Rural Health Transformation Program Post-Award Frequently Asked Questions (FAQs)

September 2026

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I. Budget

General

1. What is the process to move money between funding lines during implementation?

States should contact their assigned Grants Management Specialist (GMS) for any requests or questions regarding movement of funds between object class categories or within the same category.

(Updated 4/9/2026)

2. Can States publicly post any procurement pre-listing or other funding opportunity information prior to receiving an approved budget?

Funding opportunity information should not be posted publicly until State recipients receive an approved budget.

(Updated 4/9/2026)

3. Does CMS have an estimate of future award amounts that States can expect and use for the purposes of planning projects that require building scopes of work across multiple years?

States may budget based on the amounts previously awarded or, as an alternative, budget for the average award of $200M per subsequent year. State budgets will go up or down depending on the state's ability to meet the RHT Program checkpoints set by CMS as outlined in CMS's February 25, 2026, webinar, consistent with the State's Notice of Award (NoA) and the Notice of Funding Opportunity (NOFO).

(Updated 4/9/2026)

4. Once a State's budget is approved, what must the State do to lift restrictions on contractual costs?

The State should submit a budget amendment in GrantSolutions outlining all the detailed information required in Section F of "CMS Guidance for Preparing a Budget Request and Narrative."

(Updated 4/9/2026)

5. What is the process for submitting budget changes to CMS?

Budgetary changes should be submitted through an amendment in GrantSolutions. The approval process involves reviews by the GMS and Project Officer (PO), followed by final review and approval by the Grants Management Officer.

For changes to information provided in a State's application, such as submitting personnel names or final contractual reporting information to CMS, States should use the grant message feature. Changes that do not require prior approval include non-key administrative personnel updates, minor supply cost adjustments, and travel cost changes within the General Services Administration (GSA) rates.

(Updated 9/23/2026)

6. Why must a State obligate all funding in the Budget Period in which it was awarded? How does this impact potential redistribution of funds?

The State's authority to obligate funds (including to commit them to a contract or subaward) exists only during an active Budget Period for which the funds are available, as defined in 2 CFR 200.1. Once that period ends, States can no longer use any remaining unobligated funds to make new expenditures or commitments, as no additional costs can be incurred (2 CFR 200.1). Because these funds can no longer be committed, they cannot be spent. This means they will ultimately be classified as "unexpended" at the end of the overall spending window (i.e. the end of the fiscal year following the fiscal year in which funds were awarded) per the NOFO. Under the rule specified in 42 U.S.C. 1397ee(h)(1)(B), all unexpended funds are then

redistributed by CMS to other States. Therefore, failing to obligate funds within the allowed timeframe will result in those funds being returned and redistributed (Program Terms and Conditions - #15). If funds are obligated within the relevant Budget Period, they can, with some exceptions such as personnel and fringe benefits, be spent up to the end of the fiscal year following the fiscal year in which they were awarded, in accordance with 42 U.S.C. 1397ee(h)(1)(B). States should work closely with their GMS to ensure they are properly obligating and spending funds in accordance with all relevant statutes and regulations.

(Updated 4/9/2026)

7. Are mobile hotspots considered broadband infrastructure and thus an unallowable expenditure?

Mobile hotspots, if they are not covered telecommunications equipment or services as described in 2 CFR 200.216, can be allowable costs from a program perspective. Additionally, States should ensure they have sufficient evidence to support sustainability of these devices and any associated activities during and beyond the period of performance.

(Updated 9/23/2026)

8. May a state use Rural Health Transformation (RHT) Program funds to support a similar structure to the CMS Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model?

Yes. States may use RHT Program funds to support a similar structure to the ACCESS Model. States may use RHT Program Funds for planning, implementation, infrastructure development, workforce training, data exchange capabilities, payment model design, provider readiness activities, and other transformation efforts that facilitate adoption of an outcomes-based payment structure aligned to the ACCESS Model.

States may include adoption of payment approaches similar to ACCESS as part of approved RHT Program initiatives where those approaches support chronic disease management, innovative care delivery, provider transformation, payment reform, or data infrastructure objectives. Consistent with the RHT Program framework, implementation of such approaches may be reflected in initiative milestones, sustainability plans, and progress toward applicable technical score factors.

CMS is making available to States and Managed Care Organizations (MCOs) optional alignment resources to support them in adopting an outcomes-based payment structure similar to the ACCESS Model.

(Updated 9/23/2026)

Administrative Costs

9. Does CMS have guidance on how States are expected to track administrative costs per initiative?

The NOFO specifies that the Budget Narrative should explicitly highlight the administrative expenses (both direct and indirect). Administrative expense line items should be identified throughout the Budget Narrative to demonstrate that their sum is 10% or less of the total budget. CMS does not provide specific guidance on how States should track administrative costs within their accounting system(s).

(Updated 4/9/2026)

Obligated and Expended Funds

10. Can States move funding between budget category line items without prior approval from CMS?

States may move funding within an approved budget category identified on the SF-424A Form without prior approval, unless prior approval is required under 2 CFR 200.308(f), if the cumulative amount of transfers

between line items is 10% or less of the total of the award, as outlined in 2 CFR 200.308(i)(2) and the Standard Terms and Conditions. However, in these scenarios, CMS requests notification of the change via grant message. If States intend to transfer more than 10% of the total of the award between line items, a submission of a budget amendment is required in GrantSolutions for review and prior approval by CMS. Note that subrecipients may not independently move funds between line items or notify CMS of such a move; the primary recipient must approve those adjustments and notify CMS as appropriate. States should inform their assigned GMS and PO of all changes made.

