RURAL HEALTH TRANSFORMATION

CATEGORY E: WORKFORCE INFORMATION GUIDE

August 2026

Defining Category E Scope

Rural Health Transformation (RHT) Program funding for Category E initiatives is intended to help build a sustainable pipeline of local talent in rural communities. Section 71401 of Public Law 119-21 and the RHT Program Notice of Funding Opportunity (NOFO) Use of Funds section specify that funds may be used for "Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years." The main considerations when determining whether a given initiative falls under Category E and whether the 5-year service commitment applies are whether or not the initiative involves the recruitment and/or retention of clinical workforce and whether the individual clinician recipient is the direct beneficiary of the activity or if the rural healthcare system as a whole benefits.

Definition of Clinical Workforce

For the purposes of Category E funding, **clinical workforce is defined as all individuals who perform clinical tasks, which are activities involving the direct examination, treatment, and observation of patients, procedures, or interventions, whether with independent authority or under supervision, that directly contribute to the assessment, diagnosis, treatment, or maintenance of a patient's physical, oral, or mental health status during a healthcare encounter.** The focus of this definition is on the work performed, not on the training necessary to perform a role.

If the activity does not involve the clinical workforce, it should instead be categorized under a different Use of Funds category (often Category A). Developing the workforce that supports individuals' journeys through the healthcare system, but does not directly provide clinical services, could potentially be supported by RHT Program funds. However, these activities would be categorized under another use of funds category, such as Category A or Category H, and therefore not necessitate a 5-year service commitment.

If the activity supports recruitment and/or retention of clinical workforce talent to rural areas but benefits the larger rural healthcare system rather than an individual recipient, it may be a Category E use of funds but not subject to the 5-year service commitment (see "Key Question" for more information). However, the activity may be more appropriately categorized under another use of funds, such as Category A, D, G, H, or K depending on the nature of the activity, and similarly not subject to the 5-year service commitment. States should work closely with their Project Officer to determine whether the use of funds is Category E or another category and whether the 5-year service commitment applies.

See examples of Category E and alternative activities below:

Type	Category E	Alternative Categories
Training and Development	**Example**: Tuition reimbursements to individuals studying to become a licensed practical nurse (LPN) who commit to serving in rural areas. **Explanation**: The purpose of this program is specifically to recruit individual future LPNs to rural areas. LPNs are considered clinical workforce because they can provide clinical services such as administering medications and dressing wounds.	**Example**: Development of a State-owned digital curriculum to train new doulas in rural maternal care deserts. **Explanation**: This activity cannot fall under Category E because doulas are not considered part of the clinical workforce (see "Common Questions"). However, this activity likely could fall under Category A (Prevention and Chronic Disease) because it is promoting evidence-based interventions to improve prevention of adverse maternal and infant outcomes in rural areas.
Housing Stipends	**Example**: Funding for local, short-term housing assistance for psychiatric mental health nurse practitioners (PMHNPs) to support relocation to rural areas. **Explanation**: This short-term housing assistance directly supports an individual provider's ability to work in a rural area by offsetting relocation costs. PMHNPs are considered clinical workforce because they provide clinical services such as medication management, psychological assessment, and psychotherapy. Although this activity will also impact behavioral health (category H), the activity satisfies both category E conditions and is primarily focused on the recruitment of the provider, so it is best categorized as a workforce activity.	**Example**: Funding for local hotels or short-term housing so non-rural cardiologists (or other specialists) may provide care in rural areas while rural physician counterparts travel to non-rural areas to receive more specialized training. **Explanation**: In this case, the purpose of the housing stipends is not to recruit or retain the providers in rural areas. Instead, their purpose is to support knowledge exchange and collaboration between the rural and non-rural areas in the State while improving rural care quality and access. Therefore, this activity might more appropriately fall under Category K (fostering collaboration), for example.
Childcare	**Example**: Provision of vouchers or childcare subsidies as recruitment and retention incentives for emergency room nurses. **Explanation**: Similar to housing stipends, childcare subsidies lower an individual clinical provider's costs of living and working in a rural area and thereby serve as an incentive to recruit and retain the individual, thus satisfying both category E conditions.	**Example**: Funding for minor alterations or renovations within a hospital space to make on-site childcare available to hospital employees but not used to pay for an individual provider's childcare cost. **Explanation**: While this activity will likely aid in the recruitment and retention of providers by helping make accessible childcare generally more available, this activity is unlikely to exclusively benefit the clinical workforce; we would expect non-clinical hospital employees to benefit as well. **Additionally, because this activity involves minor alterations and renovations, it must be considered Category J (Capital Expenditures).**

5-Year Rural Service Commitment

Applicability

The second part of Category E as defined in Section 71401 of Public Law 119-21 and the NOFO permissible uses indicates that activities to recruit and/or retain clinical workforce talent should be accompanied by "commitments to serve rural communities for a minimum of 5 years." The Office of Rural Health Transformation (ORHT) has interpreted this to mean that there may be a 5-year service commitment associated with Category E activities based on whether an item or service of value is being given to or paid for the direct benefit of the individual clinician, or benefitting the broader rural health system.

