Azalea HEALTH

2026

The Definitive Guide **to Rural Healthcare**

Essential Topics for Rural Healthcare Leaders

I'm excited to share this copy of *The 2026 Definitive Guide to Rural Healthcare* with you. It includes practical tips, solutions, and strategies that I hope help you tackle the unique challenges of the rural healthcare landscape.

Whether you run a rural clinic, hospital, or health system, I hope this guide makes your work a little easier. I also hope it offers help as you build a thriving operation that serves your community, especially as you navigate the impacts of the One Big Beautiful Bill Act (OBBBA), and the opportunities of the Rural Health Transformation (RHT) Program.

Reach out to Azalea Health anytime. We are here to work with you as you make an impact on rural healthcare.

Best,



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OBBBA, the RHT Program, and the Years Ahead for Rural Healthcare

In the coming years, rural healthcare may get more challenging than ever — for providers and patients. Because of the One Big Beautiful Bill Act (OBBBA), an estimated 2.7 million people in rural America may be left insured by 2034. And $137 million fewer Medicaid dollars may be available in rural areas.

The Rural Health Transformation (RHT) Program's $50 billion fund for states over five years may help. States will get at least $100 million a year and up to $200 million a year. That still leaves a projected deficit of $87 billion.

It's not good news, but things aren't hopeless. OBBBA impacts don't take effect all at once. The RHT Program will infuse funds into rural America. And there are private grants that can help.

Committed to Your Future

To help you navigate the years ahead, Azalea Health is maintaining and sharing resources with you in an online OBBBA and RHT Program Resource Center, including articles, a timeline, live and on-demand webinars, and links to CMS, independent, and health association pages and resources.

Find the center at www.azaleahealth.com/obbba. It's updated often. And if you see something you'd like added, let us know.

One thing you'll find in the resource center is a timeline with potential impacts to Medicaid, the ACA, RHT Program, and Medicare. Find the full timeline at www.azaleahealth.com/obbba-timeline.

A Timeline of Medicaid-Specific Changes Through 2026

2025

July 1 — State directed payments (SDPs) capped at 100% of Medicaid rates in expansion states and 110% in non-expansion states; SDPs for states that exceed caps start rolling back in January 2028.

December 31 — Medicaid eligibility redetermination period reduces from 12 to 6 months for expansion enrollees not on an MEC waiver.

2026

January 1 — Incentive for non-expansion states to take Medicaid expansion financing ends.

October 1 — Unlawful immigrants are ineligible for Medicaid and CHIP; enhanced federal funding for emergency Medicaid for undocumented immigrants ends.

December 31 — Adults 19 to 64 must work, do community service, or receive education for 80 hours a month to be eligible for Medicaid. States with approved Section 1115 waivers may start earlier. One-time compliance exemptions may let some states delay until December 31, 2028.

The content here reflects Azalea Health's understanding of the OBBBA and related programs as of the time of publication. It's intended for informational purposes only and should not be considered legal, financial, or medical advice. Please consult official sources or qualified professionals for guidance specific to your organization.

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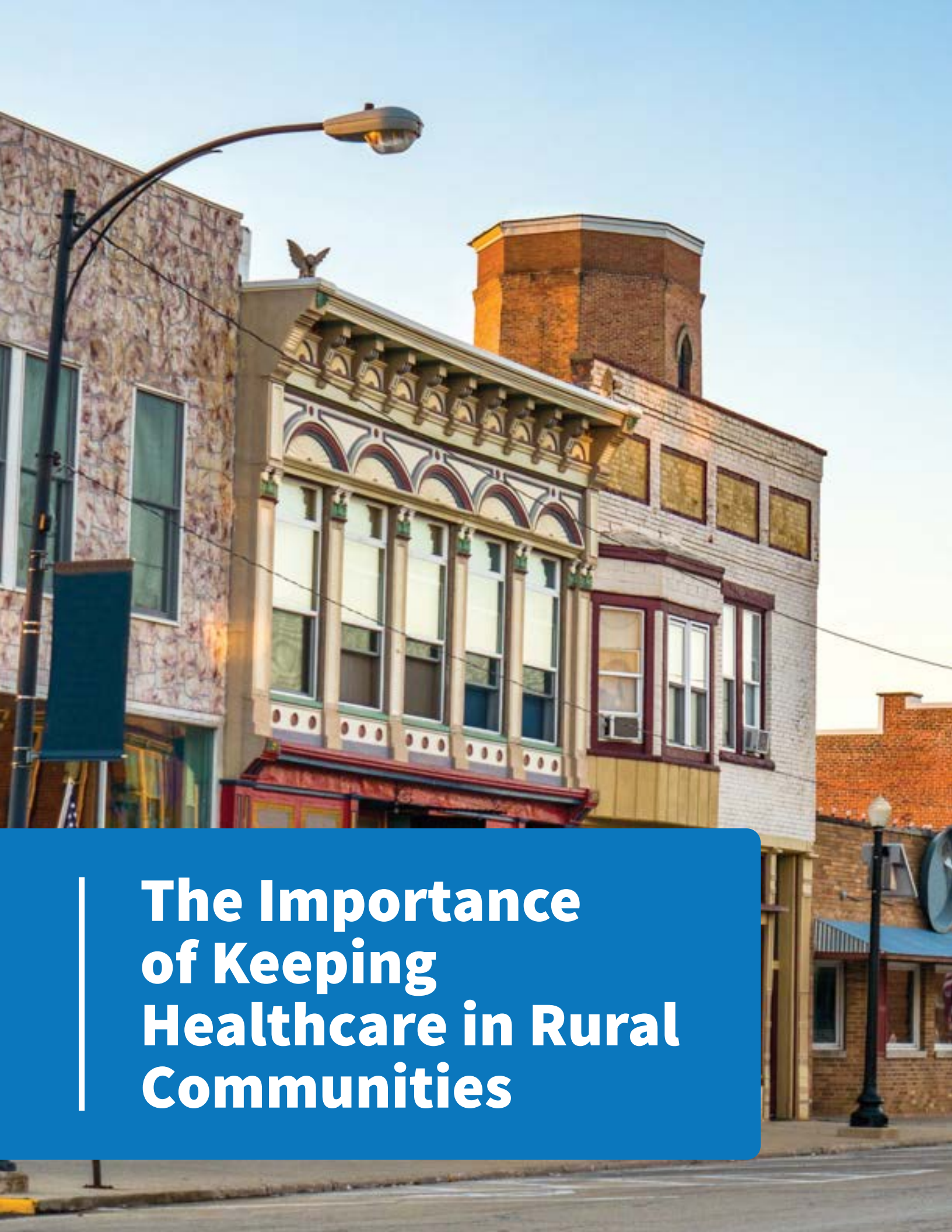
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The Importance of Keeping Healthcare in Rural Communities

The health of residents and the vitality of the community are interconnected. Keeping healthcare services within a community ensures access, improves health outcomes, and strengthens the local economy. And access to local care can help rural areas thrive.

Your practice or facility is more than just a business — it's a vital lifeline for the people you serve.

Why Local Healthcare Access Matters to Patients

An estimated one in five Americans live in a rural area — that's approximately 66 million people.[1] But local access to quality healthcare is limited for many because rural areas often have a shortage of physicians and medical facilities.

As a result, rural residents have significant health disparities. Healthcare barriers contribute to unaddressed health problems, limited access to preventive care and screenings, difficulties in managing chronic conditions, and ultimately, shorter life expectancies for rural residents.[2]

Access to healthcare close to home plays a vital role in improving health outcomes. Proximity to healthcare services isn't just convenient, it's critical.

Travel Times Make a Difference

When healthcare is available locally, patients are more likely to seek treatment when they need it. Without access to nearby providers, many rural residents delay or even skip necessary care due to long travel times, lack of transportation, or financial constraints.

Nearly one-third of adults living in rural areas lack access to high-quality surgical care at an affordable cost within an hour's drive.[3] Delays can turn manageable conditions into serious or chronic illnesses, not to mention longer and more expensive hospital stays.

Emergency Care Can't Wait

In an emergency, every minute matters. Long travel times to the nearest hospital or emergency facility increase the risk of complications and even death. A study published in *The American Journal of Managed Care* found that extended travel times for emergency surgeries are linked to higher mortality rates and added strain on health systems.[4]

Ensuring that emergency services are nearby is a life-saving necessity for rural communities.

Almost a third of adults in rural areas lack access to high-quality surgical care at an affordable cost within an hour's drive.

Chronic Disease Management Requires Ongoing Access

For individuals managing chronic conditions, like diabetes, hypertension, or heart disease, routine care is essential. When healthcare is local, it's easier for patients to get regular check-ups, and for you to adjust medications, and monitor symptoms. Consistent care can prevent costly complications and hospitalizations and lead to better quality of life and long-term outcomes.

Preventive Care Starts with Proximity

People are more likely to have preventive services, such as screenings, vaccinations, and annual wellness exams, when they're easy to access. Rural



residents with local healthcare options are more likely to take advantage of these services, which can detect issues early, reduce disease transmission, and lower overall healthcare costs.

Without local providers, preventive care often falls by the wayside and results in missed opportunities for early intervention.

How Local Healthcare Supports Stronger Communities

Healthcare is a powerful economic engine in rural communities. Beyond the direct benefits to individual health, nearby hospitals, clinics, and medical practices are critical for sustaining and strengthening the local economy.

Healthcare Facilities Create Jobs

Hospitals and clinics like yours are often among the largest employers in rural towns.[5] For example, Colorado's rural hospitals employ 16,000 community members.[6]

Rural healthcare facilities provide stable, well-paying jobs for healthcare professionals, administrative staff, maintenance crews, and more. Your employees, in turn, support surrounding businesses and create a ripple effect of economic activity.

Local Healthcare Keeps Dollars Local

When residents receive care close to home, their healthcare spending stays within your community. This recirculation of healthcare dollars strengthens the local tax base and provides funding for other essential services.

Access to Medical Services Attracts and Retains Residents

Access to quality healthcare is a deciding factor for many families, retirees, and business owners when choosing where to live or invest. Communities with a strong healthcare infrastructure are more likely to attract new residents and businesses and retain the ones they have. Local medical access is a vital part of long-term population stability and economic growth.

Strong Healthcare Systems Create Community Vitality

Well-developed healthcare systems contribute to the overall vitality of rural towns and regions. They help schools thrive by ensuring students and educators are healthy, support local government through job creation and tax revenue, and foster a sense of security that encourages civic investment and pride.

