

# Navigating the OBBBA and the Rural Health Transformation Program

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August 28, 2025

Hosted by





# Housekeeping

- All attendees are muted
- Our session will run about an hour
- Submit questions in the Q&A panel
- Recording will be emailed

**Please take our short, 5-question survey at the end of the webinar!**

Your input will shape future sessions and ensure we focus on what's most important to you.



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# What We Know Today

# H.R.1 Important Healthcare Provisions

## Medicaid Work / Community Engagement

- Adults 19–64 must work or perform community service at least 80 hours/month beginning in 2027
- Exemptions: caregivers for children <14 or people with disabilities, veterans, individuals with disabilities, inmates, pregnant women, and part-time students

## Medicaid Eligibility Checks

- Eligibility reviews increase to at least every 6 months beginning in 2027
- Currently checked annually

## Medicaid Provider Taxes

- Expansion states: maximum tax rate lowers incrementally from 6% to 3.5% between 2028–2031
- Non-expansion states: current tax rate maintained

## Affordable Care Act Reforms

- Shortens annual open enrollment by 1 month
- Eliminates low-income special enrollment period and automatic enrollment
- Includes other technical changes

# Coverage Impacts

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- Policy changes are estimated to reduce health insurance coverage for about 10 million Americans by 2034
- An additional ~4 million could lose coverage if enhanced ACA marketplace subsidies expire on Dec 31, 2025
- These losses stem from stricter eligibility rules and new paperwork requirements

# Other Bill Implications: Medicare Sequestration

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- Bill increases deficit by over \$2 trillion, triggering the Pay-As-You-Go (PAYGO) Act
- PAYGO automatically reduces federal spending when Congress passes legislation that adds to the deficit
- Could reduce Medicare provider reimbursements by up to 4%
- In other deficit increasing bills, Congress has waived PAYGO before it has gone into effect

# Translating Policy into Provider Reality

# Translating Policy into Provider Reality

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- Regulatory rules vs. anticipated requirements
- Concerns surfacing today
- How might this affect the Rural Community as a whole?

# Effects of the Rural Health Transformation Program

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- Medicaid Changes
- State Provider Taxes & Reimbursement Caps
- Operational Challenges & Alternatives
- Community Impact
- Workforce & Technology Concerns
- Impact of the Big, Beautiful Bill on the ACA

# How This May Impact Your Hospital or Practice Financially

# How OBBBA May Impact Your Hospital or Practice Financially

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- Medicaid and ACA Plans: Risks and Shifting Dynamics
- Data and Payer Mix analysis methodology
- Azalea Health OBBBA Payer Mix Impact Forecasting Model

# Payer Mix Analysis Methodology

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1. Gather Your Payer Mix Data
2. Determine Medicaid Dependence
3. Model Potential Coverage Losses
4. Account for Delays and Cost-Sharing
5. Run Sensitivity Scenarios
6. Strategize Around the Findings

A1 Hospital or Practice Info

	A	B	C	D
1	<b>Hospital or Practice Info</b>			
2				
3	Hospital or Practice Name	Your Organization		
4	State (optional)	GA		
5	Baseline Year	2024		
6				
7	<b>Baseline Payer Mix (Annual)</b>			
8				
9	<b>Payer</b>	<b>Baseline Visits</b>	<b>Net Revenue / Visit (\$)</b>	<b>Baseline Revenue (\$)</b>
10	Medicaid	2000	95	\$190,000
11	Medicare	1500	120	\$180,000
12	Commercial	2500	160	\$400,000
13	Self-Pay/Uninsured	800	60	\$48,000
14	Other	200	110	\$22,000
15	<b>TOTAL</b>	<b>7000</b>		<b>\$840,000</b>
16				
17				
18	<b>Medicaid Impact Assumptions</b>			
19				
20	Coverage loss % (base)	12.00%		
21	Extra leakage % (base) from churn/verification/cost-sharing	5.00%		
22	Shift of lost Medicaid visits to Self-Pay %	30.00%		
23	Self-Pay collection rate on shifted visits %	30.00%		
24				
25				
26				
27				
28				
29				
30				



