RWHC
Your partner. Your source.

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective - October 1, 2025

Rural Hospitals Need Targeted Policies

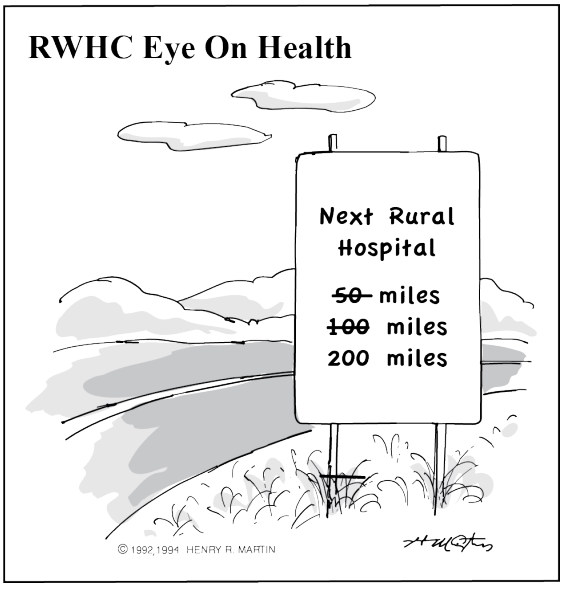
RWHC's 33rd Annual Monato Rural Health Essay Prize has been awarded to Nicholas VanDerwerker for his essay, "Challenges Faced by Rural Hospitals."

Nick is a dual MD and Master of Public Health (MPH) student at the University of Wisconsin-Madison. He grew up in Brainerd, a town in central Minnesota, and moved to Wisconsin to attend UW-Madison for his undergraduate studies. He then worked as a CNA for two years before entering medical school.



Pursuing both MD and MPH degrees has deepened his understanding of disease prevention and the broader, systems-level factors that shape health outcomes. For his MPH capstone, he is working on a project focused on helping patients with Ehlers-Danlos Syndrome—a connective tissue disorder associated with joint instability and chronic pain—better navigate the healthcare system. This fall, he is applying to residency in orthopedic surgery.

"A few years ago, my grandmother suffered a stroke while living in a small town in northern Minnesota. Witnessing her struggle to access timely and effective treatment opened my eyes to the healthcare barriers many rural residents face. Inspired by that experience, I hope to practice in a rural setting, where I can contribute to building resilient healthcare systems and serve communities with limited access to care."



"Rural hospitals across America are facing a financial crisis. As operating margins shrink, staffing shortages grow, and private equity interests increase, the backbone of rural healthcare is at risk. This paper argues that preserving the health of rural communities in Wisconsin requires targeted policy action: stabilizing healthcare funding, addressing workforce shortages, and enacting safeguards against harmful financial practices."

"Some rural residents still live on the same land that their family has been farming for generations, some find spiritual connection to the earth that their native ancestors revered for thousands of years, and some are relative newcomers who arrived for a variety of reasons. This respect and connection to the land combined with the lower cost of living and tighter sense of community make it unsurprising that many find rural areas wonderful places to live. However, healthcare in many rural areas is in crisis. This is fueled by long-running challenges including declining reimbursement, staffing challenges, and demographic changes."

"People living in rural areas tend to have worse health outcomes from chronic and preventable disease. These include increased risk of dying from heart disease, cancer, injury, and chronic

respiratory diseases. Much of this can be attributed to challenges in the social determinates of health that result in poorer health behaviors and access to care. Individuals who live in rural areas tend to be older and have higher rates of smoking, obesity, poverty, and inadequate insurance coverage. Thus, while addressing the financial stability of rural healthcare systems is critical, this must be paired with public health measures to improve health behaviors and enact policy measures to boost the economic standing of rural residents."



34th Annual $3,000 Monato Essay Prize
Best Rural Health Paper by a
University of Wisconsin Student
or recent graduate. Submit by June 1st.
www.rwhc.com/Awards.aspx

"Rural hospitals are closing, or at risk of closing, around the country. In February 2025, healthcare advisory firm Chartis estimated that 432 rural hospitals are at risk of closure. Further, many hospitals across the U.S. are running on a negative operating margin, with great variation among the states. In Kansas, 87% of rural hospitals are in the red compared with only 19% in Wisconsin (which has the second lowest rate in the country)."

