National Specialty Care Access Coalition

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Specialty Care Access Playbook

A Framework for Virtual Specialty Care Access in Rural and Underserved Communities

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The views expressed here are solely those of NSCAC.

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I. Executive Summary

THE PROBLEM

More than 60 million Americans living in rural areas, with many experiencing persistent specialty care shortages,[i] and absent strong policy action, those shortages will worsen dramatically. There are only 30 specialists per 100,000 people in rural communities, compared to 263 per 100,000 people in urban areas.[ii] Rural hospitals are closing at alarming rates, eliminating not just inpatient beds and critical outpatient services but the local infrastructure that makes specialty care coordination possible.[iii] The consequences are measurable and severe: rural maternal mortality is roughly twice the urban rate,[iv] rural stroke mortality has widened relative to urban areas over the past decade,[v] and rural children with complex conditions face access barriers that drive worse outcomes across nearly every pediatric subspecialty.[vi] These gaps are the cumulative result of decades of workforce maldistribution, payment models that disadvantage rural practice, and geographic barriers that make it prohibitively difficult for millions of Americans to access specialty care.

THE SOLUTION

Technology-enabled specialty care has emerged as an evidence-based option to address rural access gaps, particularly in time-sensitive clinical situations and specialist-scarce settings. Studies consistently show that when implemented within a clinically appropriate framework, technology-enabled specialty care delivers outcomes equivalent to in-person care while meaningfully expanding access for rural populations.[vii,viii] The virtual specialty care access network[1], which relies on an academic medical center (AMC) or large regional health system serving as an anchor for specialty care delivery across a network of rural clinical sites, has proven to be an effective vehicle for extending that care into underserved communities. The Medical University of South Carolina (MUSC) and the University of Mississippi Medical Center (UMMC) demonstrate that these models can be built, sustained, and scaled across entire states, but far more are needed across rural America before technology-enabled specialty care can meaningfully close the access gap at scale.[ix]

THE OPPORTUNITY

The Centers for Medicare and Medicaid Services (CMS) Rural Health Transformation Program (RHTP), a $50 billion, five-year federal investment with all 50 states receiving Year 1 awards averaging $200 million,[x] represents a significant federal investment in rural health infrastructure. Permanent policy reforms are needed to sustain RHTP-funded technology-enabled care models beyond the grant period, and extend those efforts to transform rural health.

[1] Also referred to as a "hub-and-spoke" model.

FUTURE VISION

NSCAC's Future State Vision for Rural Specialty Care Access

NSCAC envisions a future in which every patient, regardless of geography, has timely access to high-quality specialty care through a health system-anchored hub-and-spoke network that integrates technology-enabled and in-person care across the continuum.

Specialty care is continuous and coordinated with primary care, and providers and health systems are supported by aligned payment and policy structures that make delivering this model financially sustainable at scale. Central to this vision is the belief that technology-enabled specialty care should strengthen rural hospitals and support local providers, not replace them, leveraging technology including virtual care models, artificial intelligence (AI), and remote monitoring to expand specialist capacity and keep high-quality care as close to home as possible.

Achieving this vision requires working in genuine partnership with rural communities, by designing systems that reflect their transformation goals, priorities, and definitions of success rather than imposing solutions from the outside.

NSCAC

WHO WE ARE:

The National Specialty Care Access Coalition (NSCAC) is a coalition of **40+** health systems, integrated delivery networks, and AMCs formed to develop innovative solutions to improve rural health care access and outcomes. NSCAC also benefits from the support of early technology partners, including Sevaro, T-Mobile, AWS, and Samsung.[2]

This Playbook is NSCAC's practical, evidence-based guide to achieving federal and state policy reforms needed to close the rural specialty care gap. NSCAC members are also evaluating multiple network models, including virtual specialty care access networks, each with distinct strengths and tradeoffs. Future NSCAC work will identify the most effective models and the equitable funding, economic, and incentive structures needed to sustain them.

[2] NSCAC's technology partners did not author or review this Playbook.

FIVE FOUNDATIONAL POLICY ACTIONS:

NSCAC calls on federal and state policymakers, health systems, and payors to act on five interconnected fronts:

01 — Cross-Payor Payment & Coverage Alignment

The immediate threat of the 2027 Medicare telehealth cliff to rural specialty care investment makes this the highest priority category. Resolving this requires Congress to make these flexibilities permanent. It is also crucial that Medicare and state Medicaid agencies cover technology-enabled care modalities like eConsults, remote patient monitoring (RPM), and asynchronous care, creating a sustainable financial pathway for virtual specialty care access networks.

02 — Sustainable Financing on an FFS Chassis with a Roadmap to VBP

With Medicare and Medicaid fee-for-service (FFS) payment and coverage as the foundation, Medicare and state Medicaid agencies should work to stabilize reimbursement for core technology-enabled specialty care modalities that virtual specialty care access networks depend on for baseline revenue, while building a clear pathway toward value-based payment (VBP) structures over time. States should work with RHTP-funded programs to define post grant financial sustainability from the outset. Over time, Medicaid managed care organization (MCO) contracts, accountable care organization (ACO) participation, and the Medicare Advantage program should create pathways to develop the longitudinal, outcomes-driven payment environment that best supports coordinated specialty care.

03 — Cross-State Licensure Reform

Current multistate licensure requirements prevent specialists from serving patients across state lines. Key policy actions include targeted federal and state exceptions for defined cross-state specialty care circumstances. The long-term goal should be to improve licensure portability for clinicians in good standing, which would complement rather than replace state-based licensure oversight.

04 — Rural Digital Infrastructure Investment

Provider-side broadband gaps, the cost and complexity of integrating virtual care platforms into existing health IT systems, and patient-side device and connectivity barriers prevent technology-enabled specialty care from reaching the communities that need it most. Federal actors should prioritize rural health care facilities to receive broadband subsidies. RHTP funds should also be used to build virtual specialty care access network

digital infrastructure, with ongoing discussions with providers on how to achieve grant sustainability requirements.

05 — Administrative & Operational Optimization

Multistate enrollment burdens, inconsistent billing and supervision requirements, and complex coding rules impose costs that discourage virtual specialty care access network development and replication. Streamlining multistate Medicare provider and facility enrollment, aligning supervision rules with technology-enabled care realities, and standardizing coding requirements across payors would meaningfully reduce barriers to scale.

The Bottom Line

Closing the rural specialty care gap is within reach if virtual specialty care access networks, targeted funding, and complementary policy reforms are implemented together. Coordinated action is needed before the RHTP window closes and the 2027 telehealth cliff arrives. NSCAC is committed to the sustained advocacy needed to make the future state vision in this Playbook the standard of care for all rural Americans.

