Rural Health Transformation Program

House Health Finance and Policy Committee

February 18, 2026

The State of Rural Health Care
Minnesota Department of Health Chartbook Highlights

MINNESOTA

Key Points

Demographics

- Minnesota's population in the 65+ age group will more than double from 2024 to 2075
- Rural residents are more likely to get health care through public sources – Medicare/Medicaid/MinnesotaCare

Workforce

- Minnesota has 557 designated Health Professional Shortage Areas. There is a maldistribution of providers in the state—the majority work in the urban areas, resulting in a severe shortage of all provider types, especially in primary care and mental health in rural areas

Access

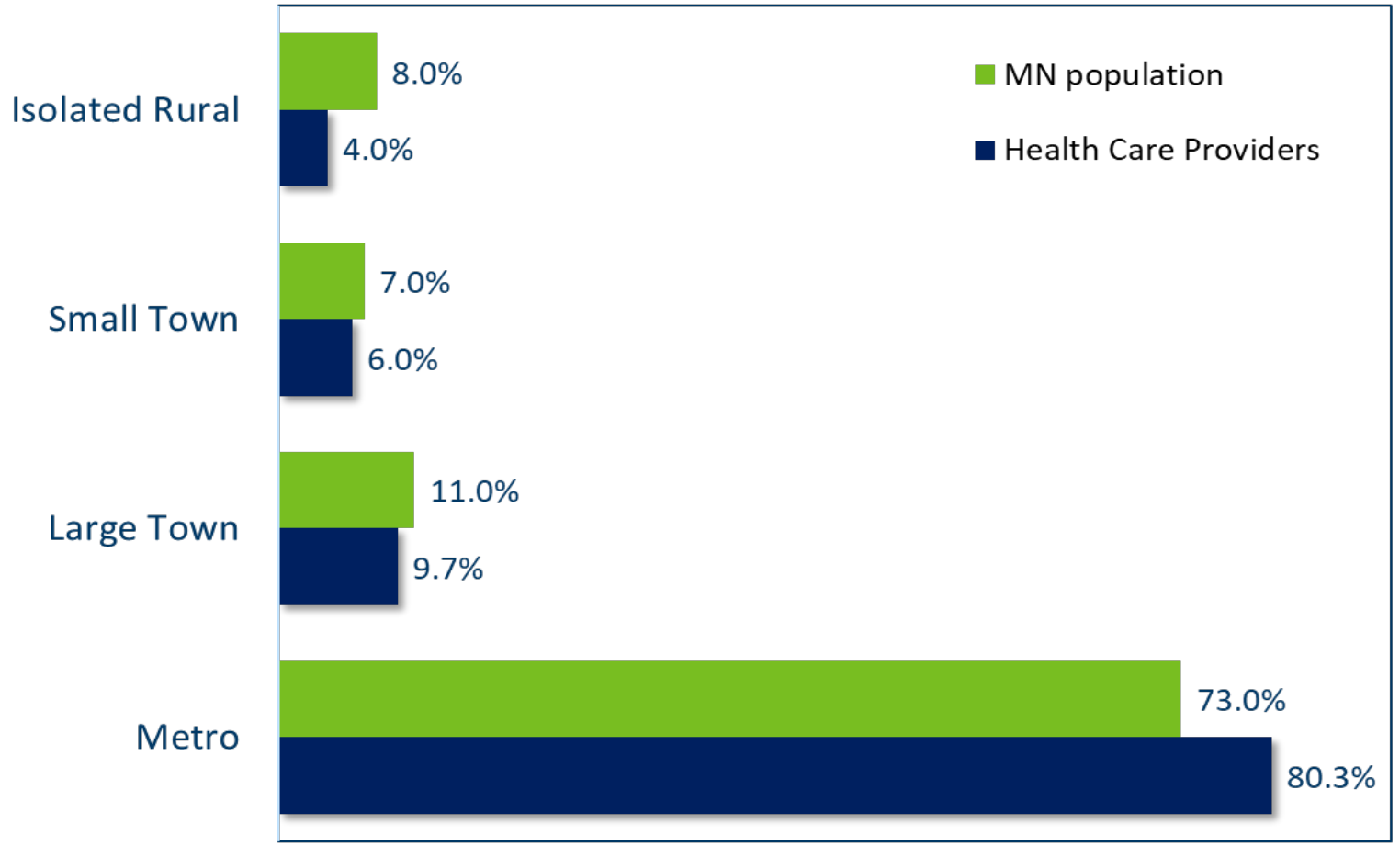
- Rural Minnesotans had lower telehealth use
- Non-metro counties have seen a loss of service availability in obstetrics services, inpatient mental health (psychiatric), and increases in outpatient psychiatric services

Health status

- Notable share of Minnesotans have chronic conditions. Share of urban and rural residents with chronic conditions are comparable

