Rural Health Transformation Program (RHTP)

Department of Public Health and Human Services, Office of Public Instruction

December 17, 2025

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Agenda

- Rural Health Transformation Program (RHTP) Overview
- School-Based Health Care Initiatives
- Rural Health Care Student Recruitment Efforts

RHTP Overview

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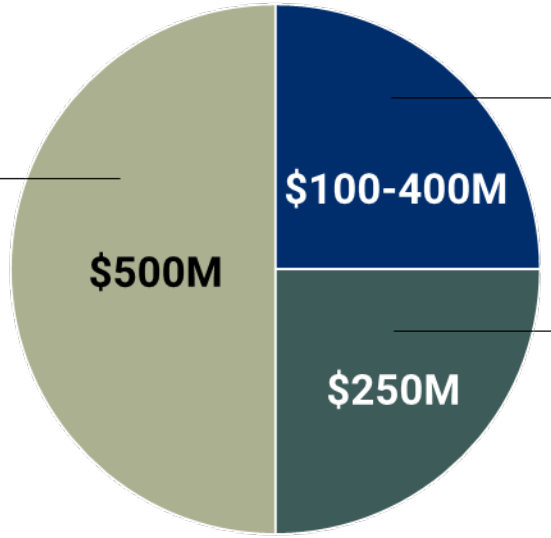
Background: Summary of Funding Opportunity

- **RHTP will provide a $50B total opportunity across states, with each state receiving funding based on a set of criteria.**

Potential Montana funding over the 5-year RHTP period (~$1B)



Baseline: Equally distributed among approved States

Application: Distributed based on application content (e.g., proposed initiatives, policy actions) and quality of application

Data: Distributed based on a pre-determined set of demographic data

RHTP Timeline

Sep.-Nov. 2025

Stakeholder consultation & application development

Nov. 5, 2025

Submission to CMS

Dec. 31, 2025

Expected award date

Jan. 2026

Implementation begins

Oct.-Nov. 2026

First review by CMS, with potential to re-allocate funds (up or down) based on progress

Implementation continues through FY31, with annual reviews / potential funding reallocations by CMS

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Stakeholder Consultation

The State consulted widely with stakeholders during application development.

During proposal development, the State:

- Conducted 1-1 consultations with Montana Hospitals, tribes, and >20 other rural health stakeholders
- Hosted a webinar with nearly 900 registrants
- Reviewed more than 300 RFI responses

During implementation, the State will:

- Continue to engage closely with stakeholders on specific initiatives
- Participate actively in a twice-annual stakeholder consultation hosted by the Montana Office of Rural Health

Montana's RHTP application includes five integrated initiatives

Montana submitted its application to the Centers for Medicare & Medicaid Services (CMS) on Nov. 5 with five integrated initiatives that align with the State's priorities

- Develop **workforce** through recruitment, training, and retention
- Ensure **rural facility sustainability** and access through partnerships and restructuring
- Launch **innovative care** delivery and payment models
- Invest in **community health and preventive** infrastructure
- Deploy modern health care **technologies** to guide rural health interventions

School-Based Health Care Initiatives

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Overview of RHTP school-based care initiatives

RHTP school-based initiatives	Implementation modality	Proposed impact metrics & targets by FY31

Site buildouts to expand school-based healthcare, including for primary and dental health care	**Partner sub-recipient** to conduct provider capacity assessments and manage buildouts in ~200 school-based care sites, using a phased approach	• **Percentage of children receiving well child visits** (baseline: 36.8%, target to consider national median of 56.6%)
		• **Improved youth mental health and risk behavior** (baseline 43% reporting risk behaviors, target: 10% decrease)
		• Improve **risk factor controls** such as:
		  ○ **Glycemic status** (baseline: 37.8% low to moderate risk, target: 10% increase)
		  ○ **BMI** (internal data not currently gathered)
		  ○ **High blood pressure** (baseline: 36.75%, target: 2% increase)

