# RURAL HEALTH AT THE INFLECTION POINT: INFRASTRUCTURE, INVESTMENT, AND ACCESS

**Sarah Tribble** 00:02

Good afternoon. I hope everybody's doing okay. I'm Sarah Jane Tribble. I'm chief rural health correspondent with KFF Health News. I've been reporting about rural communities for years now, writing about their hospital closures, their clinic cuts, their staffing shortages, what happens when federal policy changes beneath them. And I consider it a privilege to go out and work with rural communities and talk with them and to tell their stories. In rural America, more people live with chronic illnesses, and more people die younger than in other parts of the country, than in metro and urban areas. And right now, rural America is at an inflection point. Last year, when the big, beautiful bill passed, it included a $50 billion transformation plan that would be given to states, $10 billion a year over five years. So, I'm super excited today to talk with our esteemed panel about the changes and this inflection point. We have Chuck Divita with Telehealth Doc.

**Chuck Divita** 01:08

Teladoc Health.

**Sarah Tribble** 01:09

Teladoc Health.

**Chuck Divita** 01:10

It's close. Yeah.

**Sarah Tribble** 01:11

Not nervous at all. Cara James with Grantmakers in—ah, I need to look at my notes here. Grantmakers in Health. And Nandini Selvam, president of IQVIA. And each of your companies enters this conversation at a very different spot. We have a virtual care company, we have a funding company with Grantmakers, and we have a data and analytics company. So, I'm going to start very plainly. What is your interest in the $50 billion, and what does your organization want to see happen with it? Where do you fit in?

**Chuck Divita** 01:49

Well, first of all, I'm excited and encouraged that we're having a national conversation around rural health first. It's much needed, and I'm hopeful that this isn't just a moment, that this is a sustainable conversation that we're having around it, because it affects every state. It affects all of us, either directly or indirectly, whether you look at it through the tax dollar or just the human cost of it. So, Teladoc, we're a global company. We operate in about 20 countries, but our largest, by far, is the US. Right now, 100 million people have access to one or more of our services across virtual care, chronic condition management programs, and mental health. And so, we're already serving and reaching rural communities and urban communities as well across all kinds of the commercial population, Medicare, Medicaid, through health plans. So, what I'm hopeful for and what we're looking to do is use our experience, our capabilities, to really try to drive change and leverage technology and services, but importantly, locally. Because, as we all have talked about in health care, health care is local, and your ZIP code really does determine a lot about your health outcome. So I think the conversation and the focus on the innovation is really what we're interested in.

**Sarah Tribble** 02:56

Great. And Cara, what's your interest?

**Cara James** 02:58

Sure. So, first of all, thank you so much for having me, and it's really great to be in conversation with Chuck and with Nandini and with you. So, Grantmakers in Health is, the easiest way to think about us is the association for health foundations. We work with over 250 of them across the country, many of them large and small, some that you know, like the Robert Wood Johnson Foundation or the Commonwealth Fund, and a lot smaller ones who are place-based in communities supporting rural communities across the country. Most of them are place-based funders. So, they are some related to conversion hospital sales that have come, the conversion foundations from those hospital sales. But really small and know what rural is. In a survey that we did earlier this year, 60 percent of them said rural is a major or moderate priority for their work. So, lots of investments in that space. And for nearly 15 years, we have worked in partnership with the National Rural Health Association and the Federal Office of Rural Health Policy to have a rural public-private conversation to think about how we can increase the public-private partnerships between rural communities, federal government, and philanthropy to improve outcomes. So, for us, our interest in this is a little bit, as Chuck said, we want to have that national conversation and really to have this be a moment to truly seed change that we want to see in rural communities. I come to this work from the eight years that I spent at the Centers for Medicare & Medicaid Services as the director of the Office of Minority Health and cochair of the CMS Rural Health Council and developing the CMS Rural Health Strategy. And the last time we saw this much interest in rural communities was related to the opioid crisis.

**Sarah Tribble** 04:52

Right.

**Cara James** 04:53

A lot of investment, a lot of people coming in, and at the end of the day, we still have so many rural hospitals struggling, still have poor health outcomes. How do we not squander this moment in this interest?

**Sarah Tribble** 05:07

That's a great transition. Nandini, data and analytics.

**Nandini Selvam** 05:10

Yes, absolutely. So, good afternoon, everyone. I'm, you know, thrilled to be here on the stage having this conversation. So, for anyone who doesn't know IQVIA, we used to be known as IMS Health and Quintiles. We're a large health services company and do everything from CRO, clinical trials, clinical studies, all the way through data, and we're one of the large data aggregators. And so, for me, I think this conversation's super critical because everywhere we turn around, everything's led with data. So, how do we let data drive some of this discussion? And often people think of data as something that you do after it's done. So, the end of a study. Let's look at the analysis. Let's look at what happened. But if you do it right, data can also serve as a leading indicator. And in this instance, when we think of the Rural Health Transformation Program, it's 50 states. Lots of different measures, not a whole lot of common requirements. There are some, not a whole lot. So, then, how do you track this? So, one of the things we can do, and we can do this at the national level pretty centrally, is we have the ability to look at the communities. We can look at the patient level, provider level. We can look at access. We can look and see where the pharmacies are located. And just because there's availability doesn't mean it translates to access in most of these communities for all the same reasons even Cara and Chuck are talking about here. So, I think IQVIA can play a really big role in giving you early views, ongoing views, and serve as good signal detection, not only to tell you where things are going, but are we addressing the right populations? Just because you put money somewhere doesn't mean that it reaches the individuals that need to have that service.

