North Carolina Rural Health Transformation Program (NCRHTP)

Justus Warren Heart Disease and Stroke Prevention Task Force

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Purpose of Today's Overview

- Review background for Rural Health Transformation Plan
- Describe application development process
- Provide overview of NC's application to CMS for rural health transformation
- Describe next steps

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Overview: Rural Health Transformation Plan At-a-Glance

RHTP is part of H.R. 1

- States apply for financial allotments to improve the access to care, enhance technology, build strategic partnerships, and support workforce.
- Application was due November 5, 2025. The CMS must approve or deny applications by December 31, 2025; states that receive approval do not need to reapply each year.
- Governors designate a "lead entity" to submit application. NCDHHS the designee for NC.

What this means for N.C.?

Our rural population is the ***second largest in the country***. NC's strong safety net system provides a strong foundation for impact.

RHTP is an opportunity

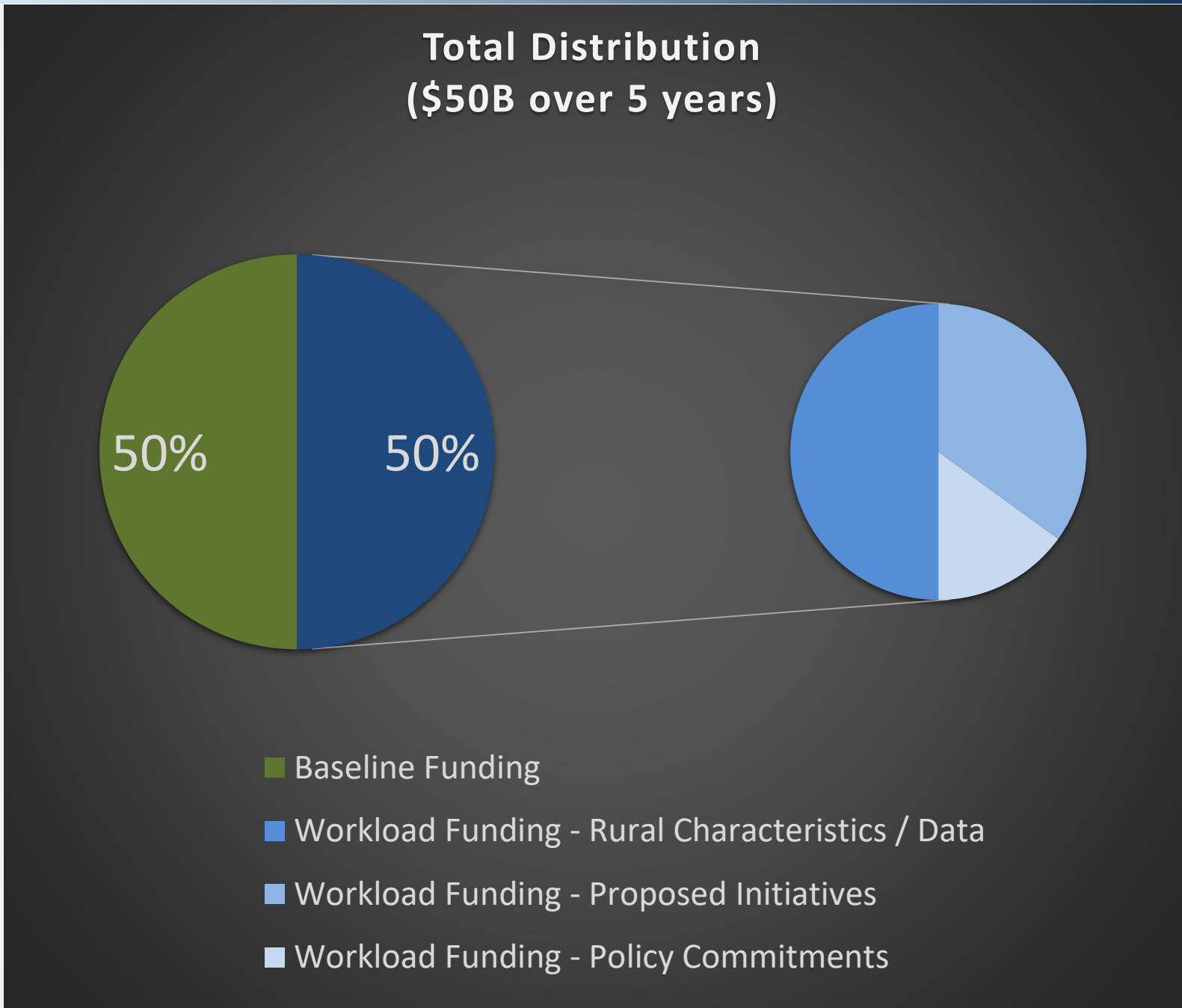
NC can build on the innovative models that work, spur sustainable innovation, support NC's rural workforce, and improve access to care for 3M individuals living in rural areas.

