National Rural Health Association's In-District Advocacy Toolkit

Now more than ever, it is important for Congress to hear from rural communities. Your advocacy is essential to drive change, support the rural health infrastructure and workforce, and improve rural health outcomes. The National Rural Health Association created an in-district toolkit to help guide your advocacy and engage your Members of Congress at the state and district level.

Table of Contents

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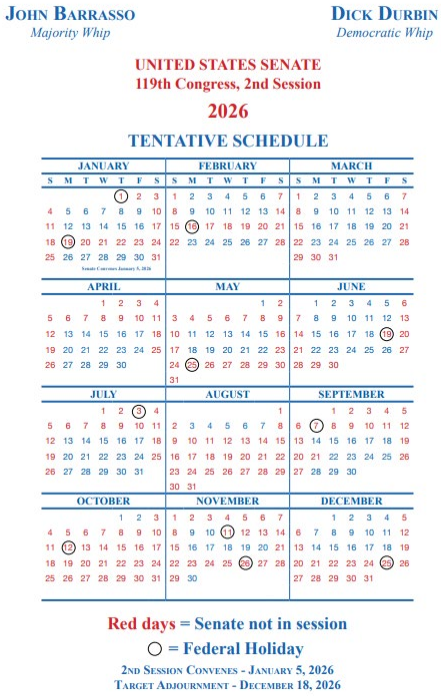
2026 Congressional Schedules

Congress has periods of time known as in-district working periods, or congressional recesses. During these periods, Members of Congress return to their home states and districts, which allows constituents the opportunity to engage with their members at home. Meeting with your elected officials or hosting them at your facility, are great ways to build your relationship and highlight the realities of rural healthcare on the ground.

2026 House Schedule

2026 Senate Schedule



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Know Your Members of Congress

Knowing your member of Congress—and how they engage with rural health issues—is the foundation of effective in-district advocacy. Quickly identify and contact elected officials representing your rural community through the following resources:

- You can identify your **Representative** on the U.S. House site. You have 1 representative who represents your congressional district.
- You can identify your **Senators** on the U.S. Senate site. You have 2 senators that represent your entire state.

Committee Assignments

Members of Congress serve on committees of jurisdiction that focus on certain policy and issue areas. Knowing which committees your designated members serve on can help you target your advocacy efforts. The current Senate Committee Assignments can be found here. The current House Committee Assignments here.

Committees that have jurisdiction over rural health related areas include:

House of Representatives	Senate
Ways and Means Committee Medicare, Medicaid (with Energy & Commerce), and tax provisions affecting health care.	Finance Committee Medicare, Medicaid, CHIP, health-related tax and coverage provisions, inc. the Affordable Care Act.
Energy and Commerce Committee Public Health Service Act, Medicaid, ACA implementation, mental health, telehealth, health IT, 340B, and most HRSA authorities.	Health, Education, Labor, and Pensions (HELP) Committee Public Health Service Act programs, inc. HRSA, workforce, public health, behavioral health, FDA.
Agriculture Committee Farm Bill and USDA rural development, nutrition, and agriculture programs.	Agriculture Committee Farm Bill and USDA programs, including rural development and nutrition.
Appropriations Committee Federal government's discretionary budget, including annual HHS, USDA, VA, and DOL funding.	Appropriations Committee Federal government's discretionary budget, including annual HHS, USDA, VA, and DOL funding.
Veterans' Affairs Committee VA health care, rural veteran access, and community care programs.	Veterans' Affairs Committee Jurisdiction over VA health care, rural veteran access, and community care programs.
Education and Workforce Committee Education, workforce development, and labor programs relevant to rural health workforce.	Special Committee on Aging Conducts oversight, investigations, and policy studies on issues affecting older Americans, including rural aging and long-term care.

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Identify District-Level Congressional Events

When members of Congress are on recess, they often host a variety of events that constituents are encouraged to attend. Events such as town halls or open forums are excellent avenues to voice your opinions and let your issues be known. To find out when events are being held in your Congressional district, monitor your lawmaker's websites and social media accounts, sign up for email alerts, or periodically call their district office for event updates.

Engaging with Your Members of Congress

Schedule a Meeting

Call or email your Representative or Senator's district office to request a meeting with your members of Congress or host a visit to your facility. When requesting a meeting, contact the in-district scheduler or staff lead who can schedule your meeting or forward your request to the correct person. Contact information for district offices can be found on their official website online. If you need help identifying the correct staff member to contact, please email NRHA's Grassroots & Communications Coordinator, Sabrina Ho (sho@ruralhealth.us). Please send any applicable media materials or pictures and a summary of the visit to NRHA's Grassroots & Communications Coordinator, Sabrina Ho (sho@ruralhealth.us).

