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Sustaining Rural Hospital Access: Adjustments to Medicare Rural Hospital Designations

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HEALTH PROGRAM

BPC's Health Program advances bipartisan policy solutions to build a more cost-effective, evidence-based health care system and improve population health. We work to strengthen and sustain Medicare and Medicaid, accelerate the shift toward value, address inefficiencies and misaligned incentives, and responsibly leverage technology and innovation.

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Executive Summary

Approximately 60 million people in the United States—20% of the population—live in rural communities and rely on rural hospitals for their health care.[1] However, many of these hospitals operate on thin margins and face mounting financial pressures. Medicare's rural designation programs provide crucial financial support to these facilities, but key provisions are set to expire in 2025. At the same time, rural hospitals struggle with the financial challenges of participating in the Medicare Advantage (MA) program, which often reimburses providers at lower rates than traditional Medicare.

Congress should make Medicare's rural designation programs permanent to help ensure the long-term stability of these hospitals and the communities they serve. The Sole Community Hospital program, established in 1983, the Medicare Dependent Hospital program, established in 1989, and the Critical Access Hospital (CAH) program, established in 1997, offer targeted financial protections to small, geographically isolated facilities.[2,3,4] Without these programs, many rural hospitals might have to cut services or close, further limiting access to care for millions of Americans.

Congress created rural hospital designations starting in 1983 to bolster health care access in underserved areas. Recognizing these programs' vital role, lawmakers have repeatedly reauthorized them over the past three decades. As the 2025 deadline approaches, making these designations permanent is critical to preserving rural America's health care infrastructure and ensuring that rural communities can access the care they need.

Beyond making the programs permanent, Congress should update payment policies to allow more rural hospitals to participate in these programs and reduce the risk of closures and service reductions. Specifically, Congress should give states greater flexibility to determine participation in the critical access hospital program. Congress should also consider permanently authorizing the Medicare Rural Community Hospital demonstration program, which helps midsized hospitals that are too large for the CAH designation but too small to remain financially stable under standard Medicare payments. Finally, Congress should pilot a new payment adjustment to help rural hospitals cover the high fixed costs of keeping open essential services—such as emergency rooms, maternal care, and behavioral health treatment—even when patient numbers are low.

To further help rural hospitals, policymakers need to make changes to Medicare Advantage's reimbursement rules and rates. Enrollment in Medicare Advantage has grown significantly in rural areas, increasing from 400,000 beneficiaries in 2010 to more than 1.8 million in 2023.[5] However, rural hospital executives report that lower MA reimbursement rates threaten the

financial sustainability of the smallest, critical access hospital providers. Strict MA prior authorization rules and payment denials further delay access to rural care and increase administrative costs for rural providers.

The secretary of the Health and Human Services Department (HHS) and Congress must also ensure that upcoming Medicare ambulance and emergency medical services (EMS) reforms stabilize access to care for all rural residents. The Bipartisan Budget Act of 2018 established a process to evaluate and reform Medicare ambulance reimbursement, but policymakers must ensure that payment reforms sustain access to EMS for all rural residents, including those served at critical access and other rural designation hospitals.[6]

This brief builds on the Bipartisan Policy Center's extensive work on strengthening the rural health care delivery system, including a 2020 report, *Confronting America's Rural Health Crisis*; a 2022 report, *The Impact of COVID-19 on the Rural Health Care Landscape*; and, most recently, a 2024 report, *The Rural Emergency Hospital Model: Year Two Progress Report*. To inform this brief, BPC examined the role of hospitals in rural economies and how Medicare's rural hospital designation programs affect the availability and financial stability of rural hospitals. BPC also received feedback from rural hospital executives, researchers, policymakers and other rural stakeholders on whether these programs require modification to increase their effectiveness. Based on this research, the report outlines recommendations to ensure that rural hospitals remain viable and accessible in the years ahead.

POLICY RECOMMENDATIONS

Allow State Flexibility in Determining Critical Access Hospital Participation

- The secretary of HHS should temporarily reestablish the "necessary provider" designation for critical access hospitals. After three years, the Government Accountability Office (GAO) should assess the designation's impact on hospital closures, health care access, and Medicare costs, and recommend whether to make it permanent.

Stabilize Rural Prospective Payment System (PPS) Hospitals

- Congress should make the Medicare dependent hospital designation and the low-volume payment adjustment program—as well as additional payments for sole community hospitals—permanent.
- The HHS secretary should conduct an updated evaluation of the Medicare Rural Community Hospital Demonstration, and Congress should consider making the program permanent if the assessment finds that the program is reducing rural hospital closures and the loss of services.

- Congress should test a new payment adjustment targeted to essential rural services.