The majority of licensed health care providers work in metropolitan areas

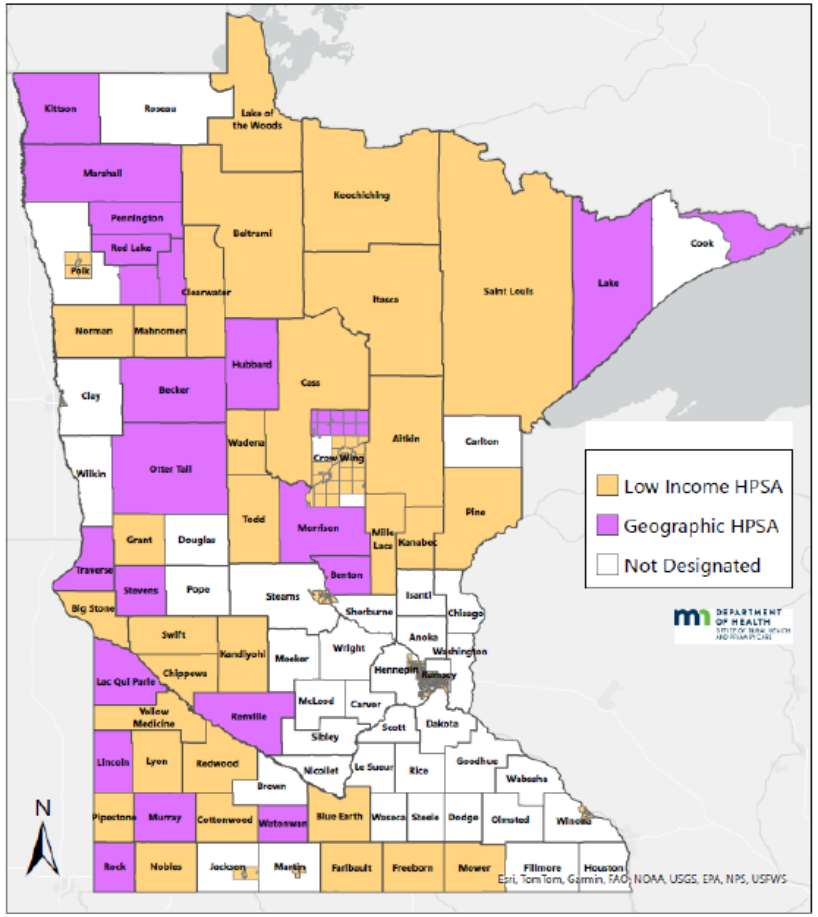
Very few licensed health care providers work in rural areas.



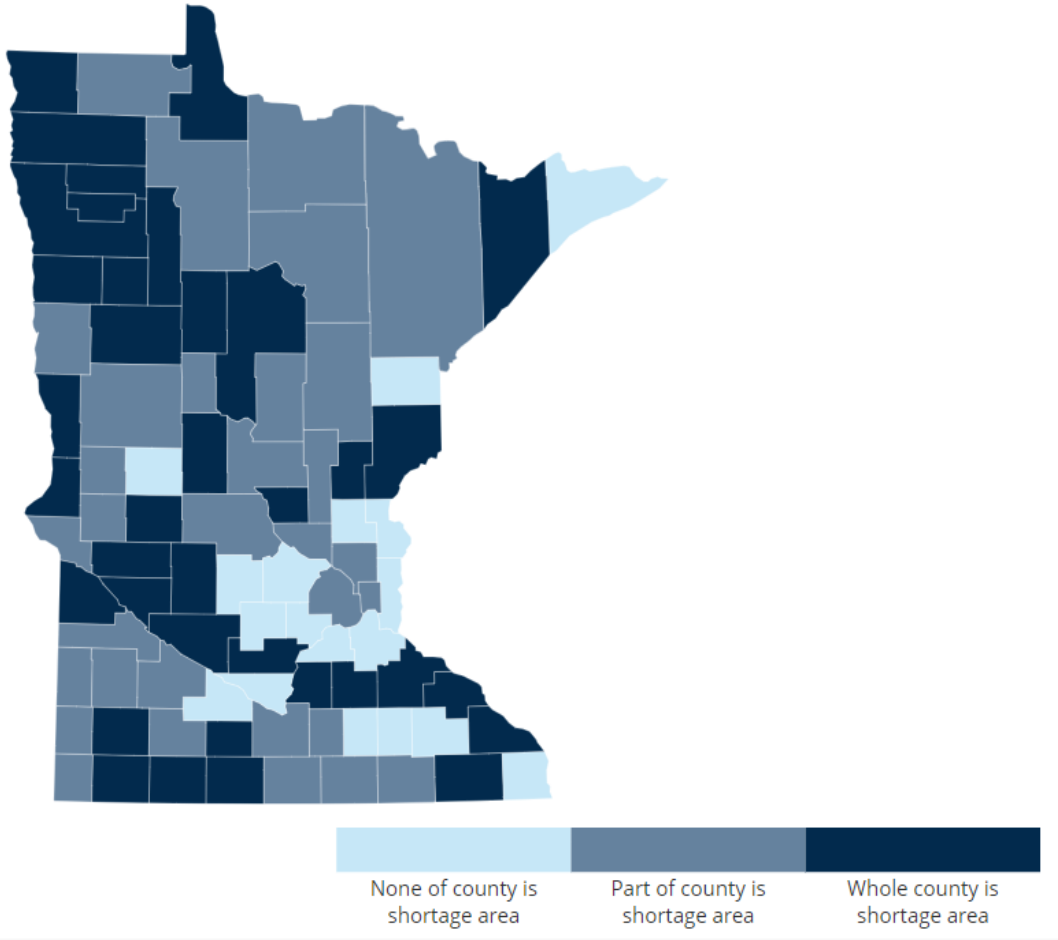
Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, 2025. Data includes: physicians, physician assistants, respiratory therapists, oral health professions, pharmacy professions, physical therapy professions, and mental health professions.

