

Updated Analysis of the Rural Health Transformation Fund on Rural Hospitals

Authored by Manatt Health

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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>.

Impact of H.R. 1 on Rural Medicaid Hospital Expenditures (Total Computable), FFYs 2025-2034 (\$ Millions)

Note: The below analysis distributes the impact of select provisions H.R. 1 on total Medicaid hospital expenditures proportionately based on the proportion of rural residents in each state. We leverage Medicare Cost Report data crosswalked with Core-Based Statistical Areas (CBSA) to develop an allocation of Medicaid hospital expenditures by urban and rural geographies by state. See footnote 1 below for additional detail on our allocation approach. In this scenario, we assume all rural health funding goes to rural hospitals.

State	Share of Medicaid Hospital Expenditures ¹	Impact on Medicaid Hospital Spend of H.R. 1 (Prior to Application of Rural Hospital Fund Support)			Rural Health Fund Part #1	Rural Health Fund Part #2	Total Rural Health Fund ²	Impact on Medicaid Hospital Spend of H.R. 1 (After Application of Rural Health Fund)	Percentage of Rural Hospital Cut Addressed by Rural Health Fund
	Rural	Total	Total	Rural	Equally Distributed Grants to States ³	Grants Made Proportionally Based on Rural Population ⁴	Total Grant	Rural	
	% of Expenditures	\$ Millions	% from Baseline ²	\$ Millions	\$ Millions	\$ Millions	\$ Millions	\$ Millions	
Total	9%	\$ (664,073)	-18.2%	\$ (56,881)	\$ 25,000	\$ 25,000	\$ 50,000	\$ (6,881)	87.9%
Alabama	12%	\$ (1,204)	-3.2%	\$ (140)	\$ 500	\$ 801	\$ 1,301	\$ 1,160	926.8%
Alaska	37%	\$ -	0.0%	\$ -	\$ 500	\$ 97	\$ 597	\$ 597	N/A
Arizona	4%	\$ (31,807)	-26.7%	\$ (1,203)	\$ 500	\$ 289	\$ 789	\$ (414)	65.6%
Arkansas	24%	\$ (3,586)	-13.7%	\$ (867)	\$ 500	\$ 506	\$ 1,006	\$ 139	116.0%
California	2%	\$ (118,919)	-20.1%	\$ (2,329)	\$ 500	\$ 859	\$ 1,359	\$ (969)	58.4%
Colorado	14%	\$ (8,235)	-18.2%	\$ (1,135)	\$ 500	\$ 304	\$ 804	\$ (331)	70.9%
Connecticut	2%	\$ (5,744)	-16.4%	\$ (138)	\$ 500	\$ 187	\$ 687	\$ 549	499.3%
Delaware	16%	\$ (1,032)	-12.1%	\$ (166)	\$ 500	\$ 65	\$ 565	\$ 399	340.6%
District of Columbia	0%	\$ (1,058)	-10.0%	\$ -	\$ -	\$ -	\$ -	\$ -	N/A
Florida	2%	\$ (12,025)	-8.7%	\$ (182)	\$ 500	\$ 688	\$ 1,188	\$ 1,005	651.2%
Georgia	12%	\$ (6,086)	-9.4%	\$ (731)	\$ 500	\$ 1,047	\$ 1,547	\$ 816	211.6%
Hawaii	24%	\$ (3,013)	-20.1%	\$ (719)	\$ 500	\$ 76	\$ 576	\$ (142)	80.2%
Idaho	15%	\$ (1,241)	-10.3%	\$ (182)	\$ 500	\$ 213	\$ 713	\$ 531	392.3%
Illinois	8%	\$ (31,312)	-19.5%	\$ (2,378)	\$ 500	\$ 632	\$ 1,132	\$ (1,246)	47.6%
Indiana	9%	\$ (12,558)	-24.7%	\$ (1,181)	\$ 500	\$ 737	\$ 1,237	\$ 57	104.8%
Iowa	37%	\$ (8,912)	-22.3%	\$ (3,279)	\$ 500	\$ 443	\$ 943	\$ (2,335)	28.8%