RHTP Use of Funds Under H.R. 1

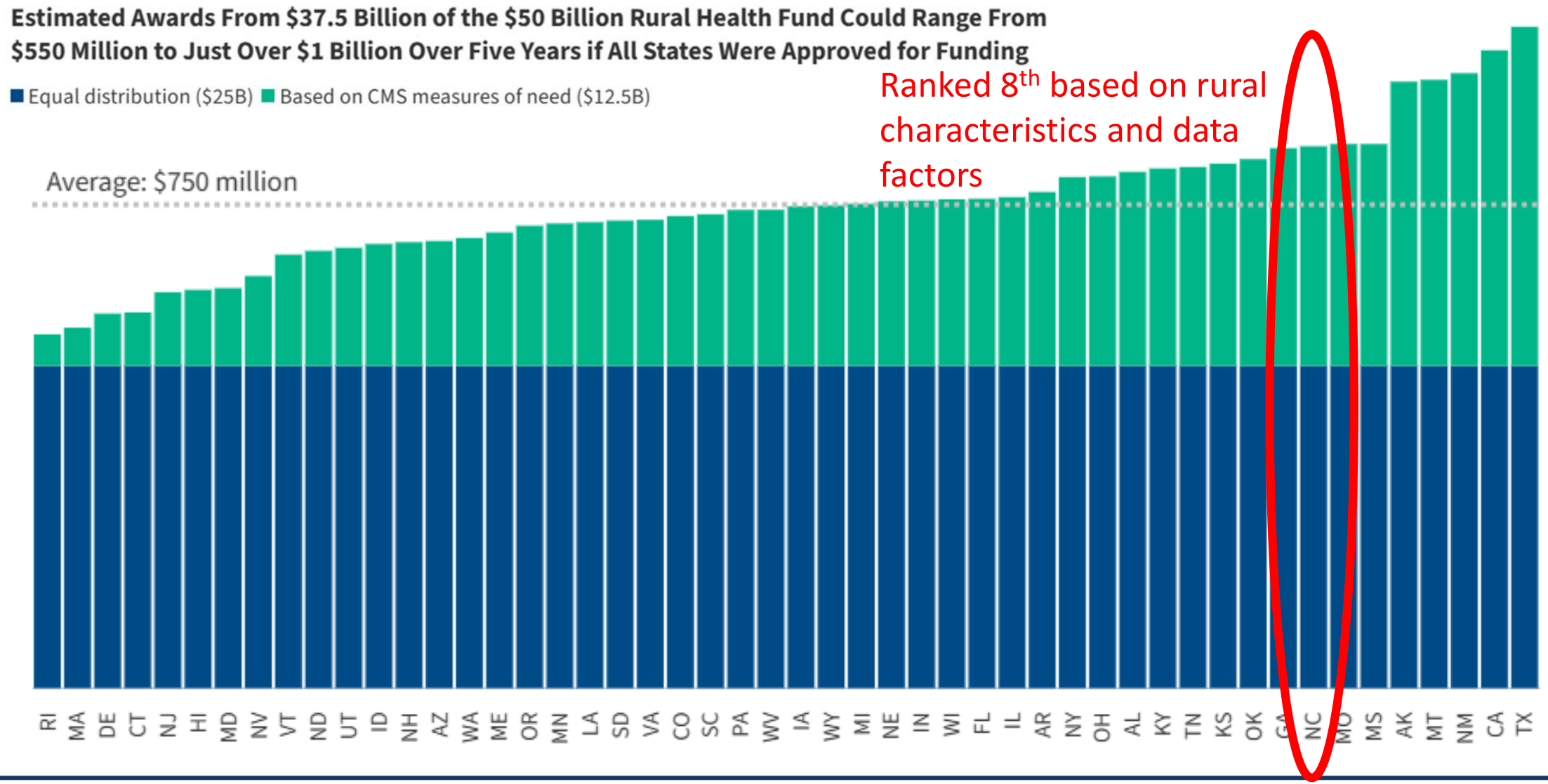
States are required to use RHT Program funds for at least three of the following approved uses:

1. **Promoting evidence-based, measurable interventions** to improve prevention and chronic disease management.
2. **Providing payments to health care providers** for the provision of health care items or services, as specified by the Administrator.
3. **Promoting consumer-facing, technology-driven solutions** for the prevention and management of chronic diseases.
4. **Providing training and technical assistance** for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.
5. **Recruiting and retaining clinical workforce talent** to rural areas, with commitments to serve rural communities for a minimum of 5 years.
6. **Providing technical assistance, software, and hardware** for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.
7. **Assisting rural communities to right-size their health care delivery systems** by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
8. **Supporting access to opioid use disorder treatment services**, other substance use disorder treatment services, and mental health services.
9. **Developing projects that support innovative models of care** that include value-based care arrangements and alternative payment models, as appropriate.
10. **Additional uses** designed to promote sustainable access to high quality rural health care services, as determined by the Administrator.

