



National Rural Health Association

Rural Hospitals, Obstetrics and USDA

2026 NNEPQIN Spring Conference

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#ruralhealth
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Chief Operations Officer

Brock Slabach has no conflicts of interest to disclose

Destination NRHA

Plan now to attend these 2026-27 events.



Rural Health Clinic Conference
Critical Access Hospital Conference

Sept. 15-16, 2026
Sept. 16-18, 2026

Kansas City, MO
Kansas City, MO

Policy Institute

Feb. 9-11, 2027

Washington, DC

Annual Conference

May 18-21, 2027

New Orleans, LA

Rural Hospital Innovation Summit

May 18-21, 2027

New Orleans, LA

Visit ruralhealth.us
for details and discounts.

Why rural?



Rural areas make up 80% of the land mass in USA

Rural areas have roughly 17% of the US Population

Rural areas provide the food, fuel and fiber to power our nation

Access to high-quality health care is a requirement to keep these important resources available

An exchange between urban and rural that must not be overlooked

Historically, public policy has disadvantaged health care in rural communities

“Rural hospitals and the rural economy rise and fall together”

“Three years after a rural hospital community closes, it costs about \$1000 in per capita income.”

- Mark Holmes, professor, University of North Carolina

- On average, 14% of total employment in *rural areas is attributed to the health sector. Natl. Center for Rural Health Works. (RHW)*
- The average CAH creates 107 jobs and generates \$4.8 million in payroll annually. (RHW)
- Health care often represent up to 20 percent of a rural community's employment and income. (RHW)
- Medical deserts form in rural communities where hospitals close.

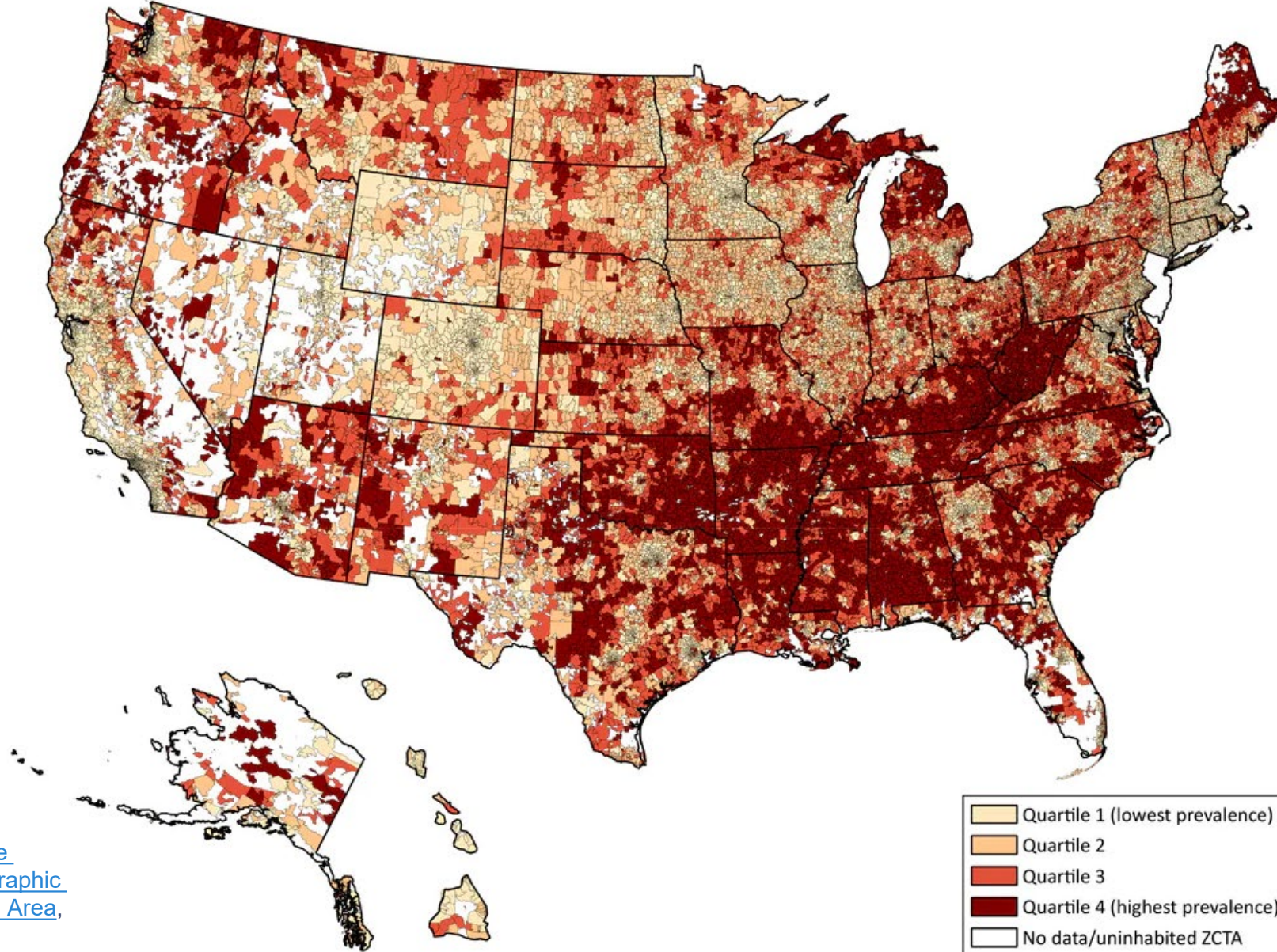
Our work together:

- Delivering Rural Opportunity: Addressing Declining Life Expectancy and Health Outcomes
- Reducing Rural Healthcare Workforce Shortages
- Investing in a Strong Rural Health Safety Net




The Context of Rural Health

Chronic disease prevalence scores by quartile across Zip Code Tabulation Areas



[Chronic Disease Prevalence in the US: Sociodemographic and Geographic Variations by Zip Code Tabulation Area](#), CDC, February, 2024


Chronic Disease Prevalence by Income

| Condition  | <\$25,000 Income | \$75,000+ Income | Disparity Ratio |
|---|------------------|------------------------|------------------|
| COPD | 15.5% | 3.5% | 4.4x higher |
| Depression | 31.0%* | Lower | High Disparity |
| Diabetes | 13.1%** | 5.1%** | 2.6x higher |
| Heart Disease | 11.8%*** | Lower | Significant |
| Stroke | 5.0% | 1.8% | 2.8x higher |
| Arthritis | 29.3%* | Lower | High Disparity |
| Cancer | 9.8% | 10.0% (at \$50k-\$75k) | Minimal/Reversed |

