2025 rural health state of the state

Instability continues to threaten rural health safety net

Reduced reimbursements, dwindling access to care, and deteriorating population health status

Across the US, the rural health safety net remains under intense pressure.

Over the last year, 18 rural hospitals closed or converted to an operating model that excludes inpatient care. That brings the total since 2010 to 182.[1] According to our newest analysis, 46% of rural hospitals have a negative operating margin, and 432 are vulnerable to closure.

This loss—and potential future loss—of access to care is compounded by rural America's weakening population health status and expanding "care deserts" for vital services such as obstetrics (OB) and chemotherapy. For the more than 46 million people who live in rural areas, the rapid deterioration of access to care and persistent financial strain raise pointed questions about the safety net's ability to continue to meet the needs of these communities in the future.

This study offers a lens into key factors driving instability throughout the rural health safety net. We have also added an exploration of rural population health domains to provide an additional layer of context for understanding care delivery challenges within rural communities.

46% of rural hospitals are in the red, and 432 are vulnerable to closure.

OTHER KEY FINDINGS INCLUDE:

In the 10 states yet to expand Medicaid under the Affordable Care Act (ACA), **53% of rural hospitals are operating in the red.**

293 rural hospitals stopped offering OB services between 2011 and 2023, while **424 ceased chemotherapy services** between 2014 and 2023.

Policies such as sequestration and bad debt reimbursement **will cost rural hospitals more than $650 million this year.**

Social drivers of health indicators show rural communities have **lower median household income (-36 percentile points) and higher rates of child poverty (+16 percentile points)** when compared to their urban peers.

Rural Americans carry a larger share of the chronic disease burden with higher rates of adult obesity (+30 percentile points) and have higher rates of premature death (+20 percentile points) than their urban counterparts.

Nearly 25% of all veterans reside in rural communities. **Access to care challenges mean that this segment is particularly vulnerable.**

Nearly half of rural hospitals are operating in the red

With nearly half of all rural hospitals still operating in the red, the adage “no margin, no mission” remains relevant. Hospitals that consistently fail to generate a positive operating margin will struggle to meet their vital mission as a safety net provider for vulnerable communities. Rural patients that need care the most are likely served by hospitals that are shedding vital services or are vulnerable to closure altogether.

Today, the national median operating margin for rural hospitals is 1.0%. Within 16 states, however, the median rural hospital operating margin is negative. At the state level, all three of Connecticut’s rural hospitals are operating in the red. 87% of Kansas’ rural hospitals are in the red, followed by Washington (76%), Oklahoma (70%), and Wyoming (70%). At the other end of the spectrum, Alaska (15%) and Wisconsin (19%) are the only states in which the percentage of rural hospitals in the red is less than 20%.

Rural hospitals located in states that have expanded Medicaid under the ACA continue to perform better financially than their counterparts in the 10 remaining non-expansion states (i.e., Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming).[2] In expansion states, the median rural hospital operating margin is 1.5%, and 43% are in the red. In our analysis, non-expansion states account for nearly 30% of all rural hospitals. 53% are in the red, and the median operating margin is -1.5%.

Policy-related reimbursement cuts will cost rural hospitals more than $650 million

Government policies such as sequestration and bad debt reimbursement continue to place added pressure on rural hospital revenues. According to our new analysis, the 2% cut in Medicare reimbursement under sequestration, will cost rural hospitals more than $509 million this year and result in over 8,000 jobs lost. States such as California ($27 million), Minnesota ($23 million), Texas ($22.8 million), and New York ($22 million) will be hit hardest by sequestration’s impact on rural hospital revenue.

Bad debt reimbursement is a 35% reduction in reimbursement for charity care. It will chip away another $159 million in rural hospital revenues and nearly 2,700 jobs in 2025. Rural hospitals in California ($14.1 million), Illinois ($10.6 million) and Wisconsin ($10.5 million) stand to be impacted the most this year by reimbursement cuts associated with charity care.

