REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-25)
Payment Models to Sustain Rural Hospitals
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2025 Annual Meeting, the House of Delegates adopted Policy D-465.994 , which asked the American Medical Association (AMA) to:

> Study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country.

Additionally, Policy D-190.969, adopted as a part of Council on Medical Service Report 6-I-23, Rural Hospital Payment Models, called for report back on recommendations for improved rural hospital payment models.

The Council reviewed information on the present state of rural hospitals and their payment systems. Currently, many rural hospitals are struggling to stay open, and the problem only seems to be increasing in magnitude. In efforts to stay open, some rural hospitals are forced to stop providing services such as obstetric/gynecologic care or chemotherapy services. Other rural hospitals are turning to private equity investment to keep their doors open. While neither of these strategies have yielded successful results, in the short term these strategies may give hospitals a few additional months or years to serve their communities. Additionally, it is projected that the newly passed legislation, One Big Beautiful Bill Act (OBBBA), will exacerbate existing challenges for rural hospitals. Specifically, the OBBBA is expected to result in rural hospitals losing approximately $137 billion dollars over 10 years. Although the bill includes a $50 billion rural health transformation fund, it is not expected to be enough to cover the overall losses. Additionally, its implementation timeline is unclear. In order to look for potential solutions for rural hospitals, the Council reviewed three existing payment models as well as one model in development. While none of these payment models provide a perfect solution or a singular answer to fixing rural hospital payment, each provides insight into what could make an alternative payment model successful. Finally, the Council intends to initiate a future report fully discussing issues impacting rural hospitals beyond payment models, such as workforce, infrastructure, federal designation(s), and supply chain.

Based on its review of alternative payment models, the Council recommends the adoption of new policy outlining minimum standards for alternative payment models for rural hospitals. Specifically, this new policy outlines that alternative payment models should include fixed cost payments, include adequate payment rates for variable services, ensure affordable patient cost-sharing, include high-quality care, and minimize administrative burdens. The Council recommends the adoption of a new policy to emphasize the importance of rural hospitals and encourage monitoring and education regarding alternative payment models. New policy is also recommended to ensure that funds allocated for rural hospitals are used for their express intent. Additionally, the Council recommends the amendment of Policy D-465.999 to update language, Policy D-465.998 to include education and advocacy around the impact of Medicare Advantage in rural hospitals, and Policy D-190.969 to remove the clause accomplished by this report. Finally, the Council recommends the reaffirmation of Policies H-465.994, H-465.982, and H-465.997, which all work to support rural hospitals beyond payment models.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-25

Subject: Payment Models to Sustain Rural Hospitals

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

At the 2025 Annual Meeting, the House of Delegates adopted Policy D-465.994, which asked the American Medical Association (AMA) to:

> Study the issue and report back the best options for achieving a new reimbursement system for rural hospital survival in our country.

Additionally, Policy D-190.969(2), adopted via Council on Medical Service Report 6-I-23, Rural Hospital Payment Models, asks our AMA to:

> Report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM).

Considering both requests, this report provides an overview of the current state of rural hospitals and rural hospital payment and a review of piloted payment models. Additionally, this report reviews AMA policy and advocacy on the topic and offers recommendations in line with the aforementioned resolution and policy.

BACKGROUND

The approximately 20 percent of Americans who live in rural communities rely heavily on the nearest hospitals for many aspects of their health care.[1] This is especially important as those living in rural settings are more likely to be sicker, older, and underinsured than those living in more urban or suburban settings. For example, individuals living in rural America are more likely to have higher rates of heart disease, cancer, and stroke.[2] Additionally, those living in rural communities often must travel significant distances to access care. Estimates show that rural individuals, on average, drive nearly a full hour to obtain any kind of surgical care and two to three times longer to reach primary care than those in urban or suburban settings.[3,4] This extended travel time is not only an inconvenience, but in some cases it can make accessing care very challenging, if not impossible, further exacerbating the existing health disparities that rural communities face.[4] More detailed information on the state of rural health can be found in Council on Medical Service Report 9-A-21, Addressing Payment and Delivery in Rural Hospitals, and Council on Medical Service Report 9-A-23, Federally Qualified Heath Centers and Rural Health Care.

