

MEDICARE & PAYER STRATEGY

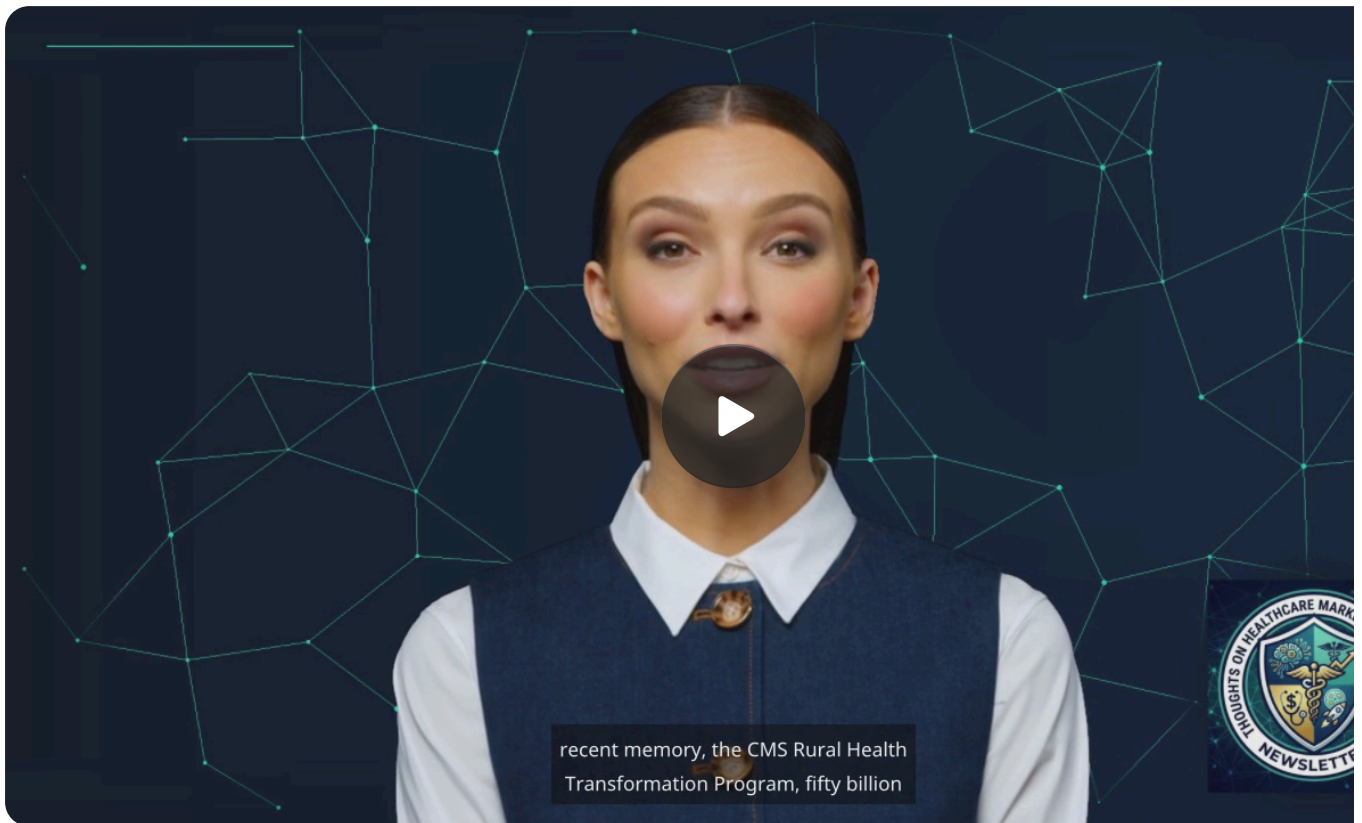
The Fifty Billion Dollar Rural Health Wager

What CMS Actually Did With the Rural Health Transformation Program, Why Capital Stack Is Bigger Than the Headline, and Where the Operating Layer Built Now

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Video Preview



Podcast, Part I (Free)



