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Federal Medicaid Cuts Would Force Rural Hospitals to the Brink of Closure

New Analysis shows cuts to Medicaid would push 55 more independent rural hospitals into the red across 26 states, leaving 380 independent rural hospitals at serious risk of closure nationwide.

To highlight the impact of looming Congressional Medicaid cuts on hospital finances across the country, and particularly in rural communities, Families USA conducted a new analysis to estimate the potential losses in hospital revenue among independent rural hospitals. The results of this analysis make clear that bureaucratic red tape from national work reporting requirements and overly frequent eligibility checks for people covered by Medicaid expansion — just two of the many proposed cuts to federal Medicaid funding — would directly harm the more than 700 independent rural hospitals delivering lifesaving care across the country, putting them at significantly greater risk of closure or acquisition by large corporate systems[1]

KEY FINDINGS:

- Independent rural hospitals could lose an estimated $465 million in total patient revenue[†] in 2026 due to federal Medicaid cuts — an average loss of $630,665 per hospital.
- Independent rural hospitals could lose on average 56% of their yearly net income[‡] due to these revenue losses (Figure 1).
- As a result of these Medicaid cuts, 55 additional independent rural hospitals across 26 states could experience negative net incomes, a 17% increase, leaving a total of 380 independent rural hospitals nationwide at serious risk of closure.
    - **Among those 55 additional hospitals newly at risk of closure, two are in Iowa, two are in Maine, four are in Missouri, four are in Nebraska, two are in North Carolina, five are in Ohio and one is in West Virginia.**

Figure 1. Rural Hospital Net Income Losses

Independent rural hospitals could lose, on average, 56% of their net income due to federal Medicaid cuts in 2026 alone.

Source: Families USA analysis of National Academy for State Health Policy's Hospital Cost Tool data.

[†] Hospital total patient revenue refers to the total revenue generated from patient services after accounting for allowances, discounts and contractual adjustments. It includes income from private insurance, Medicare, Medicaid and self-payments. This revenue is used to assess a hospital's financial health and operational efficiency given that it reflects the amount of money generated from patients for health care services delivered.
[‡] Hospital net income refers to the total revenue generated by a hospital after all expenses, including costs of goods sold, operating expenses, taxes and interests, have been deducted. Net income assesses a hospital's profitability given that is measures how much revenue exceeds expenses over time.

These findings are consistent with the broader evidence base showing cuts to Medicaid severely threaten the financial viability of rural health care providers, including independent rural providers, across the nation.[2]

Impact of rural hospital closures on health care costs and access and local economies

Losing a local hospital has devastating consequences for a rural community, including:

- Increasing the distance patients must travel to access health care.
- Reducing healthy competition among all other hospitals and health providers, driving significant price increases (on average, more than 6%), particularly if the remaining hospitals are affiliated with large corporate systems.[3]
- Leading to more rural residents forgoing needed care entirely, with deadly consequences — especially for patients experiencing emergencies, such as a heart attacks or stroke.[4]
- Reducing rural jobs by 14%, hurting rural workers and local economies.[5]

Findings from Families USA's analysis

Through this analysis, Families USA found that independent rural hospitals could lose an estimated $465 million in total patient revenue, or $630,665 on average per hospital in 2026 alone, due to federal Medicaid coverage cuts driven by a national work reporting requirement and more frequent eligibility determinations for the Medicaid expansion population (Table 1). These potential revenue losses make up a significant proportion of these hospitals' yearly incomes and could mean the difference between an independent hospital keeping its doors open and closing permanently.[6] In fact, according to this analysis, independent rural hospitals could lose on average the equivalent of 56% of their yearly net income due to these revenue losses (Table 1; Figure 1, page 1).

Table 1: Projected Independent Rural Hospital Revenue Losses Due to Medicaid Coverage Cuts, 2026

Total patient revenue	$28,152,823,182
Total patient revenue lost	**-$465,430,645**
Average patient revenue	$38,147,457
Average patient revenue lost	**-$630,665**
Total net income*	$834,639,858
Average net income**	$1,130,948
Average lost patient revenue	**-$630,665**
Percentage net income lost* **	**-56%**

* Total net income is the sum of the net income of all independent rural hospitals. Net income is defined as net patient revenue minus costs. ** Average net income is defined as the total net income divided by the total number of independent rural hospital (738). *** Percentage net income lost assumes hospitals cost/expenses will remain the same between 2023 and 2026. For more information, see methodology.

