# Welcome to Today's Virtual Workshop!

Please enter & rename yourself in Zoom using the following convention:

**[FIRST NAME] [LAST NAME]**
**(Pronouns, Organization)**
*Example: Mallory Yung (she/her/they, Health Impact Alliance)*

We will kick off the meeting shortly!

# HIA/Philips Virtual Workshop:
# Paths Forward for Rural Health Innovation

July 23, 2026

# **Agenda:** “Paths Forward for Rural Health Innovation” Workshop

| | | |
|---|---|---|
| 1 | Welcome & Introductions | *10 mins* |
| 2 | THMA Insights: Understanding RHTP Implementation<br>*Madeline Cree (Associate Director, The Academy Advisors, THMA)* | *20 mins* |
| 3 | Building the Bridge–Stabilizing Rural Ecosystems for Transformation<br>*Dr. Bill Beninati (CMO, Virtual Hospital, Intermountain Health)* | *15 mins* |
| 4 | Partnering to Drive Sustainable Digital Innovation<br>*Mike Lemnitzer (VP, State Government Healthcare, Philips)* | *15 mins* |
| 5 | Group Discussion & Commitments | *20 mins* |

# Rapid-Fire Introductions

- Share your name, title, and organization

- In **one sentence or less**, answer one of the following prompts:
  - Share **one rural health innovation initiative or opportunity** at your organization that you're excited about
  - Share **one "up-at-night" issue** about rural health innovation that has been on your mind
  - Share something **people haven't been talking about** that you're surprised by

# Why We're Here Today: Leveraging the Collective to Solve Shared Challenges

Conversations with rural health leaders surfaced 4 major themes surrounding rural health innovation

## Addressing Foundational Needs for Rural Care Providers in the RHTP "Era"

- RHTP funds **flowing to transformational projects** rather than addressing root causes of rural care ecosystem fragility.
- Certain states **employing funding mechanisms** (e.g., partial-match funding, fixed spend-down windows) that could force rural facilities into capital decisions that may negatively impact organizational viability.

*"Where I'm particularly critical of RHTP is its failure to support the existing needs of rural communities…**to go into future transformation, you need a bridge.** Right now there is no bridge, so there are going to be a lot of people who fall through that."*

## Keeping Care Close to Home

- Scaling **non-extractive "hub-and-spoke" models** that are structured for sustainability, where local hospital retains billing and revenue and patient is not "extracted" to HS facility.
- **Value-based payment** seen as the only durable long-term path to virtual care sustainability but requires scale and infrastructure most rural facilities lack on their own.

*"Rural health transformation is about how we reduce total cost of care. In order to do that, we have to think about payment redesign…rural hospitals say **I can't think about all these complex conversations around alternative payment models and everything else. I'm just trying to stay alive.**"*

## Rethinking Workforce Innovation

- **"Capacity extenders"** like community health workers and navigators seen as cost-effective & impactful workforce solution, building trust across "hard to reach" populations
- **Subspecialist recruitment** remains challenging; health systems leaning into virtual subspecialty coverage rather than hiring their way out.

*"CHWs do so much to alleviate our workers on the ground. They have the relationships, the trust, so they can really streamline care whenever there's communication or language barriers. **Often it comes down to a cultural barrier of trust."***

## Developing New Rural SDOH Interventions

- **Transportation** remains top-cited social drivers of health (SDOH) access barrier—SDOH interventions relying on vendor partnership models not replicable in rural markets.
- Winning model is **"broker, don't build"**: Embed within community infrastructure, partnering with trusted local organizations instead of duplicating their efforts.

*"I look at some of the other communities that have Instacart or Uber Health partnerships and we just don't have these partners in our communities. **It feels like it has to be more grassroots.** Figuring out how to apply SDOH innovations in a rural community context can be really different."*

# THMA Insights: Understanding RHTP Implementation

**Madeline Cree, MPH**
Associate Director, Health Policy & Strategy
*The Academy Advisors*

# Understanding the Rural Health Transformation Program

July 2026

# Rural Health Transformation (RHT) Program

## $50B in RHT Funds

- $25 billion to be **divided evenly** among the 50 states, remaining $25 billion awarded at **CMS's discretion**
  - **Texas** received highest year 1 award (**$281m**), **New Jersey** received the lowest (**$147m**)
- Each state oversees its own distribution of funding—CMS's guidance has so far been minimal, but this could change in future years
- Funding for provider payments cannot exceed **15% of the total funding award in a given budget period** and spending on infrastructure is capped at 20%.
- States must spend funds by the end of the fiscal year following the fiscal year the funds were allotted, **unspent funds will be redistributed in subsequent years and ultimately returned to the Treasury after October 1, 2032**

The program seeks to further ***5 strategic goals:***

### *Make rural America healthy again*

By supporting rural health innovations and new access points to promote preventative health and address root causes of diseases.

### *Sustainable access*

With RHT Program support, rural facilities work together—or with high-quality regional systems—to share or coordinate operations, technology, primary and specialty care, and emergency services.

### *Workforce development*

Attract and retain a high-skilled health care workforce by strengthening recruitment and retention in rural communities, help rural providers practice at the top of their license and develop a broader set of providers ( i.e. community health workers, pharmacists, and navigators).

