Transforming Rural Health: Strategy, Risk, and What Comes Next

HFMA MASI Conference

Liz Matney, Medicaid Leader · RSM US LLP · August 2026

Liz Matney, Medicaid Leader

- Elizabeth Matney is the Medicaid Leader in Risk Consulting at RSM US LLP, bringing nearly two decades of senior leadership experience in public-sector health and human services. She previously served as Iowa's Medicaid Director, overseeing an $8+ billion program serving nearly 900,000 Iowans. In that role, she led major reforms including Home and Community-Based Services transformation, postpartum coverage expansion, a comprehensive provider rate review process, and implementation of a directed payment program investing more than $900 million annually in Iowa hospitals.

Learning Objectives

1

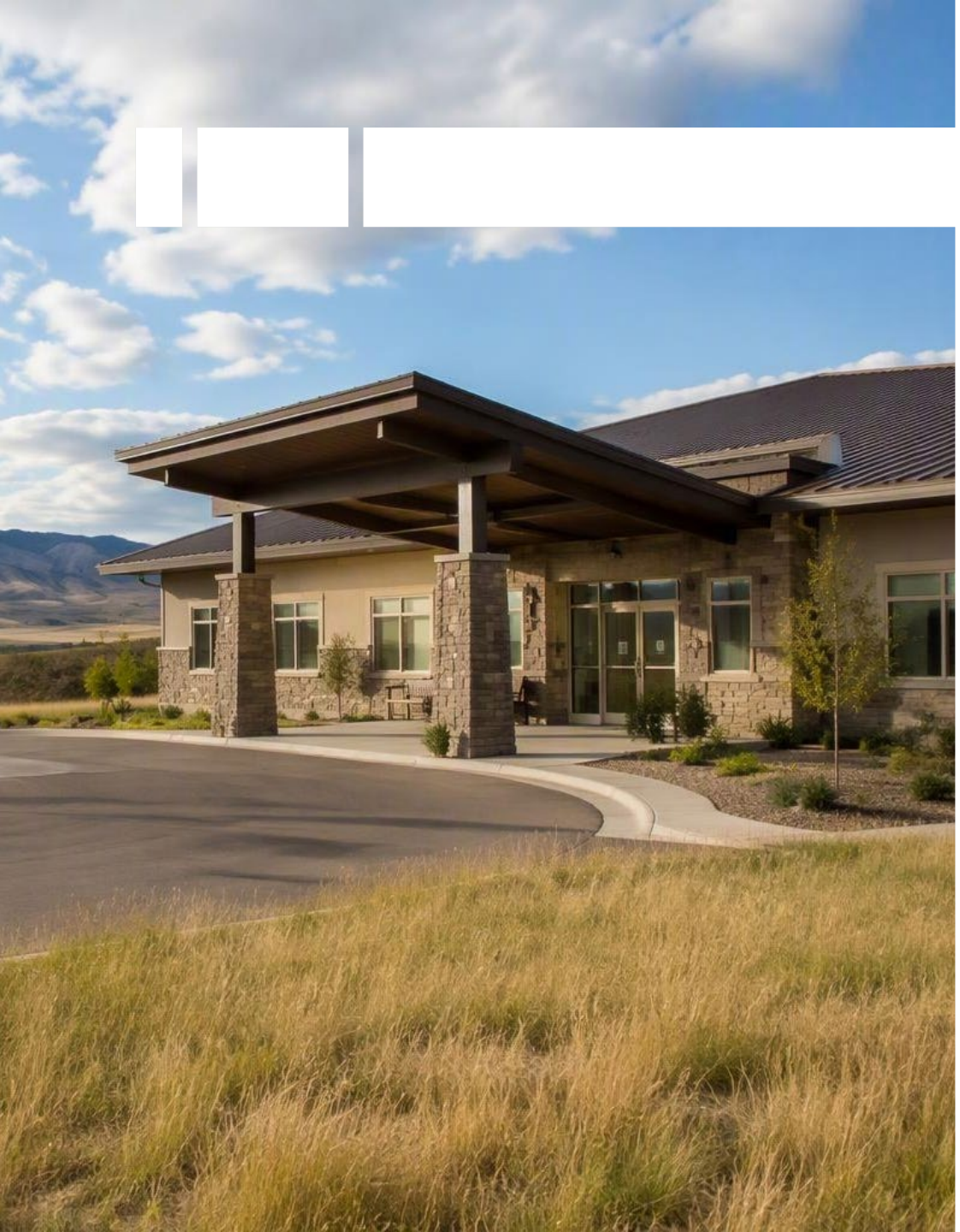
Understand the federal objectives of the Rural Health Transformation Program