II. Intro: The Specialty Care Gap and NSCAC's Future Vision

Roughly one in five Americans live in a rural area experiencing persistent provider shortages[xi,xii,xiii]; in less than 15 years, the Health Resources and Services Administration (HRSA) projects that nonurban areas will face a 58 percent physician shortage, meaning rural communities will have access to fewer than half the specialists they need across nearly every clinical specialty. [xiv] These access gaps are reflected in rural health outcomes: preventable premature deaths linked to chronic lower respiratory disease, heart diseases, and stroke, are all higher in rural areas than urban ones.[xv]

For example, within obstetrics, evidence suggests that maternal mortality rates in intensive care units (ICU) are nearly two times higher in rural areas than urban areas.[xvi] The impact of provider shortages on rural America snowballs when combined with the financial instability of rural health systems: one third of all rural hospitals in the country are at immediate risk of closing due to financial strain.[xvii] The shortages most consequential for rural health outcomes, in behavioral health, neurology, obstetrics, and pediatrics, are examined in depth in the sections that follow.

This crisis did not emerge overnight; it reflects decades of workforce maldistribution, payment models that disadvantage rural practice, and geographic barriers that limit specialty access for more than 60 million Americans. The cumulative burden of these barriers leads patients to defer or forgo care altogether, a pattern that worsens health care outcomes for time-sensitive conditions, drives avoidable emergency utilization, and deepens the health disparities that rural communities already face disproportionately.[xviii,xix,xx] These problems have been building for decades, and addressing them requires a coalition with the scale, credibility, and sustained commitment to drive the policy and infrastructure change that rural specialty care access demands.

ABOUT THE NSCAC

The NSCAC is a coalition of 40+ health systems, integrated delivery networks, and AMCs working together to meet this challenge. NSCAC is health system-led: its agenda, priorities, and proposed policies are shaped by member organizations with direct operational experience building and sustaining technology-enabled specialty care programs. Using this Playbook as a starting point, the coalition is committed to serving as a unified, sustained voice for state and federal reforms to improve rural specialty access.

PURPOSE & OBJECTIVES

This Playbook offers health system leaders, state officials, and federal policymakers a practical, action-oriented roadmap of state and federal policy actions to expand durable, virtual specialty care access network delivery in rural and underserved communities. Drawing on the operational experience of NSCAC members, this Playbook makes the case

for specifically leveraging virtual specialty care access networks to sustainably deliver virtual specialty care and reshape rural health delivery. This Playbook aims to:

1. Articulate NSCAC's future state vision of integrated virtual specialty care access networks, developed in partnership between community providers and capable health systems and AMCs.
2. Highlight high-impact specialty areas where technology-enabled care adoption and expansion can most meaningfully close access disparities.
3. Describe five foundational policy actions to enable and sustain virtual specialty care access network delivery in alignment with NSCAC's vision.
4. Explore RHTP as a catalyst for the durable payment, infrastructure, and governance reforms required to sustain virtual specialty care access networks delivering technology-enabled rural specialty care beyond the five-year grant period.
5. Translate these policy actions into implementation considerations that identify opportunities for action across federal agencies, states, payors, health systems, and smaller community providers.

Achieving NSCAC's future state vision requires first understanding the depth of the rural specialty care gap.

III. The Specialty Care Gap

SCOPE OF UNMET NEED

More than **60 million** Americans live in rural areas[xxi] experiencing severe specialty provider shortages.[xxii] Absent strong policy action, these gaps will only become worse. In 2026, the supply of psychiatrists, obstetrics and gynecology physicians, and neurologists was far lower in rural areas than in urban ones, and the maldistribution spanned nearly every specialty.[xxiii] These shortfalls create meaningful challenges for patients living in underserved areas. For example, rural neurology patients are five times more likely to travel more than 100 miles to see their neurologist compared to urban residents.[xxiv]

Specialty provider shortages translate directly into worse health outcomes. Rural populations are diagnosed with cancer at more advanced stages, have lower five-year survival rates, and face a mortality gap relative to urban populations that tripled between 1999 and 2019.[xxv,xxvi,xxvii] In addition, research tracking rural counties over 23 years found that adding just one physician per county was associated with 1.4 fewer deaths per 100,000 older adults annually.[xxviii] These findings make clear that increasing timely access to providers in rural communities saves lives.

The financial fragility of rural health systems compounds the problem. Since 2014, more than 100 rural hospitals have closed, and over 300 are at immediate risk of closure due to negative operating margins.[xxix] These closures eliminate not just inpatient beds but the local infrastructure, including diagnostic equipment, ancillary services, and specialist relationships necessary to deliver specialized care in rural communities.

ROOT CAUSES

The rural specialty care gap reflects decades of converging structural forces:

- **Workforce Maldistribution**: The physician workforce pipeline, from medical school location and residency training sites to the lifestyle, professional, and financial incentives that shape where physicians ultimately practice, has consistently favored urban settings, producing persistent rural specialist shortages that market forces alone have been unable to correct.[xxx] Workforce shortages extend to other providers as well; nurse anesthetists, nurse practitioners, and advanced practice registered nurses (APRN) are more concentrated in urban areas versus rural ones.[xxxi] By 2028, there will be an estimated 24 percent shortage of registered nurses in rural areas, compared to just five percent in urban areas.[xxxii]

- **Payment Inadequacy**: FFS payment models compound this dynamic: rural care delivery depends on the same fixed infrastructure costs as urban care (e.g., staff, equipment, facilities, and administration); however, rural providers serve substantially lower patient volumes, producing reimbursement rates that frequently fail to cover the cost of service delivery.[xxxiii] VBP models could, in principle, better align incentives for rural specialty care, but rural markets have been slow to adopt them due to barriers including limited health IT infrastructure, insufficient upfront capital, and patient panels too small to make population-level risk financially viable.[xxxiv] The payor mix makes the underlying economics more challenging: Medicare covers a higher portion of hospital discharges in rural areas compared to urban areas (53 percent vs. 45 percent in 2023), while private payors (i.e., commercial plans) covered a smaller share (19 percent) of rural discharges compared to urban areas (24 percent).[xxxv] Since Medicare and other government payors reimburse at significantly lower rates than commercial plans, rural health systems are structurally disadvantaged in ways that make specialist recruitment and retention, and investment in specialty care infrastructure, economically difficult to sustain.

- **Geographic Isolation**: Geographic and transportation barriers add a third layer of structural disadvantage; rural patients travel more than twice as far as urban patients on average to reach appropriate specialty care, often requiring time off work, childcare arrangements, and out-of-pocket transportation costs that many rural households cannot easily absorb.[xxxvi] Patients may also have unreliable internet connectivity,[xxxvii] making it challenging to access specialty care services from their homes. For practices operating in isolated communities, low patient volume can make it difficult to financially sustain full-time specialists and on-site infrastructure.[xxxviii] Geographic isolation, combined with financial sustainability concerns, make rural practice less appealing to providers,[xxxix] further exacerbating these challenges.

IV. The Promise of Technology-Enabled Specialty Care

WHY TECHNOLOGY-ENABLED CARE WORKS.