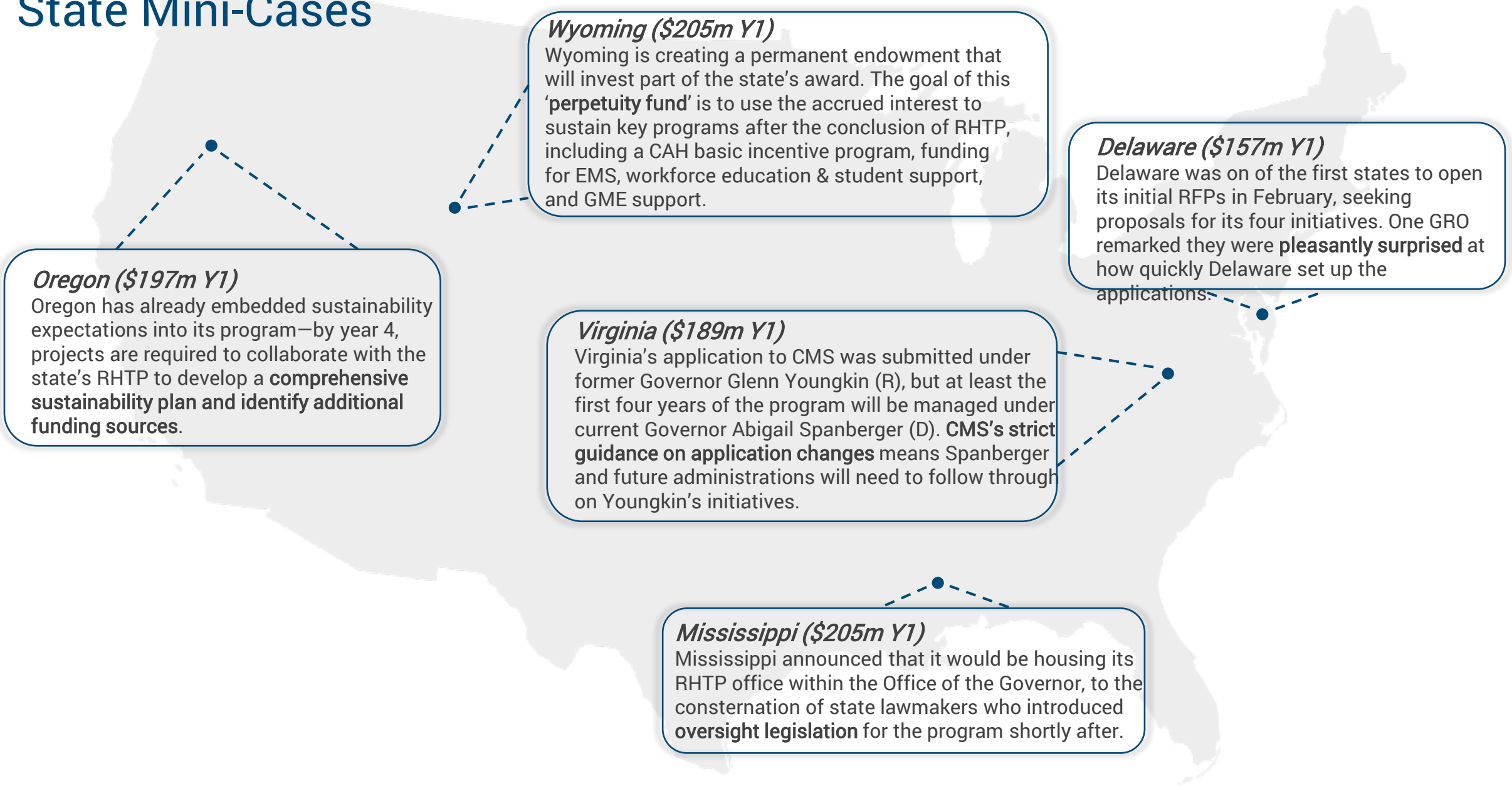
### *Innovative care*

Develop and implement payment mechanisms incentivizing providers or Accountable Care Organizations (ACOs) to reduce health care costs, improve quality of care, and shift care to lower cost settings.

### *Tech innovation*

Foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients.

# State Mini-Cases



### *Wyoming ($205m Y1)*

Wyoming is creating a permanent endowment that will invest part of the state's award. The goal of this '**perpetuity fund**' is to use the accrued interest to sustain key programs after the conclusion of RHTP, including a CAH basic incentive program, funding for EMS, workforce education & student support, and GME support.

### *Delaware ($157m Y1)*

Delaware was on of the first states to open its initial RFPs in February, seeking proposals for its four initiatives. One GRO remarked they were **pleasantly surprised** at how quickly Delaware set up the applications.

### *Oregon ($197m Y1)*

Oregon has already embedded sustainability expectations into its program—by year 4, projects are required to collaborate with the state's RHTP to develop a **comprehensive sustainability plan and identify additional funding sources**.

### *Virginia ($189m Y1)*

Virginia's application to CMS was submitted under former Governor Glenn Youngkin (R), but at least the first four years of the program will be managed under current Governor Abigail Spanberger (D). **CMS's strict guidance on application changes** means Spanberger and future administrations will need to follow through on Youngkin's initiatives.

### *Mississippi ($205m Y1)*

Mississippi announced that it would be housing its RHTP office within the Office of the Governor, to the consternation of state lawmakers who introduced **oversight legislation** for the program shortly after.

# The GRO Perspective

## Advocacy vs. Implementation

There have been limited opportunities for government relations teams to steer the distribution and tracking of RHTP funds. Some states have created opportunities for stakeholder feedback via lobbying and RFIs, but this is not a universal constant. Federal opportunities have been even fewer, but some GROs say they may try to open the conversation with their congressional delegates in the future.

## Weighing the Optics

More than one GRO shared that their health system was taking a "wait and see" approach before deciding to apply for funds, concerned that they could be seen as "hoovering up" resources that would otherwise be directed to smaller hospitals or applicants.

This sentiment was shared strongly among urban-headquartered systems, regardless of their additional rural footprint.

## Initial Concerns Over Politicization

Before CMS announced RHTP awardees, several GROs expressed deep concern that their states could be passed over for funds due to political leanings and were relieved when all 50 state applications were approved.

## Lessons from COVID-19

GROs are sensitive to the tight budget deadlines that many states operate under and worry that RHTP funds will go unspent and return to CMS, similar to COVID-19 funding.

## Stakes With Stakeholders

Patient advocacy orgs and other groups are keen to track states' spending of RHTP funds, and these dynamics have factored into health systems' responses—there is a strong desire to be seen as a partner vs. leader on initiatives.

# Is RHTP enough to sustain rural healthcare?

**Trump administration rolls out rural health funding, with strings attached**

PBS Newshour

**'One Big Beautiful Bill' Would Batter Rural Hospital Finances, Researchers Say**

KFF Health News

**Rural communities brace for Medicaid cuts in Republicans' big bill**

NBC News

**H.R. 1 Funding Cuts Will Overshadow Gains from the New Rural Health Transformation Program**

Commonwealth Fund

*In short, no, but it was never meant to.*

Recent analysis from Commonwealth Fund found that the $10 billion infusion of funds into state economies will be overshadowed by a whopping $31 billion in cuts to ACA marketplaces in 2026.

Commonwealth estimates that these cuts will lead to the loss of more than 150,000 health-related jobs, with the greatest losses concentrated in non-expansion states.

But the RHTP was created to support the health of rural communities through long-term change, not offset H.R. 1 and other cuts to federal health programs—even if those cuts themselves will add to the burden of rural patients.

# Looking ahead on RHTP & rural health

### *Hospitals and health systems are not the primary targets for funds*

Statutory restrictions have limited the flow of dollars to health systems, and states have amplified this effect by directing funds primarily to universities, the states themselves, and public health departments, with limited grant funding open to hospitals.

### *Expect robust oversight*

The Trump administration has taken a strong posture against fraud, waste, and abuse in healthcare programs—*assume the same interest in RTHP year-over-year accounting.*

### *Build for sustainability*

These funds are limited, but policymakers want long-term results—consider integrating a sustainable funding strategy early, partnering with other stakeholders, and emphasizing patient outcomes.

### *Rural hospitals and communities will still need support after RHTP*

RHTP was inspired by other health funding cuts in H.R. 1 but is not meant to replace those dollars—experts still anticipate substantial gaps in rural access in the years to come, which means the issue is ripe for future advocacy.

# POLL: To your knowledge, what level of engagement does your organization with RHTP?

*(select all that apply)*

a) We have responded to RFPs and/or are partnering with organizations that applied for funding.

b) We have engaged with **federal** policymakers & regulators to inform program rollout.

c) We have engaged with **state** policymakers & regulators to inform program implementation.

d) Our state(s) has/have not provided an opportunity to provide input on RHTP.

e) I do not have insight into how our organization is engaging with RHTP.

# Building the Bridge: Stabilizing Rural Ecosystems for Transformation

**Dr. Bill Beninati, MD, FCCM**
Chief Medical Officer, Virtual Hospital
*Intermountain Health*

# Building the Bridge—Stabilizing Rural Ecosystems for Transformation

## Rural Health Innovation Workshop

## July 23, 2026

Bill Beninati, MD, FCCM
Intermountain Health
Virtual Hospital CMO
Tele Health
Clinical Command Center
Flight and Ambulance Services
Outreach

# Disclosure

- I have no relevant financial relationships to disclose.