Grants for community-based healthy lifestyle initiatives, including school nutrition initiatives	**One-time DPHHS grants** for proposed high-impact community health initiatives (including but not limited to school-based initiatives)	

Up to ~$44M in funding could be deployed for school-based programs over 5 years

RHTP school-based initiatives	Proposed RHTP annual budget submitted to CMS, $M						
	FY26	FY27	FY28	FY29	FY30	Total	Notes
Site buildouts to expand school-based health care, including for primary and dental health care	$3.5	$7.6	$3.9	$8.6	$2.5	$26.1	Administered by partner subrecipient in a phased roll out approach
Grants for community-based healthy lifestyle initiatives, including school nutrition initiatives	$0	$0	$4.4	$4.4	$8.9	$17.7	Subset of grant funding planned to go towards school-based initiative

Total: up to $43.8M

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Rural Health Care Student Recruitment Efforts

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Student Recruitment Sub-Initiatives

Proposed health care student recruitment initiatives	Description	Proposed impact metrics & targets
Registered pre-apprenticeship programs	Pilot to connect high school students with local health care employers, directly leading to a **registered apprenticeship pathway** in a health occupation	**5% annual increases** in ratios of health professionals per 100,000 in rural communities, for all rural counties: • NPs (baseline : 76.7) • Physicians (baseline: 89.2) • RNs (baseline: 860.9) • Dental hygienists (baseline: 90.7) • EMTs (baseline: 115.0) • Pas (baseline: 70.6)
Expanded health care Career and Technical Student Associations	Reach over **1,500 rural students** for programs including MedStart, REACH, and Heads Up, through associations such as Health Occupations Students of America (HOSA) and Area Health Education Centers (AHEC)	
Employer-validated micro-credential pathways	Provide **stackable credentials** to accelerate time to employment, potentially granting **college credit** for long-term career pathways	
Support of rollout costs for credential attainment	Accelerate **industry-recognized health care credentialing** for high school students	
Expansion of state's online career exploration platform	Expand health care content, including to grow **middle school career awareness,** programs statewide	

Implemented in strong partnership with the Montana Department of Labor and Industry (as a subrecipient of RHTP funding)

~$17M over 5 years is budgeted for early exposure workforce programs

Proposed RHTP annual budget submitted to CMS for early exposure workforce programs, ($Thousands)

Budget categories	FY26	FY27	FY28	FY29	FY30	Total
Personnel & Fringe	$ 720	$ 1,260	$ 1,350	$ 1,330	$ 1,250	**$ 5,910**
Travel	$ 120	$ 200	$ 220	$ 220	$ 200	**$ 960**
Supplies	$ 200	$ 350	$ 370	$ 370	$ 350	**$ 1,630**
Contractual	$ 180	$ 310	$ 340	$ 330	$ 310	**$ 1,470**
Curriculum and related	$ 130	$ 230	$ 250	$ 240	$ 230	**$ 1,070**
Employer engagement	$ 40	$ 60	$ 70	$ 60	$ 60	**$ 290**
Participant Support	$ 480	$ 830	$ 900	$ 890	$ 830	**$ 3,930**
Startup costs and support	$ 60	$ 100	$ 110	$ 110	$ 100	**$ 470**
Tech costs	$ 50	$ 90	$ 90	$ 90	$ 90	**$ 410**
Training	$ 50	$ 90	$ 100	$ 90	$ 90	**$ 420**
Other	$ 20	$ 40	$ 40	$ 40	$ 40	**$ 170**
Total	**$ 2,040**	**$ 3,560**	**$ 3,830**	**$ 3,770**	**$ 3,530**	$ **16,730**

Conclusion

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Appendix

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Initiative 1: Develop workforce through recruitment, training, and retention

Estimated 5-year budget: $118M; allocated to DLI (100%)

To attract more health care providers to rural and frontier areas in Montana, DPHHS plans to invest RHTP funds in:

- **Recruiting health care providers** by increasing access to local pipelines and apprenticeships, and reimbursing related instruction costs
- **Increasing ability to train health care providers in rural and frontier areas** by creating more physician residency slots, rural training tracks, and incentivizing and training supervisors
- **Encouraging providers to stay in rural Montana and have ongoing training** for the skills they need to treat the rural population (e.g., primary care/behavioral health integration)

Initiative 2: Ensure rural facility financial sustainability and access through partnerships and restructuring

Estimated 5-year budget[1]: $474M; funds will be distributed across rural providers and hospitals (93%), rural community-based providers and care sites (4%), and rural health technology and connectivity (3%)

To support rural hospitals that face economic challenges due to low utilization, DPHHS plans to use RHTP funds for the following:

- **Advising on profitability** to assist rural hospitals in improving operations and profitability by providing technical assistance and financial incentives to adjust services and staffing based on community needs
- **Connecting to specialists and fostering provider partnerships** by enhancing partnerships and telehealth services that will link rural hospitals with specialists statewide, including virtual care for stroke and mental health, along with improved transportation coordination
- **Building partnerships** by fostering collaboration among rural facilities that will enhance their negotiating power to reduce costs for administrative services, medical supplies, and medications

1. Total budget includes both direct DPHHS and contractor/subrecipient managed spend

Initiative 3: Launch innovative care delivery and payment models

Estimated 5-year budget[1]: $120M; funds will be distributed across rural providers and hospitals (65%), and rural community-based providers and care sites (35%)

Montana residents frequently face challenges accessing health care services beyond hospital settings. To enhance the delivery of care in rural areas, DPHHS plans to use RHTP funds for:

- **Incentivizing value-based care,** transitioning more rural health care providers to value-based care models, which focus on reimbursing for the quality of services rendered
- **Authorizing "Treat in Place,"** empowering EMS to deliver on-site care when feasible to reduce emergency room admissions, along with upgrading ambulances and EMS equipment
- **Expanding rural pharmacy services,** permitting and equipping pharmacists to prescribe medications and offer basic primary care, as well as manage chronic diseases

1. Total budget includes both direct DPHHS and contractor/subrecipient managed spend

Initiative 4: Invest in community health and preventative infrastructure

Estimated 5-year budget[1]: $150M; funds will be distributed across rural providers and hospitals (22%), rural community-based providers and care sites (67%), and rural communities and local partners (11%)

Rural Montanans frequently lack access to preventative health care and infrastructure to promote healthy lifestyles, which leads to a high level of chronic disease. To address this, DPHHS plans to invest RHTP funds in:

- **Increasing care in community-based settings** by facilitating more primary care and behavioral health in schools through partnerships with FQHCs and other providers and purchasing/retrofitting mobile care vans to bring services to rural communities
- **Repairing outdated rural health care infrastructure** by funding minor renovations and repairs for facilities, and ensuring future Community Behavioral Health Clinics (CCBHCs) can provide crisis "safe spaces"
- **Investing in community spaces that promote healthy lifestyles** by providing one-time funding for community gardens and similar projects to improve rural population health and nutrition

1. Total budget includes both direct DPHHS and contractor/subrecipient managed spend

Initiative 5: Upgrade health care technology to coordinate and improve care

Estimated 5-year budget: $108M; funds will be distributed across rural providers and hospitals (60%), and rural health technology and connectivity (40%)

Rural communities in Montana often face limited access to care, fragmented clinical infrastructure, and gaps in data integration that hinder timely, informed decision-making. To address this, DPHHS plans to invest RHTP funds in:

- **Enhancing data usability and health interventions** by creating tools for actionable insights using Montana's health data (hospital and behavioral health bed registry) and implementing monitoring and evaluation programs leveraging data warehouse
- **Modernizing Electronic Health Record (EHR) systems for rural** providers by updating EHR systems for providers on outdated (non-HITECH certified) platforms and funding consumer-facing EHR modules to enable nutrition and chronic disease management and remote patient monitoring

