CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

The Two Different Types of Hospitals in the U.S.

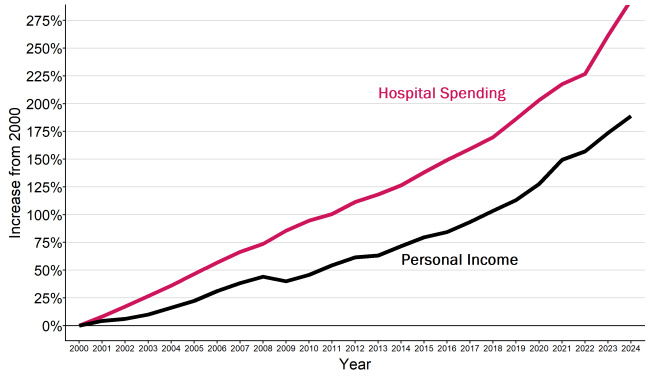
The Need to Control Hospital Spending Without Harming Patients

Hospitals are an essential part of the healthcare system. Although far more care is being delivered in patients' homes, physicians' offices, and ambulatory surgery centers today than in the past, there are many types of services that cannot be safely delivered in any setting other than a hospital.

Moreover, it is important for every community to have adequate hospital capacity available when it is needed. During the coronavirus pandemic, hospitals unexpectedly needed to provide care for tens of thousands of patients with COVID-19. Some communities were forced to erect temporary hospitals or inpatient units in order to ensure there would be adequate capacity to treat all patients who needed care.

However, hospitals are also very expensive. The United States spends more than $1.5 trillion each year on hospital services. More than one-third (36%) of total healthcare spending goes to hospitals, a far larger share than any other healthcare sector. Since 2000, national spending on hospital services nearly quadrupled, more than the increase in total healthcare spending and far more than the growth in personal income.

Cumulative Growth in National Hospital Spending and Personal Income, 2000-2024



Sources: CMS National Healthcare Expenditure Accounts, BEA Personal Income Data

Because hospitals represent such a large portion of total healthcare spending, it is impossible to make health care more affordable unless methods are found to control the growth in spending on hospital services. However, this must also be done in a way that preserves the ability of all citizens to obtain high-quality hospital care in a timely fashion.

As the country searches for policies that will control or reduce hospital spending while maintaining access to quality care, it is essential to recognize that the nation's hospitals fall into two very different categories: (1) small rural hospitals, and (2) urban and larger rural hospitals. These two groups of hospitals differ dramatically in terms of both the amount they contribute to healthcare spending growth and the size of the financial challenges they face in delivering healthcare to the communities they serve.

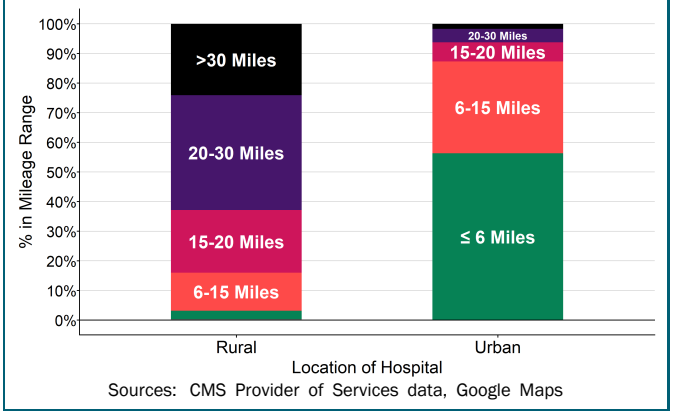
How Rural Hospitals Differ From Urban Hospitals

Over half of the nation's short-term general hospitals are located in rural areas. Rural hospitals differ from urban hospitals both in terms of size and distance from other hospitals:

Most rural hospitals are the only source of hospital care in their community. Most cities and urban areas have multiple hospitals that patients can use, but most rural communities have only one hospital that is easily accessible, if they have a hospital at all.

- The majority of urban hospitals are less than 6 miles away from another hospital, and over 80% are within a 15 mile drive from another hospital.
- In contrast, almost two-thirds of rural hospitals are more than 20 miles away from the next closest hospital, and one-fourth are 30 miles or more away.

