The 65 Percent Problem: Statutory Constraints, Measurement Bounds, and the Translation Layer Imperative in the Rural Health Transformation Program

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***Abstract*—The Rural Health Transformation Program, authorized under Section 71401 of Public Law 119-21 and administered by the Centers for Medicare and Medicaid Services (CMS) as a cooperative agreement, distributes $50 billion to state recipients over fiscal years 2026 through 2030. The authorizing statute and the CMS Notice of Funding Opportunity impose three categorical ceilings on each state's allocation: direct patient care payments cannot exceed 15 percent, infrastructure investments cannot exceed 20 percent, and state administrative expenses cannot exceed 10 percent. We show that these ceilings yield a structural lower bound: at least 65 percent of every state allocation—approximately $32.5 billion in aggregate over the program horizon—must flow into use categories that cannot be evaluated by counting facilities built or services paid for. The 65 percent bucket comprises workforce development, technology-enabled care delivery, evidence-based prevention, behavioral health, and innovative care models. Each of these categories requires facility-level outcome measurement against an external ground truth to be evaluable under cooperative agreement reporting requirements. We formalize the resulting measurement function, examine first-year state plan data for evidence of the predicted spending pattern, address five plausible counterarguments, and identify the structural component—a translation layer mapping CMS Healthcare Cost Report Information System (HCRIS) data to per-facility benchmark claims—whose construction is necessary for the program to demonstrate effectiveness. The Critical Access Hospital subsegment is identified as the architecturally tractable testbed by virtue of its regulatory uniformity under 42 CFR § 485.**

***Index Terms*—Rural Health Transformation Program, Critical Access Hospitals, CMS HCRIS, cooperative agreement reporting, measurement infrastructure, statutory caps, translation layer, first-principles analysis.**

I. Introduction

ON December 29, 2025, CMS announced first-year awards under the Rural Health Transformation (RHT) Program totaling $10 billion across all 50 states, with annual allocations averaging $200 million and ranging from $147 million (New Jersey) to $281 million (Texas) [3], [4]. The five-year program horizon (FY2026–FY2030) totals $50 billion under Public Law 119-21, Section 71401 [1]. The program is administered through a newly established CMS Office of Rural Health Transformation as a cooperative agreement, with continued state funding contingent upon documented achievement of milestones submitted in each state's approved plan [2].

The structural challenge the program now faces is not how to spend the money but how to demonstrate that the money has worked. This paper argues, on first principles, that the statutory cap structure of the program creates a binding measurement constraint, and that the resolution of that constraint requires construction of a translation layer between CMS Healthcare Cost Report Information System (HCRIS) data and facility-level performance metrics.

The argument proceeds as follows. Section II characterizes the statutory cap structure and its consequences for the allocation of funds under cooperative agreement reporting. Section III derives the arithmetic lower bound on funding that must flow to non-payment, non-capital uses. Section IV reviews first-year state plan data for evidence consistent with the predicted spending pattern. Section V formalizes the measurement function required to evaluate the residual allocation. Section VI addresses five counterarguments. Section VII specifies the translation layer required for the program to demonstrate effectiveness, drawing on architectural analogs from the Critical Assessment of Structure Prediction (CASP) experiment in computational biology [21], [22]. Section VIII concludes with policy and implementation recommendations.

The contribution is threefold. First, we establish the arithmetic bound on non-payment, non-capital allocation as a structural feature of the program rather than a state-level choice. Second, we identify the resulting measurement requirement as the binding constraint on RHT effectiveness, distinct from the financial fragility constraint addressed elsewhere in the rural health literature [18], [16]. Third, we specify the architectural requirements of the translation layer whose construction is implied by the analysis.

II. Statutory Structure of the Allocation

A. The Three Caps

Section 71401 of Public Law 119-21 and the implementing Notice of Funding Opportunity (NOFO) impose three categorical limits on state expenditure of RHT awards [1], [2]. Direct patient care payments to providers cannot exceed 15

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percent of the state allocation; the Kaiser Family Foundation analysis of the December 2025 awards confirms this limit applies cumulatively across the five-year program [4]. Infrastructure investments—defined to include capital expenditures on existing or new facility space, broadband, and information technology hardware—are restricted to 20 percent. State administrative expenses, including the operating costs of any new state office established to administer the program, are limited to 10 percent of the allocation [6].