Considerations for Distribution of RHTP Funds

- Funding across all initiatives, including direct incentives, will support facilities and providers operating in HRSA-designated rural counties and rural census tracts within Montana’s five non-rural counties
- HRSA defines 51 of Montana's 56 counties as rural. For the 5 countries that are considered metropolitan (Cascade County, Gallatin County, Lewis and Clark County, Missoula County, Yellowstone County) there may be portions that would be defined as rural based on HRSA criteria
- The State will continue to gather input from stakeholders that represent rural communities, facilities, and providers, through the Office of Rural Health twice-annual gathering and ad-hoc touch points as needed

RHTP Budget Submitted to CMS

	Spend Category Breakdown									
Sub-initiative	**Rural providers**	**Community based providers**	**Rural communities**	**Rural tech**	**DLI**	**Contractors (Rural providers)**	**Contractors (Community-based care delivery)**	**Contractor (Tech)**	**RHTP admin**	**Total**
1.1. Increase recruitment of rural health workers					$74					**$74**
1.2. Expand clinical training capacity					$29					**$29**
1.3. Retain and upskill rural healthcare workforce					$14					**$14**
2.1. Launch Center of Excellence	$350					$68				**$418**
2.2. Increase access through clinical partnerships	$7	$7		$7		$10	$10	$10		**$51**
2.3. Facilitate vendors and shared services						$5				**$5**
3.1. Implement innovative payment models						$8	$7			**$15**
3.2. Modernize EMS care model		$16					$13			**$29**
3.3. Expand access through pharmacies		$5								**$5**
3.4. Expand outpatient services	$35					$35				**$71**
4.1. Implement community-based care		$9					$61			**$70**
4.2. Repair healthcare infrastructure	$16	$16				$16	$15			**$62**
4.3. Invest in healthy lifestyles			$17							**$17**
5.1 Improve HIE usability and population health analytics				$6				$5		**$11**
5.2. Expand EMR modernization	$65			$32						**$97**
6.1 Admin									$30	**$30**
Totals	**$472**	**$53**	**$17**	**$45**	**$118**	**$142**	**$106**	**$15**	**$30**	**$1,000**

Planning for Budget Adjustment

- While the RHTP application process assumed a budget of $1B, CMS is expected to notify Montana of its actual RHTP award – likely in the range 900M-1.3B – by December 31.
- The State will then have a short window to submit a revised budget matching the awarded amount.
- The State has identified the following principles to guide budget adjustment:
  - Prioritize workforce, both for funding increases in upside scenarios and to avoid cuts in downside scenarios
  - Do not scale programs that are likely to have limited additional absorptive capacity
  - Hold Admin constant

Planning for Budget Adjustment – Illustrative View Based on These Principles

	Budget allocation scenarios ($M)					
Sub-initiatives	$900M	$950M	$1000M	$1100M	$1200M	$1300M
1.1. Increase recruitment of rural health workers	—	—	$74	↑ ↑	↑ ↑	↑ ↑
1.2. Expand clinical training capacity	—	—	$29	↑ ↑	↑ ↑	↑ ↑
1.3. Retain and upskill rural healthcare workforce	—	—	$14	↑ ↑	↑ ↑	↑ ↑
2.1. Launch CoE to implement data-backed recommendations	↓	↓	$418	↑	↑	↑
2.2. Increase regional clinical partnerships	↓	↓	$51	↑	↑	↑
2.3. Facilitate vendors and shared services	↓	↓	$5	↑	—	—
3.1. Implement innovative payment models	↓	↓	$15	↑	↑	↑
3.2. Modernize EMS care model	↓	↓	$29	—	—	—
3.3. Expand access through pharmacy enhancements	↓	↓	$5	↑	—	—
3.4. Expand outpatient services	↓	↓	$71	↑	↑	↑
4.1. Implement community-based care	↓	↓	$70	↑	—	—
4.2. Repair healthcare infrastructure	↓	↓	$62	↑	↑	↑
4.3. Invest in healthy lifestyles	↓	↓	$17	↑	↑	↑
5.1. Improve HIE usability and population health analytics	↓	↓	$11	↑	↑	↑
5.2. Expand EMR modernization for select providers	↓	↓	$97	—	—	—
Admin	—	—	$30	—	—	—

