Congress of the United States

Washington, DC 20515

November 19, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Oz:

We write with serious concerns regarding the Centers for Medicare & Medicaid Services' (CMS) implementation of the Rural Health Transformation Program (RHTP). Recent delays in second-year funding, an alarming lack of public transparency into how funds are being distributed, and uncertainty surrounding the framework CMS will use to evaluate state performance and make consequential funding decisions are jeopardizing the program's stated goal of transforming rural health care.

Rural health care in America is in an acute state of crisis. Rural Health Clinics, hospitals, and health systems were already under significant financial strain before the enactment of H.R. 1 last year. Many operate on thin or negative margins while confronting workforce shortages, low patient volumes, aging infrastructure, and growing costs. Since 2005, 197 rural hospitals have closed or stopped providing inpatient care, and access to critical services has continued to erode. Even when hospitals remain open, financial strain can force them to reduce or eliminate essential services.

These pressures are further compounded by H.R. 1, which is projected to reduce federal Medicaid spending in rural areas by roughly $137 billion over ten years, in addition to increasing uncompensated care costs by nearly $20 billion. To counter some of these cuts, H.R. 1 established RHTP and provided $50 billion over five years, leaving a massive funding gap and further accelerating the challenges for rural health providers to continue providing care. This makes it all the more important that the limited resources available through RHTP reach rural providers and patients without unnecessary delay and with clear accountability for how the funds are used.

The program's rollout created severe operational roadblocks. The U.S. Government Accountability Office (GAO) found that CMS took an average of six weeks to approve states' revised first-year budgets, leaving states only four to seven months to demonstrate progress before their performance was evaluated for future funding. CMS must not allow internal administrative delays to compress state timelines and then penalize states for a resulting lack of progress. Without timely, complete funding information from CMS, states cannot effectively plan budgets, coordinate with rural providers, or make informed decisions on how to deploy RHTP resources.

GAO also reported that CMS plans to use states' progress in implementing RHTP initiatives to help determine future awards. Given the delays and rushed implementation timeline states have

already faced, CMS should be transparent about how states will be evaluated, how funding decisions will be made, and what opportunities states will have to address concerns before funding is reduced or recovered. CMS also has significant authority to withhold, reduce, or recover RHTP funding if states fail to comply with program requirements. The prospect of funding clawbacks has raised concerns about what could happen to funding that has already been passed through to rural hospitals, clinics, and other organizations. States and rural providers need clear guidance about the circumstances in which funding may be taken back and a fair opportunity to address problems before rural communities lose resources they may already be relying on.

RHTP currently lacks sufficient guardrails to protect rural hospitals at greatest risk of closure. Under-resourced independent facilities often lack the staff to navigate rushed, prescriptive state applications, while narrow funding priorities overlook immediate needs like workforce retention, infrastructure repairs, and debt relief. Long-term transformation cannot come at the expense of keeping doors open today – CMS must provide clearer guidance, technical assistance, and flexibility for struggling providers.

These challenges are compounded by stringent reporting requirements that have created an unrealistic burden on states and grantees that could impact future award allocations from CMS. Under these strict reporting requirements, states are spending hundreds of hours reporting on in-progress projects, diverting time and resources away from demonstrating project outcomes necessary to receive continued RHTP funding. Additionally, with a lack of clear guidance from CMS, states are left in the dark about whether and how annual reports will factor into changes in second- or third-year grant awards. We therefore urge CMS to publish clear reporting requirements for RHTP funding and to incorporate state feedback following the first year of implementation. CMS can ease this burden by streamlining narrative progress reporting, but it should preserve recipient-level financial data, which states and intermediaries already maintain and which makes oversight of these funds possible.

We are similarly concerned by the lack of public visibility on the distribution of RHTP dollars. CMS requires states to submit extensive financial and performance information, but individual state progress reports have not been released by the agency. CMS's new State Data Maps are a helpful first step, but they provide only state-level funding totals, initiatives, and policy comments. The maps do not distinguish funds obligated from those spent, identify recipients, or show how much went to consultants and vendors rather than providers, and the data cannot be downloaded. Recent reporting based on state documents found that six states entered into multimillion-dollar consulting contracts totaling more than $60 million, in addition to other significant contracts with management and technology firms. Consultants, vendors, and other intermediaries can play an important role in helping states implement rural health initiatives.

