RURAL HEALTH
ASSOCIATION OF TENNESSEE

Rural Health Transformation Program Recommendations

October 7, 2025

Governor Lee,

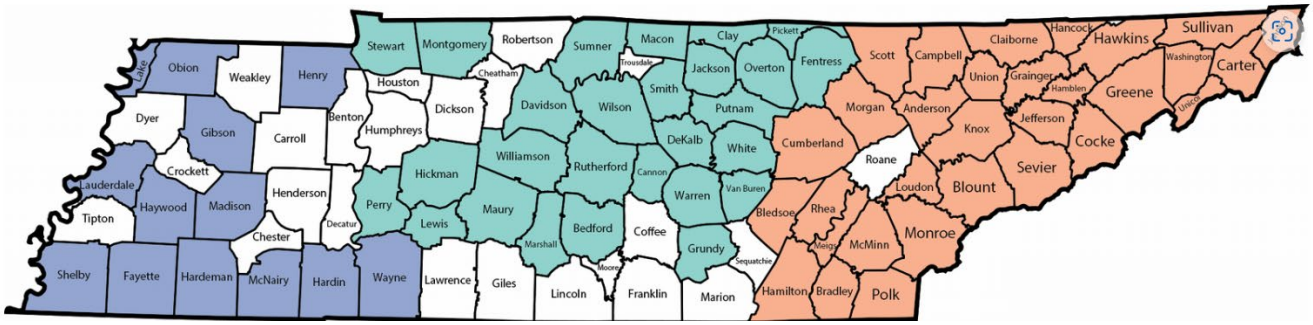
On behalf of the Rural Health Association of Tennessee (RHA), we first want to thank you and your administration for the work aimed at improving the quality of life for rural Tennesseans. Investments in infrastructure and workforce development are essential to advancing prosperity, good health, and attracting healthcare professionals to rural communities.

For more than 30 years RHA has proudly worked alongside Tennessee Department of Health, TennCare, and others to advance access to affordable, high-quality healthcare in rural Tennessee. With our members we have successfully championed important causes such as an expanded behavioral health safety-net and Medicaid dental coverage for pregnant women, to name a few.

Rural Health Program Disparities

At the same time, there are major deficiencies in some state efforts, leaving many rural and economically disadvantaged counties behind. For example, the below 24 rural counties do not have access to one or more of the following state programs:

- The Uninsured Adult Safety Net
- Provider Loan Repayment Programs
- 340B Drug Discount Program
- Reduced Cost Family Planning



Map Source: Tennessee Primary Care Association

1. Benton
2. Carroll
3. Cheatham
4. Chester
5. Coffee
6. Crockett
7. Decatur
8. Dickson
9. Dyer
10. Franklin
11. Giles
12. Henderson
13. Humphreys
14. Houston
15. Lawrence
16. Lincoln
17. Marion
18. Moore
19. Roane
20. Robertson
21. Sequatchie
22. Tipton
23. Trousdale
24. Weakley

RURAL HEALTH ASSOCIATION OF TENNESSEE

Tennessee Rural Health Care Taskforce

It was the honor of a lifetime to serve on Governor Lee's Tennessee Rural Health Care Task Force 2022 – 2023. RHA's Chief Executive Officer, Jacy Warrell, MPA, proudly chaired the Social Drivers of Health Subcommittee and championed the taskforce's recommendations through the state appropriations process that ultimately funded many of the below initiatives.

Fiscal Year 2022-2023 Through 2030-2031
TennCare Shared Savings
Award and Obligations Projection (millions)