The Socioeconomic Value of Local Care

Access to local care plays a critical role in reducing

health disparities. In 1999, adults ages 25 to 54 living in rural areas experienced a natural-cause mortality rate just 6% higher than their urban counterparts. By 2019, that difference had grown to 43%.[7]

Beyond improving health outcomes, the local care you and your staff provide enhances overall quality of life. It helps residents age in place, maintain their independence, and remain connected to the community. In times of crisis, like pandemics, natural disasters, or events like the deadly July 2025 floods in central Texas, having accessible, responsive medical services nearby was essential to protecting lives and ensuring a swift community recovery.[8]

Ways to Keep Healthcare in Your Community

Sustaining local care requires a proactive, community-driven approach. Advocacy, innovation, and strong local partnerships — combined with expanded services like behavioral health, telehealth, and chronic disease management — can strengthen access and impact. Investing in essential technology and supporting workforce recruitment and retention through incentives and grants are also key to keeping care close to home.

By providing, prioritizing, and protecting local care, you help your community thrive.

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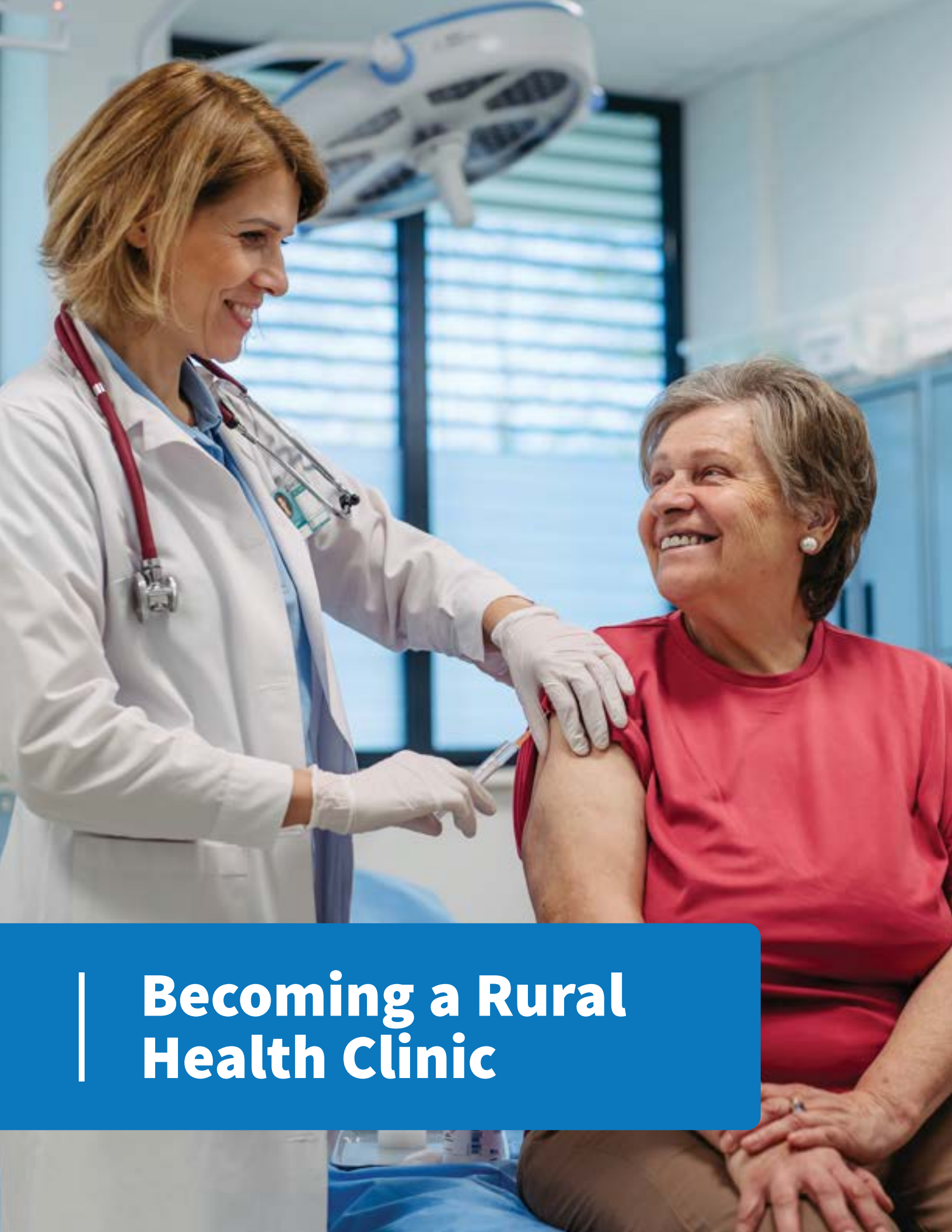
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Becoming a Rural Health Clinic



RHCs are outpatient facilities certified by the Centers for Medicare & Medicaid Services (CMS) to provide primary care services in underserved rural areas. The 5,200-plus RHCs across the country play a crucial role in expanding access to care, improving reimbursement, and strengthening community health.[9]

If you operate a rural practice, you may wonder whether becoming a rural health clinic (RHC) is the right move. RHC status can open new possibilities for your practice, potentially increase revenue, and expand access to care for your patients.

What Makes RHC Status Valuable

Becoming an RHC can strengthen your clinic's financial stability and broaden your scope of services. The primary financial advantage is that RHCs use a cost-based reimbursement to receive enhanced Medicare and Medicaid payments based on reasonable cost, which can increase revenue compared to traditional reimbursement models.

In 2025, the Medicare RHC All Inclusive Rate (AIR) Payment Limit for independent RHCs and provider-based RHCs in a hospital with 50 or more beds is $152 per visit.[10]

Medicaid reimbursements vary by state but are also cost-based for RHCs.

Say that 70% of your clinic's patients use Medicare or Medicaid and you see 100 patients a month:

- If you charge $100 a visit on a traditional payment model, you would get $10,000 that month from visits.
- After moving to RHC status, you would get up to $15,200 at 2025 AIR rates — a 52% increase.

Additional advantages of RHC status include:

- **Expanded access to patients** by permanently serving as a distant site provider for behavioral and mental telehealth services.
- **Staffing support and flexibility** with equal reimbursement rates for both physician and non-physician providers.
- **Operational flexibility** by adjusting staffing to better meet community needs.
- **Access to grants and technical assistance** available exclusively to RHCs.
- **Improved community standing** with a reputation as a trusted local provider that offers accessible care.
- **Recruitment advantage** in attracting providers who want to serve in a mission-driven, rural healthcare environment.

RHCs qualify for higher Medicare and Medicaid reimbursement rates per visit.

RHC Eligibility

Before applying for RHC status, assess whether your practice meets the required criteria. Not every practice will qualify. Your practice needs to meet all requirements.

1. Your practice is in a non-urbanized, rural area with an HPSA or MUA designation as determined by federal data and census information or in a Governor Designated and Secretary certified shortage area, and that has a population of less than 50,000.
2. Your practice isn't located at the same physical space as a Federally Qualified Health Center (FQHQ), although it can be in the same building.
3. Your practice isn't a rehabilitation or mental health facility.
4. Your practice is under the medical direction of a physician (MD or DO) and employs at least one nurse practitioner (NP) or physician assistant/associate (PA).
5. You dedicate at least 51% of your practice's operating hours to primary care services.
6. An NP, PA, or certified nurse-midwife (CNM) provides patient care services at least 50% of the time your practice operates.
7. Your practice provides a defined set of routine diagnostic and laboratory services.

Financial and Other Considerations

RHCs whose patient mix includes a high percentage of Medicare and Medicaid patients may benefit most. Clinics with patients covered mainly by commercial insurance still receive payment for these services at standard rates.

As you consider becoming an RHC, evaluate whether higher RHC payments for Medicare and Medicaid patients could offset declining reimbursements. Also factor in the cost of hiring a PA or NP if you don't already employ one.

Each year, RHCs have to submit cost and credit balance reports and undergo periodic state or federal surveys to ensure they meet standards. Your staff will need trained on RHC-specific billing processes, such as bundled and split billing. You also want to understand requirements related to EMR/EHR) use, such as the ability to generate 8371 electronic claims, comply with HIPAA and other regulations, and support quality reporting.

Steps to RHC Certification

Becoming an RHC follows key milestones that need completed in order.

1. **Document preparation:** Gather IRS records, incorporation papers, and board member information, and ensure everything is accurate and up to date.
2. **CMS application and provider enrollment form:** Submit your application and enrollment for initial certification.
3. **State or RHC accreditation organization evaluation:** After CMS verifies your eligibility, have your state or an RHC accreditation organization conduct an on-site inspection, which can take from four hours to two days.
4. **Tie-in notice (TIN):** Once you pass the evaluation, you'll receive a TIN that lets you bill for RHC services. You'll want input from someone familiar with applicable cost reports to establish Medicare and Medicaid rates as well.

More On Becoming an RHC

Converting to an RHC takes time, investment, and ongoing compliance. But for clinics serving underserved rural populations, the benefits can be significant — improved reimbursement, expanded services, and a stronger role in community health. By understanding the requirements and preparing, you can position your practice for success as a certified rural health clinic.

Learn more in the cms.gov Rural Health Clinic Fact Sheet at cms.gov/files/document/rhcfactsheetpdf.

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Best Practices to Maximize RHC Reimbursements



In 2023, hospitals absorbed $130 billion in Medicare and Medicaid underpayments — a roughly 14% annual increase over 2019.[11] And underpayments are one reason rural health clinics (RHCs) and providers want to capture every possible reimbursement dollar.

Medicare payment updates, like the newly finalized FY 2026 Inpatient Prospective Payment System (IPPS) 2.6% rate increase, will help.[12] But, by themselves won't be enough.

To protect your financial health, you need consistent, proactive strategies to maximize reimbursements.

The following best practices offer practical information and steps your RHC can take to better ensure reimbursements and improve financial stability.

RHC Medicare Bundling Rules

Bundling rules are established Medicare policy and define the services included in the All-Inclusive Rate (AIR) payment and that bill separately or are nonbillable under Medicare RHC guidelines. Understanding bundling rules that impact RHC billing practices is critical to ensure maximum and efficient reimbursements.

Some bundling rules differ for independent and provider-based RHCs (PB-RHCs). For **both independent RHC and PB-RHCs**, the following bundling rules apply.

- **Evaluation and management (E/M) visits** are subject to AIR for qualifying visits
- **Mental health services** are subject to the AIR if core service is rendered
- **Telehealth visits** are subject to AIR with RHC specific HCPCS codes
- **Minor procedures during a visit**, such as wound care, or lesion removal, are bundled as part of a qualifying visit, such as a primary visit at the same time
- **Injections or immunizations administered during visit** when a vaccine is administered is bundled; the vaccine itself is billed separately
- **Lab specimen collection** (for example CPT 36415), is bundled into the AIR and not separately reimbursed
- **Preventive services** are paid at 100% of AIR and may be bundled with another visit on same date of service (DOS)
- **Chronic care management (CCM) services** aren't bundled and are billed outside of a standard visit
- **Transitional Care Mgmt (TCM)** aren't bundled and are billed outside of a standard visit
- **Remote patient monitoring (RPM)** aren't bundled and are billed outside of a standard visit (CPT 99453 and 99454)

Billing categories that differ for RHC and PB-RHCs.