(Updated 9/23/2026)

11. Do States need to submit subaward budgets and obtain approval from CMS before a subaward may be awarded? Are States required to upload full contractual agreements for CMS approval?

States do not need to submit subaward budgets or obtain approval from CMS before a subaward is signed. State awardees are also not required to upload full contracts in the GrantSolutions system for CMS approval. Instead, the final subaward and contract reporting information for all subrecipients and contractors should be uploaded as a grant note in the GrantSolutions system once selections have been made and the final budget breakdown for the "Contractual" line item has been determined. States should consult with their assigned GMS and PO for additional questions, such as CMS requirements for engaging consultants.

(Updated 9/23/2026)

12. How does CMS oversee use of funding by and payment of subawardees?

Similar to other CMS cooperative agreements, CMS will monitor the processes and policies that States have in place to ensure appropriate payments to subaward and procurement contract recipients. Note that State awardees are responsible for tracking and monitoring use of funding and payments to subrecipients, consultants and contractors, and for ensuring subrecipients, contractors, and partners comply with all applicable administrative and federal policy requirements. As a reminder, the terms and conditions of federal awards generally flow down to subawards to subrecipients, as specified in 2 CFR 200.101(b)(1), which includes but is not limited to required annual and quarterly reporting.

(Updated 9/23/2026)

13. What was the start date for Budget Period 1? When can a State begin incurring costs?

Budget Period 1 began on December 29, 2025, which was the date that each State received its NoA. If a State's NoA included restrictions that required a budget amendment to be removed, the recipient would be able to start incurring costs when the budget amendment was approved by CMS and the restriction was lifted.

(Updated 9/23/2026)

14. Are there scenarios where obligated funds may be used for a different purpose?

In some circumstances, it may be necessary to redirect previously obligated funds, such as when the terms of the obligation are not being met by the subrecipient, contractor, or vendor. In such circumstances, a State should contact their PO and GMS to determine if a budget modification would be necessary to not pay previously obligated funds and to direct them to a different use.

(Updated 9/23/2026)

15. Is there a specified format for how States should record expenses that occur during an overlap between spending periods?

States should establish internal controls within their financial systems to ensure they are tracking all expenses, including the purpose and source of expenses, as well as the corresponding Budget Period when the expense was incurred. CMS does not have a specified format for recording expenses that occur during an overlap between spending periods; however, the quarterly and annual reporting on obligated and spent funds may require States to report on spending by Budget Period, initiative, use of funds type, and recipient name.

(Updated 9/23/2026)

16. After a State draws down funds from the Payment Management System, must it pay subrecipients or contractors immediately?

As outlined in the HHS Grants Policy Statement at time of draw down through the Payment Management System (PMS), States will certify that they will not hold cash beyond three working days. This means that once a State draws down funds from the PMS, they must disburse the funds, including both up-front advance payments and reimbursements for approved uses, within 3 business days. Note that drawdowns must be limited to the State's immediate cash needs.

(Updated 9/23/2026)

17. May a subrecipient have an administrative cost rate that exceeds 10%?

Yes. A State may allow a subrecipient to have an administrative cost rate that exceeds 10% of the subrecipient's individual award. However, section 71401 of Public Law 119-21 requires that not more than 10% of the amount allotted to a State for a fiscal year may be used by the State for administrative expenses. The State must ensure that the cumulative administrative costs across the entire State award, including all costs incurred by both the State and any subrecipients, do not exceed 10% of the total funds awarded to the State.

(Updated 9/23/2026)

18. Are States allowed to adjust their budget for future funding years of the RHT Program?

As outlined in the NOFO (page 60), States are required to submit Non-Competing Continuation (NCC) applications on an annual basis to receive funding for each subsequent Budget Period. States may use the NCC to adjust their budget or make other programmatic and administrative changes. In extenuating circumstances, States may propose to use existing allocated funding for alternative activities not originally approved in a State's initial application; such changes must be reviewed and approved by CMS before they are made. (See NOFO, page 17.) In accordance with the award terms and conditions, States should notify their PO and GMS as soon as a change is anticipated due to extenuating circumstances.

(Updated 9/23/2026)

19. Are States allowed to adjust their initiative scoring details for future funding years of the RHT Program?

States may wish to edit initiative scoring details (e.g., adding or deleting metrics) for future years of the RHT Program. CMS understands implementation may evolve, but any changes to milestones, metrics, baselines, targets, or other scoring details must be reviewed and approved by CMS before they are final. Therefore, these changes should be carefully determined and fully justified, as any adjustments should remain aligned with the State's already-

approved application and budget. Additionally, States must ensure that any changes to metrics still align with the requirements that each initiative must have at least four quantifiable metrics, of which at least one must be at the county or community level (per the NOFO, page 36). States should notify their PO as soon as a change to initiative scoring details is anticipated.

(Updated 9/23/2026)

II. Provider Recruitment or Retention

5-Year Requirement

1. My State would like to use RHT Program funds to establish a one-year, non-accredited, non-categorical internship program. Would interns who participate in the program be subjected to the 5-year service commitment?

States may use RHT Program funds as part of an approved workforce initiative to establish one-year, non-accredited internship programs such as, for example, those designed to provide dental graduates with experience in specialized fields like Oral & Maxillofacial Surgery and bridge the gap between general dental education and residency programs. Participation in these one-year internship programs would not obligate the dental graduate to the 5-year service commitment if the programs are not accredited and cannot be counted toward completion of a formal credential, degree, or certificate program.