B. Cooperative Agreement vs. Block Grant Reporting

The distinction between a cooperative agreement and a block grant is structurally consequential. Under a block grant, federal oversight is largely ex ante: the grant is conditional on initial state assurances, but subsequent reporting obligations are limited. Under a cooperative agreement, the federal partner retains substantive ongoing involvement; the recipient must demonstrate at each reporting cycle that funds are being used in accordance with the approved plan and that performance metrics are progressing toward stated targets. The Social Security Act provides for redistribution of funds that are unexpended or misused [10], and CMS has indicated continued state funding eligibility depends on documented milestone achievement [2].

C. Implication: The Residual

Let A denote a state's total RHT allocation over the program horizon, with p, k, a, and r denoting the fractions allocated to direct patient care payments, infrastructure, administration, and residual programmatic uses, respectively. The statutory ceilings are:

$$p \le 0.15, \quad k \le 0.20, \quad a \le 0.10, \tag{1}$$

with the conservation constraint $p + k + a + r = 1$ and the non-negativity constraints $p, k, a, r \ge 0$. The residual r comprises programmatic spending on workforce development, technology-enabled care delivery, evidence-based prevention, behavioral health, and innovative care models—the categories enumerated as approved uses of funds B through I in the NOFO [2]. We show next that the residual is structurally bounded from below.

III. The Arithmetic Bound

A. Formal Derivation

From the conservation constraint and the statutory ceilings:

$$\begin{aligned} r + a &= 1 - p - k && (2)\\ &\ge 1 - 0.15 - 0.20 && (3)\\ &= 0.65. && (4) \end{aligned}$$

The result is invariant under any state-level choice of intervention mix that respects the statute. A state that maximizes both p and k simultaneously cannot reduce $r + a$ below 65 percent. The corresponding strict lower bound on programmatic non-administrative residual is:

$$r \ge 1 - 0.15 - 0.20 - 0.10 = 0.55. \tag{5}$$

TABLE I
Statutory Bounds on RHT Program Allocation

Bucket	Cap	5-Yr Max	Annual Max
Direct payments (p)	$\le 15\%$	\$7.50B	\$1.50B
Infrastructure (k)	$\le 20\%$	\$10.00B	\$2.00B
Administrative (a)	$\le 10\%$	\$5.00B	\$1.00B
Residual (r)	$\ge 55\%$	$\ge$ \$27.50B	$\ge$ \$5.50B
Non-payment, non-capital ($r + a$)	$\ge 65\%$	$\ge$ \$32.50B	$\ge$ \$6.50B

B. Aggregate Magnitudes

Applied to the program-level totals ($A_{\text{total}} = \$50\text{B}$, $A_{\text{annual}} = \$10\text{B}$), the bounds yield the magnitudes in Table I and the allocation structure shown in Fig. 1. The residual programmatic component is at least \$27.5 billion over the program horizon; the non-payment, non-capital total is at least \$32.5 billion. Applied to the representative \$200 million state allocation, the corresponding magnitudes are at least \$110 million and \$130 million annually.

C. Invariance Under State Choice

The bound is a structural feature, not a prediction. States that allocate less than the cap to direct payments or infrastructure will produce a larger residual r; the bound is therefore tight only under maximum draw on the capped categories. The KFF analysis of state award characteristics indicates substantial variation in award size per rural resident (ranging from \$66 in Texas to \$6,305 in Rhode Island) [4], suggesting that state-level allocation patterns will diverge. The lower bound of 65 percent, however, holds across this variation.

IV. Empirical Evidence from First-Year State Plans

First-year state plan data, as compiled by the National Rural Health Association and the Bipartisan Policy Center, is consistent with the prediction that the residual category dominates first-year spending intent [6], [5].

A. Distribution Across 50 States

All 50 states applied for and received RHT awards in the first program year [3]. The Bipartisan Policy Center analysis of state plan technology initiatives identifies four common themes appearing across all 50 plans: modernization of health information technology infrastructure, expansion of virtual care including remote patient monitoring, scaling of artificial intelligence applications, and seeding of rural technology innovation through state-level catalyst funds [5]. Each of these categories falls in the residual r: they are neither direct provider payments nor capital infrastructure under the statutory definitions.