However, RHTP was created to strengthen rural health care, and we are concerned that too much of this limited funding could flow to large consulting and technology firms rather than supporting providers and communities on the ground. Congress and rural communities should be able to see how much funding is going to consultants, contractors, and other intermediaries, the specific activities that these entities will pursue, and how much ultimately reaches patients, rural hospitals, clinics, EMS providers, and other organizations delivering care in rural areas.

Accordingly, please respond to the following questions and requests by Wednesday, November 25, 2026.

1. Will CMS establish a centralized, public, searchable, and downloadable RHTP reporting system – building on its State Data Maps – that tracks approved plans, progress reports, and funding from award to expenditure by provider CMS Certification Number or National Provider Identifier, while distinguishing administrative, consulting, and technology spending from funds reaching community-based providers?

2. How will CMS evaluate state performance and determine future RHTP awards – including what factors and metrics will govern funding adjustments, how CMS will account for agency-caused delays or approved program modifications, and whether state-specific determinations will be made public?

3. Please explain the circumstances under which CMS may withhold, reduce, or recover RHTP funding, including through clawbacks, and how the existing 90-day remediation period will operate. What opportunities will states have to correct factual or technical errors or otherwise respond to CMS concerns before a final funding decision is made? Will CMS commit that it will not recover funds already paid to compliant rural providers and subrecipients for allowable activities because of state-level administrative failures outside of their control?

4. What steps and evaluation metrics is CMS using to ensure states direct RHTP funding to rural hospitals and providers at greatest risk of closure, particularly under-resourced facilities lacking the administrative capacity to navigate complex state applications?

5. What administrative process caused CMS to delay complete Budget Period 2 awards until November 9? Will CMS extend the November 30 revised budget deadline so states have adequate time to coordinate with rural providers, and how will this delay be factored into future performance evaluations?

Rural hospitals and providers are community lifelines bracing for steep Medicaid cuts under H.R. 1. While RHTP cannot fully replace those lost resources, available funds must reach the front lines in a timely, transparent manner – strengthening local hospitals, clinics, EMS providers, and health care workers rather than being lost to administrative delays or excessive spending on consultants and intermediaries.

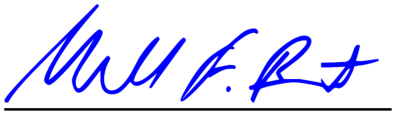
In addition to your written response, we request a briefing from CMS and the Office of Rural Health Transformation regarding the Budget Period 2 award delay and its impact on state planning, RHTP reporting and recipient transparency, state performance evaluations and future award determinations, and the procedures governing the withholding, reduction, or recovery of RHTP funds.

Sincerely,

Nikki Budzinski
Member of Congress



Terri A. Sewell
Member of Congress



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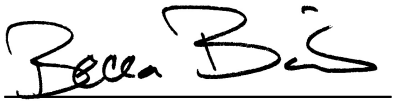

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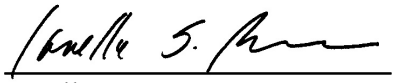

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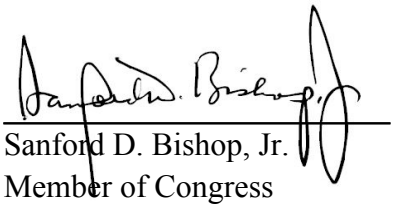

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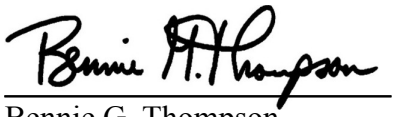

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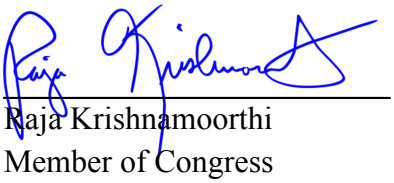

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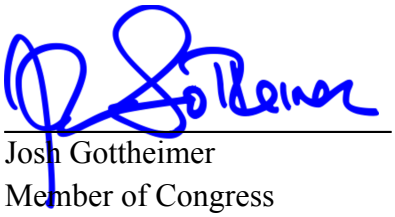

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