**Sarah Tribble** 07:05

Yeah, that's a crucial question. I want to kind of micro this in a little bit. Chuck, you're from West Virginia. It's a rural state. You grew up there. How does that inform your decision-making as the leader of a multinational company when you look at these transformation funds?

**Chuck Divita** 07:20

Yeah, well, growing up there has shaped me personally and professionally. I think as I've had different roles in health care, I've never lost that focus on really trying to impact the health and well-being of people. I think we all in this room are here because we're interested in health and we have a role to play. So, that shaped me a lot. But when I think about this issue, and these communities, they don't call it rural health, it's just health. They're just living their life. But I think about my grandparents in West Virginia, it gets rural very quickly—and he was a coal miner, and as the coal mine shut down, steel mills and everything else shut down, they stayed because that's where they raised their family. And as those communities aged, the

access to health care got harder and harder, and towards the end of his life, was on dialysis. And so, just to even get treatment, he had to get over an hour away.

**Sarah Tribble** 08:07

Drive.

**Chuck Divita** 08:08

And there was nobody that—he couldn't drive, my grandmother couldn't drive, so, they were relying on distant family because everyone else had moved away. So, watching that and flying up there and helping him sometimes has really shaped me in terms of like, we should be able to do more. We're spending enough in this country in terms of health-care expenditures. The mix of how we're spending it and the outcomes we're getting are the problems. So, yes, that's shaped me in every role I've had.

**Sarah Tribble** 08:33

Well, let's talk about spending a little bit. I don't think we can have this conversation about rural America without talking about Medicaid. And rural residents rely on Medicaid at higher rates than urban residents. Rural hospitals depend on it to stay open. Many of the smaller ones do. Over the past few years, there's been the Medicaid unwinding. States are rechecking eligibility after the pandemic, and they're checking coverage as well. Millions have been removed during that process. At the same time, the Big Beautiful Bill, so-called, last July, also cut nearly $1 trillion in Medicaid spending over the next decade. So, with that, Cara, I want to turn to you and ask you about, you know, many critics have said that $50 billion is a fraction of what rural communities need, and when you think about these Medicaid spending cuts that are coming—is the RHTP, are the transformation funds a bridge? Are they a bandage? Are they something else altogether?

**Cara James** 09:38

Yeah, it's an interesting question. So, as you said, $1 trillion in Medicaid cuts, and much of that, many places in rural communities are going to lose a lot of dollars. And it's not just Medicaid that we're talking about, because the bill also cuts SNAP, it cuts education, loan repayment programs, all of the things that layer on. And so, these are felt in those communities, and when you think about what hospitals are doing to help connect people to social services related to housing, transportation, food supports, those all got cut, too. So, it's a compounding effect that we're having. So, is this a bridge? Absolutely not. Is it a Band-Aid? No. I think it's more, in our family, we like to say it's like giving a Tic Tac to a whale.

*[Laughter]*

But really, I would say it's retail therapy. It's retail therapy for Congress to feel better about the cuts that they're doing to these communities. And so, we will see what happens. We're starting to see some of the things that are coming out. But this is not going to help sustain people, and there are so many restrictions on what they can do with that money that it's also not necessarily going where those in the communities would prefer it to go, or if it's even getting to the communities. But it's retail therapy.

**Sarah Tribble** 10:59

That's a great quote. As a journalist writing a story, I'd love to put that in a story. Nandini, IQVIA released a data analysis this summer of how the closures of pharmacies in rural areas are shaping health outcomes. I think this is an important topic to bring in because pharmacies often work as the de facto health care in many of these communities. In it, the authors at IQVIA wrote that the foundation is under strain. That's even before these Medicaid cuts come in. So, can you tell us what exactly the report says about what's happening with pharmacies in rural America in light of what's happening with Medicaid and the transformation funds?

**Nandini Selvam** 11:39

Yeah, for sure. I think we already know this, and even through COVID, we saw this trend actually increase where pharmacies started to become the location where vaccines get administered. I think gone are the days where pharmacies were just where drugs got dispensed. And as you start looking in retail settings, and we see this with some of the partners that we have around the table even here at Milken with respect to pharmacies being used as sort of the setting where other types of care are provided, and I think there's a report that came out today that talks about this as well. And what we're seeing is that when you have cuts in a pharmacy and you have one that closes, the access point really goes away in that community. So, it's not just a way for the pharmacist that's tracking an older adult, for instance. They know their patterns, their prescriptions. So, it serves as a coordination center, not just for drugs being dispensed, but really for care, I think is what we saw. And depending on what you're looking at, I think right now between 40 percent and 60 percent of even vaccines are given there versus a doctor's office. So, this really is a setting for much more than just dispensation.

**Sarah Tribble** 12:57

So, we've talked about, I mentioned the hospital closures, the clinic closures, we've talked about the pharmacies, and if they're leaving and they're the place where primary care vaccines are being given, that sort of sets the stage for what rural America is dealing with. Chuck, Teladoc joined the Collaborative for Healthy Rural America.

**Chuck Divita** 13:17

Yeah.

**Sarah Tribble** 13:18

It launched in November 2025 with the sole purpose of working with states on the Rural Transformation Funds and trying to bring change about what we just talked about. The collaborative includes Lumeris, Teladoc Health, Nuna, Deloitte, and Unite Us. These are some big players across the country, and it includes using AI for primary care. What is Teladoc's role in that collaboration, and how do you see that helping these local communities?