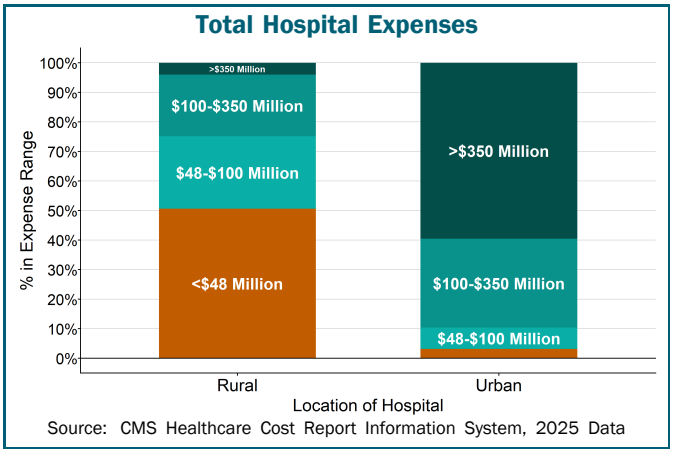
Driving Distance to Closest Alternative Hospital



Sources: CMS Provider of Services data, Google Maps

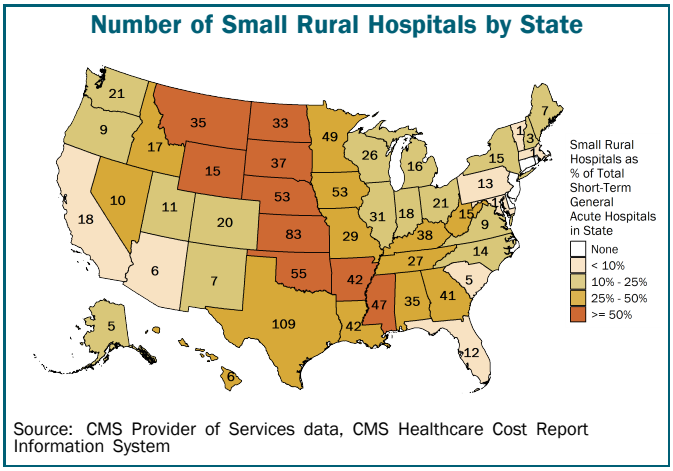
Most rural hospitals are much smaller than urban hospitals. Although there are some large hospitals located in communities that are classified as rural, most rural hospitals are much smaller than most urban hospitals. The size of a hospital has traditionally been defined in terms of the number of inpatient beds, but most of the services that hospitals deliver today are ambulatory care services, not inpatient care. Consequently, a hospital's total annual expenses is a better measure of its relative size than the number of inpatient beds.

- Most urban hospitals have over 250 inpatient beds, whereas most rural hospitals have 25 or fewer beds.
- More than half of urban hospitals have total annual expenses of more than $350 million, but less than 2% of rural hospitals are that large.
- One-half of rural hospitals have total expenses of less than $48 million, compared to only 2% of urban hospitals.



Six Differences Between *Small* Rural Hospitals and Other Hospitals

Small rural hospitals – those with annual expenses below the median for rural hospitals ($48 million in 2025) – deliver many of the same kinds of essential services that larger hospitals do. They have emergency services available around the clock, they provide basic laboratory tests and imaging studies, and they provide inpatient care and outpatient care for a wide range of health problems. However, they face far greater financial challenges in delivering essential healthcare services than both urban hospitals and larger rural hospitals.



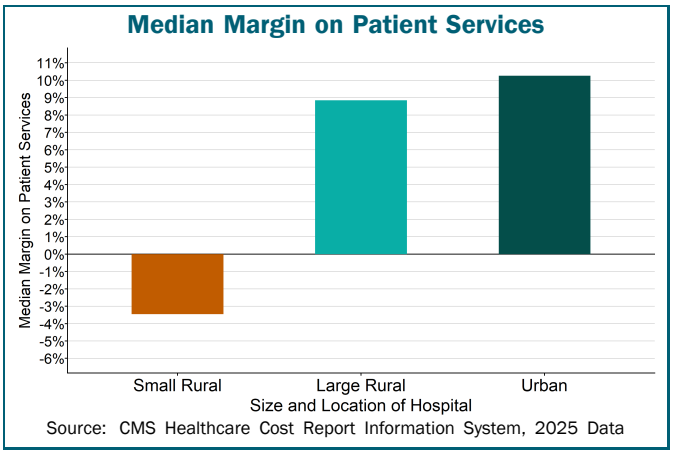
There are over 1,100 small rural hospitals in the country, representing over one-fourth of the nation's total short-term general acute care hospitals. Most states (46) have at least one small rural hospital; in 22 states, at least one-fourth of all the hospitals in the state are small rural hospitals, and in 9 of those states, 50% or more of the hospitals are small rural hospitals. Small rural hospitals are the principal source of healthcare for the residents and workers in many of the nation's agricultural areas and ranchlands; these communities use large amounts of land for crops and animals and have relatively few residents per square mile. In many cases, these hospitals are also the only source of primary care for the communities they serve.

