



Medicaid at a turning point

Rural health and H.R. 1



Medicaid's role in supporting rural providers, access, and system resilience

H.R. 1 presents a critical turning point for state Medicaid programs and rural healthcare, creating a complex landscape of new challenges and opportunities. The legislation introduces significant operational hurdles that risk disrupting coverage and threatening the solvency of rural providers already under strain. Simultaneously, H.R. 1 offers a major platform for modernization through the \$50 billion Rural Health Transformation Program (RHTP), pushing states to innovate with telehealth, address workforce shortages, and align with other programs like Supplemental Nutrition Assistance Program (SNAP).

Medicaid forms the backbone of rural communities' health, supporting nearly one quarter of rural residents and providing essential coverage for nearly half of rural children through the Medicaid Children's Health Insurance Program.¹ Beyond access, Medicaid helps ensure the financial stability of local providers, which in turn safeguards continuity of care and broader community well-being. State leaders will need to strategically balance new federal mandates with the ongoing need to transform and sustain access to care for their rural communities.

Rural health constraints

Rural providers and communities operate under a wide range of constraints. These realities often make rural areas a real-world testing ground for federal policy, offering a clear view of whether policy choices are meaningful and sustainable over time:



Workforce scarcity

Rural areas face persistent shortages of physicians, nurses, behavioral health professionals, and specialty providers. Facilities often rely on temporary or traveling staff, increasing labor costs and creating discontinuities in care. Staff turnover disrupts workflows, erodes patient trust, and drives provider burnout as practitioners are often required to cover a broad spectrum of services across multiple sites. Additionally, the absence of local specialists often forces patients to seek care in urban centers, resulting in a considerable loss of potential revenue for local rural hospitals and associated clinics.





Irregular patient volumes

Serving smaller populations, rural facilities experience fluctuating patient volumes for both routine and specialty care. This variability makes it difficult to cover high fixed operational costs—including building maintenance, expensive diagnostic equipment, and core administrative staff—and limits the viability of higher-margin specialist services. As a result, rural providers rely more heavily on less-profitable primary care and emergency services.



Transportation barriers

Beyond distance, limited access to personal or public transportation drives high no-show rates for scheduled appointments, causing revenue loss and care disruption. Missed appointments can escalate health conditions, resulting in expensive ambulance transport and emergency room visits that could have been prevented through routine care.



Geographic isolation

Geographic isolation creates a significant financial strain for both patients and providers. Long distances increase travel expenses for patients, which can discourage them from seeking routine or preventative care. This deferred care often results in more acute and expensive emergency visits down the road, increasing the uncompensated care burden on the hospital. To offset the costs of caring for uninsured and underinsured patients, hospitals rely on Disproportionate Share Hospital (DSH) payments that are funded by tax dollars. Ultimately, the financial strain originating from geographic isolation places a heavy burden not only on patients and hospitals, but also on public funds as well.



Broadband gaps

Limited high-speed internet in many rural regions restricts access to telehealth, digital health tools, and cloud-based administrative and electronic health record systems. Connectivity challenges reduce patient access, increase operational inefficiency, and create challenges for value-based payment data sharing, undermining modernizing efforts and perpetuating disparities in rural care.





Medicaid's evolution and the impact of the Affordable Care Act

Prior to the Affordable Care Act (ACA), rural hospitals and clinics relied on programs such as the Critical Access Hospital designation and DSH payments to remain financially viable. In states that expanded Medicaid coverage, millions gained health insurance, and local providers experienced improved financial stability from increased payments for services. Uninsured rates among adults under age 65 in rural areas declined significantly following ACA implementation—falling from 23.8 percent in 2010 to 12.6 percent in 2023.²

Following the ACA, states have increasingly focused on innovation in care delivery. This is a trend that was dramatically accelerated by the COVID-19 pandemic, which forced communities and providers to lean into solutions like telehealth to bridge gaps in access caused by distance and workforce shortages.

This shift has created a pivotal moment to modernize rural healthcare. Building on these lessons, current policy conversations are focused on a forward-looking agenda:

- ▶ Solidifying the central role of telehealth in care delivery
- ▶ Advancing innovative strategies to address workforce challenges
- ▶ Designing next-generation payment models to help ensure long-term sustainability and value.