The evidence base for virtual specialty care delivery has grown substantially, and for a defined set of time-sensitive clinical conditions and specialist-scarce domains, it is compelling. A 2024 systematic review of provider-to-provider telehealth in rural settings found that clinical outcomes were similar or better with telehealth-supported care compared to usual care for neonatal care, emergency care (e.g. telestroke services), and outpatient consultations across various specialties.[xl] Specialty-specific evidence reinforces this pattern. For example, a meta-analysis found tele-intensive care unit (i.e., TeleICU or T-ICU) coverage significantly reduced ICU mortality, hospital mortality, and ICU length of stay, which may be especially valuable for rural and critical access hospitals that lack on-site intensivists.[xli] Strong evidence also supports the effectiveness of technology-enabled care delivery in behavioral health,[xlii] telestroke,[xliii,xliv] and obstetrics[xlv], which are examined in depth later in this section. Across these domains, studies indicate that when implemented within a clinically appropriate framework, virtual specialty care delivers outcomes equivalent to in-person care while expanding access for rural populations.[xlvi]

THE CORE MODEL: VIRTUAL SPECIALTY CARE ACCESS NETWORKS.

NSCAC's vision relies on a virtual specialty care access network framework. Within this model, an AMC or large regional system brings specialist expertise, care coordination, and support for clinical governance across a network of rural and critical access hospital sites. Technology enables real-time and asynchronous technology-enabled care across several, connecting specialists to rural patients and providers regardless of distance. Beyond enabling communication across distance, technology can also serve as a workforce multiplier. AI-assisted triage and referral management, clinical decision support tools, and ambient documentation systems can expand the effective capacity of specialists and support other providers in managing more complex patients locally, reducing unnecessary transfers and keeping care closer to home.

Tele-mentoring models like Project ECHO, in which specialists conduct regular case-based learning sessions with local providers, build local clinical capacity over time, reducing dependence on referrals and strengthening rural providers' ability to manage complex patients in their own communities. The model also allows scarce specialist capacity to be aggregated across sites, which helps to better match limited specialist supply to current rural demand.[xlvii] The network's governance structures are co-designed with rural sites and reflect local community input. There is shared accountability for access, outcomes, and clear agreements around patient panels, referrals, and revenue retention that protects rural hospitals' financial viability and community relationships while also connecting specialists with rural patients to deliver quality care. Payment models are designed to support financial sustainability for all network participants over time.

Depending on a rural hospital's needs, they may collaborate with multiple health system specialists to best serve their patients, unconstrained by a single affiliated system's

provider list. For example, a rural hospital may partner with a primary regional health system for foundational services for tele-ICU and behavioral health consults, while simultaneously connecting with a children's hospital that can advise on a rare pediatric oncology case. Virtual specialty care access network delivery operates across a range of modalities, each serving distinct clinical and operational purposes. The right combination for any given program will depend on the clinical situation, patient population, available technology, and what the network can realistically sustain. The table below summarizes the key technology-enabled care modalities (in no particular order):

MODALITY	INTERACTION TYPE	MEDIUM(S)	SYNCHRONOUS OR ASYNCHRONOUS	PERIODIC OR LONGITUDINAL	INPATIENT OR OUTPATIENT SETTING
eConsults. Allows providers to obtain specialist guidance on diagnosis or treatment without referral.	Provider - Provider	Messaging	Asynchronous	Periodic	Outpatient
Synchronous specialty consults. Real-time specialist involvement in acute/complex cases.	Provider - Provider	Video	Synchronous	Periodic	Both
Asynchronous specialty care (store-and-forward). Specialist reviews transmitted clinical data and recommends treatment.	Provider - Patient	Messaging	Asynchronous	Periodic	Outpatient
RPM. Enables continuous chronic disease tracking and early intervention.	Provider - Patient	Continuous data transfer	Asynchronous	Longitudinal	Outpatient
Inpatient/Emergency department consult coverage. Specialist expertise for acute presentations to avoid transfer, shorten length of stay, and improve care quality	Provider- Provider	Video or audio	Synchronous	Periodic	Inpatient/ emergency department
Integrated longitudinal care pathways. Embedded specialist co-management in primary care.	Both	Video, audio, or messaging	Both	Longitudinal	Both



THE MODEL CAN BE REPLICATED

Several NSCAC member organizations have built and sustained these models at scale. The task ahead is to create the regulatory environment, financial support, and infrastructure to allow successful models to replicate across a variety of regions and health system types. Critically, that expansion must occur in partnership with rural providers and communities, who should have meaningful input into how these relationships are structured, what governance looks like, and how the benefits of these arrangements are shared. The goal is not to pull patients away from rural communities but to strengthen rural hospitals' ability to serve them, keeping high-acuity care local whenever clinically appropriate and building the clinical and financial capacity of rural sites over time.

Well-structured virtual specialty care access network agreements may include explicit provisions for revenue retention at the community provider level, ensuring that rural hospitals share in the financial benefits of the network rather than bearing the costs of participation without commensurate return.

The case studies below illustrate what deliberate, sustainability-focused virtual specialty care access network design looks like in practice at HRSA's two designated National Telehealth Centers of Excellence:

MUSC:

In 2005, MUSC launched its first telehealth program for maternal-fetal medicine services for high-risk pregnancies in underserved communities. Today, MUSC operates as the health system partner for approximately 350 sites across South Carolina, including hospitals, community clinics, schools, and alternative care settings such as nursing facilities and patient homes, with 78 percent of those sites located in completely or partially medically underserved regions. The network now delivers over 100 unique telehealth services spanning multiple specialty fields.

For most of the 40 hospitals that MUSC supports, it offers a suite of services that includes telestroke, neurology, tele-ICU, virtual nursing, tele-hospitalist, palliative care, psychiatry and behavioral health, and infectious disease, among others.

In 2008, MUSC launched one of the nation's first telestroke networks, connecting rural emergency departments to MUSC neurologists for real-time stroke evaluation and treatment guidance, a model that has been associated with faster immediate treatment and increased community-based care, allowing patients to receive time-critical care at their local hospital rather than being transferred to a distant urban stroke center. The program has demonstrated measurable improvements in door-to-needle times and stroke center certification at local community hospitals, with the highest impact observed among smaller and rural hospitals as the network expanded.

MUSC's sustainability approach centers on building the evidence base needed to support Medicaid and commercial payor reimbursement advocacy, converting clinical outcomes data into durable payment arrangements.

UMMC:

UMMC is the only AMC in Mississippi and delivers over 35 telehealth specialty services to more than 200 non-affiliated sites statewide, serving over half of Mississippi's 82 counties. Programs include TeleEmergency (partnering with 20+ hospital emergency departments), behavioral health, RPM for chronic disease management, and school-based care.

UMMC's approach to sustainability is a model for the field: in 2014, UMMC advocated successfully for one of the earliest comprehensive state telehealth parity laws in the country, requiring Medicaid, the state employee plan, and private insurers to reimburse telehealth services on the same basis as in-person care, with statutorily defined RPM reimbursement rates.

UMMC has also pursued ongoing multi-sector partnerships, including collaborations with state agencies, health information technology (IT) vendors, and telecommunications providers, to build diversified infrastructure and financing that does not depend on any single funding source.

