Medicaid cuts would push rural hospitals—and care for rural communities—over the edge

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With rural hospitals already operating on the razor's edge, cuts to Medicaid would adversely affect rural residents as well as the viability of the facilities central to delivering their care.

Even without Medicaid cuts, the rural health safety net's capacity to meet the needs of rural communities is tenuous: nearly 50% of rural hospitals are in the red, 432 are vulnerable to closure, and services are disappearing to keep the doors open.

Recent budget reconciliation efforts on Capitol Hill have pushed potential Medicaid cuts into the spotlight. The House Committee on Energy and Commerce must find $880 billion in savings over 10 years from programs in its jurisdiction. The consensus is this is only possible if the government reduces its role in funding Medicaid.[1]

Discussion of Medicaid cuts is alarming for rural hospitals. Serving communities that are older and less affluent means relying more heavily on revenue from government payers. In this analysis, we examine how cuts will likely impact already struggling rural hospitals.

An estimated 10.1 million people rely on Medicaid in rural hospital communities.

KEY FINDINGS:

Medicaid net revenue for rural hospitals amounts to $12.2 billion.

At the median, Medicaid represents $3.9 million to a rural hospital's bottom line—more than 9% of total hospital net revenue.

If Medicaid revenue were cut by 15%, rural hospitals would lose more than $1.8 billion, while a 20% loss would amount to more than $2.4 billion in lost revenue.

A 15% loss in Medicaid revenue is equivalent to more than 21,000 full-time hospital employee salaries.

How many people in rural hospital communities rely on Medicaid?

While policymakers have several scenarios for cutting Medicaid (e.g., change eligibility requirements, reduce or eliminate federal matching rates), the program's significance within rural America is clear.

Since a rural hospital's home county is often home to most of its patients, this is a useful lens for understanding how shifts in payer mix (e.g., Medicaid, Medicare, Medicare Advantage, private insurance) can impact rural hospital finances. Using this approach, we estimate the total number of Medicaid enrollees living within rural hospital communities (i.e., counties with at least one rural hospital) is more than 10 million.

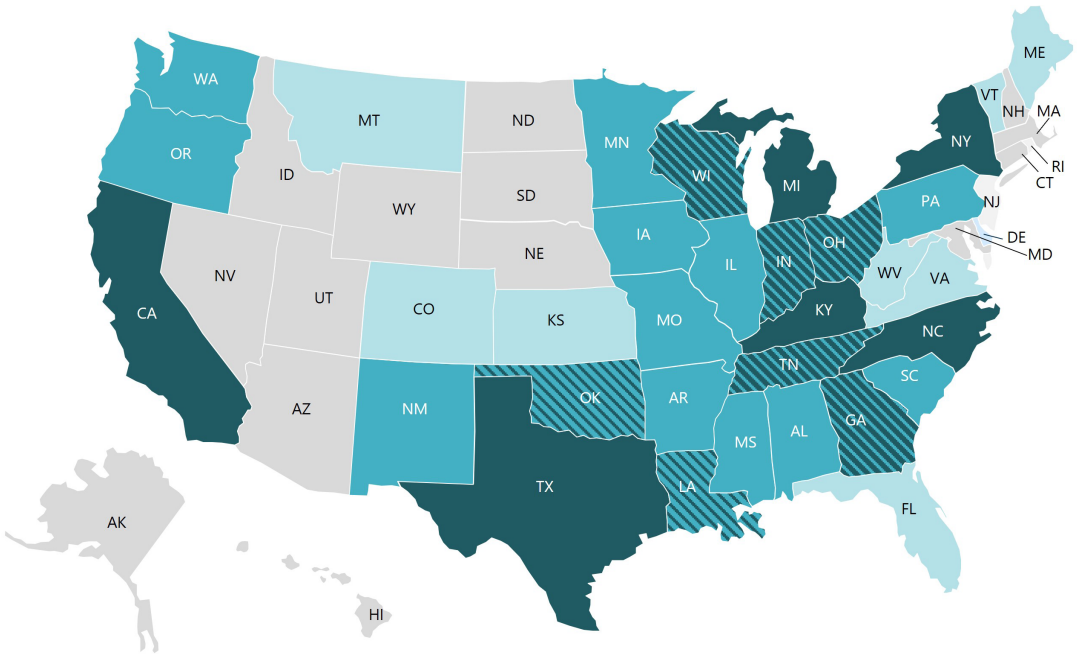
In a recent survey by KFF, 75% of rural residents indicated that Medicaid is "very important" for people in their local community, and 90% said they have a current personal or family connection to Medicaid.[2] The data from our research also demonstrates Medicaid's importance.