Kansas	22%	\$ (1,538)	-9.3%	\$ (341)	\$ 500	\$ 307	\$ 807	\$ 466	236.8%
Kentucky	20%	\$ (26,652)	-25.9%	\$ (5,376)	\$ 500	\$ 702	\$ 1,202	\$ (4,175)	22.4%
Louisiana	10%	\$ (22,660)	-22.8%	\$ (2,229)	\$ 500	\$ 500	\$ 1,000	\$ (1,229)	44.9%
Maine	35%	\$ (1,452)	-11.5%	\$ (507)	\$ 500	\$ 315	\$ 815	\$ 308	160.8%
Maryland	4%	\$ (5,549)	-11.5%	\$ (230)	\$ 500	\$ 335	\$ 835	\$ 605	362.9%
Massachusetts	1%	\$ (15,569)	-18.0%	\$ (117)	\$ 500	\$ 231	\$ 731	\$ 614	625.6%
Michigan	8%	\$ (28,431)	-22.5%	\$ (2,250)	\$ 500	\$ 1,008	\$ 1,508	\$ (742)	67.0%
Minnesota	19%	\$ (5,367)	-11.2%	\$ (1,031)	\$ 500	\$ 605	\$ 1,105	\$ 74	107.2%
Mississippi	38%	\$ (4,777)	-13.7%	\$ (1,822)	\$ 500	\$ 600	\$ 1,100	\$ (723)	60.3%
Missouri	13%	\$ (10,894)	-21.0%	\$ (1,383)	\$ 500	\$ 709	\$ 1,209	\$ (174)	87.4%
Montana	47%	\$ (2,286)	-24.0%	\$ (1,073)	\$ 500	\$ 190	\$ 690	\$ (382)	64.4%
Nebraska	33%	\$ (1,078)	-10.3%	\$ (352)	\$ 500	\$ 200	\$ 700	\$ 347	198.6%
Nevada	4%	\$ (6,881)	-21.2%	\$ (243)	\$ 500	\$ 69	\$ 569	\$ 326	234.5%
New Hampshire	56%	\$ (1,809)	-29.3%	\$ (1,012)	\$ 500	\$ 216	\$ 716	\$ (296)	70.8%
New Jersey	0%	\$ (24,331)	-26.6%	\$ -	\$ 500	\$ 219	\$ 719	\$ 719	N/A
New Mexico	18%	\$ (10,485)	-24.8%	\$ (1,870)	\$ 500	\$ 203	\$ 703	\$ (1,167)	37.6%
New York	3%	\$ (40,959)	-14.4%	\$ (1,206)	\$ 500	\$ 956	\$ 1,456	\$ 250	120.7%
North Carolina	10%	\$ (35,384)	-18.9%	\$ (3,707)	\$ 500	\$ 1,310	\$ 1,810	\$ (1,897)	48.8%
North Dakota	14%	\$ (413)	-11.6%	\$ (58)	\$ 500	\$ 115	\$ 615	\$ 557	1059.3%
Ohio	13%	\$ (22,402)	-18.9%	\$ (2,892)	\$ 500	\$ 1,055	\$ 1,555	\$ (1,337)	53.8%
Oklahoma	23%	\$ (10,719)	-18.1%	\$ (2,472)	\$ 500	\$ 528	\$ 1,028	\$ (1,444)	41.6%
Oregon	14%	\$ (17,201)	-25.6%	\$ (2,436)	\$ 500	\$ 312	\$ 812	\$ (1,625)	33.3%
Pennsylvania	6%	\$ (22,454)	-15.4%	\$ (1,408)	\$ 500	\$ 1,154	\$ 1,654	\$ 247	117.5%
Rhode Island	0%	\$ (3,012)	-22.1%	\$ -	\$ 500	\$ 37	\$ 537	\$ 537	N/A
South Carolina	7%	\$ (5,414)	-10.0%	\$ (352)	\$ 500	\$ 619	\$ 1,119	\$ 766	317.3%
South Dakota	25%	\$ (369)	-10.7%	\$ (91)	\$ 500	\$ 143	\$ 643	\$ 552	710.0%
Tennessee	10%	\$ -	0.0%	\$ -	\$ 500	\$ 880	\$ 1,380	\$ 1,380	N/A
Texas	6%	\$ (20,645)	-9.3%	\$ (1,209)	\$ 500	\$ 1,789	\$ 2,289	\$ 1,081	189.4%
Utah	9%	\$ (3,994)	-18.7%	\$ (375)	\$ 500	\$ 126	\$ 626	\$ 251	166.9%
Vermont	58%	\$ (388)	-7.4%	\$ (224)	\$ 500	\$ 157	\$ 657	\$ 433	293.5%
Virginia	6%	\$ (36,923)	-24.0%	\$ (2,098)	\$ 500	\$ 793	\$ 1,293	\$ (805)	61.6%
Washington	12%	\$ (21,788)	-25.4%	\$ (2,661)	\$ 500	\$ 483	\$ 983	\$ (1,678)	36.9%
West Virginia	21%	\$ (3,071)	-17.9%	\$ (646)	\$ 500	\$ 374	\$ 874	\$ 228	135.3%
Wisconsin	22%	\$ (2,385)	-6.5%	\$ (536)	\$ 500	\$ 732	\$ 1,232	\$ 696	229.8%
Wyoming	74%	\$ (61)	-2.7%	\$ (45)	\$ 500	\$ 83	\$ 583	\$ 538	1292.7%