WHAT MAKES THESE MODELS WORK

Both MUSC and UMMC illustrate the characteristics that distinguish sustainable virtual specialty care access networks from programs that are overly reliant on one-time grant funding. The most durable programs share a consistent set of attributes, and understanding them is essential for any health system or state looking to replicate these models:

1. Committed specialty care institution with leadership support, existing specialty depth, and operational capacity to collaborate with local rural health leaders to build complex multi-site networks and support bi-directional learning
2. Medicaid payment alignment and state agency support that provides a reliable revenue stream independent of grants or temporary flexibilities
3. State-level coordination across Medicaid, legislative, and executive leadership at every site.
4. Clear governance defining accountability for spoke-site access over time.
5. Diversified financing strategy that actively pursues value-based arrangements, while balancing financial sustainability and substantial reimbursement gaps.

HIGH-IMPACT SPECIALTY AREAS

Four specialty areas stand out as especially well-suited for technology-enabled care delivery in rural settings. Across each, rural-urban disparities translate into measurable population-level harm, and the evidence for technology-enabled care's ability to close those gaps is compelling.

Behavioral Health and Psychiatry is an acute and emblematic specialty care shortage in rural America. Two-thirds of Mental Health Professional Shortage Areas are located in rural communities.[xlviii] As of 2021, 45 percent of rural counties have no psychologist.[xlix] These access gaps have clear consequences; in 2022, rural residents had 1.5 times the rate of ED visits for nonfatal self-harm.[l] Telehealth has demonstrated strong clinical effectiveness for mental health treatment, with evidence supporting telepsychiatry across a range of

conditions including depression, anxiety, and PTSD.[li,lii] The expansion of audio-only behavioral health coverage under pandemic-era flexibilities has been particularly valuable for rural populations, given more limited broadband access.[liii] At least 15 states are pursuing behavioral health-focused initiatives through RHTP,[liv] with states like Arizona leveraging RHTP funds to expand tele-behavioral health capacity for rural Arizonans.[lv]

Neurology and Stroke represents another field where technology-enabled health services can help bridge the rural specialty care access gap, with rural stroke mortality widening rather than narrowing relative to urban areas over the past decade.[lvi] Stroke is a time-critical emergency in which every minute counts.

Patients presenting to rural EDs have historically been nearly ten times less likely to receive thrombolytic therapy as those presenting to urban primary stroke centers,[lvii] with lack of on-site neurologist coverage identified as a key driver of the gap.[lviii] Rural hospitals participating in telestroke networks have been able to substantially close that disparity, administering thrombolytics on-site rather than transferring patients for delayed evaluation.[lix]

Teleneurology Case Study: Ballad Health

In 2024, Ballad Health, which serves a largely rural region of Appalachia, replaced four separate teleneurology vendors across six hospitals with a single standardized program.

The unified model achieved a median call-to-video time of 24 seconds, retained more than 1,000 inpatient stays at community and rural hospitals through telerounding, and avoided more than 3,000 patient transfers, saving an estimated $8 million.

Telestroke implementation is also associated with faster onset-to-treatment time of 28 minutes; one study found that it doubles the likelihood of successful treatment within the three-hour window studied.[lx] States are now investing RHTP funds in telestroke models. For example, Florida has allocated $10 million in RHTP funding to build telestroke networks to enable real-time neurologist video consults.[lxi]

The value of telestroke extends beyond thrombolysis. Endovascular thrombectomy can benefit select patients with large-vessel occlusion (LVO) up to 24 hours after onset, yet access to it remains one of the largest rural-urban gaps in stroke care.[lxii] Telestroke networks help underserved hospitals identify LVO strokes quickly and decide in real time whether to treat and transfer a patient or treat locally.[lxiii,lxiv] These networks can also complement emerging models such as mobile stroke units.[lxv]

Pediatric Subspecialties present a distinct policy concern. Pediatric subspecialties tend to be highly concentrated in urban AMCs, driven by financial disincentives, declining medical student interest in pediatrics, and the geographic concentration of training programs.[lxvi] This creates disproportionate barriers to pediatric care across nearly every subspecialty in rural areas. Long travel distances are particularly burdensome for families of children with chronic or complex conditions; rural children with medically complex conditions often travel to three or more counties to attend ambulatory specialty care visits.[lxvii] Further, pediatric inpatient units declined nearly 20 percent per year between 2008 and 2018, with rural areas experiencing the steepest losses.[lxviii]

Telepediatrics programs like the Rural Texas Pediatric Tele-Connectivity Resource Program and Pediatric Access to Telemental Health Services have demonstrated the feasibility of delivering pediatric services virtually, but Medicaid coverage variability across states creates significant inconsistency in what services can be sustainably reimbursed. Medicaid is especially impactful in pediatrics, as 40 percent of rural children were enrolled in the program in 2025.[lxix] California is using RHTP funding to launch a new virtual specialty care access network model offering pediatric psychiatry eConsults to rural primary care providers.[lxx]

Pediatrics Case Study: Dartmouth TeleICN

As maternity services contract in rural America, Dartmouth Health's TeleICN program has connected rural bedside teams with board-certified neonatologists 24/7 via secure mobile audio-video, providing guidance during resuscitations, respiratory distress, unexpected deliveries, and transfer decisions.

The program reports that in more than one-third of TeleICN consultations, newborns were able to stay at their birth hospital rather than be transferred, and clinician utilization grew 48 percent from 2024 to 2025 as rural teams engaged neonatal expertise earlier in emergencies.

TeleICN's core architecture of specialist, patient site, technology-enabled consultation, and pre-launch onsite training is now being adapted to also support high-risk pregnancy care.

Women's Health needs in rural communities extend well beyond maternity care to gynecology, contraception, and menopause care, but access to women's health specialists is scarce: in 2021-2022, 79 percent of rural counties had no OB-GYN, and 58 percent of rural women lived in a county without one.[lxxi] Obstetrics has been disproportionately impacted by the financial sustainability challenges of rural hospitals. In 2022, 52 percent of rural hospitals no longer offered obstetric care.[lxxii] This trend has continued and broadened. As of 2024, more than a third of all U.S. counties qualify as maternity care deserts, meaning there is not a single hospital or birth center offering obstetric care and no obstetric clinicians.[lxxiii] Birthing people living in rural maternity care deserts travel a mean distance of 33 miles to reach the nearest obstetric facility.[lxxiv] These deserts may contribute to the rural maternal mortality rate, which is roughly twice the urban rate.[lxxv] Telehealth holds particular promise for closing maternal health gaps, especially within maternal-fetal medicine.