Changes to payer mix present new challenges for rural hospitals

Within rural communities, 39% of all Medicare-eligible individuals are enrolled in Medicare Advantage plans. The new reality of this payer mix presents unique implications for rural hospitals familiar with Traditional Medicare's processes and reimbursement.

Common reimbursement models used by Medicare Advantage often follow fee-for-service reimbursement as a percent of Medicare rates, rather than retrospective cost-based reimbursement. As a result, rural hospitals may receive a lower reimbursement than they are accustomed to for Medicare Advantage patients. Like private health plans, Medicare Advantage plans also often have administrative requirements, such as prior authorizations, which can lead to denials and additional administrative cycles.

For rural providers operating on razor-thin margins, shifts in revenue—even if temporary—can have a disproportionate impact in rural settings where Medicare insurance is typically the largest healthcare payer.

Access to inpatient care has disappeared in 182 rural communities since 2010

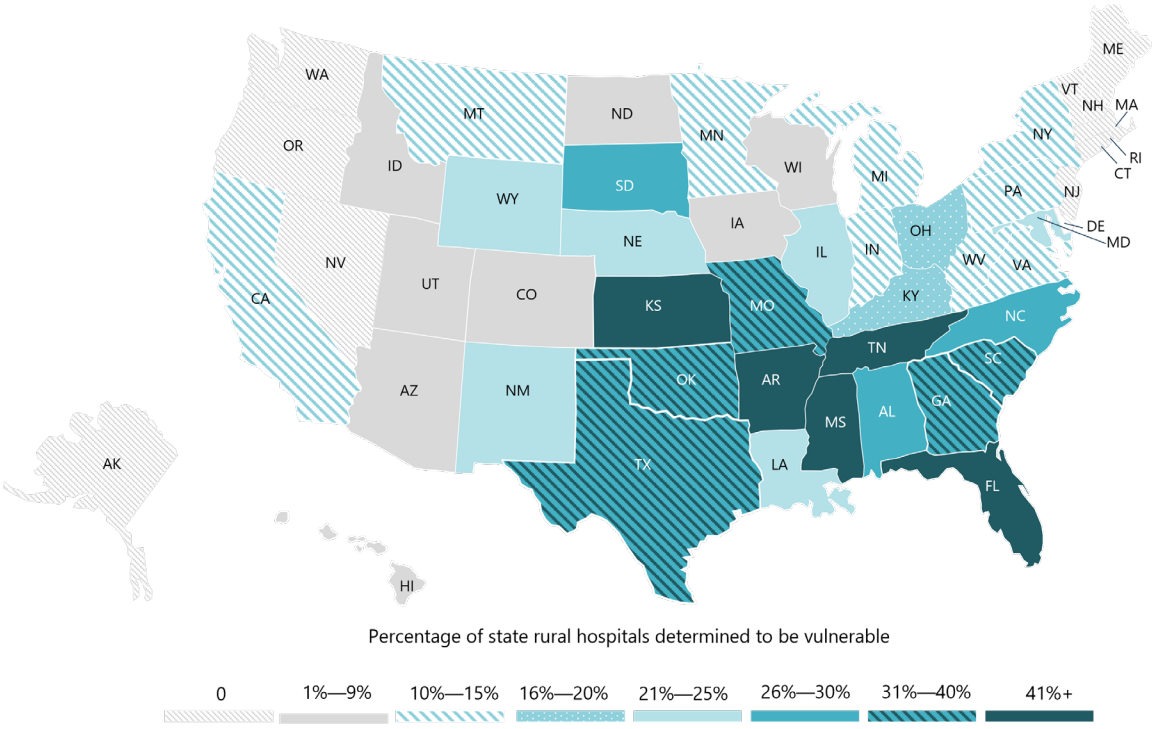
No metric has encapsulated the plight of rural hospitals since 2010 more than facility closures. In the last 15 years, 182 rural hospitals have either closed or converted to an operating model that does not provide inpatient care (e.g., long-term care, Rural Emergency Hospital). This represents approximately 10% of the nation's rural hospitals. For these communities, the loss of a rural hospital can trigger a downward spiral of economic hardship and community health status.