Minnesota has 557 designated Health Professional Shortage Areas

Health Professional Shortage Areas Dental

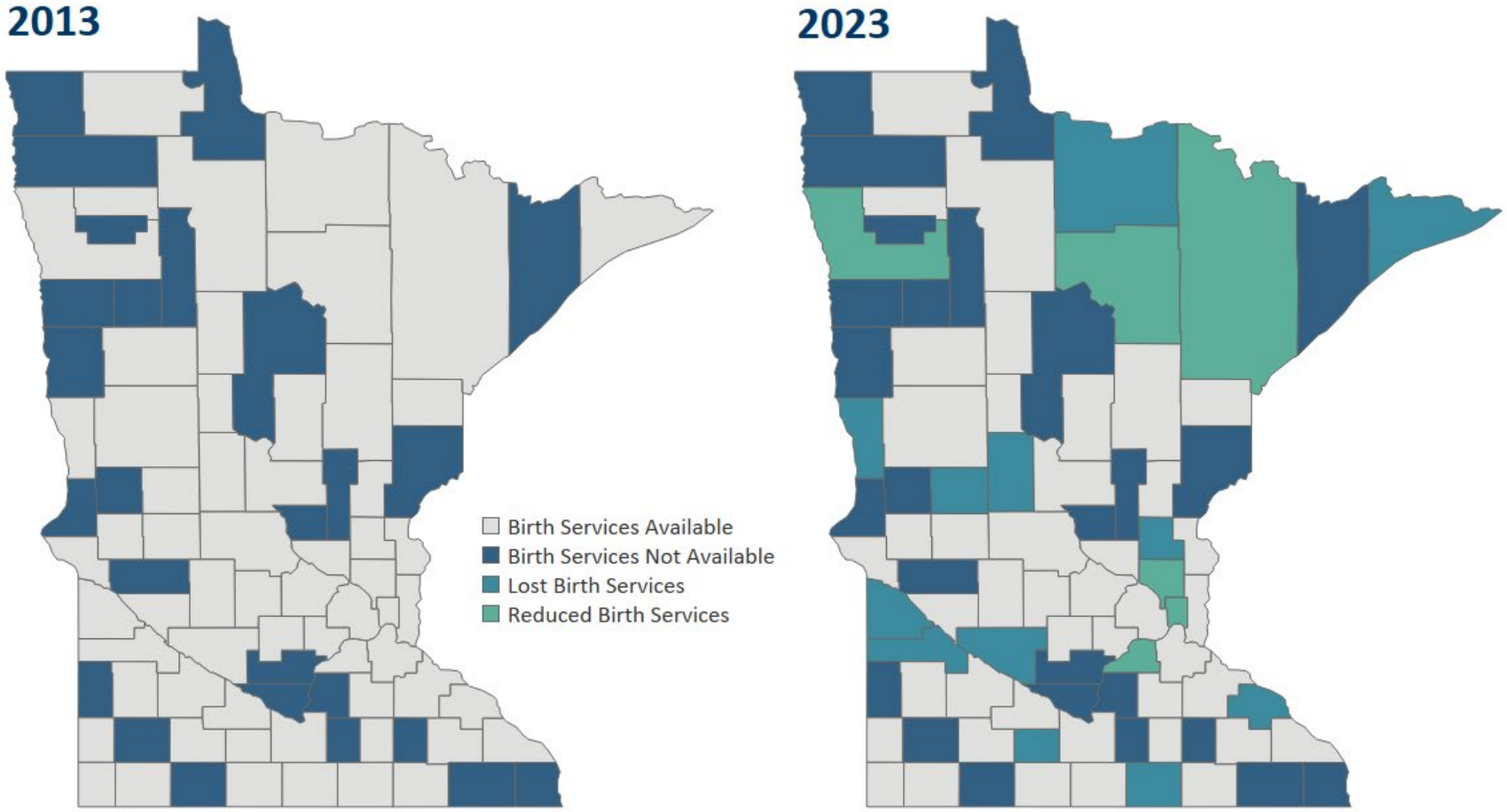


Health Professional Shortage Areas Primary Care



Source: HPSA Quarterly Report – FY 2023 – Minnesota. Downloaded from HRSA Data Warehouse (https://data.hrsa.gov/).