A systematic literature review revealed that remote monitoring and patient-generated data reduced the need for in-person visits in high-risk obstetric care while improving maternal and fetal outcomes. The same review found telehealth effective for continuation of oral and injectable contraception, underscoring its value beyond maternity care.[lxxvi] Subsequent evaluations confirm that telehealth visits for maternal-fetal medicine specifically produce comparable maternal and fetal outcomes to in-person visits, supporting telehealth as valuable alternative to facility-based care.[lxxvii,lxxviii] Four states, including Kentucky, Oklahoma, Pennsylvania, and South Dakota, are planning to deploy virtual specialty care access network models to deliver obstetric care using RHTP funding.[lxxix]

CORE DESIGN PRINCIPLES

In designing the virtual specialty care access network model that can meet present and future access challenges, NSCAC supports the following design principles:

Person-Centered Design

The patient is treated as a whole person, not a condition. Care delivery models are designed with the end user in mind, understanding that every person has their own goals, circumstances, and preferences, and patients are active participants in decisions about their own care. In practice, this means meeting patients where they are, with use of virtual tools dictated by their needs, not the availability of new digital tools. Someone with Type 2 diabetes who struggles to regularly check his A1c, for example, may benefit more from remote glucose monitoring that alerts his care team automatically than from scheduled in-person visits he cannot easily attend.

Continuous Access

Following an episodic event where telehealth services were used (e.g. Telestroke services), patients are able to build an ongoing relationship with their specialist and have tools to connect with them as needed, such as through patient portal messaging, scheduled virtual follow-ups, or remote monitoring alerts. For a patient managing heart failure, this might mean the care team receives real-time data from a home monitoring device and reaches out proactively to the patient and any relevant primary care providers when readings suggest a concerning trend, rather than waiting for the patient to present in the emergency department.

Full Network Care

Care is co-managed between the health system supplying specialty care and community-based partners, leveraging existing networks and relationships to avoid fragmented, disconnected referral pathways. Institutions providing specialty care and their partner sites share accountability for specialty access across defined geographies. Community partners are active collaborators in governance and service design. Strong virtual specialty care access networks reduce patient burden by capitalizing on the strength of each piece of the network, such as rural primary care providers, critical access hospitals, and FQHCs. These networks are supported by shared protocols, bidirectional learning, and clear escalation pathways. A rural patient with a suspected neurological condition, for example, should be

able to access a telestroke evaluation at their local critical access hospital rather than being transferred hours away for initial evaluation.

Integrated Virtual & In-Person Care

Technology is an enabler, not a replacement, for the physician-patient relationship. Virtual and in-person care are matched to clinical need and patient circumstance, and effective networks deploy multiple virtual modalities depending on what the situation requires. For a rural oncology patient, this might mean an initial in-person evaluation at a regional clinic, followed by virtual consultations for treatment planning and symptom management, with in-person visits reserved for procedures that genuinely require them.

Sustained Infrastructure

The technology, workforce, and governance structures that allow the virtual specialty care access networks to function are treated as investments with ongoing commitment and funding. Successful networks like MUSC and UMMC have built sustainably by drawing on multiple state and federal funding sources and actively pursuing payment alignment rather than depending on any single grant. Other hospitals have incorporated novel solutions like subscription models to ensure sustained infrastructure funding. Infrastructure investment also extends beyond hospital walls to ensure that patients have the devices, connectivity, and digital literacy support needed to participate in technology-enabled care.

Payment Aligned with Longitudinal, Outcome-Driven Care

The system supports FFS stabilization in the near term, with a clear pathway toward VBP structures that recognize and reward coordinated, continuous specialty care embedded in primary care. This means ensuring FFS adequately covers all core technology-enabled care modalities as a foundation, while actively building towards value-based arrangements (e.g., Medicaid MCO contracts, ACO participation, Medicare Advantage) that reward outcomes and quality of care rather than visit volume. Achievement of this principle will require careful consideration of how to adequately reimburse specialty providers who may be treating patients in rural communities that are not part of responsible population.

BARRIERS TO HEALTH SYSTEM ADOPTION

While nothing in current law prevents rural health systems from establishing telehealth capabilities, most are caught in a structural bind that makes building and sustaining technology-enabled specialty care programs very challenging, even when clinical need and community interest is high. A third of all rural hospitals operate on negative margins,[lxxx] often leaving little capacity for the capital investments in technology and infrastructure that technology-enabled specialty care programs require. Insufficient margins on services delivered to patients with private insurance,[lxxxi] combined with greater dependence on Medicare and Medicaid reimbursement,[lxxxii] makes rural health systems especially vulnerable to payment policy uncertainty; when telehealth flexibilities are temporary, rural systems cannot plan multi-year investments with confidence. The result is cautious, incremental adoption that is structurally incapable of producing the system-level transformation rural specialty care access requires.

Limited IT and administrative capacity compound this challenge. Rural hospitals adopt telehealth capabilities at significantly lower rates than their urban counterparts.[lxxxiii] Even when funding is available, rural hospitals often lack the technical workforce, clinical informatics infrastructure, and implementation expertise to stand up and sustain telehealth programs.[lxxxiv] The administrative burden of operating across multiple payors, states, and regulatory environments with inconsistent billing requirements and enrollment processes can further strain the limited management capacity of rural health systems, hampering program development.

SEIZING THE MOMENT

The rural specialty care gap is structural, persistent, and widening, and it will not close through incremental telehealth adoption or time-limited grant programs alone. Closing it requires durable infrastructure, aligned payment policy, and virtual specialty care access networks with appropriately shared accountability for specialty access.

The current moment offers a genuine opportunity to build that infrastructure, and coalitions like NSCAC exist precisely to accelerate it, connecting health systems across the country to share what works and advocate for the policy environment that allows it to scale. Despite ongoing pressure on state Medicaid budgets, the CMS RHTP represents the largest federal investment opportunity for rural health in decades: $50 billion over five years, with all 50 states receiving Year 1 awards averaging $200 million annually.[lxxxv]

RHTP is a catalyst, but it is not a long-term solution. Its five-year horizon and statutory caps on direct provider payments mean that grant funding alone cannot produce the lasting change rural communities need. The programs that survive will be the ones built on solid payment policy, licensure flexibility, and durable operational infrastructure, which is exactly what the five policy actions that follow are designed to support.

V. What Must Change: Five Foundational Policy Actions

Five interconnected structural barriers have prevented technology-enabled specialty care from scaling to meet rural need. Each must be addressed as part of a coherent policy strategy to achieve NSCAC's vision for the future. For each barrier, this section describes the problem, the recommended federal and state actions, and the measures of success for achieving each policy action. Beyond these policy-specific measures, NSCAC seeks to improve three cross-cutting outcomes to assess whether the policy changes are translating into meaningful improvements for rural patients:

- Improvement in rural hospitals' ability to retain patients in the community through virtual specialty consultation;
- Improvement in referral completion rates for rural patients receiving specialist guidance through virtual specialty consultation programs; and,
- Improvement in rural hospital economics as they enhance their ability to treat patients with more complex needs locally.

These metrics reflect whether the policy environment is enabling use of technology-enabled specialty care models to deliver meaningful results for rural patients and providers.

Policy Action 1 — Cross-Payor Payment and Coverage Alignment

BARRIER:

Fragmented and uncertain payment policy across Medicare, Medicaid, and commercial payors is the most significant barrier to sustainable rural specialty care. Without a reliable coverage and payment environment, health systems cannot make the long-term infrastructure investments needed to build and sustain durable virtual specialty care access network programs. Medicare telehealth flexibilities, which were expanded significantly during the COVID-19 public health emergency, have been extended only through December 31, 2027. The recurring cycle of short-term extensions has created a persistent investment cliff: rural health providers cannot plan multiyear infrastructure commitments when the payment environment may revert before those investments achieve financial sustainability.