2

Learn about how the Rural Health Transformation Program can be leveraged to prepare for Medicaid funding changes

3

Understand the rules of Rural Health Transformation Program funding and how to be compliant



Rural Health Is at an Inflection Point

This is not a funding story, it is a transformation story. Rural health faces structural change, not just a funding gap.

The tension leaders must manage

- Largest rural investment in decades: the $50B Rural Health Transformation fund
- Occurring alongside significant Medicaid structural changes
- Time-limited funding versus permanent reimbursement shifts
- Leaders must balance short-term opportunity with long-term sustainability

Poll #1: Where is your organization today?

01	Not started
02	Monitoring / early discussions
03	Active planning underway
04	Already executing initiatives

What Is Happening: The RHT Landscape

$50B

Total funding over five years (2026–2030)

Each one-year tranche is $10B

50 States

All states funded

Baseline funding for each state is $100m

Annual

Performance-based and re-scored every year

Annual reallocations and new budget funding dependent on previous performance

2032

Final closeout of all five, one-year funding tranches

Unused funds to be returned to the federal government

50/50

$25B distributed equally to states over 5 years

$25B distributed based on scored state application each year

The message: $50B is on the table for every state, but it's time-boxed to 2032 and re-scored every year — this is a competitive, performance-based transformation program you must act on now, not a guaranteed grant.

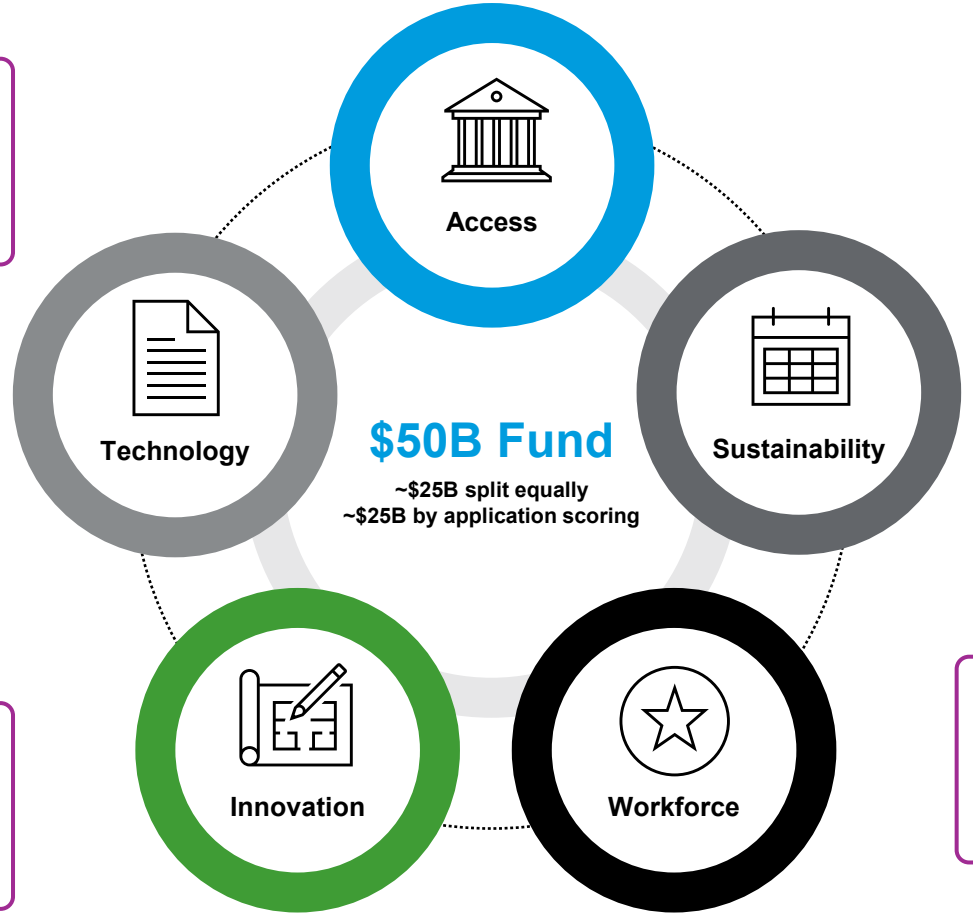
The Intent: Transformation, Not Stabilization

