Rural H.R.1 Medicaid Talking Points

Background: Rural patients disproportionately depend on coverage from public payers (Medicare, Medicaid, and Marketplace subsidies). As a result of reductions to coverage for rural residents, many rural clinics and hospitals face financial pressure that may lead to reduction or elimination of essential services, delays in much needed facility upgrades, or closure. H.R. 1 introduces sweeping Medicaid eligibility and enrollment changes. Several of its provisions will have particularly significant consequences for rural patients, providers, and state systems.

Medicaid Eligibility Redeterminations: Beginning in 2027, the Medicaid adult expansion population will have their eligibility reviewed every six months as opposed to the current cycle of once every twelve months.

- Rural Medicaid beneficiaries 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.

Medicaid Community Engagement (Work Requirements): Starting January 1, 2027, new Medicaid work requirements require able-bodied adults in the Medicaid expansion population to engage in work or other qualifying activities as a condition of receiving Medicaid benefits.

- For rural communities—where Medicaid coverage is high, jobs and training programs are limited, and providers and state agencies already face severe workforce shortages—the administrative demands, documentation requirements, and frequent verification processes pose significant risks to coverage continuity and strain rural health systems.

On June 3, 2026, CMS release the Medicaid Community Engagement Interim Final Rule implements work and activity requirements, restoring prior redetermination eligibility processes and establishing complex verification, exemption, and compliance systems that states must administer.

- States may seek good-faith extensions through 2028, and CMS will distribute $200 million in implementation grants, NRHA is concerned that rural beneficiaries and providers will still face disproportionate challenges navigating and operationalizing the new requirements.

Provider taxes: H.R. 1 freezes all current provider tax arrangements, prohibits new provider taxes, and requires a phasing down of hold harmless thresholds in Medicaid expansion

states from 6% to 3.5%. Provider taxes represent a significant amount of reimbursement to rural providers and play a key role in the financial sustainability of rural providers and facilities.

- In Medicaid expansion states, phasing down provider-tax thresholds below current levels threatens the sustainability of state Medicaid programs and would directly reduce access to care for rural residents, who already face higher uninsurance rates and fewer local providers.
- In non-expansion states, maintaining current provider-tax authority is critical; any further reductions beyond H.R. 1's limits would weaken Medicaid financing and jeopardize rural hospitals that rely on SDPs to remain solvent.

Asks:

[Your community] relies on Medicaid/Medicare/ Marketplaces to provide affordable health care coverage [insert coverage data points]. Loss of coverage, including changes to federal Medicaid policy will shift costs to rural families and providers, jeopardize rural health care systems, and worsen rural health outcomes.

- Cuts enacted in H.R. 1 are projected to reduce Medicaid spending in rural areas by $137 billion over 10 years.
- Also passed in H.R.1, the Rural Health Transformation Program provides targeted, time-limited investments intended to catalyze state modernization of rural health systems. RHTP dollars are not intended to as implemented by CMS, nor can they offset the significance in potential Medicaid funding reductions.
- Since 2010, more than 200 rural hospitals have closed or converted to models that exclude inpatient care, such as Rural Emergency Hospitals (REHs). Cuts to Medicaid will negatively impact rural hospitals. Nationally, more than 10 million rural residents rely on Medicaid. Medicaid reimbursements account for nearly 10% (or $3.9 million) in net revenue for the typical rural hospital. More than 40% of all rural hospitals are operating in the red, with about 417 rural hospitals vulnerable to closure.
    - The state of [your state] has had [XX] rural hospital closures since 2010. Currently, about [XX%] of [your state]'s rural hospitals are operating within negative margins. [Find 2025 hospital specific data in your state here]
    - [Your state] currently sits at [XX%] for statewide rural Medicaid enrollment.
- We urge Congress to delay implementation of harmful Medicaid policies enacted in H.R. 1 that will result in coverage losses for rural residents and increased uncompensated care rates for rural hospitals.
- [Personal story about Medicaid policies have impacted your rural community, facility, patients, etc.]