However, where States use RHT Program funds for stipends, housing assistance, or other incentives provided directly to the graduate participating in the non-accredited internship program, the individual receiving the incentive would be obligated to the 5-year service commitment even though the non-accredited, non-categorical internship program does not lead to a new credential or degree.

(Updated 4/9/2026)

2. Does the 5-year service commitment need to be continuous? For example, can a certified nursing assistant (CNA) take a break from his/her commitment to obtain education, then serve the remainder of the commitment in a different healthcare position?

The individual may take a break in service to obtain additional health care certification or due to extenuating circumstances, though States should ensure they discuss the implementation of such allowances with their PO. For deferrals due to additional clinical education, the State should put guardrails in place to ensure the individual's credential further serves RHT Program goals and that the 5-year service commitment is not deferred for an inappropriate length of time or purpose. For example, deferring a commitment for the length of additional health care training may be appropriate, but the individual should not defer their commitment beyond the length of the training. Similarly, while a break to obtain additional health care credentialing or other medical education might be appropriate, a break to embark upon a nonclinical course of study consistent with a switch to a nonclinical career could present a high risk that the balance of the minimum 5-year service commitment would not be completed. CMS may pursue recovery of funds from the State, consistent with applicable statutes and program requirements, if the commitment is inappropriately deferred.

(Updated 9/23/2026)

3. Can an individual benefit from more than one RHT Program workforce initiative (e.g., initial nursing certification and future upskilling)? If an individual benefits from two workforce initiatives, would this incur two separate 5-year service commitments (i.e.,

the individual would need to serve in a rural area for 10 years) or would the individual only need to serve for the single 5-year service commitment?

States may choose to allow one individual to benefit from more than one RHT Program workforce initiative. States should work closely with POs to determine (1) how to implement such initiatives in a way that most efficiently furthers program goals and (2) if participation in an additional workforce initiative may obligate the individual to an additional service commitment. Considerations for an additional 5-year service commitment may include:

- Whether participation in the additional initiative is likely to further support recruitment or retention of that individual working in rural areas without an additional 5-year service commitment; and

- Whether participation in the additional initiative could be viewed as supporting the other recruitment and retention initiative(s), such as housing during a residency, or the next step of a certification, such that it reasonably could have been defined (or other States defined it) as part of the same initiative, or if it is substantively different. If it is substantively different, individuals likely should be subject to two separate 5-year service commitments.

(Updated 9/23/2026)

4. What will CMS do if a service commitment is not met after the life of the program?

CMS expects States to establish appropriate safeguards and monitoring processes to ensure individuals fulfill the statutory 5-year service commitment. Following the period of performance, CMS may conduct audits or other oversight activities to assess compliance, including with the requirement to ensure a minimum 5-year service commitment from individuals receiving a workforce recruitment and retention incentive. States should have a plan in place to check compliance and verify contact information such as collecting an individual's tax identification number and National Provider Identifier (NPI) to match against available claims data to verify that the individual was claiming for clinical services in a rural area during the relevant time period. If instances of noncompliance are identified, CMS may pursue recovery of RHT Program funds from the State, consistent with applicable statutes and program requirements.

(Updated 9/23/2026)

5. If new residency training slots have a rural training component, but are not exclusively rural, is that allowed?

If the training or residency has a rural rotation or other component, but is not exclusively rural-focused, RHT Program funds can be used in support of the portion of training that has a rural component. There is not a specific requirement for the portion of the training that needs to be rural, but the RHT Program funds are to be used to support rural health transformation initiatives that align with the state's approved plan. For example, if a residency program is 4 years, with 1 year spent at a rural facility with a focus on the particular health needs of the local rural population and the other 3 years spent at an urban facility without such focus, then CMS generally would expect States to use a reasonable method to ensure the RHT Program funds are allocated to and do not exceed the reasonably determined or allocated costs of the 1 year of the rural-focused residency.

(Updated 9/23/2026)

6. For the purposes of the RHT Program, what are the distinctions between how the "clinical" and "nonclinical" healthcare workforce is defined? How

can States use RHT Program funds to support nonclinical healthcare 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 practice 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, but would otherwise be eligible for RHT Program funds, 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 (e.g., doulas, peer recovery coaches), 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 would not necessitate a 5-year service commitment.

(Updated 9/23/2026)

7. 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 Category E. This means that Category E does not apply and any allowable doula training or recruitment activities would need to fall under a different use of funds category (likely Category A). Therefore, the 5-year service commitment is not required.

(Updated 9/23/2026)

8. 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. However, if the State is paying for training "infrastructure" (e.g., curricula, clinical practice dummies, etc.) or providing training of limited scope and duration to existing paramedics to deliver community-based services that does not lead to a specific certification (e.g., training to existing paramedics on delivering preventive care in the home), the activity may be more appropriately aligned to Category A (Prevention and Chronic Disease) and the 5-year service commitment would not apply.

(Updated 9/23/2026)

9. 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. If the State believes that their goals are best served by including a rural service commitment for initiatives related to roles the Office of Rural Health Transformation considers nonclinical (funded under a permissible use other than Category E), they are free to include such requirements. Those commitments are allowed but not required by CMS. States should consider how these additional service commitments may present barriers to uptake.

(Updated 9/23/2026)

10. Can individuals subject to the 5-year service requirement satisfy the commitment through service provided to rural community members when the provider is not physically located in a rural location?