Key Question: Is an item or service benefitting an individual member of the clinical workforce or is it a general facilitator of clinical practice in rural areas and benefiting the broader rural healthcare system?

For the purposes of this program, an item or service of value refers either to a license or certification (regardless of whether this license or certification is required to practice in the State) or to another financial incentive or benefit. Such financial incentives or benefits include but are not limited to: a degree/license/certification, housing assistance, and childcare vouchers. If an item or service of value is being provided to the individual, the 5-year rural service commitment is likely required.

Examples of items or services of value benefitting the broader health system would include creation of a rural-focused residency rotation, provider burnout prevention activities, trainings of limited scope and duration that do not provide an additional certification/licensure/degree, K-12 clinical career exposure programs, etc. These activities would not incur a 5-year service commitment. However, some of these activities may be more appropriately categorized as Category A, D, G, H, or K or another category. States should work with their Project Officer to determine the appropriate use of funds category for these activities.

Common Questions

1. **How should States approach community health workers (CHWs) for applicability of Category E and the 5-year service commitment?**
   To establish programmatic consistency across States, ORHT will consider CHWs nonclinical workforce. This means that Category E does not apply, and any CHW training or recruitment activities fall under a different use of funds category, likely Category A. Therefore, the 5-year service commitment is not required. In accordance with Section 71401 of Public Law 119-21 and the NOFO, States have the responsibility to determine their rural health needs and develop their rural health transformation plans accordingly within the guidelines set by CMS. If a State finds its goals and initiatives are best served by requiring a service commitment, it is welcome to do so, but it is not required by CMS.

2. **How should States approach doulas for applicability of Category E and the 5-year service commitment?**
   Doulas are considered nonclinical workforce for the purposes of the RHT program. This means that Category E does not apply and any allowable doula training or recruitment activities fall under a different use of funds category, likely Category A. Therefore, the 5-year service commitment is not required. In accordance with Section 71401 of Public Law 119-21 and the NOFO, States have the responsibility to determine their rural health needs and develop their rural health transformation plans accordingly within the guidelines set by CMS. If a State finds its goals and initiatives are best served by requiring a service commitment, it is welcome to do so, but it is not required by CMS.

3. **How should States approach community paramedics for applicability of Category E and the 5-year service commitment?**
   Community paramedics are considered clinical workforce for the RHT program because they directly deliver primary care, chronic disease management, and more clinical services. This means that workforce recruitment and retention initiatives related to community paramedics would fall under Category E. Applicability of the 5-year service commitment depends on the State's approach. If the State is paying for training "infrastructure" (e.g., curricula, clinical practice dummies, etc.) or providing training of limited scope and duration that does not lead to a specific certification (e.g., training to existing paramedics on delivering preventive care in the home), the 5-year rural service commitment would not apply and another use of funds may be more appropriate, such as Category A or G depending on the nature of the activity.

4. **What if my State wants to include a 5-year or other service commitment for a nonclinical provider?**
   States may determine the best methods to ensure that RHT program funds create lasting and transformative change in rural areas. In accordance with Section 71401 of Public Law 119-21 and the NOFO, States have the responsibility to determine their rural health needs and develop their rural health transformation plans accordingly within the guidelines set by CMS. If a State believes that its goals are best served by including a rural service commitment for roles ORHT considers nonclinical, they are free to include such requirements when funding related activities under a permissible use other than Category E. Those commitments are allowed but not required by CMS. States should consider how these additional service commitments may present barriers to uptake and balance that with the transformation and sustainability goals of the program.

Tracking and Service Agreement Requirements

States are responsible for ensuring that every clinical provider who receives an individual benefit from Category E funding fulfills the entirety of their 5-year rural service commitment. When developing service agreements, States should consider how they will track these commitments and take corrective action if necessary, including beyond the life of the program. At a minimum, States must ensure they have a clearly defined method for verifying rural service that does not rely exclusively on provider attestation of compliance or service completion. Depending on the specific situation and provider type, this process may include collecting Tax Identification Numbers, National Provider Identifiers (NPIs), and/or other individualized data for matching against available claims data to verify that the provider was claiming for clinical services in a rural area during the relevant time period. In general, States have flexibility in determining the best method for tracking rural service commitment compliance but should work with their Project Officer to develop a robust tracking and verification system for rural service that aligns with program goals.