Independent RHCs	PB-RHCs
Radiology (x-rays, ultrasounds)	
Not bundled; split billing to Medicare Part B	May require split billing under parent hospital to Medicare Part A
Laboratory tests (CBC, urinalysis)	
Not included in AIR, billed separately to Medicare Part B	Not included in AIR, billed separately under parent hospital

At a high level, if a visit is part of the face-to-face provider encounter with an RHC-qualified practitioner, it's bundled. If it's diagnostic (lab, x-ray), durable (DME), or performed independently of a provider encounter, it's not bundled.

Maximizing reimbursements lets you reduce denials, capture missed revenue, and strengthen your ability to deliver care.

More Bundling Tips

- Two visits for the same condition on the same DOS are bundled and paid as one AIR
- Medical and mental health visits on the same DOS aren't bundled and are paid separately at the AIR rate
- Sick and preventative visits on the same DOS are bundled unless certain conditions (separate medically necessary illness or injury) occur, which lets them be billed and paid separately at the AIR rate

RHC 30-Day Rule

To ensure reimbursements for Medicare patients, knowing the 30-day rule is key. It applies to encounter-based, not fee-for-service billing. It specifies that if a Medicare patient has multiple same visit types (medical or mental health) at an RHC within 30 days for the same condition, only one encounter is billable. The exception is if the visits are clearly separate and distinct, and you show that the diagnosis/illness is unique from the preventive service.

Also, you can roll related services in a 30-day window into a single encounter and bill unrelated preventive services (AWV, IPPE) separately.

Medicare Credentialing and Recredentialing

Keeping Medicare credentialing current is key to maximizing reimbursements. Delays or errors can cause denials, payment interruptions, or even termination.

You want to maintain a centralized log or checklist with an automated tracking system to track your renewal dates. Tracking with simple spreadsheets and calendar reminders can help prevent costly gaps as can credentialing software.



You also want to monitor the Provider Enrollment, Chain, and Ownership System (PECOS) regularly for accuracy and notifications and quickly make updates and/or respond to revalidation notices.

Common Denials That Affect Reimbursements

A great way to maximize reimbursements is to understand common denials and address them before they happen.

Eligibility and Insurance Coverage

Medicare coverage that shows as inactive or covered by another entity, such as Medicare Advantage, frequently causes denials for RHCs that treat large volumes of Medicare patients. Medicaid patients often have lapses or transitions between Managed Medicaid plans, and lapses in or loss of coverage may increase as a result of the One Big Beautiful Bill Act (OBBBA).

To reduce denials, run eligibility checks at scheduling and check-in, and use real-time automated verification and discovery tools to flag issues early.

Coding and Modifier Errors

Incorrect CPT/HCPCS, missing required modifiers (such as CG), or mismatched diagnosis/procedure commonly lead to denials.

To prevent issues, stay current on ICD-10 and CPT/HCPCS code updates, build and maintain claim edits or scrubbing tools in your electronic health record/practice management (EHR/PM) system, and ensure your staff are trained to spot and correct coding errors. Also consider automated tools to detect and flag missing codes for billers.

Bundling Errors

Claiming services separately that are already included in the RHC AIR, such as lab draws or minor procedures, can cause denials or recoupments.

To prevent issues, have the Medicare qualifying visit list accessible, keep a list of bundled versus unbundled service by type and a list of bundling rules for Medicare versus Medicaid, and configure your EHR/PM system to bundle correctly.

Prior Authorizations

Medicare Advantage and other payers will deny claims for services that require prior authorization (PA) that wasn't attained. And in 2026, traditional

Medicare will require PA for certain services in six pilot states as part of the new CMS Wasteful and Inappropriate Service Reduction (WISeR) model.

To prevent denials now and as the WISeR model takes effect, maintain a list of services that require a PA broken down by insurance plan, document PAs with dates and reference numbers in the patient record, and build claim edits and alerts to flag claims with missing PA numbers before submission.

Also consider an AI-powered clinical billing assistant that can flag errors in real time, improve accuracy, and save your staff hours of manual work.



Strengthen Your Financial Health

By focusing on best practices, your RHC can help reduce financial risk, capture more accurate payments, and strengthen its ability to serve your patients for the long term.

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Access New Lines of Revenue by Diversifying Services



With typically tight margins, rural healthcare facilities have a unique opportunity to strengthen their financial health by expanding and enhancing the services they offer.

The One Big Beautiful Bill Act (OBBBA) passed in July 2025 makes it especially timely to explore new ways to increase revenue flows. And many rural hospitals and clinics are already taking steps or considering plans to diversify services to create added income streams to help secure long-term sustainability.

Why Diversification Matters

Even modest service additions can deliver substantial impact for rural hospitals, clinics, and providers. One rural hospital introduced monthly cataract surgery days — a move that restored trust, improved satisfaction, and brought in $1.2 million in annual revenue.[13] Whether it's colonoscopies or cardiology consults, the right specialty services can generate meaningful revenue while meeting unmet patient needs.

To keep pace with evolving health needs and strengthen a facility's future, rural providers can look beyond traditional care models.

"We've added wound care, an ortho clinic, and a cardiology clinic," said Brian Miller, CEO of DeWitt Hospital, DeWitt, Arkansas. "We're still looking every day for services to create the cashflow we need. It really depends on your community and the needs of that community. But the ones we've brought in are working really well for us."

Strategic service line expansion — from post-acute care to telehealth — offers a way to increase access, diversify income, and raise the standard of care. Following are some specialty options worth exploring.

Swing Bed and Skilled Nursing Expansion

By expanding swing bed and skilled nursing services, rural hospitals can provide post-acute care locally while generating higher daily revenues than with traditional inpatient stays. These services reduce readmissions, support patient recovery near home, and help diversify income sources.

Telepsychiatry and Counseling

Mental health and dementia care are persistent gaps in rural communities. One-fifth of people living in rural areas — approximately 6.5 million people — have a mental illness.[14] And the older population in

rural areas increases the need for dementia care, which is often complicated by a lack of available providers.

Telepsychiatry and virtual counseling help address these needs by offering accessible, discreet services for anxiety, depression, trauma, dementia, and more to both patients and caregivers. They also strengthen your position as a comprehensive care provider.

Crisis Stabilization Units

Crisis stabilization units (CSUs) offer short-term (24 to 72 hour) care for individuals having behavioral health crises. These units reduce emergency room overload, lower psychiatric hospitalizations, and provide a vital safety net during acute mental health episodes.

Telehealth and Remote Patient Monitoring (RPM)

Telehealth extends care to patients facing transportation barriers or mobility issues. When combined with remote monitoring devices, it lets you continuously manage chronic conditions, reduce unnecessary ER visits, and improve patient outcomes.

Hospital-at-Home and Post-Acute Remote Monitoring

Hospital-at-home programs let eligible patients get acute care at home, which frees up hospital capacity and cuts costs. Post-discharge remote monitoring similarly enhances recovery and reduces complications.

TeleSpecialist Consults

Many rural residents lack access to specialty care. Teleconsults in fields like neurology, cardiology, and dermatology increase access while they reduce the need for long-distance travel and improve care coordination. They also keep patients in your system.

Line and Wound Care

Outpatient and/or mobile line and wound care services support patients with central lines, chronic wounds, and infections. These programs minimize complications, reduce emergency visits, support rural healthcare systems, and offer steady revenue from ongoing care.

> "We've added wound care, an ortho clinic, and a cardiology clinic. It really depends on your community and the needs of that community. But the ones we've brought in are working really well for us."
>
> — Brian Miller, CEO of DeWitt Hospital, DeWitt, Arkansas

Outpatient Infusion Centers

Chronic conditions, like cancer or rheumatoid arthritis, can require regular infusions. By establishing outpatient infusion centers, you can offer convenient, high-value services locally while improving adherence and patient satisfaction.

Chronic Disease Management

Programs focused on treating diabetes, asthma, heart disease, arthritis, chronic kidney disease, and other chronic conditions provide patients with education, monitoring, and regular follow-up. These initiatives reduce hospitalizations and fit within value-based care models that reward quality outcomes.[15]



Community-Based Services

Community-based offerings help build trust while unlocking recurring revenue streams and include:

- **Pharmacy (340B expansion)** — contracting with retail pharmacies through the 340B Drug Pricing Program improves medication access, increases prescription capture, and brings in additional revenue that can help fund broader care services. In 2020, 340B hospitals delivered nearly $85 billion in community benefits — a 25% increase from the previous year.[16] Without the financial support of the 340B program, many communities nationwide would face reduced access to essential, lifesaving care.
- **Primary care and walk-in clinics** — local access to primary and urgent care reduces strain on emergency rooms and offers early prevention. These clinics also drive referrals for diagnostics and specialty care within your health system.
- **Wellness programs** — subscription-based wellness services, like nutrition counseling, weight loss, smoking cessation, and diabetes prevention, encourage healthy lifestyles and create consistent income while reinforcing your facility's role in preventive care.

What to Consider Before Adding Services

Before adding services, take a strategic, data-driven approach that aligns community needs with organizational capacity. Start by assessing your community's current and projected demand. Identify service gaps by analyzing health data and listening to patients. This ensures new services you offer are relevant and improve engagement.

Evaluate your payer mix to confirm a sustainable balance of Medicaid, Medicare, commercial, and self-pay patients. Also assess staffing readiness, because expansion without trained personnel can strain your resources and reduce care quality.

Review regulatory and licensing requirements, especially for services, like telehealth, behavioral health, or swing bed.

And ensure your operational infrastructure, such as technology, billing, and care coordination, can support long-term growth.

Thoughtful planning in these areas lays the groundwork for your facility's sustainable and impactful service expansion.

Your Community's Health Starts with You

Your facility is crucial to your community's health, economy, and identity. As rural populations grow and resources tighten, success depends on creative, community-driven strategies that strengthen care and financial stability.

Whether through an outpatient infusion center, telehealth, or a wellness initiative, meeting people where they are physically, emotionally, and culturally is key. Your expansion efforts build trust, improve the lives of people in your community, and ensure that geography doesn't limit care.

One rural hospital introduced monthly cataract surgery days — a move that restored trust, improved satisfaction, and brought in **$1.2 million in annual revenue.**[13]

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Navigating the Grant and Funding Process in 2026

Rural healthcare comes with more than its fair share of financial, workforce, and resource challenges. One way to help with one or all three is through grants and other funding opportunities.