# Azalea Health OBBBA PayerMix Impact Model

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A1 | fx OBBBA Impact Scenarios

	A	B	C	D	E
1	<b>OBBBA Impact Scenarios</b>				
2					
3	<b>Scenario</b>	<b>Coverage loss % (Medicaid)</b>	<b>Extra leakage %</b>	<b>Shift to Self-Pay %</b>	<b>Self-Pay collection %</b>
4	Best Case	5.00%	3.00%	35.00%	35.00%
5	Expected	12.00%	5.00%	30.00%	30.00%
6	Worst Case	20.00%	8.00%	25.00%	25.00%
7	Custom (edit here)	12.00%	5.00%	30.00%	30.00%
8					
30					

+ ☰ **README** ⌵ **Inputs** ⌵ **Payer Mix Detail** ⌵ **Scenarios** ⌵ **Results** ⌵



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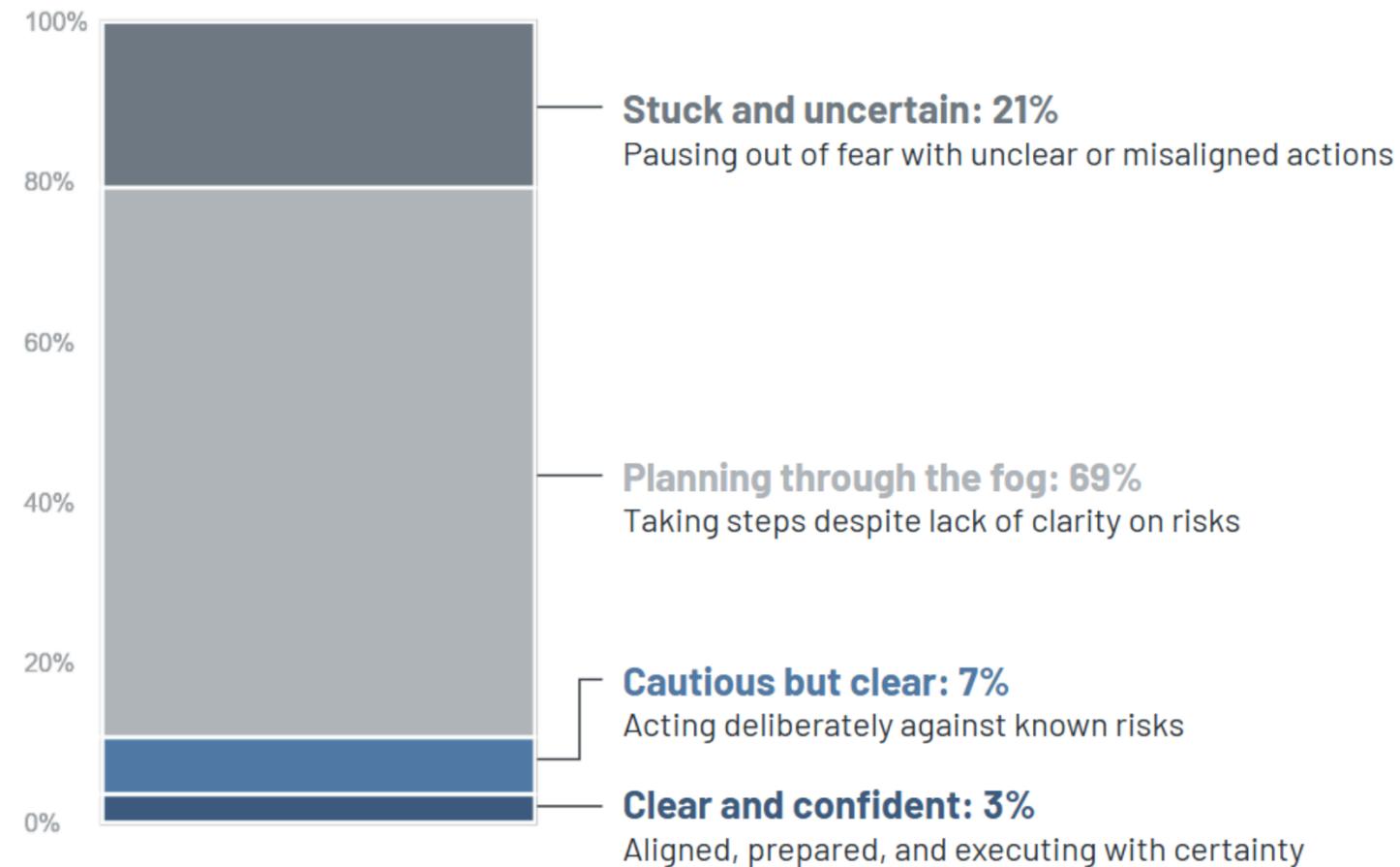
	A	B	C	D	E	F	G	H	I	J	K
1	<b>Impact Summary</b>										
2											
3	<b>Scenario</b>	<b>Baseline Medicaid Visits</b>	<b>Baseline Medicaid Rev/Visit (\$)</b>	<b>Baseline Medicaid Revenue (\$)</b>	<b>Visits Lost (Coverage Loss)</b>	<b>Additional Effective Loss (Leakage)</b>	<b>Shifted to Self-Pay (visits)</b>	<b>Self-Pay Collected (\$)</b>	<b>Net Revenue Loss (\$)</b>	<b>Net Revenue After Impact (\$)</b>	<b>% Revenue Change vs Total Baseline</b>
4	Best Case	2000	95	\$190,000	100	57	35	\$735	\$14,180	\$825,820	1.69%
5	Expected	2000	95	\$190,000	240	88	72	\$1,296	\$29,864	\$810,136	3.56%
6	Worst Case	2000	95	\$190,000	400	128	100	\$1,500	\$48,660	\$791,340	5.79%
7	Custom (edit here)	2000	95	\$190,000	240	88	72	\$1,296	\$29,864	\$810,136	3.56%
8											
9											
28											