There are six major differences between small rural hospitals and other hospitals that must be considered in establishing policies and payments for hospital services:

1. Losses on Patient Services

Most small rural hospitals lose money delivering services to patients, while most urban hospitals and larger rural hospitals make profits on patient services. The primary source of revenues for most hospitals is the payments for services they receive from health insurance plans. Most small rural hospitals are paid less for services by insurance plans than the cost of delivering those services. In contrast, most larger rural hospitals and urban hospitals have been paid more – often significantly more – than it costs them to deliver services to patients.

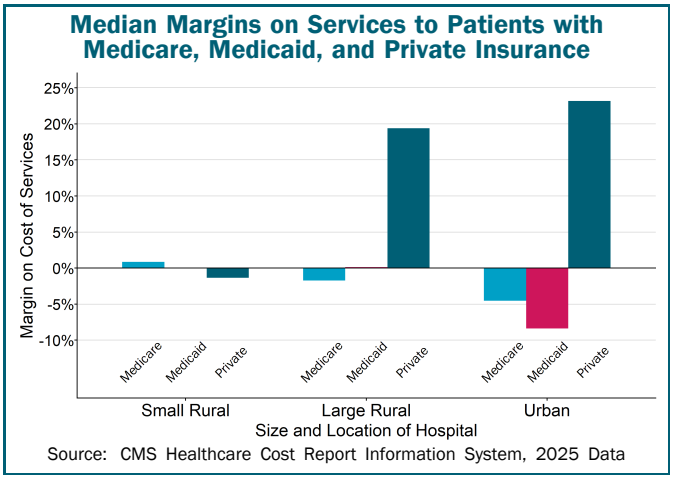
- 60% of small rural hospitals lose money delivering patient services. In 2025, the median margin on patient services for small rural hospitals was -3.5%, i.e., at the majority of the hospitals, payments were 3.5% or more below the amount it cost the hospital to deliver the services.
- In 2025, the median margin on patient services for larger rural hospitals was +8.9% and at urban hospitals it was +10.3%, i.e., most larger hospitals were paid more than it cost them to deliver their services.



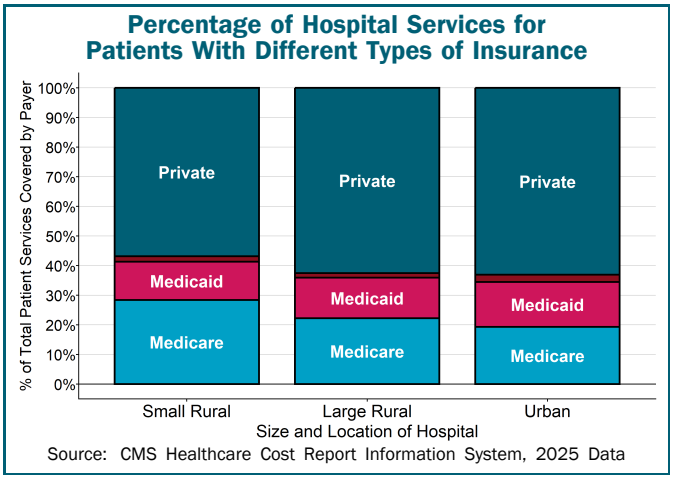
2. Inadequate Private Insurance Payments

Small rural hospitals lose money on patient services because of inadequate payments from private insurance plans, whereas urban hospitals and larger rural hospitals make large profits on services to patients with private insurance. Most hospitals lose money on Medicaid and uninsured patients, but whereas large hospitals can offset these losses with the profits they make on patients who have private insurance, small rural hospitals cannot.