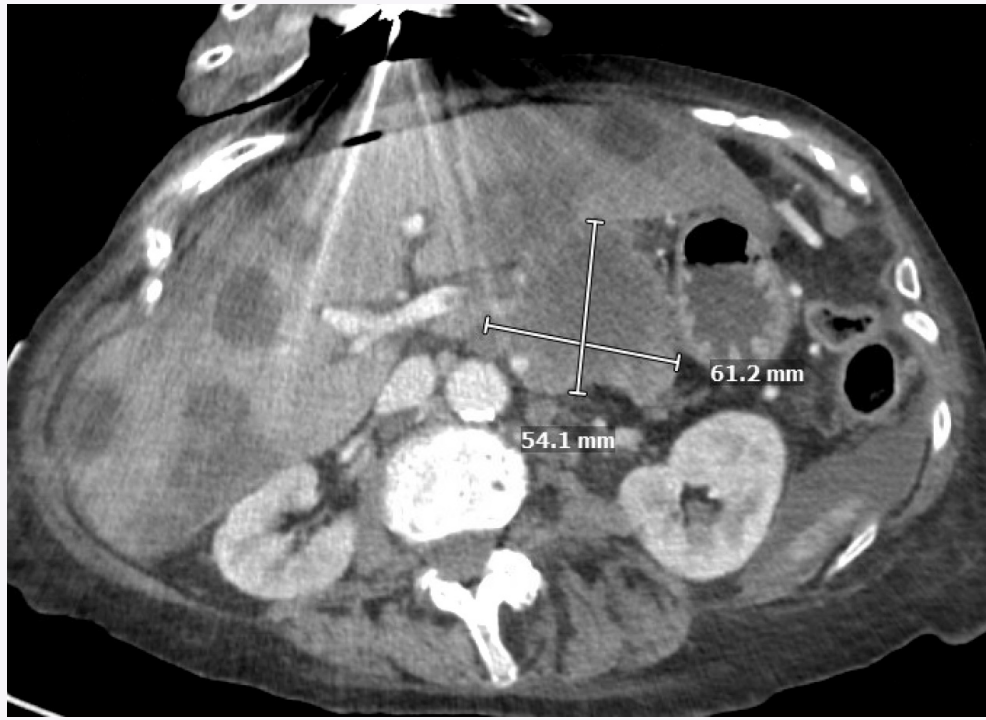
# Navigating a Difficult Discovery

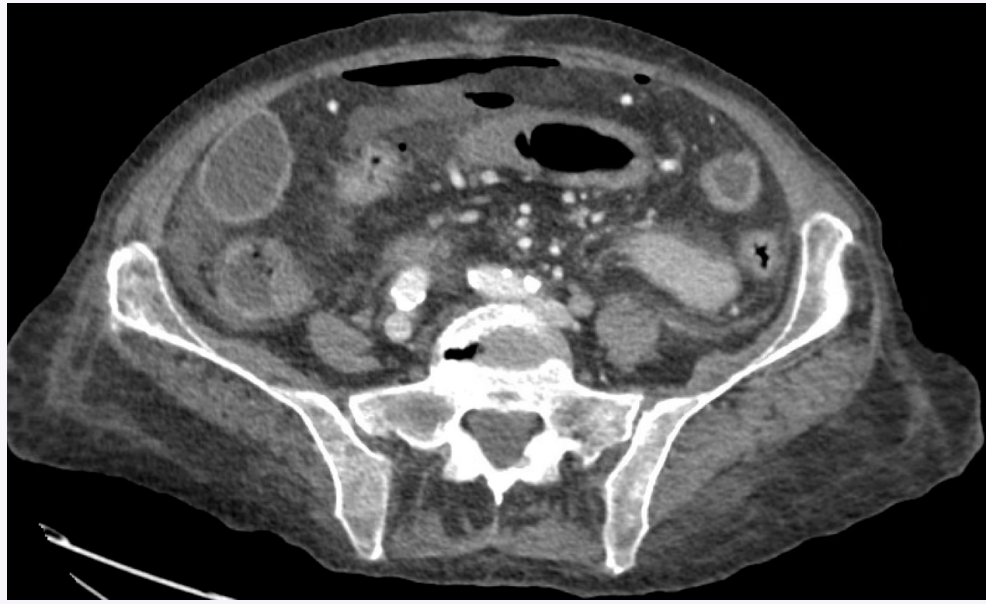
- Woman presents in septic shock in rural Utah from an abdominal source
- Local surgeon – too complex to care for here, needs helicopter transport, operation and ICU post-op
- TeleCritical Care physician
    - Looking for bed at St. George Regional Hospital (166 miles) or Utah Valley Regional Hospital (120 miles)
    - *Pending decision let's get an abdominal CT to help guide care*

# Navigating a Difficult Discovery

- CT with devastating news – pancreatic mass, widespread metastases, vascular encasement, perforated bowel with free air
- Tele-consultation with ED physician, local surgeon, trauma center surgeon, Life Flight medical control
- Transport for surgery would only result in patient dying alone after expensive and invasive treatment
- TelePalliative Care did extensive consultation with the patient and her loved ones

***Her final hours were focused on her comfort and dignity, surrounded by family***



MINDSHARE INSTITUTE
Intermountain Health

# Differing approached for urban centers interacting with rural hospitals

**…applied to this case**

## Extractive* Approach

- Fly patient to advanced center
- Admit to ICU
- Emergency laparotomy
- Ongoing ICU stay
- Ultimately fatal outcome – far from home and social support
- Transfer of funds from rural community to urban center

## Sustaining Approach

- Rapid consultation with multiple specialties via telehealth – rapid access/low cost
- Empower patient and family with knowledge about situation and options
- Care in local community
- Inevitable fatal outcome is near home and social support
- Funds for care remain in community