"Declining reimbursement and the unique characteristics of their patient populations are major challenges faced by rural healthcare systems. The 2% cut in Medicare reimbursement due to sequestration (mandated spending cuts in US Government funding) will cost rural hospitals over $500 million in revenue this year alone. Rural hospitals also provide a higher proportion of uncompensated 'charity' care to their patients, who are more likely to suffer from chronic diseases and have lower incomes. Passing legislation that permanently removes the threat of sequestration on financial reimbursement and better funds the ability of healthcare organizations to receive compensation for 'bad debt' will help hospitals maintain financial stability."

"The closure of rural maternity units has been occurring at a rapid pace. Since 2020, more than 100 rural hospitals have stopped delivering babies and only 42% of rural hospitals offer labor and delivery services. This results in long travel times to birthing centers. In fact, one third of the counties in Wisconsin lack an OBGYN physician, and less than half of rural Wisconsin women live within a half hour drive of the nearest hospital. Rural birthing centers are closing due to financial losses, declining birth rates, and provider shortages. Delivering high quality maternal care is expensive and often causes hospitals to lose money. As rural hospital operating margins are declining across the country, maternity services are often some of the first to be cut. Promoting the financial stability of rural hospitals will allow many of them to retain their OBGYN services, supporting the health of women in these underserved areas."

"Beyond funding challenges, rural hospitals face a dire shortage of medical professionals, which compounds health disparities. Around 19% of Americans live in rural areas, but only about 7.9% of physicians practice in these communities, the state of Wisconsin boasts an even greater disparity: nearly 28% of the state's population is rural, but only around 11% of physicians practice in rural areas. Rural hospitals and clinics face a greater shortage of nursing staff than the U.S. This is predicted to get worse, as the number of college graduates from rural areas (who are most likely to work in rural area) in medical school has been decreasing."

Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the "rural advocate of choice" for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare… assists Members in partnerships to make their communities healthier… generates additional revenue by services to non-Members… ongoing use of strategic alliances in pursuit of its Vision. Tim Size <**timsize@rwhc.com**>, Editor, 880 Independence Lane, Sauk City, WI 53583

www.RWHC.com

Email **office@RWHC.com** with *subscribe* on the subject line for a free e-subscription.

"With the baby boomer generation aging and requiring higher levels of healthcare, the strain on an already burdened workforce will only further grow. Fortunately, there are some solutions to tackle this issue. Dedicated training in rural areas will encourage graduates to understand what it is like to practice in a rural setting and likely will increase the number of graduates geared toward employment in these settings. When trainees obtain experience working in rural areas, they can experience the rural lifestyle and caring for rural patients, increasing their likelihood of practicing in these areas during their careers."

"Data from a variety of schools shows that rural-focused medical recruitment and training enhances the proportion of graduates practicing in rural areas. For example, the Wisconsin Academy for Rural Medicine (WARM) program at the University of Wisconsin results in over half of these graduates practicing in rural Wisconsin."

"Rural healthcare systems are vital lifelines for millions of Americans and serve as economic anchors in their communities. Yet, when financial pressures force these systems to reduce services or shut down entirely, the health and well-being of rural residents suffer. To prevent further decline, policymakers must prioritize investment in rural healthcare. Through smart policies and enhanced investment, we can ensure that rural communities receive the healthcare they deserve."

Medicare Advantage Undermines Rural

From "The Rapid Growth of Medicare Advantage Poses Challenges to Rural Hospitals" by James D. Lee, Cody L. Mullens, Adam A. Markovitz & Janice Probst, *Health Affairs Forefront*, July 21, 2025:

"Medicare Advantage (MA) now covers more than half of all Medicare beneficiaries. In rural areas, enrollment of Medicare beneficiaries in MA has surged from 11 percent in 2010 to 40 percent in 2023. The impact of MA on rural hospitals is not fully understood, but its rapid growth has raised concerns among rural health leaders that MA may threaten the financial stability of rural hospitals. This highlights a central policy paradox: **Efforts by the federal government to expand MA through generous payment and flexibilities for plans may undermine the very institutions that lawmakers have long aimed to protect**."