1. We calculate the share of Medicaid hospital expenditures in urban and rural geographies using hospital net Medicaid revenues as reported on 2023 Medicare Cost Reports (made available through HCRIIS). We allocate net Medicaid revenues for each hospital to an urban or rural geography using the hospital's address crosswalked to Core-Based Statistical Areas (CBSAs) made available by AHA. For purposes of this analysis, we consider "micropolitan" geographies to be rural. For hospitals without an identified CBSA, we include those revenues in the "unknown" category. We then allocate our projected impacts of H.R. 1 on total Medicaid hospital expenditures proportionately based on the urban/rural distribution of Medicaid hospital revenues in each state.

2. We only include the percentage impact from baseline for total expenditures since the percentage impacts are the same across the urban, rural, and unknown categories.

3. 50% of the \$25 billion rural health transformation fund will be distributed equally to all states that submit an application. We assume that all states will submit an application and receive an award. Note that entities other than rural hospitals are eligible to receive a portion of this funding so this allocation overestimates the amount of funding that will be made available to rural hospitals.

4. 50% of the \$25 billion rural health transformation fund will be distributed to states at the discretion of the CMS administrator. For modeling purposes, we assume that these funds would be distributed based on the number of rural residents in a given state compared to the total number of rural residents nationally.

5. Grants from the Rural Health Transformation Fund will be distributed from FFY 2026 to FFY 2030, with states required to spend all funds by FFY 2031. We apply each state's estimated funding allocation against the total projected reduction in Medicaid rural hospital expenditures over a ten-year period.

6. Alaska and Tennessee's Medicaid hospital spend estimates are excluded from Manatt's model due to data limitations.

Impact of H.R. 1 on Rural Medicaid Hospital Expenditures (Total Computable), FFYs 2025-2034 (\$ Millions)

Note: The below analysis distributes the impact of select provisions H.R. 1 on total Medicaid **hospital** expenditures proportionately based on the urban/rural distribution of Medicaid hospital revenues in each state. We leverage Medicare Cost Report data crosswalked with Core-Based Statistical Areas (CBSA) to develop an allocation of Medicaid hospital expenditures by urban and rural geographies by state. See footnote 1 below for additional detail on our allocation approach. We assume 80% of rural health funding goes to rural hospitals.