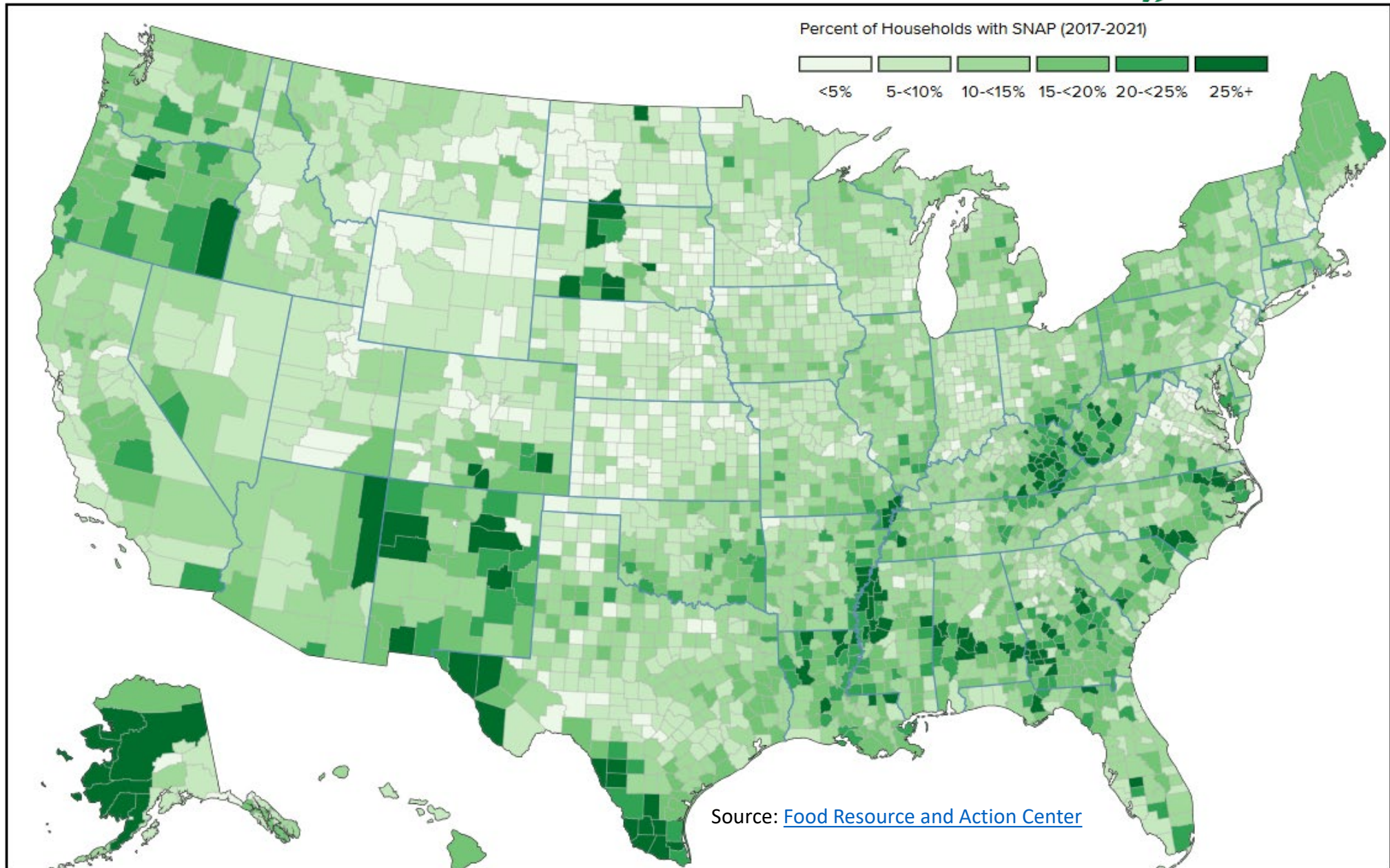
[Source: 2023 Annual Report from America's Health Rankings](#)

**Data represents general high prevalence cited for low-income groups.*

***Comparative figures for 2019-2021 from the [CDC](#).*

****Upper range for heart disease prevalence in certain low-income studies.* 

The Geography of Food Stamps

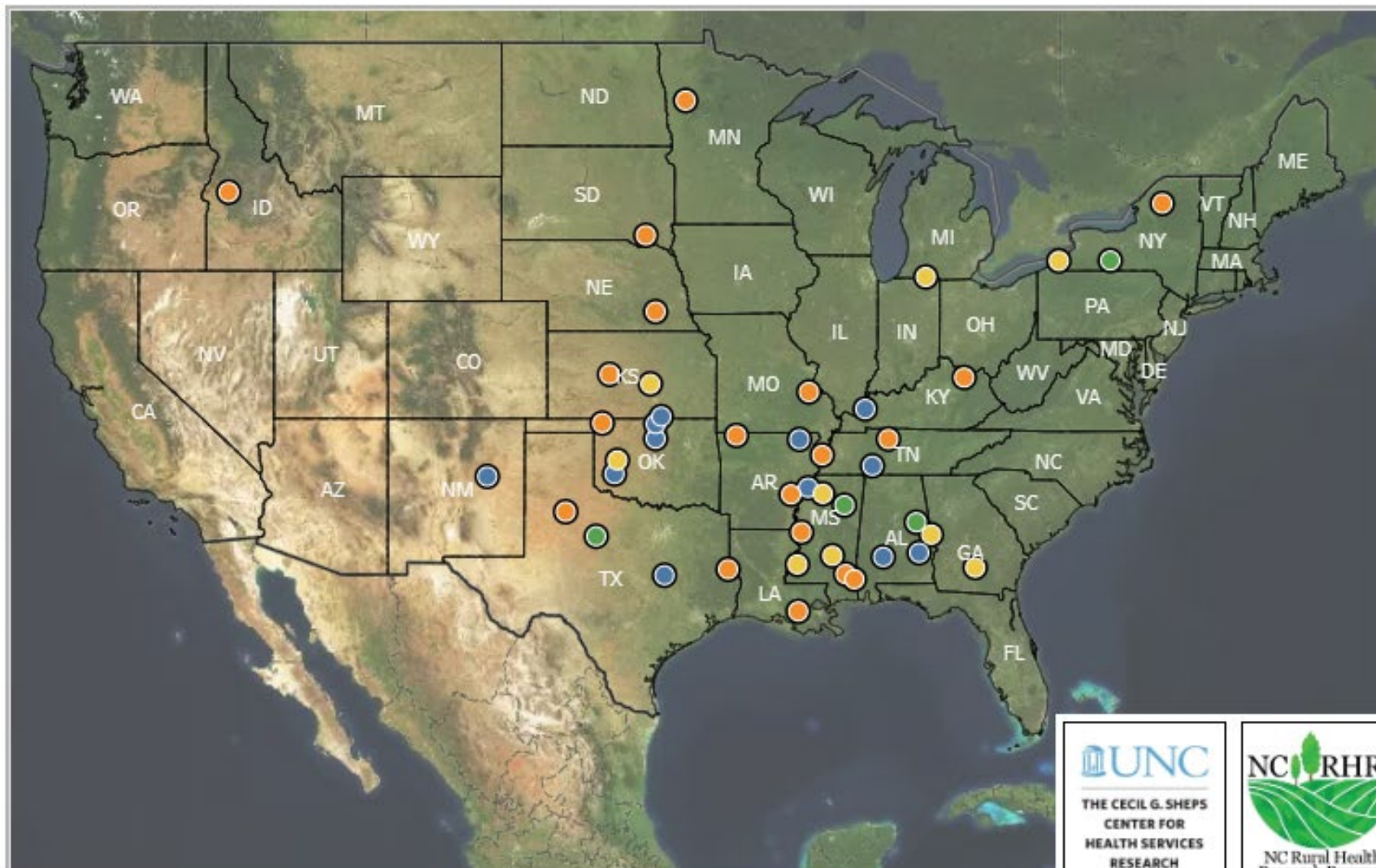
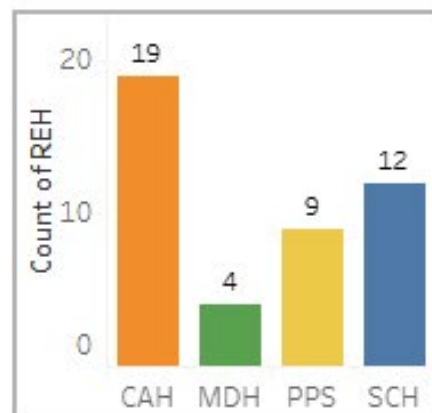
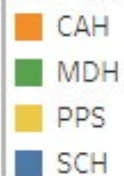