- Over half of small rural hospitals lose money on services delivered to patients with private insurance (including Medicare Advantage plans). In 2025, the median margin at small rural hospitals for patients with private insurance was -1.4%. Over one-third of small rural hospitals lost more than 10% on services delivered to patients with insurance from private health plans.
- In contrast, most urban hospitals and large rural hospitals make high profits on services to patients with private insurance. In 2025, the median profit on patients with private insurance was +20% at large rural hospitals and +23% at urban hospitals. One-fifth of urban hospitals made profits of over 50% on services to patients with private insurance.



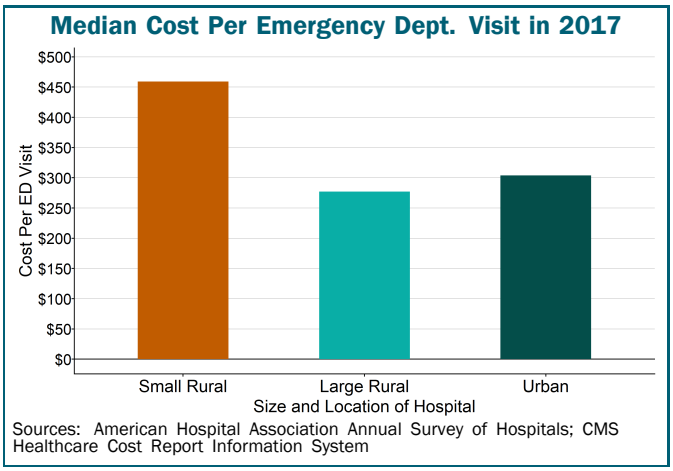
- A common myth about small rural hospitals is that almost all of their patients are on Medicare or Medicaid or are uninsured. In fact, on average, over half of the services at small rural hospitals are delivered to patients with private insurance, only slightly lower than the percentage in urban hospitals. As a result, low margins or losses on patients with private insurance, combined with losses on Medicaid and uninsured patients, cause small rural hospitals to have large overall losses on patient services.



3. Higher Cost of Delivering Services

Small rural hospitals need higher payments for essential services than larger hospitals because it costs more to deliver those services in communities with smaller populations. The average cost per patient of an emergency room visit, inpatient day, laboratory test, or imaging study is inherently higher in a small rural hospital than at a larger hospital. The reason is that there is a minimum level of staffing and equipment required to make sure these "standby" services are available on a 24/7 basis regardless of how many patients actually need to use them on any given day. For example, a hospital Emergency Department (ED) has to have at least one physician available around the clock in order to respond to injuries and medical emergencies quickly and effectively, regardless of how many patients actually have an emergency. Small rural hospitals have fewer ED visits because the communities they serve have fewer residents, but the minimum cost of staffing the ED will be the same (or even higher if it costs more to recruit physicians and nurses to the rural community), so the average cost per visit will be higher. Consequently, payments that are large enough to cover the average cost per service at larger hospitals will fail to cover the costs of the same services at small rural hospitals.

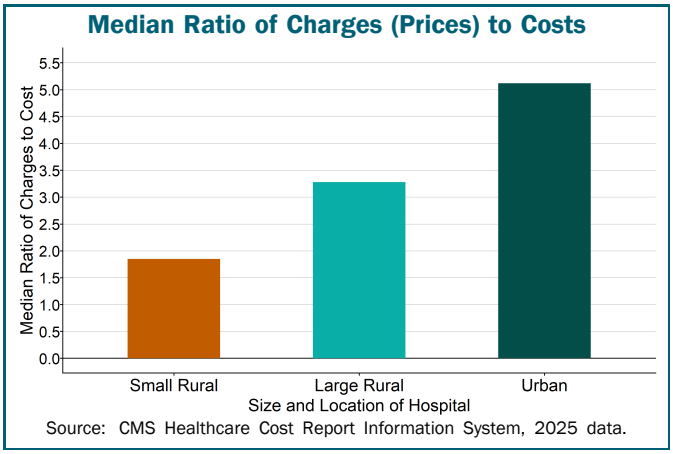
- In 2017, the median small rural hospital had fewer than 4,000 ED visits per year (about 10 visits per day). In contrast, the median was over 16,000 ED visits per year at larger rural hospitals and over 44,000 visits at urban hospitals (10 times as many as the median small rural hospital).
- Because of the smaller number of visits, the median small rural hospital had an average cost per ED visit of $462 in 2017, over 50% higher than the $278 cost per ED visit at the median large rural hospital and the $303 cost per ED visit at the median urban hospital.