Overview: RHTP Funding

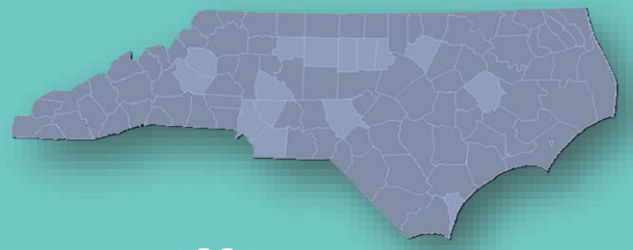


Where does NC rank in terms of rural characteristics/data?



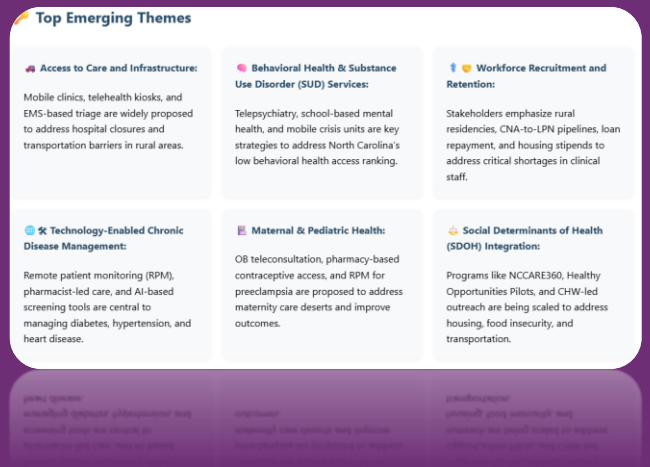
Source: KFF analysis of the CMS Rural Health Transformation Program NOFO and Sheps Center Rural Facility and population score estimates by State (Oct. 2025)

NC’s Rural Health Transformation Plan By the Numbers



3 million rural North Carolinians served across **85 counties**

420+ stakeholders engaged in application development

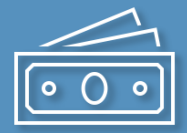


2nd largest rural population in the US

400+ rural health facilities to be reached

6 integrated initiatives addressing workforce, access, technology, behavioral health, chronic disease, and payment models

~$200 million annually in federal investment over five years



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Guiding Principles in Development of the RHT Application

Initiatives were developed by mapping state innovations and divisional needs against partner feedback and CMS's NOFO requirements. Guiding principles used to detail out each initiative and its component activities.

Guiding Principles

- ✓ **Align with Strategic Goals and Use of Funds:** Initiatives should support RHTP's five strategic goals and draw from the eleven approved use-of-funds categories. They must be evidence-based, outcomes-driven, and transformative.
- ✓ **Prioritize Measurable, Community-Level Impact:** Initiatives should include clear metrics, baseline data, and targets—ensuring accountability, scalability, and local relevance.
- ✓ **Demonstrate Stakeholder Engagement and Governance:** Initiatives should be co-designed with rural stakeholders and supported by a formal engagement framework and clear governance structure.
- ✓ **Maximize resources for rural health:** Align initiatives with initiative-based and policy-based technical score factors to strengthen the application and maximize potential funding.
- ✓ **Plan for Long-Term Sustainability:** Initiatives should include a sustainability plan beyond FY31, leverage existing infrastructure, and avoid duplication of existing programs.

INPUTS

Landscape Assessment of Rural Health Needs	Brainstorming with Division Teams	Identifying Current NC Innovations	Stakeholder meetings/inputs	Benchmarking Against NOFO Examples

Our Challenges and Needs Assessment for RHTP

Large & Diverse Rural Population

28.4% of North Carolinians—nearly 3 million people—live in rural areas, spanning counties from the coast to the mountains.

Widening Gaps in Access & Outcomes

Rural communities face persistent **disparities in health outcomes**, provider shortages, and economic challenges, with gaps in access to care and quality.

High Burden of Chronic & Behavioral Health Needs

Diabetes rates are up to 17% higher than urban areas; **90 counties are mental health shortage areas**; American Indian youth face elevated risks.

Critical Provider & Workforce Shortages

24 counties lack adequate primary care; shortages in behavioral health, oral health, and EMS are acute, impacting care delivery.