Improve the Rural Experience in the Medicare Advantage Program

- Congress should ensure that rural providers can sustainably participate in Medicare Advantage by directing GAO to conduct a robust analysis that compares traditional Medicare and Medicare Advantage reimbursement structures for rural hospitals.
- Congress should modernize Medicare Advantage prior authorization rules to reduce unnecessary administrative burdens on rural providers and improve timely access to care. Congress should also require Medicare Advantage plans to maintain accurate provider directories so that enrollees, including those in rural communities, can identify covered health care providers and services.

Strengthen Rural Emergency Medical Services

- The secretary of HHS and Congress must ensure that Medicare ambulance and emergency medical services reforms improve access to EMS care for all rural residents.

Background

Rural hospitals are struggling to stay open. Of the approximately 1,800 rural community hospitals, nearly half have fewer than 25 beds.[7] Since 2010, 167 hospitals have closed and 418 are at risk. Declining rural populations, shrinking patient volume, and growing financial pressures make it increasingly difficult to sustain operations.[8]

For the 60 million people—20% of the U.S. population—who live in rural communities, hospital closures and service cuts mean fewer care options and longer travel times for treatment.[9] A 2025 report shows that rural patients typically drive 55 minutes to reach a hospital for surgical care.[10] People living in rural areas already have higher rates of heart disease, cancer, and stroke, and losing nearby hospitals further limits access to care and risks worsening health outcomes.[11]

Over the past 15 years, 267 rural hospitals have eliminated obstetrics and gynecology services, and 382 have phased out chemotherapy.[12] Many women in rural areas must travel long distances or forgo prenatal visits due to the loss of obstetric care.[13] Lack of proper prenatal care is linked to lower birth weights, higher infant and maternal mortality, and greater risk of premature births.[14] The United States already has the highest maternal mortality rates among

developed nations, and rural hospital closures could make this worse.[15,16] Additionally, states where hospitals are ending chemotherapy services are also seeing the largest number of rural hospital closures, further limiting access to critical care.[17]

These closures have significant economic consequences. In 2020, rural hospitals generated $220 billion in economic activity and supported 1 in every 12 rural jobs.[18] Often the largest employers in their communities, rural hospitals provide stable, well-paying jobs. The average critical access hospital employs 127 full- and part-time employees, with a payroll of around $6 million.[19] One study found a 10%–12% reduction in health care jobs within three years of a hospital closure.[20] This study did not consider jobs in industries indirectly affected by the closures, such as medical suppliers or specialty care doctors who use that facility to see patients. Laid off employees sometimes leave the area or move to nearby communities, taking their business with them and creating further hardships for businesses in already struggling towns.

Many rural hospitals serve communities with lower incomes, older populations, fewer college graduates, higher uninsured rates, and worse overall health.[21] Communities with higher uninsured or unemployment rates often rely more heavily on emergency care, which is typically the most expensive to provide.[22] Without insurance coverage, the costs of uncompensated patient care fall onto already struggling hospitals, creating greater financial pressure on these rural facilities.

Since January 2005, 75 of the 195 rural hospital closures have been among hospitals paid under the Medicare Prospective Payment Systems (PPS). These facilities are ineligible for Medicare's rural designation programs or are small, geographically isolated hospitals.[23] More background on the characteristics of closed hospitals can be found in the charts below.

The Role of Public-Sector Support in Sustaining Access to Rural Hospital Care

Traditional Medicare

Congress established the first special rural hospital programs and designations in 1983, recognizing the foundational role that local hospitals played in sustaining rural communities and the financial challenges that they faced.

These programs offer financial assistance to qualifying rural hospitals beyond what they would receive under the Medicare Prospective Payment System. For example, critical access hospitals receive 101% of cost-based reimbursement, while sole community hospitals receive the higher of either the Medicare

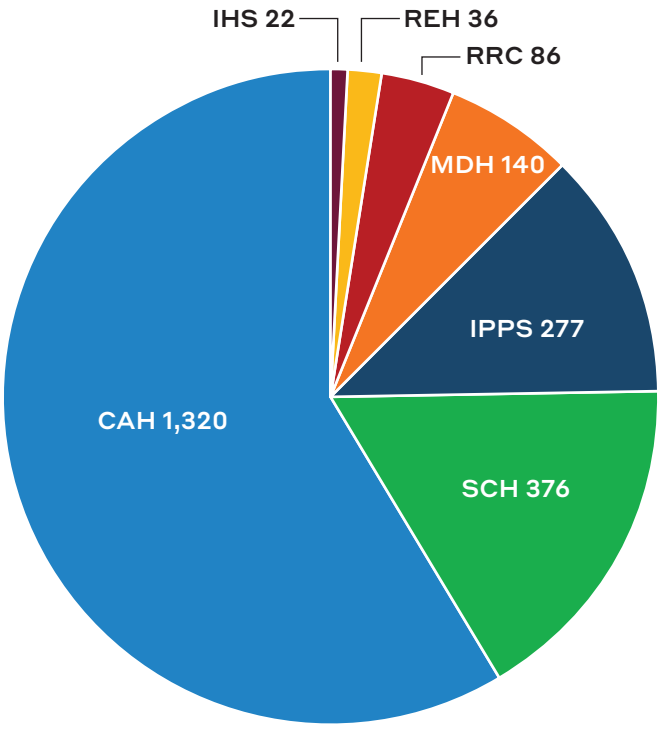
inpatient Prospective Payment System rate or a hospital-specific rate tied to individual hospital costs.[24]