RHT Program funds should be used to benefit the populations that the State has identified as rural in its application. As stated in the March 2026 5 Year Service Commitment Fact Sheet individuals subject to the rural service requirement must be physically located in rural areas and cannot satisfy the commitment through provision of telehealth, remote monitoring, or other services from non-rural site locations.

(Updated 9/23/2026)

11. Does the 5-year clock begin the date the provider begins practicing, or the date the funding/incentive was officially awarded? In cases where there is a gap between award approval and the start of service, how does CMS define the official start date for tracking the service obligation?

Generally, the 5-year service commitment would begin once a provider has received the incentive and begins serving in rural areas. For example, if a State paid for dental assistant certification/licensure, the 5-year service commitment would begin once the assistant starts serving rural communities. This may occur prior to receipt of the licensure or certification, such as in the case of residency.

(Updated 9/23/2026)

12. If a provider completes 4 out of 5 years, would CMS potentially seek to recover 100% of the funds awarded to the provider, or would the recovery be prorated based on time served? Do States have flexibility in establishing policies related to service obligation enforcement, particularly related to prorating penalties or addressing partial fulfillment of the 5-year service commitment?

In the event a provider does not complete the 5-year service commitment due to extenuating circumstances, CMS may seek to recoup funds from the State prorated based on the amount of time served. If a provider does not complete the 5-year service commitment and there are no extenuating circumstances, CMS may seek to recoup 100% of the funds awarded to the provider. States have flexibility in how they structure their 5-year service agreements but should work closely with their PO to ensure the program structure aligns with program goals and requirements.

(Updated 9/23/2026)

13. Does someone need to work full time to satisfy the service commitment? What are the definitions of full-time for the purposes of the 5-year service commitment?

To satisfy the 5-year service commitment, the provider should be working full-time. Because there are several types of providers benefitting from recruitment and retention initiatives, the definition of "full-time" should be determined by the State in collaboration with their PO. Considerations when determining what is considered full time should include:

- State law/regulations
- Norms for the relevant type of clinical workforce within the relevant rural area
- Other considerations of the particular needs of the State's rural areas that inform a reasonable definition of "full-time"

(Updated 9/23/2026)

14. Is the home address of providers relevant to the 5-year rural service commitment?

CMS has no requirement regarding the residential location of providers. The statute only requires serving rural communities for 5 years.

(Updated 9/23/2026)

15. For individuals bound by a 5-year service commitment, what specific documentation is required to verify their rural practice (e.g., NPIs, NPI location data, Tax ID numbers, employer attestations, patient encounter logs)?

States should develop an internal process which will allow them to track individuals' service in rural areas and take corrective actions if an individual does not meet their 5-year service commitment, including beyond the life of the program. At a minimum, States should ensure they have a clearly defined method to track an individual's service in rural areas beyond the individual simply attesting to service in rural areas. Depending on the specific situation and provider type, this tracking process may include Tax Identification Numbers, NPIs, NPI location data, and place of service that can be matched with available claims data to verify that the provider was claiming for clinical services in a rural area during the relevant time period. Beyond that, States have flexibility in determining the best method for tracking rural service commitment compliance but should work with their POs to develop a robust tracking and verification system for rural service that aligns with program goals.

(Updated 9/23/2026)

16. What are some considerations or best practices States should keep in mind when developing 5-year service commitment agreements?

Service agreements 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 POs 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

(Updated 9/23/2026)

17. How should States classify funded activities that support workforce transformation goals, but align with other Permissible Uses of Funds categories?

States should determine whether a given activity's primary alignment is to Category E, consistent with CMS-issued guidance, and subject to the 5-year service commitment when the primary beneficiary is the individual recipient, or if the activity is primarily

aligned to another use of funds category. For example, consider the following activities that primarily align to permissible use of funds categories other than Category E:

• Initiatives focused on nonclinical workforce would typically be categorized under Category A (Prevention and Chronic Disease) or Category H (Behavioral Health). For example, funding for individual enrollment in nonclinical doula training, would more appropriately be categorized 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. Similarly, training for peer recovery specialists in rural areas would be more appropriately categorized under Category H (Behavioral Health) because this nonclinical workforce training is supporting access to opioid use disorder (OUD) or substance use disorder (SUD) services.

• Initiatives funding minor building alterations or renovations (e.g., minor alterations of a hospital space to make on-site childcare available to hospital employees, renovations to repurpose a hotel for medical resident housing, etc.) should be classified as Category J (Capital Expenditures and Infrastructure).

In scenarios where the primary alignment to a use of funds category is unclear, States should work with their POs to identify the most appropriate permissible use of funds category based on the unique features of the initiative and the goals of the State's RHT Program.

(Updated 9/23/2026)

Non-Compete Restrictions

18. Can CMS clarify the restrictions on paying for clinician salaries, particularly as it relates to non-compete contractual limitations?

As stated in the discussion of unallowable costs included in the NOFO, RHT Program funds may not be used for clinician salaries or wage support for facilities that subject clinicians to non-compete contractual limitations. Funds may go towards clinician salaries and wage support if the clinician is not subject to a non-compete agreement and the salary/wage support is being funded as part of an approved initiative.

(Updated 4/9/2026)

III. State Policy Actions

1. If a State did not commit to a State policy change in their application, but later enacts that policy change, can the State receive credit for that State Policy Action (SPA) factor?

No. To receive score credit, a State must have committed to enacting one of the specific policies from the NOFO's list of SPA factors in their application.