Financial Instability of Rural Facilities

12 rural hospitals have closed or converted since 2006; 5 more are at immediate risk, threatening local access to emergency & inpatient care.

Barriers to Digital Health & Resource Navigation

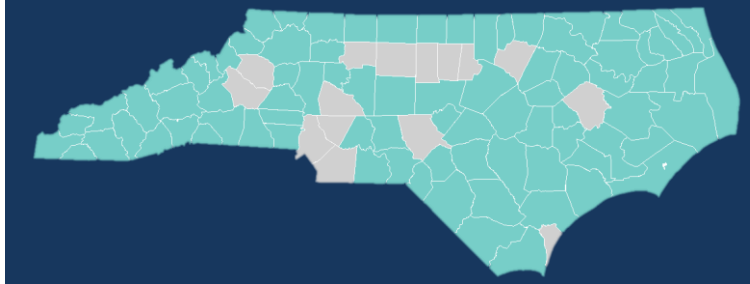
Broadband gaps and low digital literacy limit telehealth and care coordination, especially in high-poverty counties.

Gaps in Disease Mngmt, Prevention & Early Intervention

Rural families and children have less access to preventive screenings and coordinated chronic disease management.

Targeted RHTP Approach: *Investments prioritize regionally anchored hub-and-spoke networks, high-burden zip codes, persistent poverty areas, and underserved populations—including tribal communities.*

Rural Health in NC at-a-Glance



- **2.96M rural residents**—2nd highest in the U.S, spread across 85 counties (in green above)
- **5.5% uncompensated** care rate
- **28.4%** population in rural areas
- Some counties in western NC and parts of the Sandhills region meet FAR Level 2 criteria
- **28th in land area** among U.S. states (~53,819 square miles). Geographic diversity and rural dispersion create logistical and infrastructure challenges that mimic those of larger states.

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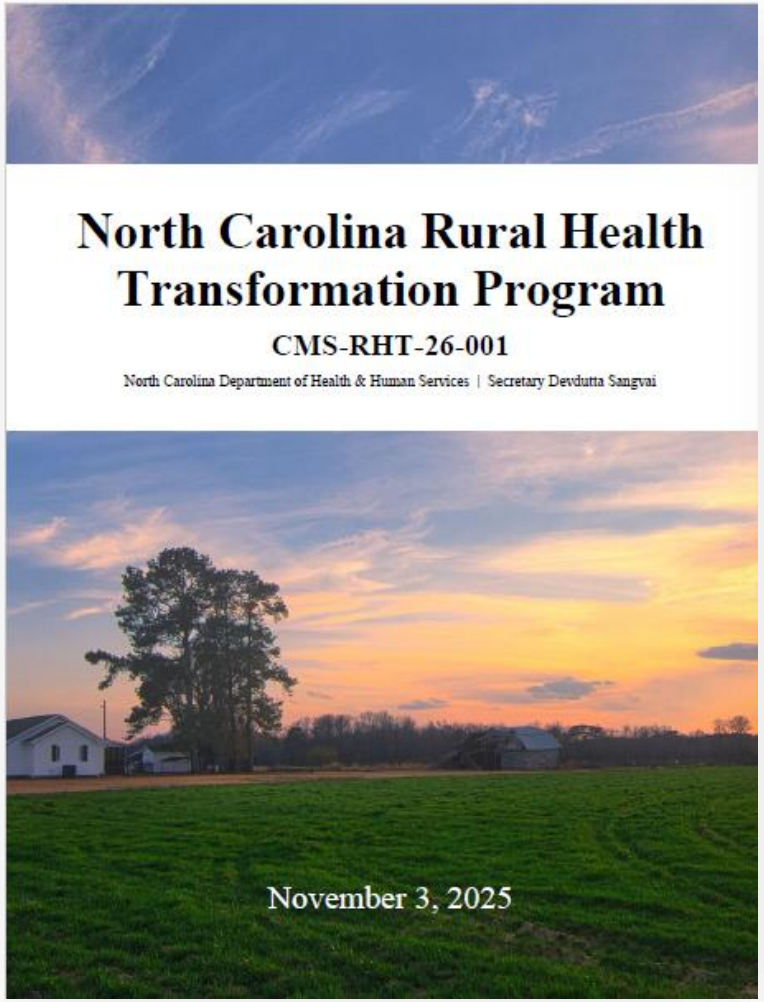
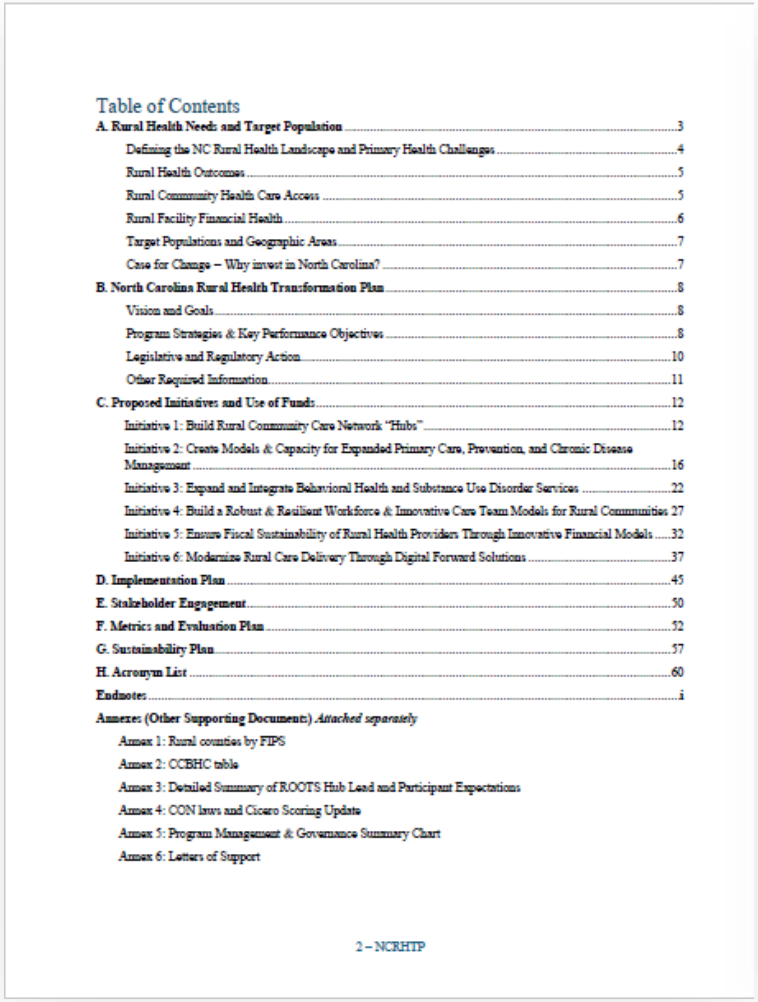
We submitted the NC Rural Health Transformation Plan (NCRHTP) on Nov. 3rd!

