TruBridge®

SPECIAL REPORT

Rural Health at a Crossroads: How RHTP and OBBBA are Reshaping Local Healthcare

Executive Summary

TruBridge conducted live polling of rural hospital executives attending the Rural Health Collaborative event at the TruBridge National Client Conference (NCC) on April 9, 2026. The survey findings provide an early look at how rural leaders view the Rural Health Transformation Program (RHTP). They also reflect how they are responding to the broader policy environment shaped by the One Big Beautiful Bill Act (OBBBA).

> **"For many rural leaders, success depends on whether patients maintain access to essential services during implementation.**

The report highlights operational challenges rural providers face over the next several years. Rural providers support transformation efforts, but they remain concerned about implementation risks. Rural hospital executives warned that transformation cannot succeed if base reimbursement and coverage stability erode before innovation funding delivers results.

The RHTP, authorized by the OBBBA, aims to strengthen America's rural communities through targeted rural health investment. The program provides $50B over 5 years beginning in FY 2026. However, national analyses show rural providers may face much larger Medicaid-related pressures under H.R.1. These pressures include an estimated $137B reduction in federal Medicaid spending across rural communities over 10 years. Rural hospital executives also expressed concern about uncompensated care, eligibility churn, and the stability of core hospital services.

Survey respondents cautioned that OBBBA-era policy changes could weaken the operational foundation needed for transformation investments to succeed. Those pressures include Medicaid reductions, eligibility changes, payer mix shifts, and coverage disruptions.

Rural executives are increasingly aware of how states are approaching RHTP-funded initiatives, but many do not believe they have enough influence to shape priorities. Executives identified workforce support, service line preservation, and technology investment as top priorities.

Survey responses highlight 3 operational priority areas:

- First, workforce shortages are already disrupting service line stability, with several respondents reporting concerns about disruption to key services.
- Second, respondents identified primary care, chronic disease management, and behavioral health as the most vulnerable service areas.
- Third, rural leaders prioritized operational stability and financial resilience over aspirational digital initiatives. They favored "grow your own" workforce pipelines over temporary staffing solutions and identified revenue cycle automation as the technology most likely to generate near-term impact.

The findings suggest rural providers measure transformation efforts against the operational realities confronting their communities. For many rural leaders, success depends on whether patients maintain access to essential services during implementation, not on the ambition of state plans. Rural health executives emphasized the need for regional coalitions, workforce and service line strategy alignment, and investments that protect both access and financial stability.

Federal and state leaders must balance long-term transformation goals with near-term access needs in rural communities. They must prioritize investments in workforce stability, core service lines, and revenue integrity to help rural providers sustain access during implementation.

Key Takeaways

Operational stability: Rural leaders support transformation efforts but warn that financial instability could derail implementation. Leaders identified reimbursement reductions and coverage disruptions as major threats to long-term sustainability.

Workforce and service line pressures: Executives identified workforce shortages as a growing threat to primary care, chronic disease management, and behavioral health services.

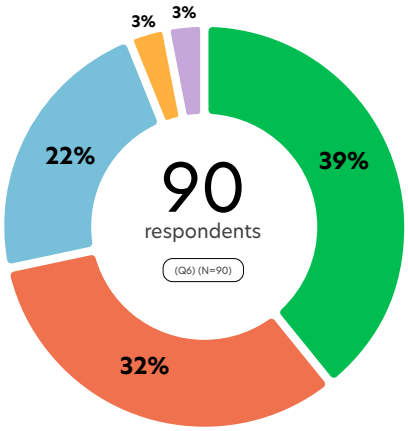
Practical investment priorities: Rural hospitals favor investments in workforce pipelines, revenue cycle automation, and financial resilience over aspirational digital initiatives.

Access-driven transformation: Rural executives measure success by whether communities maintain access to essential services during implementation.

QUESTION 1:

How would you characterize your organization's current level of engagement with your state's RHT implementation process?

