

TESTIMONY OF PAULA CHATTERJEE, MD, MPH

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**Before the
Center for Rural Pennsylvania Board of Directors Public Hearing**

**On
“Public Hearing on Rural Health Transformation in Pennsylvania:
Rural Access and Care Delivery.”**

May 6, 2026

I am testifying in my own capacity. The views expressed do not necessarily represent those of the University of Pennsylvania Health System or the Perelman School of Medicine.

Thank you for the opportunity to comment on the Rural Health Transformation Program (RHTP) and its implementation in Pennsylvania. I am a physician and Assistant Professor at the University of Pennsylvania. I practice medicine as a general internist and study health care financing, quality, and outcomes in the rural and urban safety-net.

Rural communities across the Commonwealth face higher rates of chronic disease and mortality compared to their urban counterparts.¹ These disparities reflect both health care gaps (workforce shortages, hospital closures) and the effects of broader social and economic conditions (geographic isolation, limited economic opportunities).² Therefore, durably improving rural health requires not only health care system reform but also sustained attention to the broader conditions that shape health over the life course.

My testimony will focus on three areas: (1) whether federal RHTP funding is aligned with rural health needs, (2) ensuring RHTP resources reach the highest-need communities; and (3) measuring impact from the RHTP using meaningful outcome measures.

I. Federal RHTP funding to states may not be aligned with rural health needs.

Mistargeting of investments risks diluting the impact of otherwise substantial resources. The effective targeting of resources based on clinical indicators, such as mortality rates or measures of health system capacity, may improve the efficiency and ultimate results of health spending.

In a 2026 *Journal of the American Medical Association* analysis, our team examined first-year RHTP allocations (**Figures 1 & 2**).³ We found that funding per rural resident was inversely correlated with mortality: states with the lowest rural mortality rates (e.g., Hawaii, Massachusetts, Colorado) received more than twice the funding of those with the highest rural mortality rates (e.g., Mississippi, Kentucky, Louisiana). States that lost rural hospital beds also received less funding, and funding was not associated with changes in rural physician supply. Pennsylvania is uniquely disadvantaged under the current federal approach because funding is distributed over a large rural population: more than 1 in 4 Pennsylvanians live in a rural county.¹

Our findings are consistent with broader evidence that health care resources do not naturally flow toward areas of greatest need without explicit policy design.⁴ Our findings further suggest current federal allocation methods may not reflect the clinical needs of rural people and could reinforce existing disparities without more explicit targeting to states.

¹ "About Rural Health | Rural Health Care Challenges | Rural Pennsylvania Demographics | Pennsylvania Office of Rural Health | PORH," *Pennsylvania Office of Rural Health*, n.d., accessed April 28, 2026, <https://www.porh.psu.edu/about/about-rural-health/>.

² Shannon M. Monnat, "U.S. Rural Population Health and Aging in the 2020s," *The Public Policy and Aging Report* 35, no. 1 (2025): 3–9, <https://doi.org/10.1093/ppar/prae031>.

³ Paula Chatterjee et al., "Rural Health Transformation Program Allocations and Rural Health Needs in the US," *JAMA* 335, no. 13 (2026): 1176–79, <https://doi.org/10.1001/jama.2026.1735>.

⁴ Risha Gidwani and Cheryl L. Damberg, "Changes in US Hospital Financial Performance During the COVID-19 Public Health Emergency," *JAMA Health Forum* 4, no. 7 (2023): e231928, <https://doi.org/10.1001/jamahealthforum.2023.1928>.

II. RHTP funds can have the greatest impact by reaching communities that stand to benefit from them most.

Policymakers and stakeholders have raised concerns that, without clear guardrails, RHTP funds could become concentrated among larger companies or intermediaries rather than reaching rural communities directly.⁵ These concerns have been magnified given the limited 5-year timeline for fund use and the reporting requirements associated with program participation.

Measures of RHTP success focused on local control and governance can help ensure these investments build durable capacity within rural systems and institutions. Key indicators could include the share of RHTP funds controlled locally, the number of sectors engaged in the deployment of RHTP resources at the local level, local vendor participation in health system supply chains, the presence of shared governance structures, and sustained local participation in RHTP efforts over its 5-year span.