Each Sub-Initiative has Been Designed Around One or More Models of Sustainability

1. **Time-limited initiatives with lasting impact:** RHTP funds for these initiatives cover the costs of programs or activities that will only be in operation during the RHTP period of performance but that will have a lasting impact beyond FY2031. Despite the limited time frame, these initiatives create lasting and sustainable impact by providing crucial resources (e.g., a larger workforce) that will last beyond RHTP funding, unlock transformation through network effects, and fill existing rural health gaps.
2. **Up-front investments intended to be self-sustaining:** These RHTP funds support new programs that have previously been blocked by start-up costs. Once started, these programs should pay for themselves, by averting more costs than they incur, creating a positive ROI. If costs averted are less than costs incurred, the programs will be phased out; only those programs that show positive ROI will continue beyond FY2031.
3. **Initiatives with a clear plan to transfer responsibility for operating/maintenance costs to a third party after the project period:** These RHTP funds provide necessary upfront investment for programs that require ongoing operating and/or maintenance expenditures after the project period. These initiatives each have a designated organization that will be responsible for ongoing costs after FY2031. In many cases, designated funding streams for FY2031 onwards have already been identified.

Models of Sustainability by Sub-Initiative

Sub-initiative	Time limited initiatives with lasting impact	Self-sustaining following upfront investment	Clear plan to transfer responsibility
1.1 Increase recruitment of rural health care workers	✓		
1.2 Enhance and increasing rural clinical training			✓
1.3 Retain and upskill rural health care workforce		✓	
2.1 Launch a time-limited Montana Rural Health CoE	✓		
2.2 Fostering and incentivizing clinical partnerships		✓	✓
2.3 Shared services for rural facility cost efficiency		✓	
3.1 Implement innovative payment and care models		✓	
3.2 Modernize Emergency Medical Service care model		✓	✓
3.3 Pharmacist point-of-care testing sites		✓	
3.4 Increase outpatient services	✓		
4.1 Make preventive care accessible for rural communities			✓
4.2 Update rural health care infrastructure	✓	✓	
4.3 Invest in rural healthy lifestyles			✓
5.1 Utilize HIE data to drive decisions and population health interventions		✓	
5.2 Modernize EHRs for rural providers			✓

Next Steps: Early Implementation

The State is planning for a fast start to implementation, including:

- **Stakeholder engagement and partnership formation,** which are foundational across all initiatives.
- **Governance, procurement, and contracting** are being prioritized to ensure rapid deployment and accountability.
- **Strengthening DPHHS's capacity** to oversee and manage the program
- **Establishing metrics**, baselines, and progress tracking mechanisms

Preliminary Plan For Procurements and Contracts

Topic	Initiative	Total Spend (M)
Care delivery transformation implementation support	2	$48
Montana Rural Health Center of Excellence	2	$26
Support implementation of rural provider telemedicine platforms and interfacility transport systems	2	$25
Expand IDD telehealth pilot statewide	2	$22
Modernize EMS systems	3	$8
Clinic technical support and payment model interventions	3	$13
Expansion of outpatient services and community-based care programs	3&4	$15
School-based care site delivery	4	$68
Tribal program development	4	$34
Improve HIE usability and population health analytics	5	$5

Preliminary Plan for Modified FTEs to Support RHTP

Position title	# of positions
RHTP Program Director	1
Program Managers	5
Grant Manager	1
Compliance Officer	1
Budget Analyst	1
Workforce Coordinators	2
DLI Liaison	1
Community Engagement Regional Liaisons	2
Tribal Liaisons	2
Data and Evaluation Analysts	3
EHR Integration Specialist	1

Metrics to Track Progress (1/2)

