, not temporary fixes with travel nurses.

What These Scenarios Show

- **Infrastructure must be tied to delivery.** Broadband without telehealth is incomplete.
- **Digital health is a through-line.** Every pillar—ER, maternal care, workforce—needs digital integration.
- **Equity is local.** CMS will look for proposals that specifically address the hardest-hit populations.
- **Sustainability is structural.** Apprenticeships, cybersecurity, and statewide systems endure beyond 2030.

ACTION ALERT NOW

The danger is that some states will treat the $50B as a **construction fund**—fixing roofs, buying scanners, or patching walls. CMS has seen this before, and it will not be impressed. Proposals that fail to tie infrastructure to workforce and digital health systems will almost certainly underperform. States that treat this as a chance to **rebuild ecosystems** will win.

State Readiness Landscape

By September 2025, just two months after CMS's announcement, the national map of preparedness looks less like a level playing field and more like a patchwork quilt. The **120-day deadline** has created winners and laggards before proposals are even filed.

The Early Leaders

Some states moved almost instantly, treating the July announcement like a starter's pistol.

- **Minnesota**: Convened a formal Rural Health Transformation Task Force within ten days. Subcommittees are drafting around broadband, workforce pipelines, and digital integration. Vendors report being invited into meetings early to demonstrate ROI.
- **North Carolina**: Leveraged Medicaid expansion infrastructure to integrate this program. Telehealth hubs, rural nursing apprenticeships, and broadband expansion are being bundled into a unified plan.
- **Washington**: Framed proposals as an extension of its digital-first approach to Medicaid. Officials are emphasizing cybersecurity and interoperability as sustainability anchors.
- **Pennsylvania**: Mobilized through its Office of Rural Health, engaging both hospitals and labor unions. Apprenticeship pipelines are already on the draft table.

These early leaders are characterized by **experienced policy staff, pre-existing vendor relationships, and political leadership willing to prioritize rural health.** Their advantage is compounding: the earlier the start, the more integrated and polished the proposal will be by November.

The Middle Tier

Roughly half the states are in motion but not at sprint pace. They have formed committees, but many have yet to meaningfully engage rural providers or vendors. Draft proposals exist but are siloed—separate documents for broadband, workforce, and hospital upgrades, without a unifying narrative.

Examples include **Ohio, Kentucky, and Colorado**, where task forces exist but integration is incomplete. These states may produce competitive proposals if they accelerate in September and October—but the clock is ticking.

The At-Risk Laggards

The most troubling category is states with the deepest rural need but the weakest administrative capacity.

- **Mississippi**: Its Office of Rural Health has just three analysts. As of late August, officials admitted they were still "digesting the FAQs." No task force had been convened.
- **West Virginia**: Despite Capito's role as a program champion, state health officials confessed limited capacity to write competitive proposals. Few vendor partnerships are in place.
- **Arkansas**: Delayed by leadership transitions in the health department, leaving hospitals uncertain how to contribute.
- **Montana**: Tester's home state faces a paradox—he secured the funds, but the state's lean staff has struggled to scale up in time.

These laggard states risk missing the deadline or submitting **hollow, underdeveloped proposals** that cannot compete with polished submissions from early leaders.

Emerging Patterns

- **Capacity begets capacity:** States that already had policy staff and vendor networks are racing ahead.
- **Need does not equal readiness:** The hardest-hit states are not always the best-prepared.
- **Vendor involvement is decisive:** States with early vendor engagement are producing more robust, data-driven proposals.

Narrative Snapshot

Picture the contrast: in **Raleigh**, North Carolina officials sit around a task force table with broadband leaders, hospital CEOs, and digital vendors, drafting a seamless plan. In **Jackson**, Mississippi officials stare at a whiteboard, struggling to define priorities with only a handful of staff. Both states have real rural need, but one is on track to win big and the other may lose out almost entirely.

ACTION ALERT NOW

The readiness gap is widening by the week. If nothing changes, billions could flow disproportionately to already-capable states while those with the greatest rural distress walk away with little. Unless federal technical assistance or vendor consortia step in, the program risks reinforcing inequity instead of fixing it.

Strings Attached / Scoring Without a Rubric

When CMS unveiled the Rural Health Transformation Program, it laid down only three non-negotiable rules:

1. **States are the applicants.** Hospitals, providers, and vendors cannot apply directly.
2. **Proposals are due November 5, 2025.** There will be no extensions.
3. **Impact must last beyond 2030.** Every plan must show endurance after the funding window closes.

Everything else has been left deliberately vague.

The Frustrating Ambiguity

In stakeholder webinars, state officials asked: *What defines sustainability? Does broadband alone qualify? Will CMS weight digital health more heavily than new buildings?* CMS's replies were polite but noncommittal: "We encourage holistic proposals that demonstrate lasting impact."

The absence of a rubric is not an oversight—it is a design choice. By refusing to set rigid scoring criteria, CMS is signaling that it wants states to **think creatively and integrate multiple strategies** rather than chase a checklist. But the ambiguity has triggered anxiety among under-resourced states that lack staff to guess at Washington's intent.