And while the passage of the One Big Beautiful Bill Act (OBBBA) in July 2025, affected, or will affect, the availability of many traditional federal grants, it introduced the Rural Health Transformation (RHT) Program, so that rural medical facilities of all types receive funding to help offset potential losses in revenues.

The Rural Health Transformation (RHT) Program

The RHT Program is not a grant, but part of the OBBBA. It directs $10 billion federal dollars toward rural medical facilities each year from 2026 to 2030, for a total of $50 billion.

Centers for Medicare & Medicaid Services (CMS) will distribute RHT Program funds. Half of funding will be shared equally by states that submit a rural health transformation plan to CMS by November 5, 2025. How states plan to distribute funds in-state is up to the state.

The remaining half will be distributed by CMS based on each states' rural populations and needs and other CMS criteria.

States can plan to let rural facilities use RHT Program funding for provider payments, workforce recruitment and training, new technologies, support for opioid use treatments, mental health services, preventive care, and chronic disease management.

What Rural Health Grants Are Available?

While the changes brought on by the OBBBA make the future of many federal grants unknown, the RHIhub lists other grants. Some grants that were accepting applications at the time of publishing on an ongoing basis include the following.

Universal Service's RHC Healthcare Connect Fund (HCF) Program

This program gives individual healthcare providers (HCPs) and groups of HCPs a 65% discount on broadband costs to help bring digital health solutions to rural areas.[17]

> "A big portion of what funds rural health is private foundations. There are hundreds out there that do have grant funding available."
>
> — Robert Dudzinski, Partner, Rudzina Health

USDA Distance Learning and Telemedicine Grant

The USDA grant helps rural communities use technology to connect the rest of the area, state, and country. This grant has been funded for 2026.[18]

While these national grants are available, others exist. Private foundations often offer local or regional grants. And sometimes, less popular — and even local — grants are less competitive.

Non-Grant and Private Grant Funding

Not all funding opportunities are federal grants. Private foundations and businesses also offer grant, funding, and support services for rural healthcare providers. A few to consider include those below.

Funding Opportunity	Provider	Available Assistance
Preventive Care Access[19]	Patterson Family Foundation	One of four 2025 grants specific to rural community healthcare organizations. And one example of a private foundation grant.
Rural Health Care Outcomes Accelerator[20]	American Heart Association	Free quality programs for coronary artery disease, heart failure, and stroke; access to consultants
Google's Rural Healthcare Cybersecurity Initiative[21]	Google, Health Information Sharing and Analysis Center	Technology, consulting and support services, and security training resources at a discount or no cost
Microsoft Cybersecurity Program for Rural Hospitals[22]	Microsoft	Grants and discounts; new Microsoft 365 E5 Security licenses at no cost for one year for hospitals already using eligible Microsoft solutions; free security assessment and training

Help Finding and Applying for Grants and Other Funding

The following organizations help rural hospitals and providers identify grants and/or teach you how or help you write grant applications.

Rural Health Information Hub (RHIhub) — Includes information on available funding opportunities, finding free technical assistance, and how to apply for grants.[23]

Rural Health Redesign Center — Offers help with grant research, writing, training, management, and reporting.[24]

Center for Rural Health — Offers a free grant writing toolkit for rural healthcare providers.[25]

National Organization of State Offices of Rural Health (NOSORH) — Offers paid and free trainings and webinars on grant writing and related topics.[26]

State Offices of Rural Health (SORH) — States may offer local grants, loans, and scholarships to help with healthcare services, healthcare programs, workforce training, and more. [27]

Local Community Health Organizations — Some local community health centers offer rural health grants; for example the Connecticut Health Foundation and the California Teleconnect Fund. Ask your SORH about opportunities in your area.[28, 29]

Rudzina Health, a Partner of Azalea Health — Helps hospitals identify grant opportunities, write grant proposals, and manage reporting requirements for a contingency fee. Will help identity grants whether or not you use its writing and reporting management services. Offers clients a monthly newsletter of grant opportunities.[30]

The Basics of Finding and Applying for Funding

Applying for grants and funding opportunities includes:

1. Finding the grant or opportunity you're eligible to apply for — whether federal, state, or private.
2. Creating an account to apply if needed.
3. Completing your application or writing your proposal — whether yourself or through a partner.
4. Tracking your submission to find out if you're granted funding.
5. If awarded funding, complying with any needed reporting.

What Happens When You Get Funding

In addition to getting funds, if your hospital, clinic, or office receives a grant or other funds, you may have to file a report to show that you used the funds as intended. Some organizations require quarterly or annual reports that detail project outcomes, financial status, and ongoing compliance with grant conditions. You may also be audited, particularly if you get a federal grant.

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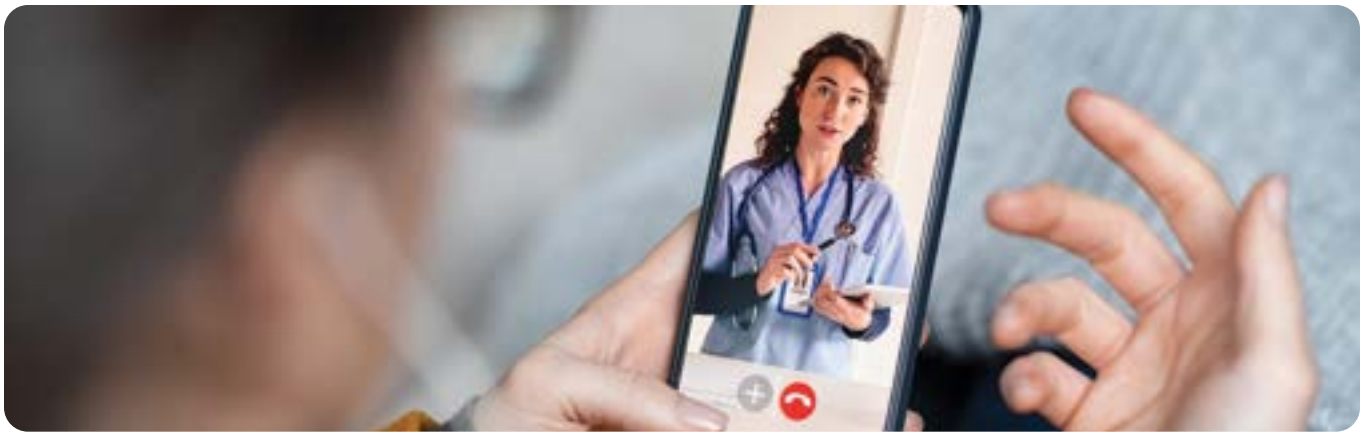
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Connected Care in Rural Health with RPM, CCM, and Telehealth



Connected care combines technology, communication systems, and data sharing to create a connection between patients, providers, and caregivers. It's not a new care management model, but it is proven to positively impact patients and providers while creating added sources of revenue.

Rural hospitals, clinics, and providers can implement connected care with little or no added investment, staff, or time. And new or proposed Centers for Medicare & Medicaid Services (CMS) policy changes for 2026 could make connected care even easier and more cost-effective.

"[With connected care,] you're able to do more with your existing resources. We know from the claims data that these are highly underutilized codes. Very small single-digit percentages of patients that are eligible to receive these services are receiving them today," said Shane Grivich, cofounder and chief strategy officer (CSO) of ChartSpan, an Azalea Health partner.

The Value of Connected Care in Rural Areas

The value of connected care includes:

- **Avoiding unnecessary transfers and related costs**, which increases revenue by increasing the number of patients treated locally.
- **Savings costs for patients and providers** by shifting from a reactive to a preventive care model while encouraging ongoing engagement between providers and patients.
- **Expanding clinical capabilities** by creating a connected infrastructure between rural and distant providers, which helps reduce provider isolation and burnout.
- **Increasing access for patients and providers** via telehealth visits and creating improved healthcare outcomes using remote patient monitoring

"We've seen from the data that you can improve your quality, measure performance, close additional care gaps, and schedule more preventative services," said Shane Grivich.

Connected Care with Remote Patient Monitoring, Chronic Care Management, and Telehealth

Connected care includes the EHR, patient engagement tools, care coordination platforms, AI, chronic care management (CCM), telehealth, and remote patient monitoring (RPM) — most of which aren't widely adopted in rural settings. But new or proposed CMS updates may make connected care more attractive for rural providers.

The Future of RPM

CMS has proposed new billing codes for how long patient data has to be collected and how long providers have to interact with patients. The proposed changes would make RPM a more adaptable tool for managing chronic and other conditions and improving outcomes. Changes would create added clinical flexibility, broader patient pools, and more scalable models for telehealth.

RPM data currently has to be collected 16 out of every 30 days (CPT 99454). The new rule would include an added code, 99XX4, for 2- to 15-day collection and make using RPM easier. It would also modify 99454 to cover 16 to 30 days.[31] Both codes would have the same reimbursement rate and could reduce denials, add billing options, and increase the patient pool.[31]

Currently providers have to engage with RPM patients for 20 minutes a month (CPT 99457). The rule would add a 10 to 19 minute engagement option (code 99XX5) reimbursed at half of CPT 99457.[31] Shorter-duration codes would let providers bill for meaningful clinical intervention, such as responding to alerts, reviewing patient data, or adjusting medications that only take a few minutes.

The Future of CCM and Advanced Primary Care Management

Proposed CMS changes for 2026 for chronic care management reflect CMS's commitment to modernize care delivery while addressing the burden of chronic disease.[32]

The proposed rule simplifies integrating behavioral health treatment into Advanced Primary Care Management (APCM) to treat both physical and mental health as part of chronic disease management.

The rule would move from the current 10 quality measures to 5 new outcome measures. The new measures would focus on chronic disease prevention, including prescreening for diabetes. They would also align payment incentives with health improvements for patients with chronic conditions

CMS also proposes broadening payment policies for digital mental health treatment devices, such as software used on phone apps, tablets, or computers.

> "We know from the claims data that these are highly underutilized codes. Very small single-digit percentages of patients that are eligible to receive these services are receiving them today."
>
> — Shane Grivich, cofounder and CSO, ChartSpan

Combined, these changes emphasize data-informed policymaking and using technology for chronic care management, which makes care more accessible and easier to administer.

The Future of Telehealth

CMS changes for 2026, outline restructuring telehealth policies with a mix of permanent expansions and the end of temporary COVID-19 policies.

CMS is proposing to expand Medicare coverage for telehealth services. This would remove the distinction between provisional and permanent services and expand services that can be done using an interactive, two-way audio-video telecommunications system.

Changes would let supervising physicians oversee visits by real-time audio-video technology instead of being physically present.

CMS is also permanently removing frequency limits for follow-up inpatient visits, nursing facility visits, and critical care consultations to provide more flexibility for ongoing patient care over telehealth.

These changes could increase patient access and provider flexibility and create new revenue streams.

