The Rural Health Landscape

Alan Morgan
CEO

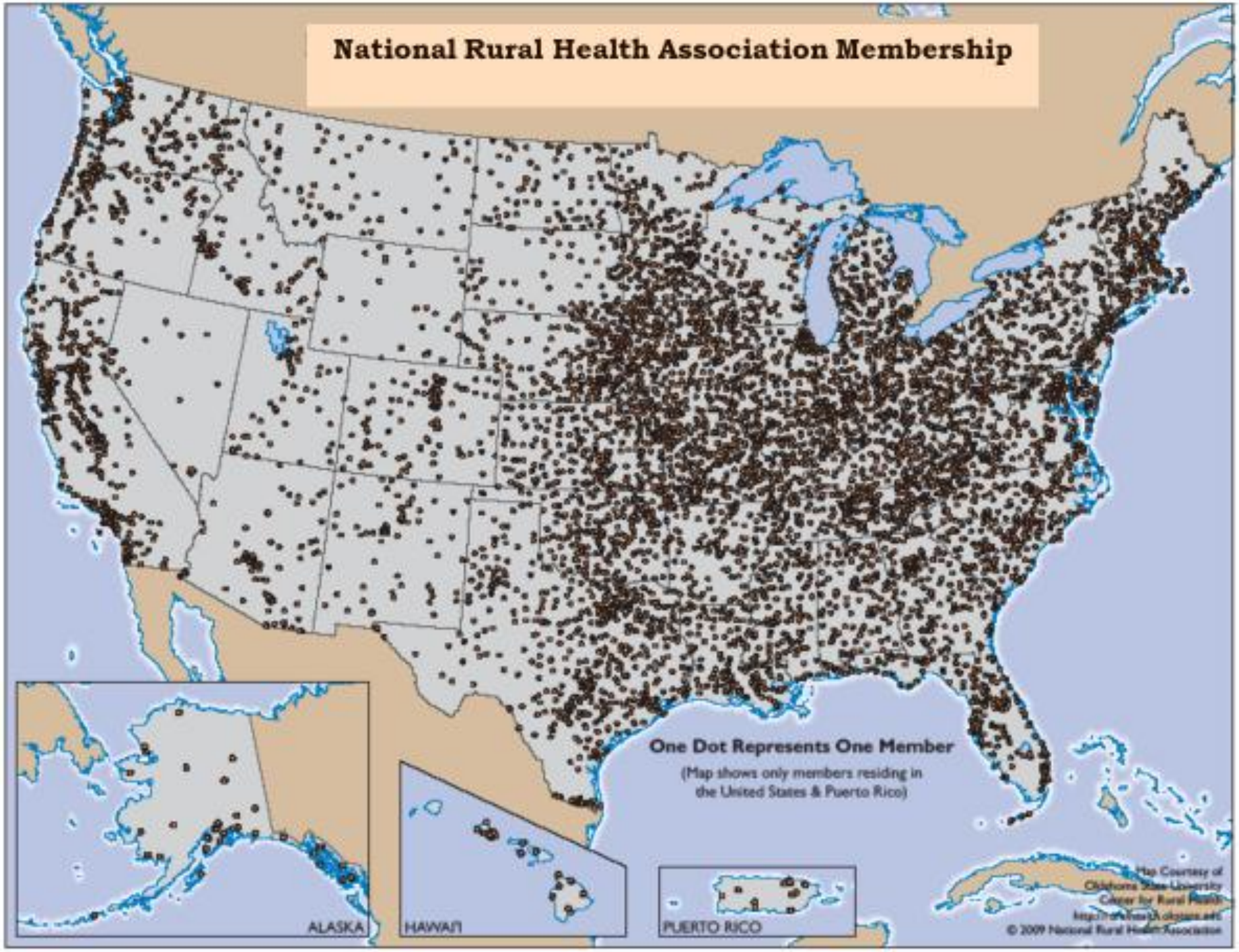
June 2026

National Rural Health Association

NRHA

Your voice. Louder.

Our mission is to provide leadership on rural health issues.


National Rural Health Association Membership
One Dot Represents One Member
(Map shows only members residing in the United States & Puerto Rico)
ALASKA
HAWAI'I
PUERTO RICO
Map Courtesy of
Oklahoma State University
Center for Rural Health
© 2009 National Rural Health Association

Choosing Rural

- University of Minnesota Age Friendly Research
- Appalachian Regional Commission “Bright Spots.”
- Institute of Medicine “Quality through Collaboration.”

The State of Rural America

- Workforce Shortages
- Vulnerable Populations
- Chronic Poverty

Rural Health Transformation Program

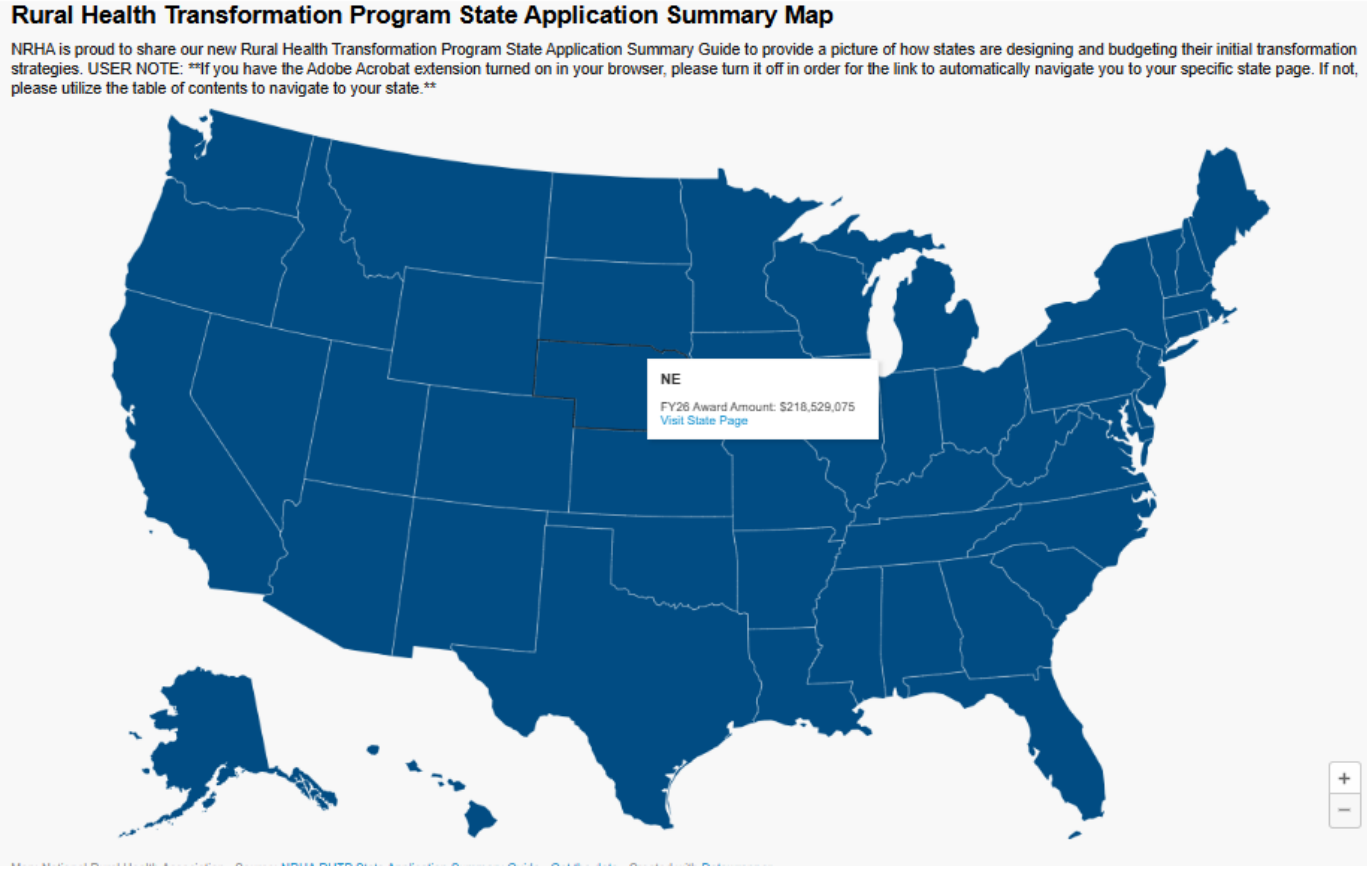
Strategic Goals

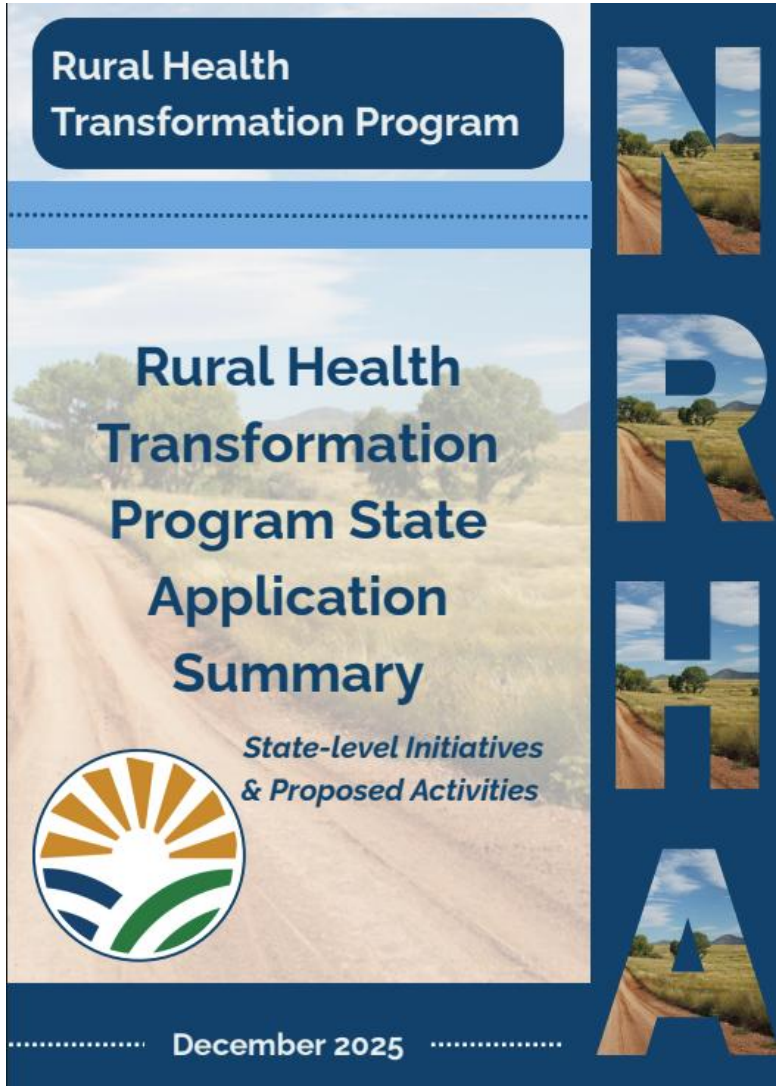
Making Rural America Healthy Again	Fostering Sustainable Access	Workforce Development	Innovative Care	Supporting Technology Innovation
1. Population health 2. Prevention 3. Chronic disease 4. Behavioral health 5. Prenatal care	1. Viable economic models 2. Appropriate care delivery 3. Provider payments	1. Strengthening recruitment and retention 2. Provider training 3. Scope of practice	1. Value base payment arrangements 2. Clinically integrated networks	1. Technology-based solutions 2. Training and technical assistance 3. Health Information Technology (HIT) investments
1	2	3	4	5

