National Rural Health Update

2025 Virginia Rural Health Association

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Government Affairs & Policy Director

November 20, 2025

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Our mission is to provide leadership on rural health issues.

What We Fight for on Behalf of Rural

- Delivering Rural Opportunity: Addressing Declining Life Expectancy and Health Outcomes
- Reducing Rural Healthcare Workforce Shortages
- Investing in a Strong Rural Health Safety Net

Agenda

- H.R. 1 overview
- Congressional activity
- Executive Branch updates
- Advocacy resources

H.R. 1: Review

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Impacts of H.R. 1 on Rural Health

20% of rural adults and 40% of rural children rely on Medicaid or CHIP.

Medicaid/CHIP Coverage in Metro and Small Town/Rural Area Counties, 2023

Search in table

County Name	County Type	Total Medicaid/CHIP Coverage Rate	Child Medicaid/CHIP Coverage Rate	Adult Medicaid/CHIP Coverage Rate	Senior Medicaid/CHIP Coverage Rate
Hawaii County	Small Town/Rural Area	23.0%	37.3%	19.8%	16.9%
Honolulu County	Metro	20.1%	33.6%	17.1%	14.1%
Kalawao County	Metro	N/A	N/A	N/A	N/A
Kauai County	Small Town/Rural Area	19.8%	33.1%	16.5%	14.5%
Maui County	Metro	20.1%	33.7%	16.5%	15.3%

Note: "Small Towns/Rural Areas" include non-metropolitan counties with no urban areas of at least 50,000 residents. The District of Columbia, New Jersey, and Rhode Island have no counties classified as Small Towns/Rural Areas. Counties marked N/A are suppressed due to poor reliability.

Source: County-level Medicaid/CHIP coverage estimates are based on an analysis of 2022-2023 American Community Survey (ACS) Public Use Microdata Sample (PUMS). • Get the data • Embed • Download image

Georgetown University McCourt School of Public Policy
CENTER FOR CHILDREN AND FAMILIES

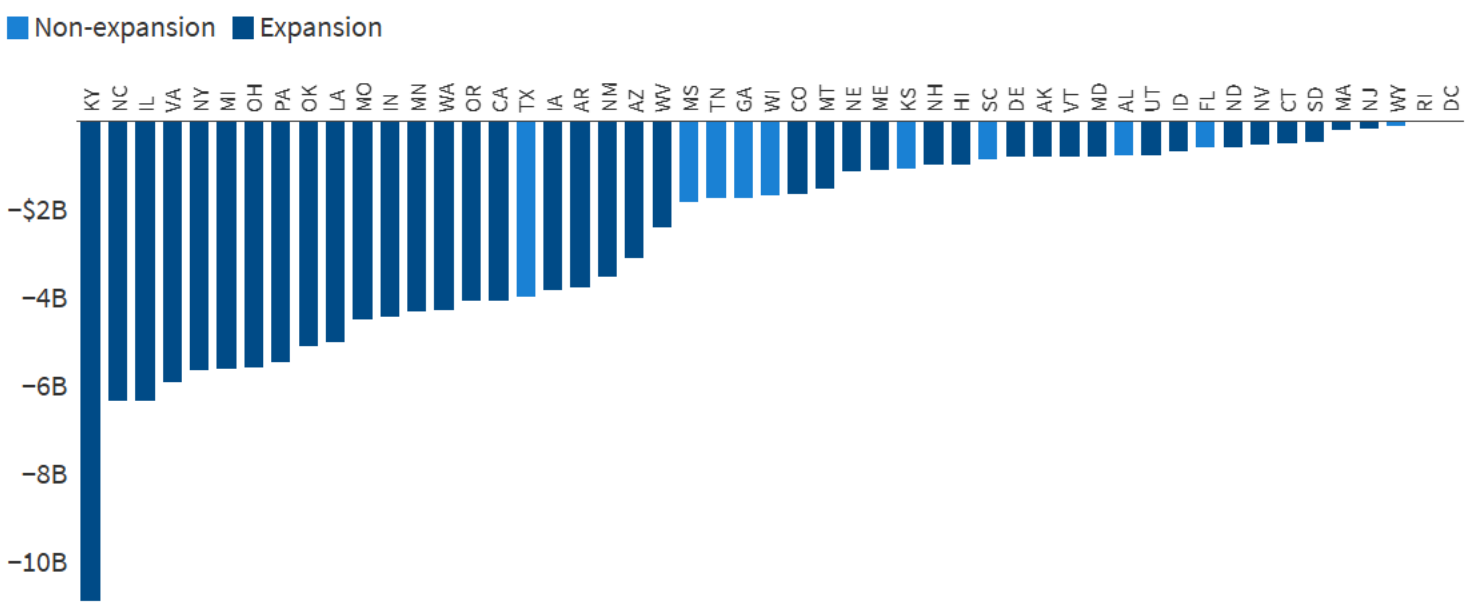
Impacts of H.R. 1 on Rural Health

Over half of the spending reductions in rural areas are among 12 states that have large rural populations & have expanded Medicaid

Figure 2

Largest Declines in Federal Medicaid Spending in Rural Areas Would Occur in States That Expanded Medicaid and Have Higher Shares of Rural Residents

Federal Medicaid spending in rural areas is estimated to decrease by $137 billion over a 10-year period under the enacted reconciliation package



Impacts of H.R. 1 on Rural Health

On average, rural hospitals are slated to **lose 21 cents out of every dollar they receive in Medicaid funding**.