Table 2. Rural Independent Hospitals at Risk of Closure, 2026

Independent rural hospitals with negative net income prior to proposed Medicaid cuts*	**325**
Additional independent rural hospitals with negative net income after accounting for lost patient revenue	**55**
Percentage increase in independent rural hospitals at risk of closure	**17%**

* Based on 2023 NASHP data.

As a result, 380 independent rural hospitals across 26 states (Table 2) could experience negative net incomes in 2026, compared with 325 independent rural hospitals in 2023 — a 17% increase in the number of independent rural hospitals that would be at significant risk of closure.

For example:

In Maine, two additional independent rural hospitals could experience negative net incomes as a result of these revenue losses, leaving all five of Maine's independent rural hospitals with projected negative net incomes in 2026 and therefore at serious risk of closure (Table 3, page 4).

Cary Medical Center in Aroostook County, Maine, could lose an estimated $794,677 in patient revenue, more than double the hospital's net income in 2023, putting it at significant risk for closure to the detriment of the health and health care of Mainers in that county (Table 4, page 8).[7] Maine residents already experience a severe health care affordability crisis due to unchecked consolidation that has resulted in only one hospital system owning more than a quarter of all Maine hospitals and clinics.[8] Furthermore, Maine hospital prices are the highest in New England, including one large hospital system charging on average 304% of what Medicare would have paid for the same hospital services in Aroostook County.[9] Losing one of the only independent hospitals in the county due to cuts to Medicaid coverage would only make this crisis worse.[10]

In Iowa, two additional independent rural hospitals could experience negative net incomes and be at serious risk of closure due to these potential revenue losses (Table 3, page 4).

Montgomery County Memorial Hospital in Montgomery County, Iowa, could lose an estimated $959,212 in patient revenue in 2026 if proposed Medicaid cuts are enacted and as a result experience a negative net income of $523,538, putting the hospital at significant risk of closure (Table 4, page 8). Montgomery County residents already experience a severe shortage of health professionals, including primary care and behavioral health care specialists, and a major hospital closure would only make this severe provider shortage worse for Iowan families.[11]

Table 3. Projected Independent Rural Hospital Revenue Losses and Hospitals at Risk of Closure Due to Medicaid Coverage Cuts by State, 2026

State	Number of Independent Rural Hospitals	Total Projected Revenue Losses	Number of Hospitals Newly at Risk of Closure Due to Medicaid Coverage Cuts
Arizona	5	$12,059,090	1
California	11	$10,372,248	2
Colorado	24	$22,495,950	3
Idaho	16	$12,296,108	2
Illinois	22	$18,438,064	1
Indiana	8	$27,044,948	2
Iowa	20	$16,196,208	2
Kentucky	16	$13,527,117	2
Maine	5	$3,381,486	2
Michigan	14	$21,418,203	1
Minnesota	22	$17,049,353	1
Missouri	17	$12,516,090	4
Montana	27	$14,758,343	3
Nebraska	46	$26,512,674	4
New Mexico	10	$17,655,973	1
North Carolina	6	$13,965,174	2
North Dakota	19	$11,533,236	3
Ohio	12	$17,161,261	5
Oklahoma	27	$18,208,942	3
Oregon	11	$28,584,570	2
Pennsylvania	4	$3,117,421	2
South Dakota	9	$3,090,809	1
Utah	8	$6,448,588	1
Vermont	6	$6,691,987	1
Washington	21	$30,964,695	3
West Virginia	5	$2,868,447	1

Rural hospitals in crisis

Since 2005, 195 rural hospitals have closed nationwide, with an additional 742 rural hospitals at significant risk of closing.[12] While the majority of rural hospitals are affiliated with big health care corporations, a subgroup of rural hospitals — independent rural hospitals — are particularly vulnerable to Medicaid cuts and subsequent closure given that 44% percent of these hospitals experienced negative net incomes in 2023 alone.[13] Medicaid is a major source of funding for these hospitals, providing up to 63% of an individual hospital's funding for delivering health care to our nation's families.[14] Medicaid expansion plays a particularly critical role in promoting the financial viability of independent rural providers, providing timely access to hospital care, and is foundational to promoting competitive and affordable rural health care markets. In fact, states that have expanded Medicaid up to 138% of the federal poverty level, as authorized under the Affordable Care Act, experience fewer hospital closures than states that have not, largely because lower uninsured rates result in reductions in uncompensated care.[15]