*Term from politico-economics, extract value from the community

# Doesn’t this look like a healthful region to live in?

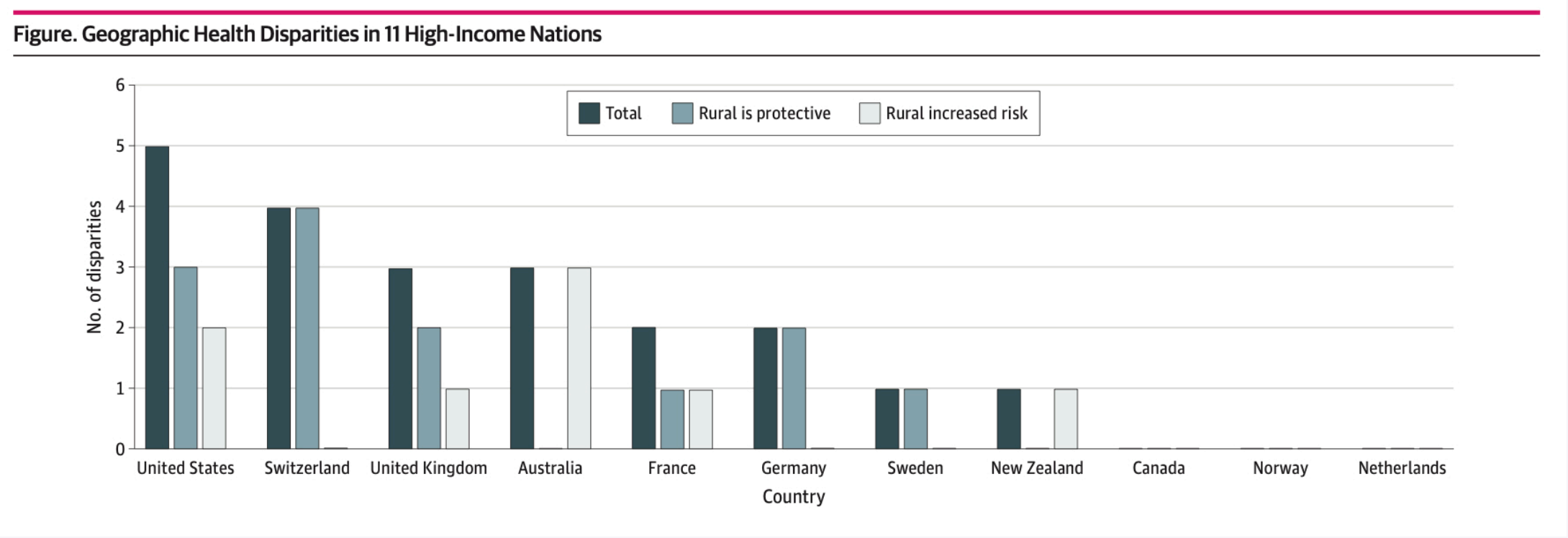
# Some realities in rural healthcare

- “Care deserts” for many life-sustaining specialties
  - 1 of 8 rural women of childbearing age lives in an Ob desert
  - 6 of 10 rural Americans live in mental health shortage areas
  - 7 of 10 live in counties without a practicing oncologist.
- Urban communities host 9x as many specialists per 100,000 residents and 2.4x as many primary care physicians as rural counterparts. 5
- 136 rural hospitals in US have closed in the past decade
  - 700 more (approximately 30% of all rural hospitals) at risk of closing
- Rural hospitals are economic engines for their communities

# Life where there is lots of “dirt between the lightbulbs”…

## Urban-Rural disparities

- Death rate is 831 per 100,000 in rural areas versus 704 per 100,000 in urban areas




MacKinnon et al JAMA Open 2023/Loccoh et al JACC 2022

# Some non-extractive models

- Hub and Spoke model:
  - Large health systems hubs and independent rural hospital spokes
- Government-funded model
- Not-for-profit model
  - Service organization is formed or extended to build a broader rural physician, administrative, & technical workforce, as well as philanthropically
- Trade Association model
  - New civically oriented, nationally scalable collective of rural hospitals
- Industry partnership
  - Private partners (e.g., technology companies) provide offerings to rural hospitals in exchange for non-monetary benefits

Our Mission

# Helping People Live the Healthiest Lives Possible®

Intermountain Health


# One model for supporting care in rural communities…

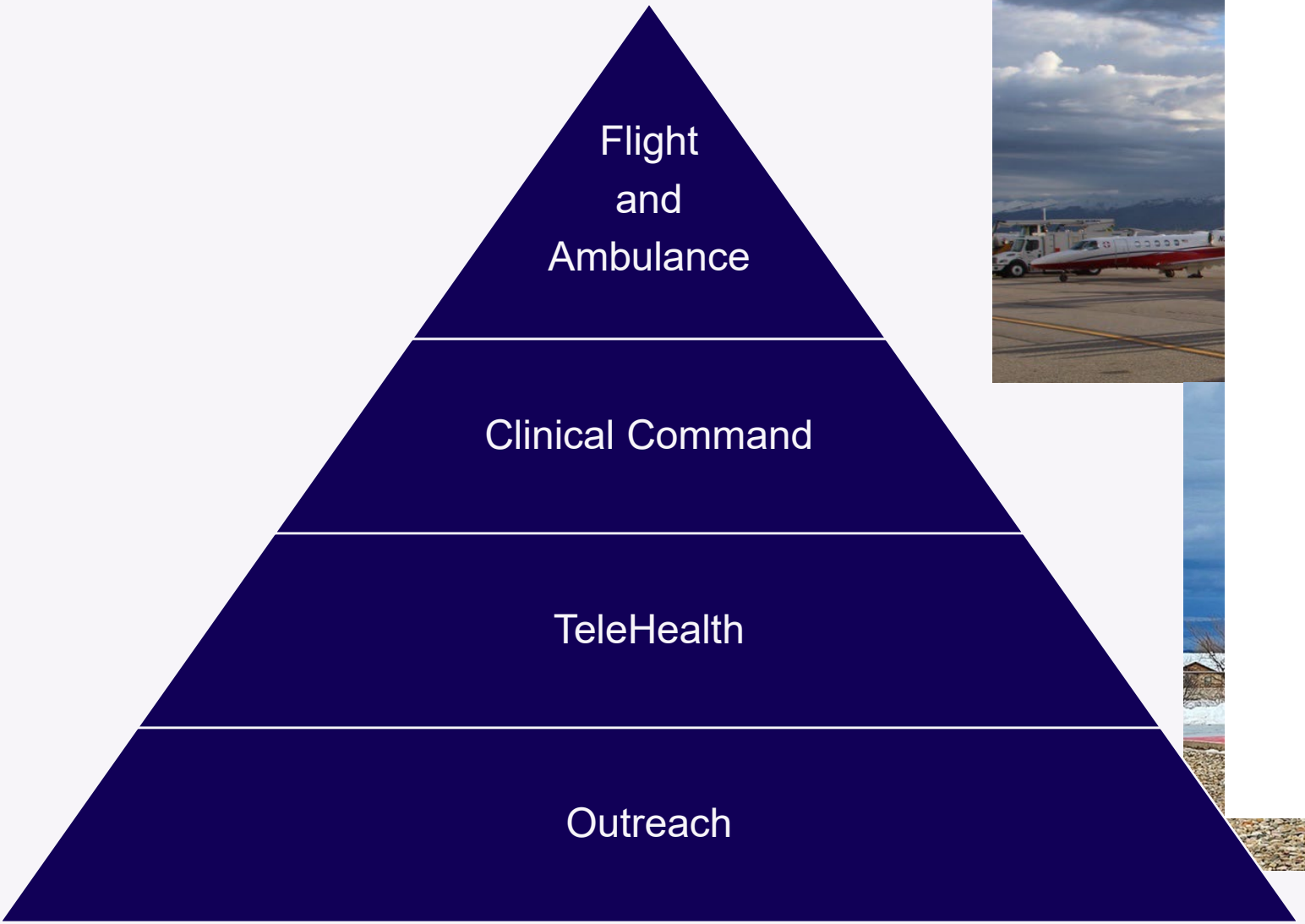
# Virtual hospital “battle cry”

Bring to bear Intermountain’s full resources to solve clinical challenges in real time