NRHA RHTP Center

State Plans Summary

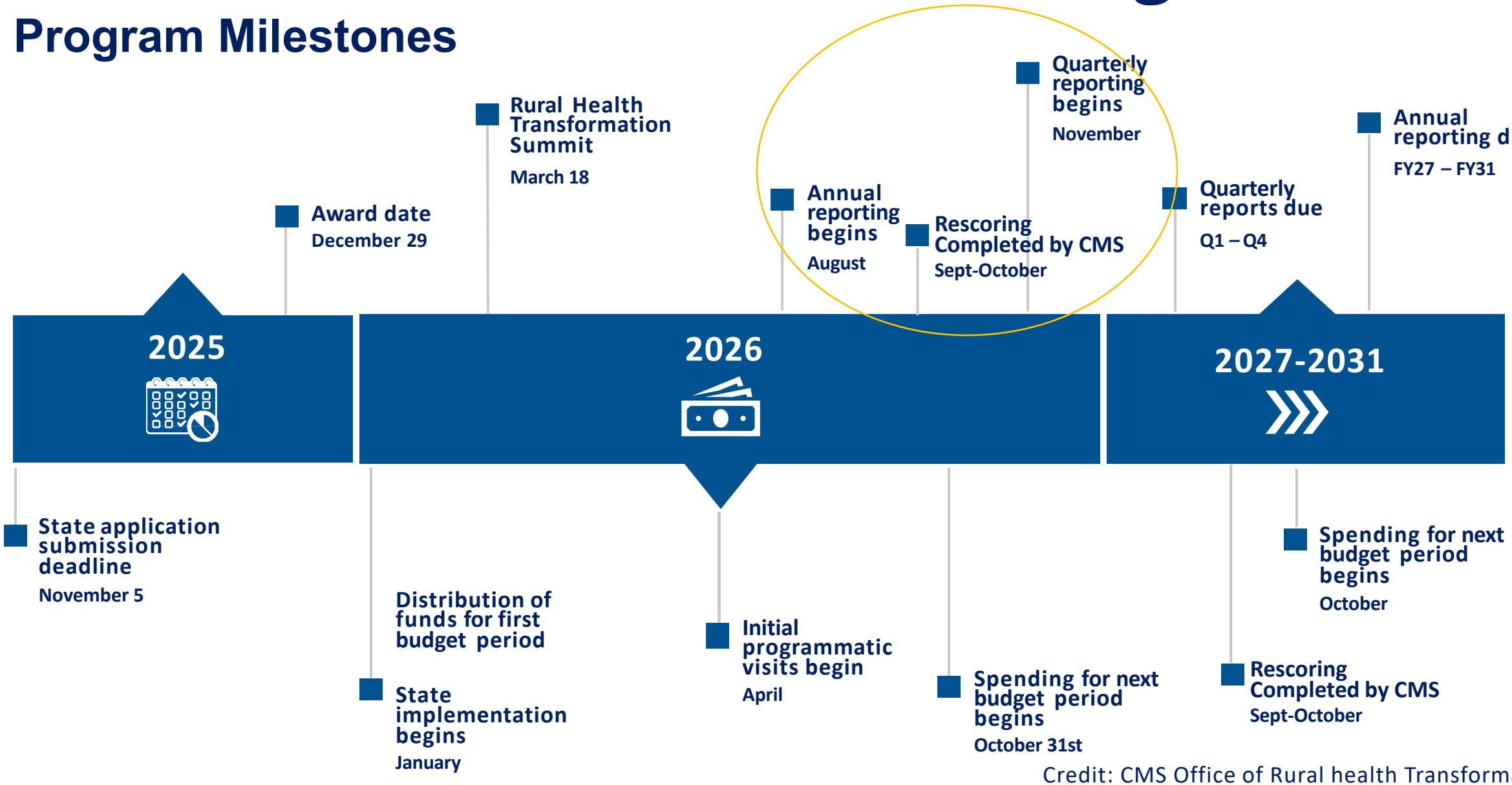
https://www.ruralhealth.us/programs/center-for-rural-health-innovation-and-system-redesign/rural-health-transformation-program





Rural Health Transformation Program

Program Milestones



Credit: CMS Office of Rural health Transformation

Rural Health Transformation Program

Continued Eligibility and Funding

- Continued funding to State depends on:
  - Availability of funds
  - Program authority
  - Satisfactory performance
  - Compliance with the terms and conditions of the Federal award
  - Compliance with reporting requirements
- Funding can be decreased or terminated if the requirements of the award are not followed.
- Centers for Medicaid & Medicare Services (CMS) can suspend or terminate the award if there are performance issues.

Reassessment

- Certain factors used to determine eligibility and funding are reviewed and updated annually to reflect each State's progress.
- Half of the available funding each budget period is allocated equally among all approved States, while the other half is distributed based on updated scores.
- **Why it matters:** States that demonstrate continued progress may receive a larger share of funding over time.

Credit: CMS Office of Rural health Transformation

Rural Health Transformation Program

Funding Limitations & Restrictions

General funding restrictions	Funds cannot be deployed to: • Pre-award costs, lobbying, meals (except in limited cases). • Construction or major building projects; new builds are unallowable. • Supplanting existing funding streams (e.g., salaries already covered by state budgets). • Cosmetic upgrades, independent research costs, telecommunications equipment flagged under federal law
Program-specific caps	• Capital expenditures (Category J): ≤20% of total award per budget period • Provider payments (Category B): ≤15% of total award per budget period • Electronic Medical Record replacement: ≤5% if already Health Information Technology for Economic and Clinical Health Act (HITECH) certified • Rural Tech Catalyst Fund initiative: ≤10% of award (or $20M, whichever is less) • Administrative costs: ≤10% (including both direct and indirect)
Noncompliance penalties	Misuse of funds, failure to meet commitments, or insufficient benefit to rural populations can trigger: • Withholding, reduction, or recovery of award funds • Proportional penalties if technical score factors are not met

Rural Health Transformation Program

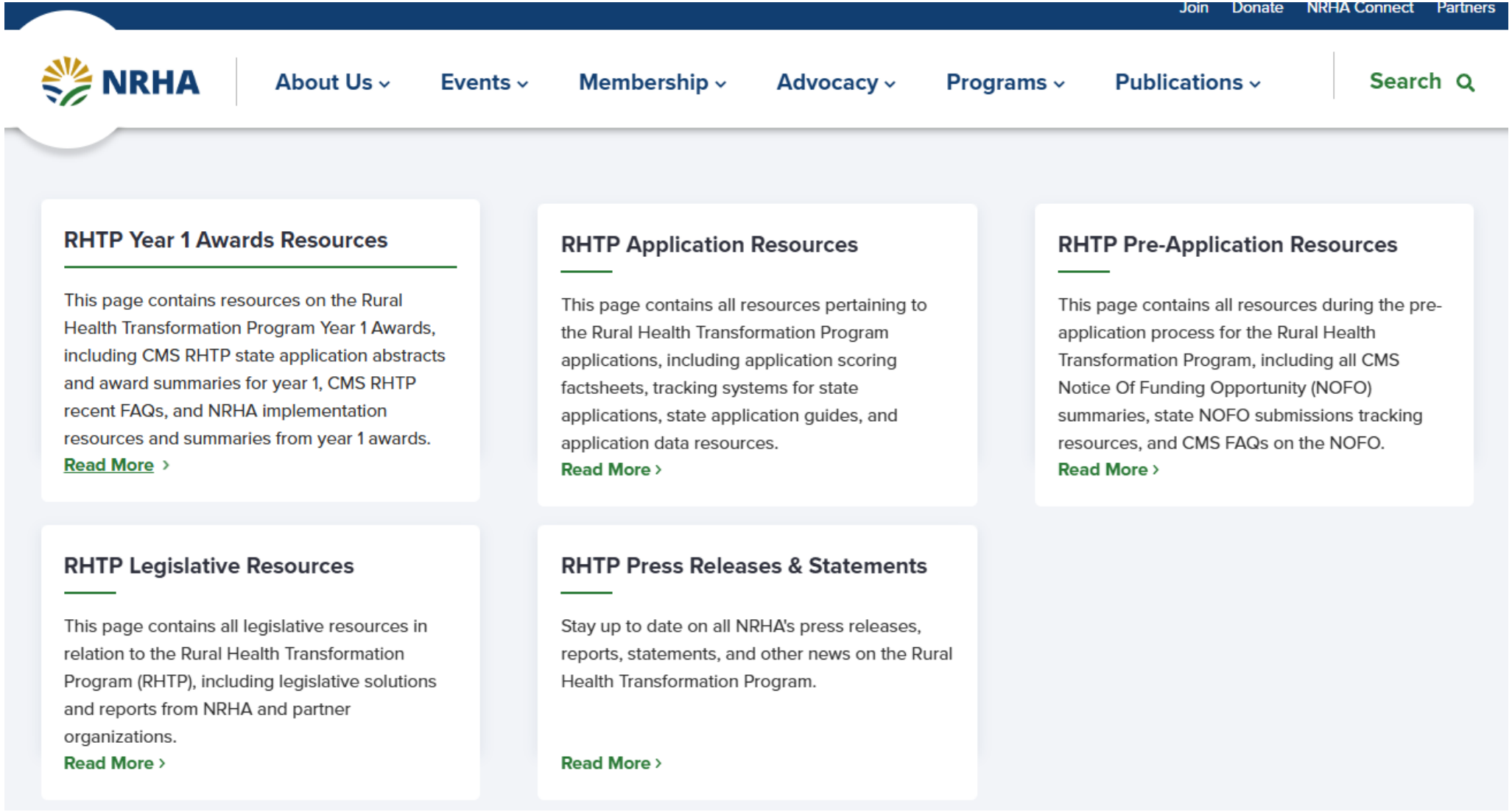
Funding Limitations & Restrictions

- Provider Payments:
  - Direct service payments (Category B) are capped at 15%
  - States may fund additional provider support like workforce recruitment initiatives and payment for non-clinical roles