What History Teaches Us

This is not the first time CMS has launched a competitive program without a clear rubric. Past initiatives give strong clues about what reviewers will prioritize:

- **Medicaid Innovation Waivers (2010s):** States that demonstrated measurable savings in cost and quality scored highest. Proposals heavy on anecdotes or light on data rarely succeeded.
- **CMMI Pilots (2012–2020):** Integration was rewarded. Proposals that tied workforce, infrastructure, and digital health together outperformed siloed projects.
- **Hospital Transformation Programs (state waivers):** Equity and access consistently appeared as implicit scoring factors, even when not spelled out.

Put simply: CMS reviewers have a pattern. They reward data-driven, equity-focused, integrated systems.

What States Should Infer

- **Evidence trumps aspiration:** Every claim should be backed by data, case studies, or projections.
- **Integration matters most:** Siloed proposals will be weaker than cohesive, cross-pillar strategies.
- **Equity is unavoidable:** Proposals ignoring disparities will face skepticism, no matter how polished.
- **Sustainability is structural:** Reviewers will look for pipelines, interoperability, and permanent systems—not one-off projects.

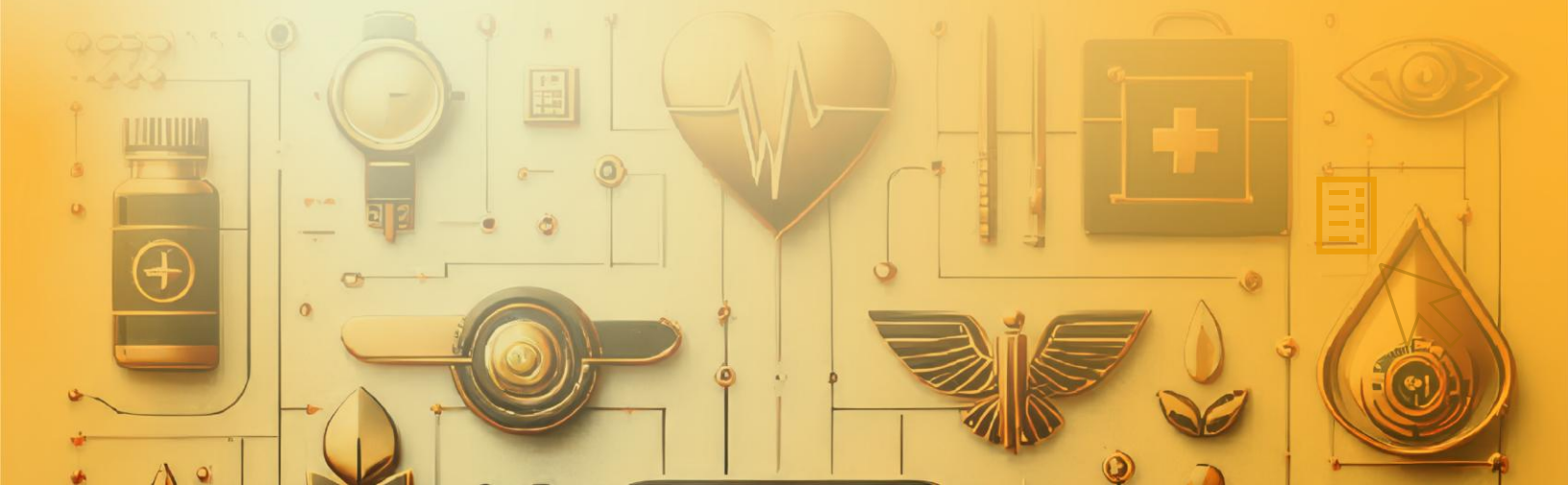
Narrative Example

Two states submit proposals. **State A** promises to build five new rural clinics, arguing they are desperately needed. The plan has no workforce pipeline, no digital health integration, and no financing model beyond the grant. **State B** proposes three clinics linked to telehealth hubs, tied to a new nursing apprenticeship program, and underpinned by a statewide cybersecurity upgrade. Both address infrastructure, but only State B demonstrates equity, integration, and sustainability. In a competitive scoring environment, **State B wins.**

ACTION ALERT NOW

States waiting for CMS to publish a rubric will wait forever. History makes the expectations clear: integration, equity, sustainability, and evidence. The only question is which states will act boldly enough to embrace those criteria—and which will stall in paralysis.

Timeline & Next Steps



The Rural Health Transformation Program is unfolding on a **compressed, unforgiving timeline.** CMS set the rules on July 8, 2025, and gave states 120 days to respond. There will be no extensions. The race ends on **November 5, 2025**.

