**Updated Analysis of the Rural Health Transformation Fund on Rural Hospitals**

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## Background

On July 4th, President Trump signed H.R. 1, the One Big Beautiful Bill Act, into law, making significant changes to Medicaid and the Marketplaces. The law includes a $50 billion Rural Health Transformation Fund (up from $25 billion included in prior versions) that may help to blunt some of the impact of H.R. 1 on rural communities. CMS and states will have significant discretion in determining which types of providers could qualify, including rural hospitals, rural health clinics, federally qualified health centers, and community mental health centers, as well as the uses for the funds provided.

- **Available Funding:** The provision allocates $10 billion per federal fiscal year (FFY) from 2026–2030 for a total of $50 billion.
- **Application:** States must submit a rural health transformation fund application to the Centers for Medicare & Medicaid Services (CMS) by a date specified by CMS. CMS is expected to release application guidance by mid-September and must approve or deny applications no later than the end of 2025. Additional information from CMS can be found at https://www.cms.gov/priorities/rural-health-transformation-rht-program/.
- **Distribution approach:** 50% of the funding will be allocated equally across all states with approved applications. Another 50% will be distributed to states at the CMS Administrator's discretion, who is required to consider a number of factors, including the state's percentage of rural residents, and the share of rural health care facilities in the state compared to such facilities nationwide. The law provides that at least one quarter of the states with an approved application must be allocated funding from this 50%.
- **Allowable Uses of Funding:** The law provides CMS and states with significant discretion in determining the allowable uses of funding. Examples of allowable activities listed in the law include payments to health care providers, promoting evidence-based interventions to improve prevention and disease management, workforce recruitment in rural areas and technology innovation.
- **Limitations:** States will not be allowed to use the funding as the non-federal share of Medicaid payments and can allocate up to 10% of the funding for administrative costs.

## Manatt Analysis

Manatt's updated analysis compared the size of the rural hospital funding gap generated by H.R. 1, as enacted, with three potential rural health transformation fund distribution scenarios. The fund is available to a range of rural providers, and the actual distribution and uses for the funds will be determined by states and CMS. Given the broad discretion states and particularly CMS will have, it is not possible to project the likely distribution. This analysis provides three illustrative examples of how funding might be shared across rural providers, and how the hospital share in each scenario compares with the losses rural hospitals are likely to experience as a result of H.R.1. Data on the funding losses and gaps faced by other rural providers are not available for modeling.

**Distribution Approach:**

- To estimate the amount each state would receive, Manatt distributed the first $25 billion equally among all 50 states (D.C. is not eligible for the transformation fund), consistent with the statutory requirements and assuming all states would submit a transformation fund application that CMS would ultimately approve.
- The remaining $25 billion was distributed for illustrative purposes among the 50 states in proportion to their share of rural residents in the 2020 U.S. Census. In practice, CMS may use different factors to distribute these dollars and may not distribute funding to all states, but the proportion of a state's population is a reasonable proxy given that it is one of the factors CMS must consider in distributing the funds. Manatt then distributed the $25 billion using three scenarios, described below.

**Scenario #1—All Rural Health Transformation Funding Goes Only to Rural Hospitals:**

- If all of the funds allocated to a state were distributed to rural hospitals, nationally those hospitals would receive all $50 billion in funding, which would address 87.9% of the cut to Medicaid rural hospital expenditures they are expected to experience from FFYs 2025-2034. This is not a likely scenario given the needs of other rural providers, but it provides a starting point for the analysis.
- Twenty-eight states would see their entire Medicaid rural hospital funding cut addressed under this scenario (without accounting for the uses of these funds).
- Four states, Iowa, Oregon, Washington, and Kentucky, would see less than half of their rural hospital funding cuts addressed.

**Scenario #2—80% of Rural Health Transformation Funding Goes to Hospitals:**

- In this scenario, nationwide rural hospitals would receive 80% of the funds, or $40 billion in funding, which would address 70.3% of the Medicaid cut they are expected to face over the next ten years.
- Fifteen states would see their entire Medicaid rural hospital funding cut addressed.
- Less than 30% of the rural hospital funding cuts would be addressed in Oregon, Iowa, Washington, and Kentucky.

**Scenario #3—Funding Allocated Based on Hospital's Share of Total Medicaid Expenditures:**

- With this scenario, Manatt assumed that states would provide hospitals with a share of the funding proportionate to hospitals' share of Medicaid spending in each state.
- Hospital expenditures are projected to account for approximately 36% of Medicaid spending nationally in FFY 2025, but there is significant variation across states. For example, hospital expenditures account for 20% of Medicaid spending in North Dakota and over half of Medicaid spending in Virginia.
- Under this scenario, nationally rural hospitals would receive $17.5 billion from the fund, filling 30.8% of the national rural hospital Medicaid funding gap created by H.R. 1.
- Rural hospitals in ten states would see their entire funding cut addressed in this scenario.
- States including North Carolina, New Mexico, Oregon, Washington, Ohio, and Kentucky would see less than 15% of their rural hospital funding gap filled.

**Conclusion**

Given the broad discretion Congress permitted with respect to both the distribution and uses of the Rural Health Transformation Fund, little is known at this point as to the extent to which the Fund will address H.R.1's reductions in Medicaid funding for rural health providers. The three scenarios modeled here offer illustrative examples of how different approaches to distribution would affect funding. As noted, the possible uses for these funds will further affect distribution and impact. States, in consultation with rural providers and stakeholders, will be developing their plans and likely weighing in with CMS and their congressional delegation as CMS develops its guidance.

## About the National Rural Health Association

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. Learn more about the association at https://www.ruralhealth.us/.

## About Manatt Health

Manatt Health is a leading professional services firm specializing in health policy, health care transformation, and Medicaid redesign. Their modeling draws upon publicly available state data including Medicaid financial management report data from the Centers for Medicare and Medicaid Services, enrollment and expenditure data from the Medicaid Budget and Expenditure System, and data from the Medicaid and CHIP Payment and Access Commission. The Manatt Health Model is tailored specifically to rural health and has been reviewed in consultation with states and other key stakeholders. For more information, visit https://www.manatt.com/health.