REH Conversion Map

44 Conversions Since 2023



Previous Medicare Payment



Common Outcomes for Rural Hospitals



90%+/- of hospitals are within these three options

Source: Stroudwater and Associates

Key Identified Risk Factors

Top-line Revenue
Growth

Operating
Performance—
margin and cash flow

Liquidity and Cash
Management

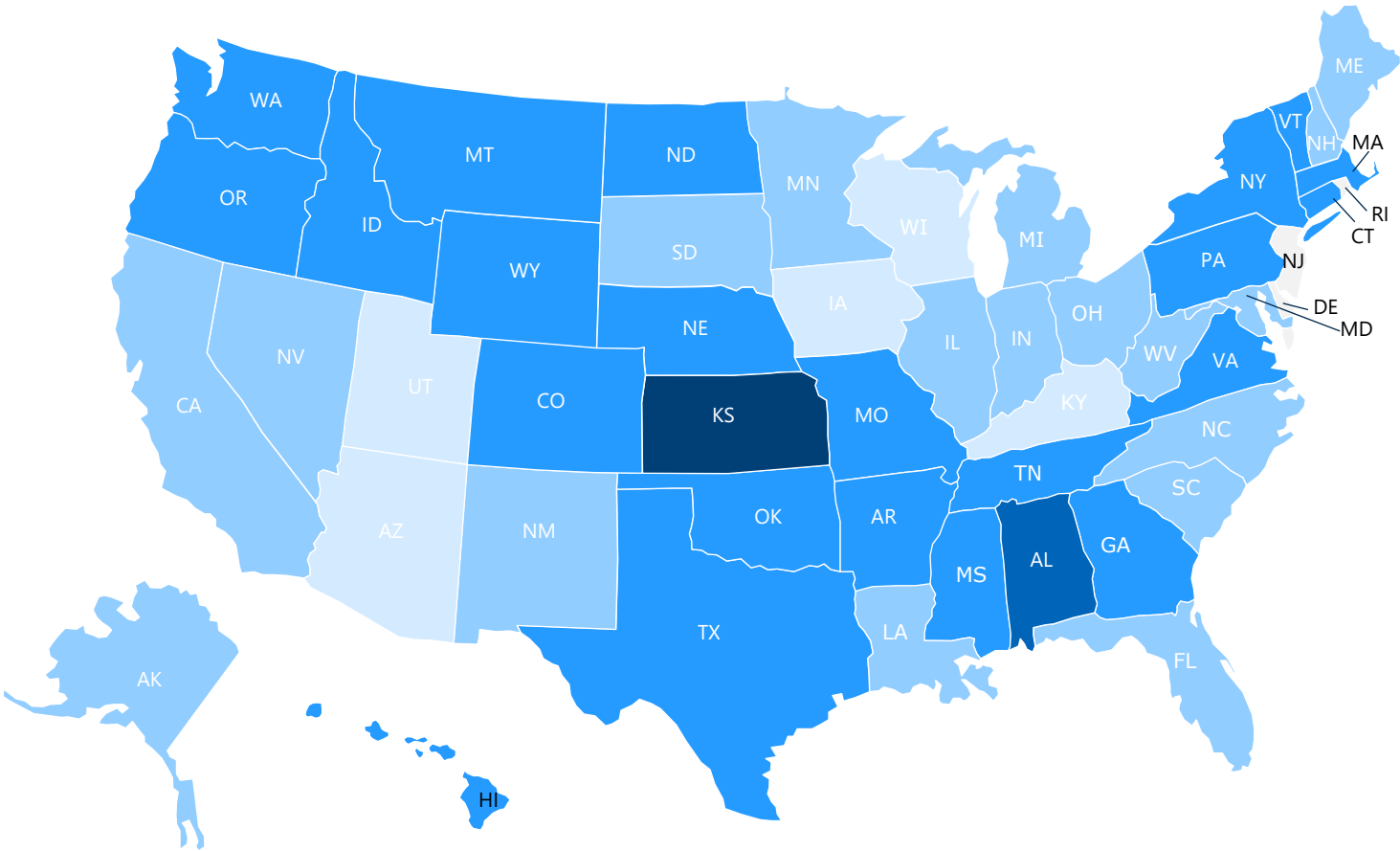
Balance Sheet
Strength and Fund
Balance

Market Position and
Market Share

Market
Demographic—
population, poverty
rate, etc.

Hospital
Characteristics—
payment
methodology (i.e.,
PPS)

More than 40% of rural hospitals are operating in the red



52.2%
of rural hospitals in non-expansion states are in the red.

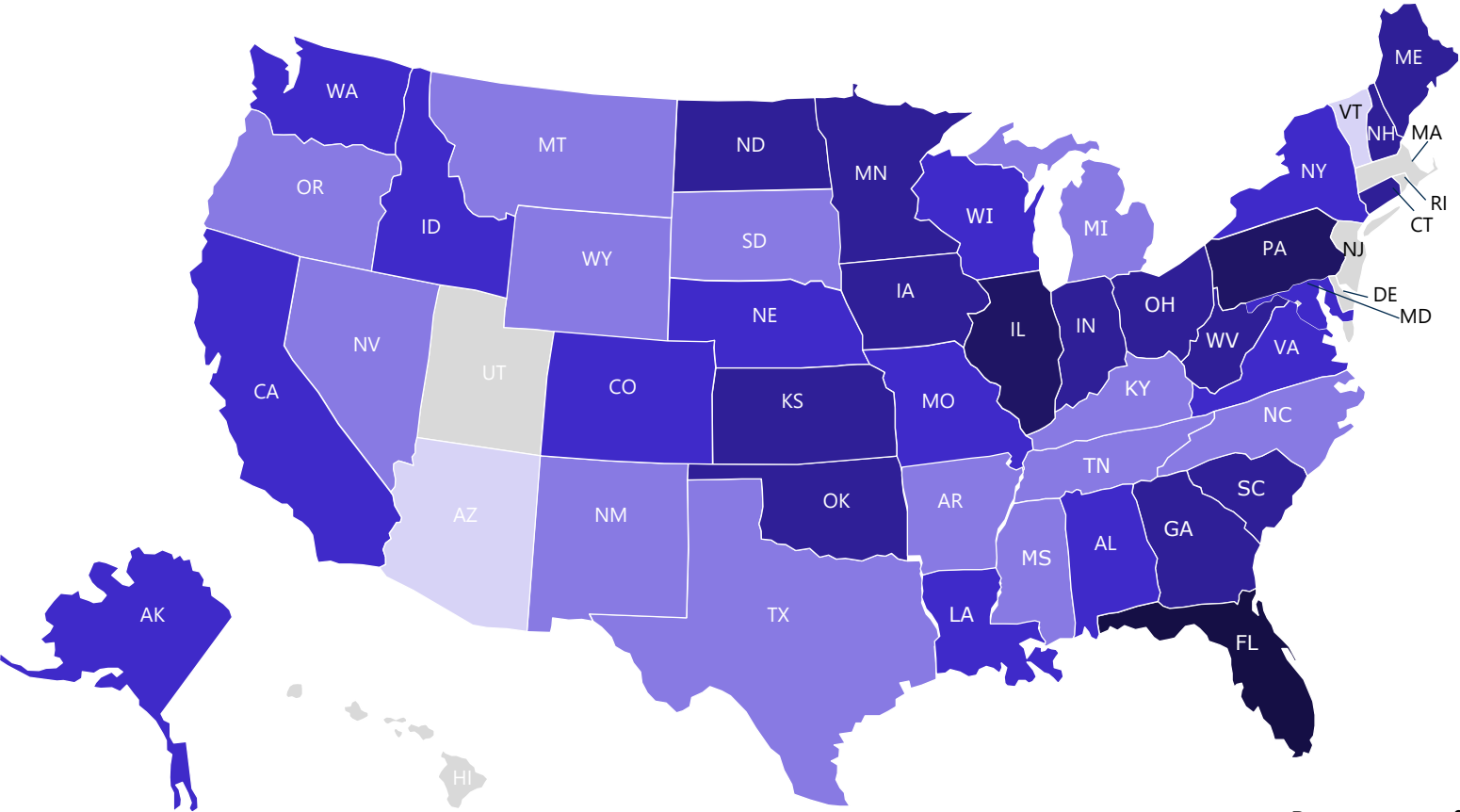
34.9%
of rural hospitals in expansion states are in the red.