The Countdown So Far

- **July 8, 2025 – Official Announcement:** CMS Administrator Chiquita Brooks-LaSure, flanked by Senators Tester, Capito, and Moran, announces the $50B program. States receive the **Dear State Medicaid Director Letter (SMDL)** the same day.
- **Late July – National Webinar:** More than 700 stakeholders log on to hear CMS explain the basics. Officials encourage "holistic proposals" but offer no scoring rubric. Anxiety and speculation ripple across state agencies.
- **August – Early Mobilizers:** Minnesota, North Carolina, Washington, and Pennsylvania convene task forces, bringing vendors and providers into the room. Mississippi, Arkansas, and West Virginia lag behind, struggling with staffing and guidance.
- **September – Drafting Intensifies:** States in the middle tier begin writing, but many still lack integration across infrastructure, workforce, and digital health. Vendors scramble to secure spots in proposals before drafts close.

October – The Critical Month

October is when the gap between leaders and laggards becomes irreversible.

- **By early October:** Most frontrunner states will have near-final drafts. They will circulate proposals internally, refine ROI models, and seek letters of support from hospitals and vendors.
- **By mid-October:** Proposal "lockdown" begins. Vendors not already embedded will find doors closing. Rural providers who stayed silent may realize their needs are missing, but it will be too late to add them meaningfully.
- **By late October:** States will finalize budgets, equity narratives, and sustainability frameworks. Only minor edits will be possible in the last days.

November 5 – Deadline Day

Every proposal must be filed with CMS by **5:00 p.m. Eastern on November 5, 2025.** There will be no exceptions. A missed deadline is an automatic disqualification.

What Happens Next

Once proposals are submitted, the process shifts to CMS.

- **November–December 2025:** CMS assembles review panels, drawing on policy staff, external experts, and possibly contracted evaluators. Proposals will be scored competitively.
- **Early 2026 – Awards Announced:** CMS is expected to announce which states secured funding in the first quarter of 2026. Awards may be staggered, with early disbursements for "shovel-ready" projects and phased approvals for more complex systems.
- **2026–2027 – Implementation Begins:** States begin spending, with quarterly reporting requirements to CMS. Expect early scrutiny on equity outcomes and digital integration.
- **2030 and Beyond – Sustainability Proof:** Proposals are required to demonstrate longevity. CMS may require states to report metrics past the funding window to prove the transformation was real, not temporary.

Key Takeaways on Timeline

- **The window is short:** 120 days from start to finish.
- **October is decisive:** Vendors and hospitals must be in proposals before mid-month.
- **CMS reviews will be rigorous:** Awards won't just be about need, but about evidence, equity, and sustainability.
- **The impact stretches to 2030+:** This is not a one-off grant but a transformation benchmark.

ACTION ALERT NOW

The greatest danger lies in complacency. Some administrators believe November 5 is "far off." It isn't. By mid-October, most proposals will already be sealed. For hospitals, vendors, and even states that delay, the train will have left the station. The November deadline is not just the end of the application window—it is the end of the opportunity, permanently.

Practical Checklists: What To Do Before November 5

The $50B Rural Health Transformation Program is not won in November—it is won in **September and October.** Every stakeholder has specific tasks to complete, and delay at any stage risks exclusion. Below are checklists designed for hospitals, state program teams, and vendors.

For Rural Hospital Administrators

You cannot assume your state knows your needs. Proposals must demonstrate community-level evidence, and that starts with you.

This Week

- Contact your state Medicaid office or rural health office. Ask: *How is our facility's input being included?*
- Begin drafting a **needs assessment**: closures, patient transfers, staffing gaps, broadband deficits. Even basic numbers are better than silence.

By Mid-October

- Partner with at least one vendor who can translate your needs into ROI data. (E.g., "remote monitoring could reduce ER transfers by 25%.")
- Provide letters of support to your state's task force, documenting your willingness to participate in pilot projects.
- Join regional or statewide workshops. Make your facility visible in the drafting process.

Before November 5

- Confirm your hospital's needs and contributions appear in the final draft.

- Collect internal board or community resolutions supporting the proposal—CMS values visible community backing.

ACTION ALERT NOW

If you wait until November to offer input, you will already be invisible.

For State Program Developers

You hold the pen, but the process is collaborative. CMS will reward states that prove integration, not top-down mandates.

This Week

- Convene (or expand) a **formal task force** with hospitals, providers, vendors, and community groups.
- Assign subcommittees for the three pillars: infrastructure, workforce, digital health.

By Mid-October

- Integrate subcommittee drafts into a **unified plan.** Do not submit siloed sections.
- Secure **letters of commitment** from rural hospitals, community colleges, and vendors. CMS will expect evidence of collaboration.
- Build the **equity case**: document disparities by geography, race, and income, and show how your proposal targets those gaps.

Before November 5

- Stress-test your proposal for **sustainability**: how will systems endure after 2030?
- Finalize budget models with realistic projections and cost savings.

- Conduct a peer review (internal or external) to ensure proposals are free from contradictions or omissions.\

ACTION ALERT NOW

States that wait until the last two weeks to "integrate" sections will submit patchwork proposals—and likely lose.

For Digital Health Vendors

You are not the applicants, but you are the differentiators. Without credible digital health integration, proposals will appear outdated and unsustainable.

