HFMA GREATER HEARTLAND

Rural health transformation

Turning federal investment into durable access while protecting the funds

Liz Matney | RSM US LLP
Jana Cook, MBA, CPA | Phelps Health

Kansas City | October 30, 2026 | 9:30 a.m.



Learning objectives

What finance leaders should be able to do after this session

1

Understand

Explain how federal funding moves through state plans, opportunities and provider agreements.

2

Compare

Describe how Missouri and Kansas are using different project portfolios and participation routes.

3

Evaluate

Test an opportunity for strategic fit, cash timing, operational capacity and post-award affordability.

4

Protect

Identify the financial, documentation and reporting controls needed to support a defensible award.

Four questions finance leaders must answer

A state and provider view of opportunity, execution and accountability

1

What is RHTP buying?

Access, delivery redesign, workforce, technology and sustainability. It is not unrestricted operating relief.

2

What are Missouri and Kansas implementing?

Each state is using a distinct portfolio, delivery model and provider participation path.

3

Should we pursue the opportunity?

Strategic fit is necessary. Capacity, evidence, cash timing and recurring affordability determine viability.

4

How do we protect the organization?

Clear terms, disciplined evidence and early issue escalation reduce recovery risk.

RHTP is temporary funding for durable system change

The state award is the start of the delivery chain, not a provider authorization to spend

Federal framework

$50 billion across fiscal years 2026 through 2030. States are the federal recipients.

State plan and award

The approved initiative, budget, amendments and written direction define the state commitment.

Provider pathway

A solicitation, subaward, contract or other state-defined arrangement establishes the provider route.

Evidence and sustainability

Spending must connect to approved scope, measurable rural benefit, supporting records and a continuation plan.

A state award announcement does not establish eligibility, approved scope or spending authority for an individual provider.

Federal authority, CMS NOFO and current award documents control.

What can be funded and what still constrains the investment

A permissible category does not by itself authorize a provider cost

A to C

Prevention, provider payments, consumer technology

D to F

Training, workforce, information technology

G to I

Care availability, behavioral health, innovative care

J to K

Capital and infrastructure, collaboration

10%

Administration

State and subrecipient aggregate

15%

Provider payments

Per budget period

20%

Capital and infrastructure

Per budget period

Generally no

New construction

Alterations, renovation and equipment only

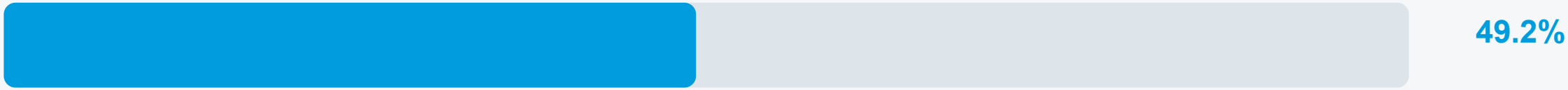
Every cost must be necessary, reasonable, allocable, approved, supported and not duplicative.

Missouri and Kansas: Budget Period 1 funds put to work

CMS state-reported information through July 31, 2026

MISSOURI

$216.3M BP1 award



$106.3M reported as put to work

KANSAS

$221.9M BP1 award



$127.0M reported as put to work

These figures include state agencies, contractors, community partners, hospitals and facilities. They are not provider cash receipts or proof of completed services.

Missouri: ToRCH Care links local hubs to statewide infrastructure

The public plan organizes transformation through five coordinated initiatives

Regional networks and hubs

Seven regional coordinating networks and 30 local community hubs are planned to coordinate physical health, behavioral health and social services.

Rural workforce

The portfolio includes cultivation, recruitment, training and retention of rural clinicians and other health professionals.

Alternative payment models

The state plan describes payment incentives tied to collaboration, quality and value. The July 31 obligation report did not provide Initiative 2 detail.

Provider transformation

The plan includes operational innovation, remote patient monitoring, ambient artificial intelligence and strategic renovations.

Digital backbone

The plan includes interoperability, data modernization and a Rural Health Data Collaborative.

Finance leader focus

- Understand the hub role and agreement structure.
- Separate state-planned activity from an executed provider award.
- Model local service costs, data requirements and recurring payment.