Rural hospitals are struggling to stay open nationwide as challenges continue to grow. Recent research demonstrates that half of rural hospitals are currently operating in a deficit, up nearly seven percent over a 12-month period, the biggest jump researchers have noted while monitoring the issue.[5] In some states, the landscape is even worse, with both Kansas and Wyoming reporting

over 80 percent of rural hospitals operating in a deficit.[5] Even for the rural hospitals that are able to stay open, many are forced to stop providing vital services, like obstetric/gynecologic (OB/GYN) care and cancer care.[6] Since 2020, over 100 labor and delivery units in rural areas have closed, and the problem is getting worse; closures seven months into 2025 have almost reached the same number that closed in the entirety of 2024.[7] These closures have led to less than half, 42 percent, of rural hospitals maintaining obstetrical care. While some maintain outpatient pre/postnatal care, many are unable to continue any OB/GYN services at all, exacerbating maternity care deserts and the maternal mortality crisis facing America.[6,7] Cancer care, including screenings, treatments, and specialty care, has also faced significant closures. Between 2014 and 2022, 382 rural hospitals were forced to stop providing chemotherapy.[8,9] States like Texas, Alabama, Mississippi, and Tennessee were the hardest hit with at least 44 percent of their rural hospitals stopping chemotherapy services.[6]

Service closures are not the only strategy that rural hospitals have adopted to keep their doors open, as nearly 60 percent of rural hospitals have affiliated with larger health systems. Although such affiliations may help some rural hospitals stay financially viable, 42 percent of rural hospitals associated with health systems continue to operate in a deficit.[5] Many rural hospitals must choose between private equity investment and closure. However, the choice to accept private equity investment may still result in a closure, albeit delayed a few months or years. While this delay in closure is likely to have a positive impact on communities while the hospital remains open, in the long term the eventual closure may harm the community further due to additional debts and/or increased difficulties in reopening the hospital. Investors often focus on buying hospitals for low prices and reaping any available profit before deeming the hospital financially unviable and closing their doors, known as a "buy and bust" model. While this can prove to be quite lucrative for the investors, it puts profit above people and negatively impacts rural communities when they lose one of the few, or the only, sources of health care.[6,10] Further detail on private equity, its practices, and related AMA policy and advocacy efforts can be found in Council on Medical Service Report 11-A-19, Corporate Investors, Council on Medical Service Report 2-I-22, Corporate Practice of Medicine, and Council on Medical Service Report 3-A-25, Regulation of Corporate Investment in the Health Care Sector.

Importantly, payment related issues are not the only source of difficulty for rural hospitals, as they also face workforce, federal designation, supply chain, and infrastructure challenges. Many rural hospitals struggle to retain or attract talent when competing with more financially stable urban or suburban hospitals that offer higher salaries, greater benefits, and/or locations viewed as more desirable. Additionally, programs designed to combat these challenges, like those that incentivize work in medically underserved areas by offering visas to International Medical Graduates or student loan forgiveness programs, are facing challenges of their own under the current Administration. Rural hospitals also face challenges such as disrupted supply chains and unstable infrastructure, especially when attempting to implement telehealth. In order to maintain services or stay open, some hospitals have explored alternative designations, like Rural Emergency Hospital (REH), which offers an allowance for the hospital to focus on emergency and outpatient care. However, designations like REH can be challenging to implement in a manner that ensures that patients have access to high-quality and physician-led care. Overall, the situation in which many rural hospitals operate is fraught with challenges that are not limited to payment models. As such, the Council intends to initiate a future report on these issues.

RURAL HOSPITAL PAYMENT

Rural hospitals face distinct challenges in that payments often do not cover the actual cost of providing services. While the mix of payers is generally the same for rural hospitals as it is for

urban hospitals (i.e., traditional Medicare, Medicare Advantage, Medicaid, and private plans), rural hospitals tend to serve a greater portion of Medicare and Medicaid beneficiaries.[11] Payer mix is even more important for rural hospitals due to the distinct expenses brought forth by delivering services in remote areas to smaller groups of patients. All hospitals, regardless of setting, have a fixed cost necessary to provide services (e.g., staff, capital equipment). Since rural hospitals have lower patient volumes, this leads to higher per-patient cost to maintain basic services.[5,6,11] Therefore, a payment that sufficiently covers a patient in a higher volume setting likely does not cover the full cost of treatment in a rural setting.[11] More detail about payer-mix and distinct payment challenges in rural settings can be found in Council on Medical Service Report 9-A-21, Addressing Payment and Delivery in Rural Hospitals, and Council on Medical Service Report 6-I-23, Rural Hospital Payment Models.