As of 2024, the number of hospitals in each rural designation were:[25]

- Critical Access Hospitals (CAHs): ~ 1,320 hospitals
- Sole Community Hospitals (SCHs): ~ 376 hospitals
- Rural Referral Centers (RRCs): ~ 86 hospitals
- Medicare Dependent Hospitals (MDHs): ~ 140 hospitals
- Rural Emergency Hospitals (REH): ~ 36 hospitals
- Inpatient Prospective Payment System (IPPS): ~ 277 hospitals
- Indian Health Service (IHS): ~22 hospitals

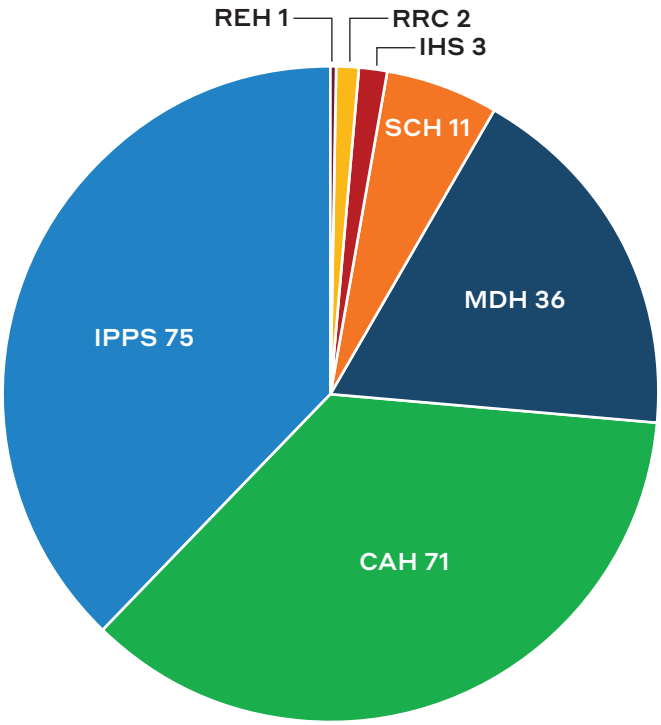
In 2003, Congress also established a unique, low-volume payment adjustment for rural hospitals; this adjustment currently supports 455 facilities.[26] See the appendix for a full description of these designations.

Figure 1. Total Number of Rural Hospitals Broken Down by Designation, 2024



Data from Cecil G. Sheps Center for Health Services Research, "List of Hospitals in the U.S.," 2024. Available at: https://www.shepscenter.unc.edu/programs-projects/rural-health/list-of-hospitals-in-the-u-s/.

Figure 2. Number of Rural Hospital Closures by Type, 2005–2025



Data from: Cecil G. Sheps Center for Health Services Research, Rural Health Closures. Available at: https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

Many rural hospitals face increasing financial challenges but are ineligible for the special Medicare rural designations. These hospitals may have slightly too many beds to qualify or may fall outside strict distance requirements. Nonetheless, they are experiencing shrinking patient volume and rising labor and supply costs. Since January 2005, 75 hospitals that closed did not qualify for rural designations.[27,28]