	Rural Hospital Expenditures	Impact on Medicaid Hospital Spend of H.R. 1 (Prior to Application of Rural Hospital Fund Support)		
	Medicaid %	Total $ Millions	Total % from Baseline	Rural $ Millions
Total	9%	$ (664,954)	-18.2%	$ (57,209)
Virginia	6%	$ (36,923)	-24.0%	$ (2,098)

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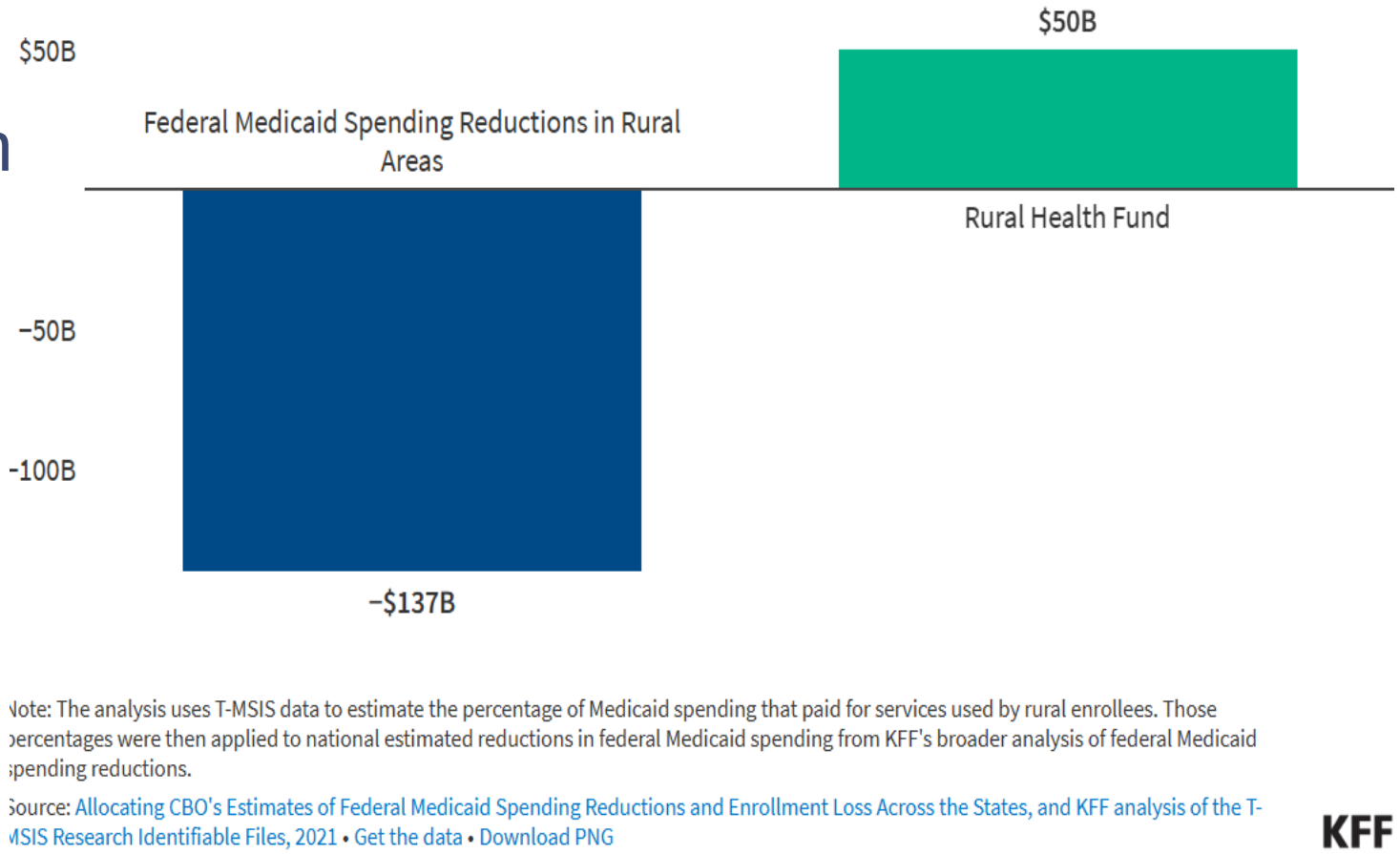
Impacts of H.R. 1 on Rural Health

Federal Medicaid spending in rural areas expected to decrease by **$137 billion**

Rural Health Transformation Program offset approx. 1/3 of this amount



Note: The analysis uses T-MSIS data to estimate the percentage of Medicaid spending that paid for services used by rural enrollees. Those percentages were then applied to national estimated reductions in federal Medicaid spending from KFF's broader analysis of federal Medicaid spending reductions.

Source: Allocating CBO's Estimates of Federal Medicaid Spending Reductions and Enrollment Loss Across the States, and KFF analysis of the T-MSIS Research Identifiable Files, 2021 • Get the data • Download PNG

KFF

H.R. 1: Medicaid Eligibility and Enrollment

Changes effective beginning January 1, 2027:

- Work Requirements: 80 hours/month with exceptions
- More Frequent Eligiblity Determinations: every 6 months
- Modifies Retroactive Eligiblity: from 3 months to 1 or 2
- Ensures Address and Eligibility Verification

Effective October 1, 2028:

- Implements Cost-Sharing for Expansion Adults

H.R. 1: Eligibility and Enrollment

Restricting Immigrant Eligbility: Lawfully present immigrants must have a “qualified” immigration status

- For Medicaid and CHIP
  - Timeline: October 1, 2026
  - Impact: Will increase number of uninsured by 100,000 in 2034
- For Marketplaces subsidized supports
  - Timeline: December 31, 2026
  - Impact: Will increase number of uninsured by 900,000 in 2034
- For Medicare
  - Timeline: No later than 18 months from enactment
  - Impact: Will increase number of uninsured by 100,000 in 2034

H.R. 1: Medicaid Financing

- Provider Taxes: Freezes current taxes, no new taxes, phased down to 3.5% beginning in 2028 for expansion states
- State Directed Payments: capped at 100 (expansion) and 110% (non-expansion)
- In response to Medicaid cuts, states are already reducing hospital payment rates

HR1 Medicaid: Long-Term Care

- Moratorium on implementing Minimum Staffing Standards for Long-Term Care Facilities until October 1, 2034
- Reduces maximum home equity limits for Medicaid long-term care eligibility to $1 million regardless of inflation
  - Exceptions for homes on farms/agricultural land
- Allows states to establish 1915(c) Home and Community Based Services (HCBS) waivers for people who do not need an institutional level of care

H.R. 1: ACA Marketplace

- Required pre-enrollment verification of eligiblity before receiving subsidized coverage- ends auto-renewal
- Recapture of excess premium tax credits (PTCs)
- Not included in H.R. 1: extension of enhanced premium tax credits (ePTCs)

H.R. 1: Medicare

- One-year 2.5% increase to Medicare Physician Fee Schedule for calendar year 2026.
- Modifies the orphan drug exclusion of Medicare Prescription Drug negotiation
- Potential Medicare sequestration increase of 4% on provider payments due to PAYGO- TBD