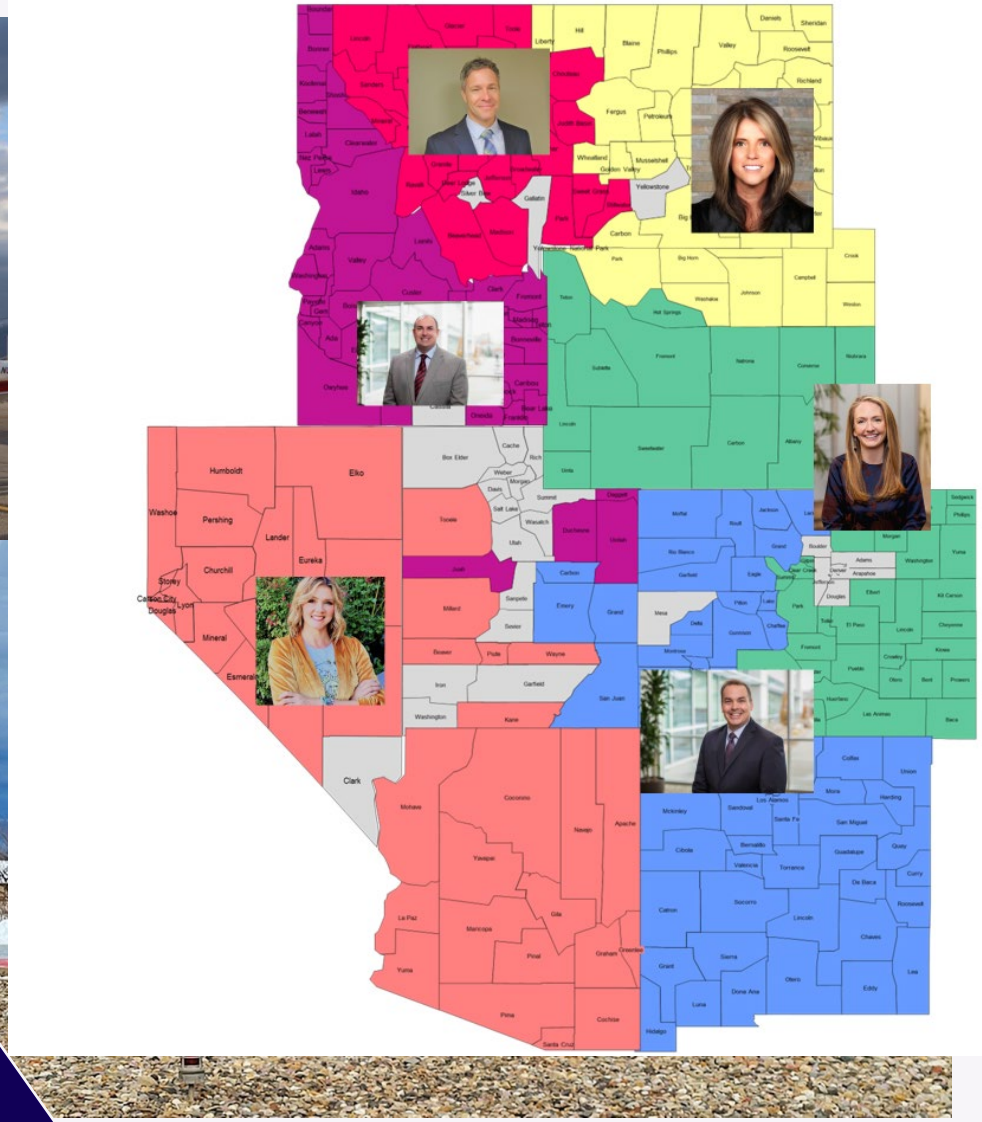
# Virtual Hospital

## - Integrated Services to Support the Community

**Organized in the Same Portfolio – Shared Leadership**

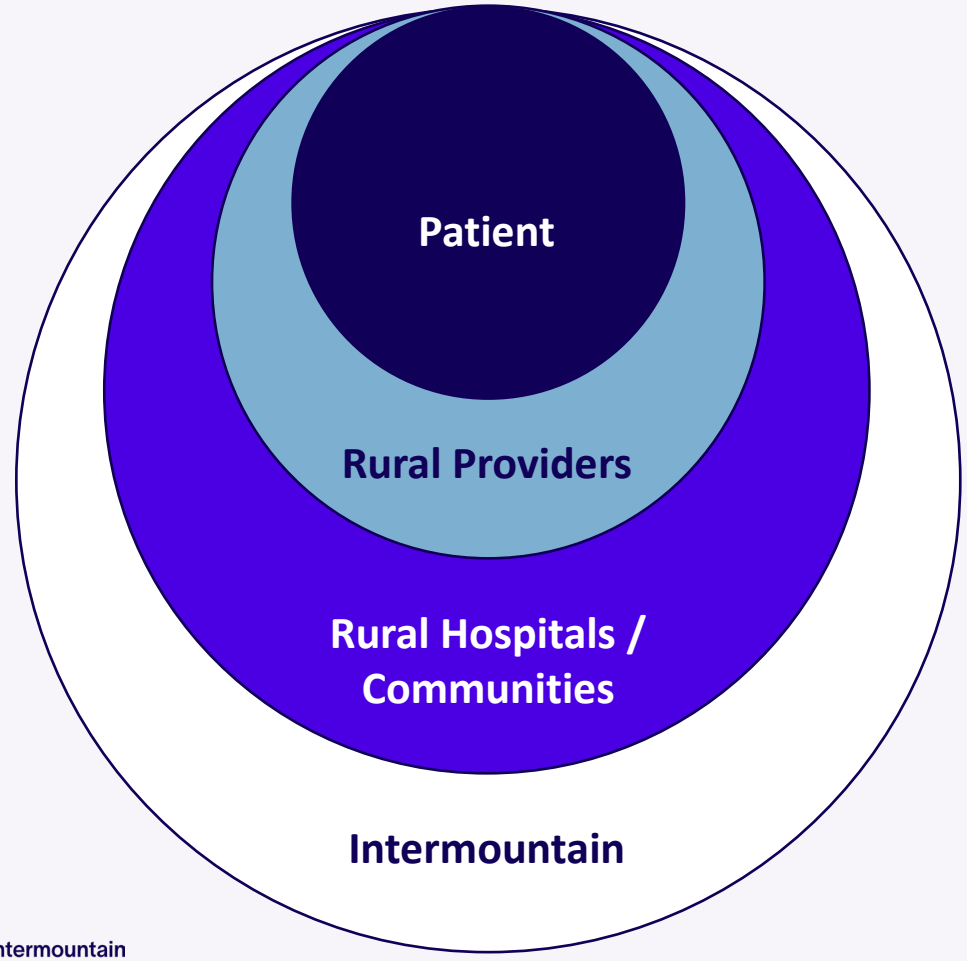




# Virtual Hospital Supporting Rural Health

## *Keep Care Local – Share limited Resources across Multiple Communities*




**Patient –** *Care Close to Home*

- Decrease or eliminate travel for care
- Heal close to loved ones
- Access to specialty care
- Rapid access to care

**Rural Providers -** *Make Life Livable*

- 24/7/365 is not sustainable
- Help for night call
- Expanded practice supported by specialty expertise – professional satisfaction
- Continue Learning

**Rural Hospitals –** *Keep Income in the Community*

- May be major employer in the area
- Local hospital receives income for bed days, pharmacy, lab, imaging
- Increase case-mix index
- Prestige of hospital in the community

**Intermountain –** *Live Our Mission and Vision*

- Decrease transport volume/revenue
- Protect capacity to receive complex patients in transfer

