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U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS
1139 LONGWORTH HOUSE OFFICE BUILDING
Washington, DC 20515

August 21, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20515

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20515

Dear Secretary Kennedy and Administrator Oz:

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) are stewards of our nation's health system. The American people entrust HHS, and specifically CMS, to strengthen critical programs such as Medicare and Medicaid for today and the future. Sadly, under the Biden-Harris Administration, costs for patients and taxpayers exploded, Medicare and Medicaid were riddled with fraud and abuse, and the previous administration opened the rolls to millions of illegal aliens and jobless, able-bodied adults – all while treating rural America as an afterthought. With President Trump's leadership, Republicans delivered The One, Big, Beautiful Bill (OBBB), to stop illegal aliens from accessing taxpayer-funded health programs, create commonsense Medicaid work requirements, and make transformational investments in rural health.[1] As our focus turns to OBBB's implementation, I write to ensure the funds under the law's **Rural Health Transformation Program (RHTP)** are, as the White House stated, "appropriately distributed and going to the most deserving, not the most politically connected."[2]

For the 20 percent of Americans – 60 million in total – that live in rural communities, insufficient access to health care is a daily crisis and contributes to worse health outcomes. These patients are often forced to drive an hour or more for basic medical services and face critical barriers when trying to receive specialized services such as oncology or maternity and obstetric care. The inability to directly and efficiently access care is devastating to rural communities across the country. It is unsurprising that rural patient cancer mortality is 13 percent higher than that of urban patients; that rural maternal mortality is twice as high as urban maternal mortality; and that rural mortality overall is 43 percent higher than urban mortality across natural causes.[3] [4] [5]

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[1] P.L. 119-21.
[2] https://www.whitehouse.gov/articles/2025/07/the-one-big-beautiful-bill-is-a-historic-investment-in-rural-healthcare/
[3] https://www.cdc.gov/nchs/data/databriefs/db417.pdf
[4] https://ajph.aphapublications.org/doi/10.2105/AJPH.2022.307134
[5] USDA ERS, "The Nature of the Rural-Urban Mortality Gap."

Access challenges are worsened when rural communities lose these critical service lines, or worse, their entire hospital facilities. **Missouri has had 12 rural hospitals close in the past decade, including five in the southeastern communities that I represent.** Nationwide, nearly 200 rural hospitals have closed in that timeframe while more than 100 rural hospitals have stopped providing maternity services in just the last five years.[6] Nearly 400 rural hospitals have stopped providing chemotherapy services since 2014.[7] While I share the excitement surrounding the benefits offered by the adoption of new and innovative technology, those I represent and millions of rural Americans like me are chiefly concerned with access to basic health services.

For this reason, my top health care priority in Congress is to improve access to care in Southeastern Missouri and throughout rural America. As Chairman of the House Committee on Ways & Means, I have undertaken a comprehensive effort to identify the root causes of rural America's health care access problem and engage in meaningful solutions. In September 2023, at the beginning of my chairmanship, I issued a request for information to health care stakeholders and rural communities across the country seeking solutions to reshape rural access to care, receiving more than 300 responses from national, state, and local stakeholders.[8] Our committee has traveled from hub and spoke care delivery sites in eastern North Carolina to emergency medical service facilities in northern Texas to Native American reservations in Arizona to see firsthand the successes and challenges of providing health care in rural America.[9] [10] [11] Our committee has held hearings examining innovative care delivery models like telehealth and hospital at home; challenges facing small, independent, and rural provider practices; the unique challenges of post-acute care delivery in rural areas; and more.[12] [13] [14] [15] Additionally, the committee approved several bills that would enhance rural access to health care, including the ***Second Chances for Rural Hospitals Act*, which would allow certain shuttered rural hospitals to reopen under the new Rural Emergency Hospital designation**, keeping vital emergency care lifelines in isolated communities.[16]

Building on the foundation we began at the committee, Congress created the RHTP through section 71401 of the OBBB, making a critical investment in America's rural communities like those in Missouri's 8th Congressional District. Under this section of the law, CMS must distribute $50 billion to states, half allocated equally, and half allocated according to your determination based on state applications. The law states this funding must be used for at least three of 10 enumerated purposes, including promoting evidence-based measures to prevent chronic disease, recruiting and retaining the rural clinical workforce, and rightsizing health care delivery systems to meet the needs of each community – all worthy goals.

