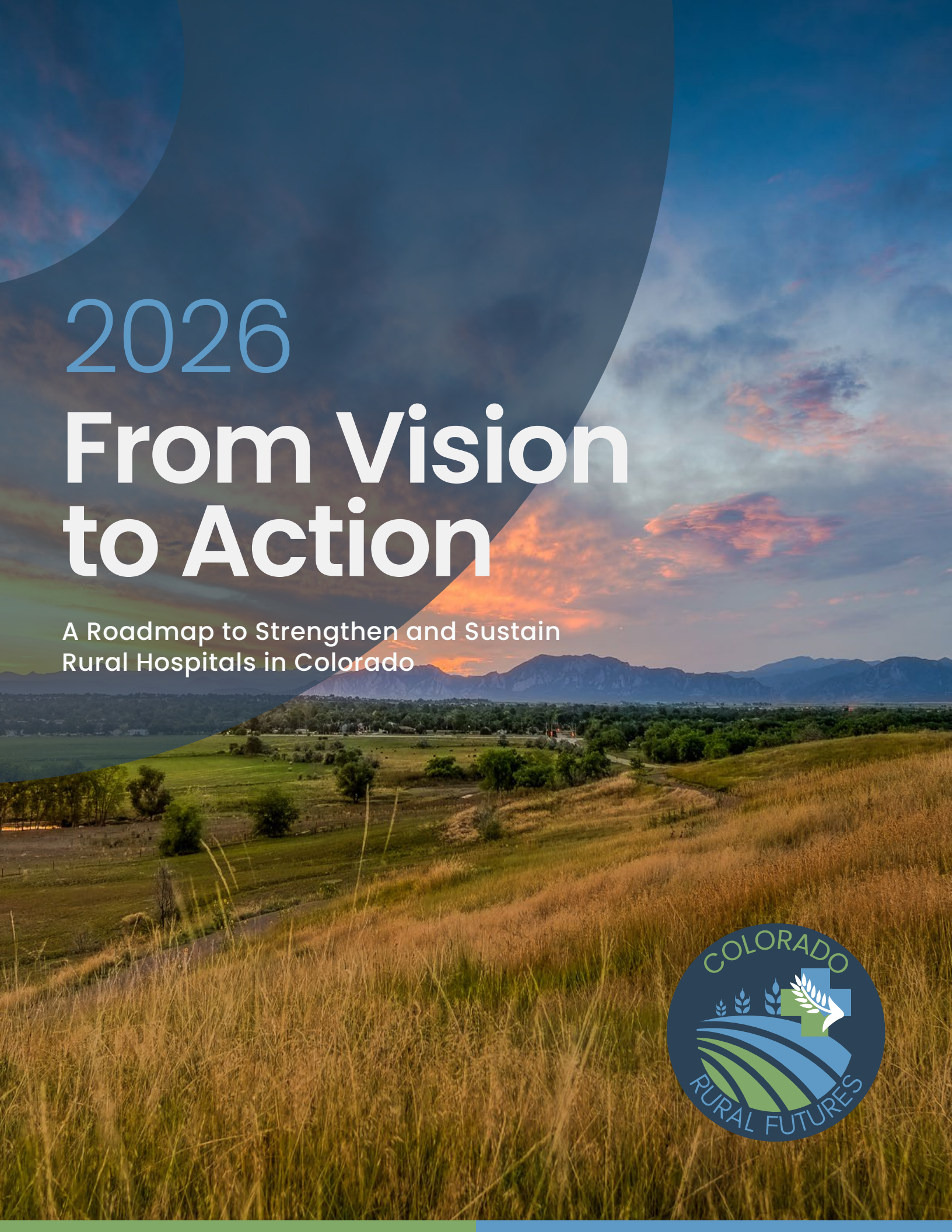

2026

From Vision to Action

A Roadmap to Strengthen and Sustain Rural Hospitals in Colorado

COLORADO RURAL FUTURES

ACKNOWLEDGMENTS

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About the Colorado Rural Futures project

The Colorado Rural Futures project was launched in 2024 with the goal of strengthening and supporting the state's rural and frontier hospitals by developing a comprehensive policy roadmap to address their challenges and improve health care delivery in these communities. The Core Leadership Team partnered with the Farley Health Policy Center to conduct a research study to generate recommendations and create this policy roadmap.

About the CU Anschutz Farley Health Policy Center

The Farley Health Policy Center develops and translates evidence to advance policies and integrate systems that improve health, equity, and well-being. With an interprofessional team of primary care and behavioral health providers, economists, and public health and policy professionals, the Farley Center has expertise in primary care finance and payment policy, rural health, workforce development, system transformation to integrate care, community-based prevention, and social policy to address disparities.

Sponsors

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Table of Contents

List of Acronyms

AHA	American Hospital Association
BBA	Balanced Budget Act of 1997
CHA	Colorado Hospital Association
CHNA	Community Health Needs Assessment
CMS	Centers for Medicare and Medicaid Services
Core Leadership Team	Colorado Rural Futures Core Leadership Team
CRHC	Colorado Rural Health Center
Farley Center	Eugene S. Farley, Jr. Health Policy Center
CAH	Critical Access Hospital
HCPF	Colorado Department of Health Care Policy and Financing
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
HSR	Health Statistics Region
MA	Medicare Advantage
OBBBA	One Big Beautiful Bill Act
RHTP	Rural Health Transformation Program
USDA	U.S. Department of Agriculture
WHA	Western Healthcare Alliance

Executive Summary

Akin to their peers nationwide, Colorado's rural and frontier hospitals face substantial challenges, including ensuring financial viability, recruiting and retaining an adequate workforce, and serving geographically isolated populations. Despite these challenges, rural and frontier hospitals are anchor institutions that deliver immense health care and economic value to their communities.