The loss of inpatient care via closure or conversion is in double digits in seven states. States suffering the greatest loss of inpatient care since 2010 are Texas (26) and Tennessee (16). Georgia, Kansas, Mississippi, Missouri, and Oklahoma are tied for third as each state has lost inpatient care in 11 communities. The loss of inpatient care is generally highest across the South from the Carolinas to Texas and then up into the Midwest. States along the Rockies and the Pacific Northwest have thus far avoided falling into this inpatient care desert.

Chartis' loss of inpatient care analysis includes facilities opting for the Rural Emergency Hospital (REH) designation because conversion requires hospitals to stop providing inpatient care. Nationally, 32 rural hospitals have converted to REH since January 2023.[3] Last year's conversion total (17) was slightly lower than the 19 in 2023. Our analysis of REH and the likelihood of rural hospitals to pursue conversion shows that about 400 facilities are "most likely" to consider REH, with 77 identified as prime candidates for the new designation.

432 rural hospitals are vulnerable to closure

Figure 1: Rural hospitals vulnerable to closure



Closures and conversions lead to questions about how many rural hospitals may follow suit. Through a multilevel logistic regression model, Chartis has conducted an extensive statistical analysis of rural hospital vulnerability to closure. An analysis of 15 different indicators[4] identified 10 as statistically significant for determining a rural hospital's likelihood to close.

Through this model, we have identified 432 rural hospitals vulnerable to closure. Of the 48 states with rural hospitals, 38 have at least one vulnerable hospital. States with the highest number of vulnerable hospitals are Texas (47), Kansas (46), Mississippi (28), Oklahoma (23), and Georgia (22).

When we look at the percentage within a state of rural hospitals vulnerable to closure, Arkansas is at the top of the list at 50%, followed closely by Mississippi (49%), Kansas (47%), and Tennessee (44%). Three states are at 34%: Georgia, Missouri, and Oklahoma.

Rural America's "care deserts" expand

Nearly *300* rural hospitals have stopped offering obstetrics.

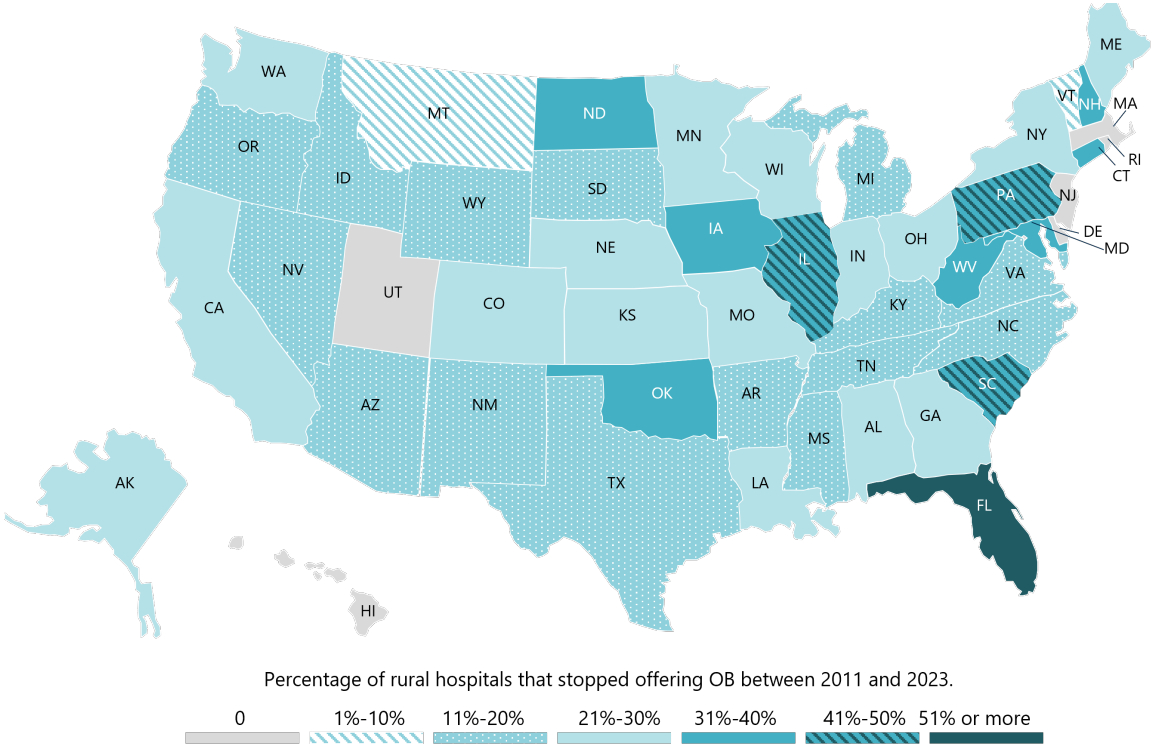
Even at facilities in which patients are admitted for inpatient care, access to services has dwindled across rural communities. Recruitment and retention of healthcare professionals are entrenched challenges within rural communities.