B. Initiative Category Frequency

The National Rural Health Association's State Application Summary Guide documents that workforce development initiatives appear in every state plan, with subaward categories

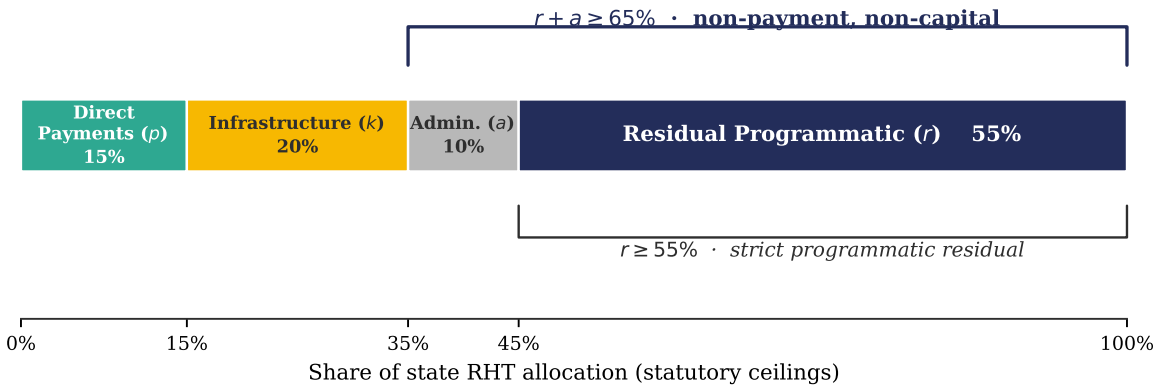

Fig. 1. Statutory allocation structure of state RHT awards. The 15-percent ceiling on direct provider payments (p) and the 20-percent ceiling on infrastructure (k) jointly imply $r + a \geq 65\%$ as a structural lower bound on non-payment, non-capital allocation. The strict residual programmatic share $r \geq 55\%$ follows once the administrative ceiling is also bound.

spanning recruitment incentives, retention payments, pipeline development, and licensure compact participation [6]. Behavioral health expansion appears in 47 of 50 plans. Evidence-based prevention initiatives appear in 41 of 50 plans. Each category corresponds to one of the residual NOFO uses of funds (A, E, H, I) and contributes to the r component of state allocations.

C. The 65 Percent Bucket in Practice

Representative state plans confirm the structural pattern. Texas allocates funding across six initiatives spanning artificial intelligence and telehealth, consumer-facing portal infrastructure, shared cybersecurity platforms, and infrastructure investments, with the majority of funding flowing to non-payment, non-capital uses [7]. California organizes its plan around regional hub-and-spoke networks anchored on Critical Access Hospitals, with workforce mapping, technology modernization, and care model innovation comprising the bulk of allocations [8]. Washington structures its plan around four pillars—tribal investments, technology and data, workforce, and behavioral health—with three of four pillars falling in the residual category [9].

The empirical pattern reinforces the arithmetic bound: states are not merely permitted to allocate the majority of funds to non-payment, non-capital uses; they are doing so. The measurement requirement attendant on these categories is therefore not hypothetical.

V. The Measurement Function

A. Performance Gap Formalization

Let $S(t) \in \mathbb{R}^n$ denote the observable state of rural healthcare sustainability at time t, with components corresponding to facility-level performance metrics: operating margin, denial rate, labor cost ratio, MBQIP composite score, and equivalent measures grounded in CMS HCRIS and Flex Monitoring Team data [18], [15]. Let S^* denote the target state vector and $S_0 = S(0)$ the baseline. The gap function is defined componentwise as:

$$G(t) = S^* - S(t), \quad G(0) = S^* - S_0. \tag{6}$$

B. Intervention Effectiveness Coefficient

For a state plan comprising a set $\mathcal{B}$ of interventions with allocated funding vector $\mathbf{x} = (x_B)_{B \in \mathcal{B}}$, the local trajectory of $S(t)$ under intervention is:

$$\frac{dS}{dt} = \sum_{B \in \mathcal{B}} \boldsymbol{\beta}_B(x_B, t) - \boldsymbol{\delta}(t), \tag{7}$$

where $\boldsymbol{\beta}_B(x_B, t)$ is the intervention effectiveness coefficient for B at funding level x_B, and $\boldsymbol{\delta}(t)$ is the environmental decay arising from closures, payer-mix shifts under recent Medicaid policy changes, and workforce attrition [17], [18]. The time to target satisfies $S(\tau) = S^*$ and is given by:

$$\tau = \int_{S_0}^{S^*} \frac{dS}{\sum_B \boldsymbol{\beta}_B - \boldsymbol{\delta}}. \tag{8}$$