State	Share of Medicaid Hospital Expenditures ¹	Impact on Medicaid Hospital Spend of H.R. 1 (Prior to Application of Rural Hospital Fund Support)			Rural Health Fund Part #1		Rural Health Fund Part #2		Total Rural Health Fund for Rural Hospitals ⁵		Impact on Medicaid Hospital Spend of H.R. 1 (After Application of Rural Health Fund)	Percentage of Rural Hospital Cut Addressed by Rural Health Fund
		Total	Total	Rural	Equally Distributed Grants to States ³		Grants Made Proportionally Based on Rural Population ⁴		Total Grant		Rural	
	% of Expenditures	\$ Millions	% from Baseline ²	\$ Millions	\$ Millions		\$ Millions		\$ Millions		\$ Millions	%
Total	9%	\$ (664,073)	-18.2%	\$ (56,881)	\$ 20,000		\$ 20,000		\$ 40,000		\$ (16,881)	70.3%
Alabama	12%	\$ (1,204)	-3.2%	\$ (140)	\$ 400		\$ 641		\$ 1,041		\$ 900	741.4%
Alaska	37%	\$ -	0.0%	\$ -	\$ 400		\$ 78		\$ 478		\$ 478	N/A
Arizona	4%	\$ (31,807)	-26.7%	\$ (1,203)	\$ 400		\$ 231		\$ 631		\$ (572)	52.5%
Arkansas	24%	\$ (3,586)	-13.7%	\$ (867)	\$ 400		\$ 404		\$ 804		\$ (62)	92.8%
California	2%	\$ (118,919)	-20.1%	\$ (2,329)	\$ 400		\$ 687		\$ 1,087		\$ (1,241)	46.7%
Colorado	14%	\$ (8,235)	-18.2%	\$ (1,135)	\$ 400		\$ 243		\$ 643		\$ (491)	56.7%
Connecticut	2%	\$ (5,744)	-16.4%	\$ (138)	\$ 400		\$ 150		\$ 550		\$ 412	399.5%
Delaware	16%	\$ (1,032)	-12.1%	\$ (166)	\$ 400		\$ 52		\$ 452		\$ 286	272.5%
District of Columbia	0%	\$ (1,058)	-10.0%	\$ -	\$ -		\$ -		\$ -		\$ -	N/A
Florida	2%	\$ (12,025)	-8.7%	\$ (182)	\$ 400		\$ 550		\$ 950		\$ 768	520.9%
Georgia	12%	\$ (6,086)	-9.4%	\$ (731)	\$ 400		\$ 838		\$ 1,238		\$ 507	169.3%
Hawaii	24%	\$ (3,013)	-20.1%	\$ (719)	\$ 400		\$ 61		\$ 461		\$ (257)	64.2%
Idaho	15%	\$ (1,241)	-10.3%	\$ (182)	\$ 400		\$ 171		\$ 571		\$ 389	313.8%
Illinois	8%	\$ (31,312)	-19.5%	\$ (2,378)	\$ 400		\$ 505		\$ 905		\$ (1,472)	38.1%
Indiana	9%	\$ (12,558)	-24.7%	\$ (1,181)	\$ 400		\$ 590		\$ 990		\$ (191)	83.8%
Iowa	37%	\$ (8,912)	-22.3%	\$ (3,279)	\$ 400		\$ 355		\$ 755		\$ (2,524)	23.0%
Kansas	22%	\$ (1,538)	-9.3%	\$ (341)	\$ 400		\$ 245		\$ 645		\$ 305	189.4%
Kentucky	20%	\$ (26,652)	-25.9%	\$ (5,376)	\$ 400		\$ 561		\$ 961		\$ (4,415)	17.9%
Louisiana	10%	\$ (22,660)	-22.8%	\$ (2,229)	\$ 400		\$ 400		\$ 800		\$ (1,429)	35.9%
Maine	35%	\$ (1,452)	-11.5%	\$ (507)	\$ 400		\$ 252		\$ 652		\$ 145	128.6%
Maryland	4%	\$ (5,549)	-11.5%	\$ (230)	\$ 400		\$ 268		\$ 668		\$ 438	290.3%