Funded Item	Beg. Balance	Act. FY23	Act. FY24	Rev. Est. FY25	Est. FY26	Est. FY27	Est. FY28	Est. FY29	Est. FY30	Est. FY31	Total
Fiscal Year 2023 Shared Savings Received	$ 0.0	$ 330.9									$ 330.9
Strong Tennessee Families Coverage			20.1	30.6	31.1	32.0	33.0	33.9	35.0	18.0	233.7
Diapers for Kids Program				11.1	11.2	11.5	11.9	12.2	12.6	11.8	82.3
Unobligated Balance											14.9
June 30, 2024 Reserve Balance			*$ 310.8*								
Fiscal Year 2024 Shared Savings Received	$ 14.9		$ 302.7								$ 317.6
Rural Health - Apprenticeship Programs				6.4	8.3	8.3	8.2	8.2			39.4
Rural Health - Training Programs				5.4	3.9	4.4	4.4	4.4			22.5
Rural Health - Specialty Care				1.1	1.1	1.0	1.0	1.0			5.2
Rural Health - Telemedicine Program				0.1							0.1
Rural Health - Pathways Program				15.8	12.7	12.7	13.3	13.3			67.8
Rural Health - Center of Excellence				1.0	1.0	1.0	1.0	1.0			5.0
Rural Health - Center of Excellence Grants				1.4	1.4	1.4	1.4	1.4			7.0
Rural Health - Health Care Resiliency Program				50.0							50.0
Behavioral Health - Community MH Center Quality Payments				7.0	7.0	7.0	7.0	7.0			35.0
Behavioral Health - Community MH Center Workforce Development				1.0	1.0	1.0	1.0	1.0			5.0
Behavioral Health - Hospitals				15.0	15.0						30.0
Behavioral Health - Care for Individuals with IDD				1.5	1.5						3.0
Behavioral Health - Substance Use Disorder Treatment				2.0	2.0	2.0	2.0	2.0			10.0
Behavioral Health - In-Home Child and Adolescent Supports				1.0	1.0	1.0	1.0	1.0			5.0
Behavioral Health - Primary Care Training				0.4	0.4	0.4	0.4	0.4			2.0
Behavioral Health - Infant and Early Childhood Training				0.2	0.2	0.1					0.5
Behavioral Health - Children's Hospitals Infrastructure Grant				10.0							10.0
Value-Based Payment Intiative - TennCare				2.0	2.0	2.0	2.0	2.0			10.0
Unobligated Balance											10.1

These Rural Health designated dollars, as well as the complementary Behavioral Health projects, will undoubtedly make a difference in rural and urban communities alike for years to come.

As an advocacy organization with the vision *"For every rural community to have the resources and support needed to achieve health and prosperity,"* we want to see every rural community benefit from state efforts. As such it is important to note: ***Very few of the above appropriated dollars have directly funded rural hospitals, clinics, and/or skilled nursing facilities.***

The above funded efforts have limitations such as:

- Apprenticeship Programs are marketed to Rural Hospitals, leaving out Centers for Medicare and Medicaid (CMS) certified Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHC), or skilled nursing facilities (SNF); Not all counties will benefit from this program.
- Health Care Resiliency Program dollars went toward important community led efforts; They did not, for the most part, directly fund hospitals, RHCs, or FQHCs.
- As currently drafted, the urban run Rural Healthcare Center of Excellence's planning and implementation grants will be open to any facility, rural or urban; Grants will not allow facilities to budget for important administrative overhead (indirect costs) necessary to manage the dollars.
- Health Training Program Grants are anticipated to go to universities and college student fees and preceptors; not to employer-led training and upskilling initiatives.

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Federal Rural Health Transformation Program

Fortunately, the One Big Beautiful Bill Act, enacted into law on July 4, 2025, created a $50 billion fund, called the Rural Health Transformation Program. These funds are an attempt to offset losses that rural health providers will experience associated with other health provisions in the legislation, particularly the Medicaid program.

Allowable Uses of Funds and Conditions:
The bill lists several allowable uses of Rural Health Transformation Program funds, such as:

- Promoting evidence-based interventions to improve prevention/ chronic disease management
- Payments to providers
- Promoting technology driven solutions for prevention and management
- Training/TA for developing and adopting technology-enabled solutions that improve care delivery in rural hospitals
- Recruiting and retaining clinical staff to rural areas with 5-year obligation to stay
- TA, software, hardware for significant tech advances to improve efficiency, cybersecurity, patient outcomes
- Assisting rural communities to right size health care delivery by identifying needed services, facilities, etc.
- Supporting access to OUD/SUD treatment
- Projects that support value-based care
- Additional uses "designed to promote sustainable access to high quality rural health care services" as determined by CMS Administrator

As a condition of receiving funds, states must submit to the CMS Administrator a plan to use the funds to carry out at least 3 of the activities listed above and annual reports on use of funds.

No more than 10% of funds can be used for state administrative expenses.

