Statement for the Record

National Rural Health Association
to the
United States Senate Committee on Finance

Full Committee Hearing on Rural Health Care: Supporting Lives and Improving Communities
May 16, 2024

May 30, 2024

Submitted via email: statementsfortherecord@finance.senate.gov

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. 219 Dirksen Senate Office Building
Washington, DC 20510

Re: Statement for the Record on Hearing on *Rural Health Care: Supporting Lives and Improving Communities*

Dear Chairman Wyden and Ranking Member Crapo:

The National Rural Health Association (NRHA) appreciates the opportunity to submit this statement for the record on the Rural Health Care: Supporting Lives and Improving Communities held by the full Committee on May 16, 2024.

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 care needs support more than ever. Using hospitals as a proxy for the wellbeing of rural health care generally, over 170 rural hospitals have closed or discontinued inpatient services since 2010. Nearly 450 more rural hospitals are considered vulnerable to closure with 50% operating with negative margins. Congress must invest in rural health to ensure providers

remain open and accessible to rural residents. Approximately 80% of rural America is medically underserved and seeing historic workforce shortages. As the Committee states, rural residents face unique barriers to accessing health care and tend to be older, sicker, and poorer than their urban counterparts. The policy solutions in our response would have a significant impact on access, affordability, and provider stability.

Summary Recommendations for Congressional Action

Congress has reconfirmed their commitment to the rural communities repeatedly over the years by providing new protections to ensure rural provider viability and to ensure patient access to health care services in rural communities. NRHA and its members share this goal of ensuring that federal health care payment policies recognize the unique practice environment in rural areas and the important contributions rural providers bring to the Medicare program and its beneficiaries.

NRHA appreciates the opportunity to provide these comments and requests that the Finance Committee consider and advance the following legislation to improve access to health care in rural communities:

- S. 3967, the Telehealth Modernization Act and S. 2016, the CONNECT for Health Act and to make all Medicare telehealth flexibilities permanent and create payment parity for Rural Health Clinics (RHCs)
- S. 948, the Healthy Moms and Babies Act aims to improve maternal and child health by increasing services, supports, and access to coordinate care and technology in rural areas
- S. 803, the Save Rural Hospitals Act, aims to enhance reimbursements to more accurately reflect the actual costs incurred by these hospitals
- S. 1110, the Rural Hospital Support Act, to make Medicare Dependent Hospital (MDH) and Low-Volume Hospital (LVH) programs permanent is essential to provide certainty to hospitals and safeguard their financial viability moving forward
- S. 1571, the Rural Hospital Closure Relief Act, to allow a limited waiver of the 35-mile requirement for Critical Access Hospital (CAH) to assist struggling rural PPS hospitals
- S. 4322, the Rural Emergency Hospital Improvement Act, to implement technical fixes to the REH designation
- S. 198, the RHC Burden Reduction Act would address RHCs outdated legislative barriers
- S. 1673, the Protecting Access to Ground Ambulance Medical services Act, extends increases Medicare payments for rural ground ambulance services
- S. 230, the Rural Physician Workforce Production Act which would lift GME caps and foster a more equitable distribution of medical education resources to rural areas
- H.R. 8235, the Rural Physician Workforce Preservation Act, to exclude reclassified hospitals from receiving slots allocated to rural hospitals unless geographically located in a rural area
- S. 2418, the Improving Care and Access to Nurses Act, to modernize Medicare policies, removing barriers that currently restrict the practice capabilities of these professionals

Further, NRHA encourages Committee members to collaborate with colleagues to support legislation outside their immediate jurisdiction including:

- S. 3193, the Telehealth Response for E-prescribing Addiction Therapy Act allows telehealth, including audio-only, to be used for prescribing buprenorphine for opioid use disorder

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- S. 1851, the Midwives for MOMS Act, proposes to expand midwifery education programs, can greatly assist in filling critical gaps in care
- S. 4079, the Rural Obstetrics Readiness Act, to support initiatives that enhance OB readiness in hospitals without dedicated OB units
- 340B Drug Pricing Program protections including SUPPORT 340B Act; H.R. 7635 340B PATIENTS Act; H.R. 2534 PROTECT 340B Act; and H.R. 8144 Rural 340B Access Act

Telehealth

COVID 19 Flexiblities

NRHA urges the Committee to consider **S. 3967, the Telehealth Modernization Act and S. 2016, the CONNECT for Health Act** in order to make all Medicare telehealth flexibilities permanent and create payment parity for RHCs.