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Abstract

The CMS Rural Health Transformation Program (RHTP) puts \$50B over FY26-30 for rural health, \$10B/yr, all 50 states approved Dec 29 2025. Half is split equally (\$100M/state/yr), half is merit-based. Range: NJ \$147M to TX \$281M. AK gets ~\$100M per rural resident, RI is the freak outlier at \$6,305. Six allowed use categories include consumer tech, workforce, IT, prevention. Hard constraints: no construction, 5% cap on EHR replacement, no supplanting existing funds, two-year obligation window starting FY26. RHTP sits on top of a much larger preexisting capital stack: HRSA FORHP \$400M+/yr, USDA Community Facilities (loans up to \$75M, \$484M to rural health in FY22-23 alone), FCC Rural Health Care Program \$744.2M cap FY26, the new HRSA Rural Hospital Provider Assistance Program (\$25M, apps due Jul 1 2026). Backdrop: 152 rural hospital closures since 2010, 432 financially vulnerable, 1,381 CAHs, 42 REHs out of 447 eligible. 67% of TX rural hospitals run negative margins.

RHTP is partial offset to OBBBA Medicaid cuts (\$911B/10yrs, \$137B in rural). E walks through what got funded, what didn't, why the procurement model deterr who wins, why the EHR cap forces an integration play, and where the operating between states, providers, and federal money actually gets built.

The Headline Number Hides the Real Story

Fifty billion dollars sounds enormous, and it is, but it is also misleading. CMS announced state allocations on December 29, 2025, and the way the trade press covered it was mostly about which state got the most and which got the least. New Jersey came in last at \$147M over the five-year window. Texas pulled the top spot at \$281M. The narrative settled around that range, which made the program look smaller and more even than it actually is. The headline number is one piece of a bigger machine.

Half of every state's allocation is distributed equally, which works out to roughly \$100M per state per year regardless of how many rural residents that state actually has. The other half is merit-based, awarded against state plans CMS scored using a rubric the Office of Rural Health Transformation published in late 2025. The merit half is where the meaningful variance lives. Alaska ended up with \$233M total, but on a per-rural-resident basis that is roughly \$990 per person, the highest in the country. Rhode Island is the freak outlier at \$6,305 per rural resident, which is mostly an artifact of having almost no rural population at all combined with the per-state total. Functionally, RI gets a giant per-capita number on a tiny denominator and the practical implication is that there is almost nothing to spend it on.

What matters more than the per-state number is what the money is allowed to do. Section 71401 of P.L. 119-21, the One Big Beautiful Bill Act passed in July 2025, authorizes six use categories. Prevention and chronic disease management. Provider payments. Consumer-facing technology, which means apps and portals that get paid directly in patient hands. Training and technical assistance for technology adoption where the statute names remote monitoring, AI, and robotics by name. Workforce

with five-year service commitments attached. And IT for cybersecurity and operational efficiency. That last category is doing more work than people realize because it is where the integration plays live.

Then there is the constraint side, which is where the program actually shapes what gets built. No construction. No cosmetic upgrades. No independent research. No restricted telecom equipment, which is the Huawei and ZTE clause. EHR replacement is capped at five percent of the state's allocation. And the supplantation rule means RHTP money cannot replace funding the state was already going to spend. So if you were going to put \$50M into rural workforce next year anyway, RHTP money cannot just absorb that line. It has to add to it.

The five percent EHR cap is the most consequential single number in the whole authorizing statute and almost nobody is talking about it. Rural hospitals are mostly running on TruBridge (formerly CPSI), Meditech Expanse, athenaCommunity, or Azalea Health. The cap means RHTP will not fund a wholesale rip-and-replace of those systems at scale, which means the layer that gets built on top of those systems has to be additive. That single sentence in the statute is what makes this an integration play and not a displacement play.

Where the Money Actually Comes From The Full Capital Stack

If RHTP were the only rural health funding stream, \$50B over five years would be a big deal but a finite one. It isn't. RHTP sits on top of an existing federal capital stack that most healthcare investors and operators do not have a complete map of, and that stack is laid out the size of the addressable spend in rural health gets close to triple the headline.