Eligible Rural Health Facilities:
The bill defines rural health facilities as the following:

- Hospitals:
    - Located in a rural area *(which is defined as outside of a Metropolitan Statistical Area per 42 U.S.C. § 1395ww(d)(2)(D))*
    - Treated as being located in a rural area
    - This captures many large, urban hospitals that have "reclassified" to rural for inpatient prospective payment system purposes, i.e. urban located rural reclassified hospitals.
    - Located in a rural census tract of an MSA
    - Critical access hospitals; Sole community hospitals; Medicare-dependent hospitals; Low-volume hospitals; Rural emergency hospitals
- Rural health clinics (CMS Certified)
- Federally qualified health centers (FQHCs) and health centers receiving Section 330 grants
- Community mental health centers (CMHCs)
- Opioid treatment programs located in a rural census tract of an MSA
- Certified community behavioral health clinics located in rural census tract of an MSA

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Rural Health Association of Tennessee Recommendations

Based on our experience as a leader on Governor Lee's Rural Health Care Taskforce, surveys of our 800^{+} members, feedback sessions, and our 30+ years' experience working with Tennessee's rural healthcare community, we offer the following set of recommendations to inform Tennessee's application for the federal Rural Health Transformation Program:

- **Dollars for hospitals and clinics should be managed by the Division of TennCare**
  Rationale: Rural Health Transformation Program funds are meant for *Medicaid Providers* who will be adversely affected by cuts to Medicaid and rises in uncompensated care. More than ever, it is crucial for our rural providers to build IT infrastructure, innovative and sustainable services, and other initiatives aimed at advancing Value Based Care policies and practices. TennCare has the most relevant experience managing similar initiatives and grant programs for rural providers and an exceptional reputation for a timely contracting and fund reimbursement process.

- **90% of funds should go directly to rural providers who meet the Rural Health Facility definition as defined by CMS**
  Rationale: ALL rural facilities who meet the CMS definition of Rural Facilities should be eligible to apply for these funds from TennCare or other appointed agency. The CEOs and Administrators of rural hospitals, clinics, FQHCs, and skilled nursing facilities know best what their facility and community needs are. In most cases, administering funds through an outside agency such as a university will mean a 30-50% reduction of dollars available to rural providers.

- **Rural Health Facilities Should be provided a "Menu of Options" for use of funds**
  Rationale: The CEOs and Administrators of rural hospitals, clinics, FQHCs, and skilled nursing facilities know best what their facility and community needs are. Additionally, healthcare providers in West, Middle, and East Tennessee are extremely different. Instead of forcing hospitals, RHCs, FQHC, and skilled nursing facilities into a one-size fits approach, RHA members want a "menu of options" such as employer-led Workforce Development programs, adoption of Closed-Loop Referral Systems, Cybersecurity, and funding for service line assessments and realignment.

- **Technical Assistance Partnerships should be included in the "Menu of Options"**
  *Rationale: M*any rural providers do not have experience managing grants in accordance with state and federal rules and regulations and therefore will need technical assistance such as the ones in Governor Lee's Rural Health Taskforce recommendations: *Vetting potential private partners to ensure capabilities and interests align with the intent and objective of the grant program; Serving as a referral and matching partner between potential vendors and grantees; and supporting program sustainability.*

RURAL HEALTH ASSOCIATION OF TENNESSEE

State Policy Agenda Opportunities

The National Rural Health Association (NRHA) has endorsed the following policies as essential for rural communities. For an expanded list of positions, see NRHA's 2025 Policy Agenda.

Priority Area 1: Investing in a Strong Rural Infrastructure

Rural health designations and programs expand access to health care, improve health outcomes, and increase the quality and efficiency of health care delivery in rural America. Over 180 rural hospitals have closed, or discontinued inpatient services, since 2010, with nearly 50% of rural hospitals are operating with negative margins and therefore vulnerable to closure. Often one of the largest employers in a rural community, hospitals provide access to care, as well as jobs and other economic opportunities. NRHA supports the following actions to strengthen and support the rural health infrastructure:

- Provide stabilizing relief for rural providers to abate the rural hospital closure crisis.
- Stop Medicare and Medicaid cuts to rural providers and address administrative barriers.
- Allow providers to utilize innovative technology and improve access through continuing the telehealth advancements.
- Modernize the Rural Health Clinic (RHC) program by updating payment policies; expanding team-based care; and incorporating essential services such as behavioral health.
- Test opportunities to improve regional and local health planning to improve distribution of essential services and improve community support for rural health services.
- Identify models of care to better support the infrastructure needs of frontier and isolated rural communities.
- Support proposals to increase access to Medicaid coverage.