Recent estimates show that Medicare beneficiaries make up about 20 percent of rural hospital patients.[12] While this could be seen as problematic for non-rural hospitals, Medicare often is the most advantageous payer as its relatively higher payment rates offset the higher costs of care distinct to rural settings. A higher rate of Medicare beneficiaries is particularly advantageous for rural hospitals designated as Critical Access Hospitals (CAHs), defined as those located 35+ miles from the nearest full-service hospital and have 25 or fewer inpatient beds. In these settings, payment for traditional Medicare beneficiaries is 101 percent of the reasonable cost for the majority of patient services.[13] However, not all rural hospitals are eligible to be designated as a CAH, and even for those that are, increased Medicare payment rates are often not enough to cover deficits from other payers.[5,13,14] Although rural hospitals frequently lose money when providing care for Medicaid beneficiaries, some states have worked to lessen this gap. Medicaid provides supplemental payments to rural hospitals, covering part of the difference between what Medicaid pays and what Medicare would have paid for the same service.[5,6] The impact of Medicaid has grown as 41 states have adopted some form of Medicaid expansion, thereby increasing the number of beneficiaries served at rural hospitals.[15] Importantly, rural hospitals, along with much of the health care system, are likely to be impacted by the recently passed One Big Beautiful Bill Act (OBBBA). Further discussion of the anticipated impact of this legislation can be found later in this report. Similar to Medicaid, private payer rates to rural hospitals are generally less than the cost of the services provided. However, unlike Medicaid, there is no subsidy to make up for the lower payment rates.[5,6]

Medicare Advantage (MA) has become a particularly problematic payer for some rural hospitals. MA plans have grown significantly over the past few years and seem to be gaining popularity even more quickly among rural populations. Estimates show that since 2015 the percentage of rural Americans enrolled in MA has increased 22 percent.[16] Recent research has demonstrated that MA plans pay approximately 90 percent of what traditional Medicare pays for the same services, as MA plans do not follow cost-based payment as traditional Medicare does.[17] Some states have reported collected payment rates for rural hospitals as low as 35 percent among MA beneficiaries.[5] The lower payment rates are problematic as the financial protections for rural hospitals and CAHs provided via traditional Medicare do not apply to MA plans.[5,16] In addition to payment issues, many MA plans apply prior authorization and other utilization management options at a greater rate than traditional Medicare. Greater use of utilization management by these plans results in increased administrative challenges for the hospitals providing care. Both payment rates and administrative burden are even more challenging for small independent rural hospitals as they lack the leverage that larger systems have in negotiating with MA payers.[6,18,19]

These payment issues are further exacerbated when patients are not insured, a problem more commonly faced by rural hospitals, leading to substantial amounts of uncompensated care that financially struggling hospitals must absorb. Unfortunately, it has been projected that passage of

the OBBBA will likely lead to 10+ million Americans losing health insurance coverage, furthering the pressure on rural hospitals to provide uncompensated care.[20] Estimates indicate that many rural communities will face significant hikes in insurance premium costs across all payer types. Specifically, it is anticipated that in 32 states rural residents will face disproportionate hikes in their out-of-pocket premiums. It is projected that residents will experience an average 107 percent premium increase, compared to 89 percent for urban residents, in addition to the national median increase of 18 percent for private health plans. Additionally, rural residents who obtain coverage through the Affordable Care Act (ACA) Marketplace will experience 28 percent higher increases than urban residents. This is particularly problematic for rural communities, and the hospitals in these communities that provide care, as these communities rely more heavily on ACA Marketplace plans to obtain health insurance.[20] Further, it is likely that the work requirements outlined in the OBBBA will lead to additional disproportionate impacts on rural communities. It is anticipated that due to the additional challenges around available rural employment and/or increased challenges around coverage redetermination in rural communities, many rural residents who are eligible for coverage will end up losing coverage.[21] These specific concerns, paired with general OBBBA coverage losses, have the potential to lead to a significant worsening of the landscape of rural health care and increased financial stress on already vulnerable rural hospitals.