For example, more than 60% of Healthcare Professional Shortage Areas (HPSAs) are in rural locations. A survey conducted previously by Chartis revealed that staffing shortages had an adverse effect on the ability to provide services. Low patient volumes and the high costs associated with providing certain services also factor into the equation.

These "care deserts" present unique challenges for patients who must travel greater distances to receive treatment and/or emergency care. Two of the services we have been tracking through this annual assessment of the rural health safety net's stability are access to obstetrics and access to chemotherapy.

Our latest research reveals that between 2011 and 2023, 293 rural hospitals stopped providing OB services. This represents 24% of the nation's rural OB units. Rural OB deserts now stretch across vast stretches of rural America and heighten the stakes in the event of a medical emergency and potentially impact prenatal and newborn care as well.

Figure 2: Diminishing access to rural obstetrics care



Florida and Pennsylvania had the highest percentage of rural hospitals that stopped offering OB during our review period at 57% and 42%, respectively. Across the country, 11 states lost 10 or more OB units during our review period. Based on the data, Iowa saw the largest decline in state-level rural OB units, losing care at 22 facilities, followed closely by Minnesota (19) and Kansas (17).

Chemotherapy has disappeared at *424* rural hospitals.

Like access to OB services, access within rural communities to chemotherapy is also dwindling across the country. Between 2014 and 2023, our research reveals that 424 rural hospitals stopped providing chemotherapy services. This represents 21% of all rural hospitals offering chemotherapy.

Based on our analysis, 51% of rural hospitals in Texas and Mississippi previously offering chemotherapy stopped providing the service. In another six states (Alaska, Florida, Georgia, Oklahoma, Tennessee, and South Carolina), 40% or more stopped offering this service.

When we look at the overall number of rural hospitals dropping chemotherapy on a state-by-state basis, Texas suffered the largest decline, with 61. Oklahoma is a distant second with 29, then Georgia with 26.

↗ Strained safety net struggles to care for vulnerable populations

Our previous research into rural population health confirmed that rural communities remain less affluent, older, and less healthy. They also have less access to care and insurance than their urban counterparts. While this characterization is useful for establishing a general baseline for what separates rural and urban communities, it does not fully capture the extent to which population health in rural America is in decline. More importantly, it does not fully capture how this weakened health status is interwoven with the instability of the rural health safety net.

We examine population health indicators by: (1) comparing rural communities to urban communities at a national level, and (2) comparing rural hospital service areas (i.e., zip codes from which a facility's patients originate) at the state level. Percentile ranks are used to show how the median rural hospital service area compares to that of all hospital service areas in the US. Each service area is comprised of the fewest number of zip codes, representing 65% of the hospital's Medicare case count over a 3-year period. It always includes the hospital's own zip code. A higher percentile rank corresponds to a higher value for the indicator.

Rural communities struggle to keep pace with more affluent peers

Social drivers of health (e.g., economic stability, access to care, education, and access to healthy food) influence population health status, whether the setting is urban centers, the surrounding suburbs, or a rural community. Across several leading social drivers of health metrics, we found that rural communities continue to struggle to match their urban counterparts.