H.R. 1: Grad PLUS Student Loans

- Eliminates Grad PLUS Program for new borrowers beginning July 1, 2026
  - Grad PLUS loans allowed students to borrow up to full cost of attendance
- Caps unsubsidized graduate loans:
  - Grad students - $20.5k per year with $100k lifetime cap
  - Professional students (MDs, etc.) - $50k per year with $200k lifetime cap
- Reforms income-based repayment plans

A View from the Hill: What's Happening in Congress

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Shutdown Showdown

- **Longest government shutdown in history (43 days) ended on November 12**
  - Shutdown due to disagreements on how to approach extending Marketplace enhanced premium tax credits (ePTCs).
- 8 Democratic Senators voted for a continuing resolution (C.R.) to reopen government in exchange for Senate Republican leadership promise to hold vote on ePTC extension in December

Shutdown Showdown

- C.R. funds federal government through **January 30, 2026**
- Extends the following through January 30, 2026 (retroactive to Oct. 1, 2025)
  - Medicare-Dependent Hospital designation
  - Low-Volume Hospital payment adjustment
  - Medicare ground ambulance add-on payments
  - Medicare telehealth flexibilities
  - National Health Service Corps, Community Health Centers, and Teaching Health Center GME mandatory funding

Shutdown Showdown

- Passed a handful of full-year FY 2026 appropriations bills, including the Agriculture-FDA bill:
  - **$2 million for Rural Hospital Technical Assistance program**
  - $40.7 million for Distance Learning and Telemedicine program
  - $1.25 billion for Community Facilities direct loans and $650 million for guaranteed loans
  - $17 million for Community Connect Grant program
  - $50.75 million for ReConnect Rural Broadband program
  - $107.5 for Supplemental Nutrition Assistance Program (SNAP)
  - $8.2 billion for WIC

FY 2026 Appropriations

- President's FY 2026 Budget Request proposed to eliminate core rural health programs, including Flex program, State Offices of Rural Health, and Area Health Education Centers
- Senate Appropriations FY 26 Labor, Health and Human Services (LHHS) bill marked up in late July **level funded from FY25 or increased funding to rural programs**
- House Appropriations FY 26 LHHS bill marked up earlier this month **level funded from FY25 or increased funding to rural programs**
  - + $100 million for Rural Hospital Provider Assistance Program
  - + $10 million for Financial and Community Sustainability for At Risk Hospitals

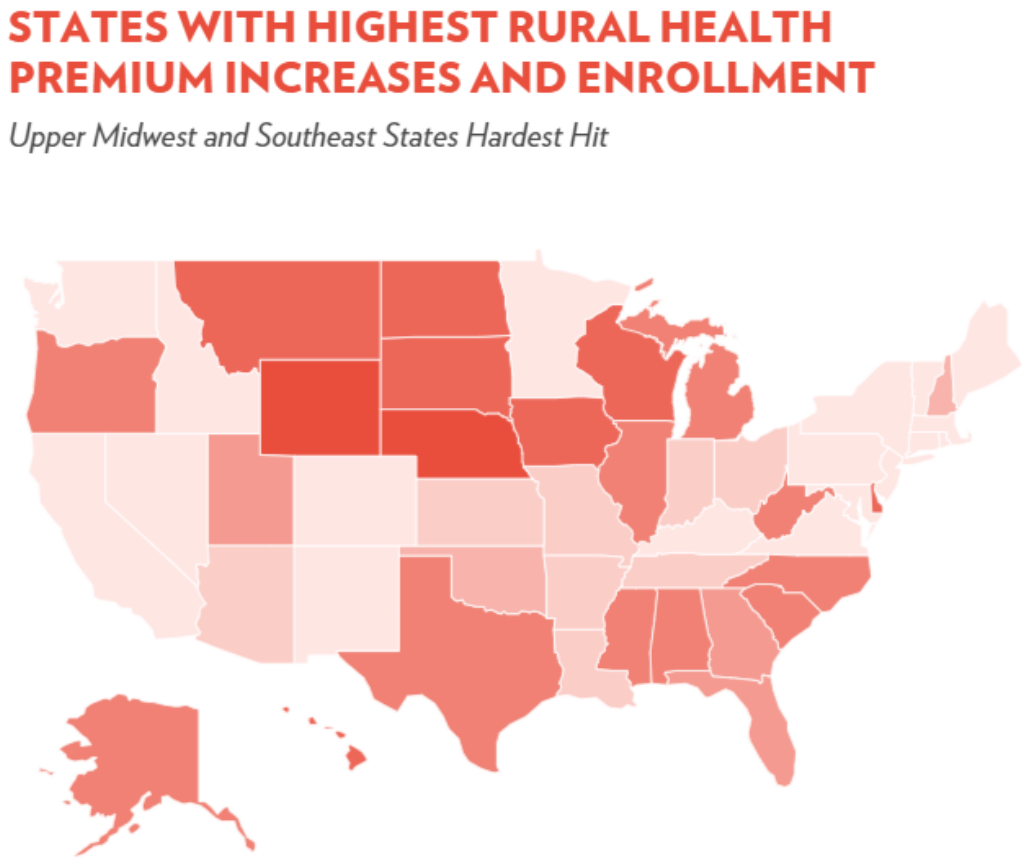
FY 2026 Appropriations Requests

	NRHA FY 26 Request	President's FY 26 Budget	HAC FY 2026 Bill	SAC FY 2026 Bill	FY 2025 Enacted
Rural Hospital Flexibility Grants	$75 million	$0	$74.277 million	$66.27 million	$64 million
Rural Hospital Stabilization Pilot Program	$15 million	$0	$20 million	$6 million	$4 million
Rural Residency Planning & Development	$14 million	$12.7 million	$14 million	$14 million	$13 million
State Offices of Rural Health	$15 million	$0	$13 million	$13.5 million	$12.5 million
CDC Office of Rural Health	$10 million	TBD	$6 million	$5 million	$5 million
Outreach Programs	$109 million	$101 million	$111million	$104 million	$101 million
RCORP Program	$155 million	$145 million	$145 million	$145 million	$145 million