See link to Application here





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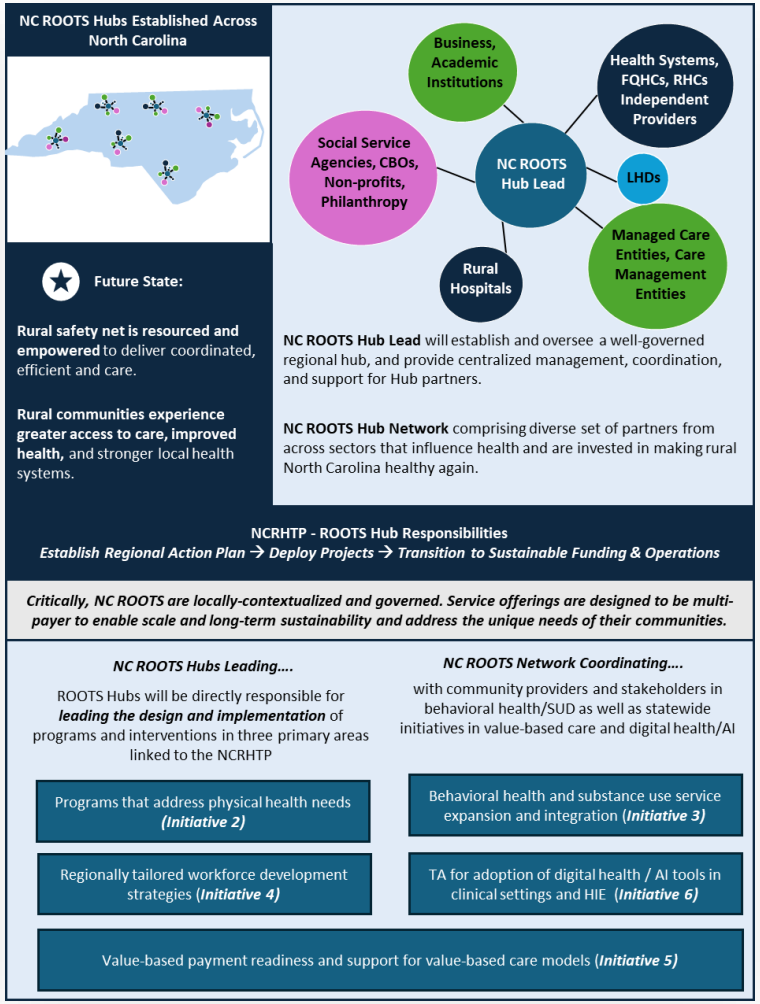