Medicaid presents a distinct but equally significant barrier: coverage and payment parity for key modalities like eConsults, RPM, and asynchronous care varies dramatically across states, making it impossible for virtual specialty care access network systems operating in multiple states to build standardized care delivery models.

Billing and coding gaps compound the problem, and commercial payor fragmentation adds a further layer of complexity. For example, many virtual specialty care services lack dedicated CPT codes, are subject to place-of-service coding rules that determine whether services are reimbursed at facility or non-facility rates, and face inconsistent payor adoption of new codes that creates compliance risk and administrative overhead. Provider-to-provider phone consultations illustrate this gap. These consults often involve substantive clinical work, such as reviewing medical records or imaging and documenting recommendations, yet are often not documented and not reimbursed.

CONNECTION TO NSCAC'S VISION:

Payment alignment is the financial precondition for NSCAC's vision of a sustainable, health system-anchored specialty care network. Without it, virtual specialty care access networks remain dependent on transient flexibilities and grant cycles rather than the durable revenue environment that lasting specialty care access requires.

FEDERAL ACTIONS	STATE ACTIONS
• Congress must make current Medicare telehealth flexibilities permanent beyond their December 31, 2027 expiration. • Medicare should ensure adequate coverage for all relevant technology-enabled care modalities, including eConsults, RPM, asynchronous care, and store-and-forward services, currently lacking dedicated coverage. • Medicare should address billing and coding gaps and discrepancies for technology-enabled specialty services, including adding new CPT codes for virtual services without dedicated codes and place-of-service clarifications (e.g. provider-to-provider phone consultations that involve substantive clinical work) • CMS should establish federal minimum Medicaid standards for coverage of all relevant modalities to end the state-by-state patchwork.	**State Medicaid agencies should:** Ensure coverage of all relevant technology-enabled care modalities in all 50 states, with video visit payment parity with in-person care and appropriate payment rates for each modality; include coverage standards as part of network adequacy requirements in managed care contracts. Explore enhanced reimbursement for high-value technology-enabled specialty services with strong evidence bases, similar to New York Medicaid's enhanced eConsult reimbursement rates, with additional enhancements for services reaching patients in rural and remote areas. Pursue coverage and payment alignment with Medicare and commercial plans to reduce fragmentation.

Measures of Success:

- Medicare telehealth flexibilities were made permanent before December 31, 2027 expiration.
- 50 states achieve Medicaid payment parity for core technology-enabled specialty modalities by 2030.
- Documented reduction in cross-payor coverage variation for virtual specialty care access network programs.
- Documented increase in the number of virtual specialty care access networks
- Programs reporting stable revenue from Medicaid and Medicare reimbursement independent of grant funding.

Policy Action 2 — Sustainable Financing to Move from an FFS Chassis to VBP

BARRIER:

Rural specialty care programs cannot survive on grant funding alone. Historically, these programs have relied on a patchwork of time-limited funding sources (e.g., HRSA rural health grants, Department of Agriculture (USDA) telehealth grants, state innovation awards, and philanthropic support) that create episodic programs rather than durable infrastructure. When funding ends, programs that have not established a sustainable revenue model often collapse, leaving communities without the specialty access they had come to rely on.

FFS payment structures and fragmented payor mixes make it difficult for rural hospitals to sustain longitudinal, infrastructure intensive specialty care models. VBP arrangements could better align incentives with coordinated specialty care, but these remain nascent in rural markets, which often lack the electronic health record and analytics capacity, upfront capital, and patient panel size that population-level risk requires. RHTP may stabilize some providers in the short term, but its five-year horizon and statutory caps on direct provider payments risk perpetuating the grant-dependent cycle absent deliberate sustainability planning from the outset.

CONNECTION TO NSCAC'S VISION:

With adequate FFS payment as the foundation, NSCAC supports building toward value-based arrangements that make rural specialty care financially sustainable at scale. The first step is ensuring FFS rates are sufficient to cover the fixed costs of maintaining technology-enabled specialty care infrastructure, even at the lower patient volumes typical of rural markets. Without that baseline, rural providers cannot afford to build or sustain the programs needed to participate in more advanced payment models. Over time, NSCAC envisions a transition toward value-based arrangements structured with rural realities in mind: upside-only shared savings models and condition-specific bundles through Medicaid MCO contracts and ACOs that reward access and outcomes without penalizing rural providers for the panel-size limitations and infrastructure constraints that are inherent to their markets.

FEDERAL ACTIONS	STATE ACTIONS
Medicare and state Medicaid agencies should stabilize the FFS foundation by ensuring payment adequacy for core telehealth specialty modalities that virtual specialty care access networks depend on for baseline revenue. A reliable FFS floor is the prerequisite for any value-based transition (see above for specific payment-related policy actions).	
• CMS should issue RHTP implementation guidance requiring states to incorporate sustainability planning requirements into subaward terms. • Centers for Medicare and Medicaid Innovation (CMMI) should advance pathways for rural health systems to participate in ACOs and total cost of care programs in ways that explicitly reward specialty access expansion (e.g. providing additional upfront investment for necessary infrastructure and separate ACO tracks for rural and safety net providers that can also provide specialized technical assistance). • CMS should also promote innovative use of RHTP funding that supports rural provider VBP alignment, e.g. Kansas's "shadow" VBP program to help ease providers into the Medicaid Shared Savings Program or the ACO LEAD model.[lxxxvi] • CMS should structure RHTP implementation to explicitly sequence toward VBP readiness, using program years one through three to stabilize FFS reimbursement and build the operational infrastructure and evidence base needed for CMMI to test a dedicated hub-and-spoke specialty care VBP model by 2029.	• State Medicaid agencies should require MCOs to include virtual specialty care access networks as in-network providers and align coverage and payment with state FFS standards, with an expectation that MCO contracts evolve over time toward value-based arrangements that reward longitudinal specialty access and population-level care rather than discrete visit volume. • State agencies distributing RHTP funds should work proactively with funded providers to define what financial sustainability entails for each funded specialty care investment, including realistic revenue diversification strategies.

Measures of Success:

- Majority of RHTP-funded specialty care programs have worked with their state to define a post grant financial sustainability approach, including diversified revenue strategies, by Year 2
- CMS issues RHTP implementation guidance explicitly requiring states to incorporate post grant sustainability planning into subaward terms by end of Year 1
- State Medicaid agencies in 40+ states require MCOs to include virtual specialty care access networks as in-network providers by 2028
- CMMI launches a dedicated technology-enabled specialty care VBP model by 2029, with active participation in 10+ states by 2032

Policy Action 3 — Cross-State Licensure Reform

THE BARRIER:

Technology-enabled specialty care often requires providers to practice across state lines, particularly in rural border communities and within virtual specialty care access networks. Under current law, providers must hold an active license in every state where they practice and where the patient is located at the time of care; this requirement imposes administrative burden and cost and inhibits health systems from building the regional, multistate networks that specialty access requires.[lxxxvii] The Interstate Medical Licensure Compact (IMLC) has expanded participation across 38 states and created a streamlined pathway to multistate licensure, unlike the full reciprocity provided by nursing and other clinician compacts.[lxxxviii,lxxxix] Many states have passed legislation implementing narrow exceptions to in-state licensure for specific use cases (e.g. continuity of care, emergency consultation, follow-up visits);[xc] but, these exceptions are inconsistent across states.