During debate prior to passage of the OBBBA, many legislators voiced particular concern as to the impact that it could have on rural hospitals. As a result, a $50 billion "rural health transformation program," generally referred to as the "rural health fund" was included in the final language.[23] This fund is designed to be implemented by states over five years beginning in 2026. Half of the funds are to be divided equally between states that have Centers for Medicare & Medicaid Services (CMS) approved applications. The other half of the funds are to be used at the discretion of CMS based on a formula that takes into account the state's rural population and need.[24] Once distributed to the state, funds should be used for activities such as improving access to hospitals and providers, improving health outcomes, enhancing the workforce, and increasing the use of emerging technologies.[23,24] While this rural health fund seems to be promising, it is unequivocally underfunded. Experts estimate that rural hospitals will lose $137 billion over ten years, meaning that the rural health fund only makes up about 37 percent of losses. Even with the rural health fund, rural hospitals are anticipated to lose $87 billion over the next decade.[23,24] This revenue loss comes primarily through the number of individuals that will lose Medicare, Medicaid, and ACA Marketplace plan coverage as portions of the OBBBA take effect. The legislation does not outline the specific criteria that CMS will use to evaluate the applications, nor which state agencies are intended to complete the application and manage the funds. Although it is anticipated that State Offices of Rural Health will play a role, the current administration has voiced intention to cut funding for these offices, leading to uncertainty as to the application and fund management.[25] The ambiguity of the rural health fund means that rural hospitals may not end up actually receiving the full funds. Further, states are given the ability to direct funding towards urban and suburban settings, with the approval of CMS.[23,24] Additionally, the legislation does not define "rural," meaning that states and/or CMS could potentially apply the term however they wish. While the impact of this legislation is yet to be determined, leaders of rural hospitals and those that study them have voiced significant concerns that the OBBBA will exacerbate current problems and may accelerate the rate of closures.[23,24,25]

ALTERNATIVE RURAL HOSPITAL PAYMENT MODELS

In recent years, a number of programs and models have been proposed and/or evaluated to assess how well they support rural hospitals and improve overall community health. Many programs utilize one or more funding models, often focusing on patient-centered, standby capacity, or global payment models. Some experts suggest that a relatively simple fix would be allowing for greater

state flexibility as to which hospitals can be designated as a CAH, such as was available until 2006. With increasing numbers of rural hospitals at risk of closure, legislators have started to explore reimplementing this flexibility through bipartisan legislation, the Rural Hospital Closure Relief Act of 2025. Alternatively, the Health and Human Services Secretary could choose to temporarily reestablish this flexibility to allow states to give this designation to struggling rural hospitals.[5] There are currently several federal programs and initiatives designed to support rural hospitals, such as Medicare Rural Hospital Flexibility, Small Rural Hospital Improvement Program, and Rural Hospital Stabilization Program. Additionally, through a variety of funding sources like state grants, CMS Innovation Center, and CMS Quality Initiatives, a number of novel payment models have been tested. Many of these payment models relay upon a type of lump sum payment, like a hospital global budget. These rates are generally set based on the hospital's historical net patient revenue with some models building in appropriate adjustments, such as inflation. A more detailed history of existing rural hospital payment programs and the principles upon which these novel models are based can be found in Council on Medical Service Report 6-I-23, Rural Hospital Payment Models.