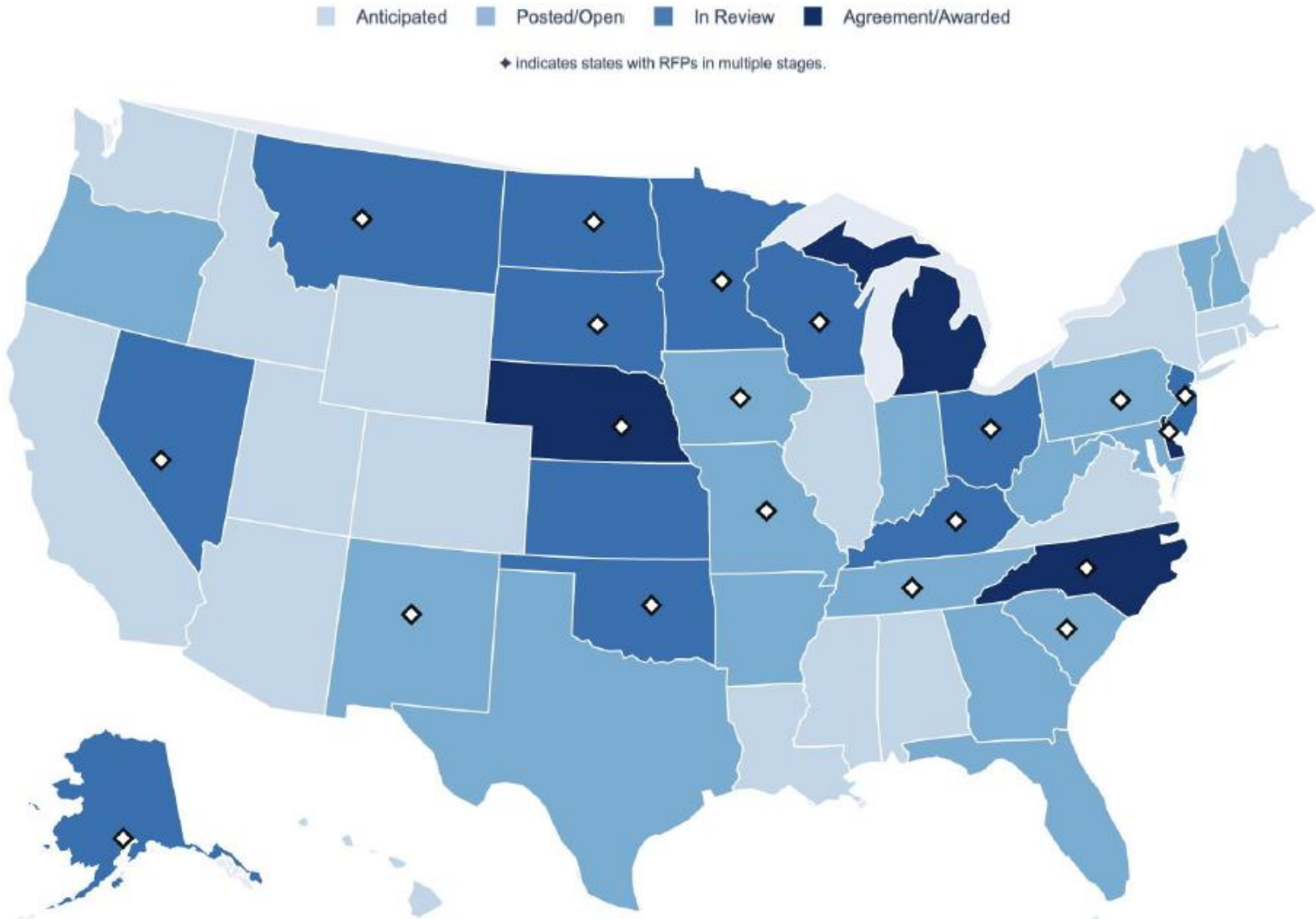
- 5-Year Rural Service Commitment:
  - Only certain workforce investments trigger the statutory 5-year rural service commitment
  - Determination made based on:
    - “”An item or service of value is offered to an individual”
    - The benefit is specific to the individual rather than the general workforce infrastructure investment

NRHA RHTP Center

https://www.ruralhealth.us/programs/center-for-rural-health-innovation-and-system-redesign/rural-health-transformation-program



NRHA RHTP Center: RPF Announcements



https://www.ruralhealth.us/programs/center-for-rural-health-innovation-and-system-redesign/rural-health-transformation-program

NRHA RHTP Center
Implementation Resources

Future of Rural Health

Findings and resources from the Future of Rural Health Summit

Rural Health Technical Assistance Model

NRHA's USDA Rural Hospital Technical Assistance

RHTP with a Rural-Aging Lens

NRHA's Tracking of State RHTP Initiatives that target rural healthy aging

Coming Soon!

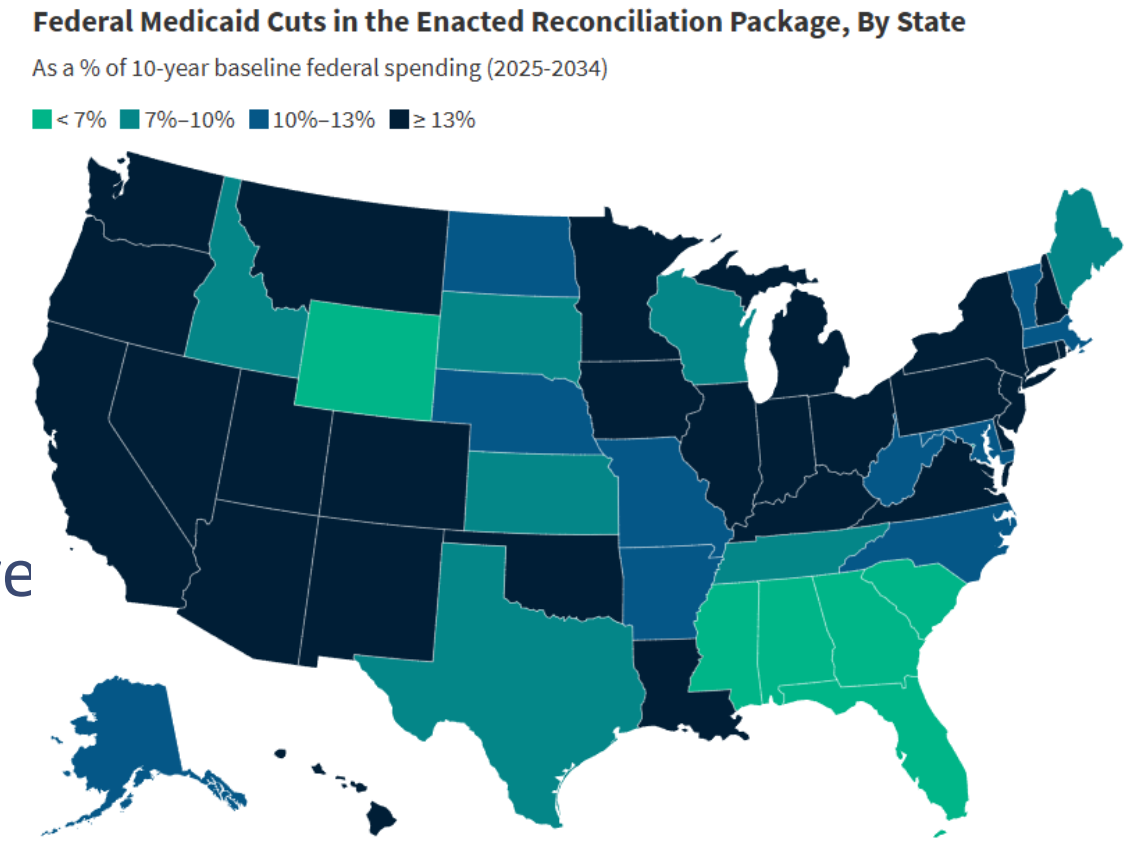
- State Policy Actions Analysis
- Investments in Rural Hospitals
- Investments in Maternal health

https://www.ruralhealth.us/programs/center-for-rural-health-innovation-and-system-redesign/rural-health-transformation-program/rhtp-resources/nrha-rhtp-implementation-resources

Impacts of H.R. 1 on Rural Health

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

- Rural Health Transformation Program only offsets a bit more than 1/3 of this amount
- Over half of the spending reductions in rural areas are among 12 states that have large rural populations and have expanded Medicaid



Source: KFF analysis of CBO estimates of the enacted reconciliation package Get the dataDownload PNG

