MEMORANDUM
Re: The One Big Beautiful Bill is a Historic Investment in Rural Healthcare

Summary: The One Big Beautiful Bill (OBBB) contains unprecedented levels of federal assistance to rural and other vulnerable hospitals. The newly created Rural Health Transformation Program will deliver an investment of $50 billion over five years to transparently and efficiently transform rural health access. The status quo has left rural hospitals vulnerable, and the President's landmark legislation makes historic investments to ensure sustainability of rural access points and improve health outcomes for Americans who rely on this care.

Overview: The Rural Health Transformation Program will provide new funding to states for a range of uses designed to make rural healthcare more effective and sustainable for the long term. Collaborating with the Centers for Medicare and Medicaid Services (CMS), states must submit detailed rural health transformation plans for improving access to community healthcare providers and ultimately improving health outcomes. CMS will monitor implementation and hold states accountable to this plan to ensure resources are delivered to the most deserving care providers and their patients, not the most politically well-connected.

Scale of Investment: To put the scale of this investment into context consider the CMS Office of the Actuary estimates Medicaid *in total* spent $19 billion on rural hospitals in 2024.[1] The Rural Health Transformation Program will provide an additional $10 billion *each year* from 2026 through 2030, representing a substantial increase in overall funding for rural hospitals.

Comparison to Other Federal Aid Programs for Rural Hospitals: Unlike other, smaller CMS programs to promote rural care, the Rural Health Transformation Program is uniquely designed to promote innovation and long-term sustainability of rural healthcare. Other Federal programs tie enhanced reimbursement to volume of services and the size or type of the hospital, limiting the ability to change over time to meet the needs of the community. Additionally, some tie Federal reimbursement to cost, reducing incentives for quality and efficiency.

- *Critical Access Hospital Program.* Created in 1997, this program provides Medicare reimbursement at 101 percent of cost for small rural hospitals under 25 beds. This program increased the revenue of 1,369 facilities by an estimated payment of $4 million each in 2022.[2] However, cost-based reimbursement was

[1] Estimate from the CMS Office of the Actuary
[2] https://www.medpac.gov/wp-content/uploads/2023/10/Tab-D-CAH-Sept-2024-FINAL.pdf

abandoned by Medicare for almost every other hospital type in the 1980s due to its widely accepted negative impact on cost and efficiency of care.[3]

- *Sole Community Hospital Program.* Created in 1983, this program provides extra Medicare reimbursement to facilities where generally other hospitals are located more than 35 miles away. The payment adjustments increased Medicare reimbursement for 467 hospitals by an estimated $835 million in 2022.[4]
- *Medicare Low-Volume Hospital Adjustment.* Created in 2003 but expanded and extended on a temporary basis ever since, this program provides extra Medicare reimbursement to hospitals with under 3,800 annual discharges. The payment adjustments increase Medicare reimbursement by around $400 million annually to 450 facilities.[5]
- *Medicare Dependent Hospital (MDH) Program.* Created as a temporary program in 1989, the MDH program has been expanded and extended ever since. This program provides extra Medicare reimbursement to hospitals with 100 or fewer beds and 60 percent of inpatient days covered by Medicare. This program increases payment by about $125 million annually at 140 facilities.[6]