C. The Observability Problem

The bound established in Section III-A implies that at least 65 percent of state allocations are directed to interventions $B \in \mathcal{B}_r \subseteq \mathcal{B}$, where $\mathcal{B}_r$ is the residual category. For each such intervention, $\boldsymbol{\beta}_B$ cannot be inferred from output counts: the number of workforce training cohorts completed, the number of telehealth platforms deployed, and the number of evidence-based curricula adopted are activity metrics, not outcome metrics. The estimation of $\boldsymbol{\beta}_B$ requires observation of $S(t)$ at the facility level.

Two requirements follow. First, baseline measurement of S_0 must be performed at sufficient granularity. CMS HCRIS provides cost report data at the facility level for all participating providers; this data is the canonical ground truth and is the same source CMS reviewers will use in evaluating state reporting [14]. Second, the variance of $\boldsymbol{\beta}_B$ under environmental perturbation must be characterized. A point estimate

TABLE II
REPRESENTATIVE CAH FACILITY: BASELINE AND TARGET STATES

Metric	S_0	S^*	**Source**
Operating margin	-2.3%	$+0.5\%$	G-3
Denial rate	8.7%	5.0%	S-10
Labor cost ratio	58.2%	52.0%	A-1
Annual revenue	\$20M	—	G-3
Medicare share (payer mix)	65%	—	S-3

Source column references HCRIS HOSP10 worksheet.

of intervention effectiveness is insufficient for cooperative agreement reporting under the conditions specified in the NOFO; uncertainty bounds are required for the reviewer to defend approval of continued funding.

The measurement substrate satisfying these requirements does not exist at the state level in the eight reviewed state plans [20]. This is the binding constraint we identify.

D. Worked Example: A Representative CAH Facility

To make the measurement function concrete, we trace the estimation of $\boldsymbol{\beta}_B$ for a representative CAH facility operating within the MV-CAHI envelope. Consider a facility with the baseline state shown in Table II and a target consistent with the CAHSP Type B threshold.

Suppose the state allocates a per-facility subaward of $x_B = \$0.75\text{M}$ to an intervention bundle $\mathcal{B}$ comprising revenue-cycle denial reduction and labor cost optimization. The effectiveness estimate $\boldsymbol{\beta}_B$ decomposes as follows. The denial reduction component is projected to close the denial rate gap of 3.7 percentage points over an 18-month implementation horizon. At an effective collection rate of 0.85 and the baseline revenue of \$20M, the recovered revenue is $0.037 \times 0.85 \times \$20\text{M} \approx \$0.63\text{M}$, equivalent to approximately 3.1 percentage points of revenue. Under cost-based reimbursement constraints [11], the net margin impact is estimated at $+1.5$ percentage points. The labor cost component, addressing a 6.2-percentage-point reduction in labor cost ratio, contributes an additional $+1.3$ percentage points of operating margin. Combined, the intervention bundle is projected to move the operating margin from -2.3% to approximately $+0.5\%$ over 24 months, reaching the CAHSP Type B target.

The CAHSP-C uncertainty quantification surrounds the point estimate with a variance bound. Under a 10% adverse shift in Medicaid payer mix—a realistic perturbation given recent Medicaid policy revisions [17]—the projected margin impact reduces from $+2.8$ to approximately $+1.9$ percentage points, still within the $\pm 15\%$ tolerance band specified by the CAHSP-C threshold. Under a 20% travel nurse cost shock, the labor cost component degrades and the combined impact reduces to approximately $+2.1$ percentage points. The 80-percent confidence interval on time-to-target is $\tau \in [16, 24]$ months. Fig. 2 illustrates the predicted trajectory with associated CAHSP-C confidence band.