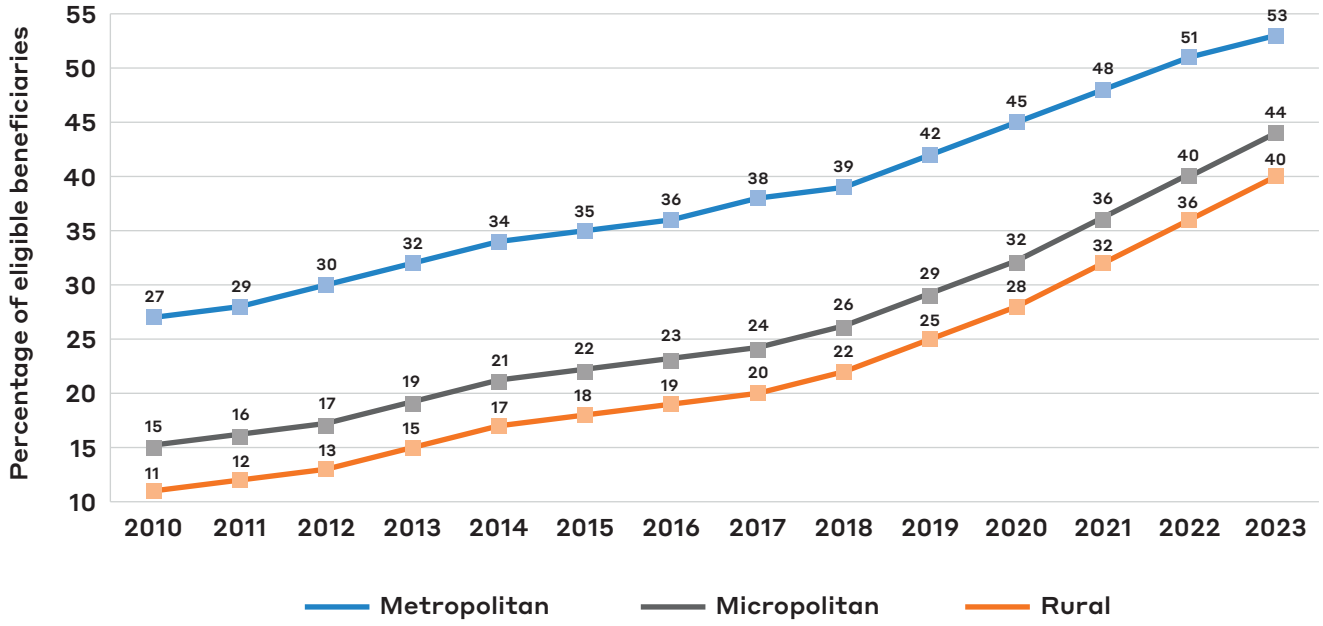
Even with support from rural designation programs, participating hospitals still struggle financially. Many programs, including Medicare dependent hospitals, sole community hospitals, and the low-volume adjustment, require periodic reauthorization by Congress—sometimes every few years or in some cases every few months.[a] The lack of program permanence contributes to financial instability and complicates long-term planning for finances, staffing, and operations. HHS staff have also noted that the absence of permanence hinders efforts to integrate these designations into new payment or care delivery models, as the department must assume they will expire.[29]

a Short-term extensions of the Medicare dependent hospital program and low-volume payment adjustment were included in the American Relief Act, 2025 (P.L. 118-158), signed by President Joe Biden on December 21, 2024, and the Full-Year Continuing Appropriations and Extensions Act, 2025 (P.L. 119-4), signed by President Donald Trump on March 15, 2025. These bills provided three-month and six-month extensions, respectively, of the policies.

Medicare Advantage

The rural designations provide financial protection only within Medicare fee-for-service, and do not extend to the private Medicare Advantage program. In recent years, more rural Medicare beneficiaries have shifted from traditional Medicare to MA. When Congress established the first rural designation program in 1983, Medicare Advantage did not exist. Today, MA enrollment has surged to 32.8 million—54% of the eligible Medicare population—and rural MA enrollment has risen from 18% in 2015 to 40% in 2023.[30,31]

Figure 3. Growth in Medicare Advantage Enrollment Since 2010



Source: KFF analysis of CMS Medicare Enrollment Files, 2010–2013

Rural hospitals must negotiate MA reimbursement rates with private insurers, and hospital executives report increasing challenges in securing cost-based reimbursement. One rural state estimated that its hospitals collected only 35% of total costs related to services provided to MA patients in 2024.[32] In another state, a rural hospital reported receiving, on average, only 83% of what traditional Medicare paid for the same services.[33] Independent hospitals that are not part of larger hospital systems have the most difficulty and least leverage in securing additional financial protections from insurers.

Rural hospitals also cite ongoing challenges with strict prior authorization rules and high payment denial rates. Unlike traditional Medicare, most patients in Medicare Advantage require prior authorization for certain services. Insurers use prior authorization to control costs and deter unnecessary care, but it can result in inappropriate denials and delays

in access to needed care. In 2023, MA insurers denied 3.2 million prior authorization requests—6.4% of all requests. Among the denied requests that were appealed, 82% were overturned. By comparison, in 2022, only 29% of appeals in traditional Medicare were overturned.[34] The Kansas Hospital Association reported that in 2024, MA plans denied 16.5% of claims, far higher than the national average of 4.8%.[35] Inappropriate denials also increase the administrative burden on hospitals. In 2022, 95% of hospitals reported spending more time seeking prior authorization approvals, and 84% saw increased administrative costs related to compliance with insurance policies, compared with prior years.[36,37]

Rural MA enrollees often face limited access to in-network providers and inaccurate provider directories. A recent congressional study of MA provider directories found that more than 80% of mental health providers listed as in-network were either not accepting new patients, unreachable, or not actually in-network. The success rate in scheduling appointments with providers listed as available was only 18%, according to the study's authors.[38] These "ghost" networks add to the confusion that patients, including those in rural areas, encounter when they try to access care through their MA plan.