Email Template(s):

General Meeting Request

Subject: In-District Meeting Request for [DATE] with Rep./Sen. [LAST NAME]

Hello [STAFFER/SCHEDULER],
My name is [YOUR NAME], and I am a constituent from [TOWN, STATE]. I am writing to request an in-district meeting with Rep./Sen. [LAST NAME]. I serve as the [TITLE] of [ORGANIZATION] in [STATE], and I would appreciate the opportunity to discuss [RURAL HEALTH TOPIC]. Please let me know if the office has availability during the [MONTH] district work period. I would be glad to adjust to a time that works best for the Member's schedule.
Thank you for your consideration.
Sincerely,
[YOUR NAME]
[TITLE]/ [ORGANIZATION]

Hosting Introduction

Subject: In-District Meeting Request for [DATE] with Rep./Sen. [LAST NAME]
Dear [STAFFER NAME],

On behalf of [INSERT NAME OF FACILITY/PROGRAM] in [INSERT CITY/TOWN], I would like to invite [SENATOR/REPRESENTATIVE] [LAST NAME] to tour [PROGRAM/FACILITY NAME] during the upcoming [MONTH] recess.
We would like to share with you the services our [program/facility] has provided our rural community. During your visit we welcome you to [tour the facility, meet our staff, talk to patients, see how our team operates, etc.]. Health care in rural America is critical to a community's overall well-being. Rural hospitals and facilities are a critical component of the rural economy, and we look forward to the opportunity to show you the role our work plays in the growth and future of our community here in [INSERT CITY/TOWN].
[INSERT short paragraph about the facility or program—what you do, job numbers, economic footprint, patients cared for, explain your role in providing care.]
We are happy to work with your team to find a date that works well for [SENATOR/REPRESENTATIVE NAME]. All of us at [INSERT NAME OF FACILITY/PROGRAM] look forward to offering a more personal look at the challenges and opportunities in providing health care in rural America through our community.

Sincerely,
[YOUR NAME]
[TITLE]/[ORGANIZATION NAME]
[ORGANIZATION ADDRESS]

Thank You/ Follow Up

Subject: Thank You - Constituent In-district Meeting [DATE] with Rep./Sen. [LAST NAME]

Hello [STAFFER/SCHEDULER],
My name is [YOUR NAME] and I am a constituent from [TOWN,STATE]. Thank you for meeting with [YOUR ORGANIZATION] on [DATE] to talk about [TOPICS DISCUSSED]. We appreciate your efforts in supporting rural health in [YOUR STATE]. Please find [any materials or resources needed for follow-up] attached as we discussed in our meeting. I look forward to continuing our relationship with your office and serving as a resource on rural health for your team. If you have any additional questions, please feel free to contact me at [YOUR EMAIL].

Sincerely,
[YOUR NAME]
[YOUR TITLE]/ [YOUR ORGANIZATION]

Meeting Success

Tips for a successful in-district meeting with your Member of Congress or their staffer. See NRHA's advocacy 101 guide for more information on best advocacy practices and tips.

- Find out who covers healthcare in the Members home state or district office.
- Share any relevant background materials with Congressional healthcare staffers so they have a chance to review them and brief the Member before your meeting.
- Use the meeting to develop a relationship with the Member. Help them get to know you and the work you do in the community.
- During the meeting, thank them for any positive actions that they've taken. Share your personal story related to the issue. Make a clear request and offer a potential solution to address the issues discussed.
- Use the talking points and resources provided in this toolkit to guide your conversation. Provide actionable requests for the next steps the member or staff can make.
- Follow up after the meeting. Be sure to get their email address and follow up with them accordingly. Thank the staffer or Member for their time. Include a reiteration of any key points mentioned, any follow-up material, and policy requests discussed.

Social Media Engagement

Social media is an effective way to amplify your message and highlight your in district advocacy. Constituents are encouraged to take photos during site visits and meetings—including a photo with your Member of Congress when appropriate. Most Members maintain public-facing accounts across major platforms; you can confirm which ones they use by visiting their official website. When posting, tag your lawmaker and briefly thank them for the meeting or restate the key issue you discussed.

Sample posts:

Thank you [@SENATOR OR REP] for meeting with [ORGANIZATION] to discuss [SHORT TOPIC]. We appreciate your commitment to #ruralhealth! @NRHA_Advocacy

Don't forget to tag @NRHA_Advocacy on Twitter and Instagram so we can amplify your post.