**Chuck Divita** 13:44

I think one of the roles is just the scope and reach that we have. The scale that we have really is unprecedented, at least in our space and what we do. The stats that I mentioned earlier. I think maybe another answer to the question is, I think, as long as I have breath in my lungs and I'm able to wake up every day, I'm going to continue to champion the fact that it's going to take multiple stakeholders to drive

change in the health-care system. We all say it, but it has to happen. And so, that collaborative was really around trying to get different parts together and see if we could speak with a more common voice to different stakeholders at the federal and state level about how we could go about this and how can we scale things and not have to duplicate efforts. We want innovation at the local level, but there's some things that we can do on a broader basis. And I think one of the benefits of this focus that we have on this transformation fund—one, it is a drop in the bucket. We're talking about hundreds of billions of dollars spent on those communities in health care every year. So, $50 billion is not going to close a gap on that. But if we can use that as a way to have local innovation and have the ability to understand what's working, what's not working, and then importantly, which is back to the collaborative, convene at a local level—how do we change the health-care environment in our community? Every rural community's different. The demographics are different. Ironically, in many rural communities, the hospital's actually the largest employer.

**Sarah Tribble** 15:05

Mm-hmm.

**Chuck Divita** 15:05

Or the school board is the largest employer. And you think, “Oh, the teachers.” Yeah, but there's custodial workers and cafeteria workers, and so you have all those issues there. And so, my hope is that that's an example of what communities can do in terms of bringing people together. Last data point, we talk a lot about Medicaid and Medicare, of course we do, in terms of these communities, but still 40 percent of it is through employer-sponsored health-care coverage. So, how are they at the table? How are those employers, those health plans, and the providers coming together to say, “This is a common problem. It affects every one of them.” And so, that's my hope, is these innovations and the transparency of what's going on will foster that because that's the only thing that's going to make this sustainable going forward.

**Sarah Tribble** 15:48

And let me try and make this a little bit more tangible, though.

**Chuck Divita** 15:50

Yeah.

**Sarah Tribble** 15:50

Because I talked to Lumeris about the AI product, and they've got a product that will follow up on high-usage patients, right?

**Chuck Divita** 15:58

Mm-hmm.

**Sarah Tribble** 15:59

And call them at home and talk to them about whether they need prescriptions or a ride or something like that. Where does Teladoc come into that play when they've got an AI agent calling folks and how does that work exactly?

**Chuck Divita** 16:11

Look, the AI space is going to continue to evolve, and in health care for sure. The way that we're using AI is we want to use it as a member of the care team. We want the clinician and the patient relationship to be on point. We want a human involved in that. However, the AI can do a lot of interesting things. It can find discrepancies. It can identify problems that maybe we're not catching. Somebody got a prescription, but guess what? They didn't fill it. Well, your doctor doesn't know whether you filled your prescription until maybe the next appointment. Some prescriptions, that may not matter, but if you have high blood pressure, that's the best way to get your high blood pressure under control is medicine. So, the interactions that AI can have, appointment scheduling, follow-ups, all of that. But from our point of view, we want to leverage our scale to make sure that that clinician is on point and that the AI is part of the care team. Lumeris is working with health systems, and they've developed a technology that helps those health systems do what I just said, which is—so, the AI is not acting alone, it's acting as part of their health system strategy. So, I think that's where we stand.

**Sarah Tribble** 17:11

And Teladoc works as a connector in that—

**Chuck Divita** 17:12

Yes.

**Sarah Tribble** 17:13

—that system.

**Chuck Divita** 17:13

And we have our own AI that we deploy in that as well.

**Sarah Tribble** 17:16

That's interesting.

**Chuck Divita** 17:16

But with the doctor on point.

**Cara James** 17:17

Could I just add a kind of contextual point? One thing to think about when we're talking about AI technology, rural communities, rural hospitals. Just one, we still have some places that have broadband issues—a lot. And so, technology is great when it works, and there's still some things that we need to do to just kind of bring everyone up to a basic floor to be able to leverage the technology. The other thing for AI

that I think about is, you know, if we flash back 10, 11 years, we were in the adoption of electronic health records. And we had Meaningful Use Stage 1. We were talking to rural providers, and many of them small solo practitioners, not necessarily having the capacity to adequately evaluate the technology or to even implement it once it came in. So, many people got to stage 1. You may recall we removed the regional extension centers, which were to help them sort of getting to those next phases, and we're kind of stuck. So, as we're thinking about AI adoption, other things in rural spaces, capacity to evaluate, to implement, and the resources needed to even train and support that is something that we need to also be providing and thinking about that support for successful implementation.