In 2024, the Colorado Rural Futures initiative was launched to address the challenges the state's rural safety-net hospitals face by developing a comprehensive policy roadmap to strengthen health care in these communities. Improving the financial and operational health of these vital organizations will require sustained focus, resources, coordination, and collaborative leadership. A policy roadmap is a critical tool to support this work.

The Colorado Rural Futures Core Leadership Team (Core Leadership Team) — a group of eight rural and frontier hospital CEOs across the state — engaged the CU Anschutz Farley Health Policy Center (Farley Center) to conduct a mixed methods policy research study to understand the root causes of distress Colorado's rural and frontier hospitals face, to identify essential health services that rural and frontier hospitals deliver within their communities, and to generate policy recommendations to strengthen these facilities.

The policy recommendations were generated through extensive analysis of data such as:

- **the existing literature,**
- **hospital- and discharge-level data from Colorado hospitals,**
- **key informant interviews of rural health experts across the country, and**
- **focus groups of Coloradans living in, delivering care in, or advocating for rural communities.**

The findings were iteratively discussed and analyzed by the Core Leadership Team and the Farley Center and were used to create this roadmap for use by stakeholders to inform advocacy efforts to strengthen the state's rural and frontier hospitals over the next three-plus years.

Thirty-eight total recommendations were identified through the Colorado Rural Futures initiative, largely directed at 20 potential state-level actions, e.g., legislation and regulation. Pertinent federal policy recommendations (11 total) — as well as organizational-level strategies (seven total) — that surfaced during the research phase are also noted in this roadmap.

The Core Leadership Team identified the following actionable recommendations as top **state legislative and/or regulatory priorities.** These priorities were evaluated for both political and implementation feasibility and their potential impact by focus group participants and external reviewers who represent rural health and policy leaders across the state of Colorado. Implementing these high-priority recommendations is key for rural hospitals to improve the health of the communities they serve.

- **Evaluate options to preserve and/or enhance the use of CHASE** (Colorado Healthcare Affordability and Sustainability Enterprise) fees for at-risk rural and frontier hospitals across the state.
- **Pursue enhanced Medicaid payment rates** for facilities whose payer mix of public payers (including Medicaid and Medicare) and uncompensated care represent a significant proportion of their business. **Increase Medicaid provider rates and/or preserve or expand health insurance access through Medicaid**, e.g., change eligibility or increase benefits.
- **Leverage the groundwork laid by the Community Care Alliance to develop a statewide rural clinically integrated network**, enhancing the ability of rural hospitals to establish the clinical, operational, and data infrastructure that supports independent providers to work together, share data and technology, coordinate care, and implement value-based and population health initiatives while meeting federal anti-trust requirements.

Legislative priorities for 2027, 2028, and beyond can be set depending on what is accomplished in the 2026 General Assembly session. In addition to the above legislative and regulatory priorities, the Core Leadership Team prioritized the following **organizational priorities** that emerged from the research:

- **Partner with the appropriate agencies to establish a fund to be used by qualifying rural and frontier hospitals for small-scale construction or renovation projects.** This fund could support hospital equipment updates or replacements, including CT scanners and MRI machines, HVAC systems, IT platforms, and more.
- **Establish a program to coordinate the planning and purchasing of capital equipment**, one that supports hospitals to collectively negotiate purchases and secure favorable financing among available state and federal options. The program could conduct infrastructure assessments to inform capital planning statewide.
- **Build upon research done in this project to further characterize essential services that should be made available in rural and frontier communities statewide.**

The recommendations produced in this roadmap were considered through the lens of myriad state and federal health policy changes over the past two years that have impacted — and will continue to impact — rural and frontier communities across the state, including a challenging Medicaid unwind process following the COVID-19 pandemic, significant structural state budget constraints, and forthcoming changes related to H.R. 1, the One Big Beautiful Bill Act (OBBBA), a federal budget reconciliation bill signed into law by President Trump on July 4, 2025.

These more recent state- and federal-level policy changes increase pressure on rural and frontier hospitals already feeling the squeeze. Challenges include a health care ecosystem in flux with mergers and acquisitions, rising enrollment in Medicare Advantage (MA) plans, challenges transitioning from fee-for-service to value-based care, lack of negotiating power with commercial payers, old infrastructure, and increasing staffing, equipment, and technology costs. This dynamic policy environment will compound rural hospitals' long-standing, systemic financial and operational difficulties and impact implementation of the recommendations within this roadmap over the next three years and beyond.

Despite these very real and evolving changes, more attention is being paid to the value and needs of health care systems that serve rural and frontier communities, both in Colorado and nationwide. For example, in April 2025, the Rural Policy Research Institute, the National Rural Health Association, and West Health released a report synthesizing a two-day convening in November 2024 with more than 40 rural health experts. This nationally focused roadmap details a cohesive approach and a series of policy recommendations to improve the health of rural Americans and their communities. In February 2026, the nonpartisan Aspen Health Strategy Group, co-chaired by former U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and former U.S. Senate Majority Leader William Frist, published its ideas to close health disparities between rural and urban Americans, calling upon health care and state and federal government leaders to partner together to effect change.