Talking Points

To support your conversations with lawmakers, NRHA provides the following high-level talking points on key rural health priorities. **A reminder that a key part of in-district advocacy is sharing impactful stories with your Member of Congress and their staff that they can take with them back to D.C. in order to make change! Please provide personal experiences and stories that are applicable for each topic when possible.**

Appropriations

Background: The House Appropriations Labor, Health and Human Services (L-HHS) Subcommittee passed its fiscal year (FY) 2027 funding bill out of the Subcommittee and sent it to the full House Appropriations Committee. **The bill includes robust funding for rural health programs, despite proposals in the President's FY 2027 Budget Request to eliminate of core programs** such as the Medicare Rural Hospital Flexibility Program (Flex), the State Offices of Rural Health (SORH), the Rural Hospital Stabilization Program, and the Rural Hospital Provider Assistance Program.

Ask: We urge Congress to fully fund rural health programs and pass a comprehensive FY 2027 appropriations package that is reflective of funding levels for rural health programs in the HAC's FY 2027 requests.

The following programs at the Federal Office of Rural Health Policy would end if Congress enacts the President's budget proposal, upending rural health care delivery in [your state]:

- The Medicare Rural Hospital Flexibility (Flex) Program helps Critical Access Hospitals (CAHs) and rural communities deliver quality, sustainable healthcare. Flex is a lifeline that keeps rural hospitals open and improves quality of care.
    - *Show number of CAHs in your state that is impacted by Flex here - Find number in spreadsheet "CAHs by state".*
    - *Show amount of Flex funding received in your state here - Find number in tab "Flex state awards".*
- The State Offices of Rural Health (SORHs) work with rural health care providers and stakeholders across the state to administer Flex programs, connect partners to resources, build capacity, and otherwise provide critical direct technical assistance.
    - *Show amount your SORH received in your state here - Find number in tab "SORH state awards".*
- The Rural Hospital Stabilization Program is a pilot technical assistance program that improves health care in rural areas by providing in-depth assistance directly to financially distressed rural hospitals to address long-term solvency and operating

models. The program provides direct funding to enhance and/or expand service lines.
    - *Please reference first cohort RHSP awardees here.*
- The Rural Hospital Provider Assistance Program: This new program, first funded in FY 2026, aims to help rural PPS hospitals with low wage indexes by providing additional funding to support recruitment and retention.
    - *Please reference list of hospitals eligible in FY 2026 here.*

The following rural programs need continued investment to sustain rural healthcare access in our rural communities:

- The Department of Agriculture Rural Hospital Technical Assistance Program provides free, targeted, on-the-ground technical assistance to rural hospitals at-risk of closure to prevent closures and maintain essential healthcare services in rural communities.
- The Rural Residency Planning and Development Program (RRPD) supports the development of new rural residency programs to address the ongoing physician shortages faced by rural communities.
    - Find RRPD grant awardees in your state here.
- The Rural Health Care Services Outreach programs supports rural, community-driven initiatives that promote improved access to care, enhance care coordination, and foster sustainable solutions for chronic disease prevention and management in rural areas.
    - Find Outreach programs' FY 2025 awardees here.
- The Rural Communities Opioid Response Programs (RCORP) addresses barriers through targeted interventions for treatment for substance use disorder (SUD), including opioid use disorder (OUD), specific to the unique needs in rural areas.
    - Find RCORP FY 2025 awardees here.
- The Office of Rural Health at the Centers for Disease Control and Prevention (CDC) strengthens the agency's focus on rural communities by coordinating rural-specific initiatives across CDC programs, improving implementation of CDC's rural public health portfolio, and advancing a strategic framework to address persistent rural health disparities. The office serves as a central hub for rural expertise, ensuring CDC's policies, data, and interventions are tailored to the unique needs of rural populations.

Resources:

- NRHA 2026 Rural Health Advocacy Asks provides an overview of NRHA's main appropriations priorities, along with details on key programs.

- Rural Health Appropriations Toolkit provides template emails, letters, and other resources to help you structure your asks to Congress on rural health appropriations and funding. It also provides more in-depth talking points on our rural health appropriations and priorities.
- NRHA FY27 Appropriations Requests
- NRHA Rural Health Appropriations Hub

Medicaid

Background: Rural patients disproportionately depend on coverage from public payers. As a result of reductions to coverage for rural residents, many clinics and hospitals face financial pressure that may lead to reduction or elimination of essential services, delays in much needed facility upgrades, or closure. H.R. 1 introduces sweeping Medicaid eligibility and enrollment changes, and several of its provisions will have particularly significant consequences for rural patients, providers, and state systems.