Massachusetts	1%	\$ (15,569)	-18.0%	\$ (117)	\$ 400		\$ 185		\$ 585		\$ 468	500.5%
Michigan	8%	\$ (28,431)	-22.5%	\$ (2,250)	\$ 400		\$ 806		\$ 1,206		\$ (1,043)	53.6%
Minnesota	19%	\$ (5,367)	-11.2%	\$ (1,031)	\$ 400		\$ 484		\$ 884		\$ (147)	85.8%
Mississippi	38%	\$ (4,777)	-13.7%	\$ (1,822)	\$ 400		\$ 480		\$ 880		\$ (943)	48.3%
Missouri	13%	\$ (10,894)	-21.0%	\$ (1,383)	\$ 400		\$ 567		\$ 967		\$ (416)	69.9%
Montana	47%	\$ (2,286)	-24.0%	\$ (1,073)	\$ 400		\$ 152		\$ 552		\$ (520)	51.5%
Nebraska	33%	\$ (1,078)	-10.3%	\$ (352)	\$ 400		\$ 160		\$ 560		\$ 207	158.8%
Nevada	4%	\$ (6,881)	-21.2%	\$ (243)	\$ 400		\$ 55		\$ 455		\$ 213	187.6%
New Hampshire	56%	\$ (1,809)	-29.3%	\$ (1,012)	\$ 400		\$ 173		\$ 573		\$ (439)	56.6%
New Jersey	0%	\$ (24,331)	-26.6%	\$ -	\$ 400		\$ 175		\$ 575		\$ 575	N/A
New Mexico	18%	\$ (10,485)	-24.8%	\$ (1,870)	\$ 400		\$ 163		\$ 563		\$ (1,307)	30.1%
New York	3%	\$ (40,959)	-14.4%	\$ (1,206)	\$ 400		\$ 765		\$ 1,165		\$ (41)	96.6%
North Carolina	10%	\$ (35,384)	-18.9%	\$ (3,707)	\$ 400		\$ 1,048		\$ 1,448		\$ (2,259)	39.1%
North Dakota	14%	\$ (413)	-11.6%	\$ (58)	\$ 400		\$ 92		\$ 492		\$ 434	847.5%
Ohio	13%	\$ (22,402)	-18.9%	\$ (2,892)	\$ 400		\$ 844		\$ 1,244		\$ (1,648)	43.0%
Oklahoma	23%	\$ (10,719)	-18.1%	\$ (2,472)	\$ 400		\$ 423		\$ 823		\$ (1,650)	33.3%
Oregon	14%	\$ (17,201)	-25.6%	\$ (2,436)	\$ 400		\$ 249		\$ 649		\$ (1,787)	26.6%
Pennsylvania	6%	\$ (22,454)	-15.4%	\$ (1,408)	\$ 400		\$ 924		\$ 1,324		\$ (84)	94.0%
Rhode Island	0%	\$ (3,012)	-22.1%	\$ -	\$ 400		\$ 30		\$ 430		\$ 430	N/A
South Carolina	7%	\$ (5,414)	-10.0%	\$ (352)	\$ 400		\$ 495		\$ 895		\$ 542	253.9%
South Dakota	25%	\$ (369)	-10.7%	\$ (91)	\$ 400		\$ 114		\$ 514		\$ 424	568.0%
Tennessee	10%	\$ -	0.0%	\$ -	\$ 400		\$ 704		\$ 1,104		\$ 1,104	N/A
Texas	6%	\$ (20,645)	-9.3%	\$ (1,209)	\$ 400		\$ 1,431		\$ 1,831		\$ 623	151.5%
Utah	9%	\$ (3,994)	-18.7%	\$ (375)	\$ 400		\$ 101		\$ 501		\$ 126	133.5%
Vermont	58%	\$ (388)	-7.4%	\$ (224)	\$ 400		\$ 126		\$ 526		\$ 302	234.8%
Virginia	6%	\$ (36,923)	-24.0%	\$ (2,098)	\$ 400		\$ 634		\$ 1,034		\$ (1,064)	49.3%
Washington	12%	\$ (21,788)	-25.4%	\$ (2,661)	\$ 400		\$ 386		\$ 786		\$ (1,875)	29.6%
West Virginia	21%	\$ (3,071)	-17.9%	\$ (646)	\$ 400		\$ 300		\$ 700		\$ 53	108.2%
Wisconsin	22%	\$ (2,385)	-6.5%	\$ (536)	\$ 400		\$ 585		\$ 985		\$ 449	183.9%
Wyoming	74%	\$ (61)	-2.7%	\$ (45)	\$ 400		\$ 66		\$ 466		\$ 421	1034.2%