**Sarah Tribble** 18:34

Yeah. I know when you look at the state progress reports, and I want to jump to tracking the dollars and what is going on with the spending of the Rural Health Transformation programs. Artificial intelligence has been a huge push for the administration when they talk about this, along with innovation, trying to use innovation to help address some of the systemic chain problems and challenges in rural America. So, let's talk about the money for a minute. States did file their annual reports at the end of August. And CMS says those reports helped inform the year two funding announcement that came earlier this week. Many of those reports, by the way, just a little plug, can be found on KFF Health News. We've had a team of reporters calling states and collecting those reports if you want to take a look at them. States that saw the largest gains in year two include North Dakota and Iowa with a bump of about $7 million or more. The biggest losses by dollar amount went to Florida with about $6 million in decrease in funding. Vermont with a $5 million decrease. New Jersey lost about $5 million as well. CMS says those year one progress reports didn't by themselves measure all those things, but those detailed quarterly reports will be coming out, I think later this month is when they're supposed to be filed. And I want to note here that year two awards were also delayed by just a couple of days. CMS saying that they discovered an additional administrative process requirement that they had to review before they met that October 30th deadline, that they had. So, my lead question is to the data expert here on stage, do we have confidence that the second round of funding went out after a full evaluation of the first round of obligated funds? Not spending, obligated funds.

**Nandini Selvam** 20:17

Ah, easy questions. I love it. So, let's unpack this a little bit. So, it's $50 billion over five years. That's what initially got funded. So, that's 10 billion a year across 50 states. Of that, five billion is allocated in equal amounts to all the states. So, out the door, and so all you're left with is five billion. That becomes variable. Now, so there are a few different things happening here. So, if you look at how the states were given that initial five billion across the 50 states, and we look at what happened between year one and year two, there's about a percent difference. So, the variability of what happened the first time versus the second time is not so different. And so, if somebody gains, somebody else lost, because that's how you keep net equal, right? So, the change was $68 million was the movement within these different states. And it's not obvious to me, at least, how that was determined, because you talked about North Dakota. North Dakota actually gained seven and a half million, but it only had about 5.6 percent of its initial year one budget that was obligated.

**Sarah Tribble** 21:33

Yeah, according to the progress report filed at—

**Nandini Selvam** 21:35

—the end of July.

**Sarah Tribble** 21:35

According to the report that—

**Nandini Selvam** 21:36

Right. Exactly.

**Sarah Tribble** 21:36

Let me just put the numbers a little bit in context, because it's $100 million is stable across for every state, right?

**Nandini Selvam** 21:44

Correct.

**Sarah Tribble** 21:44

And so, there's $100 million variable for each state. That's called the workload funding underneath CMS. So, that is the part that shifts, right?

**Nandini Selvam** 21:52

Correct.

**Sarah Tribble** 21:54

So, you're seeing that variance. When you say $68 million, that's in that, right?

**Nandini Selvam** 21:57

In that second bucket.

**Sarah Tribble** 21:59

That second part. Okay.

**Nandini Selvam** 22:00

So, every state for showing up gets $100 million. And then, it's arguable what that $100 million does, right? And they've also lost money in Medicaid in this mix. So, but let's just assume all things are equal. They start with 100, and they have another 100 that can go up or down. So, the question was how much of an evaluation happened? I can't tell. At least from the reports that are out there, we can't tell because even the obligation, depending on which report you look at, it can go through June, maybe through

September. So, there's a little bit of a lag in that. And I do think there's something intrinsically flawed with this also in that if you think about the states that need the resources the greatest, they're also likely not the best in terms of they also have to work extra hard to get the proposals out.

**Sarah Tribble** 22:54

Right.

**Nandini Selvam** 22:54

The reports out. And so, I think this is where CMS can potentially step it up a little bit with national looks across all the different states and have that onus on the states just reduce just a little bit. But evaluations, these metrics are absolutely important because just because a program gets started doesn't mean it's impactful. And that's something that we're all going to have to figure out. And I think the way this works is the obligated funds have through September, October of 2027 to be actually utilized. And there is a thing in there which says that if you don't use it up, then they can reallocate it elsewhere. So.

**Sarah Tribble** 23:40

Yeah. And I should interject here and say I did reach out to CMS and ask about the delayed funding and what the administrative hang-up was. I didn't get a response. I did actually reach out to them as well about the evaluation and have not received a response as of right before this panel. But who should do the evaluations? Should it be CMS, states? And CMS does have a data map up online, and they break down some of the state policy action items and things like that. So, you can go to the website and see it. But as far as evaluations go, who should be doing that kind of evaluation? Cara, let me ask you that. Who do you think that should be doing the evaluations—

**Cara James** 24:20

I hope you want me to say philanthropy should do that.

**Sarah Tribble** 24:22

A big federal program?

*[Laughter]*

**Cara James** 24:25

So, one of the things I will just say, putting my former Fed hat on, so CMS wasn't given resources to do the evaluation. That wasn't part of the program. So, we have seen cuts across research dollars evaluation in the federal government over time. So, that means that money has to come from some other part of the agency if it's going to get done. There are conversations that are happening with other parts of the HHS to support some pieces of evaluation. I think—

**Sarah Tribble** 24:55

Evaluation for the Rural Health Transformation program.

**Cara James** 24:58

Yes. So, I think we are going to see some things probably coming out of the Federal Office of Rural Health Policy, probably out of the CDC Office of Rural Health to help support that. Philanthropy can help and does.

**Sarah Tribble** 25:10

Mm-hmm.

**Cara James** 25:12

But one of the things that is important is philanthropy cannot replace government. So, we did a survey last year of the general public as a lot of the cuts were happening, and we saw, like 4,000-plus grants across HHS cut, and all of those grantees were calling philanthropy to fill that gap. When you ask the general public, 60 percent of them think that it is philanthropy's job to replace the federal government when essential functions aren't provided. That math does not work. When you think about—and I had former folks that I know who were calling as they were losing grants—if you had $1 million in a grant from NIH, there are only a handful of foundations who are going to be able to give you a $1 million grant. So, we just need to level set of what there is. Philanthropy is a great partner, and philanthropy is stepping up in many spaces to do things government can't.