In December 2025, the Colorado Department of Health Care Policy and Financing (HCPF) was notified by the Centers for Medicare and Medicaid Services (CMS) that the state will receive just over $200 million in federal Rural Health Transformation Program (RHTP) funds through September 2027 to address specialty care access, chronic disease, and preventable hospitalizations in all 52 rural and frontier counties and the two federally recognized tribes across Colorado. As a provision within the OBBBA, the RHTP represents a new source of funds dedicated to advancing rural health priorities within our state.

The work of Colorado Rural Futures is well situated amid the building momentum around the new RHTP and growing calls for rural health policy change at the national level. This roadmap — informed by the perspectives of more than 100 individuals living, working, and serving in rural Colorado — can inform and catalyze real policy change to strengthen rural and frontier hospitals and communities statewide.

Essential to Communities

Rural hospitals serve as anchor institutions that support both health care access and local economies

Introduction

Akin to their peers nationwide, Colorado's rural and frontier hospitals face substantial challenges, including ensuring financial viability, recruiting and retaining an adequate workforce, negotiating access to resources, preserving enough bandwidth to innovate health and health care, and serving geographically isolated populations that often face high rates of chronic disease and significant socioeconomic barriers.

Despite these challenges, rural and frontier hospitals are anchor institutions that deliver immense value to their communities by providing and facilitating access to health care services and by stimulating the local economy through job creation and attracting other businesses to the region.[1] Financially vulnerable hospitals struggle to maintain adequate services to meet community needs. A strong hospital is more effective in improving outcomes, reducing costs, and addressing the root causes of inequities. While some rural hospitals may be appropriate candidates for mergers with larger systems to preserve health care access within their communities, many would not be attractive for consolidation and may result in scaled-back services.[2] As a result, many rural hospital governing boards work hard to maintain independence as the ideal path to serve their communities.

Key stakeholders, including rural and frontier hospitals, patients, clinicians, trade associations, foundations, community-based organizations, and state and federal policymakers, are becoming increasingly aware of the difficulties these institutions — and the communities they serve — face. This is partly due to attention paid to pre-existing disparities made worse by the COVID-19 pandemic, the state's current structural budget challenges, and forthcoming changes from H.R. 1. There is also a growing realization that the economic and population health of rural and urban communities statewide are interdependent.[3]

These more recent state- and federal-level policy changes increase pressure on rural and frontier hospitals already feeling the squeeze, as they navigate a health care ecosystem in flux with mergers and acquisitions, rising enrollment in Medicare Advantage (MA) plans, challenges transitioning from fee-for-service to value-based care, lack of negotiating power with commercial payers, old infrastructure, and increasing staffing, equipment, and technology costs. This dynamic policy environment will compound rural hospitals' long-standing, systemic financial and operational difficulties.

Despite these very real and evolving changes, an increasing amount of attention is being paid to the value and needs of health care systems that serve rural and frontier communities, both in Colorado and nationwide. For example, in April 2025, the Rural Policy Research Institute, the National Rural Health Association, and West Health released a report synthesizing a two-day convening in November 2024 with more than 40 rural health experts. This nationally focused roadmap details a cohesive approach and a series of policy recommendations to improve the health of rural Americans and the communities in which they live.

$200M

Federal investment in rural health in Colorado

Through September 2027 to address specialty care access, chronic disease, and preventable hospitalizations

Full list

Scan code to view list of additional rural health efforts statewide

In February 2026, the nonpartisan Aspen Health Strategy Group, co-chaired by former HHS Secretary Kathleen Sebelius and former U.S. Senate Majority Leader William Frist, published "five big ideas" to close health disparities between rural and urban Americans, calling upon health care and state and federal government leaders to partner together to effect needed change. The report entitled "Meeting the Health Needs of Rural America" recommends letting rural communities lead, updating payment systems for rural health care, building rural economic development around health and health care, investing in prevention and population health, and modernizing rural infrastructure.

In December 2025, the Colorado Department of Health Care Policy and Financing (HCPF) was notified by the Centers for Medicare and Medicaid Services (CMS) that the state will receive just over $200 million in federal Rural Health Transformation Program (RHTP) funds through September 2027 to address specialty care access, chronic disease, and preventable hospitalizations in all 52 rural and frontier counties and the two federally recognized tribes across Colorado. As a provision within H.R. 1, the RHTP represents a new source of funds dedicated to advancing rural health priorities within the state. The work of Colorado Rural Futures is well situated amid the building momentum around the new RHTP and growing calls for positive rural health policy change at the national level.

Project goals

The Colorado Rural Futures initiative was launched in February 2024 with the goal of strengthening and supporting the state's rural and frontier safety-net hospitals by developing a comprehensive policy roadmap with recommendations to address their challenges and improve health care delivery in their communities. Improving the financial and operational health of rural and frontier hospitals in Colorado will require sustained focus, resources, coordination, and collaborative leadership. A policy roadmap is a critical tool rural health stakeholders can use to inform and align advocacy efforts.

