Joint Budget Committee

Staff Budget Briefing
FY 2026-27

Department of Health Care Policy and Financing
Impacts of H.R. 1 on Rural Healthcare

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December 10, 2025

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Impacts of H.R. 1 on Rural Healthcare

This issue brief will examine how the One Big Beautiful Bill Act, or H.R. 1, affects Colorado's rural health ecosystem. This new piece of federal legislation will implement substantial changes to Medicaid and have a sizable impact on rural healthcare in Colorado.

Summary

H.R. 1 significantly cuts federal Medicaid funding, threatening up to $2.5 billion in Colorado revenues and endangering services for over 427,000 enrollees.[1]

Colorado's 43 rural hospitals, especially non-Critical Access Hospitals, face rising financial pressure due to sequestration and shrinking supplemental payments.

Rural health care deserts persist across Colorado, 24 counties are classified as maternity care deserts and all 47 rural counties designated mental health shortage areas.[2]

H.R. 1's new work and eligibility requirements could cause tens of thousands of rural Coloradans to lose Medicaid coverage, likely increasing uninsured rates and uncompensated care.

Background

There are 43 rural hospitals in Colorado, 32 of which are Critical Access Hospitals.[3] These providers are tasked with caring for nearly 720,000, or about 12.3 percent, of Coloradans who live in rural and frontier counties.[4] Understanding how "rural" is defined is helpful when analyzing H.R. 1's impact. These definitions determine funding eligibility, data reporting standards, and reimbursement structures.

A rural hospital in Colorado is any hospital located outside a Metropolitan Statistical Area (MSA) or one that meets the criteria of a Critical Access Hospital (CAH). CAHs have no more than 25 beds and have an average length of stay under 4 days. They provide 24/7 emergency care services, and are located more than 35 miles, or 15 miles if in Mountainous terrain, from another hospital.[5] CAH's are designed to ensure emergency capacity rather than full-service operation.

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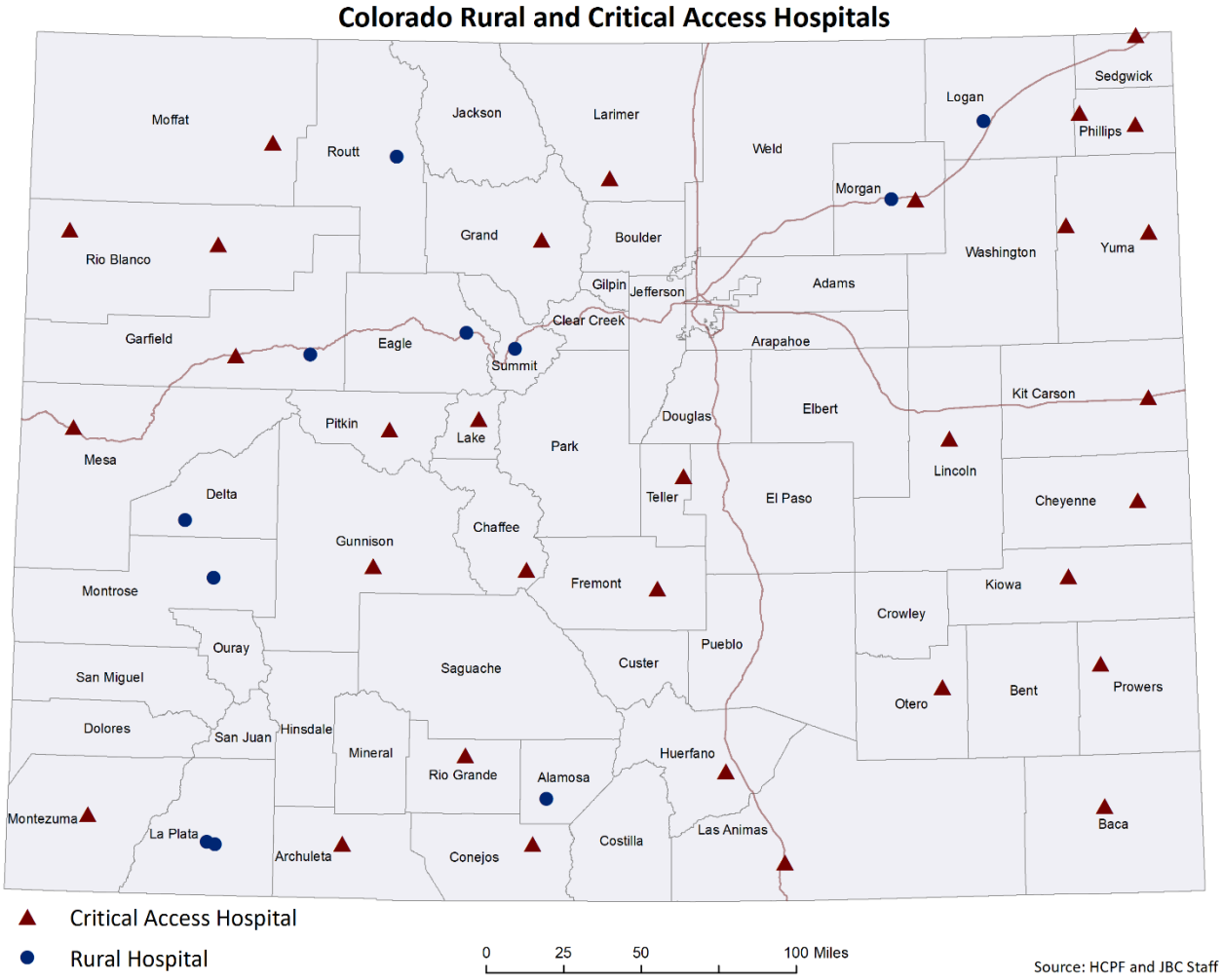
[1] Colorado Department of Health Care Policy and Financing. Understanding the Impact of H.R. 1 and Federal changes to Medicaid. https://hcpf.colorado.gov/impact