Marketplace ePTC Renewal

- **ePTCs expire December 31, 2025**
- ePTCs offer upfront financial assistance to help enrollees afford plans on the Marketplaces
  - 776,000 rural adults and 223,262 rural children enrolled in Marketplace plans
- Expand eligibility for lower health insurance premiums to individuals whose income is over 400% of the FPL and reduce the maximum household contribution, resulting in larger subsidies, at all eligible income levels

Marketplace ePTC Renewal



- ePTCs offer upfront financial assistance to help enrollees afford plans on the Marketplaces
  - 776,000 adults and 223,262 children enrolled in Marketplace plans
- Rural enrollees see an average savings of $890 per year on health coverage, which is 28% more than their urban counterparts
- Out-of-pocket premiums on average by 107 percent for rural county residents compared to 89 percent for urban county residents
- **Premiums have already been set for plan year 2026 and open enrollment begins Nov. 1**

Marketplace ePTC Renewal

- **Relevant legislation:**
  - S. 46/H.R. 247: Health Care Affordability Act
    - Permanent extension of ePTCs
  - H.R. 5145: Bipartisan Premium Tax Credit Extension Act
    - 1-year extension
- **Other proposals in D.C.:**
  - Give money directly to consumers through HSA/FSA contributions
  - Extending ePTCs but narrowing eligibility
  - Let ePTCs expire and revert to standard PTC
    - Eligibility is for households with incomes between 100%-400% of FPL

Beyond 2025: Possible Healthcare Legislative Activity

- 340B reforms
- Artificial Intelligence (AI)
- Drug shortages
- Make American Health Again (MAHA) priorities
- Pandemic and All-Hazards Preparedness Act (PAHPA) Reauthorization
- Pharmacy Benefit Manager (PBM) Reforms
- Reconciliation II…

NRHA Key Bills

Focus on Critical Access Hospitals

- **Necessary Provider Status.** S. 502: the Rural Hospital Closure Relief Act reinstates Necessary Provider status with guardrails.
- **Rural Hospital Support.** H.R. 1417/S. 1282: Rural Health Care Facility Technical Assistance Program Act
- **H.R. 3684: Save America's Rural Hospitals Act:**
  - Rescinds: 96 hour rule, 96 hour ALOS, 3-day stay swing bed
  - Medicare sequestration for rural hospitals
  - Reverses cuts to reimbursement of bad debt
  - Reopens necessary provider designation
  - Equalizes beneficary copayments for services by CAHs
  - Reauthorizes the Flex program

Focus on Rural Health Clinics

- **RHC Modernization Policies**
  - H.R. 5217: Rural Behavioral Health Improvement Act removes limits on furnishing behavioral health care
  - H.R. 5198: Rural Health Clinic Location Modernization Act fixes rural definition for RHC eligibility
  - H.R. 5199: Modernizing Rural PA and NP Utilization Act aligns PA/NP scope of practice with state laws
- **RHC Telehealth**
  - S. 2709/H.R. 5081: Telehealth Modernization Act includes RHCs as permanent distant site providers with payment parity.

Medicare Advantage

S. 1816/H.R. 3514: Improving Seniors' Timely Access To Care Act

- Streamline prior authorization requirements under MA plans
- Reduce timeline for prior authorization request
- Reporting on prior authorization, approvals, and denials

H.R. 4559: Prompt and Fair Pay Act

- Requires MA plans pay clean claims in 14 calendar days (electronic submission) or 30 calendar days
- Floor payments matching at least Traditional Medicare required

• H.R. 5454/S. 2879: MA Prompt Pay Act

- Requires MA plans pay clean claims in 14 calendar days (electronic submission) or 30 calendar days

Rural Emergency Hospitals "REH 2.0"

- Rural Emergency Hospital Improvement Act
  - Allowing of swing beds to retain access to post-acute care
  - Authorizing psychiatric, rehabilitation distinct part units, new OB DPU
  - 5% add on to services paid under the Clinical Laboratory Fee Schedule
  - Hospitals that closed between 1/2015 and 12/27/20, eligible to convert
  - National Health Service Corps eligible site
  - Small Hospital Improvement Program grant eligibility
  - Ability to revert back to NP CAH status
  - HHS authority to create waiver program for different facility types to convert
  - NEW: Medicaid payment fix
- 340B eligibility addressed through H.R. 44)

Authorization Bills

Rural Health Care Services Outreach Programs

- **H.R. 2943/S. 2301:** Improving Care in Rural America Reauthorization Act
- Reauthorizes Outreach grant programs through 2030
  - Includes Rural Health Care Services Outreach, Rural Health Network Development, and Small Health Care Provider Quality Improvement Grant Programs
- Passed out of Senate HELP Committee on 7/30
- Passed out of House Energy & Commerce Committee on 9/17
- Authority expires at end of 2025 and bill is set up for passage before end of year

Authorization Bills

Also working on introduction of –

- Rural Residency Planning and Development Program authorization
- Rural Communities Opioid Response Program authorization
- Medicare Rural Hospital Flexibility Program reauthorization

What's Happening in the Administration

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Making America Healthy Again

Key MAHA Agenda Changes

- Restructuring HHS
- Companies are reducing/eliminating artificial colors, preservatives and other harmful food additives.
- Elevating tribal affairs and IHS concerns
- Encouraging physical fitness, nutrition and other holistic treatments in medical school
- Removing ‘junk’ food from EBT eligibility in the SNAP program.
- Increasing autism visibility.
- Bringing pharma/PBMs to the table for talks.