# Contingency Planning

# The vast majority of provider and payer organizations express a high or moderate degree of uncertainty amid potential government changes.

## Levels of strategic uncertainty across the market

n=169



The HDOs that are “cautious but clear” or “clear and confident” are predominantly academic or large health systems that are proactive and not waiting to see how bad things get. They are focused on their clinical mission, and spending cuts target administration, IT backlog, and discretionary spending before considering patient-facing impacts. Spending is focused on initiatives with clear ROIs, such as revenue cycle and AI.

*“There is so much uncertainty that I can't plan for what we will do if there is a major upheaval in the Medicaid plan. **I can't fathom what the changes will be and how they will impact me.** It is that wild card in the equation that we will have to adjust to meet. We are proactive in doing bare-minimum, bare-bones philosophy but reactive in the sense that there is not much more we can do. If we must do more, what we do would be very significant.”*

—CMIO, small health system, planning through the fog

# Despite nearly ubiquitous uncertainty, HDOs are proactively implementing contingency plans (often several) to increase their odds of success.

## Contingencies in place to combat government and regulatory shifts

n=133; respondents could give multiple answers



HDOs that have contingency plans are rarely single-threaded in their approach, reporting on average two contingencies per organization.

Those reporting no contingencies in place are largely small hospitals and physician practices.