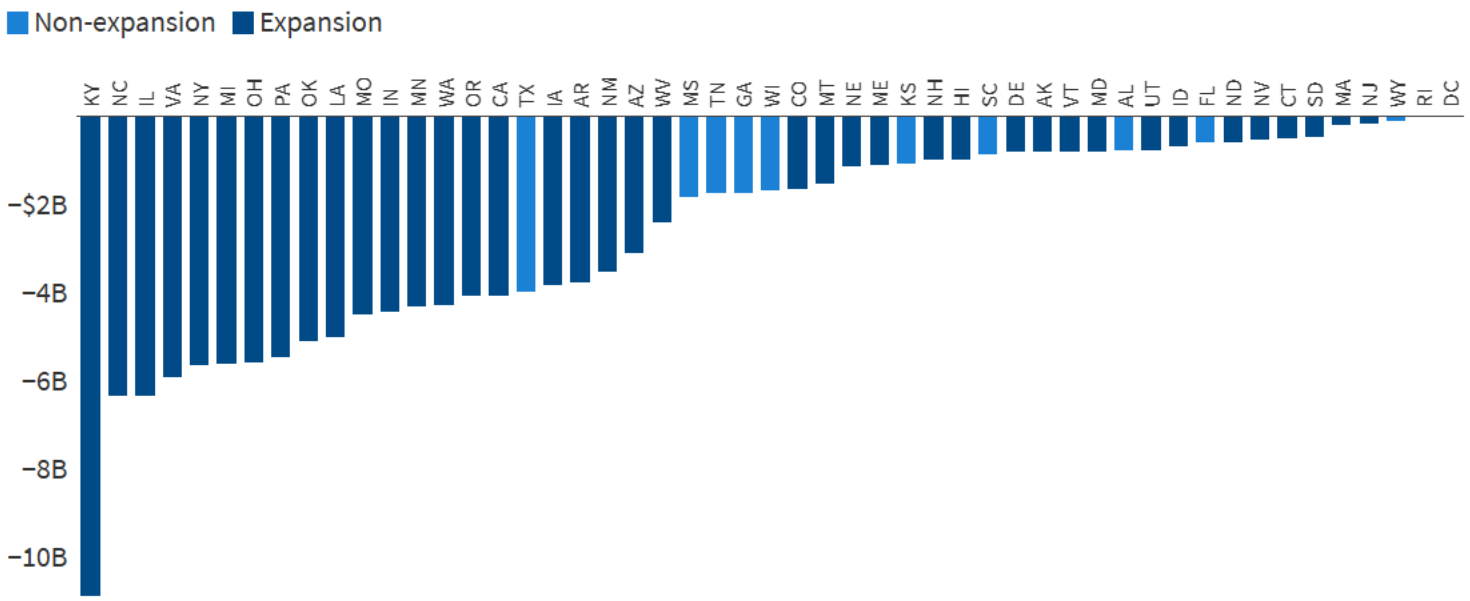
Impacts of H.R. 1 on Rural Health

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

Figure 2

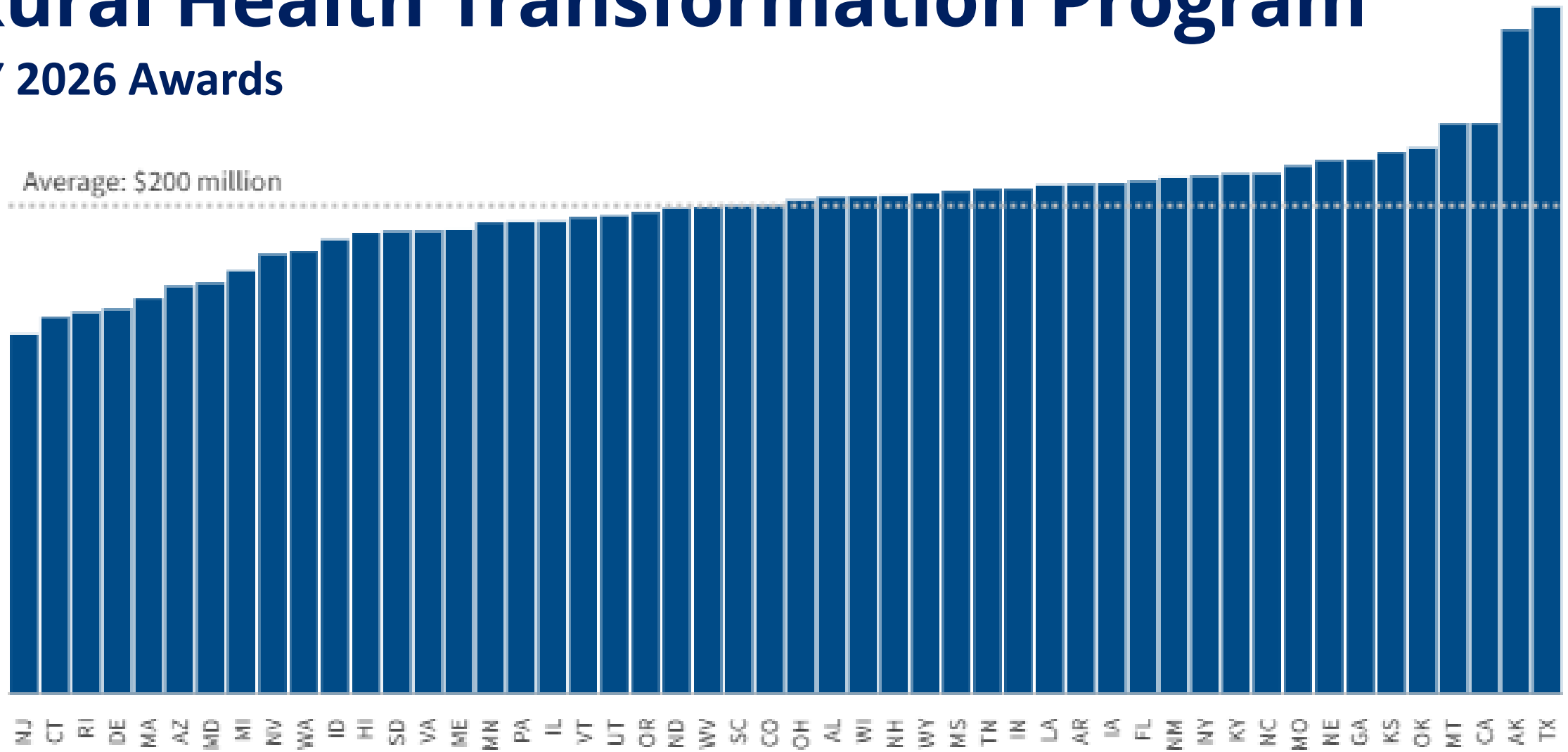
Largest Declines in Federal Medicaid Spending in Rural Areas Would Occur in States That Expanded Medicaid and Have Higher Shares of Rural Residents

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



Rural Health Transformation Program

FY 2026 Awards



Notes: DC and the U.S. territories were ineligible for funding.

Source: KFF analysis of rural health fund awards from the HHS Tracking Accountability in Government Grants System (TAGGS). Get the data

KFF

Impacts of H.R. 1 on Rural Health

Nearly 1 in 5 or 20% of rural adults and 40% of rural children rely on Medicaid or CHIP.

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

Figure 1: Rural Hospitals Could Lose 21 Cents Out of Every Dollar They Receive in Medicaid Funding

Source: KFF analysis of CBO estimates of the enacted reconciliation package Get the dataDownload PNG

NRHA 2026 Policy Priorities

- **FY27 Appropriations**
- **Rural Health Program Authorizations**
- **H.R. 1 Implementation:**
  - Medicaid financing – provider taxes and state directed payments
  - Medicaid work requirements and other eligibility changes
  - Rural Health Transformation Program
  - Coverage impacts
- **Supporting Rural Health:**
  - Sustainable Medicare reimbursement
  - 340B
  - Medicare Advantage reform
  - EMS
  - Farm Bill
  - Provider-Specific Policies

FY 2027 Appropriations

- The President's FY 2027 Budget Request released April 3
  - For the second year, proposed to eliminate core rural health programs.
- Almost every program proposed for elimination was also proposed to be cut in 2026
  - Congress ignored those requests, level or increased funding for rural health programs
- FY27 Appropriations Subcommittee for Labor, Health, and Human Services, which appropriates rural health programs, will hold their markup on
  - House: June 5th, Senate: TBD
- FY27 Appropriations on Rural Development, Ag, FDA Appropriations:
  - House: marked up FY 2027, Senate: TBD
  - Includes $2 million for Rural Hospital Technical Assistance Program

Medicare Advantage
Prior Authorization

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

- **S. 2879/H.R. 5454: MA Prompt Pay Act**
  - Requires MA plans pay clean claims in 14 calendar days (electronic submission) or 30 calendar days

340B Drug Pricing Program
Current Legislation

- H.R. 7391: Community Health Center Drug Pricing Protection Act:
  - Exempts CHCs from 340B rebate models.
- S.2372/ H.R.4581: 340B PATIENTS Act
  - Clarifies that manufacturers are required to offer 340B discount prices to covered entities.
- H.R. 44: Rural 340B Access Act of 2025
  - Makes rural emergency hospitals (REHs) eligible to participate in the 340B program.
- 340B Senate Working Group and changes to HELP leadership

Focus on Rural Hospitals
Legislative Priorities

- S. 502: Rural Hospital Closure Relief Act:
  - Reinstates Necessary Provider status with guardrails.
- S. 4141: Rural Hospital Revitalization Act:
  - Provides 0% interest loans through USDA's Community Facilities Programs to eligible hospitals for renovations or new constructions.
- S. 4233/ H.R. 8109: Save Struggling Rural Hospitals Act
  - Increases the Medicare Wage Index values for hospitals in the bottom 25th%.
- S. 4460: Rural Community Hospital Demonstration Reauthorization Act
  - Provides a clean, 5-year extension of RCHD; allows facilities that cycled out in 2025 and 2026 to rejoin.
- S. 335/ H.R. 1805 Rural Hospital Support Act
  - Makes permanent LVH & MDH designations and updates SCH and MDH base years.

Focus on Rural Hospitals

Rural Health Extenders

- Medicare-dependent hospital designation: December 31, 2026
- Low-volume hospital payment adjustment: December 31, 2026
- Medicare telehealth flexibilities: December 31, 2027
- Medicare rural ambulance add-on payments: December 31, 2027
- Hospital at home: September 30, 2030
- Medicaid disproportionate share hospital cuts delayed: September 30, 2027

https://www.ruralhealth.us/advocacy/advocacy-campaigns

Healthcare 2026: A Preview
Trump Administration Focus

1) Crushing Fraud, Waste, and Abuse
   - Example: Moratorium on new DME, hospice, and home health agencies

2) Affordability
   - TrumpRx: Drug Pricing Policy Framework, GENEROUS model
   - Site Neutrality: Provider based attestation OPPS

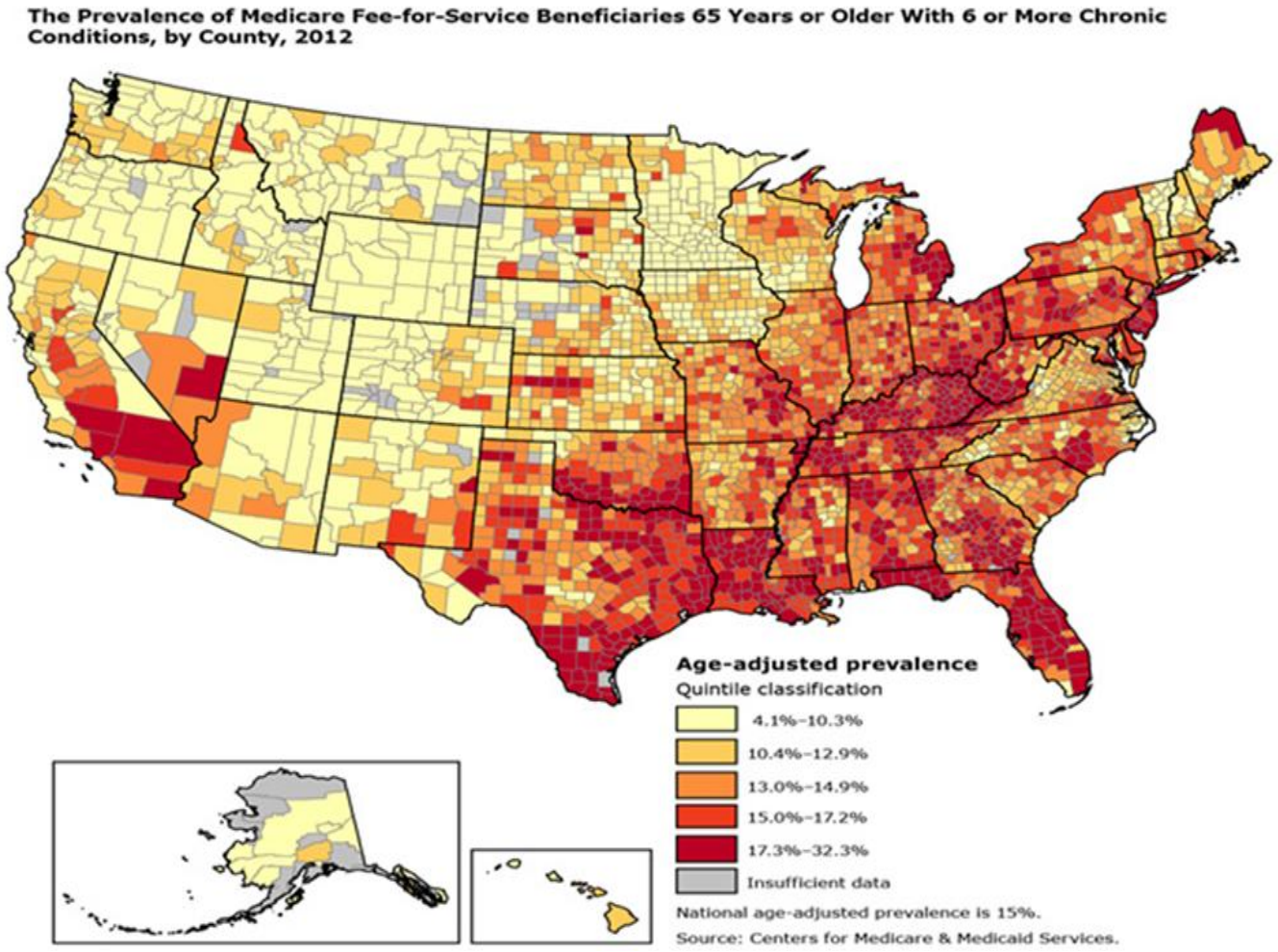
3) MAHA: Incentives for primary care intervention
   - CMS Innovation Center models: ACCESS; ACO LEAD
   - Revised Dietary Guidelines; AHA reorganization in HHS

4) AI Experimental Health Technology Ecosystem
   - Interoperability rule; WISeR model