Potential Barriers to Connected Care

There are some barriers for rural hospitals, clinics, and providers that want to take advantage of connected care. A lack of high-speed internet access is a barrier for roughly 23% of people in rural communities.[33] Investing in RPM equipment also has an upfront cost. And some populations, such as the elderly, may not be as digitally literate and struggle to use devices without help.

Operational Considerations with Connected Care

With any new service model or CMS update, there are operational needs. As you move to or consider a connected care model, know that:

- Your providers and billers will need to be aware of new and revised CPT codes
- You need to be ready and able to scale or optimize telehealth and RPM processes and tools; a third-party provider can help here
- You need to be ready to integrate data, including possibly adding a module in your EHR or reporting functions
- If you work with an outside care management provider, such as Azalea Health partner ChartSpan, you need to appoint a main point of contact at your facility
- You may need to shift tasks and responsibilities between staff and providers
- If your program adds multiple new patients and touchpoints, your team will need to be able to manage that, or you'll want to work with a third-party provider
- You may need to educate patients and providers on new technologies and engagement models

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Why Move to a Value-Based Care Model?

Many healthcare providers are paid based on the volume of services they deliver, such as the number of tests or procedures. This fee-for-service (FFS) model can result in overtreatment, poorer care, and higher costs.[34]

A value-based care (VBC) model, instead pays providers a fixed rate per patient per month or year. The rate is based on the quality of care provided and the health outcomes that result, not individual tests or procedures. VBC focuses on preventive care, chronic care management, and coordination between multiple providers to drive better patient outcomes, reduce redundant care and billing, and control costs. Providers are incentivized to keep care high and costs low because savings are kept and not forfeited.

VBC isn't new. And while FFS is still the main care model, VBC is growing. And the Centers for Medicare & Medicaid Services (CMS) aims to move all Medicare FFS users and most Medicaid recipients to a VBC model by 2030.

It makes sense for clinics and hospitals to adopt a VBC model for all patients because it leads to better outcomes, cost savings, and alignment with industry trends. Some factors though, such as self-pay affordability, private insurance contracts, and infrastructure needs, may limit the use of VBC in some cases. A focus on transitioning to VBC where possible may be a sound approach for many providers.

How VBC Payments Work

The VBC model uses risk adjustment to set a baseline payment for care based on individual patient health, usage, and care needs. Each patient is assigned a risk score/risk adjustment factor (RAF). Patients with greater healthcare needs are assigned a higher risk score. The higher a patient's risk score, the more the provider receives to manage their care.

Some VBC-based CMS Innovation Center models also use risk-based arrangements. In these arrangements, providers participating in the model agree to take some financial responsibility for care quality and cost. When providers show lower costs, they get added payments from CMS. The flip side is that if they increase costs, they may pay a penalty.

Payment is based on providers reporting on patient outcomes using their EHR systems. CMS and other payers base reimbursement on predetermined benchmarks. Payment can come as bonuses for meeting quality benchmarks, shared savings when costs stay below set targets, bundled payments for a care episode rather than visits, or a per-patient, per-month flat fee.

> CMS aims to move all Medicare FFS users and most Medicaid recipients to a **VBC model by 2030**.

The Move Toward Value-Based Care

CMS's goal in moving Medicare and Medicaid recipients to the VBC model is to lower healthcare costs on taxpayers and the Federal and state governments. And because anywhere from 5 to 61% of people in rural areas nationwide are on Medicare and almost 25% on Medicaid, rural providers want to be prepared over the next four years to provide VBC for at least these portions of their patient bases.[35] That means moving to either a pure VBC model or a hybrid VBC and FFS model.



Some private insurers and large self-insured employers also have VBC contracts with providers. These can be called pay-for-performance, bundled payments, or accountable care organization (ACO) contracts. It's likely as Medicare and Medicaid shifts to a VBC model, other private and self-insured employers will follow and the FFS model diminish.

Participation in ACOs is growing for rural areas. And CMS Payment Year 2026 rules will impact how ACOs operate. CMS will tighten risk corridors, which will mean ACOS take on more risk for patient outcomes and benefit from more efficient, value-based care practices.[36]

The Benefits of the VBC Model for Rural Providers and Patients

VBC offers unique benefits for rural healthcare providers and patients. It also helps address some of the challenges of rural healthcare with:

- **More consistent fixed rate per patient payments** to stabilize revenue, especially as patient volumes change.
- **Added financial incentives** by paying bonuses or a share of savings when targets are met.
- **Better patient outcomes** by prioritizing coordinated care for chronic disease management and preventive care.
- **Increased access** — outcomes don't have to result from in-person visits, which encourages the use of telehealth for providers and patients.
- **Improved insight.** A VBC model's support for data analytics and care management tools helps providers identify high-risk patients and targeted interventions.
- **Reduced unnecessary utilization.** VBC is designed to reduce ER visits, readmissions, and duplicate care, which can lower costs and decrease strain on resources.
- **Added financial assistance** from grants and support for technology, training, and care management resources with some programs.

Tips for a Successful Move to the VBC Model

Moving to a VBC model requires different workflows, increased collaboration with other providers, and sometimes new technologies. But there are ways to ensure your hospital, clinic, or practice is set up for success.

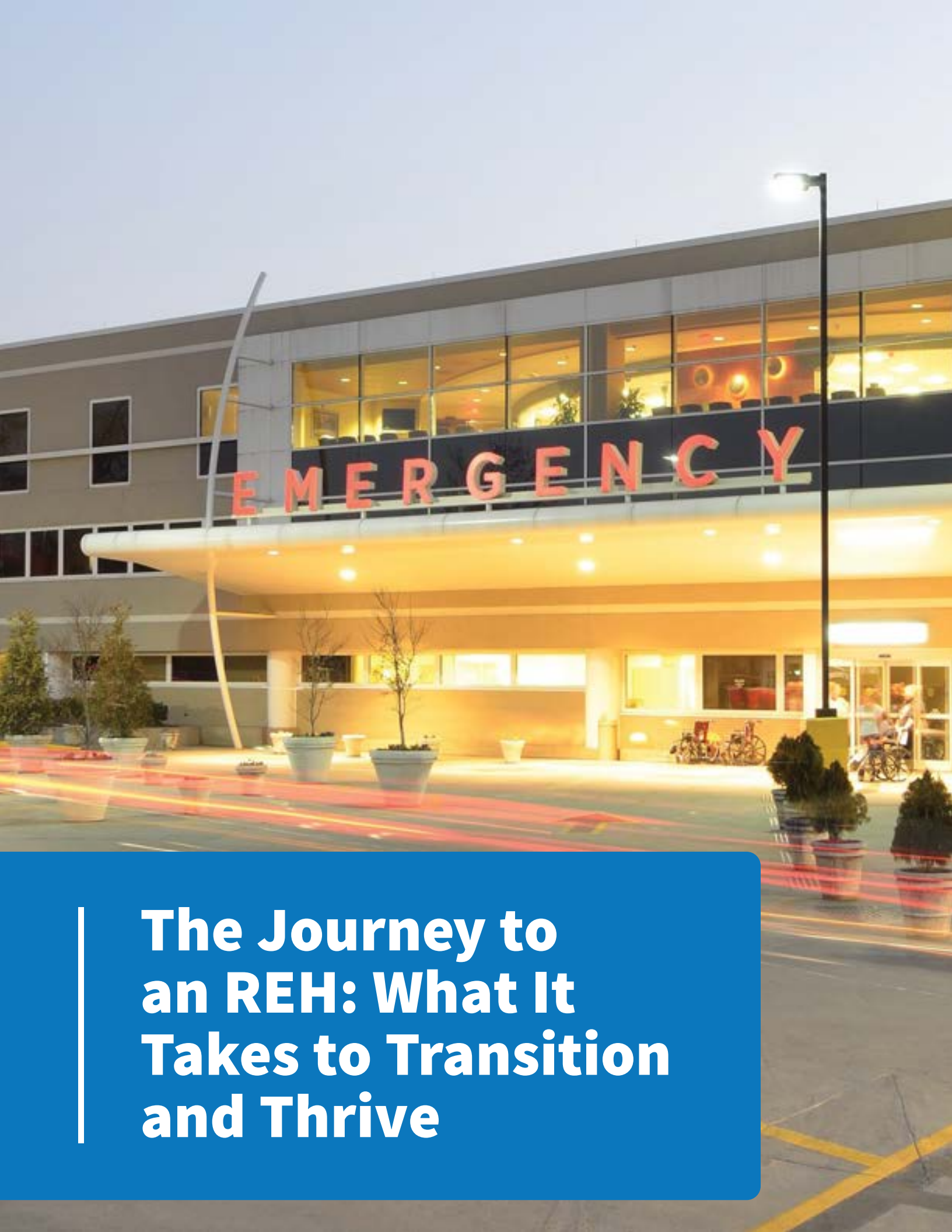
1. Make sure you have an EHR that lets you risk stratify your population based on each patient's overall health and demographics.
2. Prepare your staff. The AMA, The Health Care Payment Learning & Action Network (HCP LAN), and private VBC enablement firms, like Azalea Health partner Aledade, and training and certificate companies can help.
3. Ensure you have staff, partner, and/or technology to provide quality care, meet reporting requirements, and manage a VBC payment model.
4. Understand how a potentially small patient population might impact your risk pool and ability to report on quality improvements.
5. Make sure you're set up for coordinated care and that you are part of an HIE and your patients can connect with needed outside hospitals and specialists.
6. Get support. Non-profit and for-profit providers can help. For example, the National Rural Health Resource Center offers the Rural Healthcare Provider Transition Project that helps rural hospitals and clinics prepare for alternative payment and care delivery models. Some insurance companies also offer support and resources.

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The Journey to an REH: What It Takes to Transition and Thrive

Becoming a rural emergency hospital (REH) helps eligible hospitals access a more consistent and predictable revenue stream. Medicare adds 5% on top of the Hospital Outpatient Prospective Payment System (OPPS) rate for REHs. It also pays each REH a facility fee of $285,625.90 a month in 2025 — or $3,427,510.80 for the year.[37] And that rate may go up in 2026.

Still, the REH designation isn't right for every hospital. The flipside of more consistent revenue is providing only outpatient services, not providing inpatient care, and giving up swing bed and 340B income. But for hospitals with low inpatient volumes or inconsistent revenue, the REH designation may make perfect sense.

For DeWitt Hospital in DeWitt, Arkansas, the transition made sense. And in May 2024, it moved from a critical access hospital (CAH) to an REH.

Make Sure the Numbers Work

When considering the switch, DeWitt Hospital CEO Brian Miller asked his CPA to look at the numbers. Brian found that in one month, the hospital had 53 patients. But only five were inpatients. Others were admitted for observation.

DeWitt already transferred patients needing surgery to other hospitals. And if it moved to the REH designation, it would get paid the monthly facility payment whether it had patients or not.