One model that has been assessed in recent years is the Pennsylvania Rural Health Model (PARHM), which aims to transform rural hospitals by implementing hospital global budgets. The model includes 18 hospitals, five of which are designated CAHs, and six payers. It uses hospital global budgets that are paid on a biweekly basis, set using Medicare Fee-for-Service (FFS) rates, and adjusted for inflation and service changes.[26] While PARHM global payments exceeded the FFS rates that would have been paid in a more traditional payment structure, both hospitals and payers reported that financial unpredictability was not fully mitigated. Concerns regarding a lack of specific fund allocations and potential reconciliation payments were cited as reasons that the global payments did not support full financial stability. However, hospitals did report some improvements in the model's goal to promote community health. Specifically, there were incremental improvements in quality of care, population health of communities served, and greater community collaboration and follow-up care for those experiencing substance use disorders (SUD).[27] Hospitals participating in this model were able to implement partnerships with community organizations to improve case management for those dealing with SUD.

Experts at the Texas Organization of Rural & Community Hospitals have expressed that with some changes, PARHM could be a significant improvement for many rural hospitals. Evaluators working on the model suggest that greater financial stability could be secured with some targeted changes to the program. Specifically, increasing technical assistance, developing guardrails around the magnitude of settlement payments, and aligning incentives with value-based care models could all lead to more accurate financial forecasts.[24] Importantly, many hospitals in this model cite concerns with reconciliation payments as a major issue in gaining financial stability.[27] In order to ensure that rural hospitals are not only able to reach financial stability, but maintain financial stability, it is essential that any payer reconciliation is clear, fair, and predictable.

Similar to PARHM, a model piloted in Maryland, the Maryland Total Cost of Care Model (MD TCOC), relied on global budgets to improve quality of care and population health. However, this model was slightly different in that it focused on all-payers, instead of hospital based, global budgets.[28] Additionally, MD TCOC incorporated primary care into the model, citing the need for preventive care in addition to acute care.[27] In this model, hospitals were paid a fixed amount each year, adjusted annually for quality and untethered from patient volume.

Evaluation of the MD TCOC model demonstrated initial decreases in Medicare spending, lessened hospital admissions, and a reduction in health disparities across communities served.[28] Specifically, the model saved the state of Maryland approximately $689 million in the first three years after

implementation. Evaluators found that incentives provided via global budgets created improvements in quality measures and lowered hospital admissions. Importantly, this model relies on improvements in primary care, which are essential for maintenance of many of the mentioned outcomes.[29] If this model were to be implemented in a rural setting, this reliance on primary care could be problematic should patients have difficulty accessing care. However, should rural patients be able to access primary care the outcomes from this model indicate it could be promising for rural communities.

Another model that included all-payers is the Vermont All-Payer ACO Model (VTAPM). This model differed from MD TCOC in that it utilized Accountable Care Organizations (ACOs) to incentivize broad system transformation to decrease spending and improve population health. Eight hospitals and one ACO participated in the evaluation, which yielded mixed results.[28] This model was successful in that avoidable hospitalizations were decreased as there was an increase in collaborative approaches to address chronic health and SUD diagnoses. However, there were significant challenges with scaling the value-based care model, leading to questions about the feasibility of the model on a state-wide or national scale. Additionally, many participating hospitals reported challenges with the increased administrative burden that accompanied this model. A number of rural CAHs opted out of participation, citing an inability to handle the anticipated increases in administrative burden.[30,31] Regardless of hospital setting, physicians and other providers who participated in the VTAPM reported both greater understanding and more support for value-based programs after participation.[30] While this model did highlight some of the challenges that can come with implementing new payment models, such as educational and administrative burdens, it is possible that with appropriate technical support and funding a similar program could be scaled to support rural hospitals.

While the three aforementioned models focus on individual states, the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model is intended for nationwide implementation. While this program has not yet been implemented, it aims to increase quality of care for communities via hospital global payments and a number of non-hospital-based strategies, like cooperative funding and primary care alignment.[32] To support hospitals, the AHEAD model will provide participating hospitals with global budget payments based on Medicare FFS payment rates and adjusted for inflation and changes in community population and provided services. This program will be tested in up to eight states or territories with over 10,000 Medicare Part A and Part B beneficiaries.[32] Regardless of the type of model implemented, it is essential to ensure that appropriate investments are made upfront so that rural hospitals are able to establish the model without undue financial burden.

