

April 30, 2026

Submitted via email: WMSubmission@mail.house.gov

House Ways & Means Committee
1139 Longworth House Office Building
Washington, DC

Re: Statement for the Record – *Full Committee Hearing with Health and Human Services Secretary Robert F. Kennedy, Jr.*

Dear Chairman Smith and Ranking Member Neal:

The National Rural Health Association (NRHA) appreciates the opportunity to submit this statement for the record on the House Ways & Means Committee hearing examining the President’s Fiscal Year (FY) 2027 Department of Health and Human Services (HHS) Budget Request and policy priorities.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America’s health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America’s health needs through government advocacy, communications, education, and research.

Rural Health Transformation Program

The Rural Health Transformation Program (RHTP) is a historic investment in rural health that presents states with the unprecedented opportunity to transform rural healthcare delivery. NRHA is grateful for the efforts by members of the Committee to establish the program during last year’s reconciliation process and looks forward to its success as states work to implement their innovative initiatives.

While RHTP grew out of some Members’ concerns that reductions in Medicaid reimbursement would harm rural hospitals, HHS and the Centers for Medicare and Medicaid Services (CMS) have consistently stated that the RHTP is not intended to supplant losses associated with changes to Medicaid enacted in H.R. 1¹ nor keep rural hospital doors open. Through statements² and the Notice of Funding Opportunity (NOFO) the Department has made clear that RHTP is not a fund to provide short-term life support for rural hospitals.

Secretary Kennedy noted that rural hospitals currently receive \$20 billion in Medicaid payments per year³ and HHS is increasing these payments to rural healthcare at large by 50%, or \$10 billion per year, through the RHTP. NRHA would like to clarify for the record that rural hospitals will not receive an additional \$10 billion per year in payments from RHTP due to the sub-regulatory program guidance established by HHS for the program.⁴ Further, this calculation does not account for the

¹ An act to provide for reconciliation pursuant to title II of H. Con. Res. 14, H.R. 1, 119th Cong. (2024).

² <https://www.politico.com/news/2025/12/29/trump-admin-adoles-out-billions-for-rural-health-00707332>

³ As cited by Secretary Kennedy during the hearing, approximately 7% of Medicaid’s overall budget, or \$20 billion per year, goes to rural hospitals.

⁴ The \$50 billion in total RHTP funding will not be distributed entirely to rural hospitals, therefore rural hospitals across the country will not receive an additional \$10 billion in funding per year. Rather, the \$10 billion will be spread across many different entities that are implementing states’ initiatives. While some entities may include rural hospitals, many will be community-based organization, rural health clinics, technology vendors,



approximately \$137 billion decrease in Medicaid reimbursement across all rural providers over the next 10-year period due to H.R. 1.⁵ The \$50 billion investment in rural health, while significant and historic, makes up about one third of the projected loss of federal Medicaid funding in rural areas. While Medicaid spending will continue to grow over the next ten years, it will be at a slower rate if H.R. 1 had not been enacted and less funds will flow to rural communities. In almost all states rural areas have higher rates of Medicaid enrollment than metropolitan areas⁶ and rural hospitals disproportionately depend on reimbursement from public payers, including Medicaid. Changes to Medicaid will force many facilities to reduce or eliminate essential services, delay much-needed facility upgrades, or close their doors entirely.

Site Neutral Payment

In response to questions about supporting rural healthcare delivery, Secretary Kennedy noted that site neutral regulations would help rural communities, end the disparity between what rural and urban providers are paid, and minimize incentives for consolidation which harms rural healthcare.

Rural hospitals and their outpatient departments, both on-campus and off-campus, provide essential services required for healthcare access in rural communities. Current and proposed site neutral policies have significantly reduced payments to rural facilities and have the potential to exacerbate financial pressures on small rural hospitals. Although intended to control expenses, these policies threaten rural hospitals, potentially undermining their financial stability and jeopardizing access to essential health care services in underserved communities.

Rural hospitals heavily rely on off-campus hospital outpatient departments (HOPDs) to provide essential care in remote areas. The more rural the county where a Medicare beneficiary resides, the more likely it is that they seek care in an HOPD rather than a physician's office.⁷ In fact, rural hospitals' average share of revenue from outpatient services has increased from 66% in 2011 to almost 75% in 2021.^{8,9} Additionally, Medicare accounts for a higher percentage of outpatient revenue in rural hospitals, making Medicare OPPS payments more important in rural hospitals than urban hospitals.¹⁰ The financial burden imposed by site-neutral payments may force rural hospitals to make difficult operational decisions, such as reducing services, delaying equipment purchases, or closing departments or entire facilities. Rural hospitals face unique challenges meeting requirements to provide 24/7 emergency care, comply with EMTALA, and meet stringent conditions of participation,

and even urban hospitals. Second, there is no mandate or mechanism to ensure that rural hospitals receive any amount of RHTP dollars distributed to the states, so in some states rural hospitals may not receive any direct payments. Third, as explained above, payments to providers are capped at 15%, meaning that rural providers could only receive up to an additional \$1.5 billion per year for services provided.