The temporary flexibilities introduced during the COVID-19 Public Health Emergency, including expanded telehealth services and eased regulatory requirements, have been vital in maintaining healthcare access during the pandemic. Making these flexibilities permanent would support a sustained improvement in healthcare accessibility and efficiency in rural areas. Key flexibilities include: 1) RHCs and Federally Qualified Health Centers (FQHCs) serving as distant site providers, 2) audio-only telehealth for rural beneficiaries without reliable internet access, 3) an expanded list of authorized telehealth practitioners (including physical therapists, occupational therapists, speech-language pathologists), 4) removing geographic site requirements, and 5) allowing the beneficiary's home to serve as an originating site.

Further, RHCs may not be able to support telehealth services because of the added costs associated with furnishing them. Rural providers are less equipped to provide telehealth services without upgrading their technological infrastructure, and that can come at a significant cost. Ensuring that RHCs receive payment parity for telehealth services compared to in-person services will help expand access to beneficaries living in rural areas. The overhead for the RHC's brick-and-mortar clinic exists, in addition to the costs associated with telehealth, making payment parity a necessity. Without payment parity, it is more challenging for RHCs to make the necessary transition to telehealth.

Broadband

Supporting policies that continuously improve and expand broadband infrastructure in rural America is essential for effective telehealth delivery. Retaining audio-only telehealth services is one way to address the digital divide, as nearly one in four rural Americans cite internet access as a major barrier. However, the goal should be to make broadband accessible for all rural communities to realize the full potential of telehealth in expanding access to healthcare.

Tele-Behavioral Health

Telehealth has also shown its usefulness in providing behavioral health care to rural communities. **S. 3193, the Telehealth Response for E-prescribing Addiction Therapy Act** allows telehealth, including audio-only, to be used for prescribing buprenorphine for opioid use disorder (OUD). This act is pivotal for rural communities where nearly three-quarters of counties lack a buprenorphine provider. Current flexibilities for prescribing medications for opioid use

disorder (MOUD) via telehealth expire at the end of 2024, showing the urgent need for legislative action to ensure continued access.

Rural Provider Stability

Financial and Regulatory Challenges

Rural Hospitals: Rural hospitals operate under the same regulatory burdens as larger urban hospitals; however, the cost of compliance per discharge is often higher due to lower patient volumes. This is further complicated by rising costs in labor, drugs, and supplies, with hospitals seeing a 17.5% increase in overall expenses from 2019 to 2022, which has not been adequately matched by increases in Medicare or Medicaid reimbursement. These escalating costs, combined with inadequate reimbursement rates, have led many rural hospitals to operate at a loss, with some being forced to close. Half of rural hospitals across the country are operating on negative margins and 418 hospitals are identified as vulnerable to closure. Legislative relief from outdated and unnecessarily burdensome regulations and improved reimbursement could provide rural hospitals with the flexibility needed to sustain operations and continue serving their communities effectively.

Rural hospitals are significantly impacted by a predominantly public payer mix, with Medicare and Medicaid making up a substantial portion of their patient base. This reliance on public health programs, which often reimburse at rates lower than the cost of providing care, places rural hospitals in a precarious financial position, particularly as they also serve a higher percentage of uninsured patients. In 2020, rural hospitals faced substantial financial shortfalls, including $5.8 billion in Medicare underpayments and $1.2 billion in Medicaid underpayments, compounded by $4.6 billion in uncompensated care. These issues are further exacerbated by Medicare sequester cuts and the potential implementation of Medicaid Disproportionate Share Hospital (DSH) cuts.

To address these reimbursement issues, legislative actions such as adjusting the Medicare wage index policy and ensuring payments reflect real labor costs are crucial. Current proposals like **H.R. 3635/S. 803, the Save Rural Hospitals Act**, aim to enhance reimbursements to more accurately reflect the actual costs incurred by rural hospitals. Medicare designations designed to support the unique financial circumstances of rural hospitals, such as the MDH and LVH designations, are scheduled to expire at the end of 2024. Supporting **S. 1110, the Rural Hospital Support Act**, to make these programs permanent is essential to provide certainty to hospitals and safeguard their financial viability moving forward. The Committee should also move forward with **S. 1571, the Rural Hospital Closure Relief Act**, to allow a limited waiver of the 35-mile requirement for CAHs to assist struggling rural PPS hospitals stay viable.