Considerations for Category E Service Agreements

States are responsible for drafting, executing, and enforcing Category E service agreements. In addition to including the individualized tracking mechanism, service agreements generally should:

- Clearly state the recruitment or retention incentive that gives rise to the requirement for the service commitment.
- Include a process for providers to report and verify rural service, including the individualized tracking information discussed above.
- Clearly define what the State considers "serving rural communities." This definition may be State-defined but should align with guidance from CMS and the definition of "rural" or rurality identified in the State's application. States should work with their project officers to ensure the definition considers both the unique features of the State's rural geographies, populations, delivery systems, and availability of providers, as well as the goals of the initiative and the RHT program. At a minimum, this definition should require the provider to work in their clinical capacity in rural areas full time for the minimum 5-year duration of the agreement.
- Specify the minimum number of hours an individual will be required to work to be considered "full time." This may be based on State law/regulations, norms for the relevant type of clinical workforce within the relevant rural area, or other considerations of the particular needs of the State's rural areas that inform a reasonable definition of "full time."
- Define the actions that will be taken in the event the service commitment is not met. This should also include any flexibilities related to deferrals of the commitment due to receipt of additional clinical training or extenuating circumstances (See "Extenuating Circumstances").

Allowable and Unallowable Flexibilities

To comply with federal regulations and align with RHT Program goals, CMS has identified certain flexibilities regarding satisfaction of rural service commitments:

States may...
• Allow providers to relocate to and serve a different community within the State, provided it is still a rural community as defined by the State in their application. • Consider an individual's time spent serving rural communities while in training, provided the individual was still serving as a clinical provider. For example, a resident's time spent providing medical care in rural communities while still in residency could count towards satisfying the 5-year service commitment. • Allow providers to take a break in service to obtain additional health care certification or licensure, although States should ensure they discuss the implementation of such policies with their Project Officer. • Allow providers to benefit from more than one workforce initiative, although this practice may require additional or extended service commitments and should be discussed with the Project Officer.

States may not...

- Consider time spent serving communities outside the State regardless of whether they are rural.
- Define rural service to include provision of telehealth services to patients in a rural area while the provider is physically located in a non-rural area (i.e., providers must be physically providing services in rural areas to satisfy their commitment.)

Failure to Complete the 5-Year Service Commitment & Fund Recovery

States are responsible for setting up systems to appropriately recover funds should providers fail to complete their service commitments. They should work with their project officers to ensure oversight and enforcement systems are robust. As an enforcement mechanism, some States may wish to impose a debt with interest on individuals who fail to satisfy their 5-year service commitment. States **may not** directly impose debt with accrued interest on such providers. However, States **may** contract with a third party to distribute incentives to individuals, and the third party may impose a debt with interest on individuals who fail to meet the 5-year service commitment requirements. States may also directly recover the debt without imposing interest.

Because the 5-year service commitment is required by the authorizing statute and statutory requirements are incorporated into the award terms and conditions, failing to ensure completion of the 5-year service commitment is considered noncompliance with the terms and conditions of the award. Accordingly, if a State fails to ensure 5-year service commitments are satisfied, CMS may recover funds the State paid out to noncompliant providers from the State as outlined in the "Noncompliance" section of the NOFO. Because States generally have two fiscal years to spend funds awarded in a given budget period, States may recover and reuse funds for allowable RHT program purposes provided the deadline for expending those funds, as outlined in statute, NOFO, and Notice of Award, has not passed. In cases where the deadline has passed, CMS may recover those funds and return them to the United States Treasury.

In the event a provider does not complete the 5-year service commitment, CMS may seek to recoup funds from the State prorated based on the amount of time served. Similarly, States may prorate the amount of funds they recoup based on the amount of time served. States have flexibility in how they structure their 5-year service agreements but should work closely with their project officer to ensure the program structure aligns with program goals and requirements.

Extenuating Circumstances

It may be allowable for States to forgive the 5-year service obligation in cases where the requirement has not been fulfilled due to extenuating circumstances, such as death or disability of the committed provider. States must submit a request with documentation substantiating a provider's extenuating circumstance to CMS for review and approval for the State to write-off or otherwise forgive the 5-year service obligation without recovery of funds.

Decision Tree