Rural hospitals in states that expanded Medicaid under the Affordable Care Act have consistently fared better than peers in non-expansion states (e.g., fewer rural hospitals operating in the red, fewer rural hospitals closed or vulnerable to closure). In fact, our rural hospital vulnerability model has repeatedly identified expansion state status as a protective measure against hospital closure.

Which states have the most rural Medicaid enrollees?

In nearly 3 dozen states, the estimated number of Medicaid enrollees residing in a rural community exceeds 100,000. Many of these states have been identified in our research as places where the safety net is particularly weak and rural populations are vulnerable (i.e., a large number of hospitals in the red, closed, or vulnerable to closure and declining population health status). The states with the highest estimated rural Medicaid enrollees are Kentucky (486,338), Texas (482,236), New York (480,258), North Carolina (461,387), California (453,213) and Michigan (428,544).

Figure 1: Importance of Medicaid in rural hospital communities



Source: The Chartis Center for Rural Health, May 2025

How significant are Medicaid reimbursements to America's rural hospitals?

Government payers are the lifeblood of rural hospitals' financial model. More than 40% of rural hospital revenue is tied to Medicare.[3] According to our analysis of cost report data from more than 2,000 facilities, Medicaid accounts for 10% of rural hospital net revenue. That translates to $12.2 billion in Medicaid-related net revenue.

Our analysis found that Medicaid revenue topped $200 million in more than 2 dozen states. Rural hospitals in Kentucky ($740 million), California ($729 million), New York ($585 million), Iowa ($585 million), and Texas ($539 million) rely the most on Medicaid revenue for total dollars generated. These states are home to 2.1 million Medicaid enrollees and 449 rural hospitals, 74 of which are vulnerable to closure.

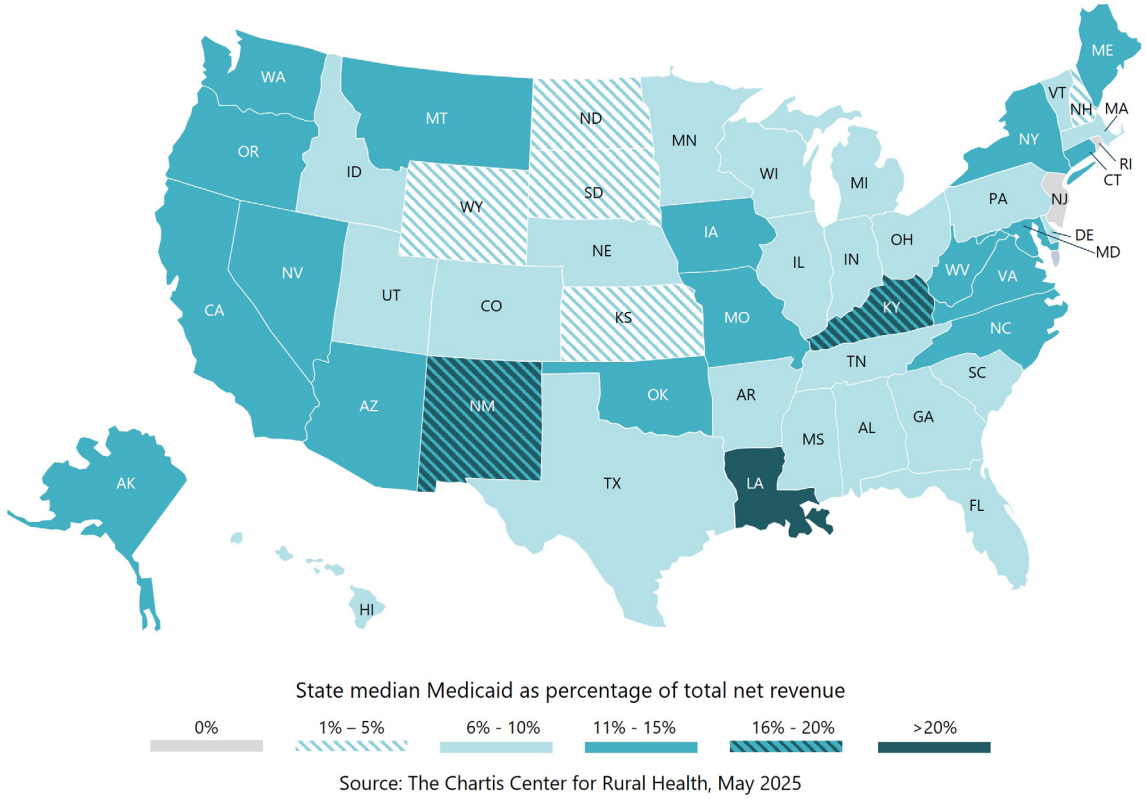
How important are Medicaid revenues on a per-hospital basis?