The Core Leadership Team — a group of eight rural and frontier hospital CEOs across the state — engaged the Farley Center to conduct a mixed methods research study to inform the creation of this evidence-based policy roadmap. The study sought to answer three key questions:

- **What are the root causes of distress Colorado's rural and frontier hospitals face?**
- **What are the essential health services that rural and frontier hospitals deliver within their communities?**
- **What are potential policy solutions to strengthen these vital facilities?**

The recommendations in this policy roadmap are primarily directed at state-level actions, such as regulation and legislation. However, this extensive study also surfaced relevant federal- and organizational-level recommendations. The roadmap intentionally focuses on rural and frontier hospitals that are often central to rural health care delivery systems and local economies alongside primary care clinics, public health departments, social services, and more. The Colorado Rural Futures project is also complementary to other initiatives statewide dedicated to improving rural health access, workforce, training, research, advocacy, and technical assistance. For a full list of these additional efforts, *please refer to the link at the QR code.*

This roadmap can serve as a foundation to develop even more comprehensive recommendations in the future to enhance the state's broader rural health care delivery ecosystem beyond hospitals and to catalyze pursuit of collaborative strategies in partnership with other initiatives in the state.

Project methods

Between February 2024 and September 2025, the Farley Center, as the Colorado Rural Futures research partner, conducted a robust mixed methods policy study, including an environmental review of nearly 150 peer-reviewed and lay media articles; a legislative scan of 9 states; 23 key informant interviews of rural health experts outside of Colorado; 10 focus groups involving 77 Colorado stakeholders, and a review of 38 Community Health Needs Assessments. Extensive quantitative analysis of hospital- and discharge-level data was also performed. A survey was fielded among rural and frontier hospital CEOs in Colorado, and an assessment of build and renovation dates for Colorado's rural and frontier hospitals was also conducted. For more in-depth descriptions of the methodologies used, please review Appendix A.

Understanding the rural context

From a federal and state geopolitical perspective, whether an area is considered "rural" is often defined by population density and distance from a city.[4] Terminology like rural-urban commuting area, non-metropolitan statistical area, micropolitan, taxing district, and frontier aim to describe rural areas from an urban perspective. Across the state, there are different types of rural environments, e.g., agricultural, mining, tourism, mountains, and plains. Rural health issues can also be considered at the intersection of other fields and services, including transportation, education, housing, economic development, and agriculture. However, rural and frontier communities use a variety of methods of self-description related to the dominant economy, as well as local culture and values.

These communities also know about the importance of having access to medical care, including how far the drive is to the nearest hospital, health center, or clinic. While the distinction of being a "Critical Access Hospital" or the level of trauma center care available may not be fully understood by the community, having a hospital nearby means everything in terms of access to primary care, routine well childcare, sports physicals, annual wellness exams, emergency and inpatient care, outpatient procedures, physical therapy, specialty care, and laboratory and radiology services. Without the rural hospital, the ability to have these services in the community is at risk. For rural or frontier communities, the loss of their hospital can mean an additional 20 miles or more to obtain care.[5] The loss of an emergency department can mean life or death. At the end of the day, rural communities themselves are best positioned to describe their health care needs, propose solutions, and identify the health and economic benefits derived from their local hospital. For the purposes of this initiative, 43 rural and frontier hospitals were identified in the state using information from the Colorado Hospital Association with input from hospital leaders.

This roadmap — informed by the perspectives of more than 100 hospital executives, clinicians, business and non-profit leaders, elected officials, and patients living, working, and serving in rural Colorado — can inform and catalyze real policy change to strengthen rural and frontier hospitals and communities statewide.

150
Articles reviewed

9
State legislative scans conducted

23
Experts interviewed

77
Stakeholders engaged in 10 focus groups

38
Community Health Needs Assessments studied

Extensive quantitative analysis

of hospital- and discharge-level data performed

Policy Recommendations

The Colorado Rural Futures initiative proposes a total of 38 recommendations, across five focus areas to strengthen and support the state's rural and frontier safety-net hospitals:

01 **Expand and protect access to clinical services.**

02 **Ensure adequate reimbursement.**

03 **Enhance access to capital.**

04 **Support executive teams and hospital governing boards.**

05 **Strengthen the clinical workforce.**

This research project initially generated a much larger pool of policy recommendations spanning financial, operational, clinical, and workforce realms. (See "What are potential policy solutions to strengthen these vital facilities?" in the Research Findings section.) This broader list was discussed with five different focus groups of rural health stakeholders in the state, comparing the various options for their impact, acceptability, and political and administrative feasibility, among other factors. The results of these focus groups, combined with findings from all phases of this mixed methods study and extensive input from reviewers, were iteratively discussed by the Core Leadership Team and the Farley Center. Through three rounds of discussion, the broader list of potential recommendations was further refined, grouped into five focus areas, and prioritized, as detailed below.

The final recommendations were also considered through the lens of myriad state and federal health policy changes over the past two years that have impacted — and will continue to impact — rural and frontier communities across Colorado, including the lingering effects of a challenging Medicaid unwind process following the COVID-19 pandemic, significant structural state budget constraints, and forthcoming changes related to H.R. 1, a federal budget reconciliation bill signed into law by President Trump on July 4, 2025.