This Week

- Identify **target states** where your solutions fit local needs (tele-ER in the Plains, cybersecurity in the Midwest, tele-maternity in the Delta).
- Contact both state task forces and rural hospitals; you need buy-in from both levels.

By Mid-October

- Deliver **data packets**: ROI case studies, cost savings per patient, equity outcomes. Provide states with plug-and-play material they can drop directly into proposals.
- Secure letters of support or memoranda of understanding with hospitals or clinics using your technology.
- Emphasize interoperability and cybersecurity in all communications—these are CMS sensitivities.

Before November 5

- Confirm you are explicitly named or referenced in state proposals.
- Prepare for post-award: assemble implementation teams and anticipate reporting requirements, because CMS will demand quarterly metrics.

ACTION ALERT NOW

Vendors that are not embedded in proposals by mid-October will be locked out. There will be no later opportunity to join.

Shared Final Reminders

- **September is about entry.** Get into the room, make your needs or solutions visible.
- **October is about embedding.** Ensure your hospital, agency, or company is explicitly included in drafts.
- **November is too late.** By then, proposals are sealed.

Closing Note: Beyond November

The **November 5 deadline** is the end of one race but the start of another. Submitting proposals closes the first chapter; implementation, oversight, and sustainability open the next.

The Immediate Future (2026–2027)

Once CMS receives proposals, reviewers will begin scoring them against each other. Awards are expected in the **first quarter of 2026.** Some states will celebrate billion-dollar wins; others will face hard lessons about underpreparedness. Early disbursements will likely go to "shovel-ready" projects, while more complex systemic reforms may be phased in.

Hospitals and vendors should prepare for the transition from proposal to implementation:

- **Hospitals** must be ready to activate partnerships—expanding telehealth clinics, launching workforce apprenticeships, or upgrading IT systems the moment funds arrive.
- **Vendors** should prepare their reporting teams now. CMS will not tolerate vague outcomes. Expect quarterly data submissions on cost savings, quality improvements, and access expansion.
- **State agencies** will shoulder intense scrutiny. The press, Congress, and rural communities will all be watching.

The Mid-Term (2028–2030)

By the late 2020s, CMS expects **visible transformation**:

- Fewer hospital closures.
- Expanded broadband coverage.
- Increased telehealth utilization rates.
- Strengthened rural workforce pipelines.
  States that fail to deliver will face not just reputational damage but potential clawbacks.

Beyond 2030

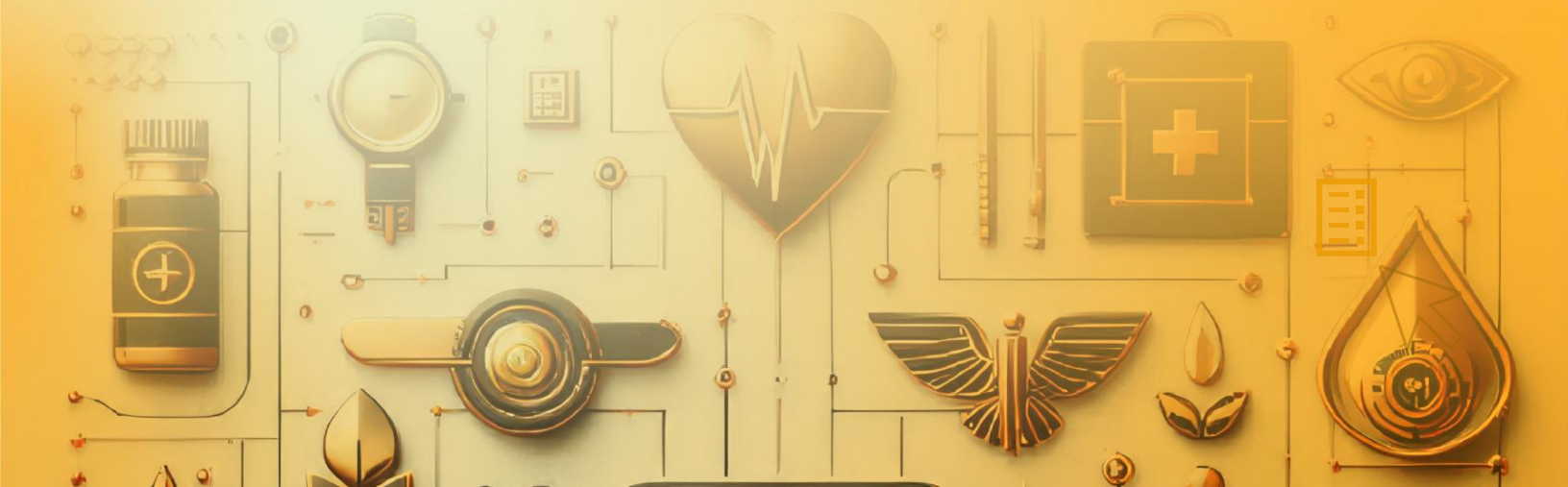
The Rural Health Transformation Program was designed with a "longevity clause." Congress wanted to ensure this was not another fleeting infusion of dollars. Sustainability means that by 2031, systems must stand on their own: workforce programs generating steady cohorts of clinicians, broadband supporting permanent digital care, cybersecurity preventing catastrophic outages, and financial models that keep hospitals solvent.