(Updated 4/9/2026)

2. How does the recovery of funds for unfulfilled SPA commitments work?

As outlined in the NOFO (page 32), States receive technical score credit for commitments to SPAs. If a State does not finalize legislative or regulatory actions by the end of the calendar year 2027 (or end of calendar year 2028 for technical score factors B.2 and B.4), CMS will recover payments made to the State based on the technical score credit associated with these commitments. In these scenarios, the points for that score factor will revert to the original baseline score, and CMS will initiate the funding recovery process for the incremental funds that were distributed based on the commitment. Also, note that if a State formally abandons a commitment early, for example, deciding after Budget Period 1 that it will no longer pursue a specific action, the points for that score factor will revert to the baseline immediately for

the upcoming Budget Periods, and CMS will initiate recovery for any incremental funds that were already paid out for previously scored Budget Periods based on the commitment.

For commitments that remain active, there are two distinct timelines for the final deadlines, depending on the specific score factor. For most SPA score factors, the deadline is the end of Calendar Year 2027. If the policy commitment is not fully implemented by the end of Calendar Year 2027, funding recovery begins in Budget Period 4. CMS will recover the incremental funds that were paid out to the State during Budget Periods 1, 2, and 3 for each unmet SPA commitment. The State's scores will also drop back to the original Baseline for Budget Periods 4 and 5. Note that SPA Factors B.2. and B.4. have a different deadline, which is the end of Calendar Year 2028. For these two score factors, if the commitment is not fully implemented by the end of Calendar Year 2028, recovery begins in Budget Period 5. CMS will recover the incremental funds paid out during Budget Periods 1 through 4, and the State's score will drop back to the original Baseline for that final Budget Period 5. To understand the specific amount of funding tied to each SPA, States should reach out to their POs.

(Updated 9/23/2026)

3. Are States allowed to abandon one but not all elements of a SPA?

Yes. SPAs are a part of the technical score used to calculate workload funding. States had the option to commit to SPAs in their applications. As outlined in the NOFO, when a State commits to making changes to State policies, they receive conditional, partial points for that factor starting in the first Budget Period (except for factors B. 2 and B. 4) (NOFO, page 48). A State may commit to multiple elements of a SPA, such as pursuing licensure compacts (D.2) for physicians, nurses, psychologists, and physician assistants. A State's technical score is influenced by the number of SPA commitments and the number of elements within these SPA commitments. As such, in scenarios where a State subsequently abandons one of these elements, CMS will recover points related to that element and previously awarded incremental funds (NOFO, page 48).

(Updated 9/23/2026)

IV. State Reporting and Oversight

General

1. Does CMS need to review States' Requests for Proposals (RFPs) and contracts?

CMS does not review State RFP/award opportunities. Once subrecipients or contractors have been selected, States must submit subaward and contractual reporting information for each agreement. Requirements for reporting contractor/subrecipient information are listed in Section F on the CMS Guidance for Preparing a Budget Request and Narrative webpage.

(Updated 9/23/2026)

2. What State-developed publications, public relations (PR) pieces, and external presentation decks and similar materials will need CMS review and approval?

States must submit any materials identifying CMS as the funder to the Program Office for review and approval, in accordance with the Stevens amendment award terms and conditions. States should email their PO and backup PO with the materials to review, and the PO will respond within two business days. States can reach out to their PO for further clarification and questions relating to specific publications.

(Updated 4/9/2026)

3. What CMS approvals and oversight are required for subrecipients issuing RFPs or public communications?

CMS does not require a review of RFPs. However, any planned external public communications should be submitted to the State's CMS Office of Rural Health Transformation PO for review and approval.

(Updated 4/9/2026)

Reporting

4. How should States report on the overall progress of an initiative when its key activities are at different stages of completion?

Progress of an initiative is assessed using the Checkpoint Model, based on completion of checkpoints with supporting evidence. These checkpoints include elements such as milestone completion, metric reporting, and post-program planning. When activities within an initiative are at different stages of completion, States should report overall progress at the initiative level rather than by individual activity. Activity completion status is captured through the checkpoints, including those for project planning, milestone completion, metric reporting, and post-program planning.

(Updated 4/9/2026)

5. Are initiative progress and checkpoint completion limited by certain years?

Checkpoint progression is not limited by year. States may complete multiple checkpoints and stages for an initiative in a single Budget Period and are encouraged to advance through the checkpoints as their implementation allows. Checkpoints in later stages for an initiative will not be scored until all checkpoints in the current stage are complete. However, checkpoints may be completed in any order. For more information on checkpoints and stages, please see CMS's webinar.

(Updated 4/9/2026)

6. Will there be a chance to edit initiative scoring details (e.g., milestone timelines, metrics, etc.)? What would the timeline be for submitted initiative updates and getting CMS approval?

There are natural points in the checkpoint model to consolidate updates and provide documentation (e.g., 0.2 Submit Project Plan and 2.4 submit Updated Project Plan), but States are not restricted to modifying metrics or milestones only at checkpoint submissions.

States should notify their PO as soon as a change is anticipated. CMS expects implementation to evolve, but any changes to milestones, metrics, baselines, targets, or other scoring details must be reviewed and approved by CMS before they are final. We can work collaboratively in regular check-ins and determine when it makes sense to submit the updates for official approval via GrantSolutions (i.e., with the quarterly/annual report, or off cycle).

(Updated 4/9/2026)

7. To reach the full score potential, what is the expectation for checkpoint progression? Should States be progressing through as many checkpoints as possible? How is progression handled for checkpoints associated with certain dates?