**Sarah Tribble** 26:13

Mm-hmm.

**Cara James** 26:13

And we can talk about how people are supporting the Rural Health Transformation program. We are hungry for evaluation. We are hungry for the learnings, and that's something we just literally finished our health policy conference yesterday and had a conversation about the Rural Health Transformation program and how philanthropy is engaging. We want to know what's working. We want to know how it's working.

**Sarah Tribble** 26:38

Right.

**Cara James** 26:38

And we want to be able to share that across the country because there are some commonalities, and how do we make that happen? So, I think there is interest in that. But can philanthropy fill the gap for government? No, and it shouldn't. And that's something of how we work together better.

**Sarah Tribble** 26:58

Yeah. I know CMS did open up a portal for the states to talk with each other, and I'm sure there's people in the room that know more about that than me. And they do want that five years to become sustainable—

**Cara James** 27:09

Right.

**Sarah Tribble** 27:09

—the innovation and findings. But just before we leave this topic, I do want to ask, really, what would a good evaluation look like? What do you suggest, Nandini to happen if they find the federal dollars to make it happen? Should it be CMS doing it? Should it be an IQVIA, an outside, nonpartisan, so to speak, expert? How should it look?

**Nandini Selvam** 27:33

Probably a good public-private partnership.

**Sarah Tribble** 27:36

Mm-hmm.

**Nandini Selvam** 27:37

CMS has to be part of the mix, not only as the funder, but they have a lot of experts. They understand the subject matter. But I do think that there isn't, as such, good visibility with data. There aren't the resources, and with the cuts we've had, they really do need the help. So, I'd say it's a mix, and the states have some responsibility as well to ensure that the dollars they're taking in is put to good use, and so, there's action that's happening on that side.

**Sarah Tribble** 28:06

Yeah. On that point with the state dollars, I just want to point out here that, and I can announce this, a new Milken Institute analysis is released today, and it looks at all 50 states' Rural Health Transformation program plans, and it found that pharmacists appear in 48 state plans, community health workers in 46. But when it looked at what states were actually planning on data systems as part of these efforts, data systems came in last. Just 20 mentions across 18 states, compared with 114 mentions of workforce development across 40 states. So, that's a striking gap. And if the states aren't doing the data systems and spending the money on the data systems to collect the information that's needed, and training people and planning for that to show whether it's working, then I guess, how do we produce that evaluation?

**Nandini Selvam** 29:01

But do you blame them, though?

**Sarah Tribble** 29:04

Right.

**Nandini Selvam** 29:05

But do you blame them, though? Because they only have a set number of dollars. They either treat the patients or they create a system to collect information to say the patient's not doing well, right? So—

**Cara James** 29:16

And you add to that what was shovel-ready. Because the speed at which the states had to put these applications together did not allow for a lot of space to be whiteboarding or creative or really innovative. So you had to—

**Sarah Tribble** 29:31

Right.

**Cara James** 29:31

—basically implement things. And when you think about sustainability. So, these are limited dollars. We don't know what's coming next. How do you sustain some of these systems? I also want to go back for a moment just on the evaluation because the data, it is a public-private partnership opportunity that also needs to involve community. And to think about not just the quantitative what happened, but the qualitative how did it happen? Because there are a lot of things that are coming through their workforce programs, systems, public health. What is working, but how is it working so that we can think about some of that larger transformation and dissemination across the space? So, we have that, and from the community's perspective, what has been that experience with it and what that starts to look like in—I think there needs to be a larger conversation. But also, what's the real-time learning that we're doing so that we can share across year two, three, four, so we're not waiting until year six or seven to find out what worked?

**Sarah Tribble** 30:35

Right. Chuck, I want to bring this back to you because when you talk about innovation at Teladoc Health, and you've got this collaborative, what are you seeing the states working on right now when it comes to this money? What excites you?

**Chuck Divita** 30:46

Yeah. In this conversation you just had, I think there's three dimensions here. I think one is certainly at the federal level and how do you make sure that there's transparency and good stewardship and all the things that we're talking about. Certainly at the state level because they had to move quickly, to your all's points, and develop a way to get the money and deploy the money and all that. But, there's also a layer that's local, and I think we can't lose that. We talked about it at the start, but each one of these communities is very unique, and there needs to be accountability at the local level of is this driving the impact, is this helping the community and the challenges that you're facing? So, I think all three of those have to happen. It's very complicated. Then, of course, across the states, we want to see what's working and what's not. You know, you went through some of the things that are happening out there with the initial grants, and they range. Most of it is going through local care delivery organizations, which you would want and you would expect. I think everything, looking from cancer care to workforce training to cyber and technology, it ranges. And the hope is that those stakeholders locally advocated for the right programs for their communities. So, it's wide-ranging, which I think is a great thing. However, it's so much that we also need

to know what's working, what's not, and I think it's just as valuable what's not working. Okay, then stop funding it and put some resources over here.

**Sarah Tribble** 32:04

Right.

**Chuck Divita** 32:05

So, I think when you look at the breadth of what's being done out there, it's impressive and it ranges across a number of issues. We could all argue about the balance of what those things are. I think the real work is going to be is it driving the kind of difference that you need in your community? And back to the sustainability point, if you don't have those stakeholders together, the funders of health care, if you will, the employers, the federal government, and the other constituencies, then all this great work will not have a sustainable financial model. So I think all of that's important.