CMS is explicit: this funding is meant to change the system, not preserve current operating models or backfill revenue losses.

Access
- Expand telehealth and mobile clinics
- Protect OB, ED, and specialty coverage

Technology
- Modernize EHR and interoperability
- Strengthen cybersecurity and data

Innovation
- Deploy remote monitoring and AI triage
- Build regional shared-services models

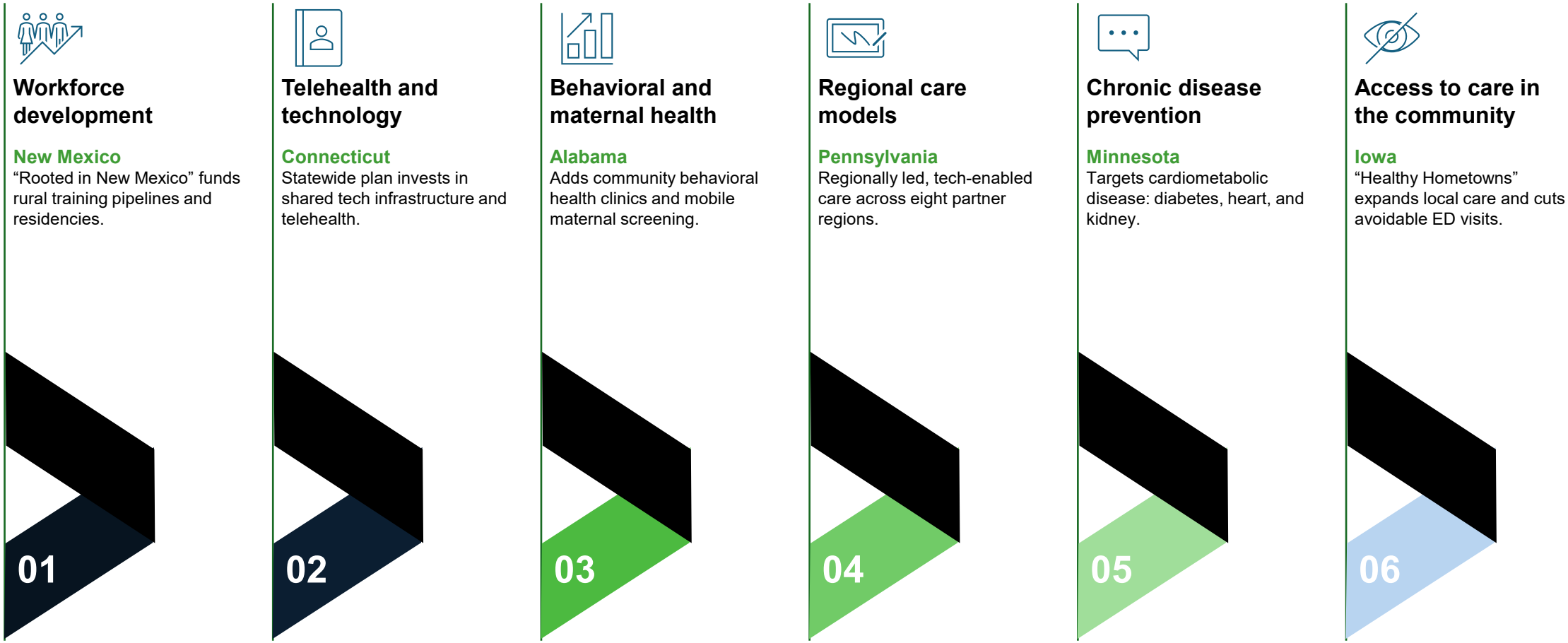


Sustainability
- Right-size service lines to demand
- Move toward value-based payment