Participant Demographics: RHT Engagement Level



- Moderately engaged - we are informed and participating when asked (35 COUNT)
- Actively engaged - we are at the table and influencing how funds are deployed (29 COUNT)
- Passively informed - we are receiving updates but not meaningfully involved (20 COUNT)
- Not yet engaged - we haven't had meaningful contact with our state on this (3 COUNT)
- Minimally engaged - we are largely watching from the sidelines (3 COUNT)

How rural leaders view transformation

The following sections summarize the 6 survey questions, roundtable discussions, response trends, and analysis from TruBridge subject-matter experts.

01. Rural leaders want more influence over RHTP priorities

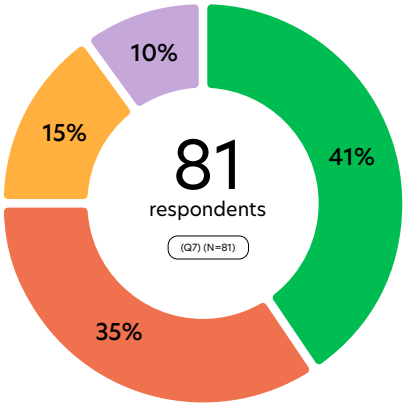
Survey responses show rural executives are actively engaging with RHTP planning efforts, but many still question how much influence they have over funding priorities. Respondents consistently pointed to concerns about operational stability, provider input, and the disconnect between state strategies and local healthcare realities. The findings suggest rural leaders want stronger visibility into how decisions are made and how investments will affect local care delivery:

- **Limits of provider engagement:** Respondents reported moderate-to-active participation across rural provider organizations, but many described uneven influence over planning and funding priorities.
- **Stakeholder participation:** Roughly 7 in 10 respondents reported direct participation when states requested input, suggesting states have made some effort to engage rural stakeholders.
- **Limited influence:** Executives want stronger input into decisions that affect staffing stability, revenue cycle performance, and vulnerable core services. Leaders emphasized that hearing about RHTP plans is not the same as shaping allocation decisions.
- **Program credibility concerns:** If states can show that rural hospitals, critical access hospitals (CAHs), and other community healthcare stakeholders had meaningful input into year 1 and year 2 funding strategies, RHTP may be easier to defend as a responsive program. Without that engagement, criticism could intensify around top-down planning structures disconnected from day-to-day rural operations.
- **Need for operational clarity:** Leaders are more engaged than indifferent, but said they need better visibility into how transformation strategies will affect day-to-day care delivery.

QUESTION 2:

Overall, how do you view the RHT Program's net impact on your hospital across the full five-year period - accounting for both the new funding AND the concurrent Medicaid cuts from H.R. 1?

RHT Area Sentiment: Perceived Net Impact



- Too early to assess (33 COUNT)
- Net negative - the Medicaid cuts will outpace what we receive from RHT funding (28 COUNT)
- Neutral - the funding and cuts largely cancel out (12 COUNT)
- Net positive - RHT funding compensates for the Medicaid reductions (8 COUNT)

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> **Respondents view RHTP as a stabilizing tool rather than a comprehensive solution.**

02. Transformation funding may not offset Medicaid pressure

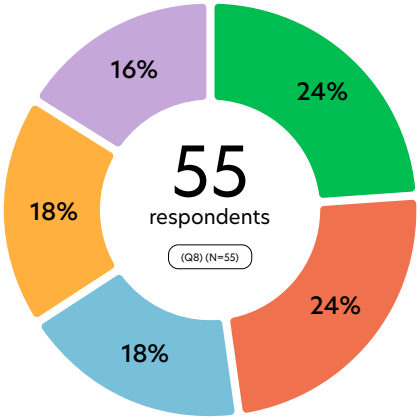
According to the survey results, rural leaders support transformation funding, but many remain uncertain about its long-term impact. Respondents identified concerns about reimbursement pressure, coverage disruption, and implementation uncertainty. The findings suggest executives view RHTP as a stabilizing opportunity rather than a complete solution:

- **Funding uncertainty:** Rural leaders remain concerned whether transformation investments will be enough to offset structural payment losses.
- **Cautious expectations:** "Too early to assess" responses reflect uncertainty, not passivity or confusion. These responses reflect a rational wait-and-see posture in a policy environment where implementation timelines, state application quality, local readiness, and Medicaid disruptions are still unfolding.
- **Negative financial impact:** 35% of executives warned that Medicaid cuts, eligibility churn, and uncompensated care pressures could outpace the benefits transformation projects generate.
- **Stabilization expectations:** Respondents view RHTP as a stabilizing tool rather than a comprehensive solution. They emphasized that historic rural investment does not automatically guarantee long-term stability for hospitals and communities.
- **Questions about policy accountability:** For elected leaders, the investments create an accountability concern: If OBBBA reduces rural Medicaid support while RHTP asks states to engineer transformation, rural leaders question who bears responsibility if hospitals lose core services during implementation.

QUESTION 3:

In the past 12 months, have workforce shortages caused your hospital to reduce or suspend a service line, or put one at serious risk?

Workforce Shortages: Service Line Impact



- At risk but stabilizing - we are actively addressing it (13 COUNT)
- Not currently - but we are a few departures away from a real problem (13 COUNT)
- Yes, we have already reduced or suspended a service line (10 COUNT)
- No, our clinical workforce is relatively stable (10 COUNT)
- Yes, a service line is at serious risk of closure within the next 12 months (9 COUNT)

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> Workforce fragility is no longer a future concern in rural care — it is an active determinant of which services communities can keep.

03. Workforce shortages are now a direct access issue

The results show workforce fragility is no longer a future concern in rural care — it is an active determinant of which services communities can keep. Few organizations describe themselves as clearly secure. Respondents identified staffing shortages as a growing threat to service line continuity, financial stability, and patient access.

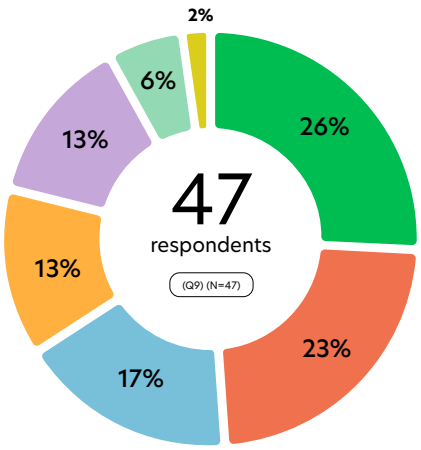
The findings suggest workforce instability is becoming one of the most immediate operational risks facing rural hospitals:

- **Operational instability:** Even respondents who have not yet lost a service line indicated they may be one resignation, retirement, or failed recruitment cycle away from operational disruption.
- **Service line vulnerability:** When obstetrics, surgery, emergency coverage, behavioral health, or primary care weaken, referral leakage rises and clinician morale falls. Hospitals can quickly lose financial stability and community trust.
- **Operational and economic impact:** Respondents described workforce gaps as simultaneous challenges to access, finances, and local economic development.
- **Impact on patient access:** Executives connected federal policy decisions to day-to-day patient impact. Federal debate often treats Medicaid reductions and transformation funds as budget abstracts, but respondents described the operational reality of those decisions. These decisions directly affect patients: service lines are cut, narrowed, or sustained only with short-term stabilization efforts.
- **Pressure on workforce retention:** If operating margins tighten, hospitals may struggle to absorb premium labor costs, offer retention packages, invest in training, or subsidize low-volume essential services.

QUESTION 4:

Which service line at your organization is most at risk and would benefit most from RHTP-supported transformation?