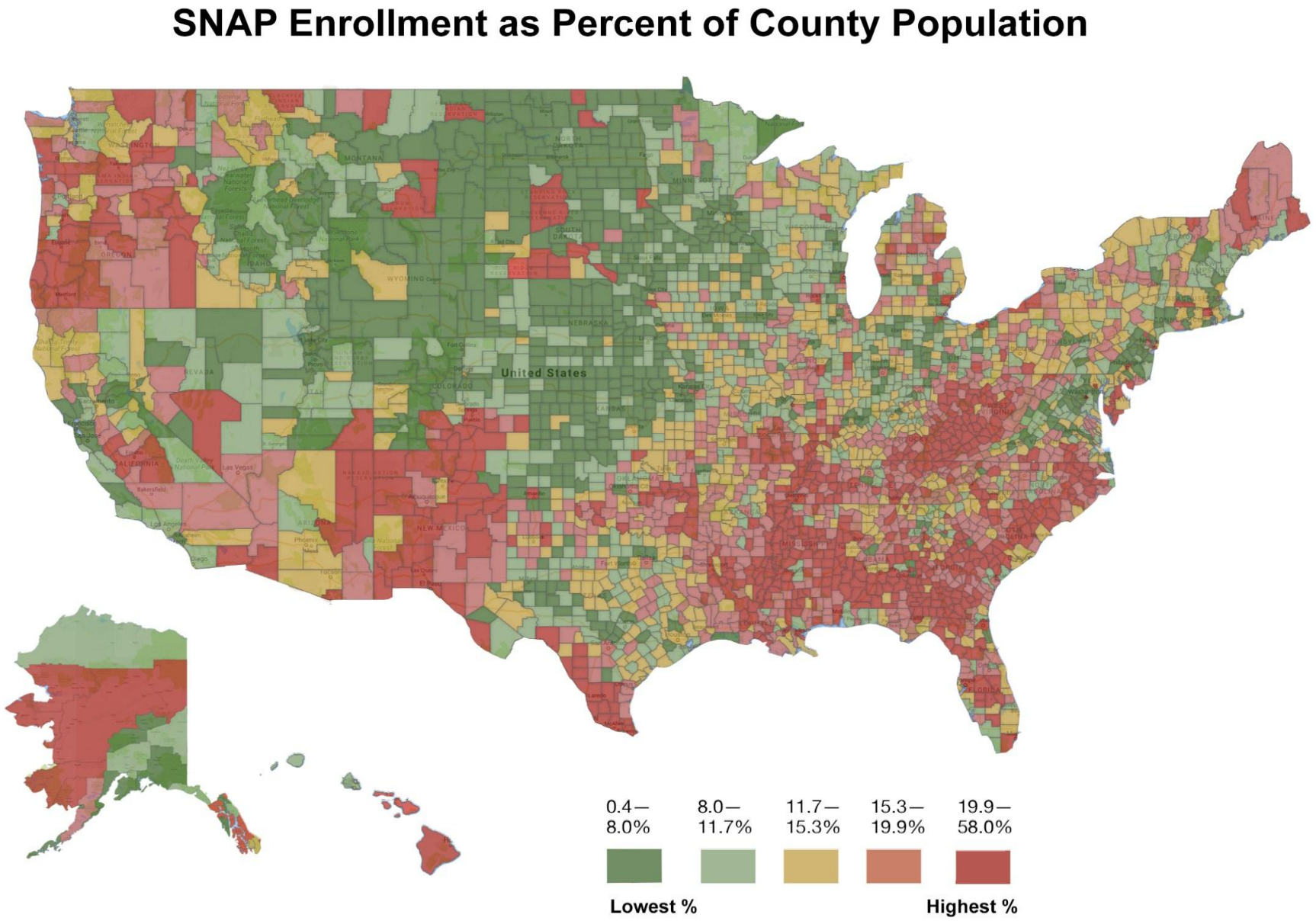
Rural has an Older, Sicker and Poorer Population

- The median age of adults living in rural areas is greater than those living in urban:
  - Rural: 51 years
  - Urban: 45 Years
- 18.4% of rural residents are age 65+, whereas its 14.5% in urban
- **Rural areas have higher rates of several health risk factors/conditions:**
  - **Obesity**
  - **Diabetes**
  - **Smoking**

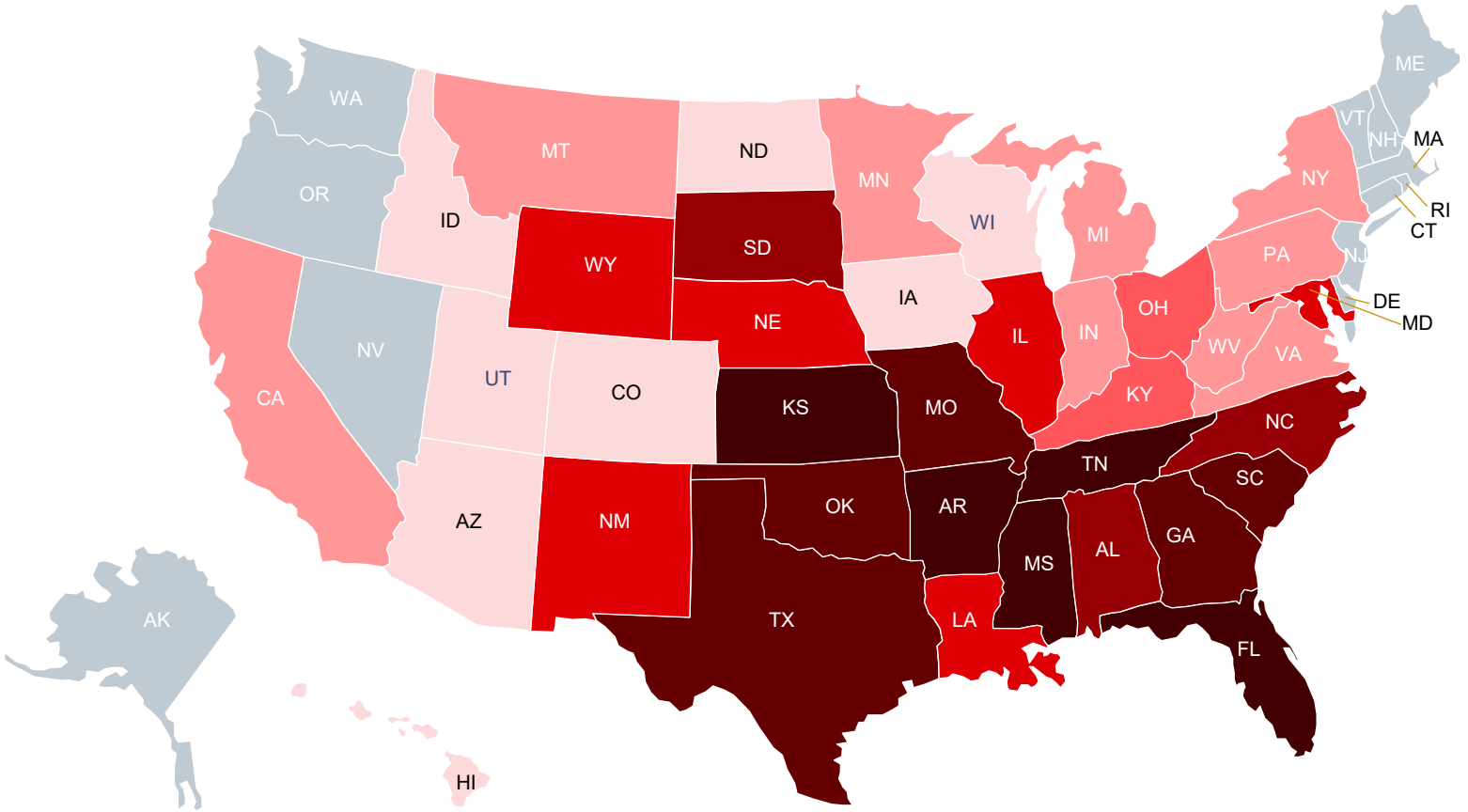
Prevalence of Medicare Patients with 6 or more Chronic Conditions



The Geography of Food Stamps



432 Rural Hospitals Vulnerable to Closure



432 rural hospitals across America are **vulnerable to closure**.

Across **15 states**, the **percentage** of rural hospitals **vulnerable to closure is 25% or higher**.

Non-expansion states are home to **205** vulnerable rural hospitals.

Percentage of State Rural Hospitals Determined to be Vulnerable

0	1%—9%	10%—15%	16%—20%	21%—25%	26%—30%	31%—40%	41%+

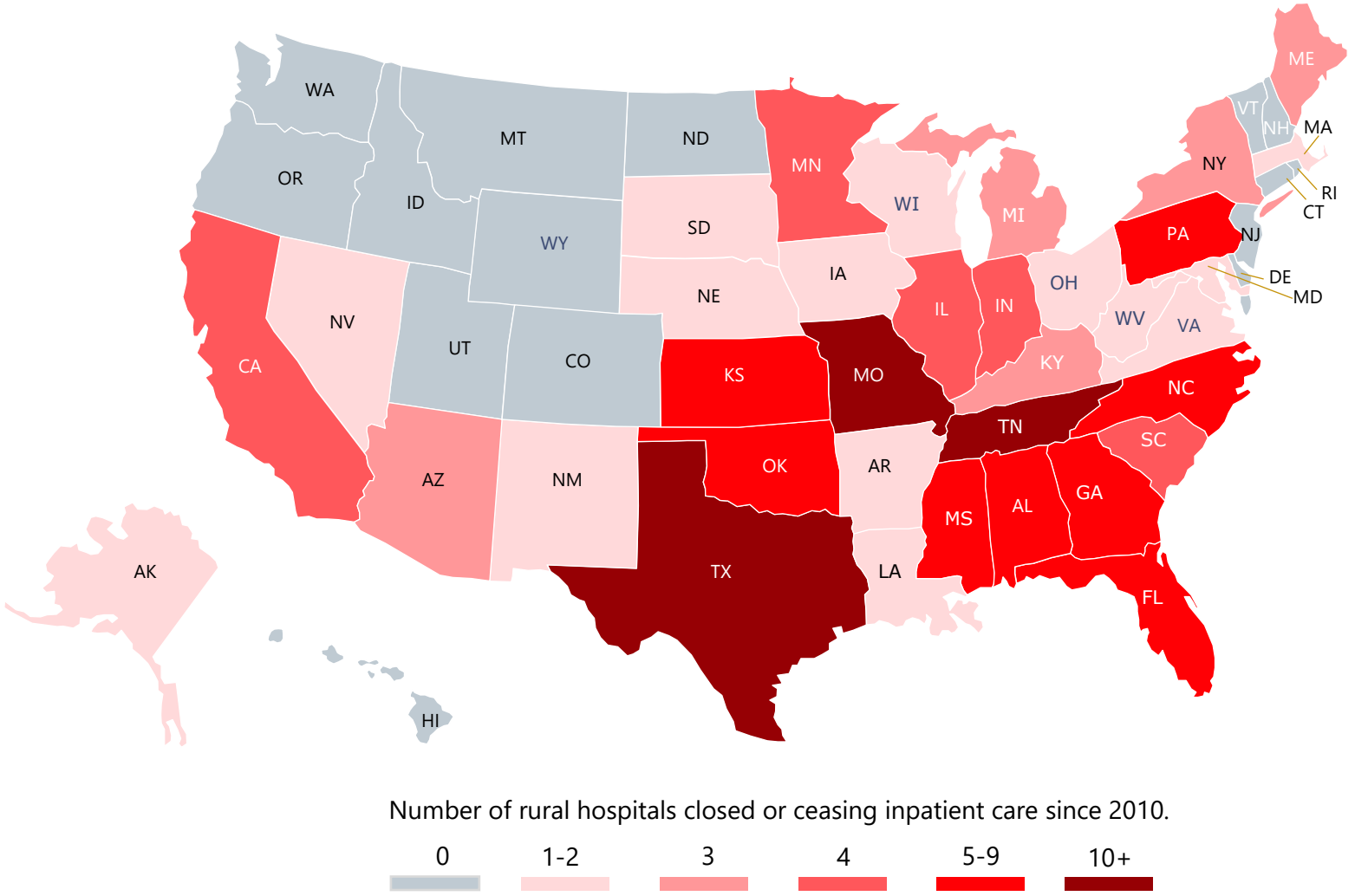
Source: The Chartis Center for Rural Health, December 2024

America’s Rural Hospital Crisis *2024

Since 2010, **access to care has deteriorated significantly** in rural communities across America.

195 rural hospitals have either closed or converted to a model that excludes inpatient care (e.g., REH).