Fragmented scope-of-practice and supervision rules for advanced practice providers (APPs) further compound this challenge. For example, the same APRN delivering the same telehealth service can practice independently in one state but require a physician collaborative agreement for a patient across the state line.[xci,xcii]

CONNECTION WITH NSCAC'S VISION:

Licensure reform allows the virtual specialty care access network model to expand into multistate regional networks that specialty care access requires. Without it, even well-funded programs are artificially constrained by state lines and are unable to provide the cross-state services that may relieve existing clinician supply issues.[xciii]

FEDERAL ACTIONS	STATE ACTIONS
Congress should: • Explore federal opportunities to improve licensure portability for clinicians in good standing, which would complement rather than replace state-based licensure oversight (e.g., specialists participating in federally recognized rural virtual specialty care access networks that cross state lines). **CMS should:** • Align federal minimum standards for Medicare and Medicaid provider enrollment requirements with any federal licensure pathway so providers authorized to practice across state lines are not hindered by payer enrollment requirements in each state. **The Department of Health and Human Services should:** • Use its existing administrative authority to advance licensure portability, including expanding HRSA's Licensure Portability Grant Program to support virtual specialty care access network participants.	**States should:** • Adopt targeted exceptions to in-state licensure requirements for rural areas to support specialty care access network models, particularly for acute/emergency situations where speed of consultation is important. • Create special-purpose telehealth licenses that allow out-of-state providers to obtain expedited authorization to practice within a defined scope. • Prioritize expanding participation in the Interstate Medical Licensure Compact (IMLC) and advancing reciprocity pathways for APPs not currently covered, including through the APRN Compact and Physician Assistant Licensure Compact.

Measures of Success:

- Measurable reduction in time, cost, and number of separate credentials required for multistate specialist licensure
- Documented increase in cross-state specialty care delivery
- Federal expedited pathway enacted or advancing in legislature by 2030
- Majority of states participating in IMLC and at least one APP compact

Policy Action 4 — Rural Digital Infrastructure Investment

BARRIER:

Technology-enabled specialty care requires digital infrastructure that many rural communities still lack, on both the patient and provider side. On the provider side, rural hospitals and clinics frequently lack the broadband connectivity, clinical informatics systems, and technical workforce needed to implement and sustain telehealth programs.[xciv] Rural hospitals adopt telehealth at significantly lower rates than urban hospitals across virtually every measure of telehealth capability, with constrained IT budgets, limited cybersecurity capacity, and reliance on outside HIE infrastructure documented as recurring barriers.[xcv] Only 14 percent of rural hospitals have fully implemented telehealth programs; limited broadband access is the most commonly cited barrier.[xcvi]

Connectivity is only one layer of the challenge. Integrating virtual care platforms into existing rural health IT ecosystems is costly and complex, and only 36 percent of rural hospitals were routinely interoperable across all four domains of electronic data exchange in 2023, compared to 47 percent of urban hospitals.[xcvii] Rural hospitals also lag in the advanced analytics capabilities that support proactive care; in 2024, 56 percent of rural hospitals used predictive AI, compared to 81 percent of urban hospitals.[xcviii]

On the patient side, as of January 2024, 27 percent of rural Americans lack access to high-speed fixed broadband, compared to roughly two percent of urban residents; rural residents also tend to be disproportionately older and less digitally connected, creating significant device access and digital literacy barriers.[xcix, c]

CONNECTION TO NSCAC'S VISION:

Digital infrastructure is foundational to NSCAC's vision. A health system-anchored virtual care network cannot function without reliable connectivity, interoperable systems, capable hardware, and resources to support patients in using virtual tools.

FEDERAL ACTIONS	STATE ACTIONS
CMS should: • Prioritize health care facilities, including rural hospitals and critical access hospitals, as anchor institutions for federal broadband subsidies. • Sustain coordination between RHTP and federal broadband investments made by the Federal Communications Commission, USDA, and National Telecommunications and Information Administration initiatives through the full five-year program period and beyond.	**States should:** • Utilize RHTP Year 1 and Year 2 funding to build and strengthen the provider-side virtual infrastructure needed to support virtual specialty care access network delivery, with explicit post grant sustainability requirements built into subaward terms. • Conduct connectivity readiness assessments at spoke sites prior to program launch. • Invest in IT workforce development and technical assistance for rural health systems implementing new telehealth systems. • Support site-to-site virtual care models that enable small clinics, not just hospitals, to serve as local access points for virtual specialty care, extending reach to patients who lack reliable home broadband. • Invest in HIE connectivity and interoperability infrastructure, including shared referral management platforms and FHIR-enabled data exchange, to support seamless care coordination between partner sites, along with the data analytics capacity needed for proactive, population-level care.

Measures of Success:

- RHTP-funded programs demonstrate connectivity readiness at spoke sites.
- Measurable reduction in technology access barriers for rural patients.
- Documented coordination between RHTP and federal broadband program awards in the majority of states.

Policy Action 5 — Administrative and Operational Optimization

BARRIER:

Beyond the structural barriers of licensure and payment, health systems building rural specialty care programs encounter administrative requirements that add cost, complexity, and delay without improving clinical outcomes. Multistate provider and facility enrollment becomes substantially more burdensome for virtual specialty care access network systems operating across multiple states and payor types; providers must enroll separately with each state Medicaid program, complete distinct commercial credentialing across each plan and state market and navigate state-by-state Medicaid telehealth coverage rules that vary in covered modalities, eligible originating sites, consent requirements, and modifier conventions. For example, a single specialist operating in five states must report each practice location in the Medicare Provider Enrollment, Chain, and Ownership System, enroll in each state's Medicaid program, and undergo a separate medical staff credential review at each participating spoke, even if the spoke relies on the central health system's primary credentialing. Even for hubs with significant administrative capacity that use more streamlined credentialing methods like credentialing by proxy, the average timeline would be 36 days for each new spoke partner; small rural hospitals often lack the administrative bandwidth to complete their side of the credentialing process at all.

While CMS made virtual direct supervision permanent for most Medicare Part B services beginning January 1, 2026, Medicaid programs and commercial payors maintain their own supervision rules, creating ongoing compliance work for programs billing across multiple payors. Coding and documentation standards for technology-enabled specialty care are similarly inconsistent and, in some cases, actively penalize the care modalities (e.g., asynchronous consultation, audio-only visits, RPM) that are most appropriate for rural populations. These administrative idiosyncrasies stack up quickly, discouraging health systems from building the scale necessary to achieve operational and financial sustainability.