HRSA's Federal Office of Rural Health Policy administers something north of \$4 billion annually across grant programs covering 64.5M rural Americans. The Pennsylvania state-level fact sheet for FY25 alone shows \$16.2M in HRSA grants. New York: \$10.5M. South Carolina: \$2.9M. New Jersey: \$754K. These are recurring, not one-time. They include the Rural Health Network Development Program, the Small Health Care

Provider Quality Improvement Program, the Rural Communities Opioid Response Program, and a basket of others. Most rural CFOs already have someone tracking these, but few investors model them as a recurring revenue surface for the business that serve those grantees.

USDA Community Facilities is the sleeper. Loans go up to \$75M and grants cover up to seventy-five percent of project cost for the smallest, lowest-income communities. The Guaranteed Loan program goes up to \$100M with an eighty percent federal guarantee, which makes the effective lending capacity functionally unbounded for rural healthcare projects that can clear underwriting. In FY22-23 alone, USDA deployed \$484M to rural healthcare specifically through the Rural Emergency Hospital Care Grant supplement. That program is administered out of an agency most healthcare people do not even think of as a healthcare funder, which is exactly where smart money is paying attention to it.

The FCC Rural Health Care Program is capped at \$744.2M for FY26, a 2.8 percent inflation increase from \$723.9M in FY25. The Healthcare Connect Fund discourages broadband and telecom for rural providers at sixty-five percent. The Connected Pilot is at eighty-five percent. Both programs are structurally underutilized because the application process is administrative purgatory, which is itself a business opportunity for whoever can productize the application motion.

The new one is the HRSA Rural Hospital Provider Assistance Program, authorized under P.L. 119-75 with \$25M for hospitals with fewer than fifty beds and a wage index below 0.90. That is a small number relative to RHTP, but the eligibility cutoff makes it the most narrowly targeted federal grant program for genuinely struggling rural hospitals, and applications are due July 1, 2026. For the operators who qualify it is the difference between making payroll and not.

Stack it up and the FY26 federal capital surface for rural health is somewhere north of \$11B, with RHTP doing \$10B of that, FORHP another \$400M plus, FCC at \$500M, USDA running parallel through loans (which do not show up the same way as appropriations but are real money), and Rural Hospital Provider Assistance at \$25M. State Medicaid match dollars on top of that. None of these programs talk to each

other, none share infrastructure, and none have a unified application or reporting layer. The fragmentation is the opportunity.

The Rural Hospital Doom Loop and Why CMS Finally Acted

The reason the program exists at all is that rural healthcare in America has been collapsing on a clock for fifteen years and Washington finally noticed. 152 rural hospitals have closed since 2010. 432 are flagged as financially vulnerable in the recent Chartis Center for Rural Health analysis. In Texas alone, sixty-seven percent rural hospitals are running negative operating margins. The pipeline has been reeling in slow motion.

The structural problem is reimbursement physics. Rural facilities serve smaller, sicker, and poorer populations. Their payer mix is heavier on Medicare and Medicaid which do not pay cost. Their commercial leverage is functionally zero because there is only one hospital in the county. Their fixed costs are similar to urban facilities (you still need a CT scanner, you still need 24/7 staffing for a Level IV ED) but their volumes are a fraction. So the unit economics are broken from the jump.

Critical Access Hospital designation, created in 1997 under the Balanced Budget Act, was supposed to fix this with cost-based reimbursement at 101 percent of allowable cost for Medicare patients. As of April 2026, there are 1,383 CAHs across forty-three states. The top three: Texas with 88, Iowa with 82, Kansas with 81. Roughly forty percent of all CAHs are in the Midwest. Connecticut, Delaware, Maryland, New Jersey, and Rhode Island have zero, which says more about how the geography of the country has been zoned than about whether those states have rural communities.

Rural Emergency Hospital is the newer designation, created by the Consolidated Appropriations Act of 2021 and operational since January 2023. REHs get OPPS five percent on outpatient services and a flat \$285,625.90 monthly facility payment which works out to about \$3.4M per year just for keeping the doors open. The catch is that REHs cannot have inpatient beds. They are outpatient and ED only. As of October 2025, forty-two hospitals have converted, out of 447 that are eligible. The

conversion rate is low because the inpatient ban is a hard pill for community hospitals to swallow even when the math is obviously better.