Priority Area 2: Reducing Rural Health Care Workforce Shortages

Maintaining an adequate supply of healthcare providers remains one of the key challenges in rural care. Nearly seventy percent of rural counties are Health Professional Shortage Areas. With far fewer physicians per capita, the maldistribution of health care providers between rural and urban areas results in unequal access to care and negatively impacts rural health. NRHA supports the following actions to help recruit, train, and obtain health care professionals in rural areas:

- Remove barriers that limit rural resident training and grow training opportunities through vehicles like rural residency training tracks programs and residency development.
- Address the shortages rural providers face in maintaining an adequate workforce through programs like the National Health Service Corps (NHSC), Nurse Corps Loan Repayment Program (NCLRP), and Title VII and VIII workforce training programs.
- Test new models of team-based care to maximize the capacity of the rural workforce to serve people living in rural areas.
- Support policies that allow trained professionals to work at the top of their licensure.

Priority Area 3: Building Rural Health Opportunity

The federal investment in rural health programs is a small portion of federal health care spending, but it is critical to rural Americans. Rural residents often encounter barriers to health care that limit their ability to obtain the services they need. Individuals living in rural areas are more likely to die of the five leading causes of death (heart disease, cancer, stroke, chronic lower respiratory disease, and unintended injury). Medical deserts are appearing across rural America, leaving many without timely access to care. Unfortunately, rural communities also see disparities in health care outcomes caused by social determinants of health coupled with geographic challenges. NRHA supports the following actions to strengthen and support the health of individuals in rural areas:

- Ensure access to health care coverage for people living in rural areas.
- Invest in public health and emergency preparedness.
- Prioritize health education, chronic disease prevention, infectious disease control, and care management as part of rural health improvement.
- Ensure that rural women have access to obstetric and maternal health care support.

Closing and Attachments

We thank you again for your administration's prioritization of Rural Health. Rural Health Association of Tennessee and our members have all strengthened our capacity to advance rural health policies and programs over the past 5 years thanks to the leadership of Tennessee Department of Health, TennCare, Tennessee Department of Mental Health and Substance Abuse Services, and Tennessee Department of Economic Development.

We stand ready to provide additional support, information, and technical assistance as is needed. In the meantime, please see the following attachments:

- Tennessee Rural Health Statistics
- Rural Health 101

To good health,

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Tennessee Rural Health Statistics

Since 2010, Tennessee has lost 8 rural hospitals to closure and 6 rural hospitals have converted

Source: UNC, 2023.

2 **Rural Emergency Hospitals**

56% of rural hospitals are without OB services

35 median minutes driving to hospital with OB services

Source: CHQPR. 2023

53% of rural hospitals are vulnerable to closure

62% of rural hospitals operate on a negative margin

Source: The Chartis Group., 2024

Health Professional Shortage Areas

Primary Care

All 52 non-metro counties are primary care HPSAs.

Mental Health

All 52 non-metro counties are mental health HPSAs.

Dental

All 52 non-metro counties are dental health HPSAs.

Source: HRSA, 2024.

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National Rural Health Association

National Rural Health Association

Rural Health 101

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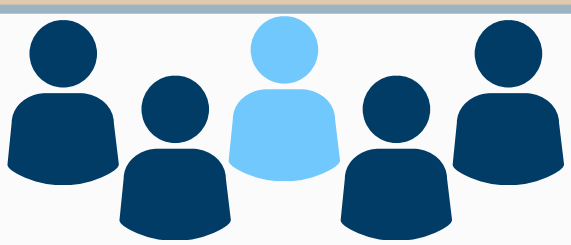
Why Rural Health?

About 61 million (15%) of Americans reside in rural areas.



Rural Barriers to Access

People living in rural areas are at greater risk of poor health conditions due to:

- Health care workforce shortages
- Lower rates of health insurance coverage
- Limited availability of health care and public health services
- Vulnerable health care facilities
- Distance and transportation limitations
- Inadequate broadband access
- Higher prevalence of chronic disease
- Lower socio-economic population

Infrastructure

Since 2010, nearly 170 rural hospitals have closed or discontinued inpatient services. Currently, 50% of rural hospitals operating on on negative margins. When a rural hospital closes, not only does the community lose access to vital health care, but a major employer and community lynchpin exits, affecting the larger community.

Critical Access Hospitals (CAHs)

CAHs reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities through receiving certain benefits, such as cost-based reimbursement for Medicare services.