III. Measuring impact from the RHTP should include changes in both health care access and in broader social and economic conditions in rural communities.

Broader economic conditions often shape the success of health care investments. For example, declining local economies often precede rural hospital closures, suggesting that sustaining rural health care requires attention to economic stability and opportunity at the community level (**Figure 3**).⁶ For this reason, ensuring that RHTP resources are allocated to strengthen both health care and the broader social and economic conditions in rural communities will be critical.

As included in the state’s current RHTP application, short-term success could be measured using outcomes that can change within five years, such as access and continuity of care. These metrics reflect both workforce capacity and system performance and can be tracked using existing public data sources. Mental health outcomes and self-reported health can sometimes improve on a shorter time scale than physical health outcomes.⁷

Durable changes in rural economic conditions will be difficult to achieve in a 5-year time horizon, especially given the broad scope of the RHTP. However, coupling implementation of the RHTP with existing efforts in the Commonwealth to expand rural economic development may offer a way to coordinate multisector, place-based investments. These efforts can offer complementary benefits and work synergistically to improve both health and economic conditions in rural areas. For example, implementation efforts under the RHTP could be focused on economically distressed rural communities where the Rural Jobs and Investment Tax Credit program is being leveraged to expand investments in rural businesses.⁸

⁵ “Big Companies Position Themselves for Payday from \$50B Federal Rural Health Fund - CBS News,” April 27, 2026, <https://www.cbsnews.com/news/big-companies-federal-rural-health-fund/>.

⁶ Paula Chatterjee et al., “Changes in Economic Outcomes before and after Rural Hospital Closures in the United States: A Difference-in-Differences Study,” *Health Services Research* 57, no. 5 (2022): 1020–28, <https://doi.org/10.1111/1475-6773.13988>.

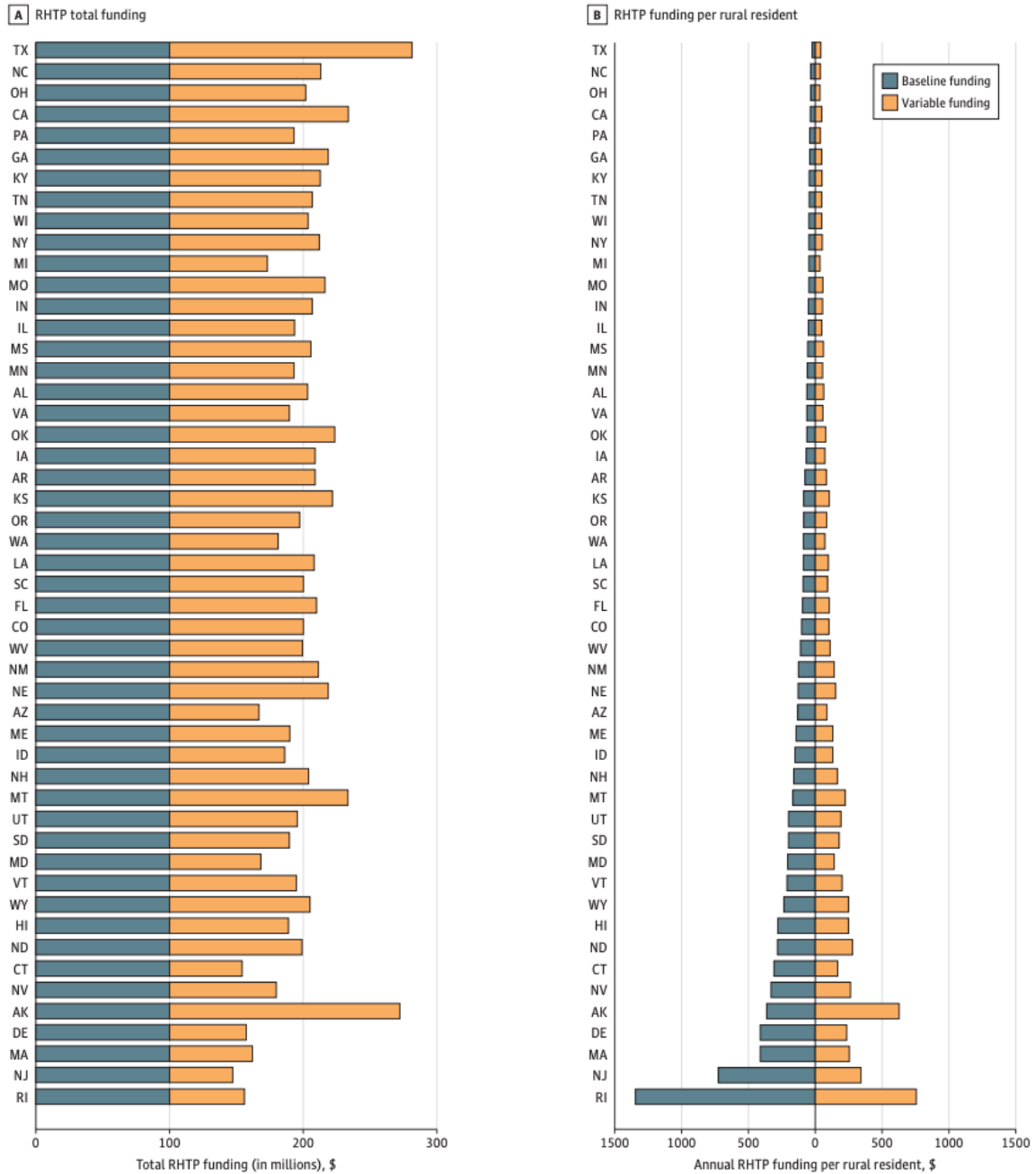
⁷ Katherine Baicker et al., “The Oregon Experiment — Effects of Medicaid on Clinical Outcomes,” *New England Journal of Medicine* 368, no. 18 (2013): 1713–22, <https://doi.org/10.1056/NEJMsa1212321>.