Service Line Most at Risk



- Primary care / chronic disease management (12 COUNT)
- Behavioral health / psychiatry / substance use disorder services (11 COUNT)
- Surgical services, including operating room and perioperative services (8 COUNT)
- Emergency department / urgent care (6 COUNT)
- Obstetrics / maternal health (6 COUNT)
- Cardiology (3 COUNT)
- Rehabilitation / wound care (1 COUNT)

04. Primary care and behavioral health remain most vulnerable

Survey responses show rural leaders remain most concerned about the service lines that form the backbone of community health. Respondents identified workforce shortages and reimbursement pressure as major threats to service line sustainability. Rural providers are prioritizing preservation of essential care access alongside transformation efforts.

Primary care vulnerability

The findings show rural leaders are most concerned with maintaining the services that support long-term community health and prevention. Primary care and chronic disease management rank highest, suggesting rural leaders are worried about the erosion of the foundation needed to manage population health, prevention, and high-cost conditions before they become emergencies. The findings also align with broader policy emphasis on prevention, wellness, and early intervention consistent with the Make America Healthy Again (MAHA) agenda. If primary care capacity is weak, many other reform goals become aspirational rather than operational.

Behavioral health access challenges

Behavioral health ranked close behind primary care as an area of concern for rural leaders. Rural communities continue to face persistent behavioral health access gaps. When psychiatric, substance use, and related services are limited, the burden shifts to emergency departments, law enforcement, schools, and families. Rural areas are disproportionately affected by workforce shortages: nearly all rural counties are designated mental health professional shortage areas, and 65% of rural counties don't have a psychiatrist. Respondents view behavioral health as central to sustainability, community need, and system capacity.

Routine and emergency care instability

The inclusion of surgery, obstetrics, and emergency and urgent care highlights how rural service line vulnerability spans both everyday access and high-acuity readiness. When reductions occur, these are among the most visible to the public. Rural leaders are focused not only on innovation, but also on preserving local access to essential care.

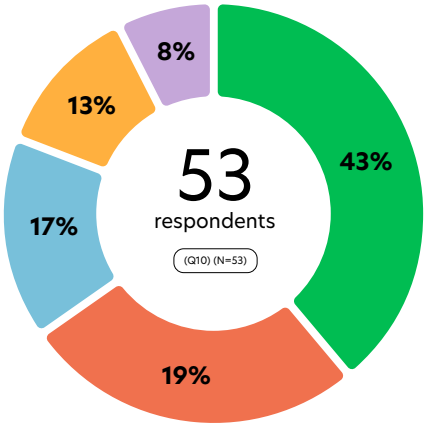
Financial vulnerability of essential services

Public analyses warn that funding reductions could limit access to critical services, including obstetrics and behavioral health. RHTP explicitly targets prevention, access, workforce, technology, and innovation. These priorities make primary care, chronic disease management, and behavioral health logical focal points for transformation. The policy challenge is that many of these services are both operationally essential and financially vulnerable. Long-term sustainability will require both redesign of capital and a stable reimbursement environment.

QUESTION 5:

From your perspective, which workforce strategy will produce the most durable results across a 5-year time horizon?

Most Durable Workforce Strategy



- "Grow your own" - pipeline programs starting in local high schools and community colleges (23 COUNT)
- Loan repayment and tuition assistance tied to rural service commitments (10 COUNT)
- Residency and fellowship programs established in rural settings (9 COUNT)
- Scope-of-practice expansion - expanding contributions from community health workers (CHWs), pharmacists, and paramedics (7 COUNT)
- Locum and rotational staffing models to bridge persistent structural gaps (4 COUNT)

05. Rural leaders favor long-term workforce pipelines

Survey responses suggest rural leaders view workforce development as a long-term community investment, not a temporary staffing solution. Respondents consistently identified local workforce pipelines and retention-focused strategies as the most sustainable approach. The findings suggest hospitals are prioritizing workforce durability over short-term staffing stabilization.

Local workforce preference

Respondents emphasized that workforce stability depends more on local talent development than temporary staffing relief. The preference for "grow your own" strategies reflect the realities of rural workforce economics and culture. Recruitment efforts succeed more often when clinicians and staff have local ties, realistic training pathways, and reasons to remain in the community beyond an initial obligation.