"**Rural hospitals serve populations with greater chronic disease burden, access challenges, and reliance on public insurance. They also operate under unique constraints: small size and low volume, thin operating margins, and limited administrative capacity. When such factors lead rural hospitals to close, it can negatively impact both patient outcomes and the local economy in these already vulnerable regions**. And so, to sustain the financial viability of rural hospitals and ensure access to this critical safety net, Congress has established several programs such as critical access hospitals (CAHs), Medicare-dependent hospitals, and low-volume payment adjustment. However, these programs only apply to beneficiaries enrolled in traditional Medicare, not those in MA. As MA enrollment rapidly expands, therefore, the protection provided by those programs is diminished. To make matters worse, MA's core features–narrow networks, negotiated payment rates, and use management–pose a particularly pointed threat to rural hospitals struggling to survive in the face of falling demand and tight margins."

"**In this commentary, we outline how key features of Medicare Advantage may interact with unique constraints of rural hospitals and propose reforms to align the expansion of MA with the imperative of preserving the rural safety net**."

"**First, rural hospitals are typically smaller**, with half of rural hospitals containing 25 or fewer beds, and face relatively high fixed costs of operation, leaving them sensitive to even small fluctuations in patient volume. These pressures are intensifying as rural populations shrink, patients bypass local rural facilities, and health care use shifts from inpatient to outpatient settings nationally. MA's use of narrow networks exacerbates this fragility, as MA networks may exclude rural hospitals, further diverting patient volume and revenue."

"**Second, rural hospitals typically operate with slimmer margins**, in part because they serve a higher share of Medicare beneficiaries compared to urban hospitals. Because MA provides lower reimbursement rates than traditional Medicare, MA's expansion can

exacerbate existing rural- urban disparities in payer mix and financial performance. MA further compounds this strain through frequent payment delays and denials, adding pressures on rural hospitals with limited cash reserves."

"**Third, MA's reliance on use management, such as prior authorization, adds administrative burden for rural hospitals that already lack resources**. With 80 percent of MA prior authorization requests ultimately approved and more than 75 percent of initial denials overturned on appeal, these processes create unnecessary delays in care and payment. Because rural facilities are smaller with lower patient volumes and limited administrative infrastructure, they face resource constraints in meeting MA's use management requirement, often at higher operational costs."

"Policy Considerations to Align MA Expansion and Rural Hospital Sustainability"

"**Rural hospitals serve as the safety net for millions of Americans and often as economic linchpins of their communities. Policy makers must act to align the ongoing expansion of MA with efforts to sustain rural hospitals**."

Strengthen Network Adequacy Criteria And Enforcement–"Current network adequacy standards for MA fail to ensure reliable access to essential services for rural patients and also miss a critical opportunity to support rural hospitals. **Rural beneficiaries disproportionately switch out of MA and back to traditional Medicare due to narrow networks and care access challenges**. MA network provider directories also frequently contain inaccurate 'ghost networks' with providers listed as in-network on paper but inaccessible in practice. Despite these access barriers, the Centers for Medicare and Medicaid Services (CMS) recently relaxed rural network adequacy standards, reducing the percentage of beneficiaries who must live within the maximum distance and time thresholds."

RWHC Eye On Health



" 'Ghost networks' are a sweet deal for insurers–listing providers on paper who you can't use in practice."

"To address these gaps, CMS should implement more rigorous, proactive network reviews with meaningful consequences for noncompliance. Congress should also consider designating CAHs and rural emergency hospitals (REHs) as essential community providers in certain areas, mirroring network adequacy standards for Affordable Care Act Marketplace plans. Additionally, CMS should reevaluate how MA plans currently can earn network adequacy 'credits,' which lower the required percentage of beneficiaries meeting maximum time and distance thresholds, while ensuring that these adjustments maintain access for rural patients. For example, under the current policy, MA plans can reduce the required percentage of beneficiaries meeting time and distance standards if they contract with telehealth providers or are located in states with certificate-of-need laws or state regulations that restrict the number of providers or facilities."