Then OBBBA happened in July 2025. The Medicaid cuts in that bill were estimated at \$911B over ten years by KFF, with \$137B of that hitting rural Medicaid specifically. RHTP was partly the offset. If the political logic is that you cannot cut Medicaid in rural America without doing something visible to soften it, \$50B over five years is something. Whether \$50B over five years actually offsets \$137B in cuts to rural Medicaid over ten is a separate question, and the answer is mathematically no, but political design holds.

What is relevant for anyone trying to build in this space is that rural hospitals are operating with a gun to their head. They will say yes to almost anything that comes with money attached. The buyer is desperate, the buyer has no negotiating leverage, and the buyer also has almost no capacity to evaluate vendors carefully because they do not have a CIO, they do not have a procurement team, and the CFO is doing finance, IT, and HR simultaneously. That is a sales environment unlike almost anywhere else in healthcare.

The Three Procurement Archetypes Determine Who Wins

CMS gave states wide latitude on how to spend their RHTP allocations, and the procurement structure each state chose is the single best predictor of who can succeed in that state. Three archetypes have emerged.

The first is the direct agency RFP model. Texas is the canonical example. The Texas Health and Human Services Commission is running Rural Texas Strong with six initiatives, including one called Rural Texas Patients in the Driver's Seat that explicitly funds consumer-facing technology. CMS approved Texas's revised budget on April 7, 2026. TORCH (the Texas Organization of Rural and Community Hospitals) is a key intermediary but the contracting authority sits with HHSC. Montana's DPH is running the same playbook with five initiatives, hosted a vendor webinar on November 11, 2026 that pulled 900 registrants (which tells you everything about the level of

vendor interest), and got CMS budget approval in February. New Mexico's HCA is running five initiatives and standing up a Rural Health Sustainability and Innovation Center to serve as the implementation backbone. New Mexico also recently joined PSYPACT, which matters for behavioral health vendors.

The second archetype is the designated administrator model. Rhode Island handed administration to its Primary Care Association, which functionally locks out independent platform vendors because the PCA's incentive is to flow money to its FQHC members, not to fund a horizontal layer. North Dakota gave infrastructure administration to the Bank of North Dakota, which is more straightforward but funnels everything through a state-owned bank's underwriting standards. Designated administrator states are not impossible to sell into but the sale has to go through the administrator first, and the administrator has its own member politics.

The third is the hybrid stakeholder advisory model. Washington's HCA, DOH, and DSHS are running RHTP jointly with broad provider input. Connecticut's DSS is doing something similar across multiple agencies. The hybrid model is slower because there are more veto points, but it is also where the most thoughtful state plans are coming out, and where horizontal platforms have the best shot because the advisory committees tend to want enterprise solutions over point products.

Any company trying to sell into RHTP money needs to know which archetype each state is running before sending a single email. The wrong motion in the wrong state is a wasted calorie. Texas wants vendors who can respond to formal RFPs. Rhode Island wants vendors who already have FQHC relationships. Washington wants vendors who can sit through ten months of stakeholder meetings without losing the will to live.

The Five Percent EHR Replacement Cap and Other Structural Constraints

The five percent EHR cap deserves its own treatment because it is the constraint that actually shapes the product strategy for anyone building in this space. The math is straightforward. Texas has \$281M to spend. Five percent of that is roughly \$14M, which is enough to subsidize partial EHR replacements at maybe twenty hospitals at the high end and not enough to do a wholesale system migration at any of the large

rural systems. So if you walked into HHSC with a pitch to replace TruBridge or Meditech statewide, the math does not work and the procurement officer can reject it.

What does work is layering on top. Most rural hospitals are running TruBridge, Meditech Expanse, athenaCommunity, or Azalea Health. Those are the incumbents and they are not going anywhere because the cost and disruption of replacement is multiples of any RHTP allocation that could fund it. The integration play is the play. Every product built for RHTP has to assume the EHR is staying, has to work with whatever is there, and has to deliver value without forcing a swap.