Temporary staffing limitations

Leaders described locum and rotational staffing models as stopgaps. They see these models as bridges, not foundations. That distinction matters as RHTP implementation prioritizes workforce development. If states rely on short-term staffing solutions without building a rural workforce pipeline, they may temporarily stabilize access without addressing retention or continuity.

Community impact

Respondents linked workforce investment to broader economic and community development goals. Pipeline programs tied to high schools, community colleges, and in-state training pathways can be pitched as both health policy and local economic opportunity. This approach is persuasive to local leaders across private and public sectors because it connects healthcare access, job creation, retention of young talent, and regional economic resilience.

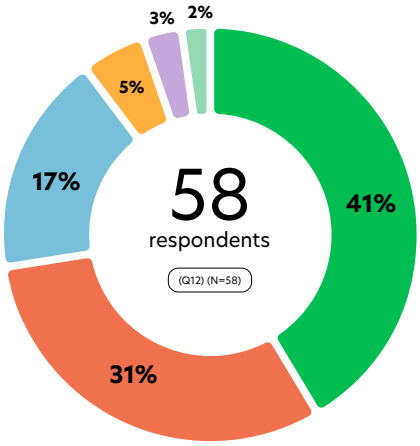
Reliance on local workforce

RHTP explicitly includes workforce investment as a strategic objective. As OBBBA-related reimbursement pressures make it harder for hospitals to compete on salary alone, local pipelines become more attractive. These pipelines help hospitals improve long-run retention and reduce dependence on premium labor. This approach also aligns with the broader rural trend of integrating education, healthcare, and economic development to stabilize communities — not just facilities.

QUESTION 6:

Which technology investment would generate the greatest near-term impact at your facility?

Greatest Near-Term Technology Impact



- Revenue cycle automation and reimbursement tools to support eligibility verification, denials management, charge capture, and collections (24 COUNT)
- EHR interoperability and data exchange upgrades (18 COUNT)
- AI-assisted clinical decision support or documentation tools (10 COUNT)
- Cybersecurity resilience and incident response capability (3 COUNT)
- Consumer-facing digital health tools (e.g., patient apps, portals, digital literacy programs) (2 COUNT)
- Remote patient monitoring (RPM) and telehealth infrastructure (1 COUNT)

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> **Rural transformation requires a financial chassis strong enough to support care redesign.**

06. Financial resilience drives technology priorities

The survey findings show rural providers prioritize financial survivability over digital sophistication. Respondents prioritized technologies that protect reimbursement, cash flow, and operational stability.

Revenue cycle prioritization

State plans often emphasize interoperability, telehealth, population health, and digital engagement. However, respondents identified technologies that support accurate reimbursement and efficient payment processes as the most immediate operational priority. The prominence of revenue cycle automation suggests denials, delayed collections, eligibility problems, and reimbursement leakage are operational and strategic threats, not back-office challenges.

Reimbursement pressures

Medicaid changes may increase eligibility churn, self-pay exposure, and uncompensated care pressure. These changes result in hospitals relying more heavily on eligibility verification, denial management, charge capture, and collections optimization. This shift does not represent a retreat from transformation goals. Instead, it is a reminder that rural transformation requires a financial chassis strong enough to support care redesign.

Interoperability and care coordination

Respondents still identified electronic health record (EHR) interoperability as an important priority for data exchange, referrals, and care coordination. The ranking order suggests hospitals under margin stress will prioritize technologies that protect cash flow before they invest in aspirational consumer-facing tools. Rural executives emphasized the need for practical technologies that keep the doors open long enough for transformation to work.

Practical technology priorities

NRHA notes that H.R.1. could reduce reimbursement while increasing uncompensated care pressure for rural clinicians who continue to treat newly uninsured patients. That financial pressure helps explain why revenue cycle technology outranked remote patient monitoring (RPM), telehealth, and consumer engagement tools. Respondents acknowledged that RHTP prioritizes technology investment. However, they emphasized that implementation will be more credible if technology funding addresses rural providers' need for financial resilience while also supporting longer-term interoperability and innovation goals.