Another significant reform for rural hospitals would be cost report modernization. Medicare cost report methods date back to 1965 and have remained largely unchanged. Cost report allocation is the foundation of all rural hospital financing. Estimates suggest that with exclusions Medicare covers 92% of hospital cost, not 101%. Often subsidiary services are non or low margin yet are critical for population health initiatives. One meaningful change to how CAHs can be reimbursed is to allow all costs associated with contracting with physicians to be included on the cost report. Congress should direct CMS to establish a working group to address key issues such as waiver or modification of CAH cost allocation regulations to allow greater integrated community services and review of cost exclusions that further reduce reimbursement to hospitals for essential services.

One silver lining of the Public Health Emergency (PHE) was that rural providers were freed from administrative burdens and outdated regulations. NRHA calls on the Committee to implement these flexibilities permanently to make rural health care administration and delivery more efficient. Of note, Congress should permanently end the 96-hour average length of stay rule for CAHs. Relatedly, NRHA urges Congress to remove the condition of payment that requires physicians to certify upon admission that a patient can reasonably expect to be discharged within 96 hours. Finally, the requirement for beneficiaries to have a 72-hour qualifying hospital stay before admission to a SNF should be removed as an outdated barrier to placing beneficiaries in the appropriate care setting.

Another threat to rural hospital stability is site neutral payment. Site neutral payment policies will disadvantage rural providers. While addressing the cost of care for rural residents is critical, it is essential that rural provider viability is not inadvertently impacted. Paying off-campus rural providers less than the full outpatient prospective payment rate contributes to destabilizing rural health care delivery. Off-campus provider-based departments (PBDs) may be the only source of care in many rural communities and thus play a critical role in keeping care local and ensuring that rural patients can receive the services that they need. Any decline in payments threatens a rural provider's ability to keep their doors open. Higher costs of PBDs in rural hospitals may be attributed to the need to spread fixed costs across a lower volume of services. Additionally, hospitals often furnish more complex care and must meet more stringent regulatory requirements than physicians' offices. Hospitals are highly regulated and the burdens that are associated with compliance should be accounted for in payment. The site neutral rate does not account for the type of care furnished nor the resources needed at off-campus PBDs.

Current House site-neutrality proposals would cost rural hospitals $272 million cuts over ten years. If Congress pursues site neutral policies, NRHA emphasizes the need to exempt rural hospitals and off-campus PBDs. Any savings generated from site neutral payment should be reinvested in the rural health care infrastructure to enact the policy solutions and legislation presented in our response. Savings could also be redirected to help rural providers address their patients' social determinants of health, like transportation or food insecurity. Many safety net providers that offer transportation or other services for patients absorb this cost because it is not reimbursable but is a huge benefit to their patient population. Removing barriers to care and addressing some social risk factors that impact health will reduce costs in the long-term because patients are receiving preventive services.

Rural Emergency Hospitals: The Rural Emergency Hospital (REH) model presents an innovative approach to preserving health care services in rural areas by offering higher Medicare reimbursement in exchange for ceasing inpatient care. This designation is one tool in the toolbox for rural hospitals that may otherwise be facing closure. However, legislative improvements are needed to make this model more accessible and financially viable for hospitals that are struggling to maintain operations. NRHA urges the Committee to consider S. 4322, the Rural Emergency Hospital Improvement Act. This bill would implement technical fixes to the REH designation, such as allowing for rehabilitation, inpatient psychiatric, and obstetric distinct part units; opening eligiblity to hospitals that closed between 2015 and December 27, 2020; creating a waiver program at CMS to allow certain facilities to convert to REH; allowing CAHs that convert to REH and back to CAH to retain necessary provider status; and more.

Medicare Advantage: Reforms in Medicare Advantage (MA) are necessary to prevent further financial strain on rural hospitals. The growth of MA enrollment is higher in nonmetropolitan counties than in metropolitan counties. MA penetration in rural areas varies by community, but overall 45% of rural Medicare beneficiaries are enrolled in an MA plan. As rural enrollment grows, CAHs and RHCs financial stability are threatened. CAHs receive 101% of reasonable costs from Traditional Medicare and RHCs receive their specific all-inclusive rate. Yet MA plans do not always pay CAHs and RHCs at their Traditional Medicare rate, undermining their financial base. In fact, about 35% of surveyed RHCs indicated that they are paid on a fee-for-service basis rather than on an encounter basis. Ensuring that MA plans reimburse at least at Traditional Medicare rates and considering rural providers in the rate-setting processes, are vital steps to prevent the financial decline of these critical institutions. Federally Qualified Health Centers (FQHCs), for example, receive a wrap around payment from Medicare when MA plans do not pay the Traditional Medicare rate.