**Sarah Tribble** 32:33

Yeah. I think when I was looking over the progress, the initial applications, I did a story because Dr. Mehmet Oz, who heads CMS, was talking about these ultrasound robots in Alabama helping out with the maternal care deserts. And if you don't know and you're in this room, maternity care is abysmal in many parts of the rural South and across the US, with some very poor health outcomes for mothers and babies—

**Chuck Divita** 32:58

Yeah.

**Sarah Tribble** 32:58

—in many areas. And so it's very exciting to think about AI and robots being used to help that, but also how tangible is that in the rural communities? And in the reporting I did, it actually works very well in Canada with local people on the scene helping out. But when you also look at the plan for the state, they also included crash carts and other things because the states did talk to their communities about what was needed in those local places. Yeah. Now, whether the dollars will go there or not, that's going to be an interesting thing to follow. But they did reach out to their local communities and stakeholders and try hard.

**Chuck Divita** 33:35

Well, you mentioned Canada. That's one of the countries that we operate in, and we actually have technology and devices I mentioned earlier that actually hospitals and health systems use. And so, in rural parts of Canada, which can get very rural—

**Sarah Tribble** 33:46

Mm-hmm.

**Chuck Divita** 33:47

—we're able to partner with the health system through the technology to keep ERs open. We're doing virtual ER, we're doing virtual primary care, bringing specialists to the community where they won't have to drive four or five hours to get there. So, I think you're right. There's an opportunity to use the physical locations, and they may be nontraditional. They may be libraries, they may be schools, they may be pharmacies like you mentioned. Wherever there's an access point, technology can play a role, but you've got to be able to bring the services in there as well. So, I'm excited about the possibilities, but again, you then have to go to, well, what's the sustainable financial model? At least in Canada, obviously, they know who's paying for it, and so they're dealing with a different set of issues. Here, who's paying for it? Medicare, Medicaid, commercial health plans.

**Sarah Tribble** 34:33

Well, the clock is ticking on the Rural Health Transformation plans, right?

**Chuck Divita** 34:35

Yeah.

**Sarah Tribble** 34:35

It's just five years. It's $10 billion a year. So—but the instruction is to find sustainability, as it is with many federal grants. Cara, I'm going to turn back to you. What's your advice for finding sustainability with these Rural Health Transformation dollars?

**Cara James** 34:51

Well, I think one of the first things is we need to know what's working. I think that there are wraparound things that can help and look at what we do to sort of build some of that in. One question we were talking about yesterday is, is there a part two? So, is there an advocacy play for a part two of this that leads to more than the $50 billion? Again, the supports, how are we building capacity in these places to be able to carry on and sustain this? When we think about how the states are implementing this, if you've seen one rural community, you've seen one rural community. States are doing this differently in terms of is there a hub and spoke? Is this being held at the governor's place? So, even some of those backbone organizations need support to have bigger capacity to be able to help reach more parts of the state and get some of those dollars out. We'll see if we have technology systems or others that are adopted. What is the sustainability support for that? And there may be places, but it's going to take an all-of-us approach and not just a this is somebody's job, but a collective shared responsibility that we have. And again, coming back to how do we lift up those lessons and think about where there may be opportunities to pool support from the employers, from the other parts of the state, and other federal places, and philanthropy with that. But we got to have these conversations, and we also need to know what's working. One concern that I have that I'm also curious about is these are dollars that are going to states, not necessarily to tribes. And so, when we think about what's happening in tribal communities, what does that look like? Because I'm not aware of many urban reservations that we have for our tribal communities, so, what does the share look like there, and what are some of those lessons learned as well?

**Sarah Tribble** 36:52

Yeah. I will add, and I'm really not just trying to talk about my stories, but I did a story on the delayed funding just initially because CMS was ahead. They came out with the awards announcement a couple of days ahead on the first year, so it was notable that it was a couple of days behind. But when I did the reporting on it and we collected these progress reports from Nevada and Idaho, Washington State, they are sending money to tribes, millions of dollars to tribes. So, that'll be very interesting to watch as well.

**Cara James** 37:24

Mm-hmm.

**Sarah Tribble** 37:24

So, I'll just give a plug for some of these western states, and I'm sure other states. Those are just a couple that I listed in my story. You mentioned hub and spoke, and that makes me think of North Carolina. And Nandini, North Carolina has a state data map up, and they have a tracking app up, and some of the other states do too. Have you seen anything out there when it comes to the way certain alliances are tracking the data? There's organizations tracking the data. Any of that help you solve the question of, are we seeing innovation that will pay off in the future? And, I feel like I'm asking a very broad question, but I'm searching for where can we find the innovation and see what's going to work?

**Nandini Selvam** 38:08

I think we haven't seen it yet. We looked through, and you and I looked at some of this too before, and it's really hard to tell because I don't even know how—so, a couple of things. Even in the way this funding's given out, there's a cap on what it can be spent for.

**Sarah Tribble** 38:28

Right.

**Nandini Selvam** 38:28

So, there's a 10 percent cap on administration, there's a 15 percent cap on provider payout.

**Sarah Tribble** 38:33

Right.

**Nandini Selvam** 38:33

So, you already have all these caps, so just add those two up and you have 25 taken off the back.

**Sarah Tribble** 38:39

There's a cap on capital.