For hospitals, this is the chance to leave survival mode behind. For vendors, it is the opportunity to prove their solutions are not luxuries but lifelines. For states, it is the rare moment to claim a **legacy investment**.

ACTION ALERT NOW

If the program delivers, it could narrow the rural health divide for a generation. If it falters, the divide will deepen, and the political will for another $50B effort may never return.

National Contacts



- **RHIhub – Rural Health Information Hub (live help)**
  - Phone: 1-800-270-1898 | Email: info@ruralhealthinfo.org | https://www.ruralhealthinfo.org/ Rural Health Information Hub
- **RHIhub – State Offices of Rural Health (SORH) master index**: https://www.ruralhealthinfo.org/organizations/state-office-of-rural-health Rural Health Information Hub
- **NOSORH – National Organization of State Offices of Rural Health (Browse by State)**: https://nosorh.org/nosorh%20-members/nosorh-members-browse-by-state/ nosorh.org
- **HRSA – State Primary Care Office (PCO) directory**: https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/contact-state-primary-care-office Bureau of Health Workforce
- **HRSA – State Offices of Rural Health (program overview)**: https://www.hrsa.gov/rural-health/grants/rural-hospitals/sorh HRSA

Alternative help sites

- NOSORH Browse by State (find your SORH staff listing): https://nosorh.org/nosorh%20-members/nosorh-members-browse-by-state/ nosorh.org
- HRSA State PCO Directory (another official door into state contacts): https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/contact-state-primary-care-office Bureau of Health Workforce

States & DC (A–Z)

Alabama

Contact The RHIhub Director, Contact Phone, Email and Website: https://www.ruralhealthinfo.org/states/alabama Rural Health Information Hub

Alaska

Contact...: https://www.ruralhealthinfo.org/states/alaska Rural Health Information Hub

Arizona

Contact...: https://www.ruralhealthinfo.org/states/arizona Rural Health Information Hub

Arkansas

Contact...: https://www.ruralhealthinfo.org/states/arkansas Rural Health Information Hub

California

Contact...: https://www.ruralhealthinfo.org/states/california Rural Health Information Hub

Colorado

Contact...: https://www.ruralhealthinfo.org/states/colorado Rural Health Information Hub

Connecticut

Contact...: https://www.ruralhealthinfo.org/states/connecticut Rural Health Information Hub

Delaware

Contact...: https://www.ruralhealthinfo.org/states/delaware Rural Health Information Hub

District of Columbia

Contact...: https://www.ruralhealthinfo.org/states/district-of-columbia Rural Health Information Hub

Florida

Contact...: https://www.ruralhealthinfo.org/states/florida Rural Health Information Hub

Georgia
Contact...: https://www.ruralhealthinfo.org/states/georgia Rural Health Information Hub

Hawaii
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Idaho
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Illinois
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Indiana
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Iowa
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Kansas
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Louisiana
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Minnesota

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Mississippi

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Missouri

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Montana

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Nebraska

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Nevada

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New Hampshire

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New Jersey

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New Mexico

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New York
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North Carolina
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North Dakota
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Ohio
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Oklahoma
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Oregon
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Pennsylvania
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Rhode Island
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South Carolina
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South Dakota
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Tennessee
Contact...: https://www.ruralhealthinfo.org/states/tennessee Rural Health Information Hub

Texas

Contact...: https://www.ruralhealthinfo.org/states/texas Rural Health Information Hub

Utah

Contact...: https://www.ruralhealthinfo.org/states/utah Rural Health Information Hub

Vermont

Contact...: https://www.ruralhealthinfo.org/states/vermont Rural Health Information Hub

Virginia

Contact...: https://www.ruralhealthinfo.org/states/virginia Rural Health Information Hub

Washington

Contact...: https://www.ruralhealthinfo.org/states/washington Rural Health Information Hub

West Virginia

Contact...: https://www.ruralhealthinfo.org/states/west-virginia Rural Health Information Hub

Wisconsin

Contact...: https://www.ruralhealthinfo.org/states/wisconsin Rural Health Information Hub

Wyoming

Contact...: https://www.ruralhealthinfo.org/states/wyoming Rural Health Information Hub