Areas of Concern

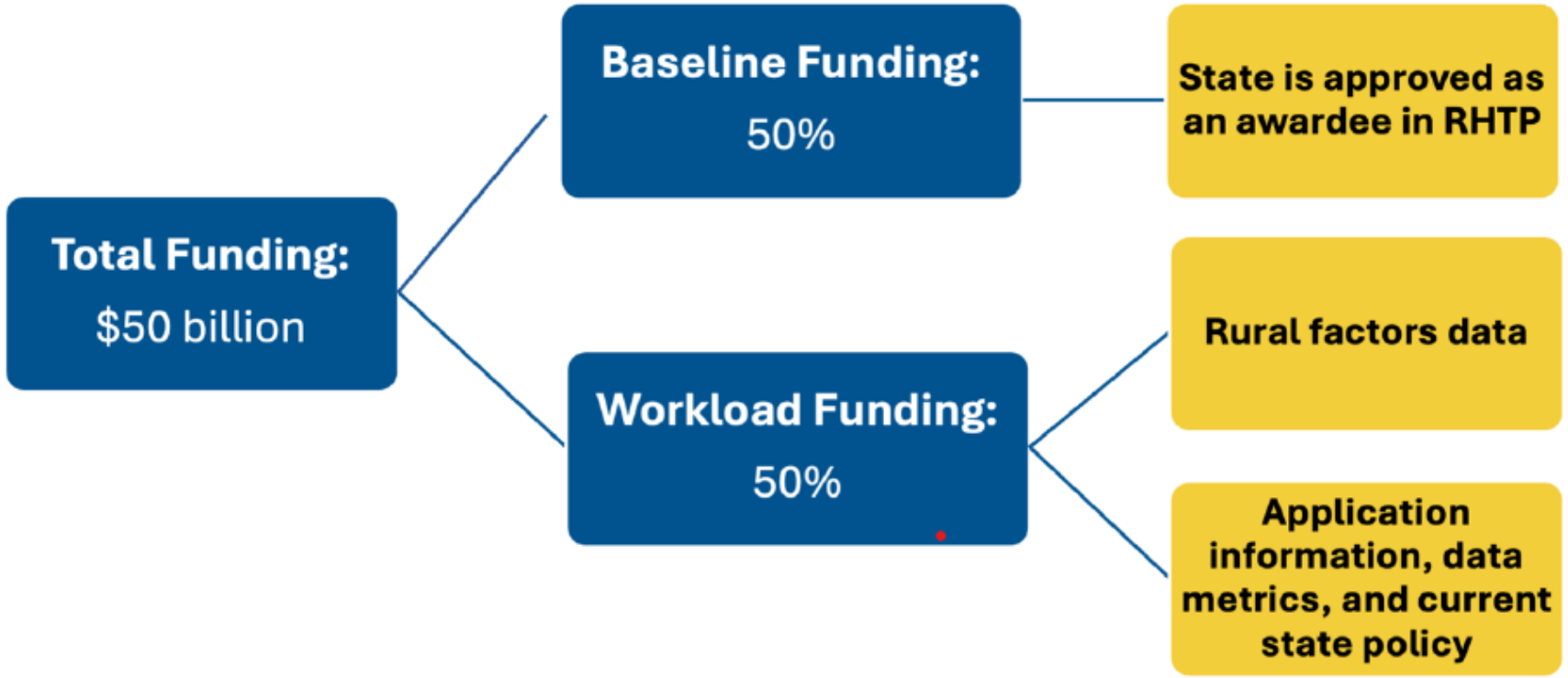
- HHS’ dissolution and reconstitution of ACIP with immunization skeptics.
- Abrupt senior staff departures and staff RIFs
- Changes to COVID-19’s EUAs, licenses and labeling.
- Cancelation of multiple mRNA research programs.
- State and industry confusion over dissemination of vaccines due to the FDA, CDC and ACIP being out of synch.

NRHA RHTP Resource Center

Rural Health Transformation Program

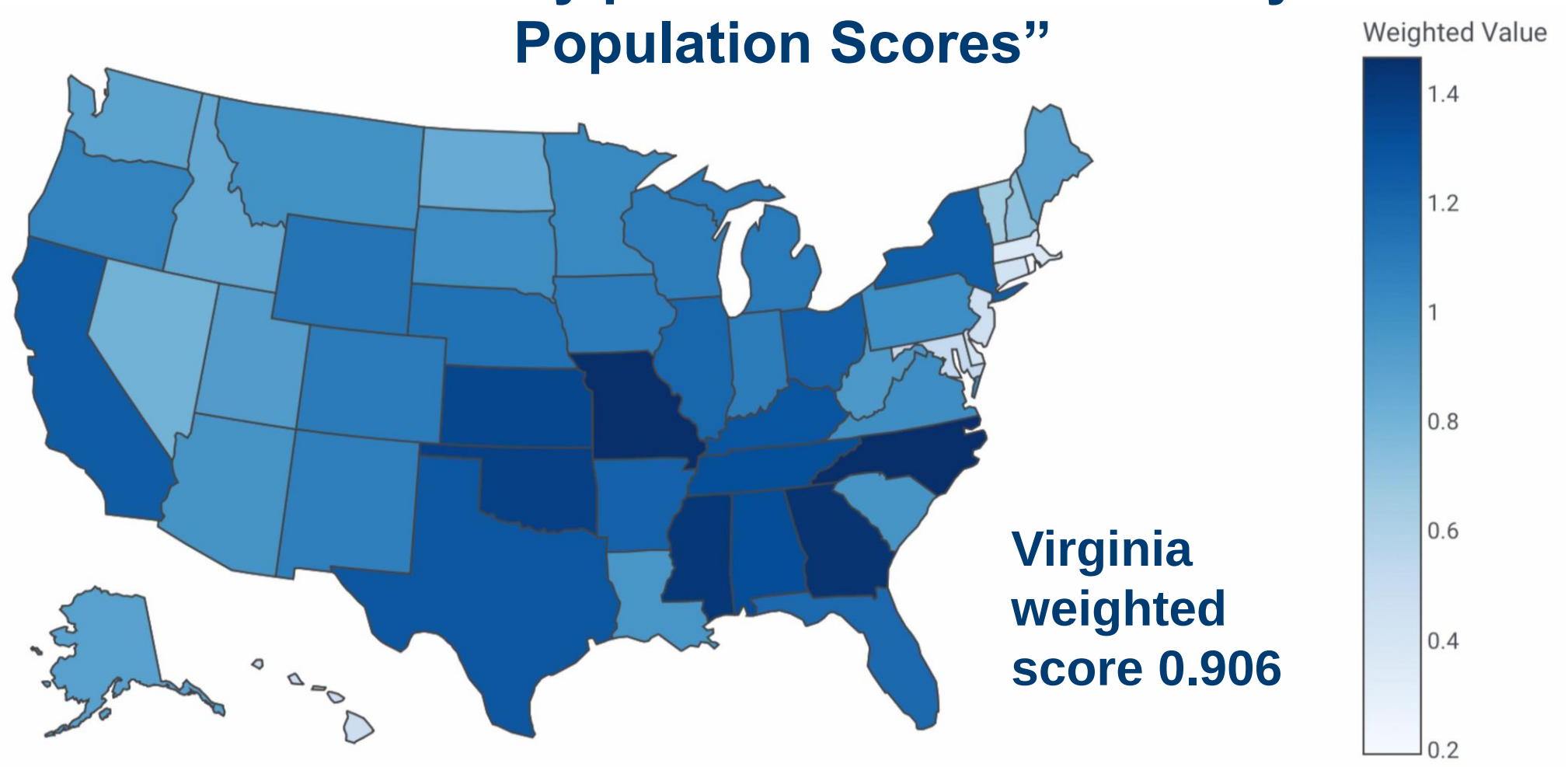
Rural Health Transformation Program

- $50 billion over 5 years for all states with approved applications
  - Distributed starting FY 2026 to FY 2030