Medicaid

Although this report does not contain specific Medicaid policy recommendations, it is important to note that Medicaid coverage directly affects rural hospitals' finances. With nearly 40% of children and 25% of older adults in rural areas enrolled in Medicaid, this health insurance program for low-income Americans is a critical funding source for rural hospitals.[39,40] It is especially crucial in rural communities with large American Indian and Alaska Native populations, where many rely on Medicaid for health coverage.[41]

Medicaid expansion under the Affordable Care Act, adopted by 41 states, has increased coverage and reduced uncompensated care costs for rural hospitals.[42,43] Expanded Medicaid coverage is also linked to better maternal and infant health outcomes, a growing concern as more rural hospitals reduce maternal care services.[44] However, about one-third of rural hospitals operate in non-expansion states, where uninsured rates are nearly double.[45,46]

In addition to reducing the number of uninsured patients served by rural hospitals, Medicaid provides additional financial support to rural hospitals through supplemental payments. Disproportionate share hospital payments help cover uncompensated care for uninsured and Medicaid patients.[47] Upper payment limit supplemental payments help to cover the gap between Medicaid payments and what Medicare would have paid for the same service.[48]

Policy Recommendations

ALLOW STATE FLEXIBILITY IN DETERMINING CRITICAL ACCESS HOSPITAL PARTICIPATION

The secretary of HHS should temporarily reestablish the "necessary provider" designation for critical access hospitals. After three years, the Government Accountability Office should assess the designation's impact on hospital closures, health care access, and Medicare costs, and recommend whether to make it permanent.

To qualify as a critical access hospital (CAH), facilities must be located more than 35 miles from the nearest full-service hospital, with some exceptions in mountainous terrains, and must have 25 or fewer inpatient hospital beds. CAHs are paid 101% of reasonable costs for most inpatient and outpatient services—higher reimbursement levels than the traditional Medicare inpatient or outpatient Prospective Payment Systems. This payment structure bolsters the finances of struggling facilities.

Until 2006, states could designate rural hospitals as CAHs under a necessary provider designation, even if the facility did not meet all eligibility criteria.[49] States most often used this authority to waive the distance requirements if it would improve or sustain local access to care. As the risk of rural hospital closures has increased, state hospital associations and individual rural hospitals have called for the reinstatement of states' authority to issue necessary provider designations to prevent closures. The bipartisan Rural Hospital Closure Relief Act of 2025, introduced in the 119th Congress by Sens. Richard Durbin (D-IL) and James Lankford (R-OK), seeks to reinstate the necessary provider designation process.[50]

The HHS secretary should temporarily reestablish the CAH necessary provider designation process for three years. This process should allow states to deem small, struggling rural hospitals eligible for the CAH program. After three years, GAO should evaluate the program's impact on patient access to rural hospital care, rural hospital closures, and Medicare spending. Additionally, GAO should recommend whether to make the state necessary provider designation permanent.

STABILIZE OTHER RURAL DESIGNATION AND SMALL PPS HOSPITALS

Congress should make the Medicare dependent hospital designation and low-volume payment adjustment program—as well as additional payments for sole community hospitals—permanent.

Many rural hospital designations or programs require Congress to reauthorize or renew certain aspects of the Medicare reimbursement or the entire designation every few months or years. These regular short-term extensions make it difficult for hospitals to plan budgets, invest in services, and retain staff. Making these programs permanent would ensure predictable funding and help protect access to care in rural communities.

- **The Medicare dependent hospital (MDH):** This designation supports hospitals with 100 or fewer inpatient beds that serve a patient population where at least 60% are covered by Medicare. The Medicare Payment Advisory Commission (MedPAC) estimates that this designation costs $125 million per year more than traditional Medicare inpatient prospective payments.[51] The program currently accounts for approximately $126 million annually in Medicare spending and is set to expire on September 30, 2025.[52,53]
- **The low-volume payment adjustment:** This program increases Medicare payment rates on a sliding scale, starting at a 25% increase for hospitals with the fewest discharges and gradually decreasing to 0% for those with 3,800 or more annual discharges. The program accounts for $382 million per year in Medicare spending.[54] It has helped stabilize rural hospitals with low patient volumes but is set to expire on September 30, 2025.[55]
- **The sole community hospital payment adjustment for outpatient services:** This adjustment provides a 7.1% increase to PPS payments for outpatient services due to higher operating costs in rural areas. Congress gave the HHS secretary authority to make this adjustment after a congressional study confirmed that rural sole community hospitals experience substantially higher expenses than other hospitals.[56] Making this adjustment permanent would provide financial stability and align with broader policies to support outpatient care in rural communities and could be done in a budget neutral manner. The adjustment is considered annually as part of the Medicare hospital outpatient Prospective Payment System rule.[57]

The HHS secretary should conduct an updated evaluation of the Medicare rural community hospital demonstration, and Congress should consider making the program permanent if the assessment finds that the program is reducing rural hospital closures and the loss of services.