⁵ Heather Saunders, Alice Burns & Zachary Levinson, *How Might Federal Medicaid Cuts in the Enacted Reconciliation Package Affect Rural Areas?*, KFF (July 24, 2025), <https://www.kff.org/medicaid/how-might-federal-medicaid-cuts-in-the-enacted-reconciliation-package-affect-rural-areas/>.

⁶ Medicaid's role in small towns and rural areas. Center For Children and Families. January 15, 2025. <https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/>.

⁷ Am. Hosp. Ass'n, *Hospitals and Health Systems Are Critical to Preserving Access to Care in Rural Communities* (Jan. 25, 2024), <https://www.aha.org/2024-01-25-analysis-hospitals-and-health-systems-are-criticalpreserving-access-care-rural-communities>.

⁸ Pranathi Sana & George Pink, Univ. of N.C. at Chapel Hill, *Medicare Covers a Lower Percentage of Outpatient Costs in Hospitals Located in Rural Areas*, <https://www.ruralhealthresearch.org/publications/1451>.

⁹ Randall John, Tyler Malone, & George Pink, Univ. of N.C. at Chapel Hill, *Trends in Revenue Sources among Rural Hospitals*, <https://www.shepscenter.unc.edu/product/trends-in-revenue-sources-among-rural-hospitals/>.

¹⁰ Sana & Pink, *supra* note 9.

which are not fully addressed by site-neutral payment rates. These challenges often result in higher costs per service compared to larger urban hospitals due to lower patient volumes, minimum staffing requirements, standby capacity needs, and more.

Site-neutral payments also threaten access to care for the most vulnerable rural patients. Dually eligible beneficiaries use HOPDs for outpatient care more than their non-dually eligible counterparts. Of this population utilizing HOPDs, 72% have a complication or comorbidity compared to 64 percent of patients that mostly visit physicians' offices.¹¹ The ramifications extend beyond financial impacts, affecting health care access in rural areas where reduced reimbursement can lead to service reductions or closures, worsening existing disparities such as longer travel distances to health care facilities and limited access to specialized services.¹²

Site-neutral payment policies pose a threat to rural hospitals by reducing reimbursement rates and potentially leading to service reductions or facility closures. Exempting rural providers from these policies is crucial to maintaining access to essential health care services in rural communities. NRHA urges policymakers to consider the unique circumstances of rural health care providers when implementing site-neutral payment policies. Extending exemptions to a broader range of rural hospitals and adjusting payment methodologies will help protect the financial viability of these critical access points. Addressing disparities in site-neutral payments is key for supporting rural health infrastructure and ensuring equitable access to care across all regions. Maintaining a robust rural health care infrastructure is crucial to ensure rural populations receive the care they need. Supporting rural hospitals through policy reforms will help preserve health care access and improve health outcomes in underserved areas.

Area Wage Index

Members of the Committee and Secretary Kennedy highlighted how the Medicare area wage index disadvantages rural hospitals compared to their urban counterparts. NRHA strongly supports Rep. Kustoff's bill, H.R. 8106, the *Save Struggling Hospitals Act*, to codify CMS' prior low wage index policy. In *Bridgeport Hospital v. Becerra*, the court compelled CMS to vacate its low wage index policy that boosted the wage index for rural hospitals in the bottom quartile.¹³ NRHA urges Congress to codify this policy by passing H.R. 8106.

Graduate Medical Education

Chairman Smith referenced the statutory loophole in the Social Security Act that allows urban hospitals to reclassify as rural for Medicare purposes and receive higher reimbursements, among other benefits. NRHA has consistently voiced concerns around how the rural reclassification loophole has impacted new Graduate Medical Education (GME) slot distribution.

In Section 126 of the Consolidated Appropriations Act, 2021, Congress created 1,000 new GME slots. Hospitals eligible to receive slots include: (1) hospitals in rural areas (or treated as being located in a rural area under the law), (2) hospitals training a number of residents in excess of their GME cap, (3) hospitals in states with new medical schools or branch campuses, and (4) hospitals that serve areas designated as health professional shortage areas (HPSAs). Additionally, Section 126 requires that at least 10 percent of the cap slots go to hospitals in each of the four categories. However, throughout four rounds of slot distribution, 10% of slots have not reached geographically rural

¹¹ Am. Hosp. Ass'n, *supra* note 8.

¹² Rural Health Info. Hub, *Rural Health Disparities*, <https://www.ruralhealthinfo.org/topics/rural-healthdisparities>.

¹³ *Bridgeport Hosp. v. Becerra*, 108 F. 4th 882 (D.C. Cir. 2024).

hospitals. CMS notes that 10% of slots have technically gone to rural hospitals because reclassified hospitals, meaning geographically urban but administratively rural hospitals, have received the majority of slots.