State-level percentage of rural hospitals with negative operating margin.



Source: The Chartis Center for Rural Health, December 2025.
**CMS Healthcare Cost Report Information System (HCRIS) Q4 2025. Operating margin is computed in accordance with Flex Monitoring Team guidance. Outliers are excluded. Hospitals for which data are unavailable are excluded. Reported Covid-19 PHE Funds (Worksheet G-3 line 24,50) excluded from operating margin. Adjustments made to operating margin to reflect full 2% sequester.

Care deserts show no signs of slowing down: Obstetrics



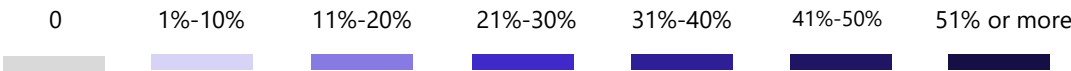
331

rural hospitals have stopped offering
OB between 2011 and 2024.

27.2%

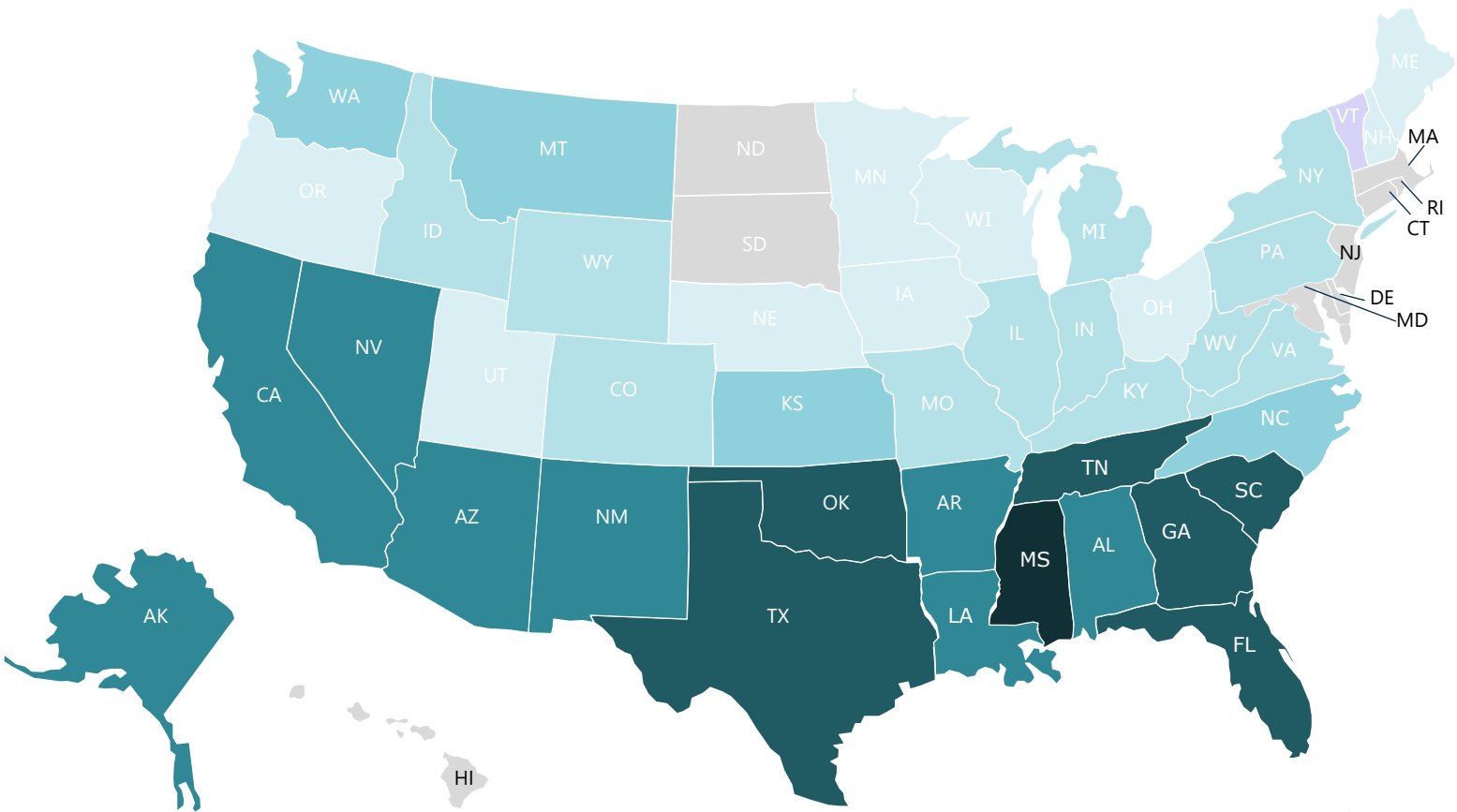
of all rural hospitals offering OB in 2011
no longer provide this service line.

Percentage of rural hospitals that stopped offering OB between 2011 and 2024.



Source: The Chartis Center for Rural Health, December 2025.

Care deserts show no signs of slowing down: Chemotherapy



448

rural hospitals have stopped offering
Chemo between 2014 and 2024.