Workforce
- Grow rural training and residencies
- Fund retention and remote staffing

National Trends in RHT Investments

Across states, six consistent themes: funding is flowing toward new models, not legacy structures.



The Reality Check: “The Math Doesn’t Math”

RHT funding does not offset Medicaid changes. RHT is transformation capital, not financial replacement.

~$137B

Estimated rural Medicaid reductions over 10 years

~$58B

Projected impact to rural hospitals

$50B

Total RHT funding (5 years, time-limited)

Structural constraints:

10% admin

15% provider payments

5% on EMR

20% on capital expenditures and infrastructure

Why This Matters for Healthcare Leaders

Short-Term Funding Opportunity (RHT) Move fast to access time-limited funds.

Long-Term Structural Pressure (Medicaid) Maintain discipline to avoid future risk.

You are managing two overlapping realities.

The tension: move fast to access funds, but stay disciplined to avoid future risk.

Key Challenges Facing Providers

Structural pressures that make transformation hard to execute.

Financial Pressure

- Medicaid dependence
- Thin margins
- Structural reimbursement risk

Working within it

- Diversify revenue and quantify Medicaid exposure early to protect margins.
- Assess revenue cycle for improvements to margin.

Operational Complexity

- Limited administrative capacity
- Need for rapid implementation

Working within it

- Lean on shared services and phased rollouts to build capacity without overextending.
- Assess workflows and where processes can be automated for efficiency.

Workforce Constraints

- Staffing shortages
- Retention challenges

Working within it

- Invest in retention, cross-training, and telehealth to stretch existing staff.
- Develop strategies for clinicians to practice at the “top of their license”.

Execution, Compliance & Leadership Risk

Problems rarely appear during execution, they surface years later.

Predictable Failure Patterns

- Speed prioritized over controls
- Documentation gaps
- Inconsistent guidance
- Late-stage audit exposure

Leadership Accountability

- Accountable to CMS, state agencies, legislatures, and communities

Biggest Risk

- Moving quickly without building defensible structure

So what: Build compliance and governance discipline now. The risk isn't moving fast, it's moving fast without a defensible structure.

Poll #2: How confident are you in execution?

01	Not confident
02	Somewhat confident
03	Confident
04	Very confident

What Providers Should Be Doing Now

Shift from opportunity thinking to readiness execution.