*[Laughter]*

**Nandini Selvam** 38:42

Right. So, maybe I didn't get through all the caps, right?

**Sarah Tribble** 38:44

Yeah.

**Nandini Selvam** 38:44

I got capped out there. But the take is, there are lots of limitations around this, and then you genuinely have people who—let's think about this community to begin with. They're already disenfranchised in so many ways. We talked about opioids. There's obviously a lot of chronic disease, access barriers, closures. And so, then now you're starting to think about innovation, and some of these places don't even have broadband. So, how are we defining it? And I haven't seen anything that immediately stands out to me as like, "This is going to be sustainable." I think for the most part, even with that initial dollars, what we're seeing is they're having a hard time obligating it.

**Sarah Tribble** 39:32

Mm-hmm.

**Nandini Selvam** 39:32

The places that obligated it the fastest—

**Sarah Tribble** 39:35

Out fast enough.

**Nandini Selvam** 39:35

—it's telling, are Connecticut and California. So, think of the two coasts, much more advanced in so many ways. And the ones with the least, including North Dakota. Who else did I see? Kansas, maybe. Don't quote me on Kansas, but North Dakota for sure. They're having difficulty even putting it out there, because they're still trying to figure out how to make the best use of those funds.

**Sarah Tribble** 40:01

Yeah.

**Nandini Selvam** 40:01

So, innovation is actually a sort of a distant milestone still.

**Sarah Tribble** 40:07

Yeah. Arkansas didn't have a lot of funds obligated according to its first progress report. But maybe Arkansas was the—I emailed them, and they said, "We got them out. We got them out before the deadline in October." So, that kind of tells you how the states are really working hard to meet these deadlines that are really superfast for the federal government and for state bureaucracy.

**Cara James** 40:25

They're working—

**Nandini Selvam** 40:26

And I think it's also really fast for the turnaround, right? Cara talked about the first time around in the submissions, but even for the second time around, and this isn't going to change because that's how it's been set up, there's just not enough time for evaluation unless you do it along the way. And that's not what we're seeing yet, and this is part of what we were talking about before. Use existing systems. Secondary data is great. People look for like, “Is it perfect?” No, it's good enough. It serves the purpose. It serves as a great leading indicator.

**Sarah Tribble** 41:00

How interesting.

**Nandini Selvam** 41:00

If something's going wrong, if it's not working, the first thing is why? Because it may just need some help. So this might be a way. I don't know that we should think of these every single time as a postmortem analysis. I do think there isn't enough time because there isn't, but there's plenty of time in those 12 months to build the plane while you fly it.

**Sarah Tribble** 41:24

Yeah.

**Nandini Selvam** 41:25

And so, I think that's part of what we're seeing here that just hasn't been evaluated. So, no, I think innovation's still a pipe dream.

**Sarah Tribble** 41:35

Mm-hmm.

**Cara James** 41:35

I think a couple other things. So, on the tracking, the National Rural Health Association is doing a lot of tracking and a lot of following—

**Nandini Selvam** 41:41

They are.

**Cara James** 41:42

—and talking. When we're talking about some of the obligation of the dollars and what's going on, we also in conversations, we're hearing from folks on the ground, at least initially, fear. And so, not necessarily going after the dollars because the clawback clause in there, that they were concerned that that would be something that—

**Sarah Tribble** 42:01

Right.

**Cara James** 42:01

—we would have as an issue. And then in some cases, you also have—literally just yesterday, was talking to a foundation CEO who was leaving our meeting to go write the grant for the Rural Health Transformation program for one of their grantees because they don't have the capacity to write the grant themselves. So, this is some of those community groups that have one individual, two individual, they're trying to do all of these things. That is a capacity issue. So, receiving dollars from the state or from the backbone is a challenge that we have to think about as well. So, how are we supporting them to be able to receive? The other thing from, as you all know, federal accounting standards, that's not necessarily something that, you know, these organizations have the ability to do. So, who's supporting that infrastructure to allow them to make sure they don't get audited and have any challenges related to that? So, there's some real practical things and lessons that we ideally should have learned over the past few years of looking at why necessarily we haven't seen as much rural pickup for some of the models—

**Sarah Tribble** 43:06

Right.

**Cara James** 43:07

—that have been coming out of CMMI. And we've talked enough to people. We know some of what are the things that need to be done, how do we create the on-ramps and the pathways and the wraparound supports to make sure that they succeed.

**Sarah Tribble** 43:20

Yeah, I don't think you can underestimate that much of this money from the state level is going out as grants, right? Which means there has to be the staff to fill out the grants to then get the grants. But in a place where you're operating a 25-bed hospital and you are challenged just to keep nurses and doctors on staff, you don't have somebody with extra bandwidth to write those grants and then go out and get those grants. Chuck—

**Cara James** 43:44

And we need the capital because those hospitals, the Hill-Burton hospitals are still very much in play.

**Sarah Tribble** 43:50

Oh, Hill-Burton. I just wanted to give a nod to the mention of Hill-Burton hospitals, which was a transformative program over 15 years, creating hospital beds, which we no longer need, which is why we have a transformative program again, so we can transform with innovation and so forth. Chuck, I see you wanting to say something, so I'm just going to turn to you and—

**Chuck Divita** 44:10

Yeah.

**Sarah Tribble** 44:10

What's your—

**Chuck Divita** 44:11

I always want to say something. Yeah.