At the median, Medicaid's contribution to a rural hospital's net revenue is $3.9 million, or 9.34% of total net revenue. Considering that the median rural hospital operating margin is less than 1.0%, this amount is significant.

In states such as Oregon, Kentucky and Virginia, the median net Medicaid revenue reported per rural hospital is significantly higher ($12.4 million, $10 million and $8 million, respectively). Only North Dakota and Kansas rural hospitals have a median revenue of less than $1 million.

Although Medicaid accounts for 9.34% of net revenue at the median, several states have a noticeably higher percentage. In states like Louisiana, New Mexico, Kentucky, Alaska, Arizona and Washington, the median is greater than 15% of total net revenue.

Figure2: At the median, Medicaid is 9.34% of total net revenue



Source: The Chartis Center for Rural Health, May 2025

Any cuts in reimbursement rates or covered care would almost certainly damage population health status and push rural hospitals deeper into the red.

What would a 15% cut to Medicaid mean for rural hospitals?

Rural hospitals already contend with annual policy-driven cuts to reimbursement. Sequestration, which is a 2% cut in Medicare reimbursement, will cost rural hospitals more than $509 million this year. Bad debt reimbursement and a 35% reduction in charity care reimbursement will claim another $159 million. These policies are factors contributing to the safety net's financial strain.

Our analysis applied a scale of incremental percentages (i.e., 5%, 10%, 15%, 20%) to understand how reducing Medicaid reimbursement would further impact rural hospitals.

Our analysis shows that a 15% cut in Medicaid revenue, for example, would cause more than $1.8 billion to vanish from rural hospital bottom lines. That's the equivalent of more than 21,000 full-time hospital employee salaries. States with rural hospitals that would lose the most revenue are Kentucky ($111.1 million), California ($109.4 million), New York ($87.8 million), Iowa ($87.7 million), and Texas ($80.9 million).

Explore Medicaid cut ***scenarios state-by-state.***

At the largest end of our scale (20%), rural hospitals would stand to lose approximately $2.4 billion in hospital revenue. A 20% reduction would equal funding for more than 28,000 full-time hospital employees.

Nationally, variance exists when comparing the state-level impact of policies like sequestration and bad debt. States with lower rates of insurance coverage are more adversely impacted by bad debt reimbursement cuts. Not surprisingly, states such as California, Illinois, and Wisconsin (which are among the most impacted by bad debt reimbursement) are likely to be highly impacted by any cuts to Medicaid.

How will states with the weakest safety net fare if Medicaid is cut?

Across different metrics (e.g., rural hospital operating margin, rural hospital vulnerability, etc.), the safety net is weakest in states that have not yet expanded Medicaid under the Affordable Care Act.

A 15% reduction in net Medicaid revenue to rural hospitals in the 10 non-expansion states would result in the loss of $335.4 million.[4] 53% of rural hospitals in these states are operating in the red, and more than 200 are vulnerable to closure.

The data suggests that the rural health safety net in these 10 states is already in jeopardy. The added financial pressure associated with the loss of Medicaid revenue would further destabilize the ability of rural hospitals in these states to deliver care within their communities.

How might the loss of Medicaid revenue impact access to care?