Appendix B — Rural Health Associations, Agencies, Programs & Helpful Portals

Federal leadership & national hubs

- **HRSA – Federal Office of Rural Health Policy (FORHP)** — HHS office that coordinates rural policy and administers major rural grant lines.
  https://www.hrsa.gov/about/organization/bureaus/forhp HRSA
- **HRSA – Rural Health (FORHP overview & grants)** — Central entry to programs, funding, and definitions of "rural."
  https://www.hrsa.gov/rural-health HRSA
- **Rural Health Information Hub (RHIhub)** — National clearinghouse funded by FORHP; live help, toolkits, funding trackers, and state-by-state contacts.
  https://www.ruralhealthinfo.org/ Rural Health Information Hub
- **RHIhub – About/University host** — Background on RHIhub's role and services.
  https://ruralhealth.und.edu/projects/rhihub Center for Rural Health
- **National Organization of State Offices of Rural Health (NOSORH)** — Membership body for the 50 State Offices of Rural Health; training, TA, and National Rural Health Day.
  https://nosorh.org/ | About: https://powerofrural.org/about-nosorh/ nosorh.org+1
- **National Rural Health Association (NRHA)** — Advocacy, education, and convenings for rural hospitals, clinics, and partners.
  https://www.ruralhealth.us/ | About: https://www.ruralhealth.us/about-us National Rural Health+1

Broadband & connectivity (critical for telehealth, RPM, EHR interoperability)

- **FCC – Rural Health Care Program (RHC)** — Discounts/subsidies for eligible providers' broadband and telecom; includes Healthcare Connect Fund. https://www.fcc.gov/general/rural-health-care-program | Guide: https://www.fcc.gov/guides/universal-service-program-rural-health-care-providers Federal Communications Commission+1

- **NTIA – BEAD Program** — $42.45B state-run broadband buildout funds (IIJA); watch state broadband offices for alignments with health access. https://broadbandusa.ntia.gov/funding-programs/broadband-equity-access-and-deployment-bead-program | Alt: https://www.ntia.gov/funding-programs/high-speed-internet-programs/broadband-equity-access-and-deployment-bead-program | Progress dashboard: https://www.ntia.gov/funding-programs/internet-all/broadband-equity-access-and-deployment-bead-program/progress-dashboard BroadbandUSA+2NTIA+2

USDA Rural Development (capital & distance care enablers)

- **USDA – Community Facilities Programs** — Loans/guarantees/grants for essential rural facilities (hospitals, clinics, EMS, public health). https://www.rd.usda.gov/programs-services/community-facilities | Program detail: https://www.rd.usda.gov/programs-services/community-facilities/community-facilities-direct-loan-grant-program | RHIhub summary: https://www.ruralhealthinfo.org/funding/91 Rural Development+2Rural Development+2

- **USDA – Distance Learning & Telemedicine (DLT) Grants** — Tele-education/telemedicine capital for hubs & end-user sites in rural areas. https://www.rd.usda.gov/programs-services/telecommunications-programs/distance-learning-telemedicine-grants | NOFO (FY2025): https://www.federalregister.gov/documents/2025/01/06/2024-30465/notice-of-funding-opportunity-for-the-distance-learning-and-telemedicine-grants-for-fiscal-year-2025 Rural Development+1

Policy, research & analytic partners (help with equity, ROI, sustainability framing)

- **FORHP Rural Data Files** — Official datasets to define/measure "rural" for analysis and targeting.
  https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files HRSA
- **NRHA Programs** — Education, leadership, quality, and policy resources for rural systems.
  https://www.ruralhealth.us/programs National Rural Health
- **RHIhub – SORH master index** — Jump to your state's SORH page, which lists **current** phone/email and official links.
  https://www.ruralhealthinfo.org/organizations/state-office-of-rural-health HRSA
- **NOSORH – Browse by State** — Alternate route to SORH staff directories and contacts.
  https://nosorh.org/nosorh%20-members/nosorh-members-browse-by-state/ Rural Development
- **HRSA – State Primary Care Offices (PCOs)** — Parallel state contacts useful for shortages/waivers and integration with rural access work.
  https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/contact-state-primary-care-office nosorh.org
- **USDA CF loan for new rural hospital (MI, 2025)** — Illustrates Community Facilities financing scale.
  News: https://www.michigansthumb.com/news/article/usda-loan-sandusky-hospital-21016040.php Huron Daily Tribune
- **USDA DLT grant (IL, 2025 cycle)** — Example of DLT supporting distance learning/tele-services that tie to health.
  News: https://www.myjournalcourier.com/news/article/lincoln-land-distance-learning-expansion-20020955.php Jacksonville Journal-Courier

Appendix C — Digital Health Vendors with Rural-Focused Products & Services

(Vendor-neutral, inclusive directory organized by use case. Examples are representative deployments for CAHs, rural PPS hospitals, FQHCs/RHCs, EMS, and county health. This is not an endorsement list; always validate security, integration, licensing, and support fit.)