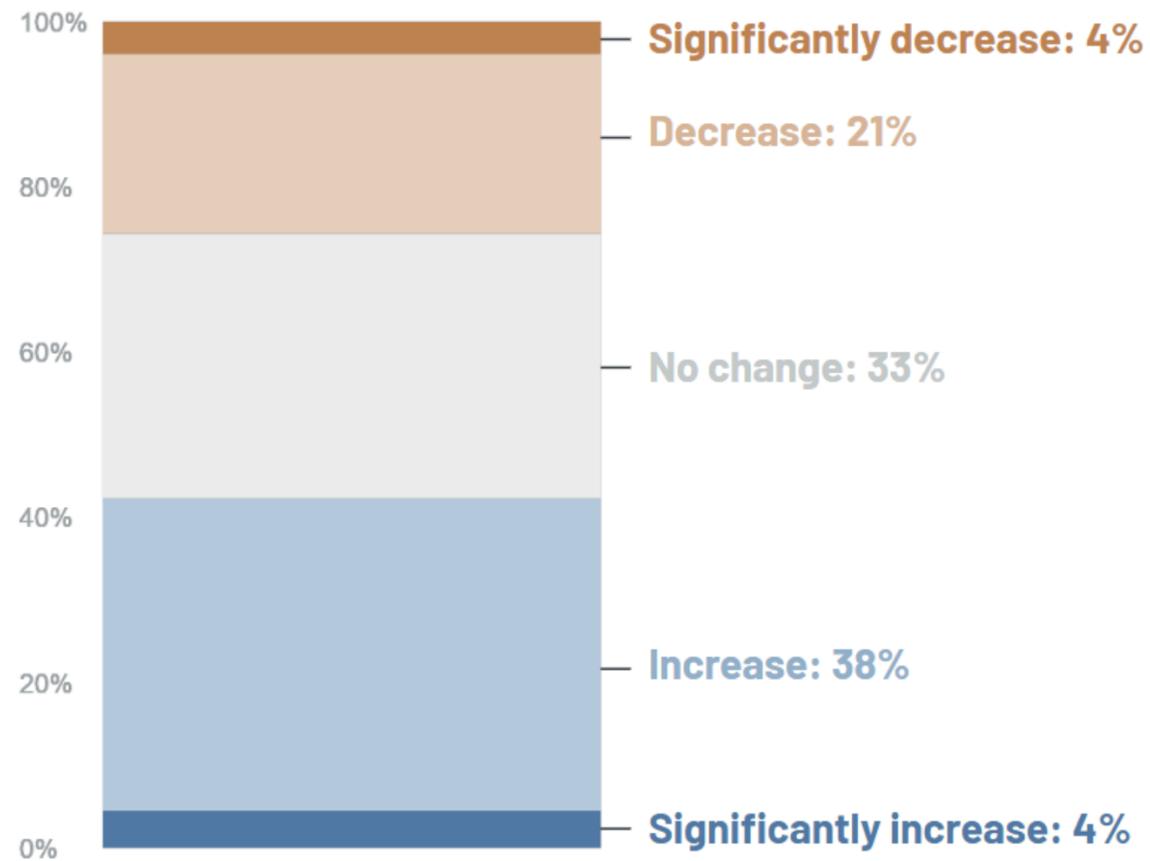
Academic health systems are the most likely to be considering workforce restructures in their contingency plans.

Workforce restructuring includes a wide range of approaches, from proactive layoffs to hiring and salary freezes. Patient-facing roles are the least likely to be affected.

# Despite uncertainty and financial pressures, HDOs are more likely to make targeted investments rather than decrease their IT spend.

## Impact of policy changes/regulatory shifts on IT spend over next 12 months

n=156



Preparedness is correlated with change in spend—the more prepared the organization is, the more likely they are to increase spend.

Health systems are 3x more likely than physician practices to be decreasing their spend (32% versus 10%); both groups are equally likely to be increasing spend.