Intermountain Health

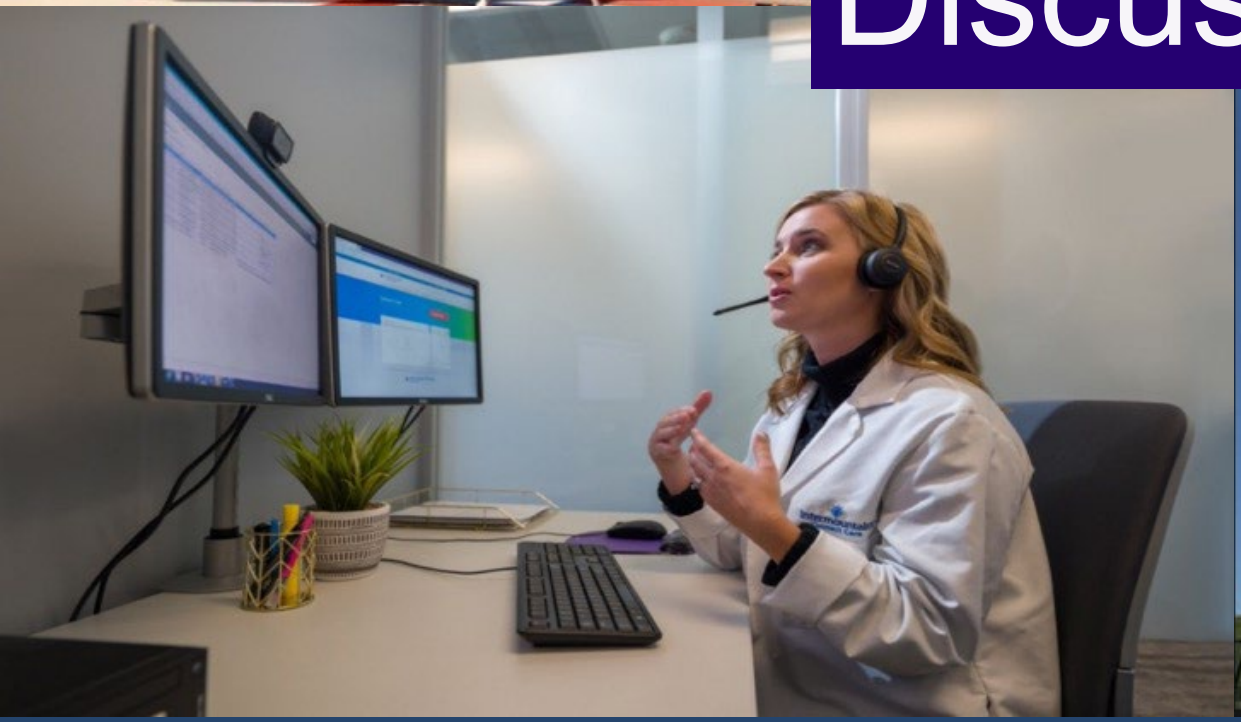
# Summary

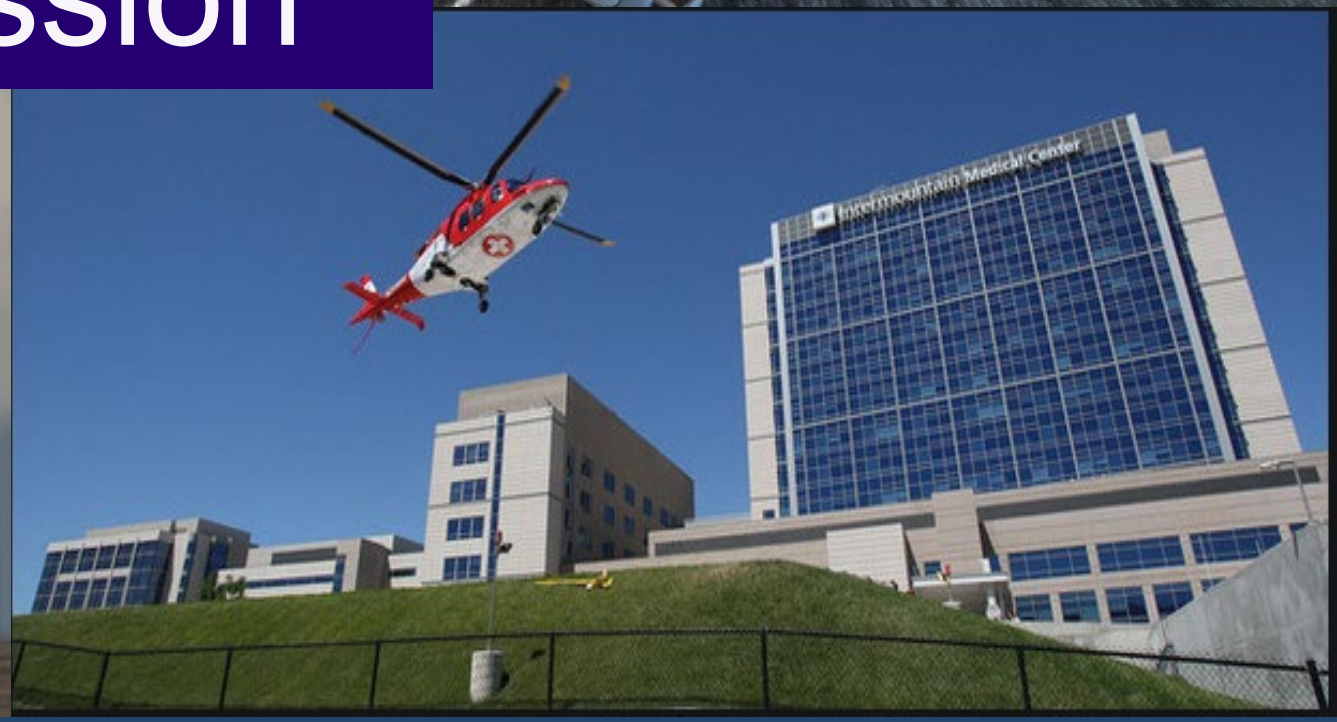
Rural healthcare – and the communities it supports are under stress

A traditional extractive approach can exacerbate the stress

Intermountain is working on a telehealth-based model to keep care local and support rural health

# Discussion





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# References


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# Partnering to Drive Sustainable Digital Innovation

**Mike Lemnitzer**
VP, State Government Healthcare
*Philips*

PHILIPS

**HMA Workshop**

# Partnering to Drive Sustainable Digital Innovation

**Mike Lemnitzer**
VP, State Government Healthcare, Philips
July 23 2026

# Addressing barriers to care access

## Hub & Spoke Virtual Models

Challenge: Rural care community members are often transferred from their rural hospital

*Opportunity:* Non-extractive “hub and spoke” models that prevent unnecessary transfers to tertiary settings while allowing smaller rural hospitals to retain billing

## Mobile Clinics


Challenge: Community members in rural areas have limited access to consistent healthcare

*Opportunity: M*obile clinics and imaging services to reach underserved rural populations, bringing care directly to them

## Remote Specialist Support

Challenge: Patients in rural settings may have reduced access to subspecialists

*Opportunity: Creating a single* remote technologist team to provide care support across multiple rural sites



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# Connecting clinical teams through hub and spoke models

## Expand expertise

**Extend specialist expertise** beyond city limits

## Connect rural hospitals

Gain remote critical care to support patients locally  while improving outcomes

## …and larger health systems

Connect remote and bedside care teams for improved care coordination and outcomes while reducing revenue leakage





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Case study

# Emory expands critical care access in rural Georgia through Philips eICU

Emory Healthcare’s eICU program is expanding 24/7 remote critical care monitoring to two rural Georgia hospitals, enhancing specialist support and helping patients receive high-level ICU care closer to home.