Medicaid Eligibility Redeterminations: Beginning in 2027, the Medicaid adult expansion population will have their eligibility reviewed every six months as opposed to the current cycle of once every twelve months.

- Rural Medicaid beneficiaries face more structural barriers to complying with eligibility redeterminations, such as lack of internet or transportation access, that puts them at higher risk for being improperly disenrolled.

Medicaid Community Engagement (Work Requirements): Starting January 1, 2027, new Medicaid work requirements require able-bodied adults in the Medicaid expansion population to engage in work or other qualifying activities as a condition of receiving Medicaid benefits.

- For rural communities—where Medicaid coverage is high, jobs and training programs are limited, and providers and state agencies already face severe workforce shortages—the administrative demands, documentation requirements, and frequent verification processes pose significant risks to coverage continuity and strain rural health systems.

On June 3, 2026, CMS release the Medicaid Community Engagement Interim Final Rule implements work and activity requirements, restoring prior redetermination eligibility processes and establishing complex verification, exemption, and compliance systems that states must administer.

- States may seek good-faith extensions through 2028, and CMS will distribute $200 million in implementation grants, but rural beneficiaries and providers will still face disproportionate challenges navigating and operationalizing the new requirements.

Provider taxes: H.R. 1 freezes all current provider tax arrangements, prohibits new provider taxes, and requires a phasing down of hold harmless thresholds in Medicaid expansion states from 6% to 3.5%. Provider taxes represent a significant amount of reimbursement to rural providers and play a key role in the financial sustainability of rural providers and facilities.

- In Medicaid expansion states, phasing down provider-tax thresholds below current levels threatens the sustainability of state Medicaid programs and would directly reduce access to care for rural residents, who already face higher uninsurance rates and fewer local providers.
- In non-expansion states, maintaining current provider-tax authority is critical; any further reductions beyond H.R. 1's limits would weaken Medicaid financing and jeopardize rural hospitals that rely on SDPs to remain solvent.

Asks:

[Your community] relies on Medicaid/Medicare/ Marketplaces to provide affordable health care coverage [insert coverage data points]. Loss of coverage, including changes to federal Medicaid policy will shift costs to rural families and providers, jeopardize rural health care systems, and worsen rural health outcomes.

- Cuts enacted in H.R. 1 are projected to reduce Medicaid spending in rural areas by $137 billion over 10 years.
- Also passed in H.R.1, the Rural Health Transformation Program provides targeted, time-limited investments intended to catalyze state modernization of rural health systems. RHTP dollars are not intended to as implemented by CMS, nor can they offset the significance in potential Medicaid funding reductions.
- Since 2010, more than 200 rural hospitals have closed or converted to models that exclude inpatient care, such as Rural Emergency Hospitals (REHs). Cuts to Medicaid will negatively impact rural hospitals. Nationally, more than 10 million rural residents rely on Medicaid. Medicaid reimbursements account for nearly 10% (or $3.9 million) in net revenue for the typical rural hospital. More than 40% of all rural hospitals are operating in the red, with about 417 rural hospitals vulnerable to closure.

  - The state of [your state] has had [XX] rural hospital closures since 2010. Currently, about [XX%] of [your state]'s rural hospitals are operating within negative margins. [Find 2025 hospital specific data in your state here]
  - [Your state] currently sits at [XX%] for statewide rural Medicaid enrollment.
- We urge Congress to delay implementation of harmful Medicaid policies enacted in H.R. 1 that will result in coverage losses for rural residents and increased uncompensated care rates for rural hospitals.
- [Personal story about Medicaid policies have impacted your rural community, facility, patients, etc.]