4. Lower Charges Relative to Costs

Small rural hospitals charge much less for their services (as a percentage of their costs) than urban and larger rural hospitals do. The prices that any hospital charges for its services have to be high enough to cover the costs of delivering the services and also high enough to offset the losses on services delivered to those patients who do not have insurance, who cannot pay the cost-sharing amounts required by their insurance, or who have an insurance plan that pays less than the cost of services. However, many hospitals charge far more than is necessary to cover their costs.

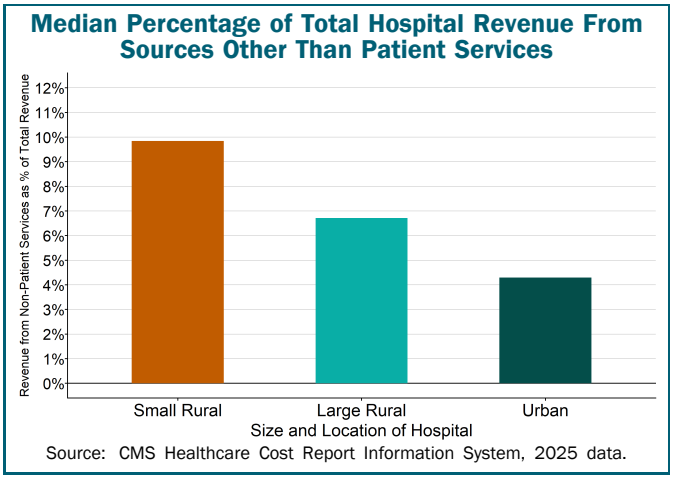
- Most urban hospitals charge more than five times as much as it costs them to deliver services. As a result, they can provide large discounts to private insurance plans and still make significant profits on their services. In 2025, the median urban hospital charged over 5 times what it cost to deliver services, and the median large rural hospital charged amounts that were over 3 times its costs. Over one-third of urban hospitals charged prices more than 6 times what it cost them to deliver services.
- In contrast, the charges for services at most small rural hospitals are less than twice what it costs the hospital to deliver those services. In 2025, the median small rural hospital charged only 1.9 times what it cost to deliver services. As a result, small rural hospitals suffer financially when they are forced to provide large discounts to health insurance plans.



5. Dependence on Government Funding

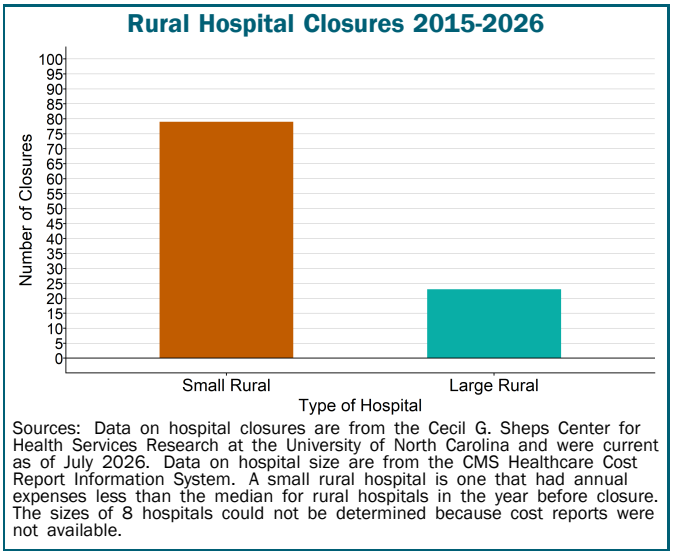
Losses on patient services make small rural hospitals more dependent on local tax levies, government subsidies, and other sources of income than urban hospitals and larger rural hospitals. If a hospital isn't paid enough by health insurance plans to cover the costs of delivering services to patients, the hospital has to find other sources of revenue in order to continue operating. Many small rural hospitals depend on local tax revenues, state grants, or profits on other activities in order to make up the losses on the services they deliver to patients.