22%

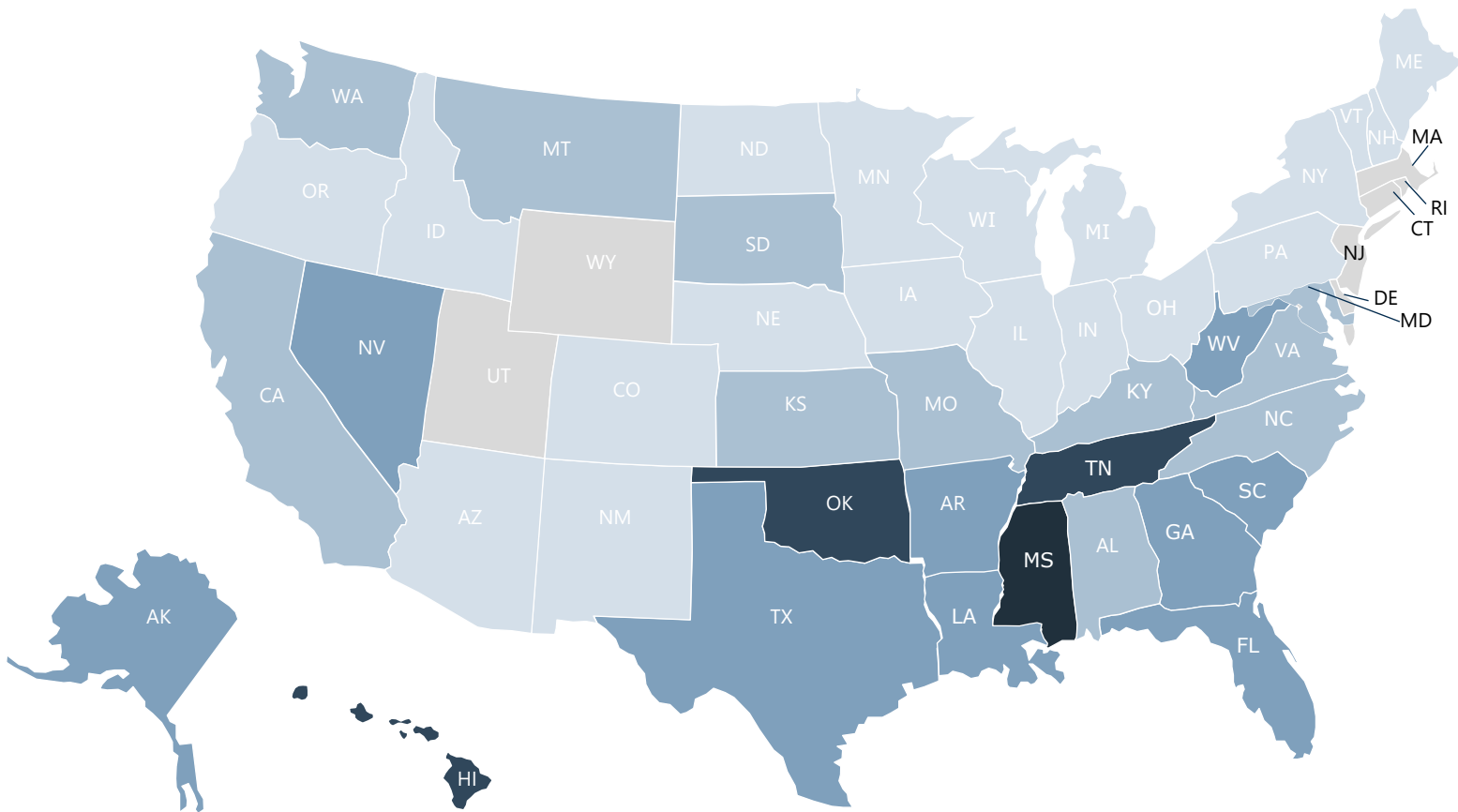
of rural hospitals offering chemo in
2014 no longer provide this service.

Percentage of rural hospitals that stopped offering chemotherapy between 2014 and 2024.



Source: The Chartis Center for Rural Health, December 2025.

Care deserts show no signs of slowing down: General Surgery



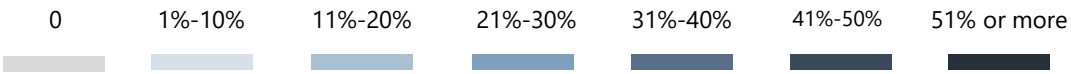
314

rural hospitals have stopped offering general surgery between 2014 and 2024.

15%

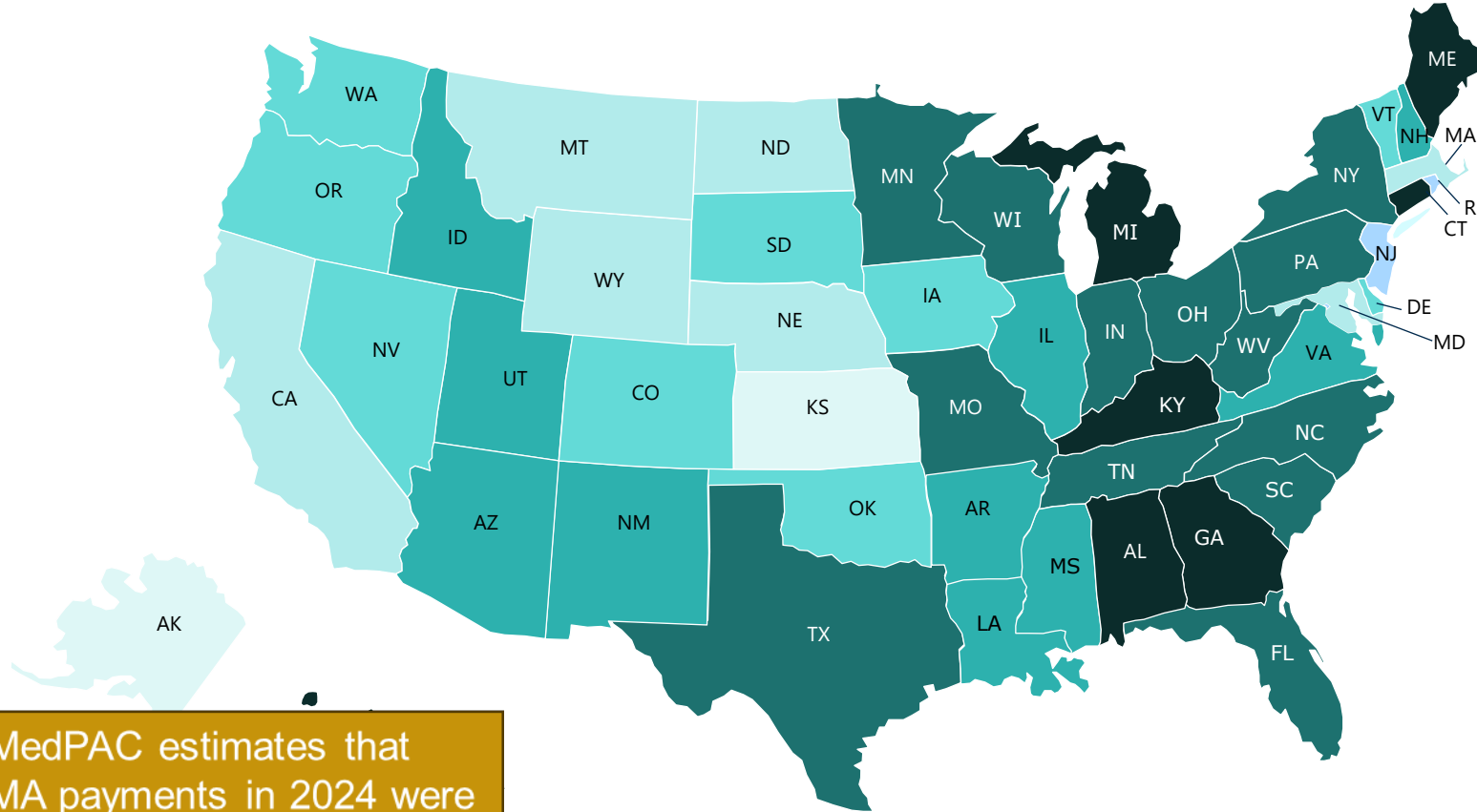
of rural hospitals offering general surgery in 2014 no longer provide the service.

Percentage of rural hospitals that stopped offering general surgery between 2014 and 2024.



Source: The Chartis Center for Rural Health, December 2025.

Medicare Advantage Penetration Nears 50%

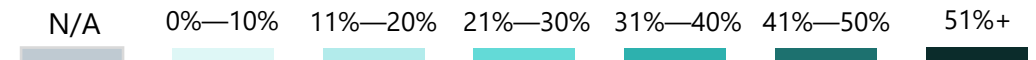


Today, **48%** of all rural Medicare beneficiaries are enrolled in a Medicare Advantage plan.

Medicare Advantage Penetration now **exceeds 50% in 7 states** (AL, CT, GA, HI, KY, ME, MI).

Around 17 percent of initial claims submitted to Medicare Advantage insurers are denied---more than half of those denials are eventually overturned. Resulting in at least a 7 percent net reduction in provider MA revenue

Medicare Advantage penetration (%) in 2023, by state.



per 2023. Rural hospital is located.

MedPAC estimates that MA payments in 2024 were 22% above traditional Medicare—a difference of \$83B in annual spending.

That's \$830B over 10 Years.