Nationally, the median household income in rural communities ranks at the 32nd percentile, while in urban communities it is the 68th percentile. This suggests urban residents tend to be more affluent than their rural peers.

Higher levels of income can be correlated with a variety of health-related choices, including food, physical activity, and healthcare. Educational barriers,' before income levels, and in particular poverty, can heavily influence these choices. For children, poverty can undermine mental and physical wellbeing and establish lifelong patterns of behavior that are often passed down to future generations.[5]

In our analysis, children living in rural communities exhibit higher rates of poverty than their peers in urban settings. Rural communities rank at the 58th percentile for child poverty, while urban communities rank at the 42nd percentile.

Health inequity is starker in rural than urban communities

Our previous analyses of population health have noted that access to care (especially primary care, behavioral health, and dental care) in rural communities lags considerably behind urban settings. Nationally, access to primary care in urban communities ranks at the 64th percentile but just the 33rd percentile in rural communities. Similarly, access to behavioral health providers is at the 63rd percentile in urban communities but the 31st percentile in rural ones.

Looking at individual state-level data:

- Access to primary care providers in rural communities is scarcest in Mississippi and Florida (both at the 13th percentile), Oklahoma (16th percentile), and Tennessee (17th percentile).
- Access to behavioral health providers in rural hospital service areas is at its lowest in North Dakota, at the 6th percentile. Georgia, Tennessee, and Texas each rank at the 9th percentile.

As much as access to care can be an obstacle for health equity, so can health literacy, broadband access, and health insurance. Although the number of uninsured has declined through the ACA, more than 25 million nonelderly adults are still without health insurance.[6]

Through our analysis, we continue to see higher levels of adults (aged 18 to 65) and children who are uninsured. For adults living in rural communities, the percent uninsured ranks at the 52nd percentile, versus the 47th percentile in urban communities. With children, the gap between rural and urban is even greater. The percentage of uninsured children in rural communities ranks at the 59th percentile but at the 40th percentile in urban communities.

Rural communities carry greater share of chronic disease burden

Adult obesity is a risk factor and potential precursor to medical conditions such as type 2 diabetes, heart disease, and stroke. It is far more prevalent in rural communities than urban ones. Our analysis reveals that the national median for adult obesity ranks at the 66th percentile for rural communities but at just the 36th percentile for urban ones. The highest rates of adult obesity within rural communities are in Mississippi (95th percentile), Louisiana (90th percentile), and Oklahoma and West Virginia (89th percentile).

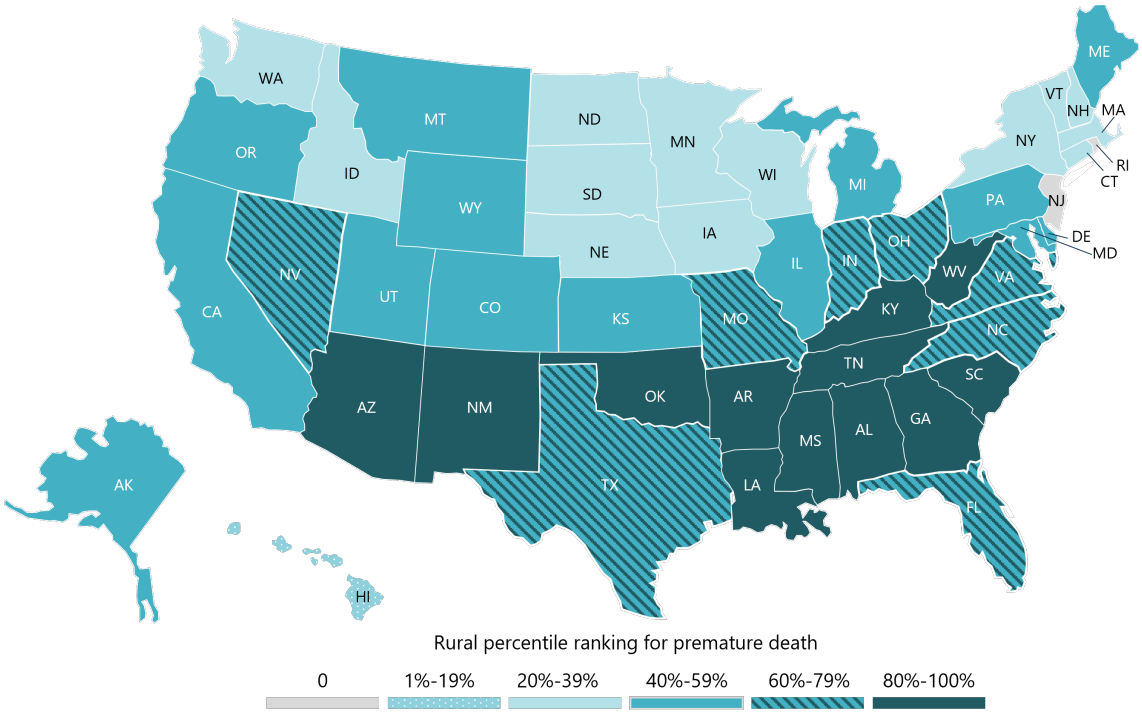
Linked to obesity, diabetes is equally prevalent at the national level in rural (51st percentile) and urban (50th percentile) communities. However, regional variances of prevalence among rural communities are stark. Four states rank at or above the 92nd percentile: Mississippi (95th), South Carolina (92nd), Louisiana (92nd), and Georgia (92nd). In total, rural communities in 13 states ranked in the top quartile (i.e., 75th percentile and above).