MA plans also often delay and deny payments, even if they previously approved the service for the beneficiary and the service was furnished. Rural providers cannot shoulder delayed or missing payments, especially as some NRHA members have noted that they are waiting on several hundred thousand dollars of payments from plans. Addressing these disparities will help stabilize rural healthcare providers and ensure that rural residents continue to have access to necessary healthcare services.

Rural Health Clinics: RHCs play a pivotal role in providing primary care in rural areas by serving 38.7 million patients per year, or 62% of all rural Americans. RHCs, like hospitals, also rely heavily upon government payers with an average of 64% of patients covered by government payers. Strengthening RHCs through improved funding and regulatory support can significantly impact the health outcomes of rural populations.

Low-cost and noncontroversial, **S. 198, the RHC Burden Reduction Act** is a commonsense piece of legislation that would make a significant difference on the day-to-day operations of RHCs by addressing outdated legislative barriers. This important bill would align RHC physician supervision requirements with state scope of practice laws governing physician assistant and nurse practitioner practice, remove outdated laboratory requirements, allow RHCs to provide an increased amount of behavioral health services, among other technical tweaks.

Further, NRHA has supported legislative work toward increasing RHC capacity for quality measure reporting through a voluntary program that would provide enhanced reimbursement. The House introduced legislation outlining this idea in the 117th Congress and we urge the Senate to consider this proposal. Addressing challenges such as the RHC payment methodology and enhancing support for these clinics can help stabilize the broader rural healthcare infrastructure, ensuring that primary care is accessible and sustainable.

Emergency Medical Services: Enhanced federal support for emergency medical services (EMS) is crucial for rural areas where response times are typically longer, and operational costs are high due to vast geographic coverage areas. Rural ambulance response times are more than double that of urban ambulances and nearly 10% of patients wait over 30 minutes for EMS personnel to arrive. About a third of rural EMS agencies in the U.S. are in immediate operational jeopardy because they cannot cover their costs, largely from insufficient Medicaid and Medicare reimbursements, which pay on average a third of actual EMS costs. Legislation such as **S. 1673/H.R. 1666, the Protecting Access to Ground Ambulance Medical services Act,** extends

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increases Medicare payments for rural ground ambulance services, is essential to sustain these vital services that often operate at a financial loss.

Transition to Value-Based Care

As health care delivery seeks to move towards value-based care, NRHA is concerned that rural providers are integrated into new models and payment opportunities. However, rural providers face challenges related to quality programs that require reporting on measures not relevant to the low-volume, rural context. This limits their participation in innovative payment models, like those administered by CMS' Innovation Center (CMMI), that could improve patient outcomes and provide alternative revenue streams. Frequently, fee-for-service reimbursement does not align with the reality of operating rural facilities, particularly due to low patient volumes. Value-based care models must consider the different rural payment mechanisms, particularly for RHCs and CAHs. Rural providers are poised to gain from value-based care, yet they struggle to participate or even be included in CMMI models.

Congress charged CMMI with developing and testing new payment and service delivery models that must achieve cost savings. The decades of underinvestment in rural health care delivery makes achieving cost savings extremely difficult. Alternative payment methodologies for rural providers and higher acuity patient mix can create additional barriers to model integration. Congress should direct investments to building out and supporting rural providers in value-based care. The Committee should grant greater authority to the HHS Secretary, through CMMI, to develop and implement voluntary alternative rural payment models. Such models should include a global budget or enhanced cost-based reimbursement. In addition, NRHA believes that exempting rural providers from CMMI's cost-savings mandate would alleviate some barriers to entry in innovative demonstration projects. Congress must equip CMMI with the authority to waive the cost savings requirement in order to develop rural-centric models or to allow rural providers to engage in CMMI models broadly without achieving cost savings at the outset.

340B Drug Pricing Program

Maintaining and strengthening the 340B Drug Pricing Program is critical for rural covered entities. This program allows these facilities to provide discounted drug prices to low-income patients, supporting the financial health of hospitals that operate on thin margins. 340B is a lifeline that allows rural safety net providers to keep their doors open and furnish critical services by stretching scarce federal resources. Rural hospitals and clinics rely upon 340B savings to help them keep needed services local for patients. NRHA developed a set of principles that should guide Congress in any 340B reform to ensure rural access to the program is protected. NRHA was pleased to see several of these principles reflected in the **Senate 340B Working Group's discussion draft of the SUPPORT 340B Act**.