AMA POLICY

There is a robust body of AMA policy to address both rural health in general and the viability of rural hospitals. Broadly, Policies H-465.997 and H-465.994 outline the AMA's stance on rural health disparities and efforts to work toward improvement in access and quality of rural health care both independently and in conjunction with relevant state medical associations and national medical specialty societies. Specifically, Policy H-465.982 focuses on AMA support for states to monitor and work with respective state governments to implement rural health demonstration projects. Policy H-465.986 outlines AMA efforts to disseminate and support states in disseminating materials and evaluation regarding Rural Health Clinics and their certifications. Additionally, Policy H-465.989 outlines AMA efforts to monitor and address the impact of billing restrictions on rural health providers and hospitals. Finally, Policy H-465.980 addresses the need to ensure that health networks in rural communities are robust enough to support the population needs.

In addition to policy on general rural health, the AMA has an existing body of policy to address the challenges facing rural hospitals. For example, Policy H-465.990 specifically addresses AMA support for legislation to reduce financial burdens on small rural hospitals in order to ensure they remain open and accessible to the communities they serve. Policies H-465.999 and D-465.999 address the complications involved with the certification rural hospitals can face when becoming a part of federal programs. Policy H-465.999 addresses Medicare rural hospital certification while D-465.999 addresses certification for CAHs. Finally, Policies D-190.969 and D-465.998 address AMA efforts to monitor and address payment and service delivery in rural hospitals.

DISCUSSION

Rural hospitals are absolutely essential to the nearly 20 percent of Americans that live in rural communities. These hospitals literally serve as a lifeline to their communities by providing critical health care services and significant economic support. Research shows that the majority of rural hospitals are operating in a deficit and many are at significant risk of closure. Further, many rural hospitals have needed to stop offering essential services, like OB/GYN and cancer care, in order to remain financially viable. The closure of these hospitals and elimination of services only exacerbates the existing health disparities for rural communities. Rural hospitals face low patient volume, which paired with fixed costs of services, leads to higher per-patient cost. As a result, the payments from many plans are not adequate to meet the actual cost of services provided. While there are some programs and subsidies through Medicare and Medicaid, this is not enough to make up for the deficits caused by other payers, especially MA plans. Recently passed legislation, OBBBA, is predicted to accelerate the struggle that many rural hospitals are experiencing. Although this legislation does include a substantial rural health fund, it is estimated that the fund will only account for about one-third of the lost revenue for rural hospitals. Accordingly, it seems likely that the financial uncertainty facing many rural hospitals will continue without the development and implementation of additional strategies.

As discussed in this report, multiple alternative payment models have been explored with the intent of creating a more financially sustainable system for rural hospitals. While none of these models have proved to be flawless, each has demonstrated potential positive changes that could be made. Paired with existing research, these models have demonstrated the importance of fixed cost payments for rural hospitals. When rural hospitals are able to rely on a predictable set payment, they are better able to plan and forecast in a manner that can lead to long-term financial stability. This is essential for rural hospitals, as patient volumes are typically not high enough to justify hospital fixed costs. Additionally, it is important to ensure that payment rates for variable services, which are defined as those that change in amount or frequency (e.g., materials), are fair and cover the expenditure. While this is not a distinct need for rural hospitals, it is particularly important as rural hospitals work towards financial stability. Finally, these models demonstrate the need to ensure that hospitals maintain affordability and high-quality care for their patients.

Consistent with several of the lessons learned from these models, the Council recommends the adoption of new policy outlining minimum standards for alternative payment models suitable for rural hospitals. These standards outline that, at a minimum, alternative payment models for rural hospitals should cover fixed costs, include adequate variable payment rates, incorporate affordable patient cost-sharing, and deliver high-quality care. To reiterate and expand upon AMA commitment to the importance of rural hospitals, the Council recommends the adoption of new policy that outlines ongoing efforts with interested national medical specialty societies and state medical associations to investigate novel payment models and support educating communities on promising models. Additionally, to work towards ensuring that funds allocated for rural hospitals are used for their intended purposes, the Council recommends the adoption of new policy.