## Challenge

Rural hospitals in Georgia have limited access to onsite intensivists, especially during nights and weekends

## Solution

Through state funding rural Georgia hospitals partnered with Emory to implement 24/7 remote eICU monitoring

## Impact

The collaboration enhances critical care oversight and provides continuous specialist support close to home and family



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Case study

# Accelerating clinical modernization at Baptist Health, Jacksonville through a CMU

Baptist Health Jacksonville created a shared CMU for its five adult hospitals to address telemetry overutilization, improve clinical efficiency, and optimize patient care.

## Challenge

Telemetry overutilization can lead to unnecessary testing, longer hospital stays and admission bottlenecks

## Solution

Dispatching the most critical situations so nursing teams receive relevant and timely information for actionable intervention

## Impact

In 2024, the 1,100-bed network reached a 10% drop in unwarranted telemetry use



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# Bringing care directly to underserved populations

### Care in the community

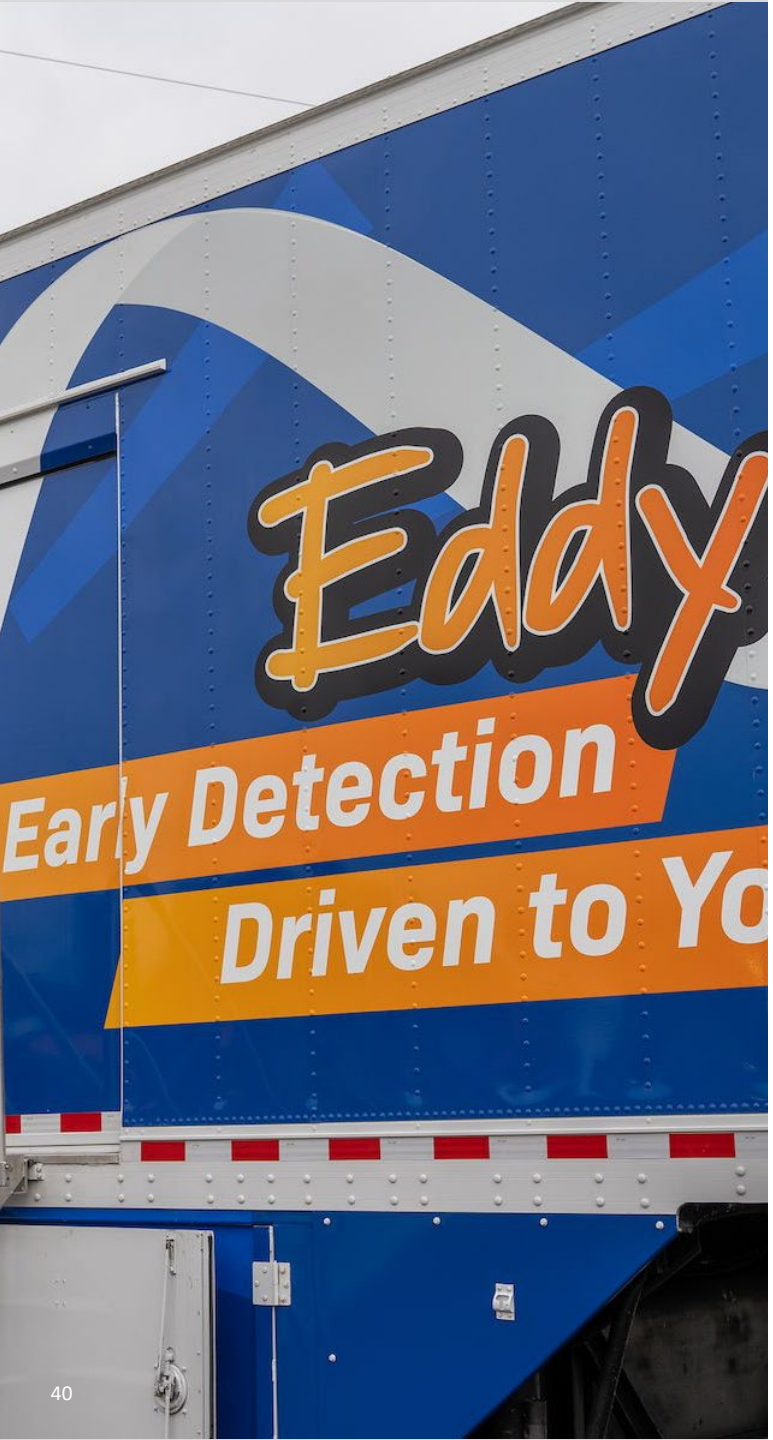
Reduce travel burdens and accelerate access to diagnostic screening

### Sustainability and scalability

Combine local partnerships with technology, workforce training, and community-based support

### Collaborative care delivery

Leverage telehealth to connect local care teams and improve outcomes




**Case study**

# New York expands lung cancer screening with Philips Mobile CT

Philips partnered with Roswell Park Comprehensive Cancer Center and the state of New York to deploy Mobile CT units, bringing advanced lung cancer screening to underserved communities across New York.

## Challenge

Low lung cancer screening rates and limited imaging access for rural and high-risk populations

## Solution

Mobile CT units delivering community-based lung cancer screening where it's needed

## Impact

Earlier detection of lung disease, greater access, and progress on state cancer prevention goals





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# Advanced imaging expertise wherever it’s needed