⁸ “Rural Jobs and Investment Tax Credit Program (RJTC),” *PA Department of Community & Economic Development*, n.d., accessed September 8, 2021, <https://dced.pa.gov/programs/rural-jobs-and-investment-tax-credit-program-rjtc/>.

Although the current federal allocation strategy disadvantages Pennsylvania given the large rural population in the Commonwealth, the RHTP presents an important opportunity to improve rural health. Its impact will depend on how resources are targeted and implemented. Aligning funding with need, investing in both health care and economic conditions, and strengthening local capacity will be critical to success. Clear, practical measures of access and local governance can help ensure the program delivers lasting improvements in rural communities.

Figure 1: Federal allocations of RHTP funding to states³

Figure 1. Bar Graphs Depicting Total and per Rural Population Rural Health Transformation Program (RHTP) Funding Across States

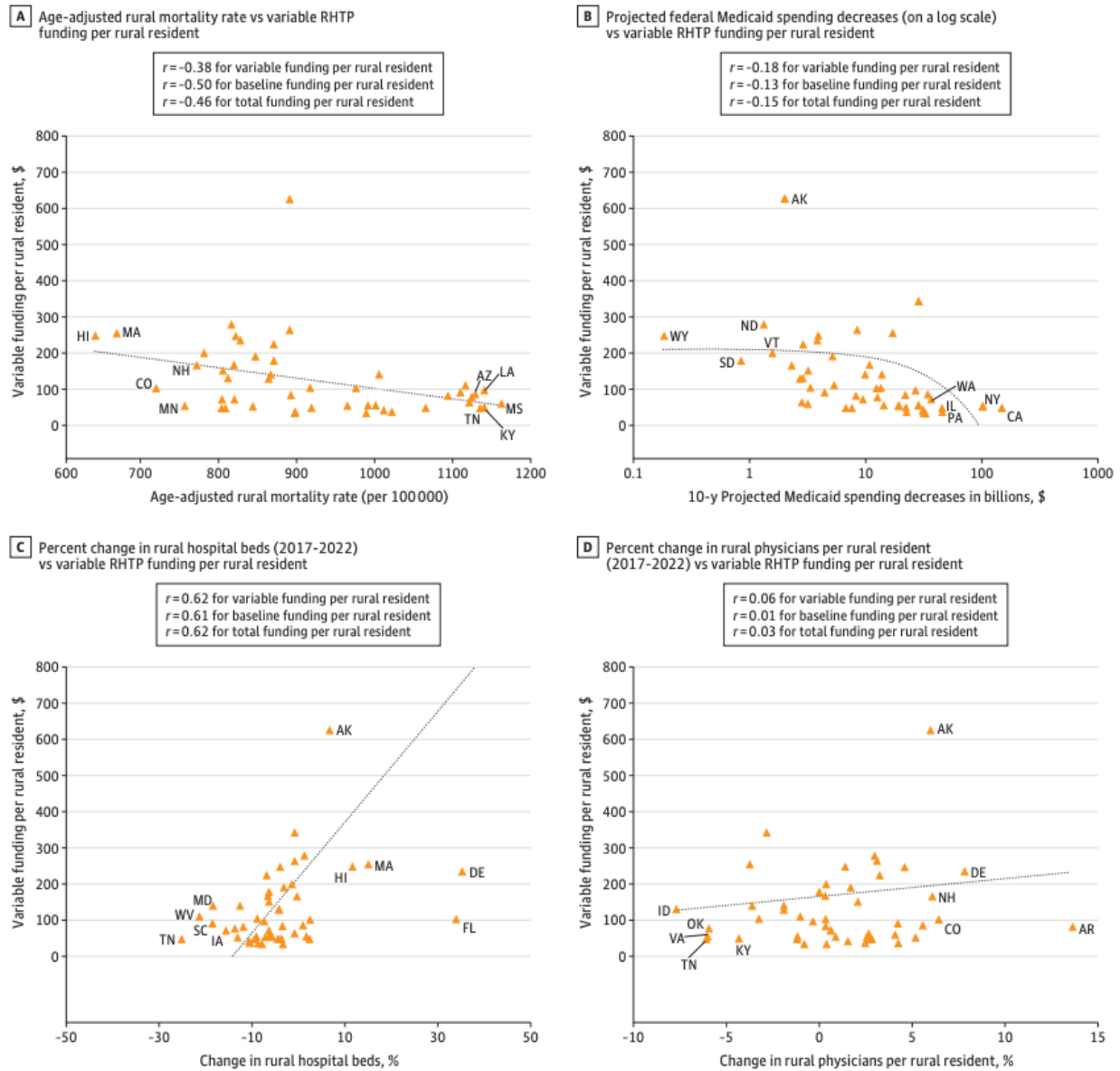


States are ordered from highest to lowest rural population. Estimates of rural population were based on Federal Office of Rural Health Policy-defined census tracts. Total funding is baseline funding allocated across states regardless of

rural population (\$100 million per state per year) and variable workload funding is based on a weighting formula considering state characteristics and proposals.

Figure 2: RHTP funds per rural resident relative to state rural health needs³

Figure 2. Scatterplots Showing Variable Rural Health Transformation Program (RHTP) Funding per Rural Resident vs State Characteristics