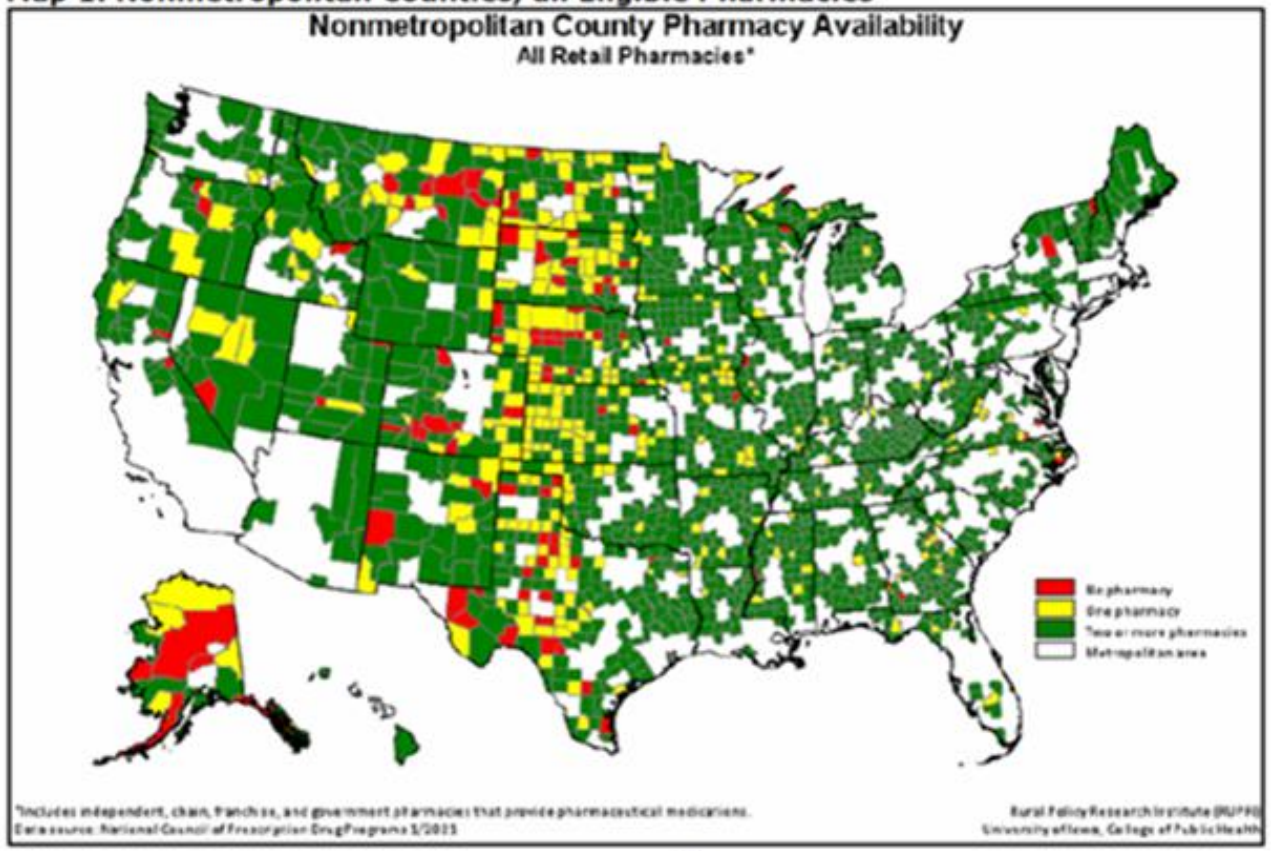
Highest loss of inpatient care tends to be in **states resisting** (or slow to adopt) **Medicaid Expansion**.



Closure Source: Cecil B. Sheps Center for Health Services Research, 10/11/23.

Rural Pharmacy Closures

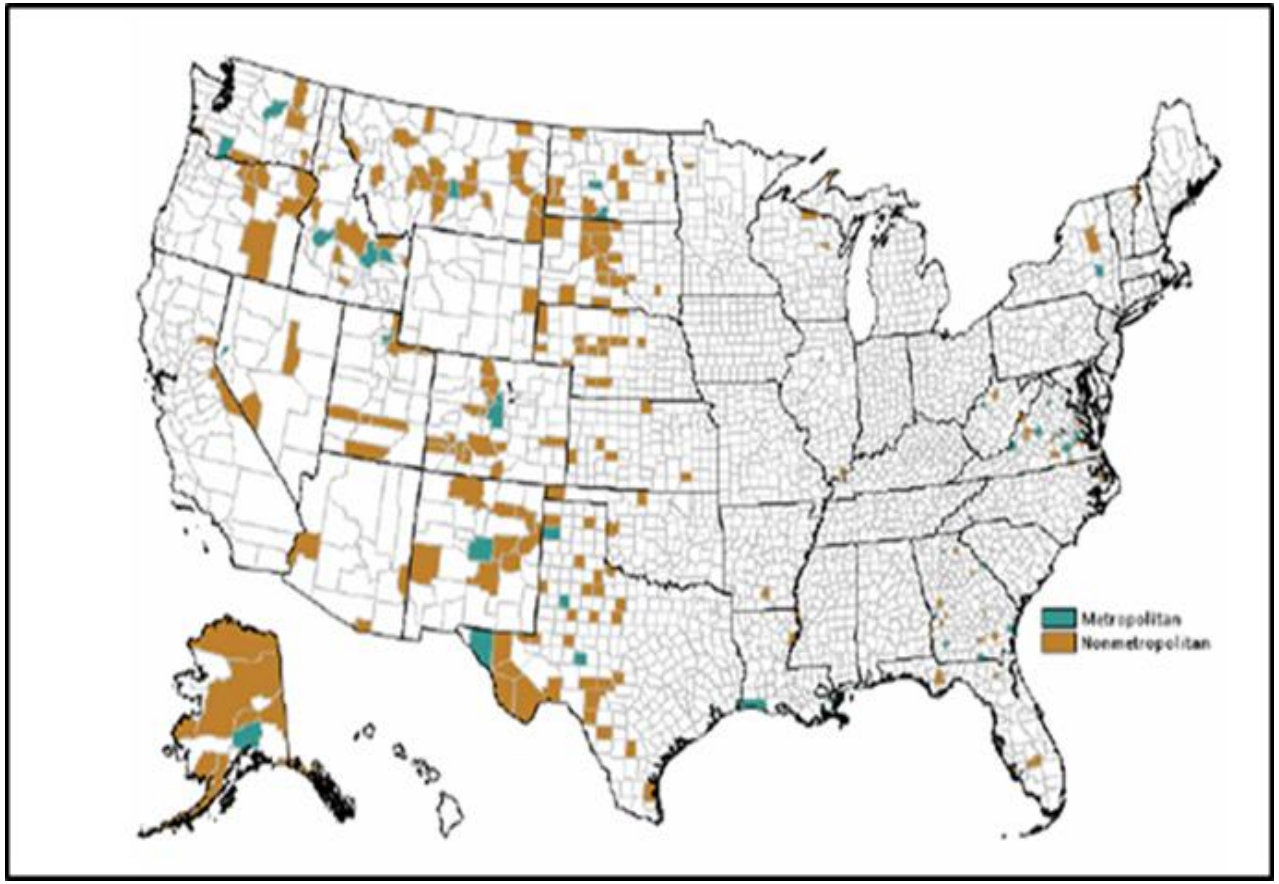
Map 1. Nonmetropolitan Counties, all Eligible Pharmacies



- From 2003 – 2018, *1,231* independently owned rural pharmacies (16.1%) closed
- 630 rural communities with at least 1 retail pharmacy in 2003 had 0 in 2018

- https://rupri.public-health.uiowa.edu/publications/policybriefs/2020/COVID%20Pharmacy%20brief.pdf

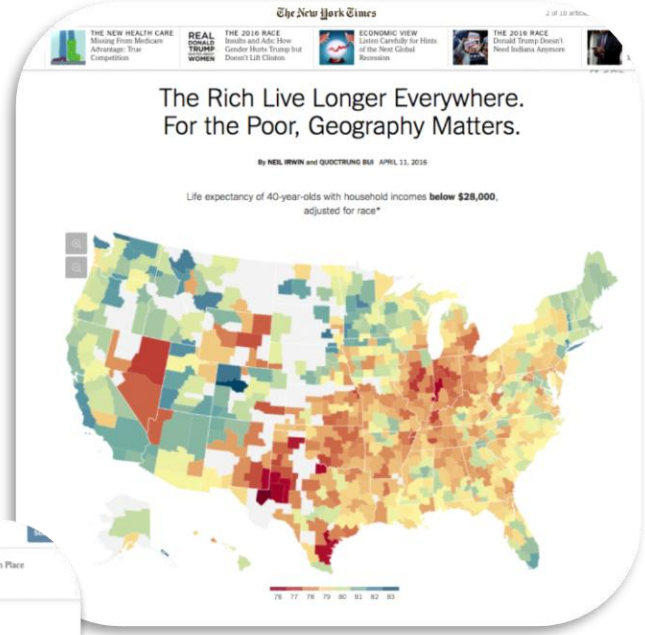
Rural Nursing Home Closures



- 10% of rural counties are nursing home deserts
- From 2008-2018, *400* rural counties experienced at least 1 nursing home closure

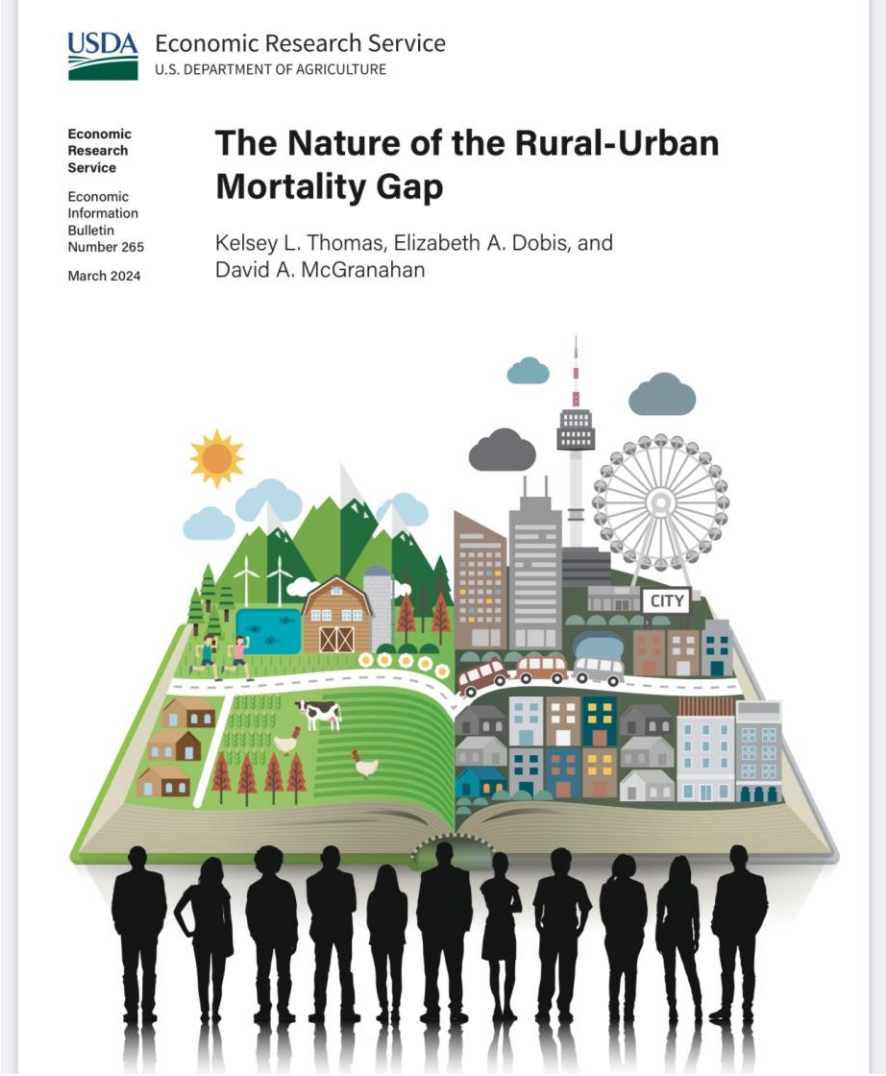
- https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf

Declining Life Expectancy



Declining Life Expectancy

There is a 20 percent higher natural-cause mortality gap in rural areas than urban areas.