Rural Prospective Payment System (PPS) Hospitals

Recognizing that many rural hospitals are the only health care facility in their communities and that their survival is vital to ensure access to health care, Congress created special PPS designations including Sole Community Hospitals (SCH), Medicare Dependent Hospitals (MDH), and Low Volume Hospitals (LVH).

Rural Health Clinics (RHCs)

RHCs are public, nonprofit, or for-profit healthcare facilities that use a team approach to healthcare delivery, using advanced practice nurses and physician assistants to provide services. To receive Centers for Medicare & Medicaid Services (CMS) certification, RCHs must be located in a non-urban area that is designated as underserved.

1,353
CAHs operating in the US

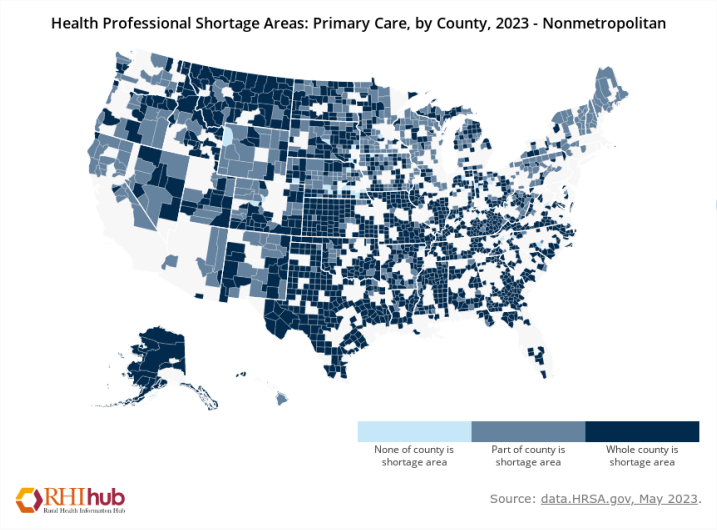
2,231
current rural PPS hospitals in the US

62%
of the rural population are served by RHCs

National Rural Health Association

www.ruralhealth.us/advocate
@nrha_advocacy

Workforce

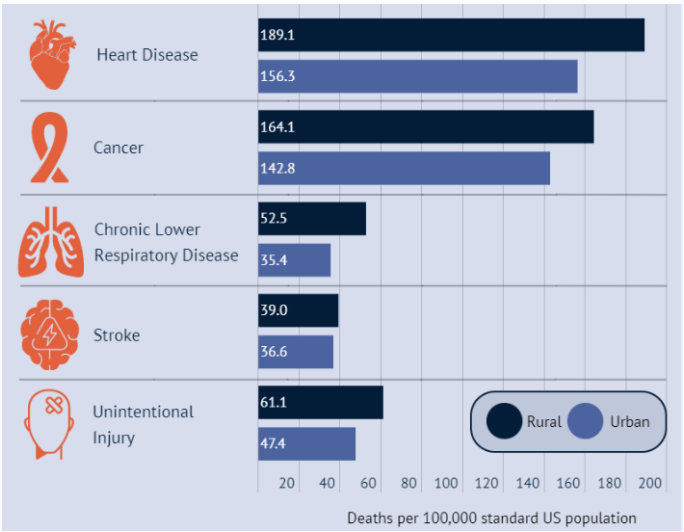


Only 10% of US physicians practice in rural areas, despite rural representing nearly 20% of the US population.

80% of rural America is medically underserved.

Students who train in a rural area are more likely to practice in a rural area. A recent study showed the likelihood of rural practice among family medicine residents experiencing at least 50% rural training time was 5-fold higher than those who did no rural training during their rotations.

Rural Mortality Disparities



Source: NIHCM.org

Equity

Rural areas are more likely to be affected by social determinants of health and inequities that prevent proper healthcare access and impact health outcomes, such as:

- **Higher rates of unemployment and poverty-** rural median incomes average 20% below urban areas, with 25% of rural children living in poverty
- **Access to safe and affordable housing-** 6% of homes in rural are considered of inadequate quality
- **Access to healthy food-** 15% of rural households are food insecure
- **Access to childcare and early childhood development-** 59% of rural communities are classified as child care deserts
- **Access to safe and affordable transportation**

Rural residents have greater transportation difficulties reaching health care providers, often traveling twice the distance compared to urban residents for care.

53% of rural Americans lack access to 25 Mbps/3 Mbps of bandwidth, the benchmark for internet speed. Lack of high-speed internet can be a hindrance to using telehealth to access health care.