Xx-quality and health outcomes metrics

Metric	Baseline	FY2031 Target
Ratio of NPs per 100,000 people in rural counties	76.7 per 100k	5% increase annually
Ratio of physicians per 100,000 people in rural counties	89.2 per 100k	5% increase annually
Ratio of RNs per 100,000 people in rural counties	860.9 per 100k	5% increase annually
Ratio of dental hygienists per 100,000 people in rural counties	90.7 per 100k	5% increase annually
Ratio of EMTs per 100,000 people in rural counties	115.0 per 100k	5% increase annually
Ratio of PAs per 100,000 people in rural communities, all rural counties	70.6 per 100k	5% increase annually
Rate of position turnover in rural counties (in health care)	Internal data on metric is not collected yet	At least to national average
Provider mental health rating	Internal data on metric is not collected yet	Higher behavioral health ratings
Average ED length-of-stay	3.9 hours	10% reduction
Rural facility operating margin	Estimated: -14.5%, to be validated and refined during FY 2026	0%; hospitals breakeven
Total facility inpatient days divided by staffed beds	39.49% average	30 pp increase
Percentage of total Medicaid visits conducted via telehealth	Expansion visits: 2.12%; expansion traditional: 2.33%	15 pp increase
% of Medicaid spend on outpatient care	72.8% spend on outpatient care	80% spend
Treat no Transport CPT use	0% (Treat no Transport not currently reimbursable)	10% of calls
Percentage of total pharmacists prescribing for Medicaid members	0% (Pharmacists currently not reimbursable)	50% participation
ED high utilizers	21.03% all; 19.86% Medicaid	10 pp decrease
Average dollar amount spent from Medicaid on Duals (PMPM)	$305 yearly average PMPM, non-disabled, no TPL, dual Medicare	Stable
Number of crisis safe spaces	1 crisis safe space	11 spaces

Metrics to Track Progress (2/2)

Xx-quality and health outcomes metrics

Metric	Baseline	FY2031 Target
Percentage of children who receive a well-child visit in the first 30 months of life (W30-CH)	Internal data on metric is not collected yet	Comparable with national median
% of diabetics with A1c control	37.80% all; 27.31% Medicaid	10 pp increase
% of those with hypertension with BP control	36.75% all; 29.74% Medicaid	10 pp increase
% of specific population with BMI levels under control	Internal data on metric is not collected yet	Higher levels of control
Behavioral health ED admissions per 1,000	50.61 per 100k	6% reduction
Deaths by suicide per 100,000 total population	26.2 per 100k statewide	10% decrease
Prevalence of students reporting mental health and related risk behaviors	43% students reported feeling sad or hopeless for two weeks or more	10% decrease
Number of Community Health Aide Program Practitioners	0 (CHAP not launched)	200 CHAP providers
Average wait time for behavioral health bed placements across non-State facilities	Internal data on metric is not collected yet	Reduction in wait time
Percentage of rural facilities and clinics participating in HIE	73% of hospitals, 43% of providers	95% for hospitals; 75% for others
Percentage of rural sites connected with HITECH-certified EHRs	88% of hospitals	95% of hospitals
Rural facility financial performance after EHR modernization	Estimated -14.48% net operating profit margin based on Definitive data; to be validated and refined during FY2026 Q2	10% increase for participating facilities

SNAP Waiver: Enacting a USDA-Approved Waiver

Factor	0 pts	25 pts	50 pts	75 pts	100 pts
B.3 SNAP Waivers	No waiver activity	Bill introduced in legislature	Bill passed authorizing waiver submission	Waiver submitted to USDA and under review	USDA-approved waiver in effect

- To achieve full points in this policy-based factor, a State must pass policy to enforce a USDA SNAP Food Restriction Waiver
- The policy must restrict one (or more) of the following:
  - Soda, candy, energy drinks, fruit/vegetable drinks with less than 50% natural juice, and prepared desserts
- Points are awarded on a discrete scale depending on where the state falls within the policy process

Implementation plan to achieve full points:

- Waiver designed, USDA application planned, and proposal drafted by Q2 2026
- Waiver sent to USDA for approval by end of Q3 2026