Medicaid Community Engagement (Work Requirements):

- *Definitions of Work, Education & Community Service:* Employment, training, and volunteer opportunities are limited and often seasonal in rural communities.
  - Rural Americans are more likely to be low-wage workers, more likely to be unemployed, and have fewer job options than urban Americans, making rural Medicaid enrollees more susceptible to losing coverage under work requirement policies. Currently, [your state/county], has an average rate of [XX%] for unemployment in comparison to the nearest urban county that sits at [XX%], emphasizing the gap in job opportunities in rural verses urban. *Use the "Unemployment" tab in KFF's tracking tool to find county-level unemployment rates in your state to show those who would not qualify for Medicaid under these requirements.*
  - **Ask:** We support CMS' definitions of work, education, and community service. However, we oppose the requirement that job search cannot be more than half the hours of a work program, a rule which applies to no other work requirement.
  - [Personal story about rural employment and how this requirement would further hinder employment rates in your rural community]
- *Exclusions*: Strong, clear exclusions—especially for postpartum individuals, caregivers, and medically frail patients—are critical.
  - Currently in [your state], only [XX%} of Medicaid applications are processed within 30 days, which is before the implementation of work requirements. In rural areas where access to providers is limited, added documentation requirements would create harmful barriers to care. Rural counties that are unable to process applications within 30 days may rely more heavily on manual reviews and may be experiencing backlogs. Additional verification

requirements from work requirements may impact application processing times for rural areas.
Reference the "application processing time" map from KFF's toolkit to show how long your state takes to process applications before the new requirements
    - **Ask:** We strongly oppose the additional requirement that the condition or diagnosis significantly impairs individuals' ability to comply with the work requirement as it places significant burden on the provider community.
    - [Personal story about any administrative burdens that further impact your facility and providers]
- *Verification & Re-Verification:* Rural beneficiaries and providers rely on streamlined verification processes.
    - Rural Medicaid enrollees may be more likely to lose coverage due to paperwork issues or red tape rather than true ineligibility.
    - Currently, [your state] consists of [XX%] of Medicaid eligible renewed on an ex-parte basis, which is a large portion of renewals for the state.
    Use the "Renewals and Disenrollment – Renewal Outcomes" tab to show, the share of people whose coverage was renewed BEFORE implementation of these new requirements.
    - **Ask:** CMS should maintain ex-parte verification, prohibit repeated checks for permanent conditions, and avoid time-limited self-attestation that increases burden in low-resource settings.

<u>Provider Taxes:</u>

- Provider taxes are central to how many states finance their Medicaid programs, and reductions to provider-tax thresholds—especially in expansion states—would destabilize Medicaid funding streams that rural hospitals depend on, increasing uncompensated care and pushing already-vulnerable facilities closer to closure.
- Most common use of provider taxes include supporting base Medicaid provider payment rates, funding supplemental provider payments, preventing Medicaid benefit cuts, and expanding Medicaid benefits.
    - Currently, [your state] receives $XX in annual federal spending for SDPs.
- While this policy would affect providers across the nation, it especially will hit rural hospitals and providers the hardest. Changes to SDPs in H.R.1 will impact inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers. SDPs have become a foundational tool to boost low Medicaid payments, and improve access and

quality, accounting for state Medicaid spending, especially for rural communities and providers.
    - (Your state) could face an estimated XX% reduction in Medicaid payments to hospitals if SDPs were limited to 100% of Medicare rates.
- SDPs are a financial lifeline for rural hospitals and clinics, helping offset chronically low Medicaid reimbursement rates and sustaining essential services such as obstetrics, behavioral health, emergency care, and long-term care in communities with thin margins and high Medicaid reliance.
- Rural hospitals face unique financial pressures, including low patient volumes, high fixed costs, and limited service lines; restricting SDPs would remove one of the few tools states have to stabilize rural facilities and prevent service cuts or closures.

Resources:

- KFF Tracker on Implementation of the 2025 Reconciliation Law Medicaid Work Requirements
- NRHA's H.R.1 Implementation Tracker
- NRHA's Letter to CMS on H.R. 1 Medicaid Implementation

Rural Health Transformation Program

Background: The Rural Health Transformation Program (RHTP) is a historic investment in rural communities, providing a total of $50 billion over a period of 5 years awarded to states based on their submitted applications.

(Your state) received ($XXX,XXX) and some promising initiatives include (list a few initiatives that you think will be most impactful in your state- use NRHA's summary guide to show how much your state was awarded and a brief overview of your state's outlined RHTP application programs, For more state-specific RHTP info, use your state RHTP webpage also linked on the guide.).

Currently, states are deploying Year One funding (*Use NRHA's RHTP RFPs by Status Map to show where your state is at for your rollout of Year 1 funding.*)
(Discuss where your state is at –identifying vendors, contracting with implementation partners, and beginning investments aligned with their approved initiative areas, etc. Are funding opportunities in your state open? Have awards been made to subcontractors?)

Ask: We urge Congress to ensure proper oversight, accountability, tracking, and rollout of RHTP funds to maximize that rural providers, hospitals, and community-based organizations are positioned to benefit from these investments.

