

CMS tightens grip on \$50B rural health fund with clawback threat



(Daniel Heuer/Bloomberg)

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By

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Key Takeaways

- CMS is actively rejecting and reshaping state plans under the \$50 billion Rural Health Transformation Program.
- Federal officials can rescind existing awards or reduce future funding if states don't meet goals.
- CMS Administrator Mehmet Oz said the clawback mechanism gives governors leverage to press their legislatures to adopt the Trump administration's priorities.

AI-assisted summary, editor reviewed

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In Maine, state health officials hoped to steer a slice of \$190 million in new federal rural health funding to shield hospitals and clinics from the fallout caused by cuts to federal health programs.

Their plan would have helped pay to treat low-income, uninsured patients.

But federal leaders overseeing the five-year, \$50 billion Rural Health Transformation Program said no.

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“It was not our decision,” said Lisa Letourneau, a senior adviser at Maine’s health department.

Letourneau told an audience of healthcare providers, advocates, and community groups during a March webinar that the change was “disappointing.”

Maine isn’t alone in having to make changes to plans pitched to win a share of the Trump administration’s new rural health fund.

Centers for Medicare & Medicaid Services Administrator Mehmet Oz praised states’ plans when announcing the rural health program awards last year and said his agency would help states “turn their ideas into lasting improvements for rural families.”

But state officials and healthcare leaders said it’s also clear the agency wants to encourage specific policy changes and hold states accountable to the promises they made and rules they agreed to follow.

During the past six months, as states raced to meet the program’s looming federal deadlines, CMS staffers worked with state health departments to make a flurry of changes, including scrapping some initiatives. The federal agency has the power to rescind existing funding — or reduce future awards — if states don’t follow rules or meet their goals. “We will take the money back” if states “don’t abide by what they wrote, if they don’t do a good job,” Oz said at an event this month in Washington, D.C.

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Congressional Republicans created the Rural Health Transformation Program as a last-minute sweetener in their One Big Beautiful Bill Act last summer. The funding was intended to offset concerns about the outsize fallout anticipated in rural communities from the law, which is expected to reduce Medicaid spending by more than \$900 billion over a decade.

On a call with reporters in December, Oz said “one of the smartest things the president and Congress” did when creating the program was to create a threat of “clawbacks,” or taking money back if states don’t do what they promised in their applications.

Oz went on to describe how the clawback mechanism gives governors leverage to press their legislatures to adopt the Trump administration’s priorities, such as instituting the presidential fitness test in schools.

“This gives you extra umph, a little bit of gusto to go after these issues,” he said.

That message was received loudly and clearly in Tennessee. Michael Hendrix, policy director for the governor’s office, said during a hearing that federal officials said the state “would be more competitive for more funding through policy change.” He said CMS also relayed that “some share of this year’s funding, if policies are not implemented, might be clawed back.”

The threat of rescinding funding has caused fear and confusion among health organization leaders, said Alan Morgan, CEO of the National Rural Health Association.

“We’re worried that facilities and organizations won’t apply for the grant money because of the fears of the clawbacks,” he said, adding that he would like the administration to clarify if federal officials could take back grant money that states have already awarded to rural health organizations.

While clawbacks are a “necessary, important tool” to address misuse of funds and ensure the money goes toward helping rural communities, they are also “a dangerous tool,” said Morgan, whose organization represents rural hospitals and clinics.

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CMS did not respond to multiple requests for comment.

States must file progress reports by the end of August. They then have until Oct. 30 to commit their first-year funding and Sept. 30, 2027, to spend it.

States are progressing at wildly different rates, with some still developing grant applications and others already distributing money, according to a tracker created by Morgan's rural health association.

In late January, Iowa became the first to award funding. The tracker shows that most states have opened grant applications, but 11 others, including Wyoming, Maine, and Colorado, have yet to post any funding opportunities.

CMS' tight control over state programs is one reason for such disparity in progress.

Instead of typical grants, the rural health program uses cooperative agreements, which require a back-and-forth partnership, said Charlie Sagona, a grant specialist at Assel Grant Services, a consulting firm that helps organizations manage grants.

"You are going to be working very, very closely with them; things will ebb and flow and change and move," said Sagona, who is helping several large hospital systems interested in winning some of the rural funding.

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Kate Sapra, deputy director of CMS' Office of Rural Health Transformation, said at a May event that the agency has "many avenues of oversight." Staffers are tracking applications for state funding and "looking to see when contracts are executed," she said.

Sapra said the agency wants to "have conversations with states before they get to the point" of putting out something that's not allowed. It's "really important to us" for the funding to reach rural providers, she added.

Sapra said her office has filled about half of 30 new slots for project officers. The officers and the states check in "at least twice a month, if not on a weekly basis."

Vermont Medicaid Director Jill Mazza Olson, who led her state's rural health application, said the officers are "very responsive."

Vermont is one of the states that had to ditch or tweak its plans. Olson said the state pulled its plan to increase housing for rural healthcare workers after

federal officials said they would evaluate the proposal based on the agency's guidelines for construction projects at healthcare facilities. Those rules allow only "minor" renovations to existing buildings or campuses.

In Colorado, state leaders changed grant eligibility rules after they "received feedback" from CMS and healthcare providers, said Marc Williams, a spokesperson for the state's Department of Health Care Policy and Financing.

Wyoming legislators and state officials spent months designing, discussing, and voting on a plan to invest most of its award into a perpetuity fund that could have generated \$28.5 million for the state to spend every year, "forever," according to materials presented to lawmakers.

The state had to pull the idea because it "was a degree too innovative for CMS to swallow," said Republican state Sen. Charles Scott, a veteran lawmaker and cattle rancher. "This whole thing has been a bit of a disappointment to us in Wyoming."

Stefan Johansson, director of the state's health department, said Wyoming's final spending plan wasn't approved until mid- to late May. He said the department hopes to begin awarding money in late summer or early fall.

"Make no mistake — it is a very compressed timeline," he said.

Across the country, Maine was forced to rework its plan to reimburse hospitals and clinics when they provide "essential" care to certain uninsured patients.

Letourneau said during her March remarks that federal officials rejected this idea because "provider payments had to be more directly linked to a rural transformation kind of activity."

Lindsay Hammes, a spokesperson for Maine's health department, told KFF Health News that funding will instead help providers transition to reimbursement models that aren't based on how many patients they treat.

Reworked plans call for spending \$28.5 million to support providers, Letourneau said in March.

"But there definitely will be more strings attached."

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