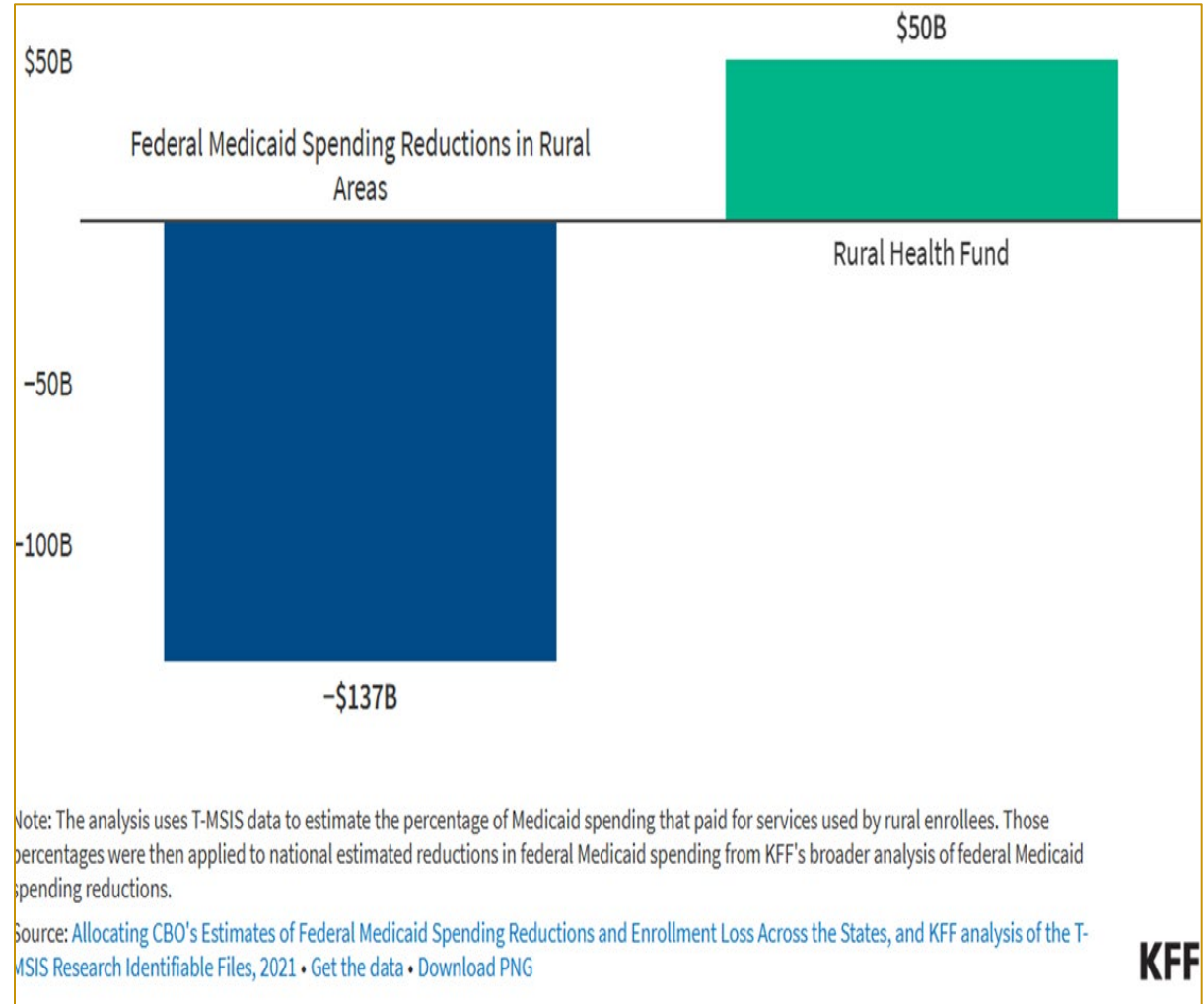
Source: [Center on Budget And Policy Priorities](#)

Rural Health Transformation Program and Innovation

OB3 Realities

- Decrease in Medicaid enrollment (~\$4M NPR at the median)
- More uninsured means more bad debt/charity
- Provider-tax reductions will hit hospital finances
- Revenue losses will cause service line closures or reductions
- Worsening outcomes in vulnerable rural populations
- ~\$137B rural reduction over 10 years

Source: Chartis Center for Rural Health



RHTP Activities

- Improve control of chronic disease (CDM)
- Reduce avoidable ED/Inpatient utilization
- Reduce Total Cost of Care (TCOC) growth
- Health technology investments linked to clinic and cost outcomes
- Telehealth and Artificial Intelligence
- “Right-sizing” facilities

RHTP Intent: Lower traditional costs and utilization in a fee-for-service payment structure

Care transformation should not outpace
Changes in payment

Rural Population
Health
Transformation

New Payment Arrangements

- Shared Savings—Lead Model
- AHEAD Model
- VBC contracting (commercial)
- Episodes of Care Payments
- Global Payments (Pennsylvania)
- Network formation (leverage)

Monetize a portion of accrued savings that would otherwise reward payers

Next Steps

- Model your hospital's exposure to Provider Tax/SDP cuts between FY28 and 32—quantify the decrease, stress testing the facility
- Model the impact of the individuals in your community that stand to lose Medicaid coverage and potential decrease in volume/revenue—estimates
- Review and update your charity care policies anticipating an increasing number of uninsured in your community—consider sliding scale fee schedule
- Monitor RHTP funded activities in your service area
- Consider VBC strategies to share in savings accrued through RHTP

VBC Resources on Innovation

The [Rural Health Value](#) (RHV) team has released resources on rural VBC topics :

- [Catalog of Value Based Initiatives for Rural Providers](#) (updated May, 2025)
- [Value-Based Care Assessment Tool](#) --Assesses an organization's value-based care capacities and readiness for value-based care using this tool from RHV
- [Introduction to Rural Clinically Integrated Networks \(CINs\)](#)
This RHV topic brief defines CINs, describes common CIN characteristics, and explores the unique value-based care advantages a rural CIN may bring to its members.
- [Glossary of Value-Based Care Terms](#) (Updated Jan. 2026) This compilation of key terms with brief definitions will help readers understand the vocabulary and terminology used in value-based care and payment.
- [How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report](#)
- [Experience in the Pennsylvania Rural Health Model: Barnes-Kasson County Hospital](#)

USDA Technical Assistance (TA) Program

Technical Assistance Process

Hospital Referral Source

- Current USDA borrowers
- Referrals from State RDs
- Word of mouth referrals, for example, self-referral from hospitals in need

Volume has steadily increased 2022-26

- USDA updated its guidance so that an existing relationship is not required to be eligible for TA, however, priority given to existing borrowers and hospitals in an eligible rural area with less than 20,000 population and located in a persistent poverty community, etc.
- Referral from state RD required for hospitals that are not current borrowers
- Continuing efforts to liaise with State RD on all projects

Technical Assistance Process

- **Characteristics of hospitals seeking assistance**
 - Hospitals selected for TA were generally trying to adapt to a Value-based Care environment, increasing Medicare Advantage payer mix, evaluate unprofitable service lines, reduce expenses through optimization where possible, and undertake strategies to increase collections and revenue



Jan. 4, 2024 Site Visit to Jersey County Hospital, Illinois
USDA RD Field Reps, Hospital CEO, Consultants and NRHA