[2] Colorado Rural Health Center. *Snapshot of Rural Health in Colorado*. https://coruralhealth.org/snapshot-of-rural-health

[3] Colorado Department of Health Care Policy and Financing. Rural Health Transformation: Fact Sheet #1. December 2023. https://hcpf.colorado.gov/sites/hcpf/files/Fact%20Sheet%20%231%20-%20%20Rural%20Health%20Transformation_0.pdf

[4] Colorado State Demography Office. Total Population by County Lookup Tool. https://demography.dola.colorado.gov/assets/lookups/county_totpop_lookup.html

[5] Centers for Medicare & Medicaid Services. Critical Access Hospitals (CAHs). https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals



Discussion

Colorado's health-care landscape is shaped by sharp geographic and population contrasts. Stretching across the eastern plains and western slope Colorado's rural regions experience persistent provider shortages, limited specialty access, and a higher dependence on Medicare and Medicaid.

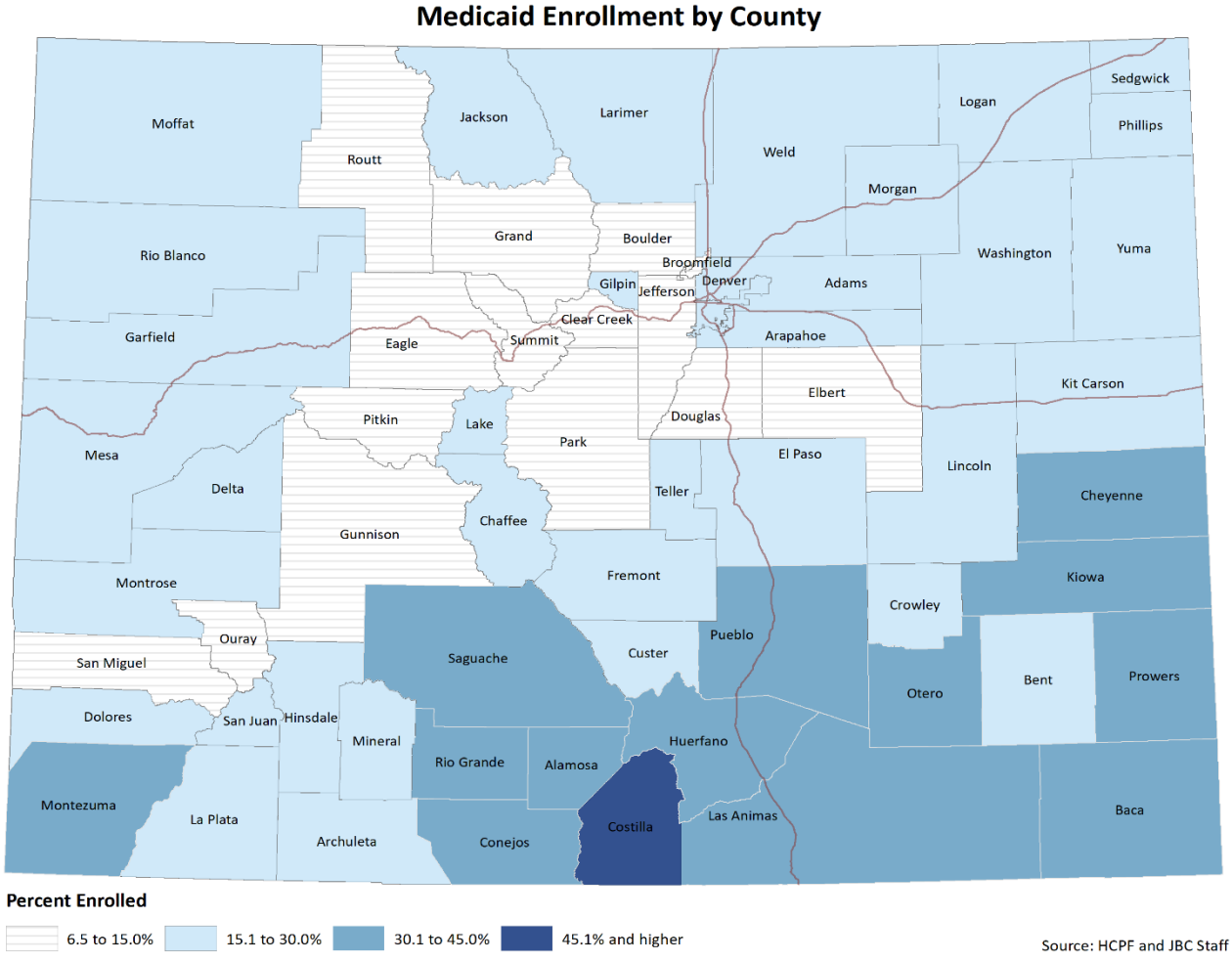
Rural communities face provider shortages with roughly 0.8 physicians per 1,000 residents in rural Colorado compared to 2.6 per 1,000 in urban areas.[6] Residents often travel long distances for care, averaging 10.5 miles to the nearest hospital, with some living more than 50 miles from a full-service hospital. These distances place a strain on emergency services and makes accessing timely treatment difficult.[7]