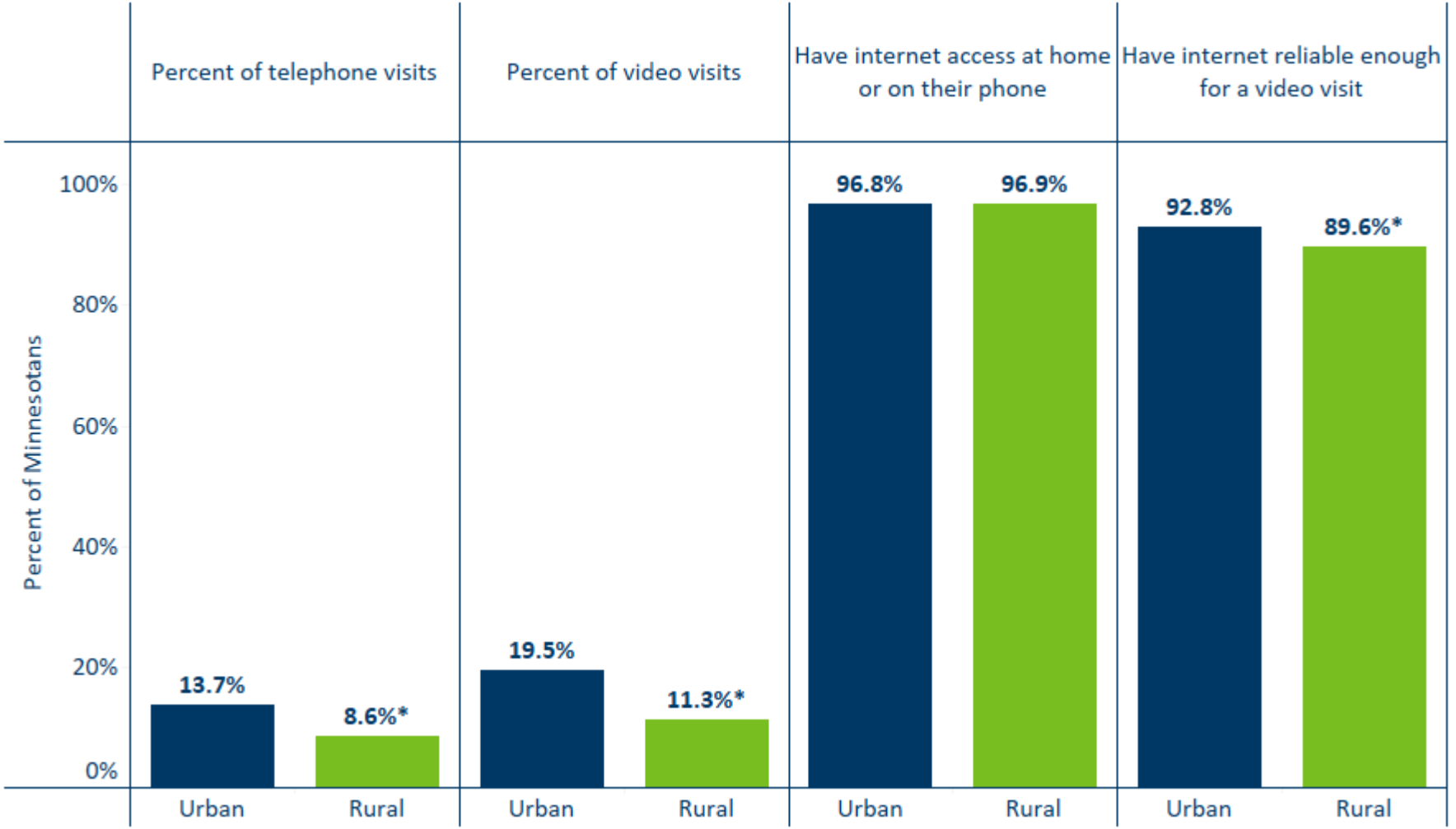
18 Minnesota counties have lost or reduced hospital birth services between 2013 and 2023



Increases in preterm births have been associated with the loss of hospital birth services in rural areas.

Rural Minnesotans had lower telehealth use

- Rural Minnesotans had lower utilization of both phone and video visits.
- One in ten rural Minnesotans lack internet reliable enough to use for a video visit.



Source: Minnesota Health Access Survey, 2023.
*Indicates significant difference from Urban at the 95% level.
Urban and Rural defined based on RUCA zip-code approximations.