Financial exposure
Quantify Medicaid revenue at risk

Scenario modeling
Model multiple financial futures

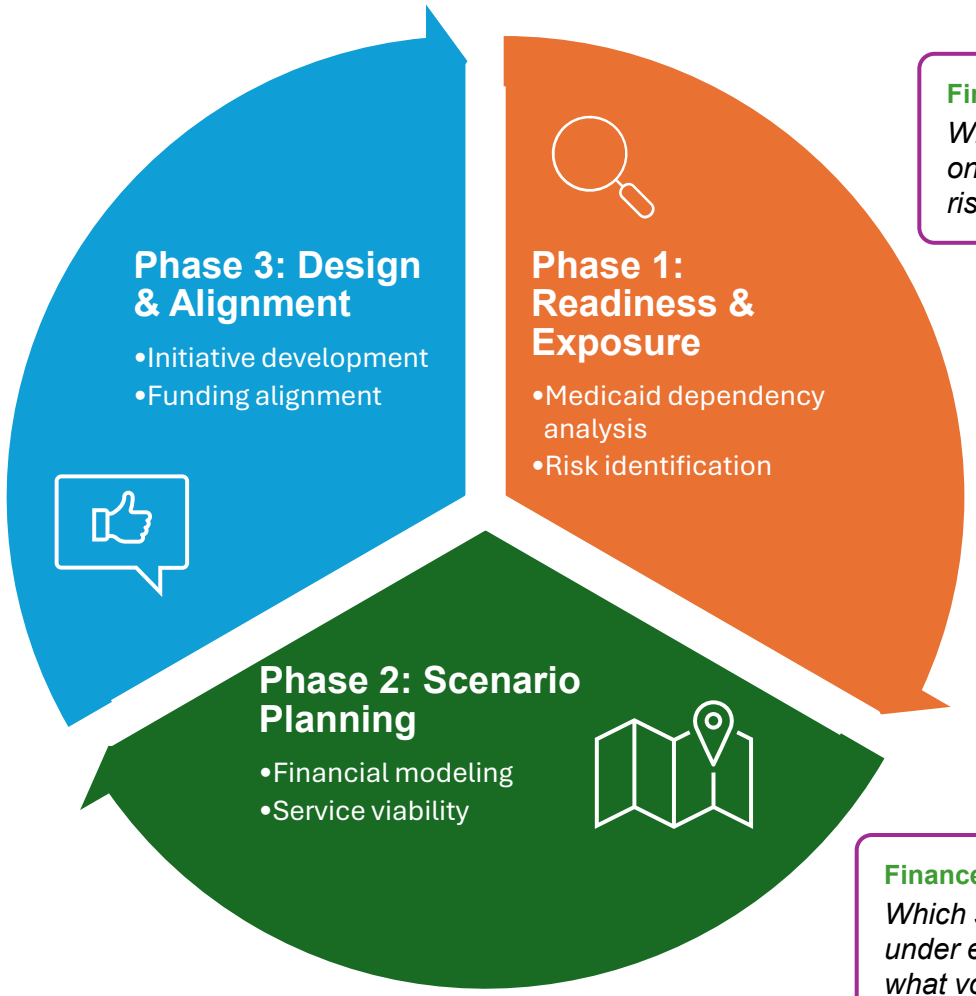
Service line evaluation
Assess which lines stay viable

Strategic state alignment
Align with state RHT priorities

The providers who act now (building readiness, aligning stakeholders, and strengthening data) will be positioned to lead when funding decisions are made.

RHT Readiness Framework

A phased approach: Phases 1 through 3.



Finance team asks

Do our initiatives match state RHT priorities and the funding criteria we must meet?

Finance team asks

What share of our revenue depends on Medicaid, and how much is at risk if rates fall?

Finance team asks

Which service lines stay viable under each funding scenario, and at what volume?

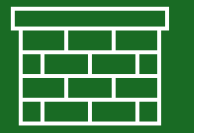
Implementation & Sustainability

Phases 4 and 5 turn planning into durable results.

Phase 4: Implementation

- Governance
- PMO structure
- Compliance controls

Phase 5: Sustainability



- Outcome measurement
- ROI tracking
- Scaling successful models

The payoff: a financially resilient rural health system that sustains access, quality, and outcomes long after the funding period ends.

What “Transformation” Actually Means

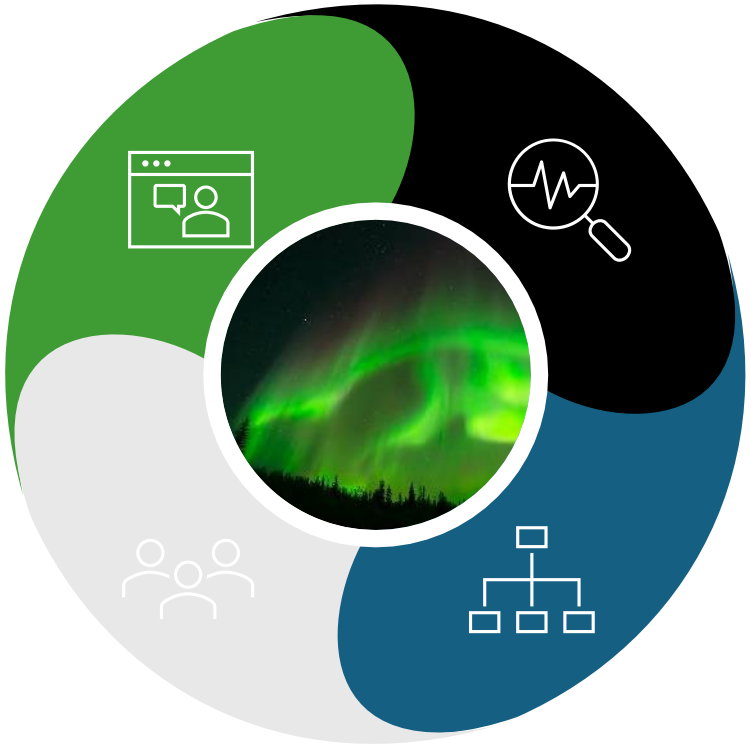
Transformation = doing things differently, not just funding them.

