



Rural Healthcare

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Ms. Tewarson explored the long-standing challenges facing rural health care and the role of the federal Rural Health Transformation Program (RHTP) in addressing these challenges. People in rural communities are aging while their healthcare systems are contracting. Hospital consolidation, facility closures, shortages of maternity and behavioral-health services, and difficulty recruiting and retaining health professionals have made access increasingly fragile.

The RHTP was created to stimulate new approaches to these problems. Congress authorized \$50 billion over five years beginning in fiscal year 2026, distributed among eligible states. Although substantial, the funding is temporary and cannot permanently solve rural healthcare problems. Ms. Tewarson therefore describes it as “catalytic” funding: States should use it to develop systems and investments that can survive after federal funding ends.

The program has five broad goals:

1. Improving rural population health through prevention and chronic-disease management;
2. Preserving sustainable access to care;
3. Strengthening the rural healthcare workforce;
4. Developing innovative models of care and payment; and
5. Using technology to make rural healthcare more efficient and accessible. Because traditional fee-for-service systems depend on patient volume, they may be poorly suited to sparsely populated or shrinking rural communities.

Implementation has been unusually rapid. States had only a few months to create administrative structures, establish procurement procedures, select projects, and obligate their first-year funds. At the same time, federal guidance continued to evolve. This created significant

administrative difficulties, particularly because states risked losing money they failed to obligate by the deadline.

Demand for the funding greatly exceeds available resources. In Alaska, for example, roughly 1,800 applications were submitted, while only a few hundred were expected to receive funding. Ms. Tewarson argued that states therefore need transparent procedures for deciding who receives money and must ensure that small rural organizations are not disadvantaged simply because larger institutions are better equipped to navigate complicated grant applications.

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A central concern is sustainability. States should avoid creating programs that disappear when federal funding ends after five years. Telehealth infrastructure, for example, should be paired with reimbursement arrangements that allow providers to continue offering telehealth after grant funding expires. Georgia is exploring a different approach for rural hospitals: Replacing conventional fee-for-service reimbursement with a global budget, which could provide greater financial stability when patient volume is low.

States are experimenting with several specific strategies. In maternity care, these include birthing centers, mobile clinics, community-based services, and technology-supported care. Arkansas is supporting mobile clinic teams serving rural pregnant patients. In primary care, states are integrating primary care with behavioral and specialty services, expanding telehealth, improving information systems, and experimenting

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with alternative payment models. Maine, for example, is developing statewide virtual primary care and closer coordination between primary and behavioral health services.

Workforce development is another major priority. Utah provides an example of a comprehensive strategy based on identifying workforce shortages through data and then targeting those shortages through graduate medical education, career-training programs, early-career pathways, preceptor programs, expanded practitioner roles, and recruitment and retention incentives. The broader principle is that rural workforce policy should be based on identified local needs rather than isolated recruitment programs.

Finally, states face financial accountability to the federal government. CMS can potentially claw back funds if states fail to fulfill commitments contained in their applications, including promised policy changes such as scope-of-practice reforms or participation in interstate workforce compacts. The overall message is that the RHTP represents a major opportunity, but its success will depend on whether states use temporary

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Conclusion

Looking ahead, Ms. Tewarson emphasized transparency, accountability, coordination, and long-term planning. States must track where money goes and whether programs produce meaningful results. They also need to coordinate RHTP investments with Medicaid, infrastructure, economic-development, and workforce policies. Rural providers must have a fair opportunity to compete for funding, rather than allowing resources to flow primarily to organizations with sophisticated grant-writing capacity.

DISCUSSION



Senator Mary Felzkowski (President of the Senate, Wisconsin): Is it likely that changes in the federal political landscape following this fall's elections could eliminate some of these requirements. The state has not approved

scope-of-practice changes and has yet to submit its Section 1310 SNAP waiver to CMS, potentially jeopardizing \$50 million in funding. Is it possible that requirements involving scope of practice, SNAP waivers, and interstate compacts could be reduced or eliminated under a new legislative majority? Or are these requirements essentially fixed, regardless of the election results?



Ms. Tewarson: Rural Health Transformation Program (RHTP) requirements will remain in place throughout the current administration. Changes would likely require substantial revisions to federal legislation, which seem unlikely

in the coming year. States should plan on meeting existing requirements rather than anticipating federal changes.



Senator Thomas Alexander (President of the Senate, South Carolina): What are the RHTP grant criteria concerning operational and recurrent expenses?

Ms. Tewarson: CMS allows grant funding for workforce operations and infrastructure but emphasizes sustainability beyond the five-year funding period. States must demonstrate how these investments will continue to support providers after federal funding ends. Salary support is negotiated on a state-by-state basis and is generally viewed as less sustainable. CMS prefers investments in technology, infrastructure, and practice development that improve long-term efficiency and expand access to care without requiring ongoing federal support. These issues are being negotiated on a state-by-state basis.



Senator Robert Stivers (President of the Senate, Kentucky): We feel pressure to address immediate workforce shortages, however, we are experimenting with programs that could

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provide sustainable solutions by recruiting students from rural communities into dual-credit programs that allow high school and college students to accelerate their education and gain professional certification. Such programs could shorten training by one or two years for careers in nursing, medicine, and radiology. These students are more likely to return to practice in their home areas. The question is whether CMS will fund these longer-term workforce development pipelines.