NRHA urges Congress against any limitations on the number and location of contract pharmacies with which rural covered entities work and encourages the Committee to introduce a Senate companion to **H.R. 7635, the 340B PATIENTS Act**. Ensuring that rural hospitals continue to benefit from 340B savings without undue restrictions is vital for keeping healthcare accessible and affordable in rural communities. NRHA also supports clear statutory restrictions on pharmaceutical benefit managers (PBMs) and payers' ability to treat 340B covered entities differently as outlined in **H.R. 2534, the PROTECT 340B Act** and reflected in the 340B Working Group's discussion draft, the SUPPORT 340B Act. These actors have increasingly

discriminated against 340B patients, covered entities, and contract pharmacies. NRHA also asks that Congress add the new REH provider type to the 340B statute as a covered entity, as outlined in **H.R. 8144, the Rural 340B Access Act**. NRHA members cite 340B eligibility as the top concern when deciding whether to convert to an REH.

Rural Workforce Support

Graduate Medical Education

Rural areas experience significant disparities in medical professional availability, notably influenced by the geographic distribution of Graduate Medical Education (GME) slots. Despite evidence suggesting that physicians trained in rural settings are more likely to continue practicing in similar environments, only 2% of residency training occurs in rural areas. Congress acknowledged the maldistribution of training opportunities in the Consolidated Appropriations Act (CAA) of 2021, which allocated 10% of the 1,000 new GME slots to rural hospitals. However, only 5.9% of GME slots went to 5 geographically rural hospitals during the first round of awards while 42 hospitals reclassified as rural received 42% slots. Analysis shows only 3% of reclassified facilities will use slots to train residents for 50% or greater time in rural areas and 6% for rural training less than 50% of time, with the remaining 92% doing no formal rural training. Analysis also shows that the majority of new slots went to residency programs located in urban health professional shortage areas (HPSAs). In the second round, two geographically rural hospitals and one urban hospital with a Rural Track Program received slots. Distribution to reclassified hospitals is technically following the law;[1] however, NRHA is concerned with this allocation of GME slots set aside for rural training to geographically urban hospitals. Further, it appears the reclassified hospitals that received slots under the first round of distribution are not training residents in rural areas. Unfortunately, this is allowed because of the reference to § 1886(d)(8)(E) in the legislative text.

To correct these discrepancies and genuinely support rural healthcare, the Committee should consider a companion bill to **H.R. 8235, the Rural Physician Workforce Preservation Act**. This bill would exclude reclassified hospitals from receiving the 10% of slots allocated to rural hospitals unless the hospital reclassified because they are in a rural Census tract of a metropolitan statistical area or are located in an area considered rural by state law or regulation. In addition, the Committee can support rural physician training through **S. 230, the Rural Physician Workforce Production Act** which would lift GME caps and foster a more equitable distribution of medical education resources to rural areas.

Another facilitator of rural training would be a minor definitional change in Rural Track Programs (RTPs). Currently, CMS only finances RTPs if greater than 50% of the training occurs in rural counties. While this covers most rural areas, it does not capture all. GME financing for RTPs should be expanded to programs training greater than 50% of the time in Federal Office of Rural Health Policy (FORHP) defined rural areas. FORHP defines rural as any non-metropolitan county plus areas in metropolitan counties with a Rural-Urban Commuting Area code of 4 or

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[1] The CAA, 2021 stated that 10% of slots must go to "[h]ospitals that are located in a rural area (as defined in section 1886(d)(2)(D)) or are *treated as being located in a rural area pursuant to section 1886(d)(8)(E).*" Hospitals treated as being located in a rural area are "reclassified" hospitals, or geographically urban hospitals that convert to "rural" for IPPS payment purposes.

higher. There are currently 353 ACGME-accredited programs with ≥50% training occurring in FORHP rural areas and only 150 programs ≥ 50% occurring in rural counties.

The discrepancies in Indirect Medical Education (IME) payments further exacerbate the challenges faced by rural hospitals, particularly those with teaching programs. Sole Community Hospitals (SCHs) and MDHs that are paid at a hospital-specific rate are unfairly excluded from receiving IME payments, which limits their capacity to train medical residents. Equitable IME payment distribution will support the development of rural training programs, crucial for addressing the ongoing healthcare provider crisis in these communities.