Rural executives stress that transformation depends on operational stability

Through the survey, rural hospital and health system leaders send a clear message: They support the Rural Health Transformation Program's investment in care redesign but have a higher order of needs. However, they worry Medicaid reductions, coverage disruptions, and payer mix shifts could outpace the value of RHTP funds if implementation does not directly address:

- Workforce fragility
- Vulnerable service lines
- Financial viability

For many rural executives, the question is less about whether transformation is necessary and more about whether they will have enough operating runway to sustain it. The survey underscores 4 themes to guide next steps:

1. Workforce stability is a direct access and service line issue, not an abstract HR problem. Many organizations are only a few departures away from losing essential services.
2. The services at greatest risk — primary care, chronic disease management, and behavioral health — are the services most critical to keeping people healthier and avoiding higher-cost, higher-acuity care.
3. Rural executives continue to prioritize practical tools like "grow your own" workforce pipelines and revenue cycle automation because they see them as prerequisites to sustaining a broader transformation agenda.
4. Health systems want a more active role in how transformation dollars are developed and deployed in their states.

The path forward isn't about choosing between optimism and realism. It is about aligning transformation policy with on-the-ground reality. Based on these findings, the following recommendations are intended for rural health executives, Centers for Medicare & Medicaid Services (CMS), and state leaders:

> **"Rural leaders are ready to do their part. They ask federal and state partners to ensure the policy environment gives them the stability, voice, and tools required to succeed.**

Recommendations for rural health executives

- **Strengthen regional coordination**: Build regional coalitions with nearby rural hospitals, federally qualified health centers (FQHCs), emergency medical services (EMS), behavioral health providers, and community organizations. These partnerships can help ensure RHTP proposals reflect delivery-system redesign rather than isolated institutional projects.
- **Prioritize workforce stability:** Shift from annual recruitment plans to rolling 12-month retention and succession strategies. Focus especially on primary care, nursing, behavioral health, anesthesia, and operating room staffing, where even small losses can destabilize access.
- **Balance short- and long-term staffing needs:** Pair long-term "grow your own" pipeline investments with targeted short-term retention efforts, such as targeted incentives, flexible scheduling, and professional development. This approach can help prevent today's staffing gaps from overwhelming tomorrow's workforce pipeline.
- **Plan for long-term sustainability:** Develop simple but robust scenario models that separate one-time transformation dollars from recurring operating revenue. When setting strategy and making capital or technology investments, explicitly factor in Medicaid, payer mix, and uncompensated care exposure.

Recommendations for CMS

- **Protect near-term access:** Clearly communicate that successful RHTP implementation must balance long-term redesign with near-term access protection, especially in markets where hospitals or key service lines are already at risk.
- **Measure operational stability:** Promote measurement frameworks that track more than spending and project counts. Include metrics such as avoided service closures, reduced vacancy durations, improved retention, and preserved access to primary care, behavioral health, and emergency services.
- **Support integrated care models:** Elevate integrated models that connect physical health, behavioral health, and chronic disease management in thinly staffed rural settings. Make clear that these models are high-value uses of RHTP resources.
- **Require stronger participant engagement:** Strengthen expectations for meaningful rural stakeholder engagement in state planning. Require transparent reporting on how provider input has shaped priorities, selection criteria, and funding decisions.

Recommendations for state leaders

- **Increase funding transparency:** Publish recurring RHTP implementation dashboards that show how funds are allocated by category, geography, and strategic goal. This transparency gives providers, communities, and policymakers a clear line of sight into where dollars are going and why.
- **Create structured rural input:** Establish advisory councils, standing listening sessions, and formal feedback channels. These structures can help rural providers transition from being passively informed to actively shaping priorities and program design.
- **Align regional workforce strategies:** Coordinate closely with workforce boards, education systems, higher education institutions, and economic development agencies to align rural health workforce strategies with broader regional talent and economic goals.
- **Reduce dependence on one-time grants:** Align health, education, and workforce-development funds where possible. This approach can help ensure rural pipeline programs and training pathways are not dependent solely on one-time healthcare grants.