Congress established the Medicare rural community hospital demonstration in 2003 to support "tweener" rural hospitals—those too large to qualify for

the critical access hospital designation, but too small to succeed under the Medicare inpatient Prospective Payment System.[58] Eligible hospitals must have fewer than 51 patient beds and be in areas with low population density. The program is capped at 30 participating hospitals.

The program tests whether providing enhanced Medicare reimbursement increases the capability of smaller rural hospitals to meet the needs of rural communities. Under the demonstration, participating hospitals receive reasonable cost reimbursement for inpatient care. The authorizing statute requires that the HHS secretary ensure the aggregate payments made in the program are budget neutral and do not result in new or additional Medicare spending.[59]

The most recent performance data suggests participation in the rural community hospital program has improved finances and led to no closures among participating facilities.[60] Since its inception, the demonstration program has been reauthorized three times.[61,62,63] It is currently slated to end on June 30, 2028. Twenty hospitals participate, and CMS is soliciting 10 additional hospitals to reach the 30-hospital cap.[64]

As the demonstration continues, the HHS secretary should conduct an updated evaluation to assess the program's impact on rural hospital closures and service reductions, particularly in the most isolated, frontier communities. The assessment should include recommendations to Congress on whether to extend or make the program permanent and should propose any necessary modifications to better target at-risk rural hospitals, while ensuring budget neutrality in the Medicare program.

Congress should test a new payment adjustment targeted to essential rural services.

For rural hospitals, fixed costs associated with maintaining essential services, such as emergency room care, labor and delivery services, and behavioral health care, cause financial strain.[65] These costs are often related to maintaining a minimum level of staffing and essential equipment to deliver time-sensitive services, regardless of patient volume. This "standby capacity" represents a fixed cost that rural hospitals must absorb, even if their patient volume and related revenue are not high enough to cover the expenditures.[66]

When hospitals cannot absorb these expenses, they are often forced to reduce services or close entirely. For example, high fixed costs have contributed to a decline in rural maternal care. Between 2012 and 2022, approximately one-quarter of all rural hospitals stopped providing obstetric services, affecting access to maternal care in 267 communities.[67] To address this issue, members of Congress have introduced legislation to provide Medicaid labor and delivery "anchor payments" to low-volume rural hospitals serving fewer than 300 obstetric patients per year.[68]

Congress should establish a demonstration to test offering rural hospitals a new fixed cost payment adjustment. This adjustment should bolster rural hospitals' ability to provide essential services, such as emergency, diagnostic, laboratory, and behavioral health services. Possible approaches include:

- A sliding-scale model based on the number of individuals within a hospital's catchment area, with the highest adjustment to the most isolated facilities.
- A payment structure similar to the additional facility payment in Medicare's Rural Emergency Hospital (REH) program, in which hospitals receive a flexible monthly payment to cover ongoing costs and critical service lines.[69,70]

Regardless of structure, the adjustment should be available to rural designation and rural PPS hospitals, with priority given to those in the lowest population density areas.

IMPROVE THE RURAL EXPERIENCE WITH MEDICARE ADVANTAGE

An increasing number of rural residents are enrolling in the private Medicare Advantage (MA) program. In 2023, more than 1.8 million rural Medicare beneficiaries were enrolled in MA, a number four times greater than in 2010.[71]

Building on traditional Medicare, the MA program combines Medicare Part A services (hospital and post-acute care, excluding hospice care) and Part B services (physician and outpatient care) into a single plan managed by private insurance companies. Most MA plans also include Part D (prescription drug) coverage. Unlike traditional Medicare, MA plans may offer additional benefits such as food vouchers or wellness programs, sometimes requiring additional premiums from beneficiaries.[72]

Congress should ensure that rural providers can sustainably participate in Medicare Advantage by directing the Government Accountability Office to conduct a robust analysis that compares traditional Medicare and Medicare Advantage reimbursement structures for rural hospitals.