### Real-time remote assistance

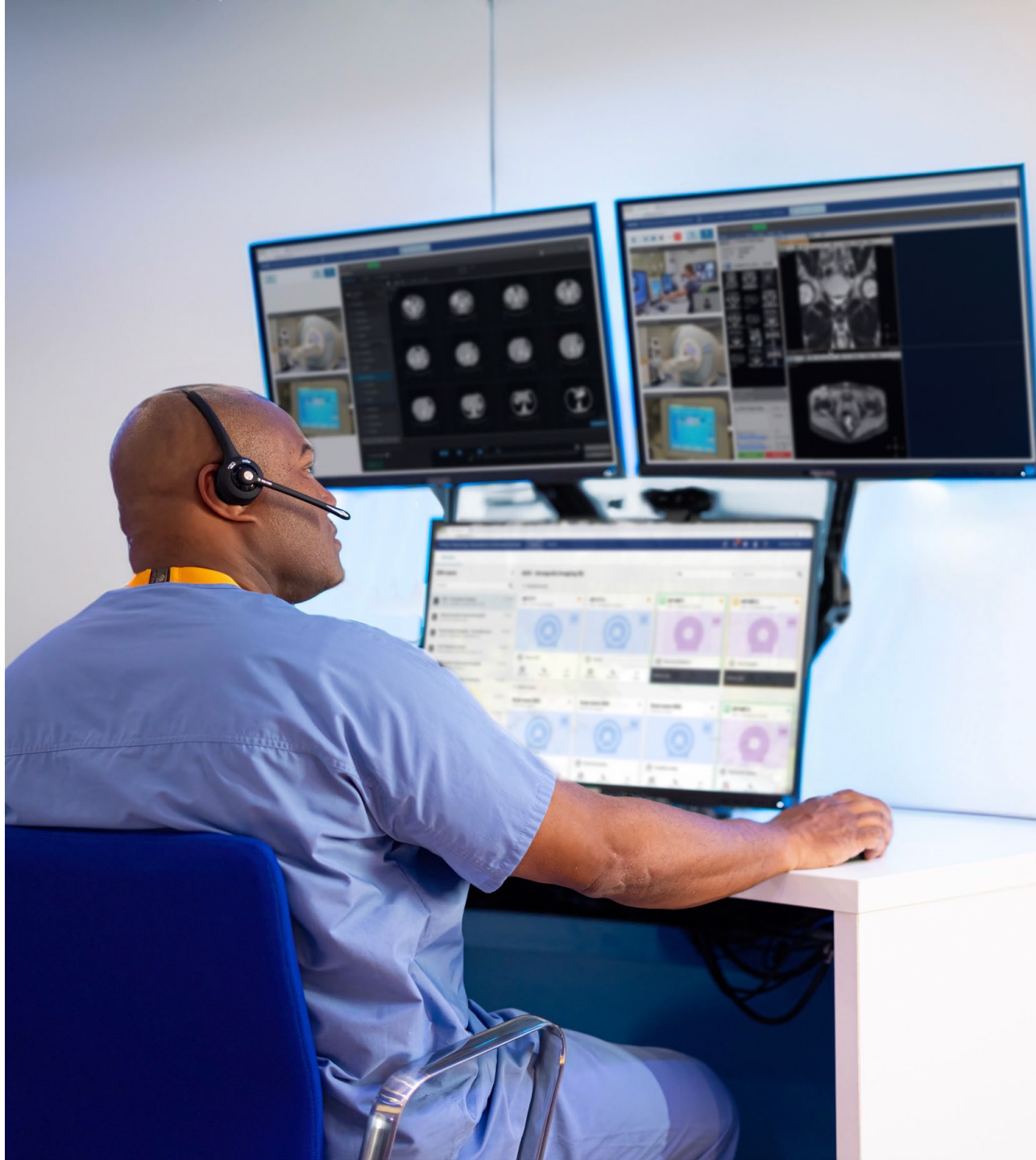
Ensuring high-quality images are acquired quickly and accurately, leading to reduced scan recalls

### Seamless collaboration

Multi-vendor, multi-modality solutions connecting imaging experts with technologists across organizations

### Staff development & retention

Continuous learning through real-time feedback and training enhance skills, job satisfaction and retention.



Case study

# Arkansas Children’s deploys Philips ROCC to provide remote cardiac imaging

In 2024, Arkansas Children’s partnered with Philips to use telemedicine and Remote Operations Command Center (ROCC) capabilities to deliver high-quality cardiac MRI and CT exams to children across rural Arkansas.

## Challenge

Limited access to pediatric cardiac imaging and scarcity of subspecialty staff in rural regions

## Solution

ROCC-enabled remote imaging lets expert technologists guide scans and support local teams

## Impact

Improved access, lower travel burdens, and enhanced pediatric imaging capacity statewide





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# Technology alone can’t transform rural healthcare-connected care models can

Build a community

Invest in technology infrastructure

Sustainability and scale

**Connect people. Connect technology. Connect care.**



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# Group Discussion & Commitments

# Workshop Discussion: Learning from our Collective Braintrust

What **rural health innovations** would you highlight from your health system?

What is the **role of leading health systems** in building the bridge towards sustainable rural health transformation? In your experience, what is most helpful in collaboration with technology partners?

Based on today's conversation, what is **one commitment** you'll take back to your organization in the next 30 days? Who is one partner you'll loop in to make sure it happens?

# Next Up with the Rural Health Innovation Workstream

### Virtual Workshop Proceedings
*Workshop participants will receive follow-up materials summarizing workshop content and main discussion points.*

### 3-Month Commitments Check-In
*HIA will follow up with workshop participants in November to understand progress that has been made on stated commitments.*

### Continuing the Conversation
*HIA will bring workshop insights to our September in-person convening with health equity leaders, providing a space to discuss opportunities for sustaining equitable impact in rural contexts.*

### Questions?

Have thoughts on this workstream or ideas for exploring cross-stakeholder collaboration opportunities?

Reach out to the HIA team at healthimpactalliance@hmacademy.com

# Appendices

# Rural Health Transformation (RHT) Program FAQ

*Can funds be clawed back?*

- *Yes,* CMS has clarified that funds that are not obligated by the end of the fiscal year following the fiscal year dollars were awarded must be returned to CMS and will be redistributed among other states in subsequent award years. Any funds still unspent by October 1, 2032, will be returned to the Treasury.

*How much will my state get next year?*

- All 50 states will receive at least $100 million each program year, the remaining annual $5 billion will be awarded by CMS in variable amounts based on a series of criteria defined by the agency, including prior year program performance. CMS has indicated that Year 1 awards represent the *maximum* amount a state can be awarded in subsequent award years, and that future year distributions can be reduced.

*Are there restrictions on who can receive funds? Who decides these restrictions?*

- *Yes*, restrictions are imposed at the state level, and not all stakeholders will be eligible to apply for and receive funds—for example, West Virginia is allowing technical partners and vendors to apply directly, whereas Oregon has restricted this class of applicants.

*Can CMS change this program in the future?*

- Technically, yes, the better question is *will they*—it's still early to know, however some members of Congress have called for program reforms already including Senators Michael Bennet (D-CO), Susan Collins (R-ME), Alex Padilla (D-CA), and John Hickenlooper (D-CO) in a letter sent to CMS Administrator Mehmet Oz.

*Can my state(s) change, add, or drop any of the initiatives approved in their initial RHTP application?*

- *Sort of*. CMS has stated clearly that states are not permitted add or delete initiatives now that all state applications have been received and approved, however, states can petition CMS to make changes to an existing initiative if they present the agency with quantitative data that "clearly and convincingly demonstrates a lack of efficacy of a specific initiative that was included in the application" and only in later program years.

# Tools to track state-level action and opportunities

NRHA RFP Status By State Interactive Map

CMS RHT Program State Project Abstracts

RHTP Hub

Rural Care Journey Dashboard

# The Health Impact Alliance

## *Driving Transformative Progress in Partnership with Health System Peers*

**The Health Impact Alliance (HIA) accelerates meaningful progress in advancing health equity across its health system partners and their communities by equipping health impact leaders and their teams with research-backed insights, ongoing leadership development, and a robust community of practice.**

### Top Areas of Focus for 2026:

- ☑ Refining Communications Capabilities
- ☑ Revising System Governance and Infrastructure
- ☑ Advancing Rural Health Impact

### Collaborative Peer Network Across:

**30**
Progressive Health Systems and Industry Partners

**300+**
Committed Practitioners

### Research-Backed Insights to Accelerate Change

Delivery of research-backed insights, toolkits across critical health equity topics with a goal of accelerating change. Facilitated roundtables and interactive workshops help to hardwire strategies. 'AskHIA' expert portal to supplement your team's research capabilities.

### Ongoing Development to Build Capacity for Health Impact

Leadership development curriculum designed for current and rising leaders spearheading equity initiatives. Access to renowned industry leaders to provide strategic guidance, executive readiness coaching.

### Consistent Collaboration with a Robust Community of Likeminded Leaders

Regular collaboration with health equity leaders and industry experts to facilitate idea exchange, connectivity and shared learning. Annual Changemakers Summit each Fall.