- While RHTP funding was not intended to directly offset changes to the Medicaid program, NRHA believes Congress designed the program to support rural providers impacted by the H.R. 1-related reimbursement reductions.
- Our concern is that without a clear rural set-aside or allocation formula, funding could disproportionately flow to larger health systems or organizations that are better positioned to apply for and administer grant opportunities.

RHTP provides a unique opportunity to address these long-standing challenges and therefore set rural hospitals up for success on their road to transformation if certain adjustments were made in program implementation.

- Rural hospitals and clinics are anchor facilities in rural communities and play an essential role as safety net providers ensuring access for individuals living in rural areas. **Without direct allocation or targeted protections for rural providers, the RHTP may fall short on meaningfully stabilizing access to care in rural areas.**
- Further, NRHA asks that CMS revise its guidance to allow for the use of funds for enhancing payment rates for already billable services and uncompensated care for rural populations to offset implications of coverage losses in rural areas. Low reimbursement rates from public payers paired with low volumes and uninsured populations are a major contributor to rural hospital financial instability.

(Do you have any implementation concerns that you want to raise to your members?)

- Resources:
  - NRHA RHTP RFP Deadlines Calendar
  - NRHA RHTP RFPs by Status Map
  - NRHA RHTP State Summary Guide
  - NRHA RHTP Webpage

Key Medicare Program Extenders

Intro: Many rural health-related programs require periodic reauthorization by Congress. The lack of program permanence contributes to financial instability and complicates rural providers' long-term planning for finances, staffing, and operations. A series of short-term extenders put rural hospitals in an uncertain position that makes long-term financial planning more difficult and ultimately undermines the benefit of the programs.

Ask: (Your organization) urges Congress to permanently extend or enact *at least* a 5-year extension for the following programs that are set to expire at the end of 2026:

- **MDH/LVH Designations**
    - **Medicare Dependent Hospitals (MDHs)** are small, rural hospitals where at least 60% of their admissions or patient days are from Medicare patients. MDHs receive the IPPS rate plus 75% of the difference between the IPPS rate and their inflation-adjusted costs from one of three base years. (Please find a list of MDHs by state from KFF here).
    - **Low-Volume Hospital (LVH) Designations** are hospitals that have fewer than 800 discharges in a fiscal year. The LVH adjustment helps isolated, rural hospitals with extremely low patient volumes to continue operating. LVHs receive a payment adjustment on a sliding scale based on volumes.
    - (Emphasize the importance of these enhanced Medicare reimbursements to your hospital and the difficulty of dealing with short-term extensions).
    - Key legislation to support: Congress must pass these bills to extend these hospital designations past January 30, 2026. If your member of Congress is not a cosponsor, ask them to cosponsor the following:
        - The *Rural Hospital Support Act* (S. 335)
        - The *Assistance for Community Hospitals Act* (H.R. 1805)

The following programs are set to expire at the end of 2027 and should also be extended by Congress past 2027:

- Medicare Telehealth Flexibilities must be made permanent in order to incentivize rural provider investment in telehealth and expand rural access to care. These flexibilities are set to expire on December 31, 2027.
- (Discuss why permanent telehealth is important to your facility. What investments in telehealth would you make if it were permanent?)
    - Key legislation to support:
        - The *CONNECT for Health Act* (S. 1261/H.R. 4206)
- Rural Ground Ambulance Payment Add-ons**:** Additional Medicare reimbursement for ground ambulance services in rural areas is critical. Rural ambulance providers are lifelines for timely emergency care but face financial challenges due to low call volumes and high operational costs. These payment add-ons are set to expire on December 31, 2027, and must be extended.
    - Key legislation to support:
        - The *Protecting Access to Ground Ambulance Medical Services Act* (S. 1643/H.R. 2232)

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- Resources:
    - NRHA Rural Health Extenders one-pager
    - NRHA MDH/LVH Extension factsheet
    - NRHA Urge Congress to Enact Long-term Rural Healthcare Extenders advocacy campaign

NRHA Advocacy Materials

NRHA has an array of leave-behind materials that can help members of Congress and their staff understand important rural health policies and related legislation. You can bring these materials to meetings to guide discussions and leave with staff or share via email as follow up material. All NRHA advocacy leave behind materials can be found on our website under "Advocacy Priority Areas."

Additional Resources

- Rural Health Data by State & Congressional District
- State Hospital Closure and Vulnerability Data
- State-Level Medicaid Data
- 2025 Federal Office of Rural Health Policy Funding Data by State
- HRSA FY 2026 data awarded grants finder