[6]Colorado Department of Health Care Policy and Financing. *Access to Hospital Services Report 2024*, Project Narrative (ACC). https://hcpf.colorado.gov/sites/hcpf/files/Project%20Narrative%20%28acc%29.pdf#:~:text=51%20Physician%20ratio%200,to%20Hospital%20Services%20Report%202024

[7]Colorado Department of Health Care Policy and Financing. *Access and Service Area Analysis 2024*, Project Narrative (ACC). https://hcpf.colorado.gov/sites/hcpf/files/Project%20Narrative%20%28acc%29.pdf#:~:text=53%20Majority%20of%20rural%20residents,and%20Service%20Area%20Analysis%202024

In rural Colorado, local maternity and mental health services are often scarce. Sixty-four percent of rural and frontier counties lack access to hospital obstetric services. Women living in maternity care deserts travel 51 miles for maternity care on average, which is 7.2 times farther than those in metro areas.[8] All 47 of Colorado's rural and frontier counties are designated mental health professional shortage areas, with only 8.2 percent of mental health providers located in rural areas.[9]

Rural hospitals often operate with thin, sometimes negative, margins. They serve aging and declining populations with higher per-patient costs and regularly act as the sole care provider. In this setting, federal and state Medicare and Medicaid policy largely influence the fiscal viability of these hospitals. Medicaid expansion in 2014 dramatically reduced uninsured rates in rural Colorado and replaced self-pay patients with Medicaid, stabilizing cash flow and reducing the rate of uncompensated care.



[8] Colorado Rural Health Center. *Snapshot of Rural Health in Colorado*. https://coruralhealth.org/snapshot-of-rural-health
[9] Colorado Rural Health Center. *Snapshot of Rural Health in Colorado* https://coruralhealth.org/snapshot-of-rural-health

The Landscape Before H.R. 1

Colorado's Medicaid expansion under the Affordable Care Act extended coverage to all adults earning up to 138 percent of the federal poverty level. This increased enrollment in Colorado Health First. Importantly, expansion did not merely broaden eligibility, it altered the financial base of rural hospitals. In many counties across the San Luis Valley, southeastern plains, and western slope, Medicaid replaced uninsured or self-pay populations as a primary payer. This change helped stabilize cash flow and reduced rates of uncompensated care. However, this expansion also deepened dependence on federal financing.

Before the passage H.R. 1, Colorado's Medicaid design was shaped by the state's constitutional constraints. To maintain access and stability within these parameters, the state relied heavily on dedicated hospital assessments, and enterprise structures that allowed the state to maximize federal matching funds.