Modernize Quality Measures and Payment Structures for Rural Realities–"CMS has long recognized the importance of supporting rural hospitals. Unfortunately, its primary programs to support rural hospitals–CAH, Medicare-dependent hospitals, sole community hospitals, and low-volume payment adjustment–base eligibility and payment on traditional Medicare patient volumes without considering the rising shift to MA. For instance, CAHs, which include 61 percent of rural hospitals, receive cost-based reimbursement for care of traditional Medicare beneficiaries, but no similar

The 2025 Wisconsin Healthcare Workforce Summit, "Optimizing Wisconsin's Healthcare Workforce" will be held on Wednesday, October 8, from 8:15 AM until 4:25 PM, and in a hybrid venue, with limited seating available on-site at the Rural Wisconsin Health Cooperative in Sauk City, or with the option of remote access to the meeting via zoom. Sponsored by the Wisconsin Council on Medical Education and Workforce. More information and registration is available at: **bit.ly/3Jk8EJf**

additional payment for MA beneficiaries. Other CMS programs, such as Medicare-dependent hospitals, sole community hospitals, and low-volume adjustment programs, are also based on traditional Medicare volumes. This discrepancy effectively decreases payments to rural hospitals and undermines these programs' goal of supporting rural hospitals."

"**To better support rural hospitals, CMS must move beyond volume-based reimbursement tied solely to the volume of traditional Medicare patients. CMS should consider strengthening MA contracts to incorporate cost-based payments for CAHs**. Policy makers should also explore blended reimbursement models that integrate service-based payment with capacity-based funding to account for the fixed costs of maintaining vital rural health care infrastructure."

"The REH program, introduced in 2023, adopts this capacity-based approach by allowing hospitals to convert to outpatient facilities with emergency services and provides a monthly payment intended to cover operational costs in addition to service-based payment. While the REH program is not a comprehensive solution, it acknowledges rural hospitals as essential infrastructure that warrants sustained investment."

"Similarly, CMS should explore all-payer population-based payment models, such as the Pennsylvania Rural Health Model and the Vermont All-Payer Accountable Care Organization Model. These models' payment rates and risk-sharing arrangements should be tailored to local health care market dynamics and hospital finances to ensure meaningful participation and success.

"The Medicare Payment Advisory Commission (MedPAC) has taken an important step by developing the Medicare Safety Safety-Net Index to identify hospitals serving a disproportionate share of lower-income Medicare beneficiaries and those with high uncompensated care burdens. Policy makers should use this tool to more effectively target additional payments and investments."

Enhance Market And Hospital-Level Data Collection–"**The impact of MA's growth on rural hospitals likely varies based on local market dynamics, existing access challenges, and each hospital's financial health**. Yet, this variation is not well tracked or documented. To better understand these effects, CMS, MedPAC, and state agencies should analyze MA's impact at hospital, market, and plan levels."

"An important factor to consider is how rural hospitals have already responded to financial pressures by pursuing mergers and system affiliations. The impact of increasing MA enrollment is likely different for small independent hospitals compared to rural hospitals affiliated with larger health systems. Given these complexities, state regulators should monitor consolidation trends, service line changes, and patient volume shifts to inform timely policy interventions. It will be critical to understand when and where additional investments and regulatory actions are warranted, and payment policies should consider these local factors to ensure access and cost control."

Reduce Administrative Friction Through Standardized Processes–"**CMS must standardize MA prior authorization and claims processes to alleviate the excessive administrative burden faced by rural hospitals**. Rural providers report high rates of MA claim denials and payment delays, yet policy makers lack comprehensive data on these challenges and how they are impacting rural hospitals. To strengthen oversight, CMS should address this data gap by analyzing use management patterns for services with high denial rates and strengthen enforcement mechanisms against inappropriate use of prior authorizations. Recent regulatory improvements by CMS, aligning MA coverage standards with traditional Medicare and implementing enhanced reporting requirements for prior authorizations starting in 2025, represent critical first steps."

Build Rural Hospital Technical And Administrative Capacity–"CMS, states, and MA plans should provide technical assistance to help rural hospitals adopt value-based care. States can support this by facilitating resource-sharing networks among rural hospitals to reduce administrative burdens. **To support independent rural hospitals, state policy makers should consider allowing small rural hospitals to collectively negotiate with payers, while implementing safeguards against excessive price increases**."

"Additionally, MA plans and rural hospitals should adopt rural-specific quality measures to improve rural hospitals' ability to participate and succeed in pay-for-

performance and other value-based payment initiatives. Traditional quality measures, often unreliable at rural hospitals due to low patient volumes, can disadvantage or exclude rural hospitals from programs that could otherwise augment revenue."