Ms. Tewarson: CMS negotiates with each state but has allowed RHTP funding for long-term healthcare workforce pipelines, including accelerated education and credentialing programs, even when participants may not enter the workforce for 10–15 years. These initiatives are considered investments in building a sustainable rural healthcare workforce.

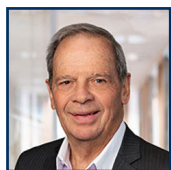
CMS favors state applications with a clear overarching mission that connects individual initiatives to broader goals. Accelerated training programs that shorten the time required to earn credentials and increase the supply of rural healthcare providers align with this approach.



Senator Bart Hester (Senate President Pro Tempore, Arkansas): Of all the applications submitted for RHTP funds, what's the best role model?

Ms. Tewarson: States are exploring innovative ways to expand rural healthcare access, including greater use of emergency medical services (EMS), mobile clinics, and technology to serve remote communities where permanent physicians or specialists are not feasible.

Long-term sustainability also requires reforming payment models for rural providers. Low patient volumes often make traditional reimbursement inadequate, and continued subsidies are not a viable permanent solution. Alternative payment structures, combined with new approaches to healthcare delivery, could improve both access and financial sustainability.

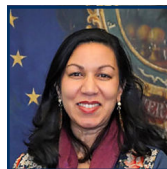


John Cullerton (Moderator): Since this program is specifically for rural hospitals, how does the federal government define rural or suburban or poor hospitals?

Ms. Tewarson: States have considerable flexibility in defining rural areas and determining which healthcare providers qualify for RHTP funding. The federal defini-

tion of a critical access hospital is one in an area that is essentially rural; however, states may include other rural healthcare facilities and providers in their grants.

The program is not intended primarily to resolve rural hospitals' financial difficulties. Consequently, direct funding to rural hospitals is capped at 15% of program funds, with the remainder supporting broader rural healthcare transformation initiatives.



Senator Kesha Ram Hinsdale (Senate Majority Leader, Vermont): Our governor proposed maternal healthcare facility closures in Brattleboro, but this generated significant public opposition. Although the governor subsequently

reversed his position, the controversy heightened concerns about creating maternal healthcare deserts in rural communities. How do federal officials view public disagreements over state healthcare decisions, particularly when those decisions appear to conflict with the state's overarching rural health transformation goals?

Ms. Tewarson: Maternity ward closures are accelerating nationwide, often driven by financial pressures and decisions made by individual health systems. A maternity care desert initiative operating across 40 states is exploring alternatives, recognizing that not all hospital closures can be prevented. Options include expanding birthing centers, increasing access to midwives and doulas, and establishing clear emergency transfer protocols. However, distance and travel time remain significant risks when serious complications arise. Long-term solutions may also require new hospital payment models.



Senator Chris Karr (Senate President Pro Tempore, South Dakota): I'm concerned about our legislature's limited involvement in administering RHTP funds. Executive agencies control funding decisions, while legislators receive

updates but have little opportunity to influence how funds are allocated or spent.



Senator Thomas Alexander (President of the Senate, South Carolina): We have taken a more collaborative approach, with legislators participating in project planning from the outset through their relationship with the state's health agency.

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Senator Mary Felzkowski (President of the Senate, Wisconsin): In Wisconsin, we had difficulties obtaining information on how RHTP funds were being used and considered using public records requests to improve transparency. We are also concerned that significant federal reforms, such as shifting from fee-for-service to bundled payments, may require CMS waivers and take several years to implement, complicating our ability to influence the program within its five-year funding period.

Ms. Tewarson: Legislative involvement varies by state, partly because executive agencies faced tight deadlines during the initial application process. Greater transparency and collaboration are needed to ensure that program investments align with broader state healthcare priorities.

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Senator Chris Karr (Senate President Pro Tempore, South Dakota): Have the cutbacks in Medicaid hit states' budgets yet? Has the implementation been delayed?

Ms. Tewarson: Major Medicaid funding changes will begin taking effect in 2027. Community engagement requirements, effective January 1, 2027, will affect Medicaid eligibility. Reductions in allowable provider taxes, which many states use to finance their share of Medicaid costs, will begin in 2027 and 2028. State-directed payments, which some states use to increase Medicaid funding to hospitals, will also begin declining in 2028.

These changes could significantly reduce funding for rural healthcare providers. However, the RHTP was not designed to fully offset these losses. Its funding is limited,

and only 15% can go directly to rural hospitals.

States will therefore face two interconnected challenges: Managing reductions in Medicaid funding while making strategic rural healthcare investments. Coordinating these efforts will be essential to maintaining access to care and supporting the long-term financial sustainability of rural providers.

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Senator Karen Spilka (President of the Senate, Massachusetts): Massachusetts has made substantial investments in healthcare workforce development and primary care reform. Initiatives include tuition-free community college programs, financial support for medical students who commit to practicing in underserved areas for five years, and efforts to transition from fee-for-service to global payments. The state is also working toward directing 15% of healthcare spending to primary care, including behavioral health.

However, we have serious concern about the impact of federal Medicaid changes, citing projections that more than 350,000 Massachusetts residents could lose coverage. This would increase uncompensated care costs for hospitals and providers, potentially shifting substantial financial responsibility to the state. These anticipated losses and uncertainty about their magnitude make long-term healthcare planning difficult, limiting the state's ability to sustain or expand investments in healthcare reform.

Ms. Tewarson: The Rural Health Transformation Program is one smaller piece of the puzzle of the broader sort of healthcare challenges that you all are navigating, all impacting you somewhat differently across your states. Think about how RHTP complements other things you are thinking about doing.