Rural Health Transformation Program

How states may perform in “Rural Facility and Population Scores”



Virginia weighted score 0.906

Rural Health Transformation Program

- Program Funding Details:
  - New construction is not allowed; some minor remodeling may be approved
    - Capital expenditures and infrastructure cannot exceed 20% of total
  - Clinical service are billable and/or changing fee schedule is not allowed
    - Provider payments cannot exceed 15% of total
  - Replacing an EMR cannot exceed 5% of total if received HITECH funding

Rural Health Transformation Program

- Application Process:
  - Lead applicant is Governor or designee- states only
  - Must include a detailed rural health transformation plan
  - Show milestones and measurable impact
  - Goals should be achievable based on timeline
  - Must be sustainable post funding
  - Workload funding may be reallocated
- Timeline
  - September 15: Application (NOFO) Released
  - September 30: Letter of Intent (Optional)
  - October: Application formation
  - November 5: Application deadline
  - December 31: Award date
  - Q1 2026: Continuous monitoring and CMS support begins.

Rural Health Transformation Program

New CMS resources:

Updated FAQs (10/28). New information of note:

- CMS will work with states who receive more/less than $200 million to make budget adjustments
- Using RHTP funds to add to an existing program *may* be allowable
- Tribally-operated IHS facilities may be subawardees, but federally operated IHS facilities may not
- States should apply for any relevant SPAs or waivers needed to implement innovative care delivery services
- More details on budgeting in application

Rules, Rules, Rules: 2025 Regulatory Update

2025 Regulatory Updates

Final rules:

- FY 26 Skilled Nursing Facility (SNF)
- FY 26 Inpatient Prospective Payment System (IPPS)
- CY 26 Medicare Advantage Policy & Technical Changes
- Marketplace Affordability and Integrity
- Preserving Medicaid Funding for Vulnerable Population
- CY 2026 Physician Fee Schedule (PFS)

Proposed rules:

- CY 2026 Hospital Outpatient Prospective Payment System (OPPS)

Deregulatory RFIs:

- HHS
- CMS
- OMB

FY 2026 IPPS Final Rule

FY 2026 Inpatient Prospective Payment System final rule

- Mandatory TEAM model: episode-based payment model for 5 surgical procedures.
  - Only for PPS hospitals but patients could be transferred to swing beds
  - New in FY 26 rule is waiver of 3-day stay before admission to swing beds
    - Initially only applied to SNFs

CY 2026 Medicare Physician Fee Schedule Final Rule

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Payment

- Conversion Factor Proposals:
  - APM Qualifying Participants: $33.57 (+3.77% from CY 2025)
  - Non-Qualifying Participants: $33.40 (+3.26%)
- Introduces –2.5% efficiency adjustment to the work RVU for non-time-based services to account for unrecognized practice efficiencies
- Proposes revising practice expense RVUs to factor in site of service, reducing facility-setting values to 50% of non-facility values
  - Essentially aligning hospital and physician office rates for PE RVU

CY 2026 Medicare Physician Fee Schedule Final Rule

Telehealth Policies

- Extends RHC/FQHC distant site telehealth authority through Dec 31, 2026 even if broader flexibilities expire in 2025.
- Virtual direct supervision made permanent, including for RHCs and FQHCs.
- Proposes simplified review of the Medicare Telehealth Services List.
- Removes frequency limits for inpatient, nursing facility, and critical care telehealth visits.
- Sunsets PHE-era teaching physician virtual presence, except in rural areas.

CY 2026 Medicare Physician Fee Schedule Final Rule

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340B Guidance

- Provides methods for Part D claim-level identification of 340B drugs.
  - Use prescriber and pharmacy NPIs to infer 340B status.
  - Voluntary (possibly mandatory in the future) claim-level reporting by 340B covered entities.

Ambulatory Specialty Model

- New mandatory APM beginning Jan 1, 2027, focused on heart failure and low back pain.
- Targeted at specific specialties and limited geographic areas
- Evaluation includes quality, cost, improvement activities, interoperability, and patient-reported outcomes

CY 2026 Medicare Physician Fee Schedule Final Rule

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Medicare Shared Savings Program

- Limits BASIC Track to one agreement period for ACOs inexperienced in risk.
- Requires ACOs to meet a 5,000 beneficiary threshold in benchmark year 3 to renew.
- Caps shared savings/losses for ACOs under 5,000 beneficiaries.
- Eliminates health equity adjustment for ACOs starting CY 2026.

Medicare Diabetes Prevention Program

- Extends COVID-era flexibilities like virtual sessions and self-reported weight through 2029.
- Proposes asynchronous delivery option to increase access in rural areas with limited in-person resources.

Dental Services

- No new dental services proposed for CY 2026 under the "inextricably linked" medical necessity standard.

CY 2026 Outpatient Prospective Payment System Proposed Rule

Payment Updates

- Proposes 2.4% payment increase for hospitals; rural hospitals see an average of 2% net increase.

340B Remedy Recoupment

- CMS proposes accelerating recoupment from 0.5% to 2% annually, cutting the recoupment period from 16 to 6 years.
- Applies broadly to all OPPS hospitals (340B and non-340B), excluding hospitals enrolled in Medicare post-January 1, 2018.
- Rural hospitals impacted disproportionately, reducing their net payment update.

CY 2026 Outpatient Prospective Payment System Proposed Rule

NRHA Your voice. Louder.

Drug Acquisition Cost Survey

- CMS will conduct a hospital acquisition cost survey in CY 2026 for outpatient drugs to inform future payment rates (CY 2027 on).
- Survey required by statute and tied to prior Supreme Court ruling on CMS' 340B payment policy.