Rural Health Transformation Program

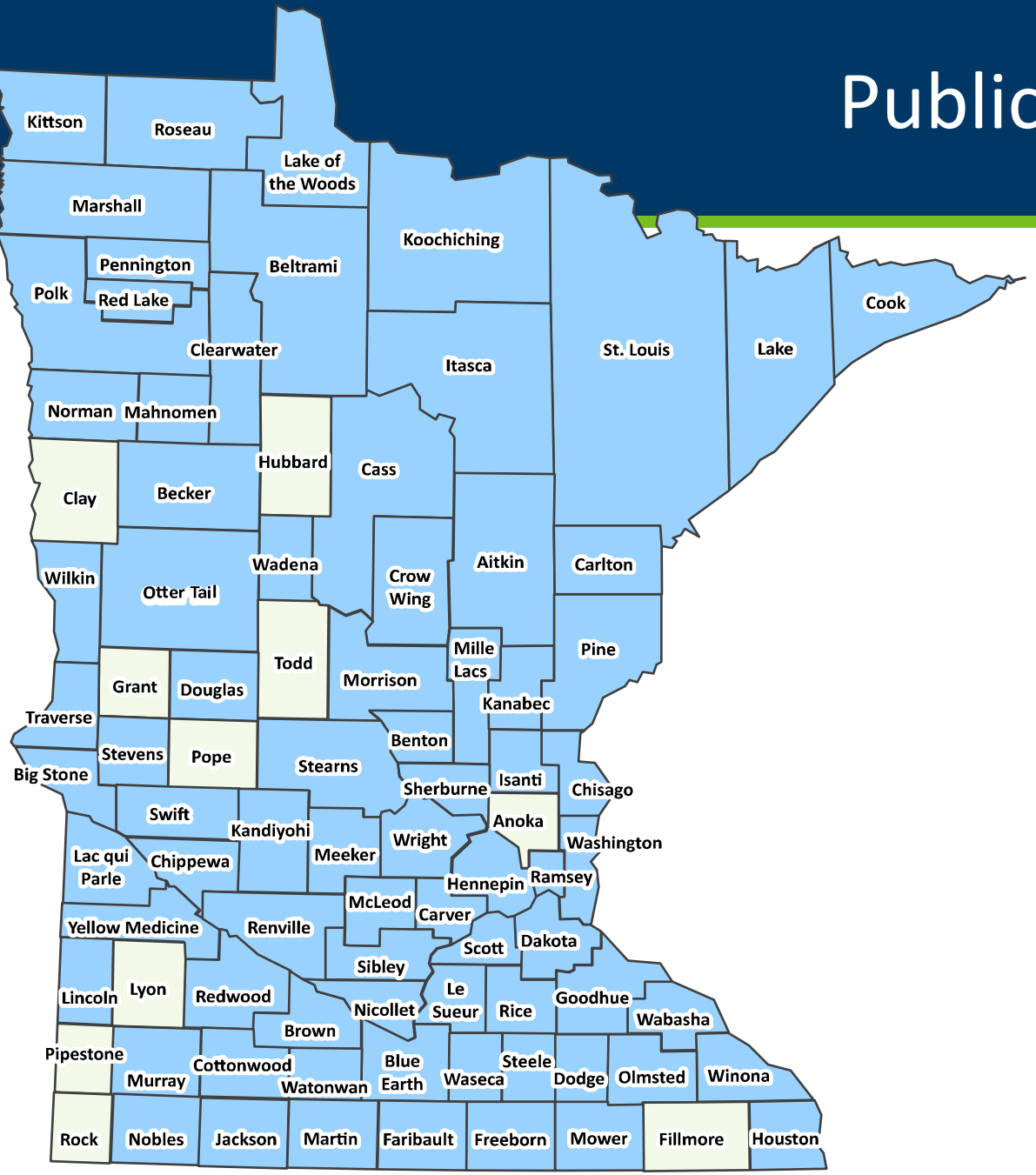
Office of Rural Health and Primary Care

NOTE: This document contains details about Minnesota's initial RHTP program proposal and does not reflect any possible future amendments made during the grant-making process in partnership with the Centers for Medicare and Medicaid Services.

Funding history

- HR1 signed into law July 4, 2025 → Rural Health Transformation Program
- $50 billion over 5 FFYs (2026-2030) = $10 billion annually to be distributed to all 50 states
- Applications were submitted to CMS on November 4, 2025.
  - Each state was asked to submit their application for $200 million annually.
  - One application was submitted for all five years of funding.
- Awards were made on December 29, 2025. MN will receive $193 million for FFY2026.

Public Input into RHTP Application



350+ public comments

All counties in Minnesota represented except: Clay, Hubbard, Grant, Pope, Todd, Anoka, Lyon, Pipestone, Rock, and Filmore.

Engagement in the application process

50 meetings with external partners

Engagement with Legislative leads and the Congressional Delegation

Collaboration with the Minnesota Hospital Association, Minnesota Association of Community Health Centers, and Minnesota Association of Community Mental Health Programs

Letters of Support from both MNleg caucuses, GOP Congressional Delegation, Senators Smith & Klobuchar, MHA, MNACHC, Essentia, Sanford, MACMHP, MMA, AMC, OEMS

Minnesota's Overall Goals

1. Improve health outcomes for rural Minnesotans with or at risk of developing cardiovascular disease, diabetes and chronic kidney disease (cardiometabolic disease)
2. Build education pathways and promote training opportunities in rural communities to sustainably expand the health care workforce in rural MN.
3. Expand health care access in rural communities by creating new access points for community-based screenings, preventive care, and chronic disease management through technology-enabled care delivery, mobile care, and increased use of community-based frontline workers.
4. Strengthen partnerships between providers to enable delivery of expanded services in rural areas through shared learning, collaborative approaches, and advanced technology interventions.
5. Strengthen and stabilize rural provider financial health through strategic investments in technology, data infrastructure, and collaborative mechanisms needed to address unique needs of rural providers.

Proposed Strategic Initiatives

Community-based preventive care and chronic disease management

Recruit and retain talent in rural communities

Sustain access to services to keep care closer to home

Create regional care models to improve whole person health

Invest in technology, infrastructure, and collaboration for financial viability

Technology

Initiative #1: Community-Based Preventive Care and Chronic Disease Management

- Chronic disease screening, education, referral, and follow-up
- Chronic disease self-management in clinic and community
- Physical activity, nutrition, and upstream drivers of health referrals
- Post-acute chronic disease care programs and support

Additional detail available on page 16 of Project Narrative

Initiative #2: Recruit and Retain Talent in Rural Communities

- Introduce more high school students to health care careers
- Develop allied health pathways through “Earn and Train” programs
- Expand rural clinical rotations
- Develop rural clinical training opportunities
- Develop a Technical Assistance Center for Excellence in Rural Clinical Training
- Pilot the Healthy Workplace strategy with a subset of rural health systems