The legislative landscape shaped by H.R. 1 does not change the fundamental mission of rural providers. Instead, it highlights the value of their deep expertise—expertise that proved indispensable during the public health emergency.

State Medicaid levers that sustain rural healthcare

For decades, state Medicaid agencies have adopted a variety of powerful financial and policy tools to manage their programs and support local providers. States have historically relied on provider taxes and other funding vehicles to raise state-matching funds, which in turn maximizes the federal dollars flowing into their healthcare systems.



DSH payments

While federally funded, states have considerable flexibility in how they distribute these critical funds to hospitals that serve a high number of Medicaid and uninsured patients.



Managed care contracting

Most Medicaid beneficiaries are enrolled in plans managed by private companies (i.e., managed care organizations). States can embed specific requirements into these contracts, such as mandating certain provider network adequacy standards in rural areas, requiring value-based payment arrangements, or offering targeted care management programs.



Graduate medical education funding

States can use Medicaid funds to support the training of new physicians in rural hospitals, creating pipelines to retain clinicians in underserved areas and addressing long-term workforce shortages.



Telehealth reimbursement policies

States have significant discretion over whether and how to pay for services delivered via telehealth. States at the forefront of this issue use their reimbursement policies as a lever to incentivize providers to adopt telehealth.



Medicaid eligibility and enrollment changes

H.R. 1 introduces several major changes to Medicaid eligibility and enrollment processes that states must implement over the next several years:³

- ▶ Starting at the end of 2026, states must conduct eligibility redeterminations for ACA expansion adults every six months instead of annually.
- ▶ Beginning in 2027, states will be required to conduct quarterly checks against the Social Security Administration’s Death Master File.
- ▶ By 2029, states must submit monthly enrollee data, including Social Security numbers, to a new federal system designed to identify and eliminate duplicate interstate enrollment. Duplicate enrollment controls must be fully implemented by October 1, 2029.






While these provisions aim to strengthen program integrity, they create a heightened risk of procedural disenrollment, particularly for rural residents with limited broadband, unreliable mail service, or nonstandard physical addressing systems (i.e., route/box numbers or landmark-based directions).



Community engagement requirements

H.R. 1 introduces new community engagement requirements that mandate that certain adults (ages 18–64) in Medicaid expansion populations work or participate in qualifying activities for at least 80 hours per month to maintain Medicaid coverage. The legislation also explicitly prohibits these requirements from being waived via a Section 1115 demonstration waiver, removing a key tool that states have historically used to customize programs for their unique populations.⁴

For many rural communities, meeting these requirements may prove challenging due to structural barriers, including:

-  Limited availability of local employment and volunteer opportunities
-  Limited access to job training or education programs
-  Transportation barriers and long travel distances
-  Seasonal or irregular work schedules common in agricultural and service industries
-  Unreliable broadband needed for reporting hours or completing online requirements.

While these logistical hurdles affect the entire community, they can create particularly severe challenges for individuals experiencing homelessness. Without a stable mailing address or reliable access to a phone or internet service, individuals may never receive notices explaining the requirements or how to document compliance.

Logistical burdens compound the challenge. Lack of transportation, absence of a permanent address for employment or volunteer verification, and the instability inherent in daily survival can make navigating a complex administrative compliance system overwhelming, heightening the risk of procedural disenrollment.



Financing pressures and rural provider stability

H.R. 1 places new constraints on the financial levers that support rural providers and a Medicaid system that is already impacted by substantial budget shortfalls nationwide:



Provider taxes

H.R. 1 freezes new or increased provider taxes and, for expansion states, gradually lowers the allowable rate to 3.5 percent by fiscal year (FY) 2032.⁴



State-directed payments (SDPs)

H.R. 1 caps SDPs at 100 percent of the Medicare rate for expansion states while phasing down grandfathered arrangements by 10 percentage points each year starting in January 2028 until they reach the applicable Medicare-based cap.⁵



These changes reduce states' flexibility to generate matching funds and to support many rural hospitals, potentially increasing the risk of closures. States must explore alternative strategies to maintain rural provider networks.