This worked example illustrates the operational form of the measurement function in Eq. (7). It also illustrates the gap: state plans currently approved for funding describe interventions and milestone outputs, but do not publish S_0 at this granularity, do not characterize $\boldsymbol{\beta}_B$ at this level of decomposition, and do not bound $\boldsymbol{\beta}_B$ under realistic environmental perturbation. The absence of this substrate is the structural problem we now resolve.

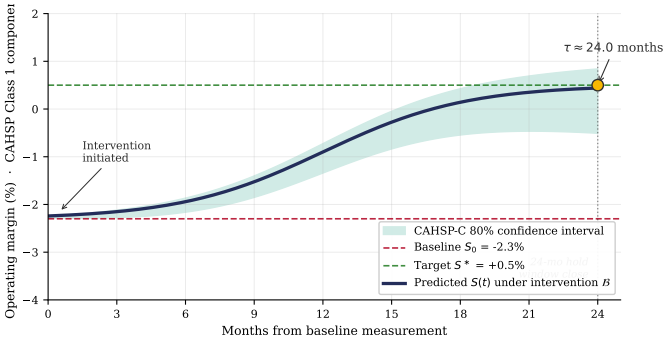

Fig. 2. Predicted trajectory of operating margin under intervention bundle $\mathcal{B}$ for a representative CAH facility. The shaded band represents the CAHSP-C 80-percent confidence interval, widening over the 24-month hold window to reflect compounding environmental uncertainty. The intervention is validated at CAHSP-C ≥ 0.65, supporting subaward approval.

VI. CRITIQUE AND COUNTERARGUMENTS

Five plausible counterarguments deserve direct engagement.

A. State Measurement Infrastructure Suffices

Several states operate Health Information Exchanges and Quality Improvement Organizations that produce outcome data. None of the eight state plans scored in companion work [20] publishes facility-level baselines normalized to Minimum Viable CAH Infrastructure constraints (25 licensed beds, 96-hour length-of-stay limit, 1–2 information technology full-time equivalents) [18], [19]. State HIE data is structured for clinical workflow and population-level reporting, not for CAH-specific benchmark scoring grounded in 42 CFR § 485 conditions of participation [11].

B. CMS Will Provide the Framework

The NOFO requires recipients to specify their own baselines, milestones, and data sources [2]. CMS reviews but does not provide the underlying measurement substrate. The burden of evidence is on the state recipient.

C. Measurement is Bureaucratic Overhead

Under 42 U.S.C. 1397ee(h)(1)(B), unexpended or misused funds are subject to redistribution [10]. CMS has indicated continued funding eligibility depends on milestone achievement [2]. The fastest path to losing access to the residual 80 percent of program funds is to fail at outcome measurement on the first 20 percent. Measurement is therefore the funding mechanism, not the bureaucratic overhead.

D. The Cap on Direct Payments is the Binding Constraint

This is partially correct. CAHs face structural financial fragility, with 44–48 percent of facilities operating at a loss and the sector median operating margin at approximately negative 2.3 percent [16], [18]. However, the constraint that determines whether the program will be judged effective is not the 15 percent cap on direct payments; it is the inability to demonstrate that the 65 percent residual produces the structural outcomes states have promised. A state could exhaust the 15 percent direct-payment cap and still fail at CMS milestone reporting if the residual 65 percent cannot be evaluated.

E. CAH-Specific Measurement is Too Narrow

RHT funding is not exclusively for Critical Access Hospitals, and the analysis here does not claim it should be. The narrower claim is that CAHs are the structurally uniform subset of rural healthcare providers: 1,376 facilities operating under identical regulatory constraints under 42 CFR § 485 [11], [13]. This uniformity makes CAH-level measurement architecturally tractable. A measurement substrate validated on CAHs transfers across the rural healthcare ecosystem with greater ease than the inverse. The CAH layer is the testbed; the substrate extends.

VII. The Translation Layer: A First-Principles Resolution

A. Required Components

The arithmetic bound, the empirical pattern, and the observability problem together imply that the program's effectiveness depends on construction of a translation layer between CMS HCRIS data and facility-level performance measurement. Three components are minimally required.

The first component is a provider registry that ingests CMS HCRIS HOSP10 cost report worksheets and produces per-facility baselines, normalized to the regulatory constraints under which CAHs operate. The registry must support every metric specified in the gap function $G(t)$.