Last, Section 131 of the CAA, 2021 provided hospitals with very low direct GME per resident amounts or FTE caps to reset those between December 27, 2020, and December 26, 2025. However, many rural teaching hospitals need a longer timeframe to take advantage of this opportunity. Rural hospitals should be given more time to reach their full training potential before a new cap is implemented. NRHA suggests that the Committee consider extending this deadline until 2030 or allowing a hospital in a geographically rural area with less than 12 FTEs to reset an FTE cap or PRA at any time.

Utilizing All Health Professionals

The maldistribution of physicians in rural areas necessitates innovative approaches to healthcare delivery and use of nonphysician practitioners (NPPs). Expanding the scope of practice for nurse practitioners (NPs), physician assistants (PAs), and other non-physician practitioners (NPPs) presents a viable solution to alleviate workforce shortages. Legislation **like S. 2418, the Improving Care and Access to Nurses Act**, aims to modernize Medicare policies, removing barriers that currently restrict the practice capabilities of these professionals. By allowing greater autonomy and expanding their roles, rural areas can better utilize the available healthcare workforce to address gaps in care provision, especially in primary and preventative care settings.

Nursing Home Staffing

Rural nursing homes are particularly vulnerable to staffing shortages, which are exacerbated by newly established stringent federal staffing mandates. The recently finalized CMS staffing standards, though well-intentioned, do not account for the unique challenges faced by rural facilities, such as the historic labor shortages and the closure of facilities in these areas. Over 200,000 more long-term care workers are needed to meet pre-pandemic staffing levels. On top of record-low workforce numbers, rural communities saw almost 500 rural nursing homes close between 2008 and 2018. This trend is not slowing. In fact, the long-term care landscape is worse in certain predominantly rural states such as Montana where 16% of the state's nursing homes closed in 2022. In the same year in Iowa, 13 of 15 nursing homes closures occurred in rural areas. A lack of post-acute care beds has ripple effects in rural health care. Patients are unable able to get access to acute care in their local rural communities because hospitals cannot discharge patients who no longer require inpatient care but cannot safely return home due to lack of long-term care facilities. Congress should look to improve the nursing workforce and home- and community-based services (HCBS) to lessen the pressure on rural nursing homes and improve patient outcomes. It is vital that legislation such as the Better Care Better Jobs Act be reintroduced, providing support for nursing homes through planning grants, quality measures, and technical assistance aimed at improving staffing and care quality without imposing unattainable requirements that could lead to further closures of rural nursing homes.

Maternal Health

The scarcity of obstetric care in rural hospitals has led to higher rates of maternal morbidity and mortality. Many rural hospitals have been forced to close obstetric units due to financial constraints and workforce shortages, exacerbating the crisis in maternal health. In 2023 alone, 23 hospitals, predominantly in rural areas, announced the closure of their OB units. This trend is alarming as over half of rural hospitals are now without an OB unit. The lack of OB provider availability, with an estimated 58.7% of rural counties lacking an obstetrician, 81.7% lacking advanced practice midwives, and 56.9% lacking family physicians who deliver babies, further compounds the issue. These shortages and closures highlight the urgent need for policy interventions that ensure the continuity of maternal care in rural communities.

To address these significant challenges in rural maternal health, robust federal support is essential. Medicaid reimbursement rates set by states do not cover the full cost of providing obstetric services. This may mean particular financial losses for hospitals providing these services in rural areas, where a higher proportion of births are covered by Medicaid. Increasing Medicaid reimbursement would help to keep obstetric services open to serve rural individuals. Proposals like **S. 948, the Healthy Moms and Babies Act** are crucial as they aim to improve maternal and child health by increasing services, supports, and access to coordinate care and technology in rural areas. Moreover, legislation such as **S. 1851, the Midwives for MOMS Act,** which proposes to expand midwifery education programs, can greatly assist in filling critical gaps in care. These efforts are particularly vital in rural areas that rely on midwives and other non-obstetrician practitioners due to ongoing workforce constraints.

Most pregnancy-related deaths are preventable with proper medical care, making it imperative for Congress to support initiatives that enhance OB readiness in hospitals without dedicated OB units. **S. 4079, the Rural Obstetrics Readiness Act,** was recently introduced to address this need. The bill includes grants from the Department of Health and Human Services (HHS) to expand OB emergency training and equipment in rural hospitals. Such measures would not only improve the immediate response capabilities of rural hospitals but also ensure a broader safety net for expectant mothers in underserved areas.

Thank you for your consideration of these comments. NRHA would be pleased to serve as a resource as the Committee considers legislation to protect and improve access to care in rural communities. Please contact Carrie Cochran-McClain at ccochran@ruralhealth.us if you have any questions.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association