April 24, 2026
Submitted via email: Statementsfortherecord@finance.senate.gov

Senate Finance Committee
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200

Re: Statement for the Record – *The President's Fiscal Year 2027 Department of Health and Human Services Budget*

Dear Chairman Crapo and Ranking Member Wyden,

The National Rural Health Association (NRHA) appreciates the opportunity to submit this statement for the record on the Committee's recent hearing, *The President's Fiscal Year 2027 Department of Health and Human Services (HHS) Budget* held on Wednesday April 22, 2026.

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 CMS have consistently stated that the RHTP is not intended to supplant losses associated with changes to Medicaid enacted in H.R. 1[1] nor keep rural hospital doors open. Through statements[2] 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.

To implement this policy, CMS has limited payments to providers for the provision of items or services not paid by insurers and/or other programs (i.e., Category B funding) to 15% of a state's total award.[3] This means that, at most, if all 50 states chose to invest the entire 15% of their RHTP funds in provider payments, rural providers could see a $7.5 billion increase in payments for services over the 5-year RHTP period, or $1.5 billion per year at a maximum. Further, this would not be specific to rural hospitals but rather across all types of rural providers. Additionally, RHTP funds for provider payments may not be used to enhance payments for inadequate reimbursement rates or for uncompensated care,[4] both of which are core issues at the heart of rural provider viability.

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[1] Signed into law as part of the One Big Beautiful Bill Act (Chapter 4—Protecting Rural Hospitals and Providers, Section 71401 of Public Law 119-21, 119th Congress (July 4, 2025)).
[2] https://www.politico.com/news/2025/12/29/trump-admin-doles-out-billions-for-rural-health-00707332
[3] RHTP NOFO and Provider payment fact sheet
[4] *Id*.

The statute establishing the RHTP allows payments to providers yet is silent on the structure of provider payments,[5] meaning that it is the Administration's decision to impose restrictions on provider payments. Despite these clear limitations, Secretary Kennedy repeatedly noted that rural hospitals currently receive $20 billion in Medicaid payments per year[6] and HHS is increasing these payments to rural hospitals by 50%, or $10 billion per year, through the RHTP. Given the constraints on RHTP provider payments noted above, NRHA would like to clarify for the record that it is not possible for rural hospitals to receive an additional $10 billion per year in payments from RHTP due to the sub-regulatory program guidance established by HHS for the program.[7] Further, this calculation does not account for the approximate $137 billion that rural providers stand to lose over the next 10-year period due to H.R. 1.[8]

To direct RHTP funds to rural hospital sustainability**, NRHA has asked CMS to revise its guidance to allow for the use of funds for enhancing payment rates for already billable services and uncompensated care for rural populations.[9] NRHA requests that Congress provide direction to the Administration to ensure the change in sub-regulatory program guidance to allow these revisions consistent with the initial intent of the law.** Low reimbursement rates from public payers paired with low volumes are a major contributor to rural hospital financial instability. RHTP provides a unique opportunity to stabilize rural hospitals and set them up for success on their road to transformation. However, as CMS has currently structured the program, rural providers may continue to face persistent financial constraints that prevent them in participation of long-term transformation.

Further, **NRHA recommends that CMS revisit other caps placed in the sub-regulatory guidance including the 5% maximum for EHR/HIT investments to increase the allowable amount and to allow retention payments to existing employees to support the rural workforce.[10]** Many rural hospitals that adopted EHRs with the assistance of meaningful use funding, now find the cost of ownership is beyond their means. In 2026, these platforms are crucial to being capable of managing care across the continuum and participating in value-base arrangements. In an era of RHTP, rural facilities need help upgrading and paying for maintenance on these systems in order to provide high quality care for the patients they serve. Further, rural hospitals struggle to attract and retain staff

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[5] 42 U.S.C. § 1397ee(h)(6)(B) ("Providing payments to health care providers for the provision of health care items or services, as specified by the Administrator").

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

[7] 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, 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.

[8] https://www.kff.org/medicaid/how-might-federal-medicaid-cuts-in-the-enacted-reconciliation-package-affect-rural-areas/

[9] https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2026/rhtp-provider-payments-letter-to-hhs.pdf

[10] *Id*.

when competing with larger, urban systems. Current CMS program guidance prohibits retention payments due to the 5-year commitment for employment arrangements.[11]

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 2010[12] and over 45% of rural hospitals currently have negative operating margins.[13] 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:

- **S. 4233: *Save Struggling Hospitals Act*** (Sen. Warner and Sen. Blackburn). Between 2020 and 2024, CMS improved Medicare reimbursement by providing a wage index adjustment for low wage index hospitals. The policy has since been struck down by the courts and this legislation would codify and restore the adjustment, making Medicare reimbursement fairer for rural, low wage hospitals.
- **H.R. 3684: *Save America's Rural Hospitals Act*** (Rep. Graves and Rep. Budzinski). This legislation would enact wholescale 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.
- **S. 502: *Rural Hospital Closure Relief Act*** (Sen. Durbin and Sen. Lankford). 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.
- **S. 4141: *Rural Hospital Revitalization Act*** (Sen. Bennet and Sen. Moran). CMS restricts states from using RHTP funds for new construction, and renovations or alterations cannot exceed 20% of total RHTP awards. However, accessible capital for aging facilities is a dire need for rural hospitals. S. 4141 would offer 0% interest loans from the Department of Agriculture to rural facilities in order to finance construction and renovations.

[11] CMS RHTP 5 year Service Commitment Fact Sheet

[12] 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/.

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

We appreciate the Committee's attention to the healthcare needs of rural Americans and the Administration's commitment to successfully administering the RHTP. The targeted policies outlined in our statement would complement RHTP and protect, sustain, and improve health care delivery for rural patients. For additional information, please contact Carrie Cochran-McClain at ccochran@ruralhealth.us.

Sincerely,

Carrie Cochran-McClain

Carrie Cochran-McClain
Chief Policy Officer
National Rural Health Association