National Rural Health Association

December 8, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: H.R. 1 Implementation

Dear Administrator Oz,

The National Rural Health Association (NRHA) is writing to share our recommendations for the agency's implementation of Medicaid changes included in H.R. 1. Many provisions in H.R. 1 have the potential to upend coverage among rural populations and must be effectuated in a way that protects rural Medicaid enrollees and rural providers.

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.

Work requirements.

As the system currently stands, Medicaid work requirements can cause adverse effects on rural providers and residents. Rural Americans are more likely to be low-wage workers, more likely to be unemployed, and have fewer job options than urban Americans, making rural Medicaid enrollees more susceptible to losing coverage under work requirement policies. As such, it is critical that the Centers for Medicare & Medicaid Services (CMS) thoughtfully implement work requirements, provide flexibility to states, and issue clear guidance to ensure minimal improper coverage losses for rural beneficiaries.

NRHA asks that CMS promote use of ex parte verifications for individuals' compliance with work requirements. Ex parte verifications would greatly ease the burden on rural enrollees as they would generally not have to submit additional information to prove compliance. CMS should facilitate a simple data matching process by issuing guidance to states to encourage use of any available payroll data and enrollment in education programs. CMS must issue guidance in the upcoming interim final rule around the standards and processes states can use for data matching to verify compliance and must include a robust and exhaustive set of sources.

CMS also must ensure that existing data sources can be used to correctly verify exemptions to work requirements. State should be able to use trusted data sources to confirm an enrollee's exempt status, such as a SNAP recipient or caregiver of children under 14 years old. Medicaid and Medicaid managed care organization (MCO) claims data may also provide information pertinent to verifying an exemption like pregnancy or enrollment in a drug addiction or alcoholic treatment and rehabilitation program. Using existing data sources will place less burden on both Medicaid enrollees and the state systems responsible for managing work requirement compliance.

It is critical that state Medicaid agencies are equipped with guidance from CMS in a timely manner. H.R. 1 requires that CMS issue an interim final rule on work requirements by June 2026 while states must be prepared to implement work requirements by January 1, 2027. Given this short timeframe, we ask that CMS prioritize finalizing the interim final rule as soon as possible to give states time to develop, test, and change their systems.

Finally, given the immense effort put on states to get work requirement systems up and running in six months following CMS' interim final rule, we urge the agency to grant good faith waivers to states, as allowed by the statute. The Secretary has authority to exempt states from compliance with work requirements until no later than December 31, 2028, so long as the state is demonstrating a "good faith effort" to comply. Many states will likely require this exemption to ensure that their systems are functional and avoid any improper coverage losses.

Eligibility redeterminations.

Beginning in 2027, Medicaid enrollees offered coverage through Medicaid expansion will have their eligibility reviewed every six months as opposed to the current cycle of once every twelve months. Echoing our request above, CMS must develop guidance for states that encourages use of existing and trusted data sources and matches data with little to no burden on enrollees. NRHA is deeply concerned about the risk of coverage disruptions for rural enrollees who remain eligible but may lose access due to bureaucratic hurdles and paperwork mistakes. Rural Medicaid beneficaries face more structural barriers to complying with eligibility redeterminations, such as lack of internet or transportation access, that puts them at higher risk for being improperly disenrolled.

Provider taxes.

H.R. 1 puts in place provider tax freezes for all current arrangements, prohibits new provider taxes, and requires a phasing down of hold harmless thresholds in Medicaid expansion states. Recent CMS guidance provides initial clarity around how the agency is interpreting statutory language, including "enacted" and "imposed" for the purposes of deciding whether new provider tax arrangements are allowed under H.R. 1.[1]

Provider taxes represent a significant amount of reimbursement to rural providers.[2] While NRHA acknowledges that changes to these arrangements are statutory, we ask CMS to ensure that further guidance and implementation are straightforward and do not go beyond the limitations provided in H.R. 1.

State directed payments.

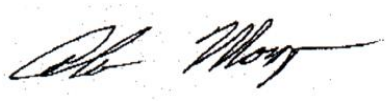
CMS also released preliminary guidance around changes to state directed payments (SDPs) ahead of rulemaking.[3] H.R. 1 only impacts SDPs for inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers. However, CMS notes in its recent guidance that future rulemaking will extend to facility types beyond the four listed in statute and regulations.[4] NRHA urges CMS to stay limited to the requirements in the statute and not expand SDP limitations to further facility types.

[1] https://www.medicaid.gov/medicaid/downloads/providertax_dcl_11142025.pdf
[2] https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/
[3] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-09092025.pdf
[4] 42 C.F.R. § 438.6(c)(2)(iii).

SDPs have allowed states to improve chronically low Medicaid reimbursement, particularly for rural providers. Rural hospitals, for example, often serve a majority of patients covered by Medicare and Medicaid.[5] Any changes, however small, to public payer rates exacerbate existing financial challenges for rural facilities. The changes to SDPs enacted in H.R. 1 will hurt rural hospitals and nursing facilities and we ask that CMS avoid imposing further SDP limitations on other rural facility types in order to preserve access to care.

NRHA appreciates CMS' efforts to improve rural healthcare and looks forward to continuing our work together. If you have any questions or would like to meet to discuss our requests above, please contact NRHA's Government Affairs and Policy Director Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[5] https://www.kff.org/health-costs/key-facts-about-hospitals/?entry=rural-hospitals-rural-discharges-by-payer#:~:text=dataDownload%20PNG-,Rural%20Discharges%20by%20Payer,-Copy%20link%20to