Missouri: project detail reported through July 31

Selected state-reported uses of Budget Period 1 funds

$15.22M

Discretionary hubs and local partner delivery

Local care gaps, including nutrition, transportation, perinatal home visits and school-based clinics.

$4.70M

Mobile health units

Mobile capacity within the regional network and hub initiative.

$24.42M

EHR replacement and implementation

Information technology investment within the Digital Backbone initiative.

$9.76M

Data analytics and reporting

Program-wide analytics, reporting and dashboards.

$3.91M

Community-tailored retention

Childcare planning, temporary housing, transportation and other rural practice supports.

$6.72M

Provider transformation tools

Remote patient monitoring and ambient artificial intelligence licensing, implementation and change support.

Selected obligations, not a complete budget and not provider cash receipts. Amounts rounded.

Kansas: five initiatives connect access, workforce, value and technology

The state plan reaches rural communities and multiple provider types

01	**Prevention**	Evidence-based practices, Accountable Food Is Medicine, community health workers and consumer-facing tools.
02	**Local primary care access**	Regional partnerships, behavioral health integration, transportation and support for provider financial performance.
03	**Sustainable workforce**	Rural residencies, rotations, nursing support, preceptor incentives and apprenticeships.
04	**Value-based care**	ACO readiness, a shadow value-based care pathway and support for accountable relationships.
05	**Data and technology**	Remote patient monitoring, telehealth navigation, emerging technology and data infrastructure.

Kansas states a goal of placing 100% of rural Medicare and Medicaid beneficiaries in accountable care relationships by 2031.

Kansas: project detail reported through July 31

Selected state-reported uses of Budget Period 1 funds

Project	Reported amount	Initiative area
Rural residency program	**$8.50M**	Workforce
Evidence-Based Practices program	**$22.38M**	Prevention
Provider payments for evidence-based practices	**$11.00M**	Provider payments
ACO Readiness Program	**$3.40M**	Value-based care
Emerging Technology Program	**$12.76M**	Technology
Remote patient monitoring	**$9.75M**	Technical assistance
Behavioral health crisis transports	**$2.71M**	Care availability
Diabetes Dock	**$1.10M**	Information technology

Selected obligations, not a complete budget and not provider cash receipts. Amounts rounded.

What the two state models mean for providers

Both states fund transformation, but the operating entry points differ

	MISSOURI	KANSAS
Primary structure	Regional networks and local community hubs	Statewide program portfolio with regional partnerships and accountable care pathways
Visible provider entry points	Hub services, mobile health, digital backbone, workforce supports and transformation tools	Evidence-based practices, regional partnership projects, workforce programs, ACO readiness and technology programs
Finance questions	What role will the organization play in the hub? What costs and data obligations sit locally?	Which program fits the provider and what recurring payment or operating support follows the grant?
Evidence focus	Hub activity, service touchpoints, utilization, outcomes and local partner performance	Program adoption, provider performance, accountable care readiness and measurable clinical or operating change

In both states, confirm the current opportunity, eligibility, instrument, approved scope and payment terms before committing resources.

Before you say yes, classify the relationship

The announcement label does not determine the federal award pathway

SUBRECIPIENT

Carries out part of the federal program

Programmatic responsibility
Performance tied to program objectives
Subaward, risk assessment and monitoring

2 CFR 200.331 and 200.332

CONTRACTOR

Provides goods or services for the program

Procurement relationship
Competitive environment
Deliverables, price and contract administration

2 CFR 200.331 and procurement rules

BENEFICIARY OR PARTICIPANT

Receives a program benefit

Eligibility and benefit conditions
May have service or use commitments
Does not carry out the federal program

Program and agreement terms

Substance governs. Classification changes procurement, monitoring, audit, reporting and flowdown requirements.

Eight tests before pursuing an award

A provider decision framework for finance, clinical, operations, technology and compliance leaders



Strategic fit

Does it solve a priority access gap?

Financial model

Can we fund total cost and cash timing?

Operational capacity

Who delivers while running today's business?

Partners

Are dependencies documented and governable?