Six Interlinked Initiatives work synergistically to achieve NCRHTP Vision & Goals

Further detailed next

Vision — *To advance innovative solutions that foster independence, improve health, and promote well-being for all rural North Carolinians*

Required Federal Elements

- *Improving Access | Improving Outcomes | Partnerships*
- *Workforce*
- *Cause Identification | Financial Solvency*
- *Technology Use | Data-Driven Solutions*

NC Rural Health Priorities

1. **Build Rural Community Care Network "Hubs"**
2. **Create Models & Capacity for Expanded Primary Care, Prevention, and Chronic Disease Management**
3. **Expand and Integrate Behavioral Health and SUD Services**
4. **Build a Robust & Resilient Workforce & Innovative Care Team Models for Rural Communities**
5. **Ensure Fiscal Sustainability of Rural Health Providers Through Innovative Financial Models**
6. **Modernize Rural Care Delivery Through Digital Forward Solutions**

Six Interlinked Initiatives work synergistically to achieve NCRHTP Vision & Goals

1

Build Rural Community Care Network "Hubs"

- Design and deploy community-tailored services that address physical health, behavioral health, substance use, and upstream wellbeing needs
- Build platforms to improve information sharing, joint training, program coordination, and group purchasing

***Performance Objective**: Establish 6 NC "ROOTS" Hubs by program Y2.*
(Improves access, outcomes, and partnerships)

2

Create Models & Capacity for Expanded Primary Care, Prevention, and Chronic Disease Management

- Expanded access to primary and specialists through digital-forward models
- Care coordination and navigation supports across local networks of care
- Upstream supports and interventions emphasizing prevention and wellness

***Performance Objective**: Decrease the percent of adults in the target rural population reporting three or more chronic health conditions from 12.1% to 9.7% by Y5.*
(Improves access, outcomes, and partnership)

3

Expand and Integrate Behavioral Health and SUD Services

- Expanded services through the CCBHCs
- Enhanced assessment & treatment programs to address critical care gaps in first episode psychosis, rural crisis, mobile, outreach & response, mobile opioid treatment and medication units, and school-based health
- New collaboratives to connect patients to care. ***Performance Objective:** Increase the number of Medicaid patients beginning MH treatment by 5% year through Y5.*
(Improves access, outcomes, and partnerships)

Six Interlinked Initiatives work synergistically to achieve NCRHTP Vision & Goals

4

Build a Robust & Resilient Workforce & Innovative Care Team Models for Rural Communities

- Expanded rural residencies and fellowships and training/certification for CHWs, peers, direct care workers and other health professionals
- Expanded simulation & interprofessional training
- Increased capacity for qualified training sites and faculty/clinical teachers
- Outreach & high-school-to-job pipelines

Performance Objective**: Decrease rural county provider vacancy rates by 10% by program Y5.* ***(Strengthens workforce)

5

Ensure Fiscal Sustainability of Rural Health Providers Through Innovative Financial Models

- Rural Medicaid VBP models via two linked programs:
  - –Primary care capitation pilot
  - –Rural hospital VBP capacity building
- Reduce operating costs and inefficiencies in care delivery

Performance Objective**: Increase participating rural hospital and primary care clinic readiness for or engagement in value-based payment models by 10-15% over baseline by program year 5* ***(Financial solvency strategy and cause identification)

6

Modernize Rural Care Delivery Through Digital Forward Solutions

- Data exchange via rural provider connectivity to the state (HIE)
- New rural precision public health models
- Expanded rural provider adoption of AI tools, virtual care models for P2P consults and complex care management in regions where specialty care is limited
- Improved digital health literacy and digital patient tools in rural communities

Performance Objective**: Reduce the gap in rural provider HIE connectivity by 70 practices by program Y3* ***(Addresses technology use and data-driven solutions)