While these recommendations are largely aimed at state-level policy action (legislation and regulation), relevant federal- and organizational-level strategies that surfaced during the study are also noted within. Public policy changes at the state and federal levels frequently result in needed transformations within organizations, particularly as new policy is implemented and inevitably evolves. While state, federal, and organizational policy recommendations are intentionally separated, there will be overlap and ramifications for other levels of policymaking and subsequent implementation. This roadmap can be used as a tool to inform and align advocacy efforts of rural health stakeholders over the next three-plus years to strengthen these vital institutions and sustain their local health care and economic impacts.

Of the 20 state-level recommendations, the Core Leadership Team identified the following actionable recommendations as top state legislative and/or regulatory priorities. These priorities were evaluated for both political and implementation feasibility and their potential impact by focus group participants and external reviewers who represent rural health and policy leaders across the state of Colorado.

RECOMMENDED STRATEGIES

20
state

11
federal

7
organizational

Implementing these high-priority recommendations is key for rural hospitals across the state to improve the health of the communities they serve.

- **Evaluate options to preserve and/or enhance the use of CHASE** (Colorado Healthcare Affordability and Sustainability Enterprise) fees for at-risk rural and frontier hospitals across the state.
- **Leverage the groundwork laid by the Community Care Alliance to develop a statewide rural clinically integrated network**, enhancing the ability of rural hospitals to establish the clinical, operational, and data infrastructure that supports independent providers to work together, share data and technology, coordinate care, and implement value-based and population health initiatives while meeting federal anti-trust requirements. Colorado can build upon the legislative intent of SB23-298 (Allow Public Hospital Collaboration Agreements) to collectively pursue joint purchasing of supplies, equipment, or insurance, health care provider recruitment, shared data services, and negotiations with commercial or government payers.
- **Pursue enhanced Medicaid payment rates** for facilities whose payer mix of public payers (including Medicaid and Medicare) and uncompensated care represent a significant proportion of their business. **Increase Medicaid provider rates and/or preserve or expand health insurance access through Medicaid**, e.g., change eligibility or increase benefits.

Advancing any of these priorities will be difficult given the state's budget deficit, rising health care costs, and cyclical budget challenges related to the Taxpayer's Bill of Rights (TABOR).[6] However, these priorities remain critical to the sustainability and impact of the state's rural and frontier hospitals and are supported by the extensive Colorado Rural Futures research process.

Legislative priorities for 2027, 2028, and beyond can be set depending on what is accomplished in the 2026 General Assembly session. In addition to the above legislative and regulatory priorities, the Core Leadership Team prioritized the following organizational priorities that also emerged from the research:

- **Partner with the appropriate agencies to establish a fund to be used by qualifying rural and frontier hospitals for small-scale construction or renovation projects.** This fund could support hospital equipment updates or replacements, including CT scanners and MRI machines, HVAC systems, IT platforms, and more.
- **Establish a program to coordinate the planning and purchasing of capital equipment**, one that supports hospitals to collectively negotiate purchases and secure favorable financing among available state and federal options. The program could conduct infrastructure assessments to inform capital planning statewide.
- **Build upon research done in this project to further characterize essential services that should be made available in rural and frontier communities statewide.**

Beyond these high-priority state- and organizational-level recommendations, another key and timely area of focus starting in 2026 is leveraging the work of Colorado Rural Futures to support HCPF as it implements the new RHTP. In December 2025, the state was notified that it will receive just over $200 million in federal funds through September 2027 with the possibility of receiving a total of over $1 billion over the next five years. These federal dollars will support several initiatives in all 52 rural and frontier counties statewide, plus the two federally recognized tribes in Colorado, including: 1) chronic disease prevention; 2) rural health system stability and connectivity; 3) expanding and strengthening the rural health workforce; 4) value-based care and alternative payment models, and 5) telehealth and digital technology infrastructure. There is synergistic alignment between the recommendations coming forth from the Colorado Rural Futures initiative and the proposed activities within RHTP.

State-Level Policy Recommendations

The following list of state-level policy recommendations is comprehensive, including those that the Core Leadership Team has prioritized for implementation starting in 2026:

Expand and protect access to clinical services:

- **Explore innovative strategies to bridge gaps in access** to mental health, primary care, and specialty services in rural areas.
- Support **more robust remote patient monitoring** services so that patients can remain closer to home, as well as mobile units and home visiting nurse programs.
- **Invest more consistently in broadband and high-speed internet** so that telehealth is more readily available statewide. Telehealth should support, not supplant, in-person care.
- Allocate more resources to **prevent mental health crises and suicides** among farmers, ranchers, and agricultural producers, as well as other at-risk groups in rural communities. The Health Innovations Network of Kansas maintains a list resources to help individuals working in agriculture with stress and mental health; these resources serve as models to consider for replication in Colorado.
- **Lower the costs of drugs and insurance** products for patients, including protecting the 340B Drug Pricing Program.

