

EW RISINGER

Excelsior Springs, Missouri

Phone: 816-674-1686 | Email: ernie@ewrisinger.com

Week 10

Rural and Underserved Care Access

"If you live there, you deserve a doctor there."

1. The Problem

Rural Americans drive two hours for basic care. 57% of U.S. counties have zero psychiatrists. 182 rural hospitals have closed or converted to non-inpatient care since 2010 — confirmed from Center for Healthcare Quality and Payment Reform data, 2025. 46 million Americans live in rural areas representing 14% of the population, yet 66.5% of primary care Health Professional Shortage Areas are located in rural communities. Rural areas have only 30 physicians per 100,000 people compared to 263 per 100,000 in urban areas. 160 million Americans live in mental health shortage areas. The rural healthcare crisis is structural — not a temporary shortage — and has been getting worse and almost entirely ignored in policy discussions.

2. The Governing Principle

If you live there, you deserve a doctor there. Every American regardless of zip code has access to same-day primary care, same-day mental health counseling by telemedicine, and emergency services within defined response times. The federal government builds the infrastructure, trains the workforce, and pays the premium required to attract providers to underserved areas because the market cannot and will not do it alone.

3. The Specific Policy

Rural Clinic Network

- **Federal Rural Clinic Network — one clinic per county seat in designated Health Professional Shortage Areas:** federally owned, professionally staffed, open 7 days. Primary care, preventive care, basic labs, and telemedicine access to specialist consultation. Rural emergency transport vouchers for households at or below 200% FPL covering the cost of transport to the nearest appropriate emergency facility.
- **Rural placement premium — 25% above urban equivalent pay:** physicians, nurses, and other providers placing in rural shortage areas receive a federal placement premium reflecting additional training required and isolation challenges. Funded through Week 12 Career Incentive Program service commitment model.
- **Rural hospital stabilization fund — stop the closures:** 432 rural hospitals are currently vulnerable to closure per Chartis 2025 Rural State of the State report, with 46% operating at a negative

margin. Federal stabilization grants for rural hospitals serving communities with no viable alternative, conditioned on quality metrics and financial transparency. The platform does not prop up poorly managed facilities — it stabilizes strategically essential ones.

Mental Health Access

- **Same-day mental health counseling by telemedicine in every rural clinic:** 57% of U.S. counties have zero psychiatrists. Telemedicine eliminates the geography barrier. Every rural clinic has a dedicated mental health telehealth suite — a private room with a high-quality connection and a trained patient navigator who stays in the room. The navigator is not a therapist. They are the bridge between a patient who has never sought mental health care and a provider on the screen.
- **Mental health provider workforce — Week 12 connection:** mental health providers are added to the NSEP qualifying fields. Full tuition plus stipend for students committing to rural shortage area placement. 20,000 new mental health provider students in Year 1, 80,000 by Year 4.

Telemedicine Infrastructure

- **Broadband access — non-negotiable prerequisite for telemedicine:** Week 19 broadband voucher program and federal rural broadband investment ensure every rural clinic has sufficient bandwidth for high-quality video consultation. A telemedicine program that does not work due to poor connectivity is not a telemedicine program.
- **Interoperability mandate:** every federal rural clinic uses a standardized EHR platform that communicates with VA, Medicare, Medicaid, and major hospital networks. A patient who presents at a rural clinic should have their complete medical history accessible to the provider treating them.

4. Estimated Cost

Rural hospital and clinic construction: approximately \$5-8 billion per year for new construction in designated shortage areas. Telemedicine infrastructure and interoperability: \$2-3 billion per year. Rural placement premium and Week 12 scholarship funding: \$1-3 billion per year (shared with Week 12 budget). Total: \$7-11 billion per year. Offset by reduced emergency room utilization and avoidable hospitalization costs — rural emergency care costs significantly more per episode than primary prevention. Source: rural hospital closure data from Center for Healthcare Quality and Payment Reform, 2025; shortage area data from HRSA.

5. Year 1 Implementation and Measurable Result

Year 1 measurable result: 100 new federal rural clinics open in designated shortage counties; rural hospital stabilization fund operational with first grants awarded within 180 days; telemedicine mental health program operational in all existing federally qualified health centers in rural areas within 90 days; rural placement premium in effect for all Week 12 scholarship recipients; baseline: 182 rural hospital closures since 2010, 57% of counties with zero psychiatrists.