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Closing the First Mile: Creating rural patient pathways

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KEY TAKEAWAYS

- Rural patients leave because no one owns the pathway home. Without a designed pathway, 65% of rural surgical patients bypass local hospitals.
- Bypass behavior, not population decline, explains rural hospital distress. Volume decline reflects care-seeking behavior changes, not fewer rural residents.
- Coordination efforts fail because they produce "observed" continuity, not "receipted" proof. When CMS secret shopper surveys begin July 2028, only documented, audit-survivable access will count.
- The Rural Health Transformation Program (RHTP) can fund the "first mile" that current policy lacks. States can pioneer accountability frameworks with documentation standards modeled on CCBHC certification requirements.

The Challenge

Beginning July 2028, CMS will enforce Medicaid managed care network adequacy through independent secret shopper surveys (CMS-2439-F, 89 FR 30819, April 2024). Results will be publicly posted. Alternative Access Standard requests, which have historically provided administrative relief, will become documented failures visible to advocates, media, and competitors. An October 2025 OIG report on Medicare Advantage directory accuracy found that Medicare Advantage plans in rural counties averaged 63% inactive providers in their directories. These "ghost networks" will fail secret shopper verification.

The structural problem runs deeper than network directories. When patients need follow-up care after discharge, screening that connects to treatment, or coordination between their FQHC and local hospital, no entity owns that pathway. Patients make rational choices in the absence of designed alternatives.

The question is not whether to invest in access solutions. CMS enforcement makes investment mandatory. The question is whether those investments will produce infrastructure that survives when 2028 arrives.

The Insight

Coordination programs have failed repeatedly, not for lack of intent, but for lack of proof architecture. The distinction between "observed" and "receipted" continuity explains why well-funded initiatives produce temporary gains that disappear when funding ends.

Observed continuity (tracking dashboards, care narratives, MOU commitments) demonstrates organizational intent. It persuades funders and satisfies grant requirements. But it does not survive scrutiny. Receipted continuity produces person-level, longitudinal, attributable proof: documented encounters with timestamps and provider identifiers, tracked referrals with confirmed receipt, verified follow-up completion with service records.

This distinction matters for RHTP implementation. The statute (P.L. 119-21, Section 71401) permits infrastructure investment, but infrastructure that produces only observed continuity creates liabilities when enforcement arrives. Infrastructure that produces receipted continuity creates assets.

Three-Horizon Value Framework

Near-term (2025 to 2026): Revenue Retention. First-mile infrastructure (community screening, navigation, documented referral pathways) keeps patients in local systems. Each patient retained represents revenue that stays local rather than leaking to urban competitors.

Medium-term (2027): Coverage Transition Navigation. With Medicaid work requirements enforced in January 2027, approximately 6 million beneficiaries will cycle on and off coverage. Coverage-agnostic infrastructure maintains patient relationships regardless of coverage status.

Long-term (2028 and beyond): Network Adequacy Compliance. When secret shopper enforcement begins (CMS-2439-F), established continuity infrastructure provides receipted proof of access. States and MCOs with documented pathways enter enforcement with assets; those without enter with public liabilities.

Primary Recommendation

States should require continuity ownership as a condition of RHTP funding, designating specific entities accountable for the patient journey with documentation standards that produce receipted, audit-survivable proof of care coordination.

Supporting Actions

1. **Designate continuity ownership in grant applications**. RHTP applicants should identify a specific entity accountable for the patient journey across acute, post-acute, and ambulatory settings. Documentation standards should follow CCBHC precedent (42 CFR § 438.208): tracked referrals, confirmed follow-ups, audit-survivable encounter records retained per CMS requirements (7 years minimum).

2. **Structure RHTP as infrastructure, not programs**. P.L. 119-21 Section 71401 permits 20% of allocations for infrastructure investment (Category J, CMS NOFO). Mobile

health assets and community access points produce returns beyond the funding period. Infrastructure that generates ongoing revenue outlasts program money.

3. **Align FQHC incentives toward partnership**. First-mile infrastructure should feed existing local providers, not compete with them. Payment models that share savings across the continuity pathway address the "wrong-pocket problem" that has stalled previous coordination efforts (Alami et al., Digital Health, 2023).

4. **Build documentation infrastructure for 2028 compliance**. Track encounters, referral completion, and follow-up confirmation from day one. This evidence base becomes network adequacy proof when secret shopper enforcement begins July 2028 (42 CFR § 422.116).

Why This, Why Now

CMS announced RHTP awards December 31, 2025. State implementation planning begins immediately. RHTP funding covers only 37% of projected rural Medicaid losses under OBBBA. States that treat it as program money will watch it run out. States that build infrastructure generating ongoing revenue will sustain returns beyond the funding period.

Starting FY2028, provider tax safe harbor reductions (6% to 3.5% by 2032) will further contract state funding capacity. Infrastructure that retains patients locally, generating revenue rather than consuming grants, becomes more valuable as fiscal pressure increases.

Decisions made in Q1 2026 will determine whether continuity infrastructure is embedded in state rural health strategy or treated as an afterthought. States and MCOs that build capacity now will negotiate from strength. Those that wait until 2027 will compete for scarce solutions at premium prices, while their network gaps become public failures in July 2028.

SOURCES

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- 42 CFR § 438.208 (Coordination and continuity of care).
- 42 CFR § 422.116 (Network adequacy, Medicare Advantage).
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