Additional detail available on page 20 of Project Narrative

Initiative #3: Sustain Access to Services to Keep Care Closer to Home

- Implement or expand models that integrate frontline staffing into care settings
- Provide technical assistance to organizations interested in frontline workforce investment
- Support Community Mental Health Postvention with Regional Coordinators Programs
- Develop community telehealth access points
- Provide local care delivery with mobile units for physical or oral health

Additional detail available on page 25 of Project Narrative

Initiative #4: Create Regional Care Models to Improve Whole Person Health

- Establish and strengthen telehealth connections to expand access to specialty expertise
- Pilot a system to compensate ambulance services for 911 responses that result in patient contact but do not require transport to an emergency department
- Support the building of a Children's Mental Health Initiative
- Develop new mental health urgent care centers
- Implement a Project ECHO network to connect rural primary care providers with mental health specialists
- Develop a Rural Telehealth Services center
- Expand access to Medications for Opioid Use Disorder
- Provide bridge grants to eligible hospitals or birthing centers for balancing service line sustainability with regional population needs
- Build rural obstetrics skills through high-fidelity simulation led by physician faculty
- Implement an ECHO network that encompasses maternal health from prenatal through delivery to post-partum care

Additional detail available on page 29 of Project Narrative

Initiative #5: Invest in Technology, Infrastructure, and Collaboration Needed for Financial Viability

- Supporting the acquisition of data management software, licenses, or technical assistance and skill-building for health care providers to boost capabilities for internal data management and utilization needs
- Providing funding to rural health care providers to leverage a range of AI applications to improve the efficiency of their clinical operations and increase the capacity for clinical staff to work at the top of their license
- Investing in a secure statewide integrated rural health data network
- Investing in cybersecurity as a necessary tool to secure safe and secure operations of advanced technologies
- Investing in revenue cycle management tools

Additional detail available on page 36 of Project Narrative

Implementation Plans

This program is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $193,090,618.14 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Terms and Conditions

- MDH received a total award of $193,090,618 for FFY2026.
- Funds are currently restricted. A revised budget was submitted to CMS on January 28 and is under review by CMS. CMS has 30 days to review following our submission, to approve or request changes.
  - We expect CMS will un-restrict some of our budget and require us to resubmit additional updates as awardee workplans are developed.
- Many restrictions on how funds may be spent, some typical of federal funding and some RHTP-specific.
  - Funds may NOT to be used for intergovernmental transfers, public expenditures, or any other expenditure that finances non-federal Medicaid share. Funds are not meant to offset Medicaid losses.
- Funds must be used by the end of the FFY following the FFY in which the funds were allotted. Unused funds will be redistributed.
- Administrative costs, including direct and indirect costs, are limited to 10% of overall spending by the State and sub-recipients.

Touch points with CMS

- Office of Rural Health and Primary Care (ORHPC) will be meeting with our newly assigned project officer soon.
- We are expected to meet with our project officer approximately twice a month.
- ORHPC will be attending a required in-person Rural Health Transformation Program event in Baltimore, MD in March
- CMS will be making in-person site visits to each state starting in April 2026; we expect these to be 2-day visits.
- The first annual report is due to CMS in August 2026. Following the first reports, reports will be quarterly, with an annual report taking the place of a quarterly report each year, and a final report spanning the entire grant period

Continued Funding

- For CMS to issue continuation funding for subsequent budget periods, Minnesota must demonstrate “satisfactory progress,” meaning:
  - Progress in implementing initiatives approved by CMS in the application
  - Adherence to the implementation plan and timeline
  - Progress on self-imposed metrics, including milestones and targets

Metrics

- State committed to demonstrating progress on proposed initiatives/activities
  - Quarterly & annual progress reports to CMS
- Metrics & targets associated with each initiative + overall key performance objectives
  - Combination of process & outcome metrics
    - Examples:
      - How many patients were screened for cardiometabolic conditions or cancer in the reporting period?
      - How many rural high school students enrolled in scrubs camp in the reporting period?
      - How many mental health urgent care centers established in the reporting period?
  - Guidance will be made available to grantees on measurement, reporting; support to mitigate progress barriers

Dissemination of funds

- Year 1 focus on efficient dissemination of funding to hospitals, federally qualified health centers (FQHCs), certified community behavioral health clinics (CCBHCs), community mental health centers (CMHCs), and Tribal Nations, with some competitive grant funding available, and some expansion of existing MDH workforce initiatives.
- Year 2 shift to a greater share of competitive grant funding toward strategic initiatives and continued support for providers, Tribes, and existing workforce initiatives.
- All funds must be spent on allowable activities to meet strategic goals, and MN must meet stringent data, reporting, and evaluation metrics to continue to receive funds.