In the latest round of distribution in December 2025, only three hospitals were geographically located in non-metro rural areas.¹⁴ Most hospitals receiving slots were classified as rural only through Medicare administrative reclassification, rather than being physically located in rural communities. Specifically, of the 63 hospitals considered rural by Medicare, 60 were not geographically rural and qualified solely through reclassification mechanisms. The first three rounds of slot distribution looked similar.

NRHA successfully included a definition of rural in H.R. 1153, the *Rural Physician Workforce Production Act*, that would accurately capture geographically rural hospitals and exclude geographically urban, reclassified hospitals. The definition in the bill includes any of the following: rural areas defined in section 1886(d)(2)(D), *not including* any hospital being treated as rural pursuant to 1886(d)(8)(E); areas with a rural-urban commuting area code equal to or greater than 4.0; and sole community hospitals. We urge the Committee to consider using this definition in all legislation moving forward in order to preserve rural opportunities for truly rural hospitals. We believe this aligns with the Chairman's priority of protecting rural hospitals.

Rural Healthcare Sustainability

NRHA appreciates the major investment in rural health provided by the RHTP. Due to the limiting factors discussed above, this investment must also be paired with long-term reimbursement policies that support rural hospitals. Rural hospitals and clinics are anchoring health care facilities in rural communities and play an essential role as safety net providers ensuring access for individuals living in rural areas. Furthermore, they employ most, if not all, of the primary care workforce in a rural community. This underscores the importance of these providers in maintaining adequate primary access points for their communities as the last line of defense in caring for vulnerable populations. Unfortunately, over 200 hospitals have closed or discontinued inpatient services since 2010¹⁵ and over 45% of rural hospitals currently have negative operating margins.¹⁶ When a rural hospital closes, not only does the community lose access to vital health care, but a major employer and community lynchpin exits, affecting the larger community.

NRHA urges Congress to pass the following bipartisan bills to strengthen rural hospital reimbursement and access to capital:

- **H.R. 3684: *Save America's Rural Hospitals Act*** (Rep. Graves and Rep. Budzinski). This legislation would enact wholesale reforms to Medicare reimbursement and remove regulatory red tape for rural hospitals, including reversing cuts to Medicare bad debt, making certain rural payment designations permanent, and increasing ground ambulance reimbursement for services in rural areas.

¹⁴ Mukesh Adhikari, et al., RuralGME, *Overview of Residency Programs Selected for CAA Sec. 126 Round Four Graduate Medical Education Slots*, (Jan. 2026), <https://www.ruralhealth.us/getmedia/fc94bdd6-c281-4f6d-a077-64cff524df0b/CAA-Sec-126-R4-Analysis-02-09-26.pdf>.

¹⁵ University of North Carolina, Cecil G. Sheps Center for Health Services Research, *Rural Hospital Closures*, available at <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

¹⁶ Chartis Center for Rural Health, *2026 rural health state of the state*, available at <https://www.chartis.com/insights/2026-rural-health-state-state>



- **H.R. 6204: *Rural Hospital Closure Relief Act*** (Rep. Vindman, Rep. Mann, and Del. Moylan). Before 2006, states could designate critical access hospitals (CAHs) as “necessary providers,” thereby waiving mileage requirements associated with the designation. The CAH designation offers enhanced Medicare reimbursement at 101% of reasonable costs, which is designed to reduce the financial vulnerability of rural hospitals and retain access to care. Small rural hospitals paid under the prospective payment system (PPS) continue to struggle financially but narrowly miss mileage criteria, barring them from converting to CAH. S. 502 would restore necessary provider status, with certain guardrails, to bring stability to small, rural hospitals.
- **H.R. 6804: *Rural Hospital Flexibility Act*** (Rep. Miller and Rep. Sewell). This bill would reauthorize the Medicare Rural Hospital Flexibility program which supports CAHs, small rural hospitals, and rural EMS. Congress created the Flex program as a bulwark against the structural challenges small rural hospitals face given their limited administrative capacity and resources. These programs ensure an annual support mechanism to support rural hospitals at a time when the risk of closure and financial stress is an ongoing problem.
- **H.R. 1805: *Assistance for Rural Community Hospitals Act*** (Rep. Miller and Rep. Sewell). This bill would extend the Medicare-dependent hospital (MDHs) and low-volume hospital (LVH) designations for 5 years and would allow sole community hospitals and MDHs to adjust their base years. MDH and LVH programs serve as a lifeline for many rural hospitals and are critical for sustaining access to care in rural areas. It is crucial that Congress enact long-term extensions for MDH and LVH designations. A series of short-term extenders for these designations put hospitals in an uncertain position that makes long-term financial planning more difficult.

NRHA thanks members of the Committee for their attention and dedication to rural healthcare. The targeted policies detailed above would protect, sustain, and improve health care delivery for rural patients alongside the RHTP. NRHA calls on Congress and the Administration to prioritize rural health and ensure rural communities have the same accessible, quality health care as their urban counterparts. For additional information, please contact Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan".

Alan Morgan
Chief Executive Officer
National Rural Health Association