Premature death is more prevalent in rural communities

Premature death, a metric that reflects the potential years of life lost before the age of 75, is more prevalent in rural communities than urban ones (62nd percentile vs. 42nd percentile).

At the state level, premature death among people living in rural communities is highest in South Carolina (95th percentile), Mississippi (94th percentile), and Tennessee (90th percentile). Other states hovering near the 90th percentile for premature death include Alabama, Arkansas, Louisiana, and New Mexico.

Figure 3: Where is premature death most likely in rural America?



Our analysis also revealed that rural Americans have higher rates of:

- Diabetes mortality (70th percentile in rural communities vs. 37th percentile in urban ones)
- Cancer mortality (70th percentile vs. 33rd percentile)
- Heart mortality (68th percentile vs. 34th percentile)

Rural communities see higher rates of suicides and other deaths of despair measures

Rural healthcare leaders, advocates, and researchers in recent years increasingly view certain population health data points through the lens of "deaths of despair" (e.g., alcohol consumption, drug overdose deaths, suicides, and gun violence). This is an important lens through which to understand population health and wellbeing because these measures can be driven in part by external socio-economic conditions (e.g., financial stability and local economic opportunity) and other disparities.

At a national level, rural and urban percentile rankings for these types of measures do reflect parity when it comes to excessive drinking (45th percentile vs. 53rd percentile) and drug overdose deaths (48th percentile vs. 51st percentile).
Excessive drinking is most prevalent within rural communities in Wisconsin (97th percentile), Montana (93rd percentile), and Alaska (89th percentile). Deaths related to drug overdose, meanwhile, are more prevalent in rural communities in West Virginia (90th percentile), Delaware (88th percentile), Kentucky (86th percentile), and Connecticut (84th percentile).

With suicides, our analysis identified sizable differences in the national data. Rural communities rank at the 69th percentile versus the 37th percentile for urban communities. Suicide-related deaths in rural communities are at their highest in Montana (98th percentile), Wyoming (97th percentile), and Arizona (96th percentile). In all, the rural median for suicides ranks at the 90th percentile or above in 10 states.

Firearm fatalities are also notably higher in rural settings (63rd percentile) than in urban settings (42nd percentile). Gun violence is a leading contributor to premature death in the US, and a majority are the result of suicides.[7] The highest rates of firearms fatalities in rural settings are in Mississippi, Wyoming, New Mexico, Nevada, and Montana.