Shifting Care Settings

Move care from inpatient to outpatient and virtual settings.

Regional Partnerships

Build shared services across organizations.



Workforce Redesign

Rethink roles, staffing, and care teams.

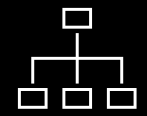
Technology-Enabled Care

Deliver connected, digital care models.

The Role of Compliance and Oversight

Monitoring begins at program start

Compliance is not administrative, it is strategic. Embedding from day one mitigates future headaches and paybacks.



Standardization is critical

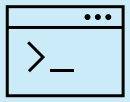
Consistent processes ensure repeatable, auditable results across programs.

Risk-based oversight is targeted

Focus scrutiny where exposure and impact are greatest.

Failure to embed compliance = future financial exposure

Gaps today become material costs and liabilities tomorrow.



What's Next and How to Use RHT

Medicaid funding changes begin to materially impact providers in 2027–2028; the RHT window closes as financial pressure increases.

Risk: Revenue Compression

- Structural, permanent Medicaid reductions rather than temporary budget constraints.
- Supplemental and directed payments phase down beginning 2027, shrinking net patient revenue.
- Lower Medicaid eligibility and enrollment push more care into uncompensated and self-pay.
- Thin margins and a fixed cost base leave little room to absorb rate cuts.
- Waiting until 2028 forces reactive cuts to services and staff.

Opportunity: System Redesign

- Use RHT to redesign cost structures, build sustainable care models, and reduce reliance on unstable funding.
- Fund telehealth, remote monitoring, and shared services to lower per-visit cost.
- Regionalize or consolidate service lines to match demand and protect access.
- Diversify revenue into value-based care, grants, and partnerships beyond Medicaid.
- Move early: front-loaded RHT dollars reward a credible transformation plan.

The call to action: act while the RHT window is open to convert unavoidable Medicaid revenue risk into a redesigned, financially sustainable system.

Poll #3: How prepared are you for 2027?

01	Not prepared
02	Early planning
03	Moderately prepared
04	Well prepared

Act early 01

Align strategy with funding intent 02

Balance speed and discipline 03

Sustain long-term 04

The Leadership Imperative

Organizations that succeed will act with discipline.

Key Takeaways

What to remember as you plan your response.

Transformation Capital

- RHT is transformation capital, not financial relief.
- Dollars are one-time and front-loaded; they fund change, not ongoing operations.

Immediate actions

- Define the transformation outcomes each dollar must buy.
- Build a multi-year business case before applying.

Execution Is the Risk

- The biggest risks are execution and compliance failures.
- Weak governance, reporting gaps, and slow rollout erode the funding's value.

Immediate actions

- Stand up a PMO with clear owners and milestones.
- Put compliance and reporting controls in place from day one.

Medicaid Is Structural

- Medicaid changes are structural and imminent.
- Cuts are permanent and begin to bite in 2027–2028, not years away.

Immediate actions

- Quantify Medicaid exposure and model rate scenarios now.
- Engage the board and state early to shape your RHT plan.

RSM

> This program moves us from a system that has too often failed rural America to one built on dignity, prevention, and sustainability.
>
> **Dr. Mehmet Oz, Centers for Medicare & Medicaid Services Administrator**

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