1) Tele-ER, Tele-ICU, Hospital-at-Home & Acute Virtual Care

- **Avel eCare** — 24/7 tele-ER/ICU, tele-pharmacy, nurse advice lines. *Example:* Night/weekend tele-ER to keep low-acuity cases local.
- **Access TeleCare (SOC Telemed)** — Specialty tele-consults (neuro/stroke, psych, ID, hospitalist). *Example:* Telestroke door-to-needle protocols across frontier sites.
- **Equum Medical** — Virtual hospitalist, virtual nursing, command centers. *Example:* Virtual nursing overlay to stabilize med-surg staffing.
- **EmOpti** — ED tele-triage/load-balancing. *Example:* Shared virtual clinician pool to reduce LWBS and transfers.
- **Current Health (Best Buy Health)** — Hospital-at-home platform, logistics & device ops. *Example:* DRG-eligible acute-to-home bundles.
- **Biofourmis** — Advanced RPM + acute/post-acute pathways. *Example:* CHF/COPD bundles monitored from a regional hub.
- **Medically Home** — Turnkey hospital-at-home operations. *Example:* Hub-and-spoke “beds without walls” for a rural region.

2) Virtual Primary Care, Behavioral Health & SUD

- **Iris Telehealth** — Tele-psychiatry for ED/inpatient/outpatient; rural credentialing. *Example:* ED tele-psych nights/weekends.
- **Boulder Care** / **Bicycle Health** — Virtual MOUD, counseling, care navigation. *Example:* OUD care coupled with local primary care.
- **Talkiatry** / **Quartet Health** — Psychiatric networks & care navigation. *Example:* Regional psych coverage across multi-clinic areas.
- **Ready** / **Hazel Health** — School-based primary/behavioral telehealth. *Example:* School tele-behavioral services feeding rural clinics.

3) Remote Patient Monitoring (RPM), Chronic Care, Cardiac & Pulmonary

- **HRS (Health Recovery Solutions)** — Full-stack RPM with care pathways. *Example:* CHF/COPD RPM to cut readmissions.
- **Clear Arch Health** / **CareSimple** / **AMC Health** — Cellular-first RPM kits. *Example:* Vitals collection where home broadband is spotty.
- **ResMed Propeller** / **Adherium** — Connected inhalers for COPD/asthma. *Example:* COPD management for farm-worker populations.
- **iRhythm (Zio)** — Extended-wear cardiac monitoring. *Example:* Mail-to-home patches with central reads.
- **Cadence** — Protocol-driven RPM with med titration. *Example:* Rural HTN/diabetes management at scale.

4) Maternal & Women's Health (Tele-OB, Remote Prenatal/Postpartum)

- **Babyscripts** — Remote prenatal/postpartum monitoring & education. *Example:* Tele-maternity where L&D closed.
- **Maven Clinic** / **Ouma Health** — Virtual OB/lactation/doula services; Medicaid/employer models. *Example:* Statewide high-risk maternal bundle.
- **Nuvo** / **HeraBEAT** — Remote fetal monitoring (selected indications). *Example:* Long-drive pregnancies with specialist oversight.

5) EHRs for Rural Hospitals & CAHs (per your guidance: include Juno Health & MEDITECH Expanse; exclude ambulatory-only athena/NextGen/eCW)

- **MEDITECH Expanse (Cloud/MaaS)** — Mobile-first, strong CAH footprint. *Example:* Multi-CAH shared instance standardizing ED/meds reconciliation.
- **Oracle Health CommunityWorks (Cerner)** — Packaged community/CAH deployment. *Example:* Hub-and-spoke with telestroke/telerad.
- **CPSI (Evident) + TruBridge** — CAH-focused clinicals + RCM services. *Example:* 3-hospital frontier network with managed RCM.
- **Epic Community Connect (affiliate hosting)** — Access Epic via regional host. *Example:* Rural hospital + clinics on a host instance with shared care plans.
- **MEDHOST** — ED-first strengths; lean IT footprint. *Example:* Independent CAH inpatient/ED with DR/BCP playbooks.
- **Juno Health** — Modular hospital EHR with modern UI. *Example:* Single-CAH go-live paired with community paramedicine documentation.

5B) Revenue Cycle & Claims Infrastructure (RCM) for Rural Hospitals/CAHs

- **Waystar** — Clearinghouse + eligibility + denials/underpayments. *Example:* Automated ERA posting + denial workqueues in CAH CBO.
- **TruBridge (CPSI)** — Managed RCM services + tech for CAHs. *Example:* DNFB reduction and KPI dashboards for small teams.
- **FinThrive (nThrive)** — Patient access, eligibility, auth, contract integrity. *Example:* Insurance discovery lowers avoidable write-offs.
- **Experian Health** — Identity, eligibility, coverage discovery, patient pay. *Example:* Up-front denial prevention in registration.
- **The SSI Group** — Clearinghouse with wide payer connectivity. *Example:* First-pass clean claim improvements.
- **Quadax** — Rev integrity + strong lab/outreach claims. *Example:* Rural lab outreach cash acceleration.

- **Availity** — Payer gateway; real-time eligibility/auth. *Example:* One pane of glass for front-end coverage checks.
- **R1 RCM** — End-to-end RCM; physician revenue cycle. *Example:* A/R sprint + denial prevention playbook.
- **Zelis** — Price transparency & payments optimization. *Example:* Streamlined payer payments, reduced paper EOBs.
- **Craneware (Revenue Integrity)** — Charge capture, pricing transparency. *Example:* Annual CDM optimization with compliant estimates.