States will receive the full score potential for an initiative-based score factor when all initiatives associated with the score factor have completed every checkpoint. States can progress through the initiative checkpoints as quickly as their implementation allows, but checkpoints in later stages will not be scored until every checkpoint in the current stage is complete. Some checkpoints are based on completing milestones

scheduled to be finished by a certain date. States can complete these checkpoints ahead of schedule. For example, checkpoint 3.2 is to complete all milestones in the State application scheduled to be finished by Q2 2028. If these Q2 2028 milestones for the initiative are all completed ahead of schedule, the State should indicate that the checkpoint is complete when the last milestone is achieved.

(Updated 4/9/2026)

8. In addition to the programmatic quarterly and annual reports, is separate financial reporting required in the Payment Management System (PMS) or GrantSolutions?

Yes. States will be required to submit annual NCC applications to receive funding for each subsequent Budget Period. Per the NOFO, States may use the NCC to adjust budget or make other administrative changes. States may revise project goals based on any reductions in funding.

(Updated 4/9/2026)

9. How does the Checkpoint Model apply to scoring Tribal initiatives that operate independently from but share overlapping factors with State based initiatives?

Tribal partnerships are an important part of many States' RHT efforts, and Tribal initiatives can play a meaningful role in advancing shared goals for improving rural health outcomes.

Under the statute and NOFO (p. 7), federally recognized Tribes are not eligible to receive RHT awards directly. The State serves as the award recipient and is responsible for overall program administration. Within this structure, Tribal partners may participate in RHT initiatives as subawardees, contributing to the State's broader transformation efforts.

Tribal subaward initiatives should be aligned with and support the initiatives included in the State's approved RHT Plan. State-defined initiatives are assessed under the Checkpoint Model, and Tribal activities contribute to the State's overall progress on those initiatives. While Tribal partners may track additional metrics to reflect their own priorities, any activities that are part of an RHT Program-supported State initiative should also be captured in a way that contributes to the State's defined metrics and milestones. To ensure accurate scoring and avoid recovery of funds, no subrecipients, including Tribes, may opt out of reporting and checkpoint requirements.

States and Tribal partners should work collaboratively to support implementation and ensure that progress can be reflected in required reporting. States are responsible for submitting data tied to the metrics and milestones defined in the approved application, including information that reflects the contributions of Tribal partners. In doing so, States should continue to engage with Tribes in a manner that respects Tribal data considerations and promotes transparency around how information will be used.

Metrics are intended to show how RHT Program funding is improving rural health and advancing shared goals across communities. CMS uses this information to understand overall program impact—not to single out, monitor, or penalize individual Tribes, providers, or other entities.

States are encouraged to maintain open communication and strong partnerships with Tribal entities and to work with their CMS POs as needed to support implementation in a way that is both respectful and compliant with program requirements. CMS is here to support States and Tribes as they work together on RHT efforts.

(Updated 9/23/2026)

10. Within the RHT Program Annual Report, what should States include for the "Number of People Served" field?

States should report an exact count of the number of individuals who have benefited from RHT Program funds during the reporting period, or use their best estimate if an exact count is not available. Note that the terms “benefited” and “served” are being used synonymously for the purposes of the Number of People Served field. Estimates should be reasonable, supported by available data, and reflect the scope and reach of the initiative. The Number of People Served should include individuals who have benefited from the initiative during the reporting period and not include future projections.

(Updated 9/23/2026)

11. For system-based initiatives that do not provide direct services (e.g., information technology (IT) systems), how should States calculate the ‘number of people served,’ and is there a requirement for this to be deduplicated count?

For initiatives that do not provide direct services, such as IT systems and Health Information Exchanges (HIEs), the existing guidance expressly allows broader population-based estimates. For example, the number may reflect the total population served by a health system, the number of patients with data in an HIE, or the total number of State residents for an appropriate statewide system. For these system-based estimates, de-duplication is not required and the estimate does not need to be limited to rural populations if the initiative has broader reach.

(Updated 9/23/2026)

12. How should States document and report on metrics that span multiple years?

As outlined in the NOFO (page 36-37), States are required to track at least four quantifiable metrics for each initiative. States should provide baseline data where possible and specify milestones or targets for each of these metrics. States will be required to report annually on initiative progress, including current values of metrics, so States should structure their metrics in a way that enables reporting and demonstration of impact on rural health over time. CMS understands that it may take time to measure changes in long-term outcomes.

(Updated 9/23/2026)

13. Should States design their implementation plan in a way that links milestones and metrics together?

Metrics refer to measurable numeric outcomes a State plans to track to evaluate success for each initiative. Milestones refer to targets or goals the State plans to meet as it progresses in its initiatives (see NOFO pages 34-37 for additional information). States have flexibility to decide whether and how to link their milestones and metrics together, depending on their unique approach and transformation plan. However, there are key requirements States must meet related to initiative-level milestones and metric-level milestones. As outlined in the NOFO (page 34-35), States are required to provide a timeline of proposed activities for each initiative, which align with key stages – from planning (Stage 0) to full implementation (Stage 5). By Stage 5, the initiative is fully implemented, the goals have been achieved, and the initiative is producing measurable outcomes that can be reported. States must include milestones and dates for each initiative, which are tied to each stage of the initiative. Separately, States are required to track and report annually on quantifiable metrics for each initiative. Where possible, States should also

denote milestones or targets specific to each metric (NOFO, page 37).