Nearly 50% of rural births currently are covered by Medicaid.[5] Yet Medicaid fails to cover the full cost of providing obstetrics (OB)-related services to the patient. It covers only about 50% of what private insurance carriers reimburse for childbirth-related services.[6]

OB services are among the costliest for a rural hospital to provide. Reimbursement realities alongside low and negative operating margins are a driving force behind expanding OB care deserts. Between 2011 and 2023, nearly 300 rural hospitals stopped offering OB. Without local access to OB, expecting mothers must travel greater distances for prenatal care, labor, and delivery—invariably increasing the risk to mother and baby.

The US maternal mortality rate rose last year (19 deaths for every 100,000 live births) and is one of the highest among wealthy nations.[7] Access to prenatal and postnatal care are contributing factors to this crisis, and cuts to Medicaid would likely intensify the financial pressures on services such as OB and further restrict access. Iowa, Texas, and Minnesota experienced the highest number of rural OB service line closures between 2011 and 2023. A 15% reduction in Medicaid in these states would amount to about $240 million in Medicaid net revenue loss.

Tracking rural healthcare's new flashpoint

As we have seen since 2010, downward pressure on the delivery of care in rural America has coincided with a hospital closure crisis. Where hospitals continue operations, they are shedding services like OB to remain financially viable. Challenges associated with new payers like Medicare Advantage have further eroded the bottom line of these safety net providers.

Cuts to Medicaid—a large payer serving more than an estimated 10 million Americans in rural hospital communities—means more harm to rural hospitals and the vulnerable populations they serve. We will continue to apply our research and analytics on this issue as the budget reconciliation process progresses.

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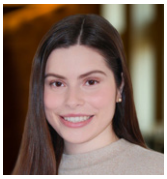

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Methodology

For this study, Chartis analyzed a total of 2,567 non-rural and 2,086 rural hospitals. Rural hospitals are located within Census tracts designated as rural by the Federal Office of Rural Health Policy (FORHP). Hospitals (rural or non-rural) meeting any of the following criteria are excluded from the analysis: Specialty facilities (defined as those where more than 80% of discharges fall under a single major diagnostic category), Facilities located on Native American territory, Facilities reporting consolidated data under another facility. Rural Prospective Payment System (PPS) hospitals with more than 200 beds.

Cost report data for these hospitals reflects the most recent available 4-quarter reporting period. For facilities reporting less than 12 months of data, an annualization adjustment factor is applied to inflate its figures.

A unique set of county codes (FIPS) is compiled for the 4,653 hospitals included in the analysis. FIPS codes that include at least one rural hospital are retained for the remainder of the analysis. The total number of Medicaid discharges for each facility is extracted (Column 14, lines 14 and 2 of Cost Report WS S3 Part 1)

from the hospital cost report (latest available as of May 8, 2025). For all counties containing at least one rural hospital, the percentage of rural Medicaid discharges within each FIPS code is calculated by dividing the total number of Medicaid discharges from the 2,086 rural hospitals by the total number of Medicaid discharges from all rural and non-rural hospitals.

The estimated number of Medicaid enrollees per county is pulled from the U.S. Census. The estimated number of rural Medicaid enrollees in each county is calculated by multiplying the percentage of rural Medicaid discharges by the estimated number of Medicaid enrollees in counties that contain at least one rural hospital.

For the financial impact analysis, we obtain the Medicaid net revenue (Line 2 of Cost Report WS S10) and net patient revenue (line 3 of Cost Report WS G3) from the hospital cost reports (latest available as of May 8, 2025). Financial cost report data is processed in accordance with established statistical standards to address outliers using the interquartile range (IQR) method. For each field within the cost report, the IQR is calculated by end year. Values exceeding the upper threshold (Q3 + 1.5 × IQR) are flagged as outliers and are substituted with the upper IQR limit. Similarly, values falling below the lower threshold (Q1 – 1.5 × IQR) are classified as outliers and replaced with the lower IQR limit. Cost report values of zero are excluded from median calculations.

Medicaid cuts at increments of 5%, 10%, 15%, and 20% are applied to the Medicaid net revenue figures to calculate the potential loss of total net revenue on the state and national level. The average salary per FTE for each hospital is obtained from the FLEX Monitoring Team. Outliers are identified and capped using the interquartile range (IQR) method. The loss of FTEs as a result of potential Medicaid cuts is calculated by dividing the total loss of Medicaid net revenue by the average salary of FTE for a given facility. The resulting figure is rounded down to the nearest whole number. The individual results for each facility are then aggregated at the state and national level.

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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