**Sarah Tribble** 44:14

But say it's 2031, and the federal money is gone, and Medicaid has been cut. What has to be true today to you—so that you can think positive about what's going to happen in West Virginia and the rest of rural America.

**Chuck Divita** 44:29

I think what I believe is achievable but very hard, which is at the end of this, do all the stakeholders or enough of the stakeholders that we're talking about here feel accountability and ownership for the health and vibrancy of the communities that they're responsible for? And so, that you're not like my grandfather, making a trade-off of leaving the place where you've built a family just because you can't get access to care, that we have tried to tackle these issues in a way that sufficiently improves the health care condition so they can live their lives. And that's going to take, like I said, the employers, the health plans, the government, and local accountability. So, it's my hope, I believe it's achievable. I think it's very hard to do when every stakeholder is incentivized to do something different. Whether you can blame that on the fee-for-service system or you can blame it on how we're organized, whatever, we have a problem in this country, and it's a huge issue. It's 18 percent of GDP. It's $5 trillion, and it's growing. It's impacting every single one of us directly or indirectly. So, my hope is that this moment of innovation or this $50 billion or the whole program itself, that we are trying to tackle those local needs. I think the country will benefit from it, and I'm certainly sure those local communities will.

**Sarah Tribble** 45:45

What is it that you're working on right now that could have changed the situation for your grandfather when he was having to drive miles and miles, hours for dialysis?

**Chuck Divita** 45:54

Well, one, I think people just take for granted they know what they know, right? I'm not sure. He probably didn't know how to advocate, and there was probably no organized way to advocate for the needs that

were there. So, everyone just exists and does what they do. I think that the local governments haven't done enough. I think the politicians haven't done enough—locally, nationally, to really identify acutely what's going to need to change in the payment mechanism in this country in terms of incentivizing the right things and then holding accountable those stakeholders to deliver on what we're all supposed to be accountable for, which is improving the health and well-being of people. So, I think balls were dropped all along the way, but if you put yourself back in my grandfather's shoes, he didn't know any better.

**Sarah Tribble** 46:39

Right. But if you had the innovation and transformative ideas, and then you have these payment mechanisms, payment systems—

**Chuck Divita** 46:47

Yeah.

**Sarah Tribble** 46:47

—that could work helping funding them, maybe something could change.

**Chuck Divita** 46:50

Absolutely. There would've been transportation available. There would've been an incentive to have dialysis centers in some of these areas. There would've been incentives along the way, and not just as a charitable thing, but as a good business and a good economic model as well. There's enough money being spent to do that.

**Sarah Tribble** 47:04

Cara, it's 2031. What do you see happening now that gives you hope for the future?

**Cara James** 47:09

What I would like to see now, and I think there is a window of opportunity that is opening, is that we have a real conversation about what our vision for rural health is and what it would take to implement that. There is no shortage of activity that is happening in rural health and in rural communities. It does not amount to anything because it's not well organized, it's not well coordinated, and we don't have a clear north star. And in this moment, there is an opportunity to radically reimagine the future of health as we're seeing cuts, we're seeing all of the changes, and people frustrated with the system that we have. Let's have the courage to dream big and to do the hard work that it would take to actually create a system that produces health and not treatment, because that's what we have now.

*[Applause]*

And to make sure that that vision includes everyone in the creation of it, including our rural communities, and that we implement the supports needed to successfully achieve it. But that's the moment that we have in front of us and the opportunity if we have the courage to take it.

**Sarah Tribble** 48:18

That's a big comment to follow up on, but Nandini, I'm going to ask you to because you sit at kind of a juncture that I think is very important for this conversation. And so, looking ahead to 2031, what are you seeing happening right now? We've talked about some of the stuff that's not happening that needs to happen, but what have you seen that's happening that gives you hope for the future?

**Nandini Selvam** 48:41

Well, so, I think Cara started to set this up a little bit. We need to just think of this as health, so it's not just rural health. Everybody has a piece of the pie, and everything's a silo. Let's talk about rural health and what the issues are. Here is the maternal. We've forgotten about the human in this mix. If we put the human back in the center of this and we sort of look at it forward, I think there is hope still because we look at the entire human and all the different needs because it's everything from Food Is Medicine, taking care to where the person is, whether it's integrated with retail pharmacies, the grocery store. But there is a whole health approach to this that we're missing. And I'll punctuate it by saying you can't really take government out of the mix because there is no substitution for it.

**Sarah Tribble** 49:31

Yeah.

**Nandini Selvam** 49:31

So, we'll be in trouble if everything pulls out, right? Philanthropy only goes so far. Everything else goes so far. So, I hope the government stakeholder continues to stay at that table because it's a required part of this. But I think looking at it as whole life or whole human health and in all the factions that they need to function, I think will be sort of the way we would make any of this sustainable.

**Sarah Tribble** 49:56

I'll leave us—we're out of time. I'll leave us with one more data point. One in five people in America, roughly 66 million people, live in rural America. So, these are 66 million people who need better health care, and we're at this inflection point, and I think we've had a great conversation about what is going right and what could be improved going forward, and I really, really appreciate all three of you for being here and having this conversation with me. Thank you.

**Cara James** 50:22

Thank you.

**Chuck Divita** 50:23

Thank you.

**Nandini Selvam** 50:28

Thanks.

*[Applause]*

*Disclaimer: This transcript was reviewed by individuals for accuracy and serves as a reference. However, it may still contain errors or omissions. Please verify any critical information independently.*