"Concurrently, state health agencies and hospital leaders should conduct comprehensive community needs assessment to align service capacity with local health needs. Data-driven expansion of high-needs services and consolidation of duplicative or underused capacities could improve both hospital sustainability and patient access. These efforts must be paired with sustained investments in rural health workforce development to address persistent staffing challenges."

"A Policy Paradox"

"**The expansion of MA in rural areas highlights a policy paradox: Despite long-standing efforts by the federal government to protect rural hospitals, its actions to expand MA may threaten these very institutions and the vulnerable populations whom they serve**. To realign the promise of MA with the viability of the rural health safety net, policy makers must strengthen network adequacy oversight, modernize payment structure for rural realities, enhance data collection, and reduce administrative friction while building rural hospital administrative capacity."

"We Must Be Worthy of Trust."

From the commentary, "Trust is the Foundation: How Policy Reversals are Retraumatizing Communities" by Tatiana A. Perez, *HealthBegins*, 8/25/25:

"It was March 2021, deep in the midst of COVID, and LA and Orange County communities were drowning in vaccine hesitancy. At the health system where I worked then, we knew that hesitancy wasn't just about misinformation—it was about mistrust earned through decades of Latine patients being dismissed, overlooked, and harmed by healthcare systems. Vaccine appointments were open, but eligible patients weren't taking them."

"So we quickly collaborated with trusted community voices and media partners. Within a week, we built a workflow, organized volunteers across departments, and personally made calls late into the night. By morning, we had scheduled 90 vaccine appointments. The next day, we booked 175 more."

"That night felt like a turning point—not just for vaccination rates, but for something more fundamental. We were rebuilding trust that had been broken for generations."

"Today, that progress is being systematically dismantled."

"**Trust in healthcare isn't a nice-to-have. It's as essential as procedures, prescriptions, and treatments.** Without it, patients delay care, avoid screenings, and suffer in silence. With it, they share symptoms honestly, follow treatment plans, and seek help early when it matters most."

"But trust is fragile. And recent policy changes are shattering what took years to build during the pandemic, with consequences that will ripple through families, communities, and healthcare systems for decades."

"This federal administration is rolling back protections that states fought to establish. California's Health Care for All initiative, sliding-scale fee programs that simplify access to care for non-citizens, policies that allowed doctors to honor their oath to 'do no harm' regardless of immigration status—all of this progress is being systematically dismantled."

"For communities like mine, this isn't just policy—it's retraumatization. These changes aren't creating new distrust; they're reactivating what was always there, confirming what people always suspected: that seeking care could put them at risk."

"I've watched this play out in my own living room. A close family member spent years avoiding essential care after being dismissed by providers. We are finally helping her navigate care for her stage 4 kidney disease. But now, despite all my professional expertise, I'm watching policies deepen trust gaps that took years for us to start healing. Now, providers must verify

immigration status for people seeking life-or-death care. Where I once told non-citizen family members, **"It's safe to seek care," now I'm not sure**."

"Healthcare leaders are caught in an impossible position. They see the value of providing care to everyone, but feel pressured to meet compliance requirements that conflict with quality care. It's a heartbreaking tension that forces institutions to choose between their mission and their funding. Yet when policy priorities conflict with quality care, trust suffers."

"The systemic costs are staggering. When communities avoid preventive care, emergency room use skyrockets, pregnancy complications increase, and chronic diseases go unmanaged until they reach crisis levels."

"The impact also extends beyond immigrant communities. LGBTQ+ individuals, already wary of discrimination, are increasingly reluctant to disclose their identities to healthcare providers. Five years of progress in health equity is eroding across marginalized communities."

"**Even under these pressures, we must protect and prioritize trust. Leaders can start with these steps:**

- **Consider the full cost.** Financial impact assessments must include the **long-term consequences of trust erosion**, not just immediate compliance costs.
- **Implement protective policies.** Healthcare organizations can establish **practices that ensure safety for immigrants accessing care, using sliding fee scales and charitable care funding rather** than federal grants for undocumented patients.
- **Communicate support clearly.** Marginalized communities **need to hear explicit, consistent messaging** about their safety and feel welcome in healthcare spaces."