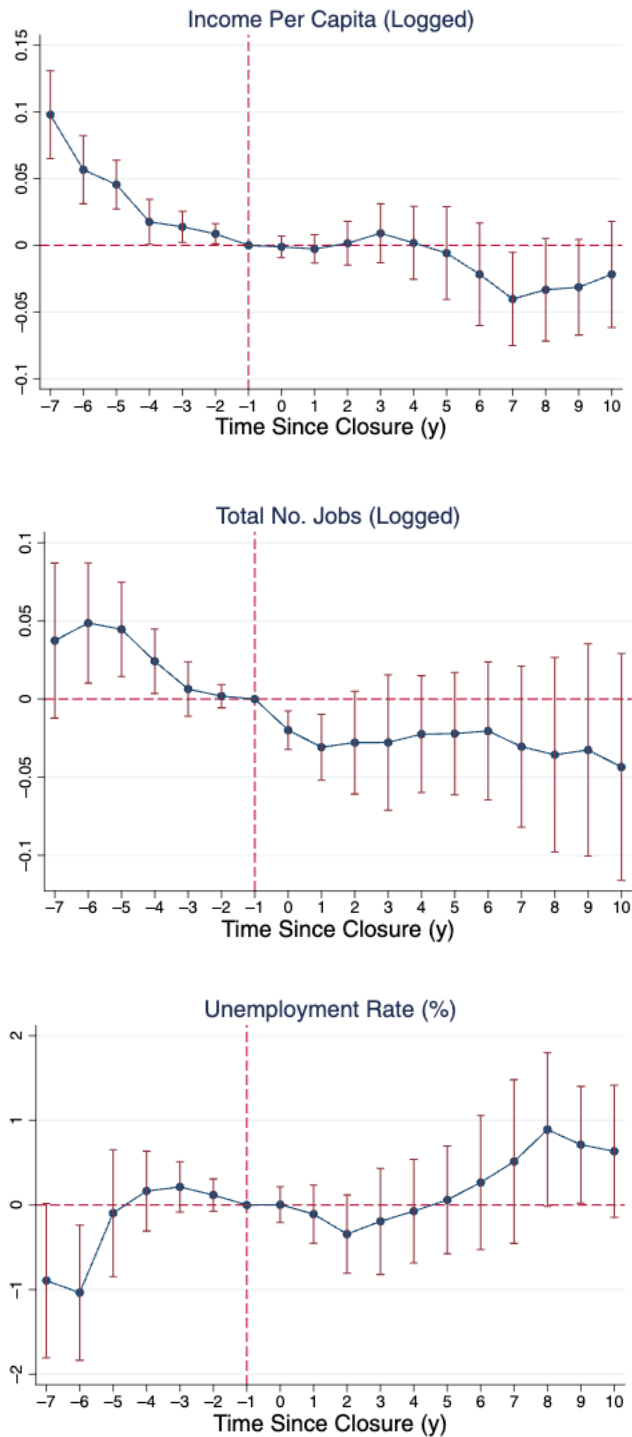


Total funding is baseline funding allocated across states regardless of rural population (\$100 million per state per year) and variable workload funding is based on a weighting formula considering state characteristics and proposals. Only the 5 at the highest and lowest ends of the range for each panel are

labeled. Full results by state are shown in [Supplement 2](#). Dotted lines represent linear regression lines of best fit. Regressions for B, C, and D include Rhode Island, which is not plotted due to being an outlier in variable funding per rural resident ([Supplement 1](#)).

³ Paula Chatterjee et al., "Rural Health Transformation Program Allocations and Rural Health Needs in the US," *JAMA* 335, no. 13 (2026): 1176–79, <https://doi.org/10.1001/jama.2026.1735>.

Figure 3: County economic trends before and after rural hospital closures



⁶ Paula Chatterjee et al., "Changes in Economic Outcomes before and after Rural Hospital Closures in the United States: A Difference-in-Differences Study," *Health Services Research* 57, no. 5 (2022): 1020–28, <https://doi.org/10.1111/1475-6773.13988>.