Of the monthly payment, Brian says, "You don't have to bill for it. You don't have to send a claim out. Medicare sends us $285,000 and some change every month, and that number stays the same all year."

Brian's advice for rural hospital CEOs looking to transition is to work with your CPA and the Rural Health Redesign Center (RHRC) who can run a proforma to understand what you might lose and gain if you switch and what makes the most sense for your hospital and community.

Brian says, "...make sure you look at everything. What was your 340B money? What was your swing bed? etc." He also recommends using numbers from more recent years, like 2023 and 2024 — instead of years impacted by COVID — and comparing your potential REH numbers against that revenue as a good way to see if transitioning makes sense.

Beyond the Numbers — Tips for a Successful Transition

Brian and his team worked with the RHRC on DeWitt's transition. RHRC is a nonprofit committed to creating access to quality rural healthcare. It has a grant to help rural hospitals understand and navigate the regulatory needs and application process. Because DeWitt Hospital was one of the first hospitals to make the switch, RHRC's guidance helped with the unknowns at the time.

> "Taking everything into consideration, the numbers came out very positive for us."
>
> — Brian Miller, CEO, DeWitt Hospital

DeWitt did have an advantage that made the switch easier — an existing nursing home. REHs lose their swing beds. But DeWitt's nursing home lets it admit patients to its nursing home for ongoing skilled nursing care.



Other REHs create a transfer arrangement with outside facilities for inpatient care. That's an area where understanding the impacts on revenue is critical. And why for some hospitals, the switch may not work and for others, it makes perfect sense.

Brian cautions hospitals to make sure they're staffed right for the transition too. DeWitt had reduced staff in 2019 and was at the right level to make the transition sustainable without negatively impacting DeWitt's high-quality care. Brian shared, "We were staffed appropriately since 2019, which made it easy."

Little to No Impact on Patients

For Dewitt residents, the change wasn't even noticeable. Patients admitted to the hospital before the change didn't know whether they were inpatients or under observation anyway.

DeWitt already transferred patients needing surgery to other hospitals. Today, patients that need inpatient status are moved to other hospitals as well. And those that need skilled nursing care are admitted to DeWitt's nursing home.

Happy with the Transition

Brian and his team at DeWitt Hospital don't regret making the switch. "Taking everything into consideration, the numbers came out very positive for us. Having the cash guaranteed each month from Medicare was a big part of that."

"And we've still got respiratory to intubate. We've got radiology, to run CT. We've got lab. We've got all that. None of that went away. We're constantly looking for other outpatient services, such as recently added sleep studies, wound care, and specialty clinics of any kind, for extra cash flow."

"As an REH, we can sustain critical care. There's some hospitals now that are going from PPS to critical access. And I know it's better than being PPS, but critical access literally in my mind is, if you make a dollar, they're going to take a dollar. If you lose a dollar, they'll give you a dollar. They make you wait 12 months to get it. You're never going to get ahead that way, which always made it hard to keep up your building or give raises."

Basic REH Requirements

You're eligible to become an REH if your hospital was a critical access hospital (CAH) or rural Prospective Payment System (PPS) hospital as of December 27, 2020, and you:[37, 38]

- Have 50 or fewer beds
- Are located in a rural area
- Offer 24x7 emergency department services
- Have at least one physician, nurse practitioner, clinical nurse specialist, or physician assistant/ associate trained in emergency care available for immediate telehealth consults or onsite within 30 minutes (60 in frontier areas) 24x7
- Offer no acute care inpatient services unless via a distinct, licensed skilled nursing facility
- Have an annual average patient stay of 24 hours or less
- Have a transfer agreement with a Level I or II trauma center
- Comply with Medicare Conditions of Participation (CoPs)
- Participate in Medicare (and Medicaid as required by state policy)
- Meet state licensure requirements if applicable

For more information on becoming an REH, see the cms.gov Rural Emergency Hospitals fact sheet or contact the RHRC.

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The Importance of Accurate Cost Reporting



Medicare and other cost reporting is crucial for determining reimbursement and protecting the financial stability of rural health clinics (RHCs) and rural hospitals. Success depends on three essentials.

- **Expert guidance** to navigate complex Centers for Medicare & Medicaid Services (CMS) regulations, interpret gray areas, ensure compliance, and capture every allowable cost to maximize reimbursements.
- **Accurate, well-documented data** to support compliance, prevent underpayments, withstand audits, and identify opportunities for greater efficiency.
- **Smart, adaptable tools** that automate allocations, integrate with existing systems, and keep pace with evolving regulations.

Together, these elements give rural healthcare organizations like yours the foundation to remain financially strong and compliant, even with limited resources.

Cost Reporting Matters More than Ever

Cost reporting determines how much RHCs and hospitals are reimbursed by Medicare and Medicaid. Inaccurate or incomplete reports can result in reduced or delayed reimbursement, and in some cases, repayment demands. And with thin operating margins in rural healthcare, even small reimbursement errors pose a risk to financial stability.

As CMS places more emphasis on audits and ties portions of reimbursement to quality and performance measures, accurate cost reporting is more critical than ever. Cost reports are a key driver of both payment levels and quality-linked incentives, which makes accuracy critical.

Navigating CMS regulations can require specialized expertise. Rural providers face complex compliance, reimbursement methodologies, and cost allocations that can affect financial outcomes. Having seasoned experts who understand both the technical requirements and the practical realities of rural healthcare operations ensures you don't leave reimbursements on the table or risk noncompliance.

Most rural hospitals, clinics, and providers dread cost reporting. But, Kari Turk, CEO of Topeka, Kansas-based Independent Practice Solutions, suggests to "Shift your mindset and see the cost report not as tedious paperwork, but as an opportunity to tell your story and prove, with numbers, why you deserve a higher adjustment or rate."

> "Shift your mindset and see the cost report not as tedious paperwork, but as an opportunity to tell your story and prove, with numbers, why you deserve a higher adjustment or rate."
>
> — Kari Turk, CEO
> Independent Practice Solutions

Common Reporting Pitfalls

Cost-reporting challenges often result from outdated or incomplete information. One of the most common errors is simply rolling forward last year's numbers without adjusting for operational changes. In some cases, facilities use the same square footage calculations for years, even after expanding services and adding space — such as new labs, radiology, exam rooms, or providers. But not adjusting square footage causes inaccurate cost allocations.

Another pitfall is neglecting bad debt tracking. Most rural facilities forget to properly track bad debt or maintain formal policies, which weakens their ability to justify reimbursements, according to Turk. Rural providers often avoid discharging patients for non-payment to preserve community relationships, but this can mean missing opportunities to recover allowable costs through proper bad-debt documentation.

Trends and Policy Shifts

Cost reporting is being shaped by changes in policies, new care models, and evolving reimbursement structures. One key trend is the impact of rural emergency hospital (REH) conversions and accountable care organization (ACO) participation. These changes can affect financial reporting, including how shared savings or penalties are reflected in cost reports. Facilities that move to these models want to adapt their data collection and allocation methods to ensure accuracy and compliance.

Another major change is the evolution of Medicare Advantage (MA) risk-adjustment factors. Updates to these models affect how your patient complexity is scored, which influences payment rates. As CMS adjusts risk categories and coding requirements, rural hospitals, clinics, and providers need to align documentation and coding practices with new standards to protect revenue and ensure fair reimbursement.

The Critical Role of Data and Tools

Specialty software designed for cost reporting plays a crucial role in this process. Unlike generic accounting platforms, these solutions are built to handle the unique allocation, compliance, and reporting needs of Medicare cost reporting. They automate complex calculations, flag inconsistencies, and integrate with existing financial systems, giving rural providers both efficiency and confidence that data meets CMS standards.

For Medicare cost reporting, having accurate data and an accessible tool to manage it is essential. CMS requires Medicare-certified institutions submit a detailed annual report that covers costs, utilization, and other operational metrics to a Medicare Administrative Contractor (MAC).

Without well-organized data, compiling this report is time-consuming and prone to errors. Errors that increase the risk of compliance issues that can affect reimbursement.

Using the right tool lets you store and quickly retrieve the exact data needed to meet CMS requirements, so you can streamline allocations, track cost centers, and ensure your figures are consistent across reporting periods. This accessibility is vital for your internal team, but also for any outside expert you hire to prepare or review the report. Providing them with clean, well-structured data enables efficient work and early error detection to help maximize allowable reimbursements.

Benefits Beyond Medicare

Outside of Medicare requirements, having clean, well-structured cost reporting data benefits other operational and strategic needs. Accurate financial and utilization data helps with grant applications, particularly from state, federal, private, or specialty medical equipment funding sources that often require detailed cost justification.

It supports compliance with multiple regulatory bodies, such as Health & Human Services (HHS), Office of Inspector General (OIG), Health Resources and Service Administration (HRSA)/340B, and others. And it provides a solid foundation for long-term sustainability planning, which helps your leadership team make informed decisions about service expansion, staffing, and capital investments.

The same disciplined data practices that ensure a strong Medicare cost report also position your organization for broader financial and operational success.

Turn Cost Reporting into a Strategic Advantage

In the end, effective cost reporting is about more than compliance. It's a proactive strategy for uncovering opportunities and strengthening operations.

"Cost reporting is a year-round effort. Don't just aim to be audit-ready," said Turk. "See it as an opportunity to tell your story, not just complete tedious paperwork. Use the process to dig deeper into departmental P&Ls [profit and loss statements], review contracts, and dust off the cobwebs in overlooked areas."



The Value of AI for Rural Health

AI is the common acronym for artificial intelligence. Another term describes it better though — augmented intelligence.[39] Where artificial intelligence implies replacing intelligence. Augmented intelligence enhances intelligence instead of replacing it. Most AI in use today augments intelligence and tackles high volume, low value and/or tedious tasks that take time and energy away from higher value tasks.

And augmented intelligence is an ideal way for healthcare providers and staff, especially in rural areas with staffing shortages and more limited resources, to do more without working more hours. Adding AI tools can help facilities and providers decrease overtime hours worked, reduce burnout, and increase recruitment and retention.

How AI Augments Healthcare

AI can help increase access to healthcare for underserved populations. And, it can help healthcare providers and staff reduce administrative tasks and access information they may not regularly have access to. Handling repetitive, manual tasks with augmented intelligence, facilitates faster workflows and can even give providers a virtual second-opinion.

Popular AI Applications for Healthcare

While AI is capable of many uses, some of the most popular in healthcare are for reducing manual work or augmenting existing knowledge.

Ambient Charting

One of the most popular uses of AI for providers today is ambient charting (also called ambient listening or ambient clinical intelligence [ACI]). It uses AI to transcribe the interaction between patient and provider into clinical notes in real-time. It also automatically turns the transcription into usable clinical notes that the provider can approve and adjust as needed. Instead of spending time typing or recording notes during or after a visit, the provider can interact with the patient and capture the interaction automatically.