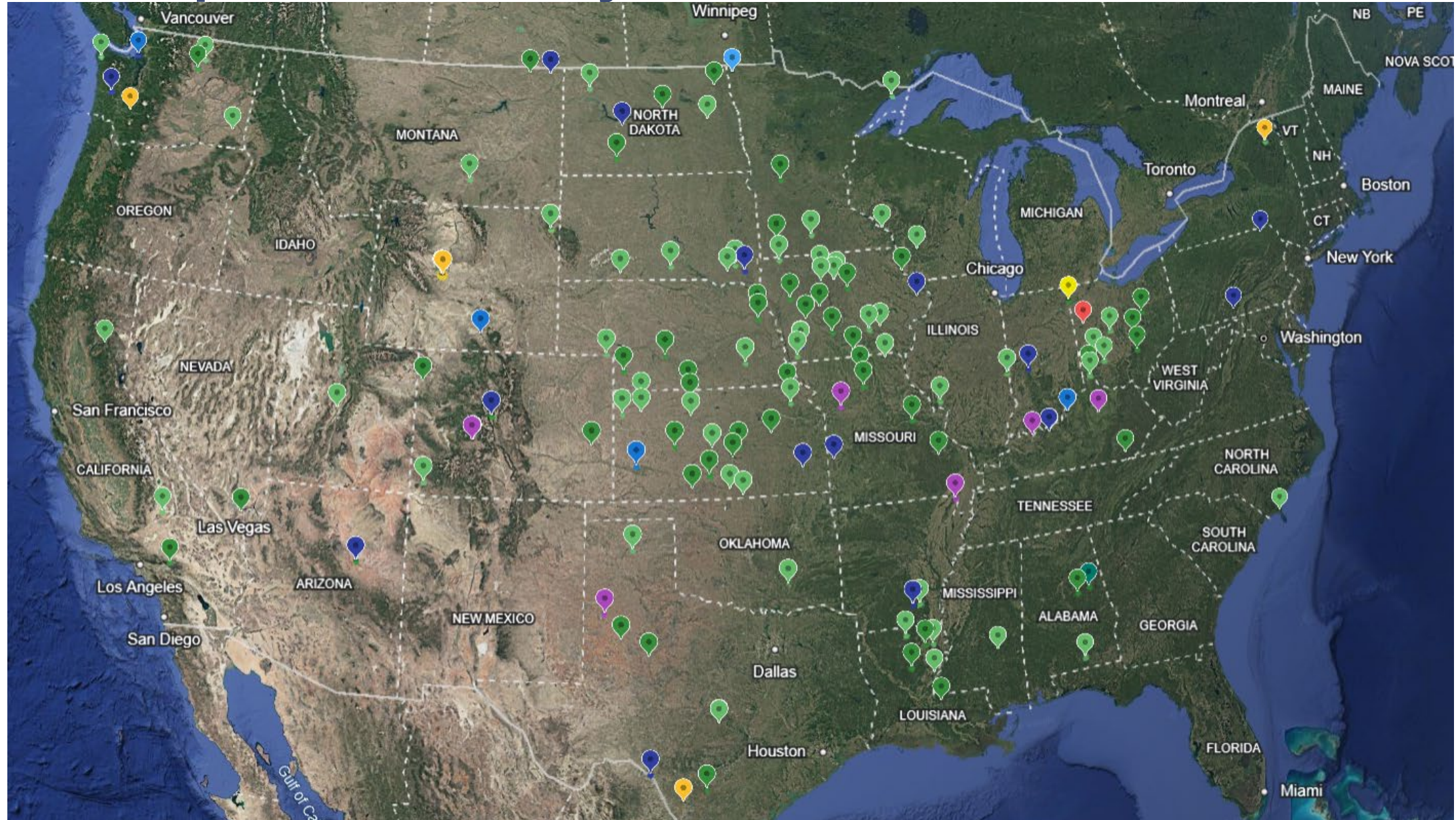
Consultant Update

- Fall, 2023 Requests for Proposals released to rebid consultant services
- Four proposals were received, reviewed and accepted
- Four consultants serving the TA program currently:
 - Eide Bailly
 - Forvis Mazars (BKD)
 - Stroudwater
 - Wipfli (newly added in 2023)
- Added Maternity, LTC and Quality Improvement to service listing

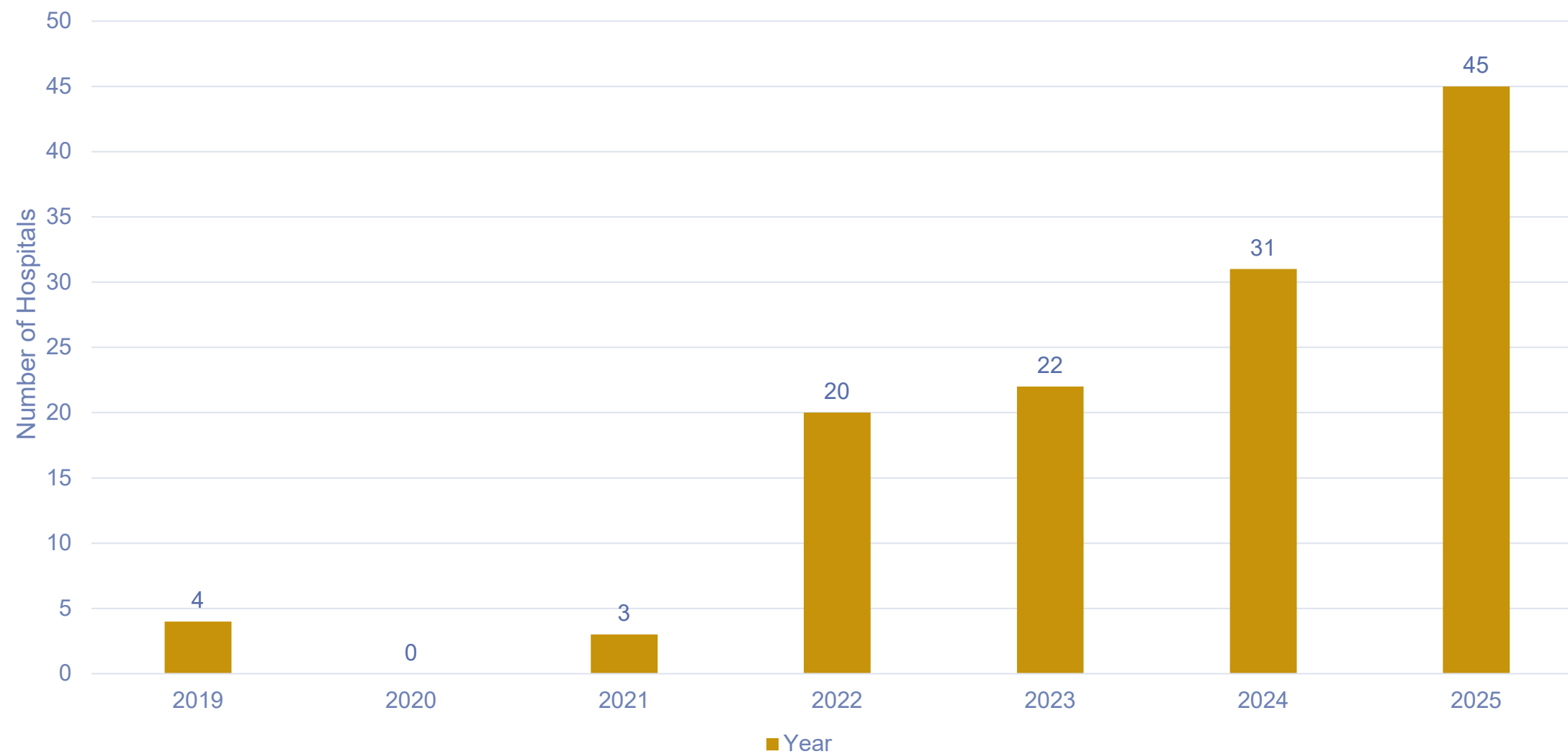
Project Status

- Project types
 - Strategic, Financial and Operational Assessment (SFOA): high-level assessment of the organization, with a focus on identifying opportunities for financial and operational improvement
 - Includes onsite assessment, report development, and onsite action planning session
 - Debt Capacity Analysis: evaluation of hospital capacity to take on additional debt in relation to identified capital project
 - Includes high-level market assessment, debt capacity financial modeling, report development, and presentation of findings/recommendations
 - Other targeted services provided, for example, service line analysis, revenue cycle and physician practice analysis.
 - Hospital Board Member Certification Program participation: over 30 USDA client hospital board members have been certified.