Preserving *independent* rural hospitals is critical for guaranteeing timely access to affordable care among rural consumers and their families. Given that rural hospital markets are already considered highly concentrated due to unchecked health care consolidation and resultant price increases (along with other demographic and geographic factors), rural Americans face high and rising health care costs, significant provider shortages and more limited choices of where they can receive care.[16] Independent rural hospitals are key to providing improved choice and competition in rural communities and are less likely to use anticompetitive practices and charge inflated prices as compared with rural hospitals affiliated with large corporate systems.[17] In fact, in 2021, hospitals affiliated with big corporations charged up to 13% higher prices for hospital care compared with independent hospitals — or $2,500 more for a single hospital visit.[18] These price differences are significant, particularly for rural patients and their families who tend to have lower incomes and higher rates of underinsurance or uninsurance.[19] Moreover, rural hospitals owned by large corporate systems are more likely to shut down key service lines (for example, maternal and neonatal health, surgery, and mental health), have lower patient experience and health care quality scores, or close down entirely.[20]

Cuts to Medicaid funding would exacerbate America's rural health crisis by undermining the financial sustainability of the limited number of independent providers left in rural America. Allowing these independent hospitals to close would only drive further consolidation in rural areas, dramatically increase health care prices, and eliminate rural Americans' access to critical lifesaving hospital services.[21]

Conclusion

The evidence is clear: **Medicaid cuts will exacerbate the existing rural health crisis** by forcing independent rural hospitals to scale back services or close altogether, undermining basic access to care for rural communities and the only form of meaningful competition in many rural hospital markets, all while increasing health care costs. Protecting Medicaid funding is therefore critical to protecting the health and financial security of rural families.

Appendix: Methodology

Families USA conducted an original analysis to estimate the potential losses in hospital revenue among independent rural hospitals if policies to impose mandatory national work requirements and more frequent eligibility checks on the Medicaid expansion population were enacted. The analysis relies on a number of data sources, including:

1. National Academy for State Health Policy (NASHP) hospital financing data for calendar year 2023 (originally sourced from Medicare Cost Reports). This data source includes individual hospital data on net patient revenue; payer mix; bed count; address information, including ZIP code; system affiliation status; and net income.[22]
2. An Urban Institute analysis that uses economic modeling to estimate hospital spending losses (among the nonelderly) by state and hospital referral region for calendar year 2026. This modeling is based off the assumption that all applicable states were to drop expanded Medicaid eligibility due to the removal of enhanced federal Medicaid funding (that is, enhanced Federal Medical Assistance Percentage (FMAP)) for spending related to Medicaid expansion populations.
3. Two Congressional Budget Office analyses that estimated federal savings associated with removing expanded FMAP funding and, separately, certain provisions included in the House version of the One Big Beautiful Bill Act as of May 22, 2025, including a national work reporting requirement and more frequent eligibility redeterminations for Medicaid expansion populations.[23]

Importantly, this analysis does not factor in additional impacts of proposed cuts to Medicaid posed by freezing provider taxes, changes in state-directed payments, or any other proposed cut to Medicaid or Marketplace coverage — all of which could lead to significant additional revenue losses for independent rural hospitals.

The analysis also relies on a crosswalk between U.S. ZIP code and hospital referral region compiled by the Dartmouth Clinical and Translational Science Institute to compare and combine the Urban Institute projections and NASHP hospital data, described in more detail below. Lastly, the analysis relies on the U.S. Department of Agriculture (USDA) rural-urban commuting area (RUCA) designations, which measure geographic areas by their degree of urbanization and adjacency to a metropolitan area, to identify an individual hospital's status as either an urban or rural hospital.[24]

Based on these data, Families USA calculated estimates for how much revenue select hospitals could lose if federal lawmakers enact reforms to impose a national work reporting requirement and more frequent eligibility checks for the Medicaid expansion population. Specifically, Families USA took the following analytic steps:

1. **Calculate each hospital's net patient revenue from non-Medicare payers (for example, commercial payers or Medicaid).** This was done by subtracting 100 by the percentage of Medicare and Medicare Advantage payer mix fields from the NASHP data — which is the percentage of gross charges associated with non-Medicare and non-Medicare Advantage payers — and multiplying it by the hospital's total net patient revenue. This allowed Families USA to calculate an estimate of the hospital's non-Medicare or non-Medicare Advantage net patient revenue in order to isolate each hospital's revenue that is primarily associated with nonelderly populations to align with the comparison with the Urban Institute's modeling projections.
2. **Multiply each hospital's non-Medicare net patient revenue by the percentage change in hospital spending as estimated by the Urban Institute in order to calculate a hospital's total revenue losses if federal Medicaid coverage cuts were enacted.** Since the Urban Institute's projections were calculated at the hospital referral region (HRR) level, Families USA used an individual hospital's address information, including ZIP code, to identify a hospital's HRR and then compared those HRRs with the Urban Institute's projections to identify the appropriate projected percentage change and HRR pair.
3. **Add up the estimated total revenue losses, which were calculated at the individual hospital level, to calculate a national estimate of total revenue losses** across all independent hospitals (that is, non-system-affiliated hospitals) and hospitals residing in rural areas as defined by hospitals whose ZIP codes are located in a county that has a USDA RUCA of 4 or higher.[25]

To calculate a hospital's total revenue loss, Families USA adjusted the Urban Institute's modeling projection, including its percentage change in hospital spending figures. This allowed Families USA to account for the particular subset of Medicaid provisions included in the House budget reconciliation package that is the focus of this analysis, including a national work reporting requirement and more frequent eligibility checks for the Medicaid expansion population. Importantly, the Urban Institute's modeling projections were based on lawmakers completely reversing and removing expanded FMAP funding and all states removing their expanded Medicaid eligibility. Families USA accounted for this by calculating an adjuster (that is, a percentage) that sought to estimate the degree to which the policy scenario used by the Urban Institute and the policies included in the House budget reconciliation bill differ and thus drive different levels of coverage losses and subsequently different levels of revenue losses among independent rural hospitals. This was done by dividing the total federal savings scores calculated by the Congressional Budget Office associated with the national work reporting requirement and more frequent eligibility redeterminations that are included in the House-passed One Big Beautiful Bill Act by the total federal savings figures calculated by the Congressional Budget Office that are associated with removing expanded FMAP to all applicable states. The resulting percentage, which equaled 55.89%, was then applied to the Urban Institute's hospital spending projections. In other words, Families USA estimated that a national work reporting requirement and more frequent

eligibility checks collectively have 56% of the equivalent impact on coverage losses and ultimately on hospital revenues compared with a complete removal of expanded FMAP, and all applicable states removing their expanded Medicaid eligibility. Families USA then adjusted the Urban Institute's hospital spending projections accordingly.

Families USA applied the 55.89% adjustment to the fixed percentage sourced from Urban Institute data, which estimated the percentage change in hospital spending at the HRR level. Families USA used address information of selected hospitals from the NASHP hospital data, including ZIP code data and a crosswalk between ZIP code and HRR from the Dartmouth Clinical and Translational Science Institute, to identify the HRRs for selected hospitals. Families USA then compared those HRRs with the Urban Institute projections to identify the projected percentage change in hospital revenue to apply to the hospital's net patient revenue. This analysis reasonably assumes that projected changes to hospital spending by HRR would roughly correlate to hospital spending changes at the hospital level within each respective HRR.

To identify hospitals at risk of closure, Families USA compared the individual hospital's projected lost revenue in 2026 to the hospital's net income as reported in 2023. Hospitals with projected revenue losses greater than their net income are reasonably assumed to be at heightened risk of closure. Importantly, the analysis conservatively assumes each hospital's 2026 costs will remain the same as in 2023 (Table 4). In addition, individual hospitals that previously reported negative net incomes in 2023 were considered at risk of closure as well for the purposes of this analysis.