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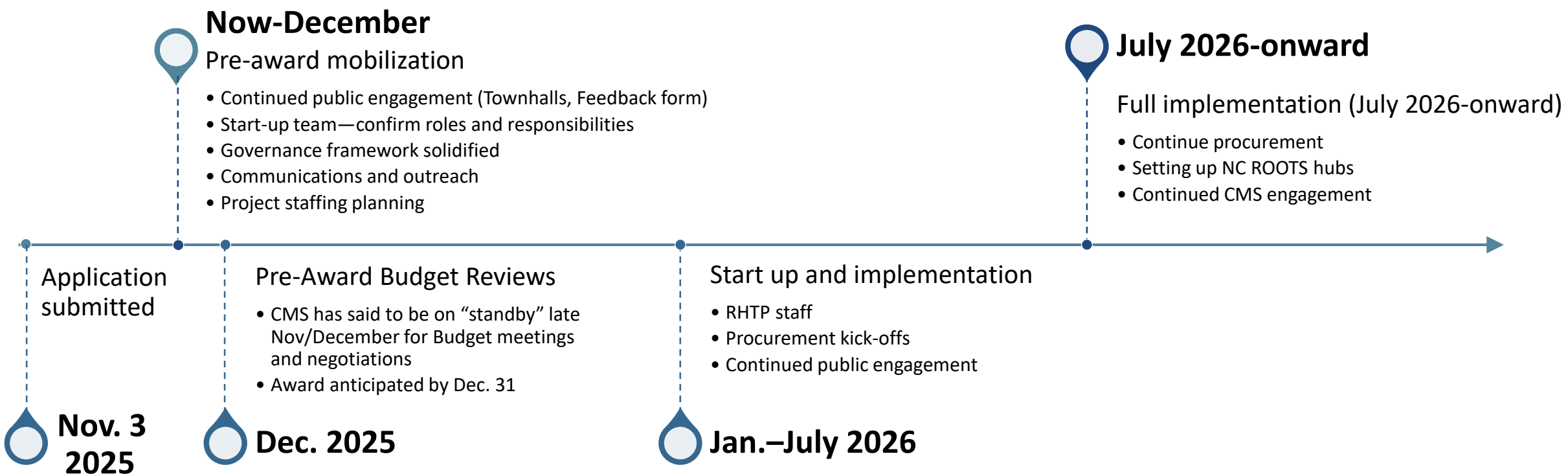
What's Next – Timeline & Milestones



Next Steps

For more information:

- **NC's RHTP Application:** https://www.ncdhhs.gov/divisions/office-rural-health/rural-health-transformation-program
- **Press Release**: North Carolina to Apply for the Rural Health Transformation Program
- **Website**: Rural Health Transformation Program

Relevance to JWTF

- ✓ Residents of rural areas have difficulty accessing care.
- ✓ Higher burden of chronic disease such as DM and HTN.
- ✓ More elders.
- ✓ Acute care services for CV disease and stroke are more limited and less timely.

Discussion & Feedback

Appendix

Funding Policies and Limitations

CMS will not allow the following costs:

- **Pre-award costs.**
- **Meeting matching requirements for any other federal funds or local entities.**
- **Services, equipment, or supports that are the legal responsibility of another party** under federal, State, or tribal law, such as vocational rehabilitation or education services.
- **Services, equipment, or supports that are the legal responsibility of another party under any civil rights law**, such as modifying a workplace or providing accommodations that are obligations under law.
- **Goods or services not allocable to the project.**
- **Supplanting existing State, local, tribal, or private funding** of infrastructure or services, such as staff salaries.
- **Construction or building expansion,** purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increases the value of the capital or useful life as a direct cost.
- **The cost of independent research and development**, including their proportionate share of indirect costs. See 2 CFR 300.477.
- **Funds related to any activity designed to influence** the enactment of legislation, appropriations, regulation, administrative action, or executive order.
- **Purchase of covered telecommunications and video surveillance equipment** (See 2 CFR 200.216) as well as financial assistance to households for installation and monthly broadband internet costs.
- **Meals**, unless in limited circumstances such as:
  - Subjects and patients under study.
  - Where specifically approved as part of the project or program activity, such as in programs providing children's services.
  - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.
- **Activities prohibited under 2 CFR 200.450 and the HHS Grants Policy Statement**, including but not limited to: Paying the salary or expenses of any grant recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any State government, State legislature, or local legislature or legislative body.
- **Lobbying**, but awardees can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying.

RHT Program Specific Limitations

CMS will also not allow the following RHT-specific costs:

- **New construction.** Supplanting funding for in-process or planned construction projects or directing funding towards new construction builds is unallowable. Renovations or alterations, as described in category J of the program requirements and expectations use of funds section, are allowed if they are clearly linked to program goals.
    - **Category J funding cannot exceed 20% of the total funding** CMS awards states in a given budget period.
- **To replace payment for clinical services that could be reimbursed by insurance. CMS will not accept payments to clinical services if they duplicate billable services and/or attempt to change payment amounts of existing fee schedules.** (If a state plans to fund direct health care services, the state must justify why they are not already reimbursable, how the payment will fill a gap in care coverage (such as uncompensated care or services not covered by insurance), and/or how they transform the current care delivery model.)
    - **Funding for provider payments**, as described in category B of the program requirements and expectations use of funds section, **cannot exceed 15% of the total funding** CMS awards states in a given budget period.
    - **Funding cannot be used for initiatives that fund certain cosmetic and experimental procedures** that fall within the definition of a specified **sex-trait modification procedure** at 45 CFR 156.400 because that is beyond the scope of this program.
- **No more than 5% of total funding CMS awards to a state in a given budget period can support funding the replacement of an EMR system** if a previous HITECH certified EMR system is already in place as of September 1, 2025.
- **Funding towards initiatives similar to the "Rural Tech Catalyst Fund Initiative"** (as described in the appendix) cannot exceed the lesser of (1) 10% of total funding awarded to a State in a given budget period or (2) $20M of total funding awarded to a State in a given budget period, and funding is subject to all restrictions and requirements described in the example initiative
- **Clinician salaries or wage supports** for facilities that subject clinicians to **non-compete contractual limitations**.
- **None of the funding shall be used by the state for an expenditure that is attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-Federal share of expenditures required under any provision of law.**
- SSA Section 2105(c), paragraphs (1), (7), and (9) apply as funding limitations. These limitations are related to general limitations, limitations on **payment for abortions, and citizenship documentation requirements for payments made with respect to an individual.**

CMS's Rural Health Transformation Program Strategic Goals

Make rural America healthy again

- Support rural health innovations and new access points to promote preventative health and address root causes of diseases. Projects will use evidence-based, outcomes-driven interventions to improve disease prevention, chronic disease management, behavioral health, and prenatal care.

Sustainable access

- Help rural providers become long-term access points for care by improving efficiency and sustainability. With RHT Program support, rural facilities work together—or with high-quality regional systems—to share or coordinate operations, technology, primary and specialty care, and emergency services.

Workforce development

- Attract and retain a high-skilled health care workforce by strengthening recruitment and retention of healthcare providers in rural communities. Help rural providers practice at the top of their license and develop a broader set of providers to serve a rural community's needs, such as community health workers, pharmacists, and individuals trained to help patients navigate the healthcare system.

Innovative care

- Spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements. Develop and implement payment mechanisms incentivizing providers or Accountable Care Organizations (ACOs) to reduce health care costs, improve quality of care, and shift care to lower cost settings.

Tech innovation

- Foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients. Projects support access to remote care, improve data sharing, strengthen cybersecurity, and invest in emerging technologies.

RHT Program Use of Funds Requirements

Approved states may use funds awarded by CMS to invest in at least three of the permissible uses below:

- **Prevention and chronic disease**
- **Provider payments** (no more than 15% of total funds)
- **Consumer tech solutions**
- **Training and technical assistance**
- **Workforce** (commitment to serve rural communities for 5 years)
- **Information technology advances** (subject to restrictions)
- **Appropriate care availability**
- **Mental health (MH) and substance use disorder (SUD)**
- **Innovative care**

Additional uses, as determined by the Administrator:

- **Capital expenditures and infrastructure** (including minor building alterations or renovations and equipment upgrades, subject to restrictions; no more than 20% of total funds)
- **Fostering collaboration** (strengthening local and regional partnerships; both rural and other participating providers)

Note: No more than 10% of the amount allotted to a state for a budget period may be used by the state for administrative expenses. This 10% limit applies to administrative costs for the entire budget, including indirect and direct costs. See appendix for more information on unallowable costs.

Rural Health Transformation Fund: Program Eligibility

The notice of funding opportunity was released on September 15th and is due to CMS on November 5th.

Only states may apply for awards. Each state will submit one application for funding for the five-year period.

States may consult and involve numerous partners like universities, local health departments, community-based organizations, and provider associations in designing and implementing the planned activities proposed in the application and may sub-award or contract RHT Program funds to such partners for various activities.

Subgrantees and subrecipients for NC's program will be determined by the state's use of funds referenced earlier, but may include "rural health providers" as defined in H.R.1.

Providers Included in Definition of "Rural Health Facility" in H.R.1

- Hospitals located outside of metropolitan statistical areas (MSA)
- Hospitals that have reclassified as rural (this includes some hospitals in urban areas)
- Hospitals located in a rural census tract of an MSA
- Critical Access Hospitals
- Sole Community Hospitals
- Medicare-Dependent Small Rural Hospitals
- Low Volume Hospitals
- Rural Emergency Hospitals
- Rural Health Clinics
- Federally Qualified Health Centers
- Community Mental Health Centers
- Health Centers receiving section 330 grants
- Opioid Treatment Programs (OTPs) located in a rural census tract of an MSA
- Certified Community Behavioral Health Clinics located in a rural census tract of an MSA

Note: While H.R.1 requires CMS to consider the number of rural health facilities in a state when determining funding allocations, the law doesn't explicitly define which providers are eligible for funding.