Ensure adequate reimbursement:

- **Seek adequate reimbursement** from both public and private payers for essential services delivered by rural and frontier hospitals within their communities, including through innovative payment and delivery models. Incentivize payers to reimburse at levels more likely to cover high fixed costs in rural facilities.
- **Evaluate options to preserve and/or enhance the use of CHASE** (Colorado Healthcare Affordability and Sustainability Enterprise) fees for at-risk rural and frontier hospitals across the state.
- **Pursue enhanced Medicaid payment rates** for facilities whose payer mix of public payers (including Medicaid and Medicare) and uncompensated care represent a significant proportion of their business.
- **Increase Medicaid provider rates and/or preserve or expand health insurance access through Medicaid**, e.g., change eligibility or increase benefits.
- **Leverage the groundwork laid by the Community Care Alliance to develop a statewide rural clinically integrated network**, enhancing the ability of rural hospitals to establish the clinical, operational, and data infrastructure that supports independent providers to work together, share data and technology, coordinate care, and implement value-based and population health initiatives while meeting federal anti-trust requirements. Colorado can build upon the legislative intent of SB23-298 (Allow Public Hospital Collaboration Agreements) to collectively pursue joint purchasing of supplies, equipment, or insurance, health care provider recruitment, shared data services, and negotiations with commercial or government payers.
- **Design a payer performance scorecard** that rates payers on their ability to meet contract requirements, pay rural hospitals promptly, limit denials for payment, etc.
- Identify options under the state's authority to **improve the utility of Medicare Advantage (MA)** plans in rural communities, e.g., creating a statewide MA plan, making it easier to switch from MA back to traditional Medicare, and assuring that MA plans cover the total cost of hospital care as a replacement for fee-for-service Medicare.

Enhance access to capital:

- **Develop a statewide technical assistance program** for the use of architects, building planners, and master facility planning consultants, as well as financial counseling and evaluation to inform infrastructure planning and implementation.
- **Provide tax breaks for infrastructure improvements** for rural facilities, e.g., New Markets tax credits, enterprise zones, and community benefit credits.

Support executive teams and hospital governing boards:

- Fund development of **training programs for hospital administrators** within Colorado's higher education institutions and **provide tuition support** for hospital executives to participate in these and existing leadership programs at other institutions, e.g., Dartmouth Master of Health Care Delivery Science.
- Partner with a state agency or organization to **develop or expand training materials and programs for hospital governing board members** akin to what the Colorado Association of School Boards or the Western Healthcare Alliance offers.
- **Modify HB22-1005 (Health-care Preceptors Tax Credit)** to allow rural and frontier hospital CEOs and other executive leaders, e.g., CFOs and COOs, to qualify for tax credits for mentoring or precepting health care administration students and/or early career professionals.

Strengthen the clinical workforce:

- **Enhance existing rural rotations for medical students, resident physicians, and other clinicians**, so they become more familiar with a team-based approach to caring for rural communities.
- Change state laws and regulations to **make it easier for out-of-state clinicians to offer telehealth services** in Colorado.
- **Offer broader student loan forgiveness or interest rate decreases** for health care workers and administrators choosing to work in rural hospitals, across multiple roles and specialties.

Federal-Level Policy Recommendations

Ensure adequate reimbursement:

- Protect the 340B Drug Pricing Program administered by the Health Resources and Services Administration (HRSA).
- Enhance the Rural Hospital Stabilization Fund administered by HRSA.
- Eliminate sequestration for critical access hospitals.
- Modernize the cost-based reimbursement system to include innovative care delivery models and long-term care provided by critical access hospitals.
- Require Medicaid to pay at cost +1, akin to Medicare for critical access hospitals.
- Continue to monitor and improve the Rural Emergency Hospital designation.
- Encourage the CMS Innovation Center to design and implement rural-specific models, building upon the lessons learned in the Pennsylvania Rural Health Model and others.
- Promote many needed changes to the Medicare Advantage program:
  - Fix marketing practices.
  - Curb delays and denials in payment.
  - Ensure network adequacy standards.
  - Follow traditional Medicare coverage guidelines and fee schedule for reimbursement.

Enhance access to capital:

- Revamp USDA loan processes, as well as increase loan amounts available and decrease interest rates.
- Facilitate passage of The Hospital Revitalization Act.
- Publicize and enhance the USDA technical assistance funding for program development, financial counseling, and architect/master facility planning.

Organizational-Level Recommendations

Expand and protect access to clinical services:

- **Form regional collaborations** to improve access to care, e.g., rural obstetrics coalitions to share resources and provide preparedness training for obstetrical emergencies.
- **Broker partnerships between rural hospitals and other community providers**, e.g., public health, federally qualified health centers, and human service organizations, to improve health and health care locally.
- Build upon research done in this project to further characterize essential services that should be made available in rural and frontier communities statewide.

Enhance access to capital:

- **Partner with the appropriate agencies to establish a fund to be used by qualifying rural and frontier hospitals for small-scale construction or renovation projects.** This fund could support hospital equipment updates or replacements, including CT scanners and MRI machines, HVAC systems, IT platforms, and more.
- **Establish a program to coordinate the planning and purchasing of capital equipment**, one that supports hospitals to collectively negotiate purchases and secure favorable financing among available state and federal options. The program could conduct infrastructure assessments to inform capital planning statewide.

Strengthen the clinical workforce:

- **Encourage partnerships with local school districts** to create pathways for interested traditional and non-traditional students entering health care occupations.
- Create opportunities for the state's community colleges to work collaboratively with rural hospitals to **develop more robust training programs for ancillary professions**, e.g., medical assistants, lab technicians, and certified nursing assistants.