Critical access and other rural designation hospitals report increasing challenges in securing MA reimbursements that match traditional Medicare rates.[73] Although this issue is nationwide, some argue it is more pronounced in rural areas due to limited private plan competition, which weakens hospitals' bargaining power and adds to their financial pressures.[74]

Discrepancies between traditional Medicare and Medicare Advantage payments are particularly straining the smallest critical access hospitals. Traditional Medicare includes cost-reporting mechanisms that assess annual costs for critical access hospitals (CAHs) and provide a "make-whole payment"

if costs exceed traditional Medicare payments in a given year. However, Medicare Advantage lacks a similar process for reconciling payments for CAHs, potentially creating funding shortfalls for these facilities.[75]

To address this challenge, some rural stakeholders have proposed shifting the payment negotiation burden away from CAHs to local Medicare administrative contractors. In this proposed structure, Medicare administrative contractors would reimburse CAHs and then seek reimbursement from the relevant MA insurance plan. This mechanism would ensure payment uniformity between traditional Medicare and Medicare Advantage, streamlining the payment process for CAH services.[76]

Congress should direct the Government Accountability Office to conduct a robust analysis comparing the reimbursement structures of traditional Medicare and MA for rural hospital care. This analysis should identify whether differences in payment structures affect the financial stability and availability of services at rural designation hospitals. Based on this evaluation, Congress should enact reforms to ensure sustainable access to rural hospital care in the Medicare Advantage program.

Congress should modernize Medicare Advantage prior authorization rules to reduce unnecessary administrative burdens on rural providers and improve timely access to care. Congress should also require Medicare Advantage plans to maintain accurate provider directories so that enrollees, including those in rural communities, can identify covered health care providers and services.

Rural hospitals and MA enrollees report ongoing concerns with restrictive prior authorization rules and inappropriate denials of care. In 2024, the Centers for Medicare & Medicaid Services (CMS) updated rules to clarify when prior authorization can be used, but hospitals and beneficiaries still express concerns about the administrative burden associated with MA prior authorization rules and their impact on access to care.[77,78]

In response, a bicameral, bipartisan group of lawmakers proposed the Improving Seniors' Timely Access to Care Act of 2024 to further improve the MA prior authorization process and reduce inappropriate care denials.[79] This legislation aims to enhance the experience of all MA beneficiaries and reduce unnecessary administrative costs for health care providers.

Rural hospital executives also report that many MA patients lack access to comprehensive, up-to-date information on covered health care providers and services in their area. The resulting confusion leads patients to inadvertently receive costly out-of-network care or delay care as they seek clarity from their plan on coverage.[80]

The Medicare & You Handbook Improvement Act of 2022 was introduced in a previous Congress to update the information available to beneficiaries and

to ensure that MA enrollees have accurate information on in-network local health care providers.[81] Other bipartisan legislation, such as the REAL Health Providers Act, introduced by Sens. Michael Bennet (D-CO) and Thom Tillis (R-NC), would require MA plans to maintain updated provider directories and ensure that patients do not incur out-of-network costs for appointments with health providers incorrectly listed as in-network.[82]

STABILIZE RURAL EMERGENCY MEDICAL SERVICES

The secretary of HHS and Congress must ensure that Medicare ambulance and emergency medical services reforms improve access to EMS care for all rural residents.

Rural hospitals report declining access to emergency medical services (EMS), which include patient transport and interfacility transfers. Rural EMS response times are nearly double those in urban areas, and even brief delays in EMS response can significantly increase mortality rates.[83] At the same time, the EMS workforce is shrinking due to rural population decline, an aging resident base, and fewer young professionals entering the field.[84]

Rural hospital leaders describe serious gaps in EMS coverage, with some patients waiting up to four hours for transport and many local EMS crews too stretched to handle interfacility transfers.[85] One facility leader said that just five EMS personnel handle 70% of the shifts in their community. Another executive noted that backups often occur when ambulances are used to transport a patient between facilities, leaving fewer ambulances available for urgent 911 calls.[86]

Given these challenges, rural hospital executives, staff, and community leaders are eager to collaborate with policymakers to improve access to vital EMS care. Currently, rural hospitals can receive Medicare temporary add-on payments when they own and operate ambulance services—a 3% increase for rural ambulance services and a roughly 22% increase for "super-rural areas," defined as those in the lowest quartile of population density.[87,88] Congress introduced these payments in 2002 to ensure adequate reimbursement as Medicare payment for ambulance services shifted from a charge and cost-based structure to a fee schedule. These adjustments expire on September 30, 2025.[89]

Even with these payment adjustments, rural EMS providers report that Medicare reimbursement rates do not fully cover ambulance transport costs. Recognizing these challenges, Congress directed the HHS secretary in the Bipartisan Budget Act of 2018 to evaluate and potentially reform Medicare ambulance reimbursement. As part of this evaluation, CMS is collecting revenue and cost data from ambulance providers to inform MedPAC's

upcoming recommendations to Congress on how to strengthen the Medicare ambulance reimbursement structure.[90]

As the HHS secretary and Congress consider Medicare ambulance reform, policymakers must ensure the payment model supports continued access to EMS care for all rural residents, including those served at critical access and other rural designation hospitals.