Hospitals Served by Location



USDA Hospitals Served



High Level Findings

- Estimated \$2.4M in financial opportunity/impact identified per completed SFOA
- Over life of project:
 - 71 SFOAs for an estimated total impact of \$170M
 - 42 Debt Capacity/Market Analysis
 - 12 Other targeted services
- Major areas of improvement identified included
 - Revenue cycle (Chargemaster, POS collections, third-party contracts, etc.)
 - Cost report opportunities
 - 340B utilization
 - Swing bed program growth
 - Market share capture, including obstetrics
 - Inpatient Service Growth (e.g., admission process optimization, “Care Spectrum” development, etc.)
 - Outpatient service growth (e.g., new service lines promotion of services in the community, improved patient access, etc.).
 - Hospital and clinic designation strategies
 - Physician Practice operational improvements
 - RHC Strategy
 - Rural Emergency Hospital Conversion (Nebraska)
 - Board Training (Riverton, Wyoming)
- Debt capacity analyses suggest capacity for capital improvements and potential USDA financing opportunities

High Level Findings

- Estimated \$2.4M in financial opportunity identified per completed SFOA (\$170M in total) since program start (71)
 - Approximate return on investment (ROI) of 44 per completed hospital with average cost of engagement at approximately \$55K
 - The following percentiles in terms of total financial on an individual hospital basis
 - 25th: \$1.4M \$99.4M impact
 - Median: \$2.4M \$170M impact
 - 75th: \$5.2M \$369M impact
- Debt capacity analyses suggest capacity for capital improvements and potential USDA financing opportunities
 - Several organizations moving forward with applying for USDA financing based on results of debt capacity analysis

2026 Project Status

- Project types
 - Strategic, Financial and Operational Assessment (SFOA): high-level assessment of the organization, with a focus on identifying opportunities for financial and operational improvement
 - Includes data analysis, onsite assessment, report development, and onsite action planning session
 - Debt Capacity Analysis: evaluation of hospital capacity to take on additional debt in relation to identified capital project
 - Includes high-level market assessment, debt capacity financial modeling, report development, and presentation of findings/recommendations
- 45 projects in 2025 (15 SFOAs and 30 miscellaneous)
- 17 projects in progress from 2025 and 3 new starts in 2026

How to Apply

- More information can be found on [NRHAs website](#)
- Meet qualifications for participation:
 - Population
 - [Rural Development Eligibility Lookup Tool](#)
 - Loan status:
 - Current USDA CFL Loan—automatically qualified
 - Not a current USDA borrower—need a state rural development referral
- Fill out an [application form](#) and we'll be in touch for a discovery call
- Easy!



Conclusion

Join with us in Our Combined Work to:

- Delivering Rural Opportunity: Addressing Declining Life Expectancy and Health Outcomes
- Reducing Rural Healthcare Workforce Shortages
- Investing in a Strong Rural Health Safety Net



NRHA Programs

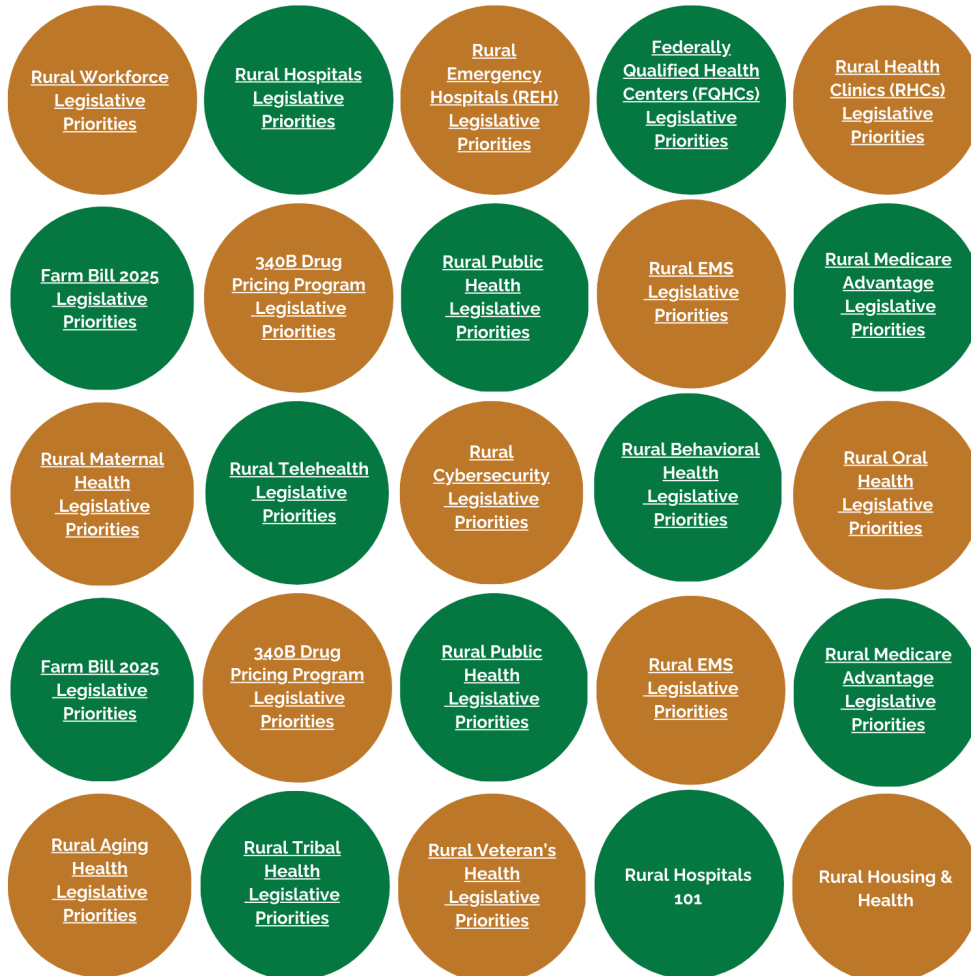
- [National Rural Age-Friendly Initiative](#)
- [Rural Community Health Worker Training Academy](#)
- [Southwest Health Initiatives](#)
- [Rural Oral Health Initiative](#)
- [Rural Hospital Technical Assistance Program](#)
- [Rural Health Fellows Leadership Program](#)
- [Rural Health Transformation Program Resources](#)





NRHA Advocacy Materials: Topic-Specific 1 pagers

These topic-specific advocacy materials can be used to provide support for targeted initiatives about rural health legislative priorities.



Advocacy Materials

- We have updated all our core and topic-specific advocacy leave-behinds!



NRHA Advocacy Materials: Core Materials 1 pagers

These core advocacy materials can be used to provide support for main priorities and initiatives about rural health legislative priorities.



Advocacy Campaigns




Urge Congress to Invest in Rural Health




Urge Congress to Reject Site-Neutral Payment Reforms




Support Rural Hospitals: Cosponsor H.R. 3684, Save America's Rural Hospitals Act



Urge Congress to Renew Marketplace Enhanced Premium Tax Credits



Urge Congress to Extend Rural Healthcare Bills and Programs



Urge Congress to authorize vital rural health programs





NRHA

Your voice. Louder.

Thank you.

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