Hospital Provider Fee

Colorado's Hospital Provider Fee is an assessment used to leverage federal Medicaid matching funds.[10] Hospitals are charged a fee based on patient income. The Department uses the fee as the states share to drawn down additional federal dollars. This approach currently finances coverage for over 427,000 low-income Coloradans and supports improved hospital reimbursement rates.[11]

In FY 2024-25, Colorado hospitals paid roughly $1.2 billion in HAS fees. These fees combined with federal matching revenues totaled $5 billion for Colorado hospitals. Thanks to these funds, Medicaid payments to Colorado hospitals rose from covering only ~54¢ of each dollar of cost before 2010 to about 79¢ by 2023.[12]

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[10] Colorado General Assembly. *The Health Care Affordability Act and the Hospital Provider Fee*. September 2023. https://content.leg.colorado.gov/sites/default/files/r25-685_hospital_provider_fee-accessible.pdf#:~:text=The%20Health%20Care%20Affordability%20Act,fee%2C%20to%20draw%20additional

[11] Colorado Department of Health Care Policy and Financing. *Colorado Medicaid Fact Sheet: Provider Fee*. June 2024. https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20Medicaid%20Fact%20Sheet%20-%20Provider%20Fee%20-B.pdf#:~:text=Financing%20health%20coverage%20for%20more,1%2C000%20pregnant%20women%20in%20CHIP

[12] Colorado Department of Health Care Policy and Financing. *Colorado Medicaid Insights and Potential Federal Reduction Impacts*. July 2, 2024. https://hcpf.colorado.gov/sites/hcpf/files/HCPF_CO_Medicaid_Insights_and_Potential_Federal_Reduction_Impacts_7-2.pdf#:~:text=Before%20the%20implementation%20of%20the,due%20to%20the%20CHASE%20program

Rural Hospital Funding Structure

Medicare hospital reimbursements have been reduced by 2 percent across-the-board since 2013 due to sequestration under the Budget Control Act of 2011.[13] Sequestration is a uniform Medicare payment reduction that squeezes hospitals finances by trimming already limited payments and exacerbating budget shortfalls.[14]

H.R. 1's Medicaid Provisions and Implementation Timeline

H.R. 1 was signed into law July 2025 and introduces sweeping Medicaid changes. Its Medicaid provisions include new work requirements, tighter coverage criteria, reductions in federal contributions, and enhanced oversight duties.

New Provider Fee Limit

H.R. 1 enacts significant Medicaid funding cuts and cost shifts that challenge Colorado's budget. Overall, the law substantially reduces federal Medicaid contributions effectively shifting a greater share of costs to states. H.R. 1 imposes new limits on Colorado's hospital provider fee. Under current law the maximum hospital provider fee that State can collect is 6.0 percent of hospital net patient revenues. Beginning in 2027, that maximum decreases by 0.5 percent each year, until it reaches 3.5 percent of hospital revenues in 2032. This phased cap on the provider fee could reduce the federal funds Colorado collects for hospitals by $1.5 billion to $3.9 billion when fully implemented.

H.R. 1 restricts state directed payments by capping them at Medicare rate levels by 2028. Colorado had anticipated using such payments to generate $725 million (including $446 million federal funds) in FFY 2025–26. Under H.R. 1 these amounts will be scaled down 10 percent yearly starting in FFY 2027–28.

These fiscal changes translate to large funding shortfalls for Colorado's Medicaid program. The lost provider fee and payment revenues currently finance supplemental hospital payments and services for roughly 425,000 expansion enrollees. Unless the state backfills the gap with General Fund dollars, H.R. 1's funding cuts will force reductions in provider reimbursements, covered services, or enrollment.

Eligibility and Administrative Reforms

H.R. 1 tightens Medicaid eligibility and adds new administrative requirements, impacting both enrollees and program operations. A notable change is the introduction of "community engagement" or work requirements. Beginning January 2027 able-bodied adults in the Medicaid expansion

[13] U.S. Government Accountability Office. *Budget Issues: Sequestration and Its Effects on Federal Programs*. GAO-23-105950, March 2023. https://www.gao.gov/assets/gao-23-105950.pdf#:~:text=The%20Budget%20Control%20Act%20of,For%20example%2C%20payments%20to%20critical

[14] U.S. Government Accountability Office. *Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors*. GAO-18-634, August 2018. https://www.gao.gov/products/gao-18-634#:~:text=it%20difficult%20to%20cover%20their,and%20enrollment%20experienced%20fewer%20closures

population must now complete 80 hours per month of work or other qualifying activities to maintain coverage. Numerous exemptions apply, such as for pregnant women, youth, seniors, individuals with disabilities, or people with caregiving responsibilities. However, the Department still estimates that roughly 377,000 Medicaid adults will be subject to these work requirements and may be at risk of losing coverage.[15]

The law also mandates more frequent eligibility redeterminations, requiring states to recheck expansion enrollees' eligibility every six months instead of annually. This increased frequency means some individuals may lose coverage sooner, potentially increasing churn and uninsured rates.