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2. We only include the percentage impact from baseline for total expenditures since the percentage impacts are the same across the urban, rural, and unknown categories.

3. 50% of the \$25 billion rural health transformation fund will be distributed equally to all states that submit an application. We assume that all states will submit an application and receive an award. Note that entities other than rural hospitals are eligible to receive a portion of this funding so this allocation overestimates the amount of funding that will be made available to rural hospitals.

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Impact of H.R. 1 on Rural Medicaid Hospital Expenditures (Total Computable), FFYs 2025-2034 (\$ Millions)

Note: The below analysis distributes the impact of select provisions H.R. 1 on total Medicaid hospital expenditures proportionately based on the urban/rural distribution of Medicaid hospital revenues in each state. We leverage Medicare Cost Report data crosswalked with Core-Based Statistical Areas (CBSA) to develop an allocation of Medicaid hospital expenditures by urban and rural geographies by state. See footnote 1 below for additional detail on our allocation approach. We assume the percentage of funding going to hospitals is based on the proportion of a state's projected total FFY 2025 Medicaid expenditures that are Medicaid hospital expenditures.

State	Share of Medicaid Hospital Expenditures ¹	Impact on Medicaid Hospital Spend of H.R. 1 (Prior to Application of Rural Hospital Fund Support)				Rural Health Fund Part #1	Rural Health Fund Part #2	Total Rural Health Fund for Rural Hospitals ⁵	Percentage of Rural Health Fund Allocated to Rural Hospitals	Impact on Medicaid Hospital Spend of H.R. 1 (After Application of Rural Health Fund)	Percentage of Rural Hospital Cut Addressed by Rural Health Fund				
		Rural	Total	Total	Rural										
												Equally Distributed Grants to States ³	Grants Made Proportionally Based on Rural Population ⁴	Total Grant	FFY 2025 Percentage of Total Medicaid Expenditures Attributable to Hospitals
% of Expenditures	\$ Millions	% from Baseline ²	\$ Millions	\$ Millions	\$ Millions	\$ Millions	Percentage	\$ Millions	%						
Total	9%	(\$64,073)	-18.2%	(\$56,881)	\$8,408	\$9,118	\$17,527	36%	(\$39,354)	30.8%					
Alabama	12%	\$(1,204)	-3.2%	\$(140)	\$200	\$321	\$521	40%	\$381	371.2%					
Alaska	37%	\$-	0.0%	\$-	\$115	\$22	\$137	23%	\$137	N/A					
Arizona	4%	\$(31,807)	-26.7%	\$(1,203)	\$199	\$115	\$313	40%	\$(889)	26.0%					
Arkansas	24%	\$(3,586)	-13.7%	\$(867)	\$138	\$139	\$277	28%	\$(590)	32.0%					
California	2%	\$(118,919)	-20.1%	\$(2,329)	\$170	\$293	\$463	34%	\$(1,865)	19.9%					
Colorado	14%	\$(8,235)	-18.2%	\$(1,135)	\$163	\$99	\$262	33%	\$(873)	23.1%					
Connecticut	2%	\$(5,744)	-16.4%	\$(138)	\$136	\$51	\$187	27%	\$49	135.7%					
Delaware	16%	\$(1,032)	-12.1%	\$(166)	\$114	\$15	\$129	23%	\$(37)	78.0%					
District of Columbia	0%	\$(1,058)	-10.0%	\$-	\$-	\$-	\$-	0%	\$-	N/A					
Florida	2%	\$(12,025)	-8.7%	\$(182)	\$177	\$243	\$420	35%	\$238	230.4%					
Georgia	12%	\$(6,086)	-9.4%	\$(731)	\$175	\$367	\$542	35%	\$(190)	74.1%					