Medicaid Community Engagement (Work Requirements):

- *Definitions of Work, Education & Community Service:* Employment, training, and volunteer opportunities are limited and often seasonal in rural communities.
    - 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. Currently, [your state/county], has an average rate of [XX%] for unemployment in comparison to the nearest urban county that sits at [XX%], emphasizing the gap in job opportunities in rural verses urban. *Use the "Unemployment" tab in KFF's tracking tool to find county-level unemployment rates in your state to show those who would not qualify for Medicaid under these requirements.*
    - **Ask:** We support CMS' definitions of work, education, and community service. However, we oppose the requirement that job search cannot be more than half the hours of a work program, a rule which applies to no other work requirement.
    - [Personal story about rural employment and how this requirement would further hinder employment rates in your rural community]
- *Exclusions*: Strong, clear exclusions—especially for postpartum individuals, caregivers, and medically frail patients—are critical.
    - Currently in [your state], only [XX%} of Medicaid applications are processed within 30 days, which is before the implementation of work requirements. In rural areas where access to providers is limited, added documentation requirements would create harmful barriers to care. Rural counties that are unable to process applications within 30 days may rely more heavily on manual reviews and may be experiencing backlogs. Additional verification requirements from work requirements may impact application processing times for rural areas.
      Reference the "application processing time" map from KFF's toolkit to show how long your state takes to process applications before the new requirements
    - **Ask:** We strongly oppose the additional requirement that the condition or diagnosis significantly impairs individuals' ability to comply with the work requirement as it places significant burden on the provider community.
    - [Personal story about any administrative burdens that further impact your facility and providers]

- *Verification & Re-Verification:* Rural beneficiaries and providers rely on streamlined verification processes.
    - Rural Medicaid enrollees may be more likely to lose coverage due to paperwork issues or red tape rather than true ineligibility.
    - Currently, [your state] consists of [XX%] of Medicaid eligible renewed on an ex-parte basis, which is a large portion of renewals for the state. *Use the "Renewals and Disenrollment – Renewal Outcomes" tab to show, the share of people whose coverage was renewed BEFORE implementation of these new requirements.*
    - **Ask:** CMS should maintain ex-parte verification, prohibit repeated checks for permanent conditions, and avoid time-limited self-attestation that increases burden in low-resource settings.

Provider Taxes:

- Provider taxes are central to how many states finance their Medicaid programs, and reductions to provider-tax thresholds—especially in expansion states—would destabilize Medicaid funding streams that rural hospitals depend on, increasing uncompensated care and pushing already-vulnerable facilities closer to closure.
- Most common use of provider taxes include supporting base Medicaid provider payment rates, funding supplemental provider payments, preventing Medicaid benefit cuts, and expanding Medicaid benefits.
    - Currently, [your state] receives $XX in annual federal spending for SDPs.
- While this policy would affect providers across the nation, it especially will hit rural hospitals and providers the hardest. Changes to SDPs in H.R.1 will impact inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers. SDPs have become a foundational tool to boost low Medicaid payments, and improve access and quality, accounting for state Medicaid spending, especially for rural communities and providers.
    - (Your state) could face an estimated XX% reduction in Medicaid payments to hospitals if SDPs were limited to 100% of Medicare rates.
- SDPs are a financial lifeline for rural hospitals and clinics, helping offset chronically low Medicaid reimbursement rates and sustaining essential services such as obstetrics, behavioral health, emergency care, and long-term care in communities with thin margins and high Medicaid reliance.
- Rural hospitals face unique financial pressures, including low patient volumes, high fixed costs, and limited service lines; restricting SDPs would remove one of the

few tools states have to stabilize rural facilities and prevent service cuts or closures.

Resources:

- KFF Tracker on Implementation of the 2025 Reconciliation Law Medicaid Work Requirements
- NRHA's H.R.1 Implementation Tracker
- NRHA's Letter to CMS on H.R. 1 Medicaid Implementation
- NRHA's Comments to CMS on Community Engagement
- NRHA's Comments to CMS on State Directed Payments