CONNECTION TO NSCAC'S VISION:

Administrative simplification allows virtual specialty care access networks to be operationally replicable beyond individual programs. Without it, each new program must navigate the full complexity from scratch, preventing the standardization that scale requires.

FEDERAL ACTIONS	STATE ACTIONS
• CMS should streamline multistate Medicare provider and facility enrollment for virtual specialty care access network programs, including reciprocal recognition of credentialing decisions for participating providers. • CMS should align supervision and incident to billing rules with the realities of virtual specialty care delivery and standardize coding and documentation requirements across Medicare and Medicaid. • CMS should clarify which telehealth service costs incurred by critical access hospitals (e.g., per-consult telestroke fees, per-bed tele-ICU subscription costs) may be included in their Medicare cost reports.	• State Medicaid agencies should align Medicaid coding, documentation, and supervision requirements for technology-enabled specialty services with Medicare and align Medicaid managed care contract terms for telehealth specialty services to reduce operational variability across MCO partners. • States should pursue reciprocal recognition of credentialing decisions for providers participating in multistate networks.

Measures of Success:

- Measurable reduction in time-to-enrollment and administrative cost for virtual specialty care access networks.
- Reduction in payor-specific billing variation for core technology-enabled specialty modalities.
- Federal action taken to streamline multistate Medicare enrollment for hub-and-spoke programs, with documented reduction in average time-to-enrollment.

VI. Turning Policy into Action: Implementation Considerations

Section V defines the key policy actions that NSCAC believes will drive change. Achieving them requires specific federal, state, and private actors to take deliberate, coordinated steps to translate policy into practice. The following table identifies the core mandate and role of five key stakeholder groups whose decisions will determine whether the policy changes called for in this Playbook are enacted, implemented, and sustained.

ACTOR	CORE MANDATE	HOW THEY ADVANCE THE POLICY ACTIONS
Federal Government	Establish a permanent regulatory and payment foundation that health systems, states, and payers need to build durable virtual specialty care access network programs.	Congress must act to make Medicare telehealth permanence a reality. CMS must use RHTP implementation authority to drive state Medicaid alignment and sustainability planning. CMMI must design the VBP pathways that make virtual specialty care access network programs financially durable beyond the grant period.
States	Deploy RHTP as a catalyst for sustainable, long-term reform rather than a limited five-year program.	States hold the most consequential implementation decisions: Medicaid payment alignment, licensure reform, and infrastructure investment. States that treat RHTP as the beginning of a permanent policy shift will produce programs that outlast the grant period; those that treat it as a funding opportunity alone will not.
Payors	Reduce the coverage fragmentation that makes multi-payor virtual specialty care access network operations financially unsustainable.	Payors must align coverage policies, simplify prior authorization, and move toward value-based arrangements that reward longitudinal specialty access, replacing the patchwork of inconsistent benefit designs with a stable financial environment that virtual specialty care access network systems can plan around.

ACTOR	CORE MANDATE	HOW THEY ADVANCE THE POLICY ACTIONS
Major Health Systems	Assume shared accountability for specialty access, rather than just offering telehealth services. Develop collaborative partnerships with rural providers that help them most effectively leverage available funding to establish specialty care access that is valuable to their community.	Major health systems are the operational engine of NSCAC's vision. Their investment in networks, governance, and payor contracting, as well as their sustained advocacy for policy changes that will make replication possible, ultimately determines how far and how fast the model scales. Partnership agreements between rural hospitals and tertiary/urban partners should explicitly promote investment and improved financial status of rural hospitals.
Rural-Based Providers and Clinics	Integrate technology-enabled specialty care into standard workflows and ensure rural realities shape network design. Assess and select health system partners that meet community needs and are best able to support and strengthen existing rural capabilities.	Rural providers are the access point for patients and the source of the operational knowledge that makes virtual specialty care access network programs work in practice. Their active participation in network co-design and policy advocacy ensures that solutions reflect the constraints and needs of rural care delivery. Rural providers should advocate for partnership agreements that prioritize the financial health and long-term sustainability of their institutions.

VII. Conclusion: The Path Forward

The rural specialty care gap is closeable, and for the first time in a long time, the resources and political conditions needed to close it are aligned. RHTP has directed meaningful funding into rural health transformation, and there is genuine bipartisan support to build on it. The evidence for technology-enabled specialty care is solid, and health systems across the country, including several in this coalition, have shown it can be done at scale.

What stands between the current moment and lasting change is targeted policy reform. Cross-state licensure rules that prevent specialists from reaching rural patients. Medicare telehealth flexibilities that expire in 2027 without Congressional action. Medicaid coverage that varies so widely across states that building a multistate virtual specialty care access network program means navigating a different set of rules in each one. Administrative requirements that make replication harder than it needs to be. These are solvable problems, and this Playbook lays out how to solve them.

NSCAC calls on federal and state policymakers, health systems, and payors to move decisively on five fronts: reform cross-state licensure so specialists can practice where patients are; make Medicare telehealth permanent and align Medicaid and commercial coverage so programs have a reliable revenue foundation; invest RHTP and broadband funds in digital infrastructure built to last beyond the grant period; stabilize FFS payment and build toward value-based arrangements that reward longitudinal care; and streamline the enrollment, billing, and coding requirements that hinder program replication.

This Playbook focuses on the five policy actions NSCAC believes are most foundational to scaling virtual specialty care access networks. Additional areas, including rural workforce development pipelines, home-based and community-based specialty care models, rural health innovation infrastructure, and emerging connectivity and data-exchange solutions represent important priorities that NSCAC intends to address through future coalition efforts.

The coalition behind this Playbook has the operational experience, geographic reach, and policy credibility to drive this agenda forward. NSCAC will continue advocating with policymakers and payors until high-quality virtual specialty care is the standard of care for rural Americans, not the exception.

VIII. Appendix: NSCAC Playbook Contributors

NSCAC Member Organizations*

- AdventHealth
- Adventist Health
- Advocate Health
- Ballad Health
- Banner Health
- Center for Telehealth and eHealth Law (CTeL)
- Children's Hospital Association
- Children's Nebraska
- ChristianaCare
- Cincinnati Children's Hospital
- Cone Health
- Dartmouth Health
- Denver Health
- Forrest General
- Hackensack Meridian Health
- Intermountain
- Johns Hopkins - Howard County Medical Center
- Lehigh Valley Heart and Vascular Institute
- Lurie Children's
- Marshall Medical Center
- Medical University of South Carolina (MUSC)
- MyMichigan Health
- Nathan Littauer Hospital & Nursing Home
- North Mississippi Health Systems
- Northern Nevada Health System (NNHS)
- Renown Health
- Roswell Park Cancer Center
- Rural Freeman Hospitals
- Rural Health Community
- RUSH University Medical Center
- Rutgers Robert Wood Johnson Medical School
- Sanford Health
- University Hospitals
- University of Chicago – UCM
- University of Mississippi Medical Center (UMMC)
- University of Rochester Medical System
- University of Utah Health
- University of Southern California – Keck Medicine
- Wisconsin Children's

**Health system members shown. NSCAC's 40+ total members also include corporate partners.*

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