Testimony

Paula Chatterjee, MD, MPH

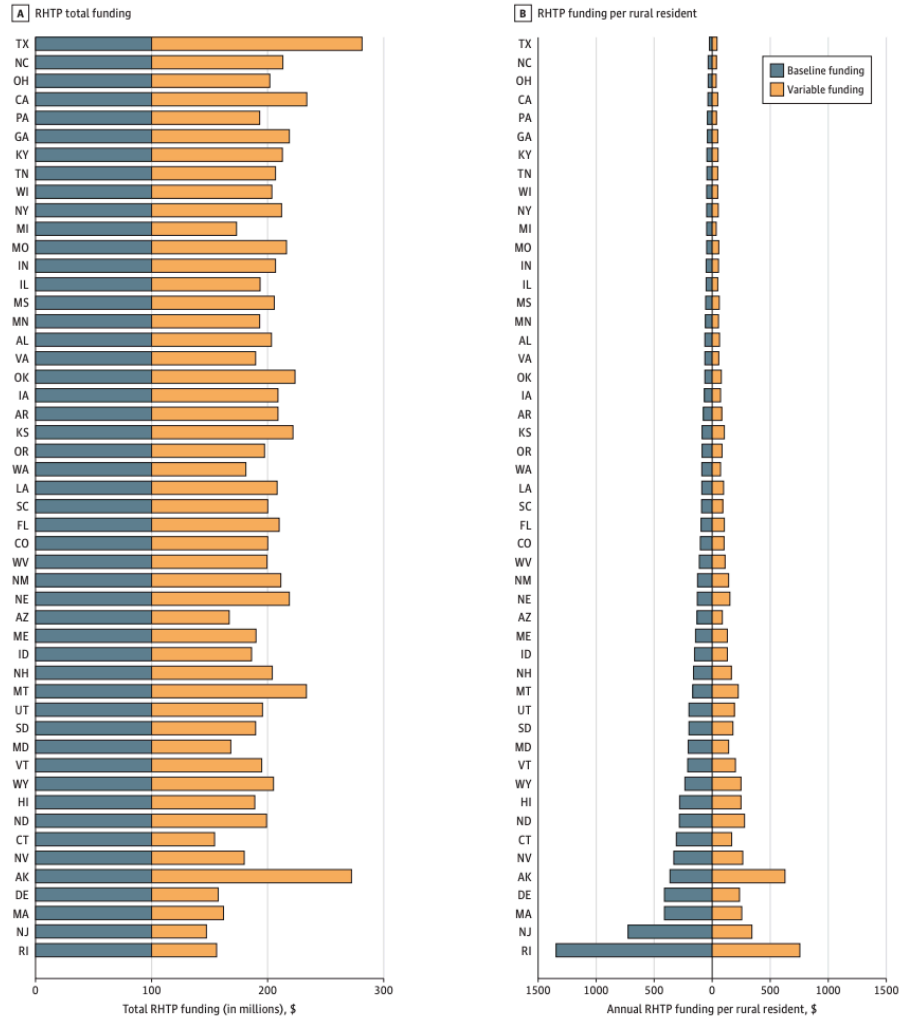
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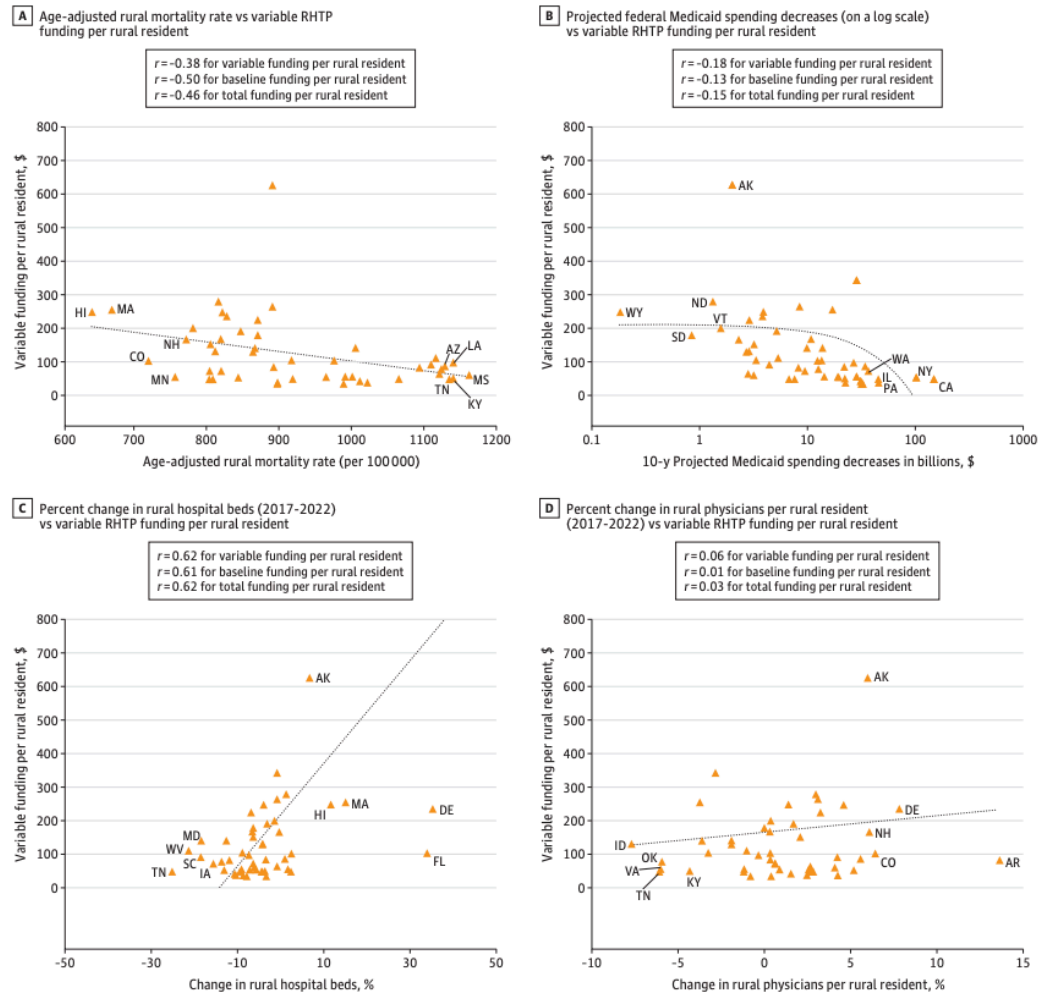
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- Total RHTP funding ranged from \$147 million (NJ) to \$281 million (TX).
- There was no clear relationship between state RHTP funding and the size of a state's rural population.