- Most small rural hospitals receive more than 10% of their total revenues from sources other than payments for services to patients, and one-fifth receive more than 20% of their revenues that way.
- In contrast, most larger rural hospitals receive less than 7% of their revenues from sources and activities other than patient services, and most urban hospitals receive only 4% of their revenues that way.
- More than 40% of small rural hospitals are able to receive local and state tax revenues because they are government-owned or are operated by public hospital districts, compared to only 24% of larger rural hospitals and 10% of urban hospitals.



6. Greater Likelihood of Closure

Small rural hospitals are more likely to close due to inadequate revenues. If a hospital does not receive sufficient revenues from insurance payments or government funding to cover its costs over multiple years, it will ultimately be forced to close. Over 100 rural hospitals have closed in the past decade, and 72% of these closures have been small rural hospitals. Many more small rural hospitals would likely have been forced to close during the pandemic had it not been for the large federal grants they received. Since these grants were only temporary and small hospitals experienced significant increases in costs during and after the pandemic, more small rural hospitals may have to close in the near future unless better ways of paying them are implemented.

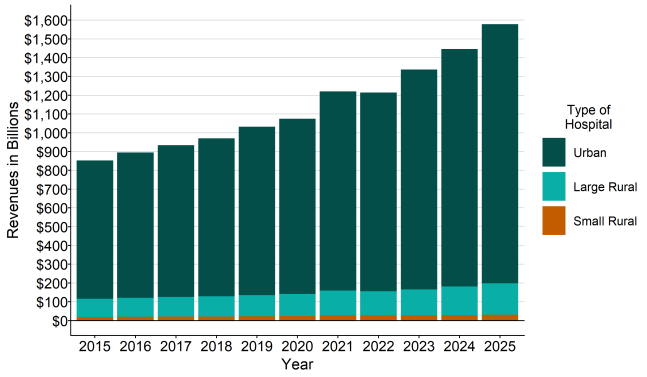


Efforts to Control Healthcare Spending Need to Differentiate Small Rural Hospitals and Larger Hospitals

Clearly, there are very significant differences between small rural hospitals and larger hospitals (both urban and rural). These differences have important implications for designing policies that control or reduce spending on hospital services while ensuring access to essential health services for citizens in all parts of the country:

- Little in the way of savings can be achieved by reducing payments to small rural hospitals. Although small rural hospitals represent more than 25% of the short-term general hospitals in the country, they receive only 2% of national spending on hospital services, and they account for only 2% of the significant increase in national hospital spending that has occurred in recent years. Revenues at small rural hospitals increased by $15 billion nationally from 2015 to 2025, compared to an increase of nearly $700 billion at urban and large rural hospitals. Even a large reduction in spending on services at small rural hospitals would have only a minuscule impact on total national healthcare spending.

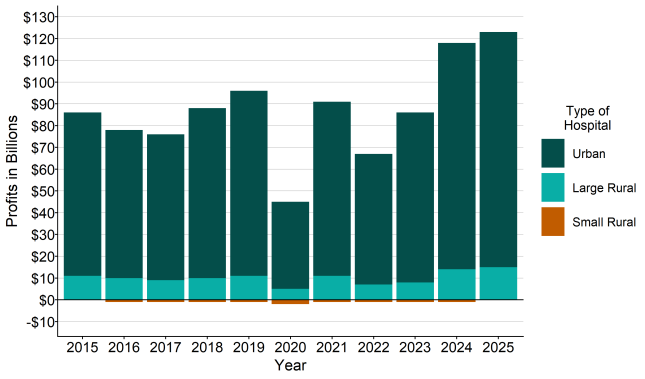
Total National Spending on Short-Term Acute Hospitals (Billions)



Source: CMS Healthcare Cost Report Information System‘

- Reducing payments to small rural hospitals will accelerate closures and reduce access to services for rural communities. Policies and programs designed to reduce spending on hospitals by cutting payments for hospital services or reducing utilization of hospital services will have a far more negative impact on small rural hospitals than larger hospitals, because profit margins at most small rural hospitals are already low or negative. Even a small reduction in revenues at small rural hospitals could force more of them to close. Although revenues decreased for most hospitals in 2020 due to the coronavirus pandemic, the majority of urban hospitals and large rural hospitals remained profitable, whereas an even higher proportion of small rural hospitals lost money on patient services. Many small rural hospitals were only able to continue operating because the special federal assistance provided to hospitals during the pandemic enabled them to offset these losses. In 2021, profits on patient services increased at urban and large rural hospitals, but most small rural hospitals continued to lose money on patient services. Most urban and large rural hospitals remained profitable in 2022, 2023, 2024, and 2025, while most small rural hospitals continued losing money on patient services.