Looking ahead to implementation:

The recommendations listed above necessitate iterative discussion and prioritization by many stakeholders (including rural and frontier hospital executives, state lawmakers, clinicians, trade associations, and patients) to determine which ones will ultimately move forward and when. Numerous details, such as scope, timing, resources, roles and responsibilities, risk management, evaluation strategies, and more, would need to be determined for each recommendation prior to implementation. The Colorado Rural Futures research study identified several overarching themes that can shape stakeholders' approach to implementing any of these recommendations, including:

- Multilateral approaches are required, as multiple parties are needed at the table to address several challenges simultaneously. For example, it's hard to effectively address clinical workforce shortages without concurrently tackling adequate reimbursement.
- Wherever possible, solutions should leverage existing programs, services, or organizational initiatives.
- While many stakeholders expressed a desire to independently solve challenges, they also emphasized a desire to meaningfully engage local, state, and federal government partners and invite them to truly invest in rural and frontier communities.
- The notion of regional collaboration for a variety of purposes, including joint purchasing of equipment and supplies, care coordination, and creative workforce solutions, was widely supported.
- As legislation and regulation are developed, it is critical to engage rural leaders and community members with lived experience in the process and ensure they have a seat at the decision-making table. Such an approach can inform state lawmakers about the unintended consequences of policy proposals on rural and frontier communities.

Research Findings

Over 45 million people reside in rural counties across the U.S. today.[7] In Colorado, just under 14% of the population — 800,000 people — lives in a rural community.[8] On average, people living in rural areas are older, have lower incomes, and have a greater dependence on public insurance.[9] Since 2005, more than 180 rural hospitals have closed their doors entirely or stopped offering inpatient services[10], and more than 400 rural hospitals — over 20% of all rural hospitals nationwide[11] — are still considered at high or immediate risk for closing. In 2025, 11 rural Colorado hospitals were deemed at risk of closing, while two were considered at immediate risk for closure. Furthermore, 17 rural hospitals across the state operated service lines with losses. Even though Colorado has not recently had a rural hospital close its doors, the risk is real.

A rural hospital is not only a source of local health care services, but also commonly the largest or one of the largest employers in the region and a major impetus for attracting other businesses to the area. When a rural hospital closes, individuals whose jobs are lost may commute to other communities for work and may ultimately choose to leave. As a result, the tax base declines, and education, public safety, and social services suffer. After a local hospital ceases operations, families must travel farther to access health care they once had close to home. Both the population and economic health of a rural region can deteriorate rapidly after a hospital closes.[12]

The Colorado Rural Futures project sought to answer three key questions about the root causes of distress rural and frontier hospitals across the state face, what services they currently deliver within their communities, and what policy recommendations at the state, federal, and organizational levels — if implemented — could strengthen these valuable institutions. These questions are answered below by synthesizing findings across multiple facets of this mixed methods research study. For more detailed findings by data source and method, please see Appendix B.

What are the root causes of distress Colorado's rural and frontier hospitals face?

Several causes of distress were identified throughout the research study, principally centered around hospital finances and operations. Financial stressors include relatively poorer reimbursement from commercial payers compared to their urban counterparts, lack of negotiating power for adequate rates, payer mixes with a greater reliance on public insurance that tends to pay less than private insurance, rising amounts of uncompensated care and bad debt (revenue that hospitals expected to collect but did not receive), declining economies of scale, and increasing costs of personnel, equipment, and technology.[13,14] Predominant fee-for-service payment models are often not suitable or adequate in rural areas, and the move from volume-driven to value-based care has been a challenging transition for many rural health care delivery systems to make.

Furthermore, the rapid rise in enrollment in Medicare Advantage (MA) plans has impacted the bottom line for many of the state's rural and frontier hospitals.[15] More than 50% of eligible Medicare beneficiaries in Colorado are now enrolled in MA plans. For example, MA carriers advertise widely to potential beneficiaries, including those living in rural communities. However, these plans do not adequately contract with rural facilities including hospitals, outpatient clinics, laboratories and imaging services, and/or subacute care and swing beds, leading to access challenges related to narrow networks.[16] Rural patients often do not understand that their MA plan is not the same as traditional Medicare and may not adequately cover local rural facility fees, nor allow for care in the local swing bed. The rise of MA has also been associated with increased administrative burden, lower reimbursement rates, and delays and denials in payment.[17]

800,000

Coloradans

Live in a rural community

180

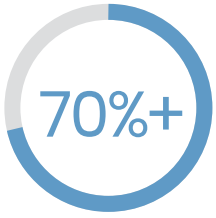
Rural hospitals nationwide

Have closed their doors or stopped inpatient services since 2005

-44% to 32%

Operating margins vary widely

Average and median margins are below 0



of Colorado's

rural and frontier hospitals are critical access hospitals

Rural and frontier hospitals in the state also encounter challenges with Medicaid reimbursement, which is frequently below the breakeven point.[18] This becomes a concern as these facilities care for higher rates of patients with Medicaid. Overall, the state's Medicaid redetermination process after the COVID-19 pandemic has negatively impacted hospitals by causing self-pay rates to increase, decreasing cash flow, and increasing bad debt and uncompensated care. The Colorado General Assembly is also grappling with rising health care costs in the Medicaid program[19], now more than double the TABOR limit, which will force tough decisions to balance the state's budget over the next few years, e.g., reduce benefits or limit eligibility. This trend, plus additional anticipated cuts to Medicaid reimbursement as provisions of H.R. 1 are implemented over the next decade, will continue to stress rural hospitals' financial situations.[20]

Over the last several years, the operating margin for rural hospitals in the state has varied widely (-44% to 32%) with a mean and median value less than 0, demonstrating substantial variation in financial stability and resources for patient care. This shows that Colorado's rural hospitals are generally small and at risk of or in financial crisis, but that varying organizational locations (e.g., resort towns with a large tax base) and sizes may influence financial performance.