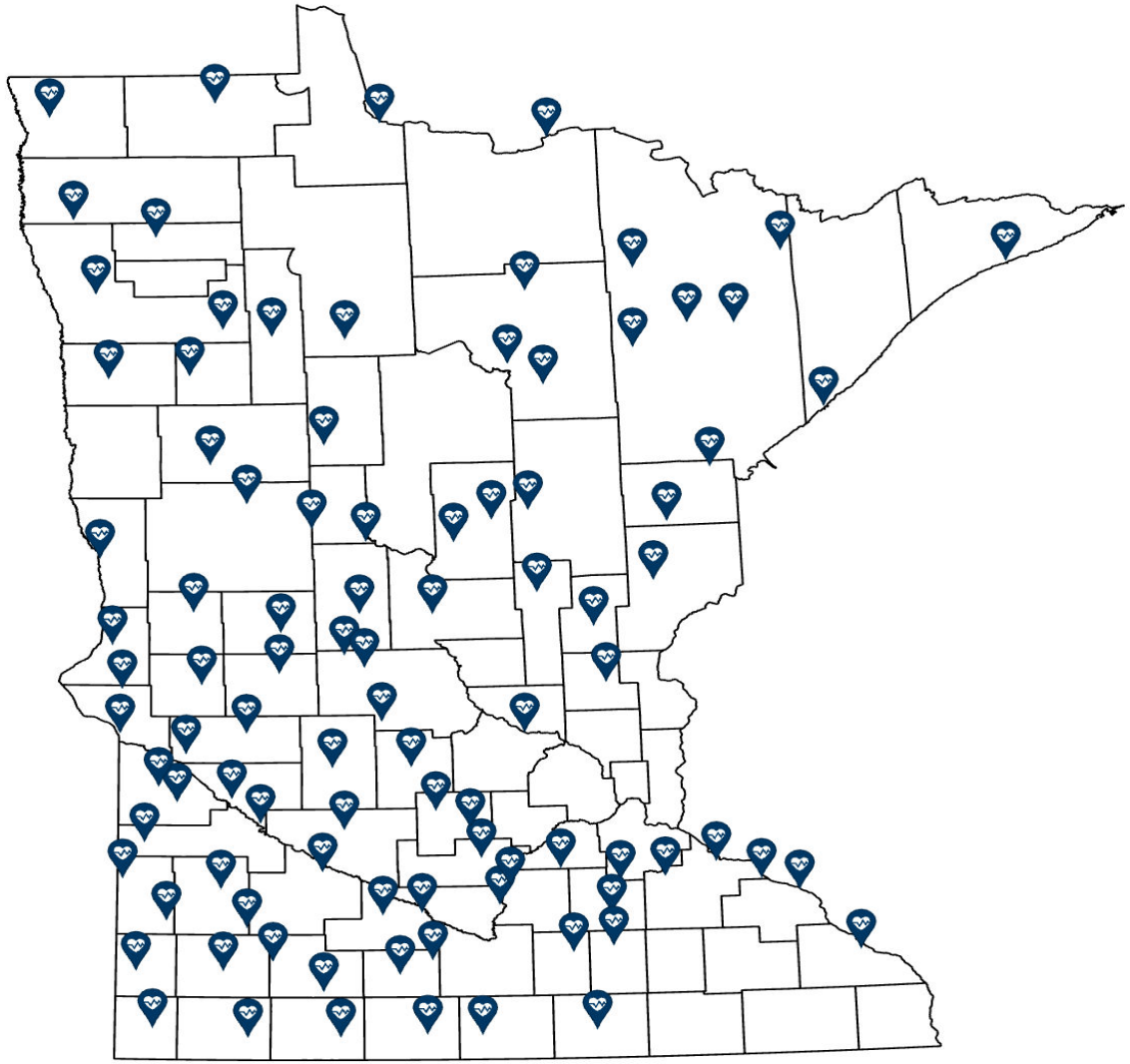
Allocation: Year 1

	%	$193M/year scenario
Hospitals (through a formula in year 1)	70%	$135M
FQHCs	5%	$9.7M
Community Mental Health Centers and CCBHCs	3%	$5.8M
Tribes	2%	$3.8M
Competitive Opportunities for Providers/Communities/Regional Partnerships	7%	$13.5M
Scaling Up What Works	7%	$13.5M
Technical Assistance	1%	$1.9M
Admin	5%	$9.7M