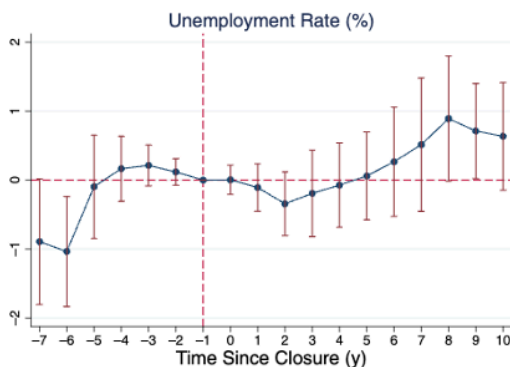
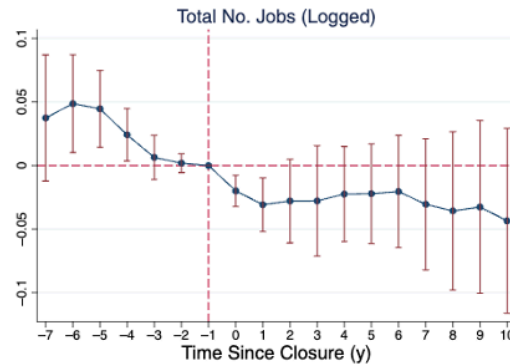
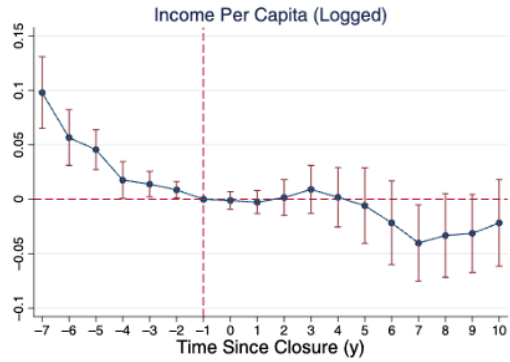
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labeled. Full results by state are shown in [Supplement 2](#). Dotted lines represent linear regression lines of best fit. Regressions for B, C, and D include Rhode Island, which is not plotted due to being an outlier in variable funding per rural resident ([Supplement 1](#)).

- States with the lowest rural mortality rates received more than 2x the per-rural-resident funding vs. states with the highest rural mortality rates.
- States that lost rural hospital beds received less per-rural-resident funding vs. states that gained rural hospital beds
- There was little correlation between per-rural-resident funding and whether a state had lost vs gained rural physicians



- Local economic decline often precedes rural hospital closures.
- Declining hospital occupancy rates and worsening hospital finances may result from broader “upstream” economic drivers.
- Efforts to reduce rural hospital closures may require a broader focus on strengthening local economies in order to be successful.