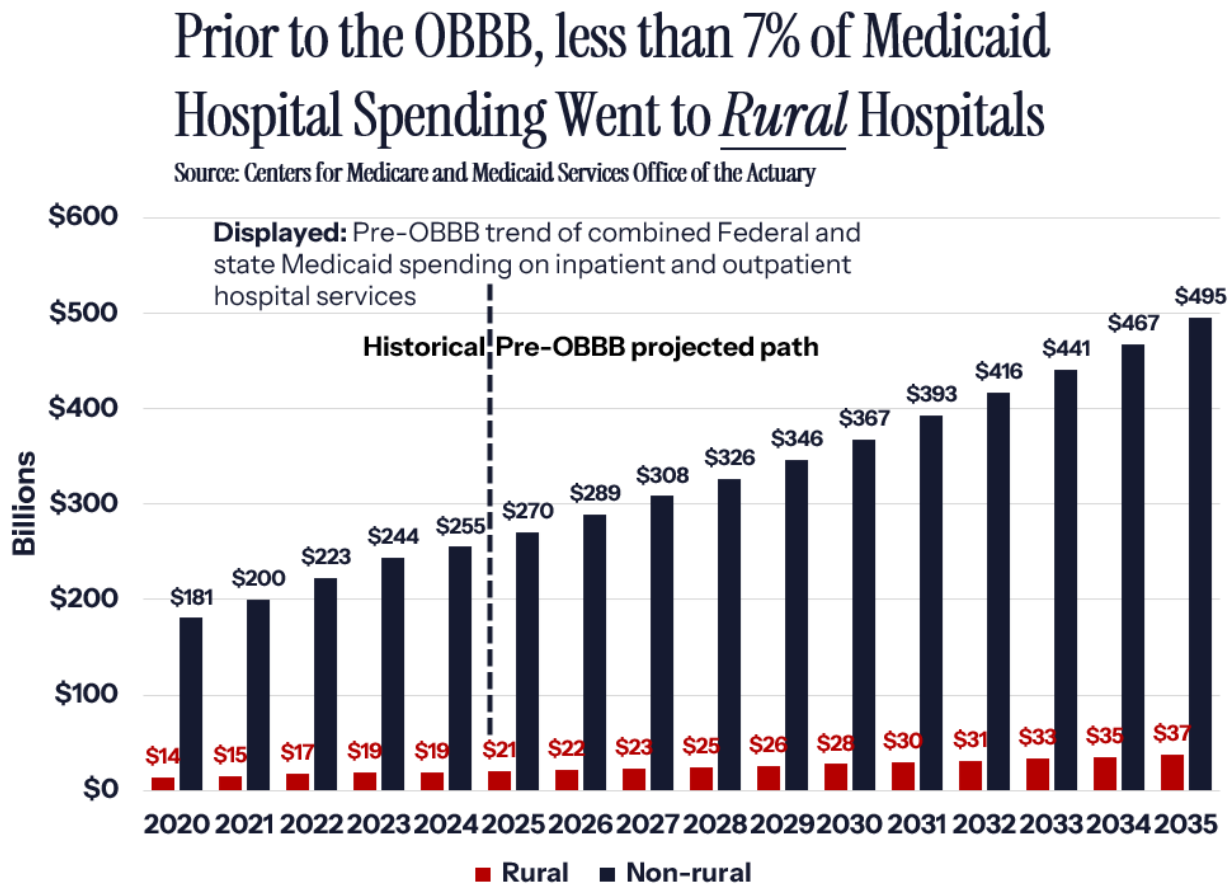
Distinct from these other programs, the Rural Health Transformation Program is designed to provide a flexible source of investment that will promote innovation and efficiency in how states, hospitals, and other healthcare providers meet the needs of their communities.

Legacy Programs do not Solve Systemic Challenges: Rural hospitals suffer from longstanding challenges with extremely low patient volume. They have both smaller bed counts than urban hospitals and occupancy rates that are much lower (37%) than those of their urban counterparts (62%).[7] By linking funding support to reimbursement for services, legacy programs do not promote long-term sustainability because the overall volume of services provided in these facilities remains low. This leaves these hospitals without the resources to make proactive upgrades in technology to improve efficiency or adapt to changing models of care. The Rural Hospital Transformation Program, however, will provide these facilities with flexible support that can be used to help these facilities make investments

[3] Jonathan Oberlander, *The Political Life of Medicare*, Chicago University Press, 2003, pgs 120-121.
[4] https://hilltopinstitute.org/wp-content/uploads/2024/06/SoleCommunityHospitals-ARM-2024.pdf
[5] https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2025/05/BPC_Rural_Hospitals_Issue_Brief_FINAL.pdf
[6] https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2025/05/BPC_Rural_Hospitals_Issue_Brief_FINAL.pdf
[7] https://www.aha.org/system/files/media/file/2023/05/aha-statement-to-senate-finance-committee-subcommittee-on-health-on-improving-rural-health-care-access-5-17-2023.pdf

necessary to make the hospital better meet the needs of the communities they serve and become more sustainable over the long term.

Overall Medicaid Spending As a Flawed Proxy for Rural Hospital Financial Health: The proliferation of analyses financed by industry or partisan critics that crudely rely on total Medicaid spending as a proxy for rural hospital financial health are flawed for a number of reasons. Due to much lower volume in rural areas, the CMS Actuary estimates only 7% of Medicaid hospital spending (inpatient and outpatient) even reaches rural hospitals. This is why despite record growth in Medicaid spending and enrollment over the past decade, immense challenges related to healthcare access in rural areas persist in both expansion and non-expansion states.



Additionally, these analyses rely on an overly pessimistic and skewed projection of the provisions to incentivize work among the able-bodied, working age population on Medicaid. The estimates rely on an extrapolation from one analysis of the experience in one state over a period of four months six years ago and apply it nationwide despite

significant updates in technology and learned experience from the application of work requirements in other Federal programs.[8]

Conclusion: The OBBB departs from the failed policy roadmap followed over the past decades that has left rural America behind. Decades of minor funding tweaks for struggling hospitals tied to the volume of services, followed by a singular focus by the Biden and Obama administrations on expanding enrollment in government healthcare programs, has left many rural communities on the brink of losing access to care. By eliminating waste, fraud, and abuse in the broader Medicaid program, the OBBB freed up resources for a transparent and direct, once-in-a-generation investment in rural care.

[8] https://www.whitehouse.gov/wp-content/uploads/2025/03/Medicaid-Community-Engagement-Requirements-and-the-Value-of-Work.pdf