> "I've reduced the strain on my hands and saved hours each day."
>
> — Tamara Maher, DO, family practice physician, on ambient charting with Azalea Clinical Assistant

The notes attach to the patient's record in the EHR and are protected by the same security processes that protect the record itself.

A research paper published in *ScienceDirect* found that providers who use AI for documentation has less burnout and frustration and spent 2.5 fewer hours a week working on documentation after hours.[40]

Another study done by the American Heart Association found that using AI for documentation reduced rural provider's burden by 40% in Medicare Chronic Care Management (CCM) settings.[41]

And the Azalea Health AI Clinical Assistant tool, powered by Suki, is shown to reduce amended encounters by 48%, save providers 20 hours a month, and increase same-day encounter close rates by 25 points.[42]

AI charting can help with recruitment and retention too. Younger providers expect modern technologies and often prefer not to do things manually.



AI Treatment and Diagnosis Augmentation

A growing use of AI is using it to help providers diagnose and treat patients through on-the-spot second opinion and early detection abilities. AI can analyze X-rays or CT-scans to augment or validate what a provider sees. It can even detect patterns a provider may not see initially to help with early prevention and even improve patient outcomes.

> "If you want to be able to provide more precise notes, better patient care, better follow up, and just overall better service to the clinic and the patient, there's no better way to do it."
>
> — Brian Gabber, DC, Gabbert Medical, on ambient charting with Azalea AI Clinical Assistant

This is known as predictive analytics. AI analyzes anonymized historical data to spot trends, predict responses or outcomes, and suggest diagnostic possibilities and customized treatment and dosage plans. Examples include using AI to identify patterns that show a patient is at risk of developing diabetes or heart disease based on health history, lifestyle, and more compared to known patient populations.

Using AI to customize treatment plans or identify disease early can save a provider the time needed to manually find and compare patients based on inclusion and exclusion criteria.

AI can even be used to give providers access to specialized knowledge. For example, a physician assistant/associate can use AI as a coach to perform a more advanced procedure.

Similarly remote monitoring can give providers a way to monitor patients at a distance without seeing them in-person. For example blood pressure monitors or glucose meters can be used to collect and send data for provider review. Monitoring can be continuous or done with the provider during a telehealth visit.

Operational Augmentation

AI tools can help increase operational efficiency too. AI chatbots and virtual assistants can do routine tasks, like scheduling appointments, sending appointment reminders, educating patients, and answering basic medical questions to free up staff and provider time.

AI billing augmentation not only saves teams time, it can also increase revenue. An AI billing tool can flag coding errors before bills are submitted. It can use predictive analytics to assess how likely a claim is to be denied and alert the biller before the claim is submitted. AI can flag inconsistent information to show billers what to check. And it can automatically flag claims that need follow-up, so billers spend less time tracking statuses.

Billers save the hours of time they might spend tediously verifying codes focusing on other tasks. And those hours saved, equal money in your pocket. Money you can use to pay your team to do more important work instead of chasing claim denials and coding errors.

The end result is that your organization has fewer denials and gets faster approvals, which means you get paid faster and spend less paying staff to do busy work.

The AI Adoption Landscape in Rural Health

Despite its promise, AI adoption in healthcare in general is below average compared to other industries.[43] Even so, an AMA survey found that in 2024, two out of three physicians (66%) were using AI — 78% more than in 2023.[44]

Specific usage and sentiment data for rural providers and facilities is lacking. But a questionnaire emailed to 48 providers at a rural medical center in Texas in May 2024 found that 58% of respondents were willing to use AI in their practices. It also found though that trust in AI around data privacy, accuracy and patient safety was a concern.[45]

And concerns are valid. It's important to ensure any AI used is compliant and secure and understand that it exists only to augment provider and staff knowledge, not replace it.

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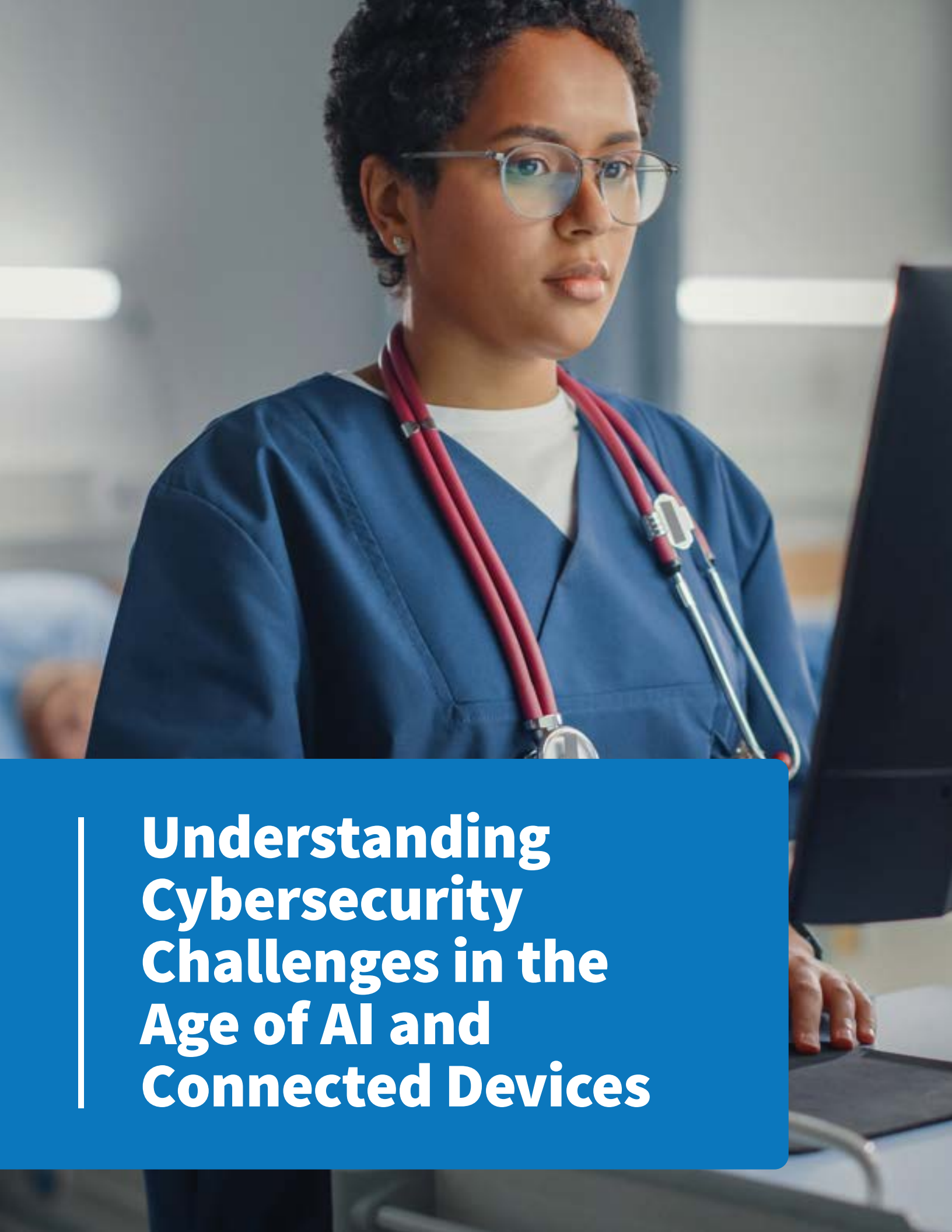
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Understanding Cybersecurity Challenges in the Age of AI and Connected Devices



AI can play two different roles in your healthcare organization. You can use stand-alone AI tools or integrate tools with your EHR or imaging machines to add efficiency. Staff can access AI tools on their own too, think ChatGTP, Copilot, or Gemini.

AI can process a lot of patient data when you let it. But every AI touch point can introduce a new way attackers can access sensitive data. And attacks have consequences — 84% of ransomware attacks on rural hospitals from 2016 to 2021 created serious operational disruption. Those included system downtime, scheduling interruptions, and more.[46] Add connected tablets, notebooks, and/or phones and security gets even more complex.

Where typical breaches often involve stealing data, AI lets attackers do even more — from automating attacks targeted at staff to cracking passwords to impersonating real users. It can even remodel data, known as model poisoning. In poisoning, attackers train data to deliver fake results that can affect patient health and safety, billing accuracy, and more.

And as a smaller or rural hospital or clinic, hackers and scammers can see you as an easy target.

But security challenges from AI and connected devices are manageable. Azalea VP of Infrastructure and Security Bill Burke shares what to know and what you can do to prepare for and tackle cybersecurity challenges in the age of AI and connected devices.

Start with Your Vendor

AI systems can process a lot of patient data, especially when looking for trends across a database. Keeping data safe starts with ensuring your AI tool or vendor is compliant and doing its own due diligence. Bill suggests:

- **Make sure your vendor's technology and processes are HIPAA-compliant.** That's true even if you're letting staff use ChatGTP, Copilot, or Gemini (more below).
- **Use encrypted data storage and transmission.** If you store data onsite or transmit it offsite, make sure you use modern encryption and a

secure web connection. Ask vendors about their encryption at-rest and in-transit practices. Some cloud services, including Azalea Health, let you manage your own encryption keys. This means only you can unlock your data, and even the cloud provider can't.

- **Make sure your vendor has security certifications**, specifically SOC 2, HITRUST, and ONC, and that they update, monitor and validate their model(s) regularly to avoid model poisoning.
- **Make sure to have a business associate agreement (BAA) in place** with any AI vendor whose tool interacts with your PHI. That's true even if you let staff use PHI in ChatGPT or another solution. Getting a BAA with ChatGPT or other vendor requires added steps — and costs — beyond the normal monthly subscription. Be sure to ask what's needed.

Ensure Security at the Staff and Device Level

Bill shares that one of the best ways to keep patients and your facility safe when using AI, and in general, is to stay in control. Limit access to data to the bare minimum. That's true for users and systems.

Use only AI and other tools that include permissions-based access controls. For example, a nurse doesn't need to see a patient's billing information and front-office staff don't need to see a patient's medical history. Your solution should let you control who can see what and what they can do with what they can access. Your vendor should be able to help set this up or, at the very least, train you how to do it.

Many breaches result from user error or phishing attacks. Don't let staff and providers access hospital tools with their own devices without controls in place, such as secure vendor apps, multifactor authentication (MFA), or mobile device management software controlled by your IT team. Only let people who need it, access facility tools on their own devices. And make sure they understand if they use their own ChatGPT or other tool, they can't use PHI in it.