Hawaii	24%	\$(3,013)	-20.1%	\$(719)	\$166	\$25	\$192	33%	\$(527)	26.7%					
Idaho	15%	\$(1,241)	-10.3%	\$(182)	\$138	\$59	\$197	28%	\$15	108.4%					
Illinois	8%	\$(31,312)	-19.5%	\$(2,378)	\$199	\$251	\$450	40%	\$(1,928)	18.9%					
Indiana	9%	\$(12,558)	-24.7%	\$(1,181)	\$115	\$170	\$285	23%	\$(895)	24.2%					
Iowa	37%	\$(8,912)	-22.3%	\$(3,279)	\$258	\$229	\$487	52%	\$(2,792)	14.9%					
Kansas	22%	\$(1,538)	-9.3%	\$(341)	\$143	\$88	\$231	29%	\$(110)	67.7%					
Kentucky	20%	\$(26,652)	-25.9%	\$(5,376)	\$245	\$344	\$589	49%	\$(4,787)	11.0%					
Louisiana	10%	\$(22,660)	-22.8%	\$(2,229)	\$207	\$206	\$413	41%	\$(1,816)	18.5%					
Maine	35%	\$(1,452)	-11.5%	\$(507)	\$121	\$76	\$198	24%	\$(309)	39.0%					
Maryland	4%	\$(5,549)	-11.5%	\$(230)	\$111	\$74	\$185	22%	\$(45)	80.3%					
Massachusetts	1%	\$(15,569)	-18.0%	\$(117)	\$139	\$64	\$203	28%	\$86	173.9%					
Michigan	8%	\$(28,431)	-22.5%	\$(2,250)	\$233	\$470	\$703	47%	\$(1,547)	31.2%					
Minnesota	19%	\$(5,367)	-11.2%	\$(1,031)	\$113	\$137	\$250	23%	\$(781)	24.3%					
Mississippi	38%	\$(4,777)	-13.7%	\$(1,822)	\$235	\$282	\$517	47%	\$(1,306)	28.4%					
Missouri	13%	\$(10,894)	-21.0%	\$(1,383)	\$146	\$207	\$353	29%	\$(1,030)	25.5%					
Montana	47%	\$(2,286)	-24.0%	\$(1,073)	\$195	\$74	\$269	39%	\$(804)	25.1%					
Nebraska	33%	\$(1,078)	-10.3%	\$(352)	\$102	\$41	\$143	20%	\$(210)	40.5%					
Nevada	4%	\$(6,881)	-21.2%	\$(243)	\$216	\$30	\$245	43%	\$3	101.1%					
New Hampshire	56%	\$(1,809)	-29.3%	\$(1,012)	\$123	\$53	\$176	25%	\$(837)	17.3%					
New Jersey	0%	\$(24,331)	-26.6%	\$-	\$163	\$71	\$234	33%	\$234	N/A					
New Mexico	18%	\$(10,485)	-24.8%	\$(1,870)	\$178	\$72	\$250	36%	\$(1,620)	13.4%					
New York	3%	\$(40,959)	-14.4%	\$(1,206)	\$115	\$221	\$336	23%	\$(870)	27.9%					
North Carolina	10%	\$(35,384)	-18.9%	\$(3,707)	\$262	\$685	\$947	52%	\$(2,760)	25.5%					
North Dakota	14%	\$(413)	-11.6%	\$(58)	\$99	\$23	\$122	20%	\$64	209.6%					
Ohio	13%	\$(22,402)	-18.9%	\$(2,892)	\$136	\$286	\$422	27%	\$(2,471)	14.6%					
Oklahoma	23%	\$(10,719)	-18.1%	\$(2,472)	\$234	\$248	\$482	47%	\$(1,990)	19.5%					
Oregon	14%	\$(17,201)	-25.6%	\$(2,436)	\$159	\$99	\$258	32%	\$(2,178)	10.6%					
Pennsylvania	6%	\$(22,454)	-15.4%	\$(1,408)	\$130	\$300	\$430	26%	\$(977)	30.6%					
Rhode Island	0%	\$(3,012)	-22.1%	\$-	\$160	\$12	\$172	32%	\$172	N/A					
South Carolina	7%	\$(5,414)	-10.0%	\$(352)	\$258	\$319	\$577	52%	\$224	163.6%					
South Dakota	25%	\$(369)	-10.7%	\$(91)	\$107	\$31	\$137	21%	\$47	151.7%					
Tennessee	10%	\$-	0.0%	\$-	\$256	\$451	\$707	51%	\$707	N/A					
Texas	6%	\$(20,645)	-9.3%	\$(1,209)	\$216	\$775	\$991	43%	\$(217)	82.0%					
Utah	9%	\$(3,994)	-18.7%	\$(375)	\$195	\$49	\$245	39%	\$(131)	65.2%					
Vermont	58%	\$(388)	-7.4%	\$(224)	\$117	\$37	\$153	23%	\$(71)	68.4%					
Virginia	6%	\$(36,923)	-24.0%	\$(2,098)	\$264	\$419	\$682	53%	\$(1,415)	32.5%					
Washington	12%	\$(21,788)	-25.4%	\$(2,661)	\$171	\$165	\$336	34%	\$(2,325)	12.6%					
West Virginia	21%	\$(3,071)	-17.9%	\$(646)	\$136	\$102	\$237	27%	\$(409)	36.7%					
Wisconsin	22%	\$(2,385)	-6.5%	\$(536)	\$128	\$188	\$316	26%	\$(220)	58.9%					
Wyoming	74%	\$(61)	-2.7%	\$(45)	\$134	\$22	\$156	27%	\$111	346.5%					