(Updated 9/23/2026)

14. Does CMS need to approve any additions or deletions to the metrics?

Yes, any additions or deletions must ultimately be approved by CMS. Therefore, these changes should be carefully determined and fully justified, as any adjustments should remain aligned with the State's already-approved application and budget.

(*Updated 9/23/2026)*

15. How should States establish their metric timelines?

A State has the flexibility to establish metric timelines that are appropriate for the State's approach. Note, however, that States should specify milestones or targets for these metrics, if possible (NOFO, Page 37). Additionally, States will be required to report on performance metric progress during annual reporting (NOFO, Page 37). States may consider aligning metric timelines to provide the most updated metric progress data for inclusion into annual reports.

(Updated 9/23/2026)

16. In scenarios where metrics were identified as unclear by CMS, do States need to update the project narrative as well as information submitted in the Initiative Information Reports (IIR)?

For any metrics identified as unclear by CMS, States should provide clarification in the IIR. States do not need to update the existing project narrative.

(Updated 9/23/2026)

17. How should States report baseline values, if they were not previously included in the State's application?

As part of the application process, States were required to include program key performance objectives. Where possible, this would include specific and measurable objectives with both baseline data and targets (NOFO, Page 31). Upon review of the metrics in State applications, CMS requested additional clarification from States if baseline data were unavailable or unclear. States can provide clarification on baseline values through the IIR using the 'First Reported Value to be Used as Baseline' and the 'State comments' columns and/or through the Annual or Quarterly reports.

(Updated 9/23/2026)

Stevens Amendment

18. When does CMS need to review communications materials?

In accordance with the Stevens Amendment (Consolidated Appropriations Act, 2026, P.L. 119-75, Division B, Title V, Sec. 505.) and as required by the award terms and conditions (see Standard Term and Condition 13), CMS reviews written or scripted public-facing material. Internal communications, verbal communications, and responses to media inquiries do not require CMS review. Two business days are required for CMS review.

(Updated 9/23/2026)

19. Does the Stevens Amendment apply to radio ads and social media posts?

Yes. While radio ads and social media posts are not explicitly named in the Stevens Amendment, the requirement applies broadly to "statements" and "other documents" describing federally funded programs. This has been interpreted to include radio ads, podcasts, websites, and social media.

(Updated 9/23/2026)

20. Do radio ads and social media posts need to include the full Stevens amendment disclosure (including percentages and dollar amounts)?

The full disclosure (percentage and dollar amounts of federal and non-federal funding) is the standard requirement. However, for time- and character-limited formats like radio and Twitter/X, a condensed funding statement may be used if paired with a clear reference to federal funding and a website where the full disclosure is available.

Examples include:

- "Funded by the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services. Learn more at [website]."
- "This program is supported by CMS. For full funding details, visit [website]."

(Updated 9/23/2026)

21. Where should the full Stevens amendment disclosure be located for reference in time- and character-limited formats?

The full disclosure should be posted on a public-facing webpage (e.g., program website, landing page) that is:

- Clearly accessible
- Directly linked from the ad or post (when feasible) or the website must be spelled out.

(Updated 9/23/2026)

22. Does the disclosure language need to be verbatim from the NoA?

No. The language does not need to be verbatim, but it must include all required elements (i.e., the funding source and the percentage and dollar amount of the program supported with federal funds).

(Updated 9/23/2026)

V. Subawardee/Contractor Engagement and Management

1. Can States communicate with subrecipients identified in their applications while CMS is reviewing budget amendments and prior to CMS' approval of the amended budget?

Recipients may communicate with identified subrecipients before budget approval but may not execute any agreements, obligate funds, authorize project activities to begin, or conduct other similar activities until the relevant budget categories are approved and unrestricted.

(Updated 4/9/2026)

VI. Other

1. Are State Authorized Organizational Representatives (AORs) that are considered key personnel required to attend the Rural Health Program Summit in March?

Whether the AOR is considered key personnel required to attend the Rural Health Transformation Summit will depend on their unique role. Attendees should include anyone instrumental in the daily operations of RHT Program in their State. States may reach out to their PO for further clarification regarding Summit attendance expectations specific to their State.

(Updated 4/9/2026)

2. Can RHT Program funds be used in a community that the State considers to be rural but is not identified as rural under the Health Resources and Services Administration (HRSA) definition?

RHT Program funds should be used to benefit the populations that the State has identified as rural in its application, which may differ from HRSA definitions.

(Updated 4/9/2026)

3. Are States limited in terms of supporting regional or county collaboration?

If funds are being used to benefit rural residents of the State, States may support collaboration between rural and non-rural counties. For example, a hospital or specialist that is located in a non-rural area may provide telehealth support to rural areas. States may reach out to their PO for further clarification on allowable collaborative arrangements within the scope of the State's Rural Health Transformation plan.

(Updated 4/9/2026)

4. Does CMS need to review and approve State issued press releases and State responses to press inquiries?

Press releases drafted by the State (written and scheduled in advance) should be submitted for review and approval by the CMS Program Office. Further information can be found in the program terms and conditions. For press inquiries that come into the States for their reply, the Program Office does **not** need to review.

(Updated 4/9/2026)

5. What happens with RHT Program operations if there is a federal government shutdown?

The CMS Office of Rural Health Transformation will continue operations in the case of a federal government shutdown because funding for this Office has been previously appropriated under Public Law 119-21, Section 71401.

(Updated 4/9/2026)

6. Are States required to submit contracts through GrantSolutions for review?

States are not required to upload signed contracts to GrantSolutions, and an AOR letter is not required for each contract, but States should include a detailed budget breakdown for each contract as a grant message to confirm the details for CMS recordkeeping. For multiple contracts executed simultaneously, budget information may be submitted in one document. CMS approval is not needed to execute the contract provided any restriction on contractual funds has been lifted previously.