Also make sure staff and providers understand what the risks are and why it's important to protect data. Make sure they're aware of ransomware and phishing threats that might come through their work and personal devices. The AHA, CISA, HHS 405(d), and others offer free security training resources. Microsoft has a free Microsoft Cybersecurity Program for Rural Hospitals.[47]

84% of ransomware attacks on rural hospitals from 2016 to 2021 created serious operational disruption.[48]

Mind Your Organizational Ps and Qs

Along with training staff and setting rigid controls, have organizational best practices in place. Bill breaks this into four key areas:

1. **Define your regulatory and liability issues** — clearly understand who owns a failure, you or the AI vendor. If it's the vendor, make sure responsibility is outlined in your contract. Also make sure you and your vendor stay up on evolving regulations around healthcare and the use of AI, such as those set by NIST and HHS. Note that the HIPAA Security Rule may change in 2026 to include stricter requirements around

cybersecurity. It proposes mandating MFA, encryption, enhanced BAAs, annual audits and self assessments, and more.

2. **Document data governance** — write and maintain a detailed policy on who owns, accesses, and manages data used by your systems, devices, staff, and AI tools.
3. **Use audit logs or ensure your AI vendor does** — ensure all interactions that your AI tools, staff, and providers have with PHI are logged and can be reviewed whenever needed.
4. **Create an incident response plan** that includes AI-related threats. And test your response to a potential breach or malfunction against your plan so you're prepared. As part of your plan include how you'll let patients know about a breach and the steps you'll take. Share this plan on your website or in your privacy policy.
5. **Have cyber liability insurance** as part of your overall security strategy. Insurance can help cover you and your patients after breaches or ransomware attacks and cover your regulatory fines, legal costs, and more.

Manage the Complexity

This all sounds like a lot, and it can be, especially for ambulatory clinics and rural hospitals with single-person or small IT teams. A few ideas Bill shares to make preparing for and managing for AI-based cyberthreats easier are to:

- **Prioritize cybersecurity basics**, such as patching and backing up local hardware and devices, using MFA for all logins, and training staff and providers to recognize attacks.
- **Lean on technology grants** for rural and small providers. Google offers its Google's Rural Healthcare Cybersecurity Initiative and Microsoft offers its Microsoft Cybersecurity Program for Rural Hospitals.[47, 48] Your state State Office of Rural Health (SORH) may be able to point you to more options as well.
- **Consider turning to a managed security service provider (MSSP) or regional health IT coalition** for support. Ask your HIMSS chapter, regional extension center, state or local HIE, or state department of health for possible options and organizations.

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Key CMS Regulatory Updates for Rural Healthcare in 2026

The Centers for Medicare & Medicaid Services (CMS) announced proposed policy changes for the 2026 Medicare Physician Fee Schedule (PFS).[49] Final changes depend on a comment period that ended September 12, 2025, and will go into effect on or after January 1, 2026. Other recent regulatory changes are finalized. Changes — approved and pending — will impact rural healthcare in specific ways.

Medicare Prior Authorization Updates

Medicare prior authorizations (PAs) for hospitals and providers are final and include:

- Mandated Fast Healthcare Interoperability Resources (FHIR) APIs for patient access, provider, access, prior authorization, and payer-to-payer be in use by January 1, 2026, and technically compliant by January 1, 2027. APIs were originally mandated in 2024.[50]
- Insurers adhere to a 7-day response time for PAs on all Medicare Advantage (MA) plans.[51]

These changes help ensure faster responses, fewer delays, and a lower provider workload.

As a rural hospital, clinic, or provider, to prepare, you want to make sure your EHR supports FHIR APIs, you track PA response times, and you train staff.

Key 2026 Medicare PFS Proposed Updates

Some proposed changes to the PFS that may impact rural hospitals, clinics, and providers are outlined below.

RHC and FQHC Coding Updates

PFS updates propose letting rural health clinics (RHCs) and federally qualified health centers (FQHCs) use new optional add-on billing codes for behavioral health integration (BHI) and psychiatric collaborative care services and that they can permanently see patients over telehealth.

If the proposal becomes final, G0512 would be unbundled into new codes 99492, 99493, 99494, and G2214 starting January 1, 2026.

These changes would offer more billing and revenue options, an expanded patient pool, continued support for telehealth, and more accurate payments. You would need to pay attention to coding and documentation and potentially train staff on the telehealth model and billing.

Rate Setting and Conversion Factor Updates

Starting in 2026, there may be separate Medicare conversion factors for qualifying alternative payment model (APM) participants (QPs) and non-QPs. Updates would result in a 2026 conversion factor of $33.59 for QPs (a 3.83% increase) and $33.42 for non-QPs (a 3.62% increase). This would be the first payment increase for physicians in five years.

RHCs are typically reimbursed by Medicare under the All-Inclusive Rate (AIR) and not the PFS for most services. The AIR isn't changing. Services, like care management, telehealth, and preventive services, though, are reimbursed using PFS rates. RHCs may get higher reimbursements for these services, whether or not they're APM participants.

CMS also proposes updates to the geographic practice cost indices (GPCIs) and malpractice relative value units (RVUs) that may result in Medicare payments going up or down depending on your location and speciality.

Payment Rate Adjustments

CMS wants to change how it determines payment rates for physician services. For most non-time-



based procedures, it wants to apply an "efficiency adjustment" for efficiency gains over time.

There may be a 2.5% reduction in Medicare reimbursements for all but time-based services. CMS doesn't expect more than a 1% change in total relative value units (RVUs). Still, services commonly done in rural areas — such as imaging or routine procedures — may lead to a greater impact as may smaller rural patient volumes that make efficiency gains harder to achieve. There could be more scrutiny of how services are valued and lower payments for some procedures too.

Practice Expense Updates

CMS proposes updating its practice expense methodology, such as recognizing higher indirect costs for office-based compared to facility-based practitioners. It also plans to use hospital data to set rates for some services, like radiation therapy and some remote patient monitoring.

This could change how Medicare payments are calculated for indirect practice expenses. Independent, office-based practices may see higher compensation for overhead. Hospitals though may see lower reimbursements for the same services.

Overall using hospital data could lead to payments more aligned with real-world costs.

Telehealth Service Updates

CMS proposes simplifying how Medicare Telehealth Services List items are added in 2026 and eliminating the difference between provisional and permanent telehealth services. It proposes eliminating HCPCS code G0136 and adding codes 90849 (multiple family group psytx); G0473 (group behavioral counseling 2–10); G0545 (inherent visit to inpt); and 92622 and 92623 (diagnostic analysis, programming and verification of an auditory osseointegrated sound processor).

Frequency limits for telehealth inpatient visits, nursing facility visits, and critical care consultations would be eliminated (HCPCS codes 99231–99233, 99307–99310, and G0508 and G0509).

Updates would also make using real-time audio-visual technology (not audio-only) for direct supervision of some services permanent and allow virtual supervision for all but some surgical procedures (010 and 090). In rural areas, the ability for providers to supervise residents virtually would be extended.

These changes would expand access and improve outcomes while giving providers more flexibility and fewer restrictions for telehealth services. They would also make scheduling and staffing more efficient. Providers could continue billing under HCPCS code G2025, including audio-only communications until December 31, 2026.

Improved Care for Chronic Illness and Behavioral Health Needs

Proposed updates include making chronic disease prevention and management a national priority and integrating behavior health into primary care. This would include new optional add-on billing codes to support BHI and psychiatric collaborative care as part of advanced primary care management (APCM).

HCPCS code G0511 (general care management) sunsetted September 30, 2025. And in 2026, RHCs and FQHCs will bill individual CPT/HCPCS codes for CCM, APCM, behavioral health integration, and remote monitoring — G0556 for patients with zero to one chronic conditions, G0557 for patients with two or more chronic conditions, and G0558 for qualified medicare beneficiaries with two or more chronic conditions.

CMS also proposes expanding payment for digital mental health treatment (DMHT) devices.

These updates could give providers and practices more revenue streams. They could also make it easier to incorporate technology into treatment plans.

IPPS and LTCH PPS Updates

On July 31, 2025, CMS finalized new payment rates for 2026 for the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS).[52, 53] CMS finalized a 2.6% increase to operating payment rates for acute care hospitals under the IPPS that will increase total hospital payments by $5 billion and add payments



of $192 million for inpatient cases involving new medical technologies. Disproportionate share hospitals will get a $2 billion increase in Medicare uncompensated care payments.

CMS also finalized a 2.7% increase to the standard payment rate for long-term care hospitals operating under the LTCH PPS.

These updates give financial support to rural hospitals and long-term care facilities. They could help hospitals sustain operations, adopt new technologies, and continue providing care for underserved rural populations.

CMS ACO-REACH Quality Updates

CMS finalized Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) quality updates for PY2026.[54]

- An increase in the quality withhold from 2% to 5% requires ACOs to show stronger quality outcomes and earn back a larger portion of payments.
- Changes to the High Performers Pool (HPP) where the higher 5% withhold creates a larger potential bonus for high-performing organizations.

Quality measures won't change in 2026. But, ACOs that struggle with quality performance may face larger financial penalties and forfeit 5% rather than 2% of their benchmark for poor quality outcomes.

Expanded eCQM Reporting

Starting in 2026, hospitals that participate in the CMS Promoting Interoperability Program will report eight electronic Clinical Quality Measures (eCQMs). CMS also proposes introducing eCQM reporting to the Rural Emergency Hospital Quality Reporting (REHQR) program as an option to chart abstraction starting in 2027.

Hospitals want to make sure their EHR systems can capture and report on the new eCQMs and train staff on the changes.

Removal of Selected Measures

CMS proposes eliminating COVID-19 vaccine reporting, the Hospital Commitment to Health Equity measure, and Social Determinants of Health (SDOH) screening measures from the Hospital Inpatient Quality Reporting (IQR) Program, Outpatient Quality Reporting (OQR) Program, and Rural Emergency Hospital Quality Reporting (REHQR) Program in 2026. The goal is to reduce the reporting burden while encouraging hospitals to address patient health and equity in other ways.

Enhanced Security and Interoperability

To strengthen EHR security and data exchange, CMS is updating the Security Risk Analysis, SAFER Guides, and Health Information Exchange measures for hospitals and CAHs that participate in the Promoting Interoperability program.

To comply with these changes, hospitals may need to upgrade their EHR, do IT training, or work with consultants or regional health information exchanges (HIEs).

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About Azalea Health

Azalea Health is a cloud-based health IT company focused on strengthening rural and community-based healthcare. Its integrated platform includes electronic health records, revenue cycle management, and AI-enabled tools that help providers navigate the unique challenges of delivering care in underserved and resource-limited settings. Designed for ambulatory practices, rural clinics, and rural hospitals, Azalea solutions simplify workflows, support financial sustainability, and improve care coordination, so providers can focus on the communities they serve. Learn more at www.azaleahealth.com.

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