Compliance burden

Can we meet procurement, evidence and reporting terms?

Outcomes

Can we establish a credible baseline?

Sustainability

Who pays for staff, licenses and maintenance later?

Financial risk

What can be withheld, disallowed or recovered?

The business case must survive the end of the grant

Build the recurring operating model before the first dollar is spent

1

Access case

Defined rural gap, population and service pathway

2

Delivery case

Workforce, technology, referral and partner dependencies

3

Evidence case

Baseline, milestones, data owner and source records

4

Economic case

Total cost, cash timing, reimbursement and avoided cost

5

Sustainability

Post-award owner, financing and exit decision

Grant-only staffing

If the care model ends when temporary positions end, the proposal does not have a durable operating model.

Technology without adoption

Licenses, integration, workflow change, training, cybersecurity and support belong in the cost model.

Outcomes without a baseline

Define the source system, owner, reporting frequency and reconciliation before accepting a target.

A defensible expenditure has an unbroken evidence chain

Finance should be able to trace each material cost from authority to result



ALLOWABLE + APPROVED + DOCUMENTED + MEASURABLE + SUSTAINABLE

Prior approval

Was approval obtained before implementation?

Cap tracking

Does the cost fit category and aggregate limits?

Nonduplication

Is another payer or funding source covering it?

Procurement

Is competition and price reasonableness documented?

Report reconciliation

Can reported performance be reconciled to records?

Provider controls should support delivery, not create a second bureaucracy

Prepare once and document continuously

GOVERN	SET UP	SPEND	DELIVER	CHANGE	PROVE
Executive sponsor Accountable owner Decision rights	Agreement register Budget crosswalk Roles and training	Purchase and payroll support Approvals Segregation	Milestones and metrics Partner performance Data quality	Written approvals Version control Issue log	Evidence file Reconciliation Closeout
01	02	03	04	05	06

Recovery risk is not one event

Name the pathway before deciding how to prevent or respond

Pathway	Trigger	Potential consequence	Provider response
Redistribution	Funds remain unexpended by the statutory deadline	Balance may move to other states	Timing and obligation forecasting
Disallowance or recovery	Cost is unallowable, unsupported or outside approved scope	Repayment, debt or withholding	Preapproval and evidence chain
Policy score recovery	A scored state policy commitment is not completed	Incremental funding may be recovered	State commitment tracking
Lower future funding	Checkpoint, performance or scoring decline	Reduced future funding	Reliable measures and milestone delivery
General remedies	Serious or persistent noncompliance	Conditions, withholding, suspension or termination	Early correction and escalation

State and provider collaboration works when decisions are specific and documented

The strongest relationship combines clear terms with early operational feedback



State perspective

Translate priorities into clear selection and award terms.

Distinguish mandatory rules from state design choices.

Provide consistent written guidance and change control.

Use risk-based oversight and targeted assistance.

Provider perspective

Bring operational reality before terms are final.

Ask about cash flow, evidence, milestones and remedies.

Name partner dependencies and capacity constraints.

Surface issues before a report or payment is due.

A 90-day provider readiness plan

A management sequence, not a federal deadline

DAYS 0 TO 30

Understand and assign

- Map award requirements to agreement terms.
- Name executive, finance, program, data and compliance owners.
- Confirm classification, budget, milestones, reporting and approval rules.

DAYS 31 TO 60

Build and rehearse

- Configure project codes and the evidence repository.
- Train procurement, payroll, accounts payable and program teams.
- Rehearse invoice and performance reporting using a sample month.

DAYS 61 TO 90

Test and improve

- Run a sample review and source-to-report reconciliation.
- Validate partner files and applicable flowdowns.
- Escalate gaps and document corrective actions and approved changes.

Three commitments for durable rural transformation

Design the care model, operating capacity, controls and financing pathway together

DESIGN

Start with the rural access problem. Build the delivery model, partnership structure and recurring economics around it.

EVIDENCE

Make scope, spending, milestones, decisions and course corrections traceable from the first day.

SUSTAIN

Decide who will operate and finance what works after temporary funding ends.

Questions and discussion

What evidence will you wish you had one year from now?