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[6] https://ruralhospitals.chqpr.org
[7] https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf
[8] https://gop-waysandmeans.house.gov/wp-content/uploads/2023/09/WM-Rural-Health-Care-RFI.pdf
[9] https://waysandmeans.house.gov/2023/10/18/in-north-carolina-patients-doctors-and-local-leaders-share-challenges-of-accessing-health-care-in-rural-communities/
[10] https://waysandmeans.house.gov/2024/03/21/in-texas-americans-highlight-need-for-access-to-emergency-care-in-rural-and-underserved-communities/
[11] https://waysandmeans.house.gov/2024/05/14/in-arizona-tribal-leaders-share-difficult-challenges-facing-their-communities/
[12] https://waysandmeans.house.gov/2024/03/14/were-keeping-patients-independent-and-healthier-at-home-for-longer/
[13] https://waysandmeans.house.gov/2024/05/28/five-key-moments-from-health-subcommittee-hearing-on-the-collapse-of-private-practice/
[14] https://waysandmeans.house.gov/2024/07/05/three-key-moments-hearing-on-value-based-care/
[15] https://waysandmeans.house.gov/2025/03/14/four-key-moments-hearing-on-ensuring-access-to-quality-post-acute-care/
[16] https://www.congress.gov/bill/118th-congress/house-bill/8246

However, like any government financial incentive, there is a risk the RHTP will be gamed, so I urge caution in its implementation. **Too often, well-intentioned support for rural health has been funneled instead to urban facilities, padding already robust bottom lines, financing executive salaries and marketing budgets**. Just this month, a study described large urban hospitals' use of an arcane Medicare loophole to classify themselves as both *urban* and *rural* simultaneously, allowing them the extensive financial benefits Medicare provides to each.[17] [18] This loophole results in a massive redirection of scarce resources away from truly rural facilities and into the bottom lines of "dually classified" urban hospitals, through significant Medicare payment increases, lower indigent population-servicing percentages to qualify for the lucrative 340B drug discount program, and access to up to 90 of 100 newly funded graduate medical education slots dedicated to rural areas, leaving only 10 slots to improve access to care in truly rural communities.

The need for real solutions in rural America is greater than ever, and your agencies have a once-in-a-generation opportunity to **ensure RHTP funds benefit the communities in rural America that need it most**, rather than the "most politically connected" facilities with a proven track record of lavish spending on executive salaries and marketing.[19] **I stress the importance and specifically ask your agencies to implement the RHTP with the following principles in mind:**

- Consider the truest measures of "rurality" when reviewing state applications.
    - As part, we encourage HHS and CMS to work expeditiously with the U.S. Department of Agriculture to promptly update the census data used to determine Rural-Urban Commuting Area (RUCA) codes – a critical measurement of rurality specified in the RHTP statute.
- Prioritize states whose applications demonstrate:
    - A loss in access to health care services relative to other states, measured by rural hospital closures, service line reductions, or similar metrics;
    - Significant total *truly rural* resident populations and associated trends; and
    - Significant *truly rural* resident populations relative to other resident populations, population density, and to other states and associated trends.
- Ensure RHTP funds are benefited by *truly rural* facilities rather than facilities located in urban areas, such as "dually classified" hospitals and other urban health facilities masquerading as rural.
- Ensure states can use RHTP funds to right size and/or relocate existing rural facilities, especially in instances when a facility can retain and restore access to care, through the Rural Emergency Hospital (REH) designation.
    - Additionally, ensure that previously closed rural facilities can access funding needed to right size, relocate, and/or reopen under their previous designation or another designation such as REH.
- Ensure states can use RHTP funds to support rural facilities in reopening previously closed or adding new service lines, such as maternity and labor/delivery services.

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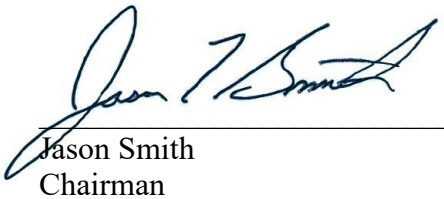
[17] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00019
[18] https://waysandmeans.house.gov/2025/08/19/study-urban-hospitals-are-posing-as-rural-facilities-to-exploit-benefits-intended-specifically-for-rural-communities/
[19] https://waysandmeans.house.gov/2023/04/28/top-four-takeaways-from-ways-and-means-oversight-hearing-on-non-profit-hospitals/

- Ensure states can use RHTP funds to promote sustainable measures to improve the financial status of rural providers including investments in technical assistance for improved contract review between providers, payers, and vendors.
- Ensure states can use RHTP funds to improve rural patient access to care through innovative transportation arrangements that bring patients to care, care to patients, and patients back to their communities.
- Closely monitor state disbursements of RHTP funds, especially to ensure they are not used to subsidize lobbying, marketing, or political activity; this may include requiring states to issue reports for congressional and public inspection, showing spending by line item, and through frequent audits of such reports.
- Closely monitor end usage of RHTP funds following state disbursement, which may be accomplished by requiring state RHTP applications to include proposed metrics each state will use to track to demonstrate the funding was used to successfully deliver on the proposed elements of the state's RHTP application; such metrics could also be reported for congressional and public inspection.

Thank you for your dedication to serving America's most vulnerable rural communities. I welcome additional discussion on this matter and other issues important to rural America.

Sincerely,



Jason Smith
Chairman
House Committee on Ways and Means

CC: Brooke Rollins, Secretary, U.S. Department of Agriculture