"Watching five years of progress unravel is heartbreaking. Trust, once broken, takes generations to rebuild. But I still think about that night in 2021—and **how quickly things can change when we choose to center trust and community care over bureaucratic barriers**."

"We still have a choice. Every patient encounter, every policy decision, every conversation is an opportunity to build bridges or tear them down. **The communities we serve are watching, and they're deciding whether we can be trusted with their lives.**"

"**We must be worthy of that trust**."

Leadership Insights: "In Control"

The *Leadership Insights* series is by Corrie Searles, RWHC Leadership Development Educator. You can find back issues at **www.RWHC.com**.

In workshops offered through RWHC, my colleagues and I often reference the *Circle of Influence* by Stephen Covey. We preach on the importance of narrowing our efforts to impact those parts of our lives that we can control and influence, letting go of aspects that are beyond our control.

For example, I can push on a mountain that's in my way with all my might but it still won't move. So why waste my energy trying to move the mountain? I can, however, determine a path over or around it and invest my energy in purposeful, fruitful outcomes that move me forward.

All too often we similarly waste our energy fighting unwinnable battles or fretting over unknowns. We habitually focus on what we can't control rather than using our energy to take action. We worry, complain, and blame, which serves no good. We put more effort into fixating on the problem itself than using our influence to

Support RWHC Healthy Wisconsin



The foundation focuses on community & economic development as well as the healthcare workforce.

Email timsize@RWHC.com to discuss how you might support this work.

overcome it. In so doing, we relinquish our power over to the problem rather than the solution. We succumb to playing the part of victims rather than owners of resolution. In the end, it's a waste of time and emotional stamina. Here are four strategies to overcome the tendency to try to control the uncontrollable:

Wait to Worry–In a study conducted at Penn State University, it was discovered only 8.6% of things we worry about actually come true. That means there's a whopping 91% of waste going into false alarms, needless anxiety, stress, and lost sleep. We would be well-served to wait until we know there's definite cause for concern and, even then, react only to what we can control.

Narrow the Focus–The next time you begin the spinning action of worry and complaining, write down all the concerns. Go back and circle only those which have a greater than 75% likelihood of actually occurring. Of those, decide which you have any control or influence over; cross out the rest. Return to the remaining one or two and put your effort into determining what proactive measures can be taken now to minimize or prevent the concern from imposing negative impact.

Budget Your Energy–Like money in our personal bank accounts, we each have only finite amounts of time and energy allotted to use. If you're going to spend those precious resources, choose to allocate them wisely. Focus on investing your time and energy on things within your control and influence. You get zero return when investing your time and energy on things outside your control. As Tim Kight wrote, *"Don't let what you can't do distract you from what you can do."*

Ask the Right Questions–While we can't always control the situation itself, we do have control over our response. Choose to be solution-focused. Asking action-based questions such as these will move you towards action, accountability, and control rather than blame and helplessness:

- *What do I know for sure?*
- *What is the best action I can take at this moment?*
- *What action can I take now to move me in the direction of a positive outcome?*
- *How can I improve this situation?*

There will always be circumstances beyond our control. Avoid the trap of wasting energy pushing against mountains that won't move. Choose to invest energy only into those efforts for which you have control and influence. **Question:** ***How can you use these same tactics to guide the worries and concerns of employees you lead?***

"When you can't control what's happening, challenge yourself to control the way you respond to what's happening. That's where your power is."
- Unknown

Explore these workshops and programs offered by our RWHC Education Team to improve skills of staying *In Control*:

- *MindSET*
- *MindSET Reboot*
- *Using Questions to Foster Critical Thinking and Challenge Victim Thinking*
- *Understanding/Developing Emotional Intelligence*

To learn more, visit: **https://www.rwhc.com/Services/Educational-Services/Leadership-Series** or email me at **csearles@rwhc.com**.

Consider joining our Leadership Bites program: **https://www.rwhc.com/Services/Educational-Services/Leadership-Bites**

RWHC Eye On Health



"I only read year-old newspapers; helps me avoid worrying about what didn't happen."

About the Author: Corrie Searles, MPT, Leadership Development Educator. In Corrie's role as Leadership Development Educator at RWHC, her aim is to empower leaders–formal and informal–to create positive influence that enables others to serve well.