The survey results make clear that rural leaders are ready to do their part. They ask federal and state partners to ensure the policy environment gives them the stability, voice, and tools required to succeed.

Methodology

We used a real-time audience polling platform to survey an audience of rural hospital and health system executives attending the TruBridge National Client Conference. The poll was conducted live during conference sessions on April 9, 2026, with respondents submitting answers via their own devices. The sample represents a voluntary response sample of conference participants and is not intended to be a statistically representative sample of all rural hospitals or health systems.

Respondents included senior leaders from critical access hospitals, small rural and community hospitals, and some larger rural health systems, with roles such as CEO/President, CFO, CIO/CTO, CMO/clinical leadership, and other executive or senior leadership positions. Participation in the poll was voluntary. Responses were collected anonymously, and no individually identifying information about respondents or their organizations was captured or reported.

All survey questions were multiple-choice and single-select unless otherwise noted. While approximately 100 executives were in the audience, the number of respondents varies by question due to item non-response (not all participants answered every question). As a result, the base (n) for each item is reported with the corresponding chart or table, and percentages are calculated from the valid responses to that question only.

All percentages in this report are rounded to the nearest whole number. Because of rounding, percentages in some charts and tables may sum to slightly more or slightly less than 100%. Basic data checks were performed to identify and exclude incomplete or obviously invalid responses where applicable, and select response options were grouped or labeled for clarity (for example, by region or hospital type).

The estimates and opinions expressed in this report are based solely on the survey results and the interpretation of those results by TruBridge subject-matter experts. Findings reflect self-reported perceptions and experiences collected in a live conference environment and should be interpreted in that context. Given the use of a convenience sample, results should not be generalized to all rural hospitals without caution.

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About TruBridge

TruBridge proudly supports rural and community healthcare providers in their efforts to stay strong, independent, and deeply rooted in the communities they serve. Backed by more than 45 years of healthcare experience and trusted by over 1,500 clients nationwide, TruBridge offers a mix of technology, services, and strategic expertise — including revenue cycle management (RCM), electronic health records (EHR), and analytics — all designed singularly for the realities of rural and community healthcare. With a steadfast commitment to keeping care local, TruBridge helps hospitals flourish as the economic heart of their communities, delivering high-quality, deeply personal care close to home.

Addendum: Additional survey results

PARTICIPANT DEMOGRAPHICS: PRIMARY ROLE (N=90)

RESPONSE	COUNT	PERCENTAGE
Other Executive or Senior Leader	45	50%
CFO / Chief Financial Officer	17	19%
CEO / President	12	13%
CIO / CTO / Chief Digital or Information Officer	9	10%
CMO / Chief Medical Officer / Clinical Leadership	7	8%

PARTICIPANT DEMOGRAPHICS: HOSPITAL / HEALTH SYSTEM TYPE (N=89)

RESPONSE	COUNT	PERCENTAGE
Critical access hospital (CAH) - 25 beds or fewer	58	65%
Small rural hospital - 26 to 99 beds	23	26%
Mid-size rural hospital - 100 to 299 beds	7	8%
Larger rural hospital / health system - 300+ beds	1	1%

PARTICIPANT DEMOGRAPHICS: REGION (N=89)

RESPONSE	COUNT	PERCENTAGE
Midwest	33	37%
South	30	34%
West	15	17%
Southeast	7	8%
Northeast	4	4%

PARTICIPANT DEMOGRAPHICS: CURRENT OPERATING MARGIN STATUS (N=90)

RESPONSE	COUNT	PERCENTAGE
Positive operating margin	31	34%
Negative operating margin	21	23%
Operating near breakeven (within +/- 1%)	18	20%
Unsure	13	14%
Prefer not to say	7	8%