That reframes the competitive landscape entirely. TruBridge is not a competitor at the operating layer. TruBridge is a channel partner, because TruBridge has the rural hospital relationships and an installed base, but TruBridge does not have state contracts and does not have a horizontal platform across multiple EHRs. The right product strategy is to be EHR-agnostic at the data layer and EHR-friendly at the partnership layer. The companies that have been trying to displace rural EHRs have been wrong for ten years and the five percent cap just locked that wrongness into federal statute.

The other structural constraint worth flagging is the supplantation rule. RHTP dollars cannot substitute for existing state spend. So if a state was going to allocate Medicaid HCBS dollars to a particular workforce program, RHTP cannot pay for that program instead. It has to be incremental. CMS will be watching state budget submissions over the next four years to enforce this, and the enforcement mechanism is that future RHTP draws can be paused if a state gets caught supplanting. Which means the politically risk-averse path for a state agency is to fund only genuinely new programs with RHTP dollars. New programs need new vendors. That is the supplantation rule, an accidental gift to anyone trying to enter the market.

Construction is out, which is a big deal because the lazy answer to rural health care is build a new hospital. That is not allowed. Cosmetic upgrades are out, which closes the door on facility-based vendors who were positioning to sell HVAC or elevators or whatever. Restricted telecom is out, which mostly affects the cybersecurity and networking vendors and is just a Huawei and ZTE problem. Research is out, which

closes the door on academic medical centers trying to use RHTP as research grant supplement. Each of those exclusions is a wall, and walls determine doors.

The Operating Layer Thesis

The simplest way to think about what gets built on top of all this is that rural health as of mid-2026, has the federal money but does not have the operating layer to all of it. State agencies are getting \$100M to \$281M each to deploy over five years and most of them have rural health offices with five to fifteen people. Provider organizations CAHs, REHs, and FQHCs running on skeleton crews. The federal grant programs have administrative complexity that rural CFOs cannot navigate without help. There is no horizontal platform that connects state contracts on one side, provider software on another, federal grant administration on a third, and cross-state benchmarking on a fourth.

The opportunity is to build that platform. The pieces are not novel individually. Governments contract with vendors all the time. Healthcare software companies contract with providers all the time. Grant administration is a real category. Benchmarking exists. What is novel is putting them in the same company and connecting them, because the connection between state contract revenue and provider software stickiness is what makes the unit economics work in a market where individual rural facilities cannot pay enough to support a typical SaaS company.

The architecture that fits is something like a four-layer stack. A funding orchestration layer that helps states deploy RHTP money and providers apply for federal grant money. A care delivery layer that runs the actual programs, whether that is chronic disease management, virtual specialty consults, workforce development, or remote patient monitoring. A state command center layer that gives the state agency a real-time view of what is working and what is not. And a data and benchmarking layer that creates network effects across states by letting each state see how its programs compare. The first two layers generate revenue from state contracts and provider subscriptions. The third creates switching costs because once a state agency is running its rural pro-

out of a particular dashboard it is institutionally married to that vendor. The fou
the moat.

Revenue across the four layers comes from a mix that any healthcare investor wil
recognize. State implementation contracts at \$4M to \$8M annual contract value,
a take-rate component of roughly two percent on the funds the platform helps d
Provider SaaS at \$50K to \$250K per facility depending on size and module count
Grant administration fees as a percentage of funds raised. Value-based care
arrangements with the larger rural systems. Data licensing to pharma, payers, an
policy researchers once the cross-state dataset has scale. Each line is a real reven
stream that has been proven elsewhere in healthcare. The combination is what is

Five-year financials on a plausible ramp get to \$121M ARR by Year 5 starting fro
\$2M in Year 1, with breakeven in Year 4 and Series A use of funds around \$20M
numbers are conservative against the size of the underlying capital stack but the
assume the company actually wins state contracts in five Tier 1 states and lands
provider software in two hundred plus rural facilities, which is the execution ris

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