Amid instability and declining access to care, rural veterans are particularly vulnerable

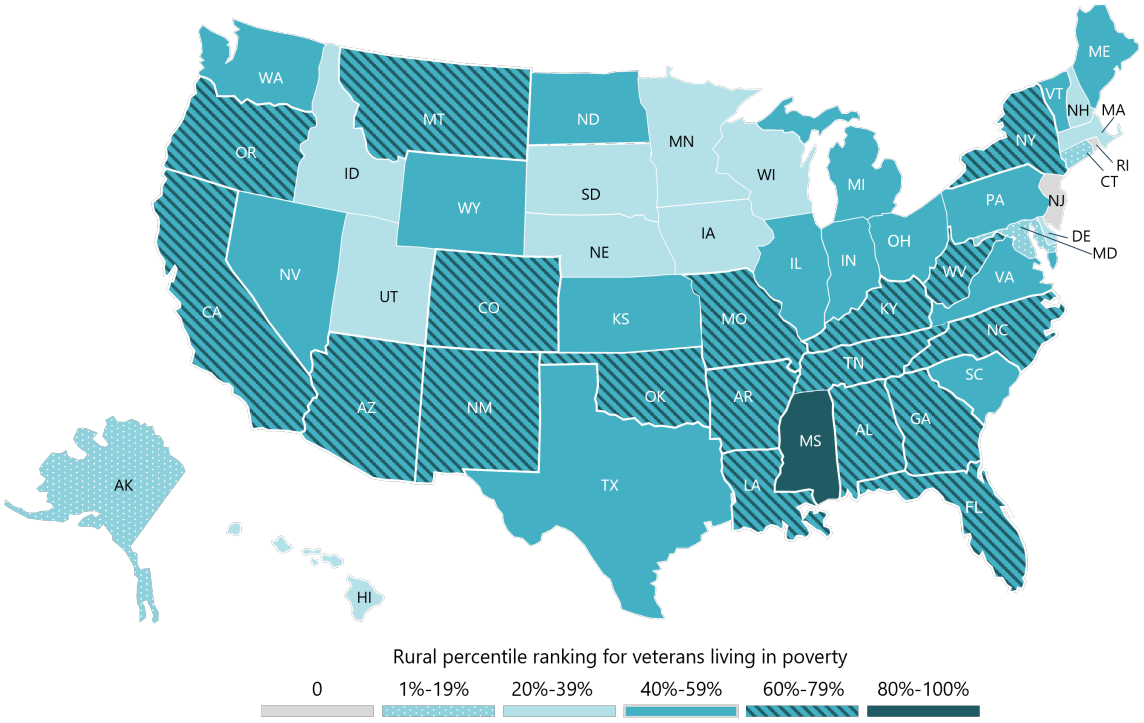
According to the US Department of Veterans Affairs (VA), 4.4 million veterans reside in rural communities.[8] Our analysis shows that a greater proportion of veterans reside in rural communities (60th percentile) than urban communities (38th percentile).

Nearly 2 million of the 4.4 million veterans living in rural communities are not enrolled in the Veterans Health Administration (VHA). More than 40% of rural veterans have a service-related disability, 54% are over the age of 65, and 31% earn less than $35,000 per year.[9]

Long wait times nationally for appointments at VA facilities are well documented. According to a study published in 2022 on geographic variation in appointment wait times for veterans, the mean wait time was 29 days for a primary care visit and nearly 34 days for a behavioral health appointment.[10] Veterans are particularly vulnerable, given the broad instability and declining access to care reverberating throughout the rural health safety net.

For example, we found the highest rates of veterans living in poverty in rural communities in Mississippi, Alabama, Oregon and Kentucky. These states rank between the 87th and 76th percentiles. In total, 28 of the 48 states with rural hospitals rank above the 50th percentile, which indicates that poverty among veterans in rural areas is more equally distributed across the country than some of the other population health metrics discussed in this paper.

Figure 4: States with the highest concentration of veterans living in poverty in rural communities



When the metric includes a disability, however, the roll call of states and the complexion of the map does change. Here, states with the highest rates of veterans living in poverty with a disability in rural communities are Tennessee (86th percentile), Arkansas (83rd percentile), Oklahoma (79th percentile), and Oregon (78th percentile).

