February 23, 2026

Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Rural Health Transformation Program

Dear Administrator Oz:

The Personalized Medicine Coalition (PMC), a multi-stakeholder group comprising nearly 200 institutions from across the health care spectrum, appreciates the Centers for Medicare & Medicaid Services' (CMS) efforts to address barriers individuals living in rural communities across the United States face in receiving timely access to health care. PMC and CMS share the goal of achieving better health outcomes for all Americans. As CMS guides states in implementing funding available to them through the Rural Health Transformation Program, we urge CMS to look at personalized medicine for opportunities to better diagnose, treat, and prevent serious and chronic diseases.

PMC defines personalized medicine as an evolving field in which physicians use diagnostic tests and individual details about a person's health to determine which medical treatments will work best for each patient or use medical interventions to alter molecular mechanisms that impact health. By combining data from diagnostic tests with an individual's medical history, circumstances, and values, health care providers can develop targeted treatment and prevention plans with their patients.

Personalized medicine is helping to shift the patient and provider experiences away from trial-and-error toward a more streamlined process for making clinical decisions, which leads to improved patient outcomes, a reduction in unnecessary treatment costs, and better patient and provider satisfaction. PMC and its members are leading the way in personalized medicine and in developing evidence showing how patients and the health care system can benefit from appropriate testing and tailored treatment as soon as possible during their clinical experiences.

Statement of Neutrality

Many of PMC's members will represent their own interests on aspects of the Rural Health Transformation Program and will actively advocate for those positions. PMC's comments are designed to provide feedback so that the general concept of personalized medicine can advance

and are not intended to adversely impact the ability of individual PMC members, alone or in combination, to pursue separate activities with respect to the Rural Health Transformation Program.

Access Challenges in Rural Areas

Rural communities have long been at the heart of the U.S. economy, culture, and identity. However, individuals living in rural areas have also faced some of the nation's most complex health challenges, from hospital closures and workforce shortages to high rates of chronic disease. Overall life expectancy decreases as rurality increases, with residents in many rural counties having a life expectancy 2 to 3 years lower than those in mostly urban counties.[i]

Individuals living in rural America are 38.8 percent more likely to suffer from coronary heart disease, 8.6 percent more likely to suffer from diabetes, and 5.5 percent more likely to suffer from obesity compared to those living in urban centers.[ii] Cancer, a disease area where personalized medicine has led to overall improvements in patient care, remains the second leading cause of death in rural America, with rural patients 20 percent less likely to be diagnosed at an early stage compared to their urban counterparts.[iii]

Medical deserts are appearing across rural America leaving many people without timely access to care. Rural areas often have fewer primary and specialty care physicians as well as fewer home and community-based service providers compared to urban areas.[iv] Although an estimated 16 percent of the U.S. population resides in rural areas, 65 percent of rural counties now lack a medical oncologist and a significant number of rural patients do not have access to pathologists with subspecialty expertise, leaving them to travel long distances to access diagnostic services that inform their care.[v]

Addressing rural health gaps leading to poorer health and declining life expectancy rates should be a top priority of the Rural Health Transformation Program. With all fifty states applying for funding, we anticipate that widespread rural health innovation will begin taking place this year. Implementation of the Rural Health Transformation Program should support appropriate investments that equip rural communities with the modern tools and partnerships to become healthier and self-sustaining.

Rural Infrastructure Investment

Investments targeting high-impact areas of need in rural areas, such as virtual care expansion, interoperability and data integration, advanced analytics and AI-enabled tools, wearable technology, and workflow automation can build local capacity for technology adoption and data-driven decision-making that is the foundation for personalized medicine. Personalized medicine has significantly improved cancer survival rates in recent decades, but oncology still has pronounced variability and availability in rural settings. Rural patterns in cancer mortality appear to be worsening, likely due to the effects of rurality on access to cancer prevention, diagnosis, and treatment services, as well as the higher prevalence of risk factors in these areas.[vi]

The Rural Health Transformation Program can help address gaps in cancer care caused by geographic isolation, limited laboratory infrastructure, and workforce shortages that can delay test results. Potentially avoidable delays directly contribute to advanced disease stages at diagnosis, higher treatment costs, and avoidable morbidity for rural patients. Digital pathology is

one approach that can enable faster and accurate diagnosis, pave the way for personalized medicine to be available in rural communities, and potentially leverage AI-enabled biomarker analysis to inform the use of targeted therapies.

Digital pathology incorporates the acquisition, management, and interpretation of pathology information in a digital environment. Digitization of glass slides allows for remote examination by a pathologist and can be done in conjunction with the use of AI algorithms to aid in the diagnosis of cancer. Remote examinations can help care for patients in rural areas by allowing providers to use digital pathology scanners to scan patient tissue slides and share them with specialists who may be out of state. This approach reduces the need for a rural patient to travel great distances or providers having to physically ship specimens to a cancer hospital. Some studies have shown that digital pathology can reduce diagnostic turnaround times by up to 50 percent.

Despite the efficiencies created by connecting rural sites with subspecialty expertise, adoption of digital pathology in the U.S. remains below 5 percent due to infrastructure demands, interoperability, and reimbursement challenges. Investment in infrastructure through the Rural Health Transformation Program in this one area could have a measurable impact on the timeliness of diagnosis patients receive for the second leading cause of death in rural communities and ensure that all Americans have access to care that is appropriate for their clinical situation regardless of where they live.

Conclusion

PMC applauds CMS for recognizing that the process of making changes and promoting innovation requires upfront investments that are frequently difficult for rural communities to make alone. The Rural Health Transformation Program funding can jumpstart modifications that may result in lasting improvements to health care access, rural health outcomes, and overall wellbeing of rural communities.

We believe that disparities in access to diagnostic information to guide personalized medicine should be a priority for states as they implement the Rural Health Transformation Program. We look forward to serving as a resource to you and your colleagues at CMS as you oversee the Rural Health Transformation Program. If you have any questions about the contents of this letter, please contact me at 202-499-0986 or cbens@personalizedmedicinecoalition.org.

Sincerely,

Cynthia A. Bens
Senior Vice President, Public Policy

[i] University of Wisconsin Public Health Institute. *County Health Rankings and Roadmap.* https://www.countyhealthrankings.org/health-data/population-health-and-well-being/length-of-life/life-span/life-expectancy?year=2025. (accessed February 6, 2026).

[ii] National Rural Health Association. *Driving Rural Precision Medicine Progress*. January 10, 2019. https://www.ruralhealth.us/blogs/2019/01/driving-rural-precision-medicine-progress (accessed February 6, 2026).
[iii] Centers for Disease Control and Prevention. National Center for Health Statistics. *Trends in Death Rates in Urban and Rural Areas: United States.* https://www.cdc.gov/nchs/products/databriefs/db417.htm (accessed February 6, 2026)
[iv] Health Resources and Administration (HRSA). Rural Access to Health Care Services Request for Information 2019. https://www.hrsa.gov/rural-health/rfi-rural-health-care-access (accessed February 6, 2026).
[v] National Institutes of Health. National Cancer Institute Rural-Urban Patters of Cancer. https://gis.cancer.gov/storymap/rural-urban/index.html (accessed February 6, 2026).
[vi] Bhatia S, et. al. *Rural-Urban Disparities in Cancer Outcomes: Opportunities for Future Research*. Journal of the National Cancer Institute. February 11, 2022. https://pmc.ncbi.nlm.nih.gov/articles/PMC9275775/ (accessed February 6, 2026).