Rural Population since 2015

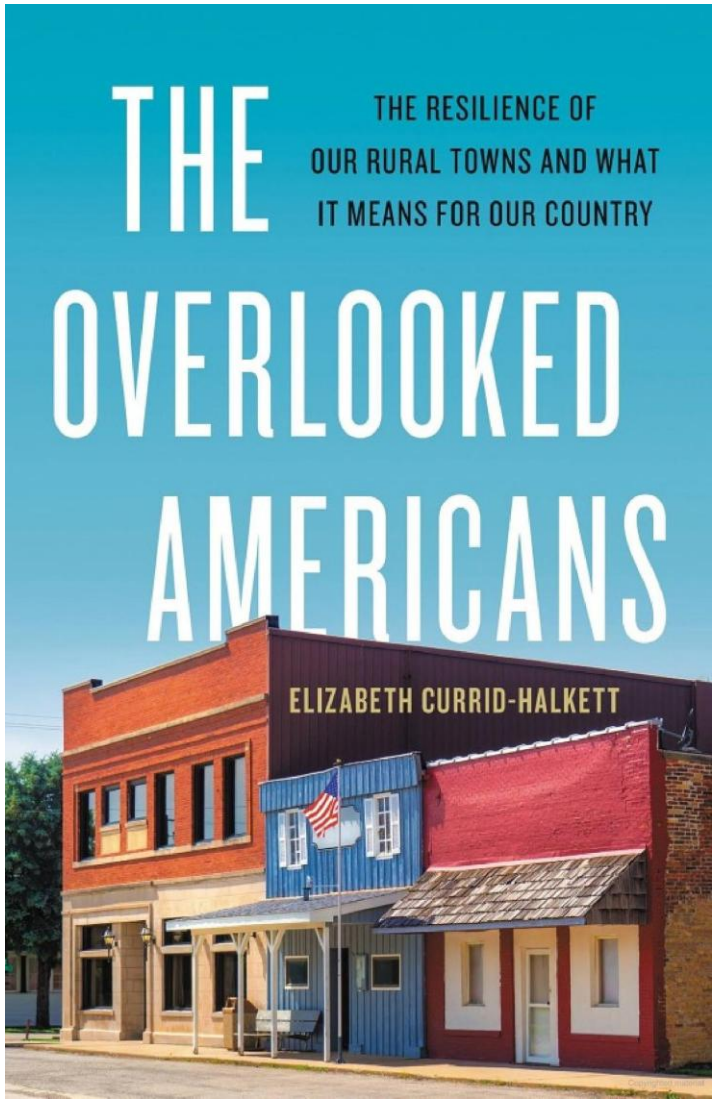
- U.S. Census shows that population in nonmetropolitan counties remained stable from 2014 to 2023 at about 46 million.
- (2014-2018 rural adjacent to urban saw growth.)

What is happening in Rural?

"By most economic measures, rural Americans are doing surprisingly well. Higer home ownership, less income inequality, and a comparable median income.

One thing is clear from my research: Life in rural America is not the drumbeat of heartache and destitution."

The Overlooked Americans
Currid-Halkett 2023



NRHA
Your voice. Louder.

Choosing Rural

"…In asking about their secrets for people living long, healthy lives, we were able to begin to understand not just why older adults stay, but how older adults are able to age successfully in their communities."

"They're not leaving their home; this is where they were born, this is where they will die.": Key Informant Perspectives From the U.S. Counties With the Greatest Concentration of the Oldest Old

-Carrie Henning-Smith, Megan Lahr, and Jill Tanem. Division of Health Policy and Management, University of Minnesota School of Public Health, Minneapolis, MN, USA

How Do Rural People Age Well?

"…The lifestyle and community subtheme attributed the high prevalence of oldest old to individual characteristics and behaviors, including **eating well, staying active, avoiding tobacco and other substances, working hard, having good coping skills, and going outside often**."

"They're not leaving their home; this is where they were born, this is where they will die.": Key Informant Perspectives From the U.S. Counties With the Greatest Concentration of the Oldest Old

-Carrie Henning-Smith, Megan Lahr, and Jill Tanem. Division of Health Policy and Management, University of Minnesota School of Public Health, Minneapolis, MN, USA

Relevance of Rural Providers

"Finally, under the subtheme of providing current services and amenities, many respondents mentioned the importance of formal health care services in the county, including clinics, hospitals, specialists, and long-term care (e.g., nursing homes, assisted living, and Medicare swing beds). And, several respondents also described home care services in the county, including help with errands, home maintenance/repair, and home health care. Above and beyond the simple presence of services, however, several respondents also described the importance of commitment to the community by providers themselves."

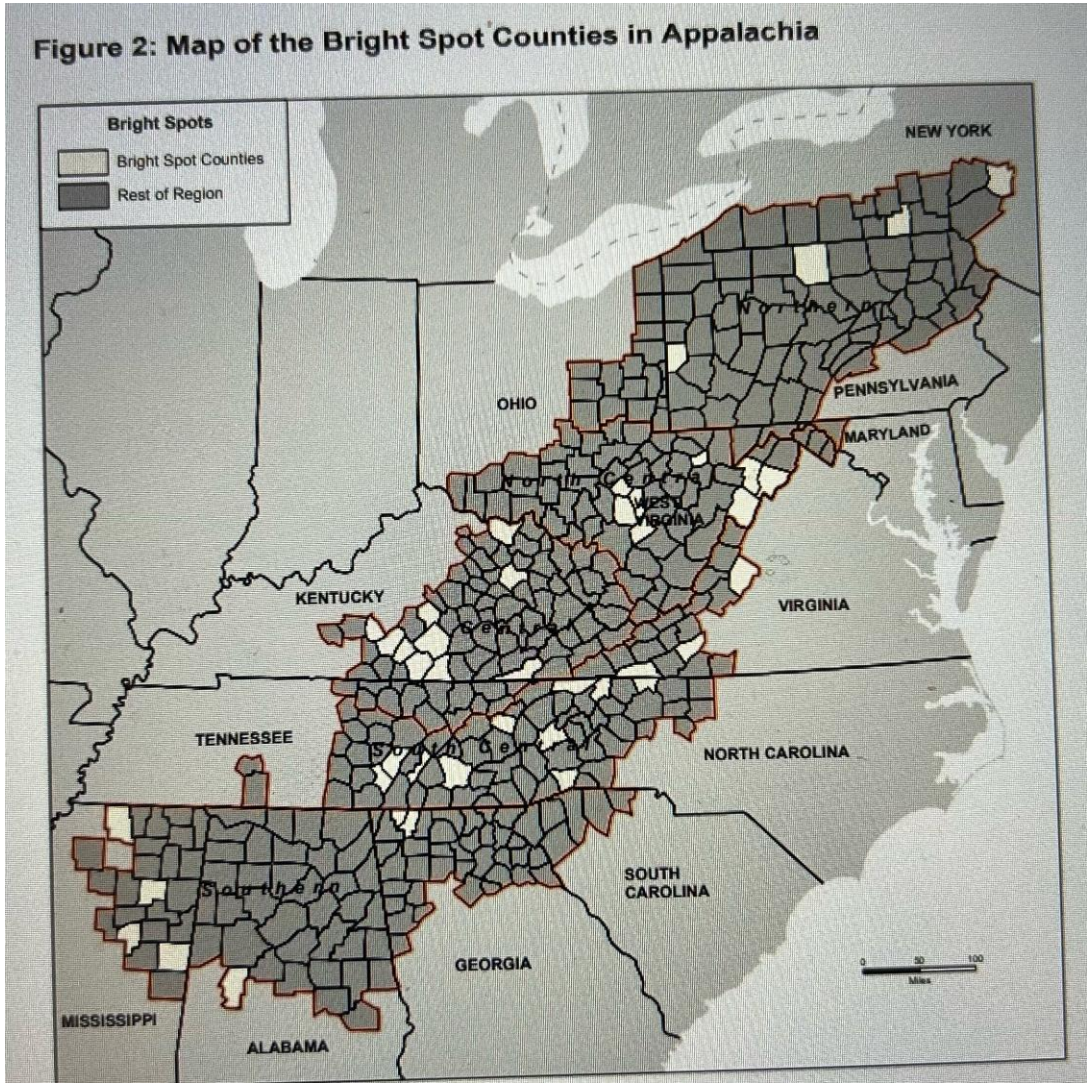
Rural “Bright Spots.”

Appalachian Regional Commission – “Bright Spots” research

- The Creating a Culture of Health in Appalachia initiative defines a **Bright Spot** as an Appalachian county that has better-than-expected health outcomes given its characteristics and resource levels—that is, the socioeconomics, demographics, behaviors, health care facilities, and other factors that influence health outcomes.

- **Author(s):** G. Mark Holmes, Nancy M. Lane, William Holding, Randy Randolph, Jonathan Rodgers, Pam Silberman, Lisa Villamil, Thomas A. Arcury, Kelly Ivey, Daniel Goolsby, Ashli Keyser, and J&J Editorial
- **Author Organization(s):** Appalachian Regional Commission; PDA, Inc.; Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill

Rural “Bright Spots.”



Bright Spots

- Our findings suggest that traditional public health initiatives should accompany efforts to develop community health infrastructure. For example, funding for community health workers trained to communicate chronic disease prevention behaviors might reach deeper into community values and have a greater impact on population health than the supply of additional providers alone.

- Overall, this study supports an emerging body of literature that attests to the association between positive population health outcomes and a community's social, economic, and environmental factors.