A 2023 report from the VA highlights this vulnerability for veterans. The report noted that suicide rates among recent VHA users were slightly higher for residents of rural areas. According to the data in the report, the suicide rate in rural or highly rural areas in 2021 was 44.3 per 100,000, compared to 40.0 per 100,000 for veterans in urban areas.[11]

Legislative efforts, such as the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, highlight efforts to develop rural health policy that expands access to care for veterans living in rural communities. Under the Mission Act, veterans can seek care outside the VA network through community providers, based on eligibility requirements (e.g., drive time to VA facility or wait time for an appointment exceeds time thresholds).

Additional initiatives such as the External Provider Scheduling (EPS) system, which is being piloted in states like Nebraska, are helping to create new efficiencies between community care and the VHA. For example, EPS leverages digital connectivity in place of calls and faxes to reduce wait times and improve access to timely care. For rural veterans, however, rural hospital closures and declining access to community care could potentially hinder the intended benefits of policies such as the Mission Act and initiatives like EPS.

> “Our analysis of population health domains indicates that rural hospitals will be challenged to meet the needs of vulnerable communities in the years ahead.”
>
> Michael Topchik
> Executive Director
> The Chartis Center for Rural Health

Stabilizing the rural health safety net one step at a time

Our previous look at population health within rural communities suggested that when compared to their urban counterparts, rural Americans were older, less healthy, and less affluent.

Today's more expansive and nuanced analysis affirms those previous baseline findings and suggests that the vulnerability of rural communities will continue to present financial and operational challenges for rural hospitals in the years ahead.

Nationally, the rural health safety net remains unstable, with 46% of rural hospitals in the red, 432 vulnerable to closure, and care deserts expanding. Creating greater stability in the rural health safety net not only requires alleviating some of the reimbursement pressure but also reversing the direction of detrimental population health trends.

At the federal level, the introduction of the REH designation has proven to be a positive step forward. Healthcare services, which may have otherwise disappeared, remain available in 32 rural communities. Legislative amendments to improve the program (e.g., addressing 340B covered entity status, allowing Swing Beds, etc.) could potentially open the door for a larger number of rural hospitals to convert to REH. Other legislative efforts aimed at reopening necessary provider status and expanding access to capital, for example, could also help improve the financial viability of rural hospitals. A mix of initiatives at the state level, such as the Commonwealth Fund in Pennsylvania, the 2024 Health Care Delivery and Access Act in New Mexico, and the organization of tax districts in states like Washington and Iowa have also helped to ease the financial burden for rural hospitals and support maintaining access to care. .

Reversing population health trends, however, may require longer-term efforts. Nonetheless, exciting and diverse innovation is taking place across the country. The Innovation for Maternal Health Outcomes in Minnesota (I-MOM) initiative, for example, is improving outcomes in communities experiencing the highest rates of disparities, including rural communities. Individual hospitals are also working to move the needle, often in partnership with other community organizations. In rural New York, for instance, the University of Rochester Medical Center launched an initiative last year to improve access to care through telehealth stations in banks.

These programs and initiatives represent action and innovation across all bands of the rural healthcare spectrum. Ideally, these efforts and subsequent success stories will help to inspire other stakeholders working to address the persistent instability across the rural health safety net.

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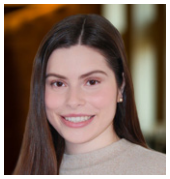

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Additional resources

Download our data visualization compendium for heat map views across a variety of safety net indicators and rural population health domains.

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About Chartis

The challenges facing US healthcare are longstanding and all too familiar. We are Chartis, and we believe in better. We work with over 900 clients annually to develop and activate transformative strategies, operating models, and organizational enterprises that make US healthcare more affordable, accessible, safe, and human. With over 1,000 professionals, we help providers, payers, technology innovators, retail companies, and investors create and embrace solutions that tangibly and materially reshape healthcare for the better. Our family of brands—Chartis, Jarrard, Greeley, and HealthScape Advisors—is 100% focused on healthcare and each has a longstanding commitment to helping transform healthcare in big and small ways.

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