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Advancing Health in America

Rural Hospitals at Risk:
Cuts to Medicaid Would Further Threaten Access

Medicaid, which covers over 16 million people in rural communities, helps address barriers to health care and sustain rural hospitals. But many in Congress are considering Medicaid cuts that would have a devastating impact on rural hospitals and patients.

The One Big Beautiful Bill Act (H.R. 1) would result in 1.8 million individuals in rural communities losing their Medicaid coverage by 2034. In addition, select Medicaid provisions in H.R. 1 would result in a $50.4 billion reduction in federal Medicaid spending on rural hospitals over 10 years.[1] See the chart on the next page for a state-by-state breakdown of rural spending and coverage losses.

Rural Hospitals Are Already Struggling:

- **48%** of rural hospitals operated at a financial loss in 2023.[2]
- **92** rural hospitals have closed their doors or been unable to continue providing inpatient services over the past 10 years.[3]
- Rural hospitals lose money on several **critical service lines**, including behavioral health, pulmonology, obstetrics, and burns and wounds.[4]

Medicaid is Critical to Rural Hospitals:

- **16.1 million** people living in rural communities are covered by Medicaid.[5]
- In nine states, **over 50%** of the Medicaid population lives in rural communities: Montana, South Dakota, Wyoming, Mississippi, Vermont, Kentucky, North Dakota, Alaska and Maine.[6]
- **47%** of rural births in the U.S. are covered by Medicaid.[7]
- **65%** of nursing home residents in rural counties are covered by Medicaid.[8]

Medicaid Already Pays Rural Hospitals Far Less Than the Cost of Care:

- Medicaid paid rural hospitals **approximately 63 cents on the dollar** for inpatient obstetrics care in 2024.[9]
  - There has been a **16%** decline in rural counties with hospital-based obstetric care services over the last decade.[10]
- Similarly, Medicaid payments covered approximately just **70%** of costs for behavioral health services in hospital settings, which include substance use disorder treatment.[11]

End Notes:

1 Modeling of select H.R. 1 Medicaid provisions conducted by Manatt Health Strategies, LLC. This analysis accounts for the following H.R. 1 Medicaid provisions: (1) mandatory community engagement (work) requirements, (2) increasing frequency of eligibility redeterminations for certain individuals, (3) ban on new or increased provider taxes, (4) revising the payment limit for state directed payments (SDPs), (5) reduction in the expansion FMAP in states providing coverage to certain undocumented immigrants and (6) the repeal of rules relating to eligibility and enrollment in Medicaid, CHIP, the Medicare Savings Programs (MSPs) and the Basic Health Program (BHP).

2 AHA analysis of RAND Hospital Cost Report data.

3 AHA analysis of data from Cecil G. Sheps Center for Health Services Research.

4 AHA analysis of industry benchmark data from Strata Decision Technology LLC.

5 Kaiser Family Foundation (KFF).

6 KFF.

7 AHA analysis of data from CDC Wonder.

8 Rural Policy Research Institute.

9 AHA analysis of industry benchmark data from Strata Decision Technology LLC.

10 University of Minnesota Rural Health Research Center.

11 AHA analysis of industry benchmark data from Strata Decision Technology LLC.

State	10-Year Rural Medicaid Coverage Loss Through 2034	10-Year Federal Rural Hospital Impact Through 2034
United States	**-1.8M**	**-$50.4B**
Alabama	-15.4K	-$265M
Alaska	-17.2K	-$382M
Arizona	-41.1K	-$905M
Arkansas	-51.1K	-$1,109M
California	-134.9K	-$2,057M
Colorado	-28.4K	-$835M
Connecticut	-8.0K	-$135M
Delaware	-6.5K	-$174M
District of Columbia	0K	$0M
Florida	-7.9K	-$210M
Georgia	-17.6K	-$540M
Hawaii	-24.9K	-$507M
Idaho	-17.2K	-$362M
Illinois	-53.8K	-$2,014M
Indiana	-64.6K	-$1,139M
Iowa	-37.7K	-$2,666M
Kansas	-5.3K	-$306M
Kentucky	-142.3K	-$4,012M
Louisiana	-79.0K	-$1,875M
Maine	-32.7K	-$640M
Maryland	-8.6K	-$267M
Massachusetts	-6.3K	-$81M
Michigan	-68.2K	-$2,008M
Minnesota	-36.2K	-$1,065M
Mississippi	-19.3K	-$1,529M
Missouri	-51.4K	-$1,522M
Montana	-22.3K	-$1,076M
Nebraska	-13.2K	-$375M
Nevada	-10.1K	-$230M
New Hampshire	-12.6K	-$753M
New Jersey	-5.7K	$0M
New Mexico	-55.2K	-$1,380M
New York	-70.9K	-$1,125M
North Carolina	-82.0K	-$2,988M
North Dakota	-7.0K	-$61M
Ohio	-86.0K	-$2,497M
Oklahoma	-51.1K	-$2,372M
Oregon	-83.6K	-$1,979M
Pennsylvania	-55.0K	-$1,131M
Rhode Island	0K	$0M
South Carolina	-5.1K	-$410M
South Dakota	-12.2K	-$95M
Tennessee	-16.3K	-$726M
Texas	-19.9K	-$1,047M
Utah	-7.4K	-$327M
Vermont	-11.3K	-$233M
Virginia	-55.5K	-$1,655M
Washington	-49.3K	-$1,997M
West Virginia	-30.0K	-$664M
Wisconsin	-30.1K	-$607M
Wyoming	-1.6K	-$33M

Source: Modeling of select H.R. 1 Medicaid provisions conducted by Manatt Health Strategies, LLC. This analysis accounts for the following H.R. 1 Medicaid provisions: (1) mandatory community engagement (work) requirements, (2) increasing frequency of eligibility redeterminations for certain individuals, (3) ban on new or increased provider taxes, (4) revising the payment limit for state directed payments (SDPs), (5) reduction in the expansion FMAP in states providing coverage to certain undocumented immigrants and (6) the repeal of rules relating to eligibility and enrollment in Medicaid, CHIP, the Medicare Savings Programs (MSPs) and the Basic Health Program (BHP).

Notes: State values will not sum to national totals due to rounding. Rural Medicaid coverage losses are based on the geographical distribution of Medicaid enrollees. Rural hospital impacts are based on the geographical distribution of Medicaid hospital expenditures.