Further, the Council recommends minor amendments to Policy D-465.999 to request the reintroduction of the "necessary provider" designation. To address the new and growing impact of MA on rural hospitals, the Council recommends that Policy D-465.998 be amended by the addition of a new fifth clause supporting not only education around MA plans in rural settings but also encouraging all payers, regardless of type, to provide adequate payment to rural hospitals. Additionally, the Council recommends that the second clause of Policy D-190.969 be rescinded as it has been accomplished by this report. Finally, while the Council intends to initiate a future report focused exclusively on non-payment model challenges facing rural hospitals, in the interim a number of reaffirmations are recommended. Specifically, the Council recommends the reaffirmation of Policies H-465.994, H-465.982, and H-465.997 which collectively work to improve rural health via telemedicine, innovative workforce challenges, managed care, as well as the creation and implementation of community-based solutions.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the following minimum standards for alternative payment models to rural hospitals in order to enhance their financial sustainability and ensure access to care:

a. Fixed Cost Payment: Rural hospitals should be paid an agreed upon and fixed sum delivered on a predictable schedule that is not tied to patient volume.
b. Adequate Payment Rates: All payers should ensure that payments made for variable services are adequate to cover the full cost of care provision.
c. Patient Cost-Sharing: Any out-of-pocket payments made by patients should be reasonable and affordable.
d. Accountability and Transparency: Care delivered should be of high-quality, evidence-based, and part of a physician-led team.
e. Administrative Simplicity: Models should minimize administrative burdens.

2. That our AMA believes that rural hospitals are essential to the communities they serve. To ensure that these hospitals have adequate support to remain open and financially viable, our AMA will continue to work with interested national medical specialty societies and state medical associations to:

a. support and monitor novel payment models for rural hospitals and encourage uniform reporting; and
b. support educating patients, physicians, and non-physician practitioners on alternative payment models for rural hospitals.

3.That our AMA support that funds allocated for rural hospitals be used to enhance or maintain rural health care.

4. That our AMA work to vigorously oppose Medicaid cuts as they significantly impact at-risk rural hospitals.

5. That Policy D-465.999 be amended to read:

Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) support the reintroduction of the state-

designated Critical Access Hospital (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

6. That Policy D-465.998 be amended by addition of a new recommendation 5 to read:

> 5. Our AMA support educating patients, physicians, and non-physician practitioners on the impact of Medicare Advantage plans on rural hospitals and encourage all payers to provide adequate payment to support the financial stability of rural hospitals.

6. That Policies H-465.994, H-465.982, H-290.951, and H-465.997 be reaffirmed.

7. That the second clause of Policy D-190.969 be rescinded, as having been completed with this report. (Rescind HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 3-I-25
Payment Models to Sustain Rural Hospitals
Policy Appendix

Rural Hospital Payment Models, D-190.969

1. Our American Medical Association supports and encourages efforts to develop and implement proposals for improving payment models to rural hospitals.
2. Our AMA will report back no later than the 2026 Annual Meeting on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM). (CMS Rep. 6, I-23)

Addressing Payment and Delivery in Rural Hospitals, D-465.998

1. Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
    a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.
    b. Provide adequate service-based payments to cover the costs of services delivered in small communities.
    c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.
    d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.
    e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.
    f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
2. Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
3. Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.
4. Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians. (CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 6, I-23)

Access to and Quality of Rural Health Care, H-465.997

1. Our American Medical Association believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources.
2. In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued. (CMS Rep. G, A-

87; Modified: Sunset Report, I-97; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21; Reaffirmed: BOT Rep. 07, I-24)

Improving Rural Health, H-465.994

1. Our American Medical Association (AMA):
    a. supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health,
    b. urges physicians practicing in rural areas to be actively involved in these efforts, and
    c. advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
    a. Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
    b. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
    c. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
    d. Advocate for adequate and sustained funding for public health staffing and programs
3. Our American Medical Association will work with relevant stakeholders to develop a national strategy to eliminate rural cancer disparities in screening, treatment, and outcomes and achieve health equity in cancer outcomes across all geographic regions.
4. Our AMA calls for increased federal and state funding to support research on rural cancer disparities and equity in care, access, and outcomes and development of interventions to address those disparities.
5. Our AMA advocates for evidence-based collaborative models for innovative telementoring/ teleconsultation between health care systems, academic medical centers, and community physicians to improve access to cancer screening, diagnosis, treatment, rehabilitation, and patient services in rural areas. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22; Reaffirmed: CMS Rep. 09, A-23; Reaffirmed: Res. 724, A-23; Appended: Res. 919, I-24)