Table 4. Projected Revenue Losses Among a Sample of Independent Rural Hospitals Newly at Risk of Closure Due to Medicaid Coverage Cuts, 2026*

*For full list of hospitals contact Policy@familiesusa.org

Name	County and State	Projected Revenue Lost	Net Income	Percentage Net Income Lost	Net Income, accounting for lost revenue
La Paz Regional Hospital	La Paz County, Arizona	-$1,337,650	$924,426	-145%	-$413,224
Fairchild Medical Center	Siskiyou County, California	-$5,021,861	$3,530,197	-142%	-$1,491,664
Lincoln Community Hospital	Lincoln County, Colorado	-$326,757	$35,799	-912%	-$290,958

Continued on the following pages.

Name	County and State	Projected Revenue Lost	Net Income	Percentage Net Income Lost	Net Income, accounting for lost revenue
Montgomery County Memorial Hospital	Montgomery County, Iowa	-$959,212	$433,674	-221%	-$525,538
Bear Lake Memorial Hospital	Bear Lake County, Idaho	-$479,461	$435,784	-110%	-$43,677
Marshall Browning Hospital	Perry County, Illinois	-$495,563	$175,680	-282%	-$319,883
Marion General Hospital	Grant County, Indianapolis	-$7,551,640	$1,240,627	-609%	-$6,311,013
Caldwell County Hospital	Caldwell County, Kentucky	-$480,855	$4,335	-11,092%	-$476,520
Cary Medical Center	Aroostook County, Maine	-$794,677	$348,681	-228%	-$445,996
McKenzie Health System	Sanilac County, Michigan	-$778,023	$7,888	-9,863%	-$770,135
United Hospital District	Blue Earth County, Minnesota	-$906,078	$895,369	-101%	-$10,709
Texas County Memorial Hospital	Texas County, Missouri	-$996,232	$799,387	-125%	-$196,845
Northern Montana Hospital	Hill County, Montana	-$2,429,988	$2,377,343	-102%	-$52,645
Granville Medical Center	Granville County, North Carolina	-$2,746,828	$2,558,801	-107%	-$188,027
Southwest Healthcare Services	Bowman County, North Dakota	-$528,321	$386,874	-137%	-$141,447
Community Hospital	Red Willow County, Nebraska	-$604,959	$41,580	-1,455%	-$563,379
Holy Cross Hospital	Taos County, New Mexico	-$2,548,124	$486,134.00	-524%	-$2,061,990
Mary Rutan Hospital	Logan County, Ohio	-$2,393,046	$253,359	-945%	-$2,139,687
Lindsay Municipal Hospital	Garvin County Oklahoma	-$642,409	$482,741	-133%	-$159,668

Name	County and State	Projected Revenue Lost	Net Income	Percentage Net Income Lost	Net Income, accounting for lost revenue
Southern Coos General Hospital	Coos County, Oregon	-$1,206,465	$1,136,125	-106%	-$70,340
Barness-Kasson County Hospital	Susquehanna County, Pennsylvania	-$735,634	$224,828	-327%	-$510,806
Douglas County Memorial Hospital	Douglas County, South Dakota	-$88,148	$76,525	-115%	-$11,623
Gunnison Valley Hospital	Sanpete County, Utah	-$2,392,227	$146,968	-1,628%	-$2,245,259
Northeastern Vermont Regional Hospital	Calcedonia County, Vermont	-$1,793,156	$1,699,911	-105%	-$93,245
Whitman Hospital & Medical Center	Whitman County, Washington	-$1,546,182	$1,167,420	-132%	-$378,762
Roane General Hospital	Roane County, West Virginia	-$1,082,027	$387,471	-279%	-$694,556

Endnotes

[1] Health Care Providers Would Experience Significant Revenue Losses and Uncompensated Care Increases in the Face of Reduced Federal Support for Medicaid Expansion: Results by State and Substate Region, Under the Scenario Where All States Drop the Medicaid Expansion; An "independent rural hospital" is defined as a hospital that is not identified as being affiliated through common ownership or joint management with a health system according to the U.S. Agency for Healthcare Research and Quality 2018-2022 Compendium of U.S. Health Systems database. For more information, see https://www.ahrq.gov/sites/default/files/wysiwyg/chsp/compendium/2022-Compendium-TechDoc.pdf.

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MCD2025-15