Rural Health Transformation Program: Opportunities and execution risks

The Rural Health Transformation Program offers states a major opportunity for states to stabilize and modernize rural health systems. The program is designed to help support:

- ▶ New healthcare access points
- ▶ Sustainable local care delivery models
- ▶ Recruitment and retention of healthcare professionals
- ▶ Innovative value-based care arrangements
- ▶ Technology and digital tool adoption, such as remote patient monitoring.

The program allocates \$50 billion from FY 2026–2030 through a competitive, one-time application process, with awards determined in part by rural population, facility mix, and hospital conditions.⁶

To ensure responsible use of funds, the legislation establishes several guardrails:



Funds cannot be applied to the Medicaid state share



Unspent funds must be returned by FY 2032



Beginning March 31, 2028, remaining funds will be redistributed annually.

Success requires alignment of Medicaid payment and access strategies with transformation efforts. Tight financing constraints under H.R. 1 increase execution risk, requiring states to move quickly and strategically to avoid forfeiture or claw-backs while ensuring that transformation efforts are financially sustainable.



Waivers: Innovation under constraint

States have traditionally relied on a robust toolkit of federal authorities to tailor solutions for rural healthcare challenges, including:

- ▶ Section 1115 demonstration waivers
- ▶ Section 1915(b) managed care waivers
- ▶ Section 1915(c) home and community-based services waivers
- ▶ State plan amendments.

Utilizing these tools, states have been able to test and implement solutions such as telehealth, service integration, and mobile clinics. However, H.R. 1 introduces new challenges by tightening the requirements for many of these initiatives:



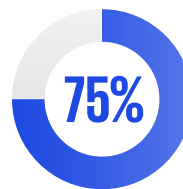
The Department of Health and Human Services (HHS) must certify that federal costs will not exceed what would have been spent without the waiver



Tolerance for speculative savings is narrower, potentially stifling innovative rural health innovations.

Cross-program alignment: Medicaid and SNAP

H.R. 1's impact extends beyond Medicaid, introducing changes to the Supplemental Nutrition Assistance Program (SNAP). H.R. 1 expands the age range for the Able-Bodied Adults Without Dependents (ABAWD) work requirement to 18–64, limits access to waivers, and sunsets funding for SNAP Education.



Additionally, it shifts administrative costs, requiring states to cover 75 percent of these expenses by fiscal year 2027.⁷

These adjustments are likely to increase churn in SNAP enrollment, reduce nutritional education access, and create administrative burdens—particularly in high-poverty rural communities. By rethinking administrative processes and outreach, states can improve health outcomes, strengthen community engagement, and coordinate services across Medicaid and SNAP to better meet rural residents' needs.





Conclusion

H.R. 1 marks a pivotal moment for rural healthcare, driving a reevaluation of how states support their most vulnerable communities. The legislation presents a dual-edged sword: on one side, it imposes significant operational hurdles and financial constraints that could jeopardize coverage for residents and threaten the solvency of already fragile rural providers. At the same time, the \$50 billion RHTP offers a historic opportunity to modernize, providing a critical platform for states to invest in telehealth, address chronic workforce shortages, and build sustainable, value-based care models.

The path forward demands more than simple compliance; it requires creative and strategic leadership. Success will hinge on the ability of state leaders to not only navigate the new requirements but also to break down silos and foster cross-program collaboration between Medicaid and other programs. By weaving these modernization efforts into the very fabric of their state programs, they can help ensure that innovation leads to a more resilient and sustainable healthcare system for rural America.

At KPMG, we aim to think big while understanding that progress is often made in increments. Wherever you are on your transformation journey, KPMG is here to help you think creatively, plan intentionally, and deliver successfully on your objectives. We bring decades of experience in large-scale healthcare and state and local government transformations, working with agencies to navigate complex policy shifts, modernize, and innovate. Our approach helps you not only meet the demands of H.R. 1 and deliver on RHTP commitments but also turn these mandates into opportunities, building sustainable capabilities for the future.

Sources

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