On the administrative side, H.R. 1 compels state Medicaid agencies to strengthen oversight and data checks. States must regularly cross-check enrollees against death records, verify enrollee addresses, and share information with other states to prevent duplicate enrollments. Audit requirements are also tightened to monitor payment errors more closely. These eligibility and administrative reforms raise operational complexity and costs for states. Colorado will need new systems, staff effort, and outreach to implement work tracking and more frequent case reviews. Providers may also feel downstream effects, as they assist patients in complying with new rules and absorb care for those who lose coverage due to administrative barriers. Overall, H.R. 1's eligibility and admin changes aim to reduce enrollment and spending, but they introduce significant new bureaucratic burdens on Medicaid programs.

Rural Health Transformation Fund

H.R. 1 created the Rural Health Transformation Program (RHTF), a federal fund to support rural healthcare systems. Congress appropriated $50 billion for this program, to be allocated to states over five years to help rural hospitals and providers adapt and remain financially viable. Half of the RHTF funding will be split equally among all states, and the other half distributed based on each state's demonstrated rural health needs and opportunities. Awarded grants will be announced by the end of 2025. While this influx of federal funds will aid Colorado's rural providers, it is relatively small compared to the Medicaid funding losses the state faces. The reduction in Colorado's hospital provider fee cap is projected to cost the state up to $3.9 billion in federal Medicaid dollars.[16] The Congressional Budget Office's estimated $911 billion federal Medicaid cut nationwide implies significantly larger shortfalls for states than the one-time rural fund can cover. RHTF will provide Colorado with some

[15] Colorado Department of Health Care Policy and Financing (HCPF). *Work Requirements Fact Sheet: Impacts of Federal H.R. 1 Work Requirements on Colorado's Medicaid Program.* October 2025 https://hcpf.colorado.gov/sites/hcpf/files/Work_Requirements_Fact_Sheet.pdf#:~:text=Through%20such%20a%20mandate%2C%20states%20would%20have,be%20at%20risk%20of%20losing%20Medicaid%20coverage.

[16] Colorado General Assembly. *Medicaid Impacts from the One Big Beautiful Bill Act*. October 2025. https://content.leg.colorado.gov/sites/default/files/medicaid_impacts_from_the_one_big_beautiful_bill_act_placeholder-accessible.pdf#:~:text=FY%202031,covered%20under%20the%20ACA%20expansion

transitional support, but it falls short of offsetting the broader Medicaid funding reductions imposed by H.R. 1.

Options

With Medicaid reforms straining rural health systems, Colorado can look to a range of mitigation strategies that have been implemented or proposed in other states. These strategies aim to maintain access to care and financial viability for rural providers despite funding challenges. To respond to Medicaid reforms and safeguard rural access, Colorado can adopt a range of tested strategies already used by other states.

Rural Health Transformation Models

States like Pennsylvania and Maryland have implemented global budget models that provide rural hospitals with fixed annual payments, reducing financial volatility and enabling investment in primary care and telehealth.[17] Colorado could explore similar stable payment structures for its vulnerable hospitals.

Medicaid Value-Based Payments and Waivers

Programs like Colorado's Hospital Transformation Program (HTP) reward rural hospitals for improving outcomes using provider fee funds. Other states have used Medicaid Section 1115 waivers to create targeted payment pools for distressed hospitals. Colorado may pursue similar waivers or repurpose Rural Health Transformation Fund (RHTF) dollars into flexible rural support mechanisms. The General Assembly could appropriate additional funding to support rural hospitals, but it would likely require enabling legislation, especially if the funding structure involves creating or modifying a grant program, leveraging Medicaid matching funds, or altering the Hospital Provider Fee framework.

Telehealth and Integrated Care

Telehealth remains critical in rural care delivery, especially in behavioral health. Colorado's Office of eHealth Innovation has piloted successful tele-behavioral models that could scale statewide. Participation in Accountable Care Organizations (ACOs) and use of medical homes can help rural providers coordinate care and share in savings.

Conclusion

In summary, a multipronged strategy that includes innovative payment models, expanded telehealth, targeted waivers, insurance market support, and rural workforce investment will be critical for Colorado to preserve rural care access under H.R. 1.

[17] Centers for Medicare & Medicaid Services. *Pennsylvania Rural Health Model*. https://www.cms.gov/priorities/innovation/innovation-models/pa-rural-health-model