1. We calculate the share of Medicaid hospital expenditures in urban and rural geographies using hospital net Medicaid revenues as reported on 2023 Medicare Cost Reports (made available through HCRIS). We allocate net Medicaid revenues for each hospital to an urban or rural geography using the hospital's address crosswalked to Core-Based Statistical Areas (CBSAs) made available by AHA. For purposes of this analysis, we consider "micropolitan" geographies to be rural. For hospitals without an identified CBSA, we include those revenues in the "unknown" category. We then allocate our projected impacts of H.R.1 on total Medicaid hospital expenditures proportionately based on the urban/rural distribution of Medicaid hospital revenues in each state.

2. We only include the percentage impact from baseline for total expenditures since the percentage impacts are the same across the urban, rural, and unknown categories.

3. 50% of the \$25 billion rural health transformation fund will be distributed equally to all states that submit an application. We assume that all states will submit an application and receive an award. Note that entities other than rural hospitals are eligible to receive a portion of this funding so this allocation overestimates the amount of funding that will be made available to rural hospitals.

4. 50% of the \$25 billion rural health transformation fund will be distributed to states at the discretion of the CMS administrator. For modeling purposes, we assume that these funds would be distributed based on the number of rural residents in a given state compared to the total number of rural residents nationally.

5. Grants from the Rural Health Transformation Fund will be distributed from FFY 2026 to FFY 2030, with states required to spend all funds by FFY 2031. We apply each state's estimated funding allocation against the total projected reduction in Medicaid rural hospital expenditures over a ten-year period.

6. Alaska and Tennessee's Medicaid hospital spend estimates are excluded from Manatt's model due to data limitations.