Need for a New Model

- Rural hospital closures
  - Closures could resume after covid funding is gone
- Declining inpatient utilization
  - Average revenue coming from outpatient services increased from 66.5% in 2011 to 74.2% in 2019
- Access to emergency care
  - Study show rural ED care for potentially life-threatening conditions is comparable to that in urban settings
  - Importance of ensuring access to treatment at local EDs in rural and frontier communities

CMS Center for Innovation

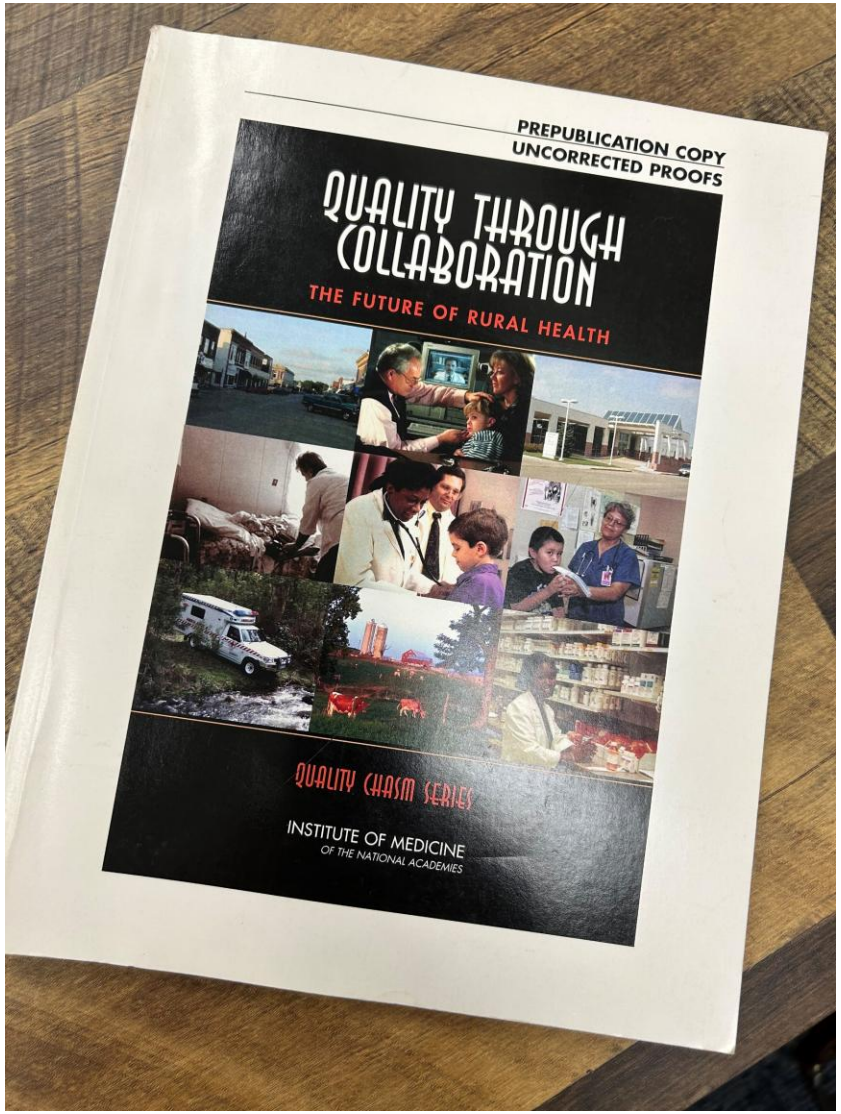
OLDER MODELS

- Frontier Extended Stay Clinic (FESC)
- Frontier Community Health Integration Project (F-CHIP)
- Rural Community Hospital Demonstration Program

NEWER MODELS

- Global Budget Model
  – Sen. Bob Casey (D-PA)
- 24/7 ER Model with Cost-Based Reimbursement
  – Rural Emergency Hospital

Rural Collaboration and Leadership



Rural Quality

- Strong sense of community responsibility, propensity toward collaboration (unique ways to develop and provide services needed.)

- Ability to create regional networks to provide greater access to state-of-the-art health care.
  - Institute Of Medicine “Quality through Collaboration”

Rural Quality

- Rural hospitals consistently outperform urban hospitals on patient experience metrics and patients often report higher levels of trust in their providers.
  - Joynt et al., 2016

Rural Quality

- Rural hospitals are more likely to practice patient-centered care as opposed to “more expensive” specialized care, which drives up Medicare costs.
  - Hiler 2014

Rural Quality

- Rural hospital preform better than urban hospitals in Medicare's Hospital Value-Based Payment Program.

- Rural hospitals scored better than their urban counterparts in postoperative wound infection rates and measures of health care related to infections.
  - Joynt et al, 2016

Rural Quality

- Rural home health care agencies are initiate care more quickly than their urban counterparts and typically outperform in the care process measure.
  - New York University, 2022

Rural Quality

- Patients seeking prenatal care at rural hospitals are less likely to experience potentially avoidable maternity complications.
  - Laditka et al, 2005

The Rural Provider Environment

-1400 total Federally Qualified Community Health Centers

(600 rural, serve 1 in 5 rural residents)

-5000 Rural Health Clinics

-1300 Critical Access Hospitals

-500 Rural Prospective Payment Hospitals

Drivers behind rural workforce shortage

- COVID-19 burnout/exhaustion
- Baby Boomers are retiring
- Desire for flexible work schedules
- New options like remote work/digital opportunities
- Salary and benefit limitations
- Education opportunities limited
- Rural patients need more services
- Rural practice characteristics
- Rural communities lack spouse opportunities

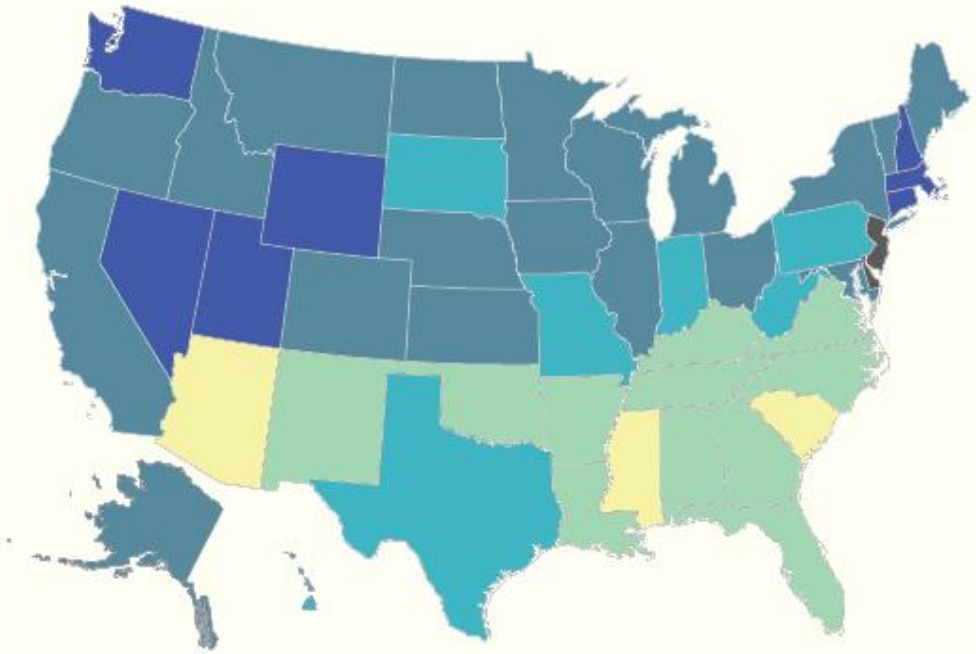
Drivers behind rural workforce shortage

Only 4.3% of incoming medical students in 2017 were from rural areas.

-Health Affairs 2017

The Digital Divide in Rural America

RURAL HOUSEHOLDS WITH BROADBAND SUBSCRIPTIONS



Source: Housing Assistance Council tabulations of American Community Survey 2016- 1 year variable B28002. Rural refers to outside OMB-designated metropolitan areas.

HOUSEHOLDS WITH BROADBAND SUBSCRIPTIONS

Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year.

83% METROPOLITAN

VS

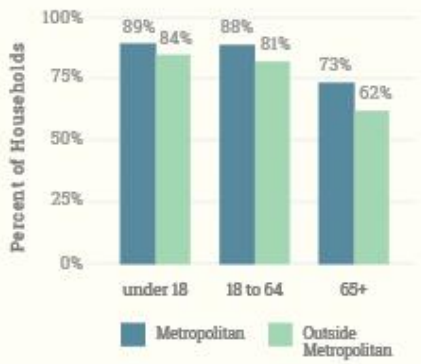
73% OUTSIDE METROPOLITAN

BROADBAND SUBSCRIPTIONS

BY INCOME

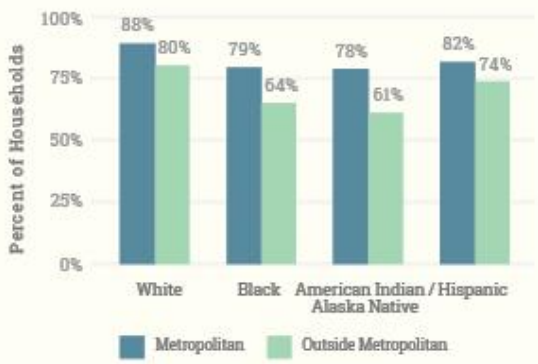
Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year.

BY AGE



Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year.

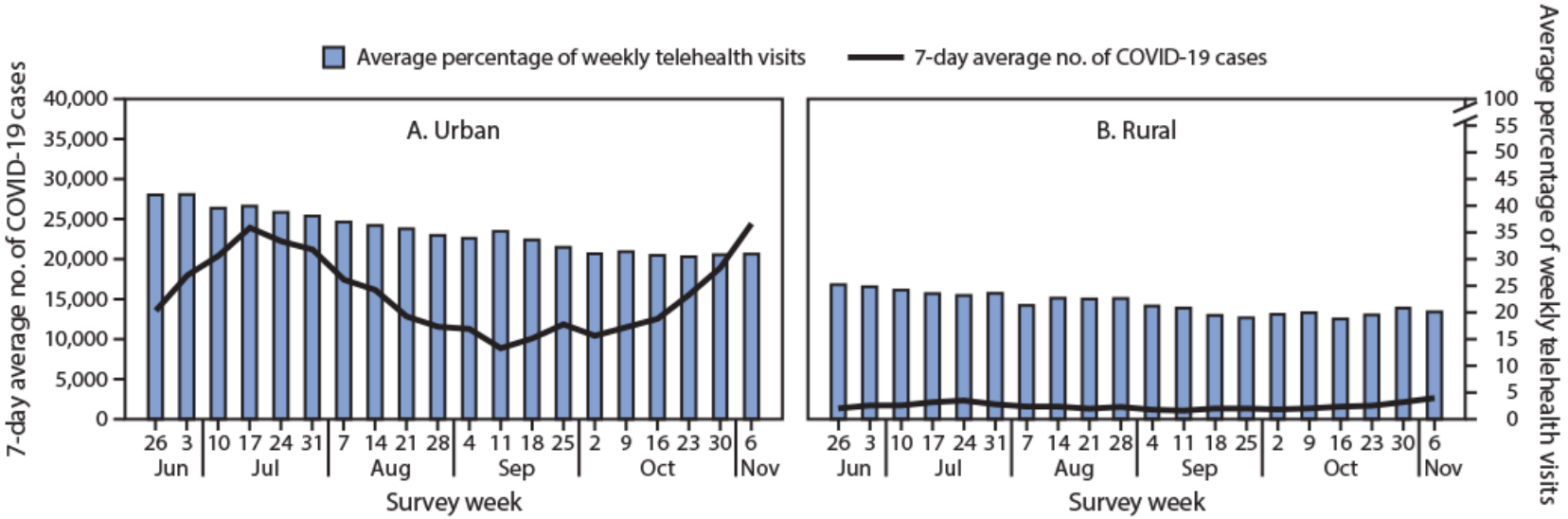
BY RACE / ETHNICITY



Source: Housing Assistance Council tabulations of American Community Survey 2016 - 1 year.

2021 Rural vs. Urban

- Cohort study of 36 million Americans with private insurance
- 0.3% of contacts in 2019 to 23.6% of all contacts in 2020 (March-June)
- This represents a 79x increase
- Rural-urban disparity



The Rural Context

- Rural areas make up 80% of the land mass in USA
- Rural areas have roughly 17% of the US Population
- Rural areas provide the food, fuel and fiber to power our nation

Takeaways

- A new framing for rural health

(A researched-based competitive advantage for rural communities.)

- Leadership and collaboration matters.

- The case for rural hospitals as community assets.

- Policy need to link reimbursements to SDOH/Public health.

NRHA

Your voice. Louder.

amorgan@nrharural.org

@amorganrural (TWITTER)