6) Interoperability, HIE/API Utilities & Health Data Networks

- **Kno2** — Simple exchange/DirectTrust; "fax-to-FHIR" pragmatism. *Example:* Referral loops between CAHs and specialists.
- **Redox** — API integration layer for app-to-EHR connectivity. *Example:* Vendor bundles for multi-state deployments.
- **Health Gorilla** / **Particle Health** — National record location/retrieval. *Example:* Cross-state data for migrant/ag workers.
- **Lyniate (Rhapsody/Corepoint)** / **InterSystems HealthShare** — Interface engines & HIE platforms. *Example:* State HIE backbones with rural on-ramps.

7) Digital Front Door, Triage & Asynchronous Care

- **GYANT** / **Infermedica** / **Ada Health** — AI intake & symptom triage. *Example:* After-hours routing to reduce low-acuity ED use.
- **QliqSOFT (Quincy)** / **Spruce Health** — Secure messaging, navigation, referrals. *Example:* Low-bandwidth clinic texting + care coordination.

8) Imaging, Teleradiology & Cloud PACS (Bandwidth-aware)

- **Intelerad (Ambra)** / **Sectra** / **Novarad** — Cloud PACS/VNA & exchange. *Example:* Image routing to distant radiology groups.
- **vRad** / **Radiology Partners (telerad divisions)** — 24/7 reads. *Example:* Night coverage to prevent transfers.

9) Cybersecurity, Resilience & Data Protection (Healthcare-focused)

- **Claroty (Medigate) / Armis / Cynerio** — IoMT/biomed visibility & segmentation. *Example:* Secure device networks in small hospitals.
- **Clearwater / Meditology / Fortified Health Security** — HIPAA risk programs & virtual CISO. *Example:* Rural security roadmap aligned to 405(d).
- **CrowdStrike / Palo Alto Networks** — MDR/EDR and network security sized for lean IT. *Example:* Managed detection/response without 24/7 SOC.

10) Workforce, Scheduling, Credentialing & Virtual Nursing

- **QGenda / AMiON** — Physician/APP scheduling across sites. *Example:* Regional call/rotation coverage for multi-CAH systems.
- **Trusted Health / Incredible Health** — Talent marketplaces; rural pipelines. *Example:* Permanent hires replacing travel dependency.
- **Caregility / AvaSure** — Virtual nursing & telesitting. *Example:* Observation and discharge support without adding FTEs.

11) EMS, Tele-EMS & Community Paramedicine

- **Pulsara / Twiage** — Pre-hospital communication & hospital activation. *Example:* Rural stroke/STEMI activation with teleneuro.
- **ESO** — EMS documentation & data for QI/hand-offs. *Example:* Community paramedicine linked to CAH clinics.

12) Public Health, Immunization & Lab Connectivity

- **STChealth** — IIS connectivity & reminder/recall. *Example:* County vax drives coordinated with clinics/schools.
- **LigoLab / Orchard Software / Sunquest** — LIS for community hospitals & outreach. *Example:* Hub lab serving remote clinics.

13) Tele-Pharmacy & 340B Support

- **PipelineRx (Omnicell) / TelePharm** — Remote verification & counseling. *Example:* Overnight pharmacist coverage for CAHs.
- **Craneware (Sentry Data Systems) / Macro Helix** — 340B analytics/compliance. *Example:* Sustain rural pharmacy access with audit-ready tracking.

How to use Appendix C in state proposals

- Assemble **ecosystems, not point tools**: pair an EHR core with interoperability, RPM, tele-ER, maternal, cyber, and an RCM stack.
- Require **rural-specific case studies** (metrics: readmissions, ED LWBS, time-to-tPA, maternal complication flags, denial rate, DNFB days, days in A/R).
- Specify **low-bandwidth modes, cellular-first kits, and simple integration paths** for frontier counties.
- Bake in **training & sustainability** (virtual nursing workflows, vendor-supported change management, annual security reviews) to satisfy the 2030+ requirement.

About Black Book Research

Black Book Research is the independent, vendor-agnostic—and proudly unbiased—industry guarddog for healthcare technology and services decision-makers. In 2025 we released a suite of **Rural Healthcare Reports gratis to the industry**, spotlighting what actually works for critical access hospitals, rural PPS systems, FQHCs/RHCs, EMS, and county health. Our software and services ratings are built on a continuously updated database of **3.5+ million validated opinions** from frontline users of healthcare IT, equipment, and services—first-hand customer experience gathered over the past decade, not recycled marketing claims. Using rigorous, transparent methodologies and multi-dimensional scoring, Black Book benchmarks vendors across categories and maturity curves to separate durable value from hype. The result: clear, vendor-neutral signal that helps states, rural providers, and innovators align on sustainable solutions—especially where budgets are thin, bandwidth is scarce, and every decision must deliver measurable impact.