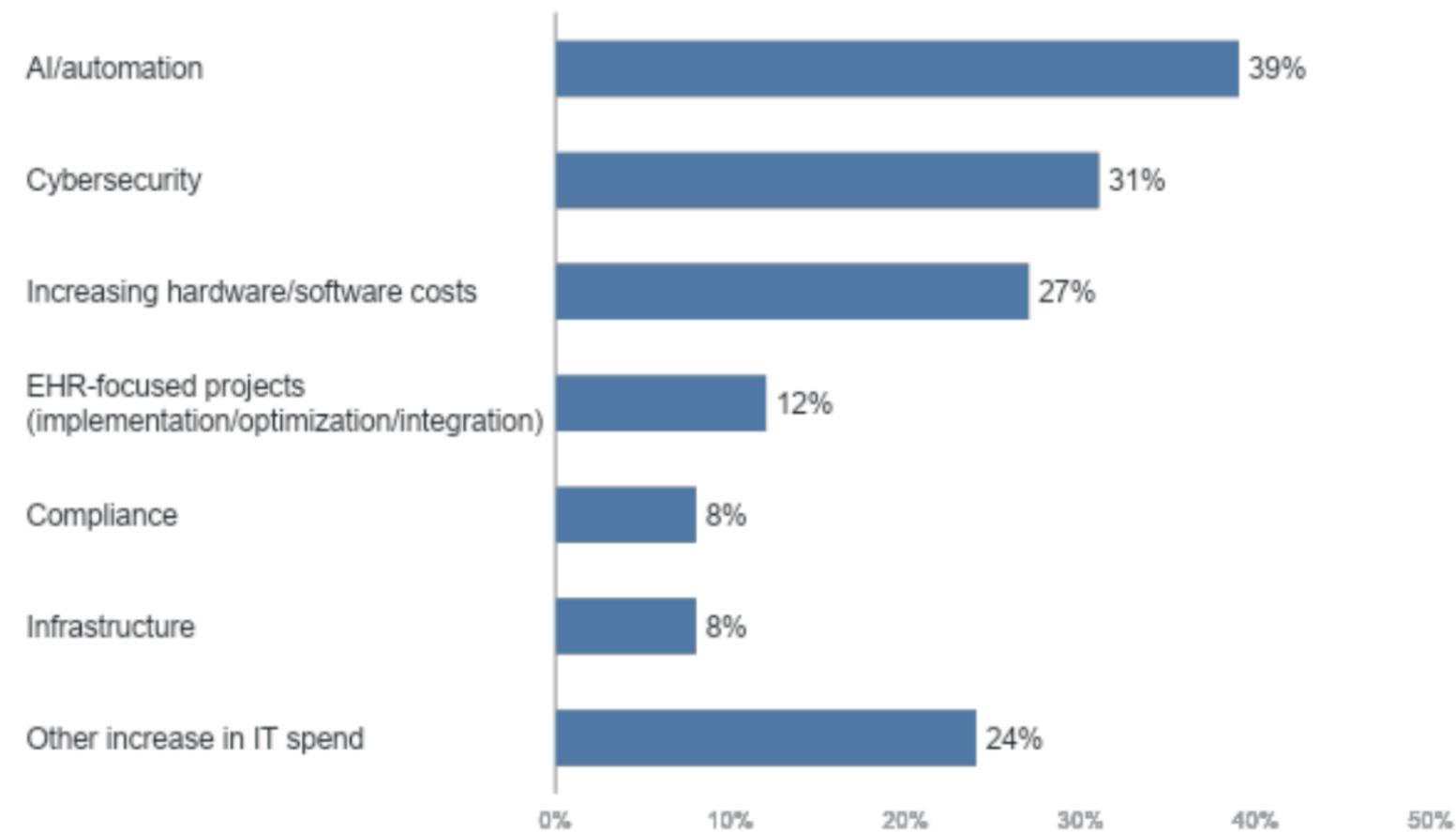
Small health systems and academic health systems are the most likely to say they are reducing their spend.

Small physician practices are largely in a holding pattern.

# IT spend is focused on areas that have strong ROI, increase efficiency, and reduce organizational risk.

## Where are organizations increasing IT spend?

n=49; respondents could give multiple answers



Health systems are investing more heavily in (1) AI and (2) the increasing costs of hardware/software (caused by tariffs and inflation).

Physician practices are more heavily focused on cybersecurity and EHR-focused projects.

*“I think **we will invest more in some of the AI technologies, like ambient listening. We will invest a little more in integrating some of our mergers and acquisitions such that we can see some of the economies of scale and some of the additional revenues. We have projects that have pretty significant returns on investment. Those are the things that are going to see a little more of an investment, and then we have to balance that out by slowing down investment in some of the more routine things that are more discretionary in nature.**”*

—VP, academic health system

# The Funding Process & Steps to Take

# Rural Health Transformation Program

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- \$50B fund distributed at \$10B/year (2026-2030) by CMS to states
- Not a provider relief fund style pot of money
- CMS has indicated states will be receiving applications in September
- These plans are expected to be “detailed transformation plans”
- Funding split: 50% of appropriated funds equally distributed amongst all states with approved application; remaining 50% distributed at CMS discretion amongst at least 25% of states with application

# Questions?

**Submit your questions on the Q&A panel on the right side of the screen.**

For additional questions after today's session, contact us at [obbba@azaleahealth.com](mailto:obbba@azaleahealth.com)

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