Aggregate National Hospital Profits on Patient Services (Billions)



Source: CMS Healthcare Cost Report Information System

Rural Hospitals Need Better Payments from Both Private and Public Payers

The data show that there is little to be gained by reducing spending on small rural hospitals and much to be lost by doing so. Conversely, providing adequate payments to small rural hospitals could preserve access to essential healthcare services for rural communities with minimal impact on overall healthcare spending. The losses on patient services at all of the small rural hospitals in the country could be eliminated for only $2.2 billion per year – that is less than two-tenths of one percent of current national spending on all hospitals.

Unfortunately, Medicare payment policies are making things worse for small rural hospitals rather than better:

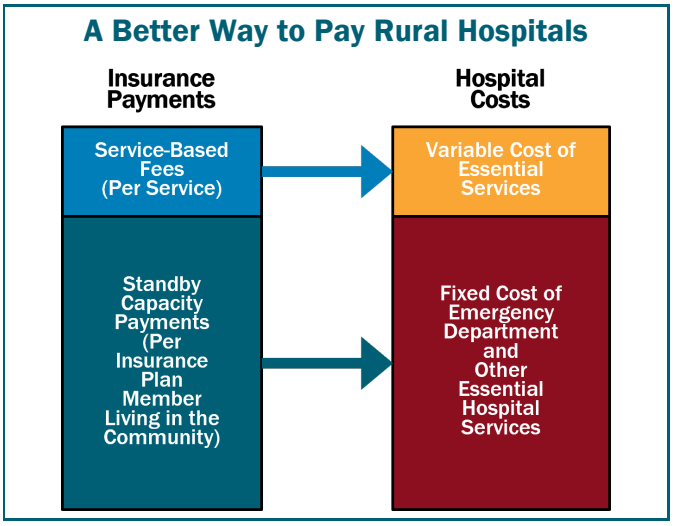
- **Cuts in Payments to Critical Access Hospitals.** Although Medicare Inpatient Prospective Payment System (IPPS) payments to hospitals increase each year, most small rural hospitals do not benefit from this. Over 80% of small rural hospitals are designated as Critical Access Hospitals and are not paid under IPPS. Medicare payments to Critical Access Hospitals were reduced because of the return of sequestration reductions. Medicare now pays Critical Access Hospitals only 99% of what it costs the hospitals to deliver services, which means that most small rural hospitals are guaranteed to lose money on services they deliver to Medicare beneficiaries.
- **Reducing Access to Inpatient Care.** The new federal Rural Emergency Hospital program has been promoted as a way of preventing rural hospital closures. However, it requires a hospital to close its inpatient unit, thereby eliminating a service that proved to be essential in most communities during the pandemic. This also prevents the hospital from delivering rehabilitation and long-term care services in its swing beds. In addition, unlike Medicare payments to Critical Access Hospitals, the payments for a Rural Emergency Hospital's outpatient services are not based on the actual cost of delivering hospital services in rural areas.
- **Creating Budgets That Are Smaller Than What It Costs to Deliver Care.** The Center for Medicare and Medicaid Innovation (CMMI) has proposed creating "global budgets" as a way of helping rural hospitals. However, the programs CMMI has developed to test this concept (the CHART and AHEAD Models) would increase losses for small hospitals by reducing their Medicare revenue.