Site Neutral Payment Expansion

- Proposes site neutral rates for drug administration in excepted off-campus PBDs, cutting reimbursement by ~65%.
- SCHs are exempt.
- CMS seeks comment on expanding neutrality to on-campus clinic visits and imaging.

CY 2026 Outpatient Prospective Payment System Proposed Rule

Hospital Price Transparency (HPT)

- Hospitals must disclose 10th, median, and 90th percentile allowed amounts in machine-readable files.
- Executive attestation must now include CEO name and affirmation that data is complete, accurate, and in dollar amounts.
- Proposes 35% penalty reduction for accepting CMS noncompliance without contest.

340B Rebate Pilot Program

- In response to recent litigation, HRSA published guidelines for pilot rebate models
- Pilot rebate models may begin **Jan. 1, 2026**
- **General guidelines:**
  - Applies to all covered entity types
  - Covered entities have 45 days to submit claims data:
    - On next slide
  - Manufacturers must issue rebates or denials with documentation within 10 days of receipt
  - Currently scheduled for 2026 only; many stakeholders believe it will be expanded
  - Only drugs selected for Medicare drug price negotiation are eligible
- HRSA published FAQs, which add a bit more clarity to some provisions of rebate model
- Momentum on the Hill: Reps. Matsui (D-CA) and Johnson (R-SD) sent letter opposing rebate models to HRSA
  - 166 bipartisan co-signers

340B Rebate Model

- **Approved 8 manufacturers' plans for 9 drugs:**
  - Eliquis, Enbrel, Farxiga, Imbruvica, Januvia, Jardiance, Novolog, Stelara, Xarelto
  - Only drugs chosen for Medicare drug price negotiation were eligible
- HRSA did not provide detailed overviews of the approved plans, it generally indicated that the plans "met all the requirements as stated"
- All manufacturers will use the Beacon Platform
  - Operated by same parent company as 340B ESP

Rural MedPAC Activity

- Reducing beneficiary cost sharing at CAHs
  - In June report, MedPAC recommended that Congress:
    - Set coinsurance for outpatient services at critical access hospitals equal to 20% of the payment amount for services that require cost sharing; and
    - Place a cap on critical access hospitals' outpatient coinsurance equal to the inpatient deductible.
  - Explored, but did not make recommendation on, charge based coinsurance at RHCs
    - Looked at capping coinsurance at 20% of AIR
    - Would have reduced beneficiary coinsurance in 2022 by 19% overall, reduced RHC payments by 3.9% overall

WISER Model: Expanded Prior Authorization

- CMMI announced an electronic prior authorization model, Wasteful and Inappropriate Service Reduction (WISER) Model
- Begins January 1, 2026, and concludes December 31, 2031
- Contracting with vendors to review select items/services through:
  - Prior authorization
  - Prepayment medical review
- Applies to claims submitted by providers in Arizona, New Jersey, Ohio, Oklahoma, Texas, and Washington
  - Accounts for 1/5 of Medicare beneficiaries
- Items and services selected are those that present a higher risk of improper billing or offer limited clinical value compared to cost
  - Full list in Federal Register notice

Advocate With Us!

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Advocacy leave-behinds

All materials in the NRHA [Advocacy Priority Areas]

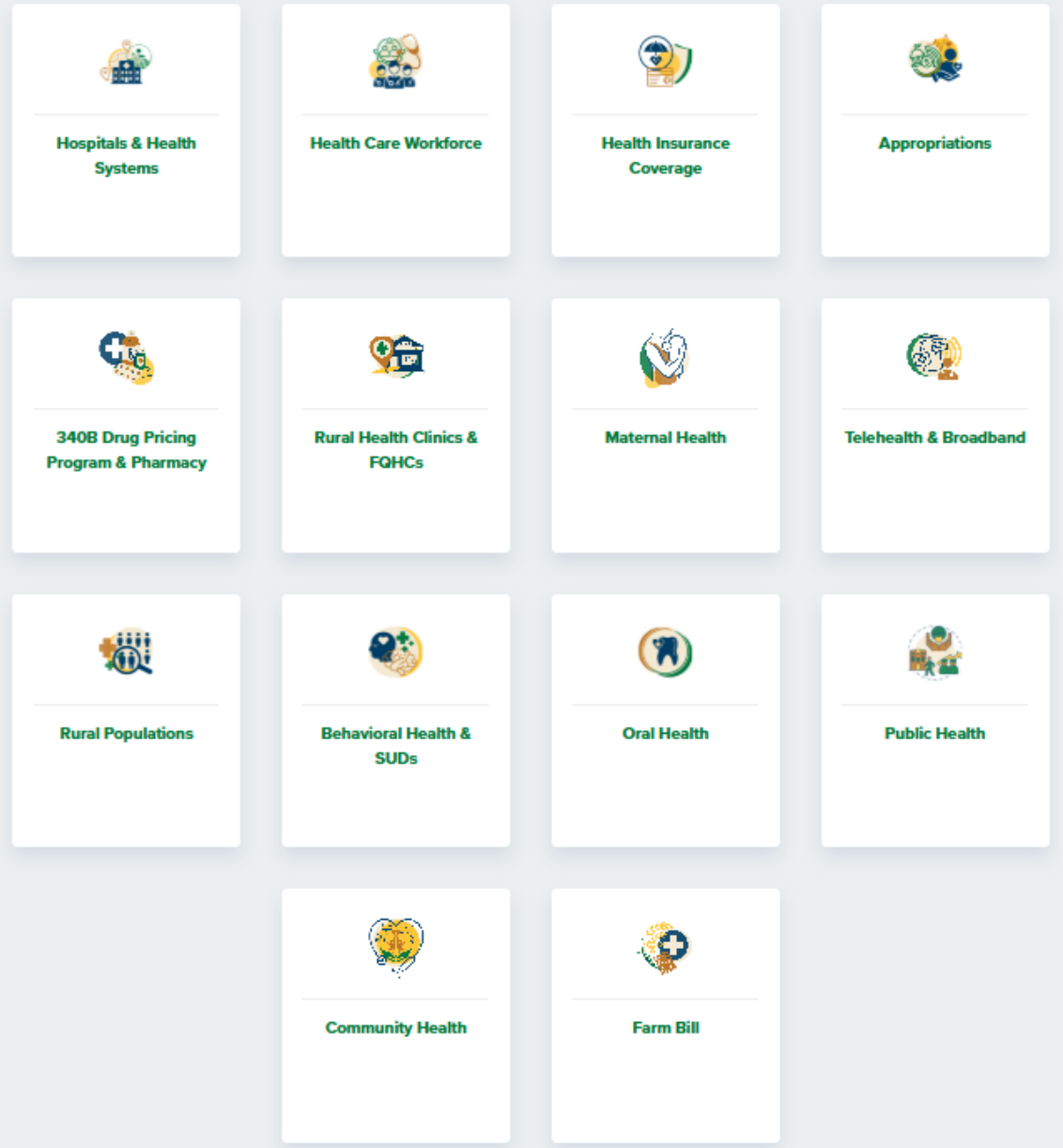
Core materials include:

- NRHA 2025 legislative agenda
- FY26 Appropriations requests
- Rural health 101
- Expiring rural health Medicare extenders
- Rural program reauthorizations

Topic-specific one-pagers include:

- Rural hospitals 101
- 340B
- Rural Health Clinics
- Public health
- And more!

RuralHealth.US/AdvocacyAreas



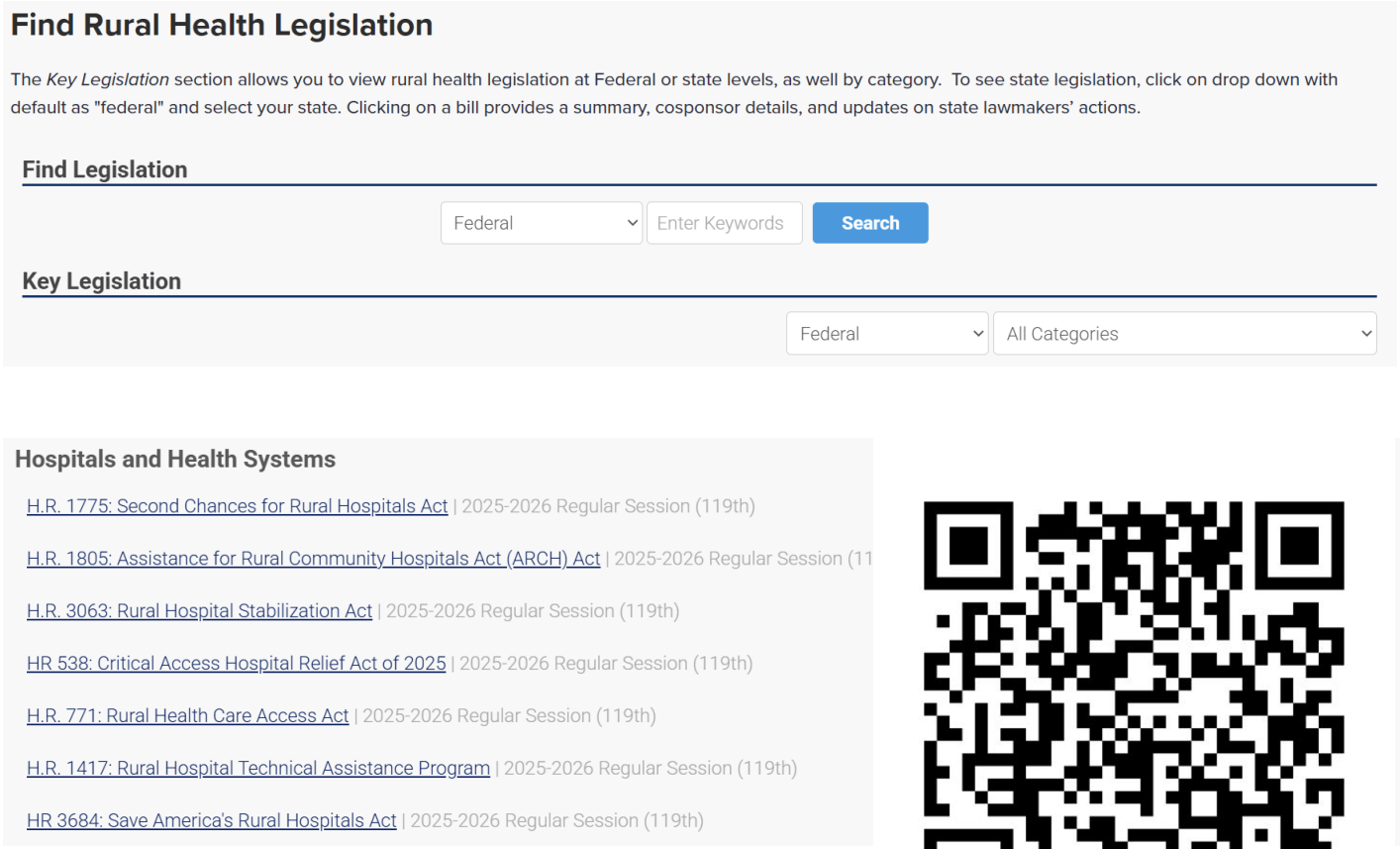
Advocacy campaigns

NRHA's advocacy campaigns allow you to send pre-drafted messages to your elected officials on current rural health priorities. Please find all advocacy campaigns on our website under Advocacy Campaigns, along with instructions on how best to use these campaigns.

RuralHealth.US/Campaigns

Legislative tracker

- Tracks Congressional bills supported by NRHA, including state legislation
- Can sort by topic, including **hospitals and health systems** and **rural health clinics**
- Direct access to all bill information
- Reach out to NRHA's Government Affairs team with any questions



RuralHealth.US/Legislation

2025 NRHA advocacy goodies

- Sign up to receive NRHA's Rural Roundup & NRHA Today
- Register for NRHA's monthly Grassroots Call
- Coming to D.C.? Let us arrange Hill visits for you!
- Contact your NRHA Government Affairs team:
  - Email: Carrie Cochran-McClain, Alexa McKinley Abel, Zil Joyce Dixon Romero, Sabrina Ho, Marguerite Peterseim
- Engage with NRHA Advocacy online:

One-stop scan of our advocacy goodies here

National Rural Health Association

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2026 Rural Health Policy Institute

February 10-12, 2026

Save the Date!

At-a-glance agenda available

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Thank you.

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