Rural Health, H-465.982

1. Our American Medical Association encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations.
2. Our AMA encourages state associations to work with their respective state governments to implement rural health demonstration projects.
3. Our AMA will provide all adequate resources to assist state associations in dealing with managed competition in rural areas. (CMS Rep. H, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed: CMS Rep. 01, A-23)

Rural Health, H-465.986

1. The AMA urges CMS to disseminate widely information on the Rural Health Clinics Program, not only to states and health facilities but to state medical associations as well.
2. The AMA encourages state medical associations to evaluate the potential benefits and drawbacks to rural practices of seeking certification as rural health clinics and transmit the result of such evaluation to their members.
3. The AMA encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions to identify any modifications needed to allow the most effective use of mid-level practitioners in improving access to care, while assuring appropriate physician direction and supervision of such practitioners. (CMS Rep. A, A-91; Reaffirmed by CMS Rep. 8, A-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15)

Rural Health, H-465.989

It is the policy of the AMA that: (1) the AMA closely monitor the impact of balance billing restrictions mandated by the Budget Reconciliation legislation on reimbursement levels and access to care in rural areas, and take action as needed to moderate that impact; (2) the AMA closely monitor implementation of the legislation establishing essential access community hospitals and rural primary care hospitals, to ensure that this program is implemented in a manner conducive to high quality of patient care and consistent with Association policy concerning the functions and supervision of physician assistants and nurse practitioners; (3) state medical associations be encouraged to monitor similarly and to influence any legislation or regulations governing the development and operation of such limited service rural hospital facilities in their own jurisdictions; and (4) the AMA establish liaison with the American Hospital Association, Congress and the Centers for Medicare & Medicaid Services regarding any further development of essential access community hospitals and rural primary care hospitals grants. (CMS Rep. K, A-90; Modified: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: CMS Rep. 3, A-15)

Elimination of Payment Differentials Between Urban and Rural Medical Care, H-240.971

Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population. (Res. 107, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20)

Rural Community Health Networks H-465.980

AMA policy is that development of rural community health networks be organized using the following principles: (1) Local delivery systems should be organized around the physical, mental and social needs of the community;

(2) Clinical decision-making and financial management should reside within the community health network whenever feasible with physicians retaining responsibility for a network's medical, quality and utilization management;

(3) Savings generated by community health networks should be reinvested in the local health care delivery system, rather than redirected elsewhere, since rural health systems and economies are fundamentally intertwined;

(4) Patients should retain access to the spectrum of local health services, thereby preserving patient-physician relationships and continuity of care; and

(5) Participation in rural community health networks should be voluntary, but open to all qualified rural physicians and other health care providers wishing to participate. (Sub. Res. 721, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17)

Closing of Small Rural Hospitals, H-465.990
Our American Medical Association encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care. (Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10: Reaffirmed in lieu of Res. 807, I-13; Reaffirmed: CMS Rep. 3, A-15)

Certification of Rural Hospitals for Medicare, H-465.999
The AMA (1) urges the Secretary of HHS to reassess the regulations prescribing conditions of participation and to adopt a more realistic and humanitarian approach toward certification of small, rural area hospitals, and (2) recommends that state medical associations and state licensing and certifying agencies establish and maintain close surveillance of the certification and accreditation problems of small hospitals. (Res. 42, A-68Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18)

Critical Access Hospital Necessary Provider Designation, D-465.999
Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) opposes the elimination of the state-designated Critical Access Hospital (CAH) "necessary provider" designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program. (Res. 102, A-14; Reaffirmed: CMS Rep. 01, A-24)

Enhancing Rural Physician Practices, H-465.981
1. Our American Medical Association supports legislation to extend the 10 percent Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
2. Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
3. Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
4. Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
5. Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities. (CMS Rep. 9, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Appended: CME Rep. 3, I-21; Reaffirmed: BOT Rep. 11, A-23; Reaffirmed: Res. 215, I-24)