Conclusion

Rural hospitals are a critical source of health care and a major economic driver for rural communities, yet many face financial challenges that threaten their survival.

Congress and the Department of Health and Human Services must act to stabilize rural hospitals by making key Medicare programs permanent, allowing more struggling hospitals to participate, and piloting new models to sustain essential services in rural communities.

Policymakers should also improve rural America's Medicare Advantage experience by ensuring fair hospital payments, modernizing prior authorization rules, and requiring accurate provider directories. Finally, they must address gaps in emergency medical services to ensure that rural communities have timely access to lifesaving care.

These policies will provide the financial stability that rural hospitals need to continue serving their communities for years to come.

Appendix: Rural Provider Designations and Payment Adjustments

Facility Type	Statutory Definition	Medicare Payment Rate
Rural Hospital Designations		
Rural Emergency Hospital (REH)[91]	To convert to the REH designation, a provider must be a critical access hospital (CAH) or small rural hospital with no more than 50 beds as of the date of enactment of the REH model (December 7, 2020). REHs may not offer inpatient services or have swing beds. REHs may offer emergency department, observation, and outpatient care, as well as skilled nursing facility (SNF) care in a distinct part unit.	REHs receive two types of Medicare payments: an "enhanced outpatient Prospective Payment System" (OPPS) payment that is tied to services provided, and an additional, flexible "additional facility payment" (AFP). The enhanced OPPS payment equals the typical Medicare OPPS rate (as set forth in 1833 (t)(1) of the Social Security Act), plus an additional 5%.[92] The AFP is a fixed amount that CMS calculates every year based on a formula set forth in the REH statute and is updated annually through an inflationary adjustment.
Critical Access Hospital (CAH)[93]	CAHs must be in a rural area and more than 35 miles from the nearest hospital, with some exceptions; must have 25 or fewer inpatient beds or 25 or fewer total inpatient plus swing beds; have an average annual length of stay of 96 hours or fewer; and have 24-hour emergency care service using on-site or on-call staff.	CAHs are paid 101% of reasonable costs for most inpatient and outpatient services. CAHs are not paid under Medicare's Inpatient Prospective Payment System (IPPS).
Sole Community Hospital (SCH)[94]	Hospitals can qualify for the SCH designation based on various criteria, including being located at least 35 miles from the nearest IPPS hospital; being located 25–35 miles from other hospitals; and being the exclusive provider in the area, or having less than 50 beds. A hospital can also qualify if it is rural and 15–25 miles from a hospital that is inaccessible; or if it is rural and travel time to nearest hospital is at least 45 minutes.	SCHs are paid on the higher of the IPPS rate or a base year federal rate.
Medicare Dependent Hospital (MDH)[95]	MDHs must be in a rural area; have 100 inpatient beds or fewer; and are not otherwise classified as a Sole Community Hospital. Also, at least 60% of its inpatient discharges must be Medicare Part A patients (this is a key criterion that identifies these facilities as "Medicare dependent").	MDHs are paid based on the higher of the IPPS rate or a blended rate based on a statutorily defined based year.

Facility Type	Statutory Definition	Medicare Payment Rate
Rural Referral Center (RRC)[96]	RRCs are rural or urban tertiary hospitals that receive referrals from surrounding rural acute care hospitals. Any acute care hospital can be classified for Medicare purposes as an RRC if it meets one of several qualifying criteria based on location, bed size, and/or referral patterns. Some RRCs may also be Sole Community Hospitals or Medicare-Dependent Hospitals.	RRCs get certain advantages, such as receiving a higher rate of Medicare Disproportionate Share Hospital (DSH) payments, which are provided to hospitals that treat a high percentage of low-income or uninsured patients.
Rural Payment Adjustments		
Low-Volume Rural Adjustment[97]	A hospital must have fewer than 3,800 total patient discharges per year and be located more than 15 miles from the nearest hospital.	Low-volume hospitals receive a sliding-scale, per-discharge add-on payment. This additional payment is added to the individual hospital's IPPS rate.
Disproportionate Share Hospital (DSH)[98]	SSA Section 1886(d)(5)(F) provides additional Medicare payments to hospitals serving a significantly disproportionate number of low-income patients.	DSH hospitals receive a Medicare DSH payment adjustment that is typically calculated based on the share of the hospital's low-income patients. Each Medicare DSH-eligible hospital gets an uncompensated care payment based on its share of uncompensated care costs compared with all Medicare DSH-eligible hospitals.

Endnotes

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