Medicaid Cuts & Rural Impact

Medicaid in Rural America

Medicaid provides essential health coverage for residents of small towns and rural communities, playing a significant role in these areas when compared to metropolitan regions. **Almost 20% of rural adults and 40% of rural children are covered by Medicaid and CHIP.** Large reductions in federal Medicaid funding would put Americans living in rural communities and their health care systems at serious risk.

Medicaid funding is critical for sustaining rural healthcare systems, including hospitals, rural health clinics, EMS agencies, and community health centers. A strong relationship exists between Medicaid coverage levels and the financial viability of rural hospitals and providers. Medicaid expansion is associated with improved hospital financial performance and substantially lower likelihoods of closure, especially in rural markets and counties with large numbers of uninsured adults before Medicaid expansion (2).

- Nearly 50% of rural hospitals operate with negative margins (3). Further reductions in Medicaid funding would force many facilities to:
  - Reduce or eliminate essential services
  - Delay much-needed equipment upgrades
  - Close their doors entirely
- Rural hospital closures would leave many residents without nearby health care access, forcing them to travel long distances for even basic treatments and emergency care. As a result, many patients may forgo preventive or routine care, leading to higher utilization of emergency departments, increasing costs to the larger health care system. Rural hospitals are the largest employers in many rural areas, creating further economic challenges for individuals living in rural communities.

Cuts to Medicaid would shift health care costs onto rural families, many of whom already struggle with financial instability. Without Medicaid, families would face higher out-of-pocket expenses, leading many to delay or forgo necessary treatments and worse health outcomes. Medicaid cuts, combined with ACA Marketplace changes, will result in significant coverage losses– at least 7.7 million individuals will lose health insurance, according to the Congressional Budget Office.

Restrictions on Future State-Directed Payments

Proposal: This proposal would limit future state-directed payments (SDPs) to 100% of Medicare rates in expansion states and 110% in non-expansion states. Generally, states are not allowed to implement requirements on how Medicaid managed care organizations (MCOs) pay providers but may use separate payment terms, to provide a fixed amount of directed payment funding outside of the base capitation rate.

Impact on Rural: By capping SDPs, this legislation could stifle access to care for rural Medicaid MCO enrollees because providers may stop accepting these patients due to low reimbursement. Rural hospitals, which often rely on SDPs to offset chronically low Medicaid base rates, may see reduced revenues, threatening their financial viability and leading to service cutbacks or closures. This would diminish access to care for rural populations already facing provider shortages and long travel times. While existing payments are grandfathered, new or modified SDPs in expansion states would be restricted, limiting states' flexibility to respond to rural health needs. Overall, the proposal risks deepening disparities in access and care quality for rural Medicaid beneficiaries.

Eligibility and Enrollment Changes

Proposal: Limiting retroactive coverage to one month prior to application for coverage (currently 3 months) and increasing frequency of eligibility redeterminations to every 6 months (currently 12 months) for expansion adults.

Impact on Rural: More frequent eligibility redeterminations create paperwork and administrative burdens for rural enrollees who face challenges complying due to limited broadband and internet access, transportation, and other unique rural barriers.

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Imposing Onerous Medicaid Work Reporting Requirements.

Proposal: Effective no later than December 31, 2026, or earlier at state option, new proposed requirements include:

- States to condition Medicaid eligibility for individuals ages 19-64 applying for coverage or enrolled through the ACA expansion group on working or participating in qualifying activities for at least 80 hours per month,
- Requires states to verify that individuals applying for coverage meet requirements for 1 or more consecutive months preceding the month of application and at redetermination,

Impact on Rural: This proposal would harm rural health populations by tying Medicaid eligibility to rigid work requirements that do not reflect the realities of rural employment, where jobs are often seasonal, part-time, or informal. It adds significant administrative burdens that rural residents, many of whom lack internet access or reliable transportation, may struggle to meet, risking coverage loss due to paperwork issues rather than true ineligibility. By prohibiting states from using waivers, the policy removes flexibility to adapt to local economic conditions or emergencies. Ultimately, this would reduce coverage, worsen health outcomes, and increase strain on already overburdened rural health providers.

Limitations on New or Increased Provider Taxes.

Proposal: Freezing provider taxes at current rates and prohibiting any new provider tax arrangements. States rely on a variety of sources to finance Medicaid programs, including taxes and assessments on health care providers and managed care plans. As of 2018, provider taxes accounted for about 17% of the state share of the cost of Medicaid (5).

Impact on Rural: Restricting use of state-directed provider payments threatens their rural providers who rely on these funds to sustain key services. In the 2010s, two-thirds of all rural hospital closures nationally were in the South, where most states have not expanded Medicaid and the greatest number of rural hospitals have closed (7). There are no direct federal savings from eliminating the taxes themselves, but rather from downstream effects on program spending and beneficiary coverage. The Congressional Budget Office projects that, in aggregate, states would replace approximately 50% of the lost provider tax revenue and many state Medicaid budgets are too strained to take on extra costs (8). The remainder would be addressed through reductions in provider reimbursement, scope of benefits, or eligibility categories. Because provider taxes have become a significant source of non-federal share, limiting this authority can substantially reduce overall state Medicaid spending and, in turn, stifle rural access to care.

Eliminating Enhanced Expansion Matching Rates and Lowering Minimum Matching Rates.

Proposal: Sunsetting the temporary +5% FMAP increase provided under the American Rescue Plan for states newly expanding Medicaid, eliminating a key financial incentive.

- aAdditionally, 9 states—Arizona, Arkansas, Illinois, Indiana, Montana, New Hampshire, North Carolina, Utah, and Virginia—have "trigger" laws that would automatically end Medicaid expansion if the enhanced FMAP is reduced. Three others—Idaho, Iowa, and New Mexico—allow their Medicaid agencies or legislatures to reconsider or reverse expansion under these conditions.

Impact on Rural: Almost two-thirds of the rural uninsured population lives in states that are not expanding Medicaid at this time. Among uninsured rural individuals, about 15% are estimated to fall into the coverage gap compared to 9% of the uninsured in metropolitan areas. Rural hospitals often serve lower-income populations that are less likely to have health insurance or more likely to be covered by Medicaid or Medicare, making public payers extremely important to hospital financial viability (13). Medicaid expansion is correlated with better rural hospital financial performance. Rural hospital closures are more likely in states that have not expanded Medicaid (2).

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