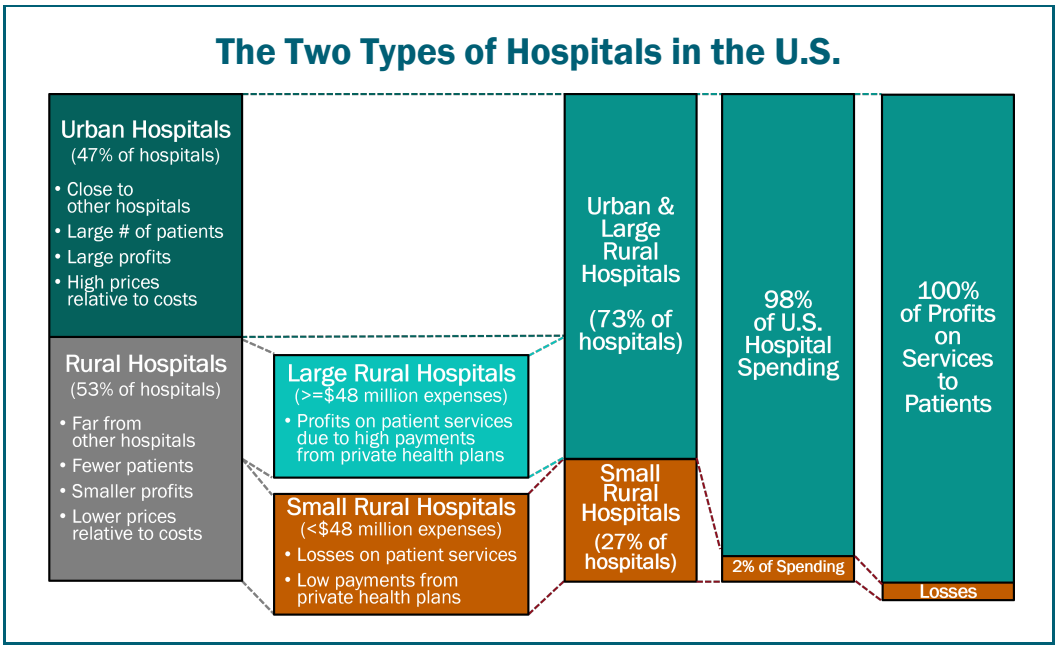
Moreover, most proposals for helping small rural hospitals have focused on changing payments under Original Medicare, even though the primary cause of financial losses at small rural hospitals is inadequate payments from *private* health insurance plans (including both employer-sponsored insurance and Medicare Advantage plans). Even if Medicare payments for small rural hospitals were increased, it would not prevent rural hospital closures unless there were also significant increases in payments from private health insurance plans, Medicare Advantage plans, and state Medicaid programs.

Creating A Better Way of Paying Small Rural Hospitals

The financial problems at small rural hospitals are caused not only by the inadequate *amounts* paid by private health insurance and Medicaid plans, but by the problematic *method* all payers use to pay for services. Small rural hospitals are paid for delivering individual services to patients, but there is no payment for what residents of a rural community would likely view as one of the most important services of all – the availability of physicians, nurses, and equipment to treat an injury or serious health problem quickly if the resident experiences an injury or problem. Having health insurance that pays fees for ED visits, laboratory tests, or treatments is of little value if there is no Emergency Department, laboratory, or treatment capability available in the community for the resident to use.

A hospital's ability to deliver a service on short notice is often referred to as "standby capacity," because a minimum level of personnel and equipment must be standing by in case a patient needs the service, even if it turns out that no patient actually does need it. The coronavirus pandemic made many people aware for the first time that current payment systems do not ensure that hospitals have enough standby capacity to handle unexpectedly large increases in the number of patients who need hospital care. While large hospitals can pay for the costs of standby capacity using the profits they make on delivering services, small rural hospitals do not have that ability.



Communities don't support their fire departments by charging high fees to people who are unlucky enough to have fires, and small rural hospitals shouldn't be forced to support themselves solely by charging high fees to people who are ill or injured. In order to preserve and strengthen essential hospital services in rural communities, small rural hospitals need to receive two types of payments from both private and public payers: ***Standby Capacity Payments*** to support the fixed costs of essential services at the hospital, and ***Service-Based Fees*** to cover the additional costs incurred when individual services are delivered.

More details on how to design and implement this approach are described in the Center for Healthcare Quality and Payment Reform's report *A Better Way to Pay Rural Hospitals*. Citizens, businesses, local governments, state government, and the federal government must all take action to ensure that every payer provides adequate and appropriate payments for small rural hospitals before more rural communities lose access to essential healthcare services.