The second component is a citation engine that traces every metric value to a specific HCRIS line item, worksheet, and reporting period. Without this traceability, state reporting cannot survive cooperative agreement review; CMS reviewers must be able to reconstruct any reported metric from the underlying federal data in a bounded time. The audit defensibility requirement is structural.

The third component is an uncertainty quantification engine that computes per-intervention confidence intervals on the effectiveness coefficient $\boldsymbol{\beta}_B$. The engine must characterize sensitivity to payer-mix variation, workforce-availability variation, and the time-to-target distribution under each. This is the component that converts state plan claims from point estimates to defensible variance-bounded predictions.

B. The CASP and AlphaFold Analog

The structural analogy is to the Critical Assessment of Structure Prediction (CASP) experiment in computational biology [21]. CASP organized the protein folding field for five decades by defining a blind-prediction benchmark with structured scoring, declared ground truth, and a quantitative measure of solution success. The 2020 AlphaFold result—a discontinuous leap in prediction accuracy—was legible to the field only because the benchmark structure existed: the magnitude of the achievement could be measured because the field had already specified what would count as solving the problem [22]. Critically, AlphaFold's predictions are accompanied by a per-residue confidence score (pLDDT) that allows downstream users to filter high-confidence predictions from low-confidence ones, preventing overinterpretation of fragile outputs.

The rural health sustainability problem warrants the same architectural approach. The Critical Assessment of Hospital Sustainability and Performance (CAHSP) framework, introduced in companion work, provides this structure: a defined scoring system across five problem classes, declared ground truth in CMS HCRIS and MBQIP, a breakthrough threshold (CAHSP score ≥ 85 on Type B targets), and a per-intervention confidence index (CAHSP-C) analogous to pLDDT [20]. The framework converts the measurement requirement from open-ended to bounded; once accepted, it provides CMS reviewers a defensible substrate against which state reporting can be evaluated.

C. Critical Access Hospitals as the Architectural Testbed

The Critical Access Hospital designation, established under the Balanced Budget Act of 1997 and governed by 42 CFR § 485 [11], [12], defines a class of approximately 1,376 facilities operating under identical regulatory constraints: 25 licensed beds, 96-hour length-of-stay limit, 35-mile distance requirement from the nearest hospital, and cost-based Medicare reimbursement. This uniformity is rare in healthcare and serves an architectural function: a substrate validated against CAH operational constraints transfers across the entire CAH cohort without re-engineering. The Minimum Viable CAH Infrastructure envelope specified in prior work [19] formalizes the test conditions under which any candidate translation layer must demonstrate viability.

VIII. Conclusion and Recommendations

The Rural Health Transformation Program imposes a binding arithmetic constraint on the disposition of $50 billion in federal funds. At least 65 percent of every state allocation must flow into use categories whose effectiveness cannot be evaluated by counting facilities built or services paid for. This residual must be measured at the facility level against an external ground truth, with uncertainty bounds suitable for cooperative agreement review. The translation layer between CMS HCRIS data and per-facility performance metrics is the binding constraint on the program's ability to demonstrate effectiveness and, accordingly, on its eligibility for continued funding under the cooperative agreement structure.

We offer four recommendations.

1) Policy: CMS should publish a reference measurement substrate as technical assistance, recognizing that the burden of evidence the NOFO places on state recipients exceeds the measurement infrastructure most states currently possess. In

the absence of a federal reference, state recipients should adopt a substrate—such as the Critical Assessment of Hospital Sustainability and Performance framework—developed against the same federal datasets CMS reviewers will use.

2) Implementation: State recipients should establish facility-level baselines for the CAH subset of their rural health system within 90 days of CMS-approved final budget. The CAH subset, by virtue of its regulatory uniformity, is the architecturally tractable starting point.

3) Research: Subsequent work should publish full 50-state coverage scoring against the CAHSP framework, initiate the 24-month prospective validation cycle against HCRIS-grounded measurement, and document negative results with the same rigor as positive findings under the Learn-Scale-Disrupt feedback methodology specified in prior work [19].

4) Equity: The translation layer must be designed to surface intervention performance for facilities serving underrepresented populations, including tribal communities and frontier regions, to ensure that aggregate program success does not mask localized failure.

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