(Updated 4/9/2026)

7. Are subrecipients required to spend received funds within three days of receipt?

Department of Treasury regulations stipulate that federal funds should be drawn only to meet immediate needs and must not be held for more than three working days. This rule applies for both recipients and subrecipients.

(Updated 4/9/2026)

8. Can States get an extension on the amount of time they have to obligate or spend funds?

No. To have funds available for expenditure, they must be obligated by the State during the Budget Period in which they were awarded. In accordance with the authorizing statute, all funds unexpended by the end of the fiscal year following the fiscal year in which they were awarded must be redistributed.

(Updated 4/9/2026)

9. How should States change their AOR in GrantSolutions?

States can submit a Revision NoA other in GrantSolutions. They should include a cover letter from the current AOR requesting the change to the new AOR. States must also include a resume or CV for the new AOR.

(Updated 4/9/2026)

10. To avoid the duplication of costs between Budget Periods, which specific categories of expenditures must be fully expended within the Budget Period they were incurred?

To avoid duplication of costs across Budget Periods, personnel-related costs, such as salary and fringe, must be expended within the Budget Period in which the expense is incurred.

(Updated 4/9/2026)

11. May a State make changes to the initiatives during implementation or to add/delete initiatives?

Since CMS evaluated all proposals and awarded all funds based on the initiatives described within State applications, except as discussed below, States are not permitted to make changes to their approved initiatives or add/delete initiatives. CMS awarded funding specifically and exclusively for the activities outlined in each State's approved application. CMS will recover funding that is used in a manner inconsistent with the activities described in a State's approved application.

Changes to approved initiatives will not be considered unless an awardee presents robust, quantitative data to CMS that clearly and convincingly demonstrates a lack of efficacy of a specific initiative that was included in the application. Such requests will only be evaluated in later years of the program, after sufficient data have been collected, and will be reviewed strictly on a case-by-case basis at CMS's sole discretion. No changes to initiatives may be implemented prior to receiving explicit written approval from CMS. Awardees must coordinate with their assigned POs immediately if concerns arise regarding initiative performance or the State's ability to continue an initiative. Awardees may not unilaterally modify, suspend, or cancel an initiative, or redirect funding approved for an initiative or activities within a particular initiative without prior CMS approval.

(Updated 4/9/2026)

12. Would provider payment for services delivered though a clinical consultation line be considered a reimbursable service and therefore not an allowable use of RHT Program award funds?

Provider payments under Category B are intended for the provision of items and services not currently paid by insurance or other health coverage programs and cannot be used to enhance payment rates for currently billable items. If the service is not currently paid for by insurance or other health coverage programs, then it may be allowable, but it must be related to the State's RHT Plan and be consistent with sustainability beyond the life of the program. As stated on page 19 of the NOFO, States must "justify why [services] 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 [services] transform the current care delivery model."

States with approved project plans that include Category B uses of funds may work with their assigned CMS PO to address the unique details of their program, including allowable provider payments. Additionally, States may only use up to 15% of their total awarded funds in a given Budget Period for allowable Category B uses.

Please see the Provider Payments Fact Sheet for more information on Category B funding for provider payments.

(Updated 9/23/2026)

13. Multi-state training models have been raised as a potential area to utilize RHT Program funding. What

should States keep in mind when partnering on the planning and execution of training program activities and initiatives?

A State may decide to coordinate with other States on planning and execution of approved activities and initiatives, including the development of training programs. States should bear in mind that the RHT Program is a State-based, State-specific program, and while collaboration is allowable, each State is required to spend award funding consistent with the approved uses of funds for their State and the terms and conditions of the award. To ensure accurate reporting and scoring, any expenses shared between collaborating States should use a clear cost allocation formula.

Further, States should note that certain workforce recruitment and retention initiatives/programs require a 5-year rural clinical service commitment. Individuals subject to the 5-year rural clinical service commitment are required to practice in a rural area within the same State that provided the recruitment or retention incentive to satisfy the 5-year rural clinical service commitment. Practice within a rural area of a collaborating State would not satisfy the 5-year commitment.

(Updated 9/23/2026)

14. How can the Quality Innovation Network–Quality Improvement Organization (QIN-QIO) help my organization if we are involved in the RHT Program?

States participating in the RHT Program are encouraged to collaborate with their regional QIN-QIO to support quality improvement, care coordination, patient safety, and other transformation activities. Any such collaboration must be structured to avoid duplication of federal funding. States are responsible for ensuring that costs charged to the RHT Program award are necessary, reasonable, allocable, and distinct from services available through the QIN-QIO program, consistent with applicable federal award requirements and cost principles.

Updated (9/23/2026)

15. Are all federally qualified health centers (FQHCs) eligible for funding, or only those serving rural populations?

All RHT Program funding must align with the requirements as specified in the NOFO's permissible use of funds section (NOFO page 11-12), in statute (Section 71401 of Public Law 119-21), and as specified in State's approved cooperative agreement. Funding FQHCs located in non-rural areas may still be supported if the services they provide clearly benefit rural residents, for example, through telehealth, mobile health, other outreach to rural communities. States should ensure that any FQHC-related expenditures are clearly tied to rural health transformation goals as outlined in their approved application and their NoA and should work closely with their PO to ensure that they are effectively supporting rural populations.

Updated (9/23/2026)