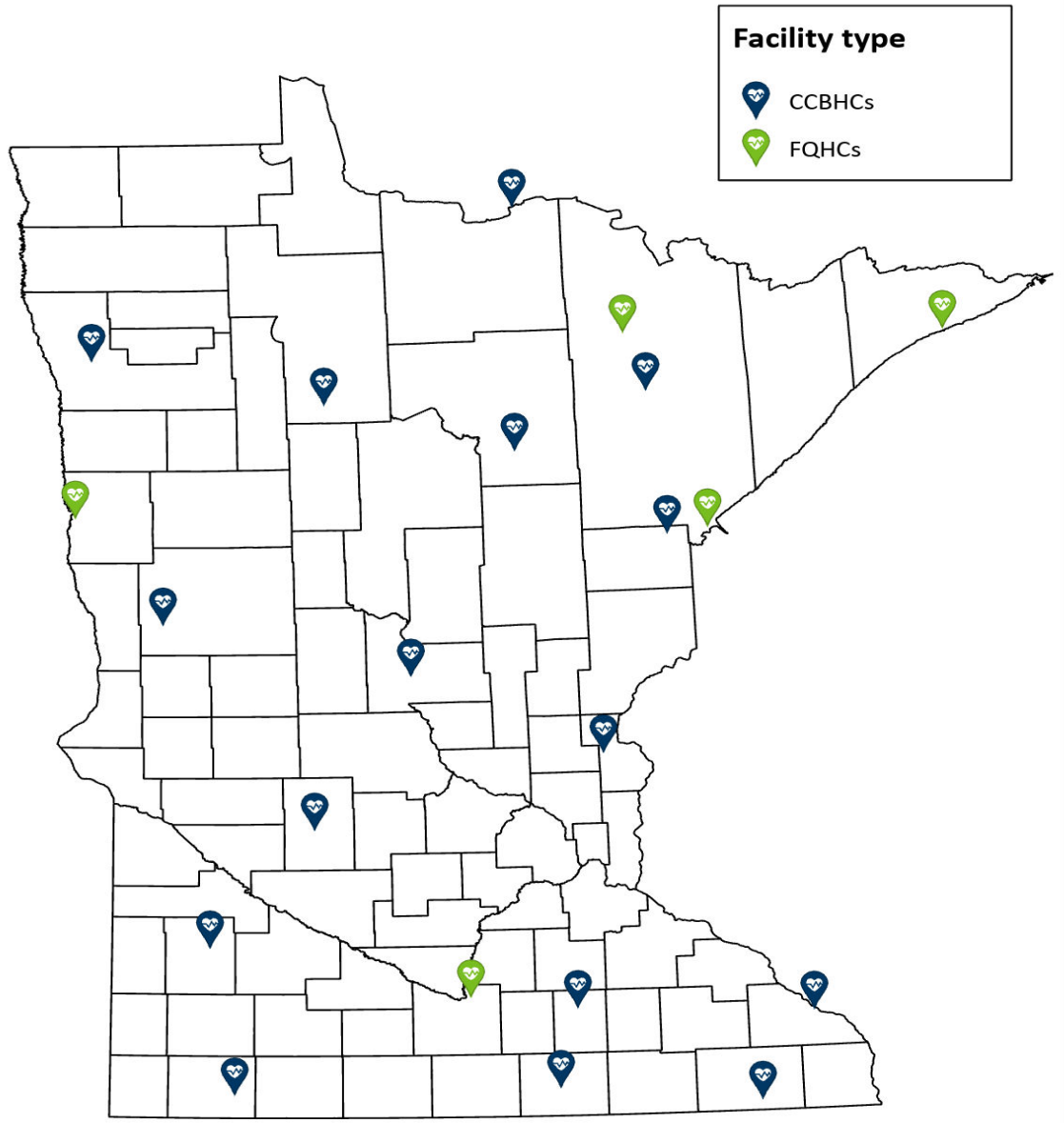
Year 1 Direct Allocation Grants

- Year 1 focuses on efficient distribution of funding to rural hospitals, federally qualified health centers (FQHCs), certified community behavioral health clinics (CCBHCs), community mental health centers (CMHCs), and Tribal Nations
- Those entities were named in application; MDH sought sole-source approval for those groups of eligible entities.
- Aiming to publish Notices of Grant Opportunity (one for rural hospitals, one for FQHCs, one for CCBHCs/CMHCs, one for Tribal Nations) in early March
- Grant agreement template approval in process that would speed up grant approvals
- Hoping for grant agreement start date in June if possible

Map of 94 hospitals eligible for RHT funds in Year 1



CCBHCs/CMHCs/FQHCs eligible for Yr1 Allocation Funds



Note: Entity main sites shown

Other recipients

- Some additional organizations were identified to receive funding in year 1, on a slightly later timeline than the direct allocation grants
- MDH has received sole source approval of these grant recipients.
- Examples of sole source grants:
  - University of Minnesota Rural Clinical Training Technical Assistance Center, FM OB Fellowship and Obstetric Simulation Training
  - K-12 Healthcare Exposure Grants to Healthforce Minnesota and the MN Community Health Worker Alliance
- Some competitive funding opportunities will also be available in year 1, on a slightly later timeline than the direct allocation grants

Contracts

- We will issue several competitive Professional / Technical contract opportunities
- Examples of competitive contracts:
  - Technical assistance (TA) for implementing community-based and clinical chronic disease management strategies
  - TA related to billing and sustainability for organizations strengthening their frontline health care workforce
  - TA related to expanding access to Medications for Opioid Use Disorder
  - Studies of some RHTP activities and their impact
- Interagency Agreement with the Office of Emergency Medical Services

Compliance & Program Integrity

- Partnering with MDH Internal Audit, Financial Management, General Counsel and others from outset to ensure all requirements & best practices are baked in
- Incorporating all relevant compliance elements into NOFOs/RFPs, grant agreement and contract templates, grantee guidance
- Providing ongoing TA for grantees from grant managers, evaluation team, content experts
- Review of progress reports and invoices by at least two staff members
- Training grants staff using existing MDH and ORHPC SOPs and resources, adding information specific to RHTP requirements
- In-person monitoring visits

Partner Engagement

MDH meets regularly with all partners receiving direct funding in year 1 and has shared outlines of available activities and timelines so that they are better prepared when the grant opportunities open

Public facing webinars and technical assistance will be available when grant opportunities open

Staying engaged

Website: Rural Health Transformation Plan - MN Dept. of Health

Email: rural.transformation.mdh@state.mn.us

Updates: *Subscribe for news on the RHTP*

Watch for regional conversations, updates/input through existing bodies

Questions?

Thank You!

Office of Rural Health and Primary Care RHTP Team

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