More than 70% of Colorado's rural and frontier hospitals (n=32)[21] are critical access hospitals (CAHs), which are designations given by CMS to eligible facilities with 25 or fewer inpatient beds; most are located 35 miles from the nearest hospital, although exceptions exist. CAHs provide 24/7 emergency care and maintain an average length of stay for acute care patients of 96 hours or less on an annual basis. This facility type, which provides cost-based reimbursement for Medicare services, was created by the Balanced Budget Act of 1997 (BBA) after more than 400 rural hospitals permanently closed in the 1980s and early 1990s.[22]

Many concerns were raised about CAHs during this research project. The authorizing legislation was regarded as being helpful initially to stabilize rural hospital finances but may no longer provide needed stability.[23] Rural hospitals have long faced revenue volatility, with some insurers paying right at or just below cost (including Medicaid historically) and others above cost (some commercial contracts). Early on, CAH funding made up for the overall negative margins from other payers. In subsequent years, as the loss from some payers became larger (e.g., declining Medicaid reimbursement) and the positive margins from commercial payers grew smaller while coverage shifted to higher Medicaid and lower commercial-covered lives, CAH funding could no longer reliably cover the losses driven by this payer mix. In addition, federal sequestration has also negatively impacted CAHs.[24] While CAHs receive 101% of costs for delivering Medicare services per the BBA, since April 1, 2013, they have been subject to a 2% cut established by the Budget Control Act of 2011. Subsequent laws have extended this sequestration through 2032.[25]

The research also highlighted several operational challenges rural and frontier hospitals currently face, including workforce recruitment and retention, access to capital, health system consolidation, administrative burdens in a fragmented payer environment, changing demographics of rural patients, caregivers, and clinicians, and resources required to maintain state and federal regulatory compliance and invest in innovative care delivery models.[26] Hospital administrators expressed concerns about maintaining diverse service lines, especially maternity care.

In the survey of rural and frontier hospital CEOs across the state, the most pressing operational issues they identified were cybersecurity, aging infrastructure, poor reimbursement from different payers, and the increasing number of regulations and new legislation to understand and comply with.

While key informants were glad to see Congress pay attention to rural health care delivery challenges and create new facility types, they shared concerns about the Rural Emergency Hospital designation. While it still allows a facility to provide emergency and outpatient care, the model eliminates the possibility of delivering inpatient services.[27]

Lack of access to capital to renovate, expand, or build new facilities, combined with poor financial reserves and low — frequently negative — operating margins, is a particularly difficult challenge for the state's rural hospitals, especially for aging hospitals built with financing from the federal Hill-Burton Act of 1946 that provided communities with loans and construction grants to build hospitals where they were needed. In Colorado, 24 hospitals were built with support of this program through 1975, when the Hill-Burton Act was amended and incorporated into the Public Health Service Act. Four additional hospitals were built between 1976 and 1997, when the program stopped receiving federal financial support. Most of the rural hospitals in Colorado are more than 50 years old.[28]

Figure 1. Original Build Dates for Colorado's 43 Rural and Frontier Hospitals.

Concurrent with the Colorado Rural Futures project in 2024, Jack Pitsor, a Master of Public Policy student at Duke University, conducted a survey on rural hospital capital needs in the state, as part of an internship with CHA. In his report entitled, *"The Rural Hospital Capital Conundrum: State and Federal Funding Opportunities to Assist Colorado Rural Hospitals with Their Capital Needs,"* he reported that responses from 25 rural and frontier hospital CEOs indicated a total of more than $67.5 million in "smaller scale" (<$5 million) capital project needs, with an average cost of $2.9 million.[29] CEO respondents revealed a total of more than $413 million in "larger scale" (≥$5 million) capital project needs, with an average cost of $21.7 million.[30] Renovations and/or replacements of brick-and-mortar facilities were cited as the most common need.

Most Colorado rural hospitals are

50+

years old

What are the essential health services that rural and frontier hospitals deliver within their communities?

Rural and frontier hospitals in Colorado play an important role in delivering the following services, which may be considered core to meeting rural patient needs: emergency and trauma care, acute inpatient care, skilled nursing care (including through use of swing beds), perinatal and maternal health care (both labor and delivery and care during and after pregnancy), laboratory and imaging services in support of primary and specialty care such as orthopedics, and outpatient primary care service lines including operating rural health clinics and delivering rehabilitation services. Rural hospitals also play an important role in providing infusion and chemotherapy, serving individuals with mental and behavioral health needs, including substance use disorders and for those experiencing a mental health crisis, and identifying social needs and making referrals accordingly. In interpreting these findings, it is important to consider that rural hospitals often serve safety-net roles when other resources in the community – such as community mental health centers – are limited and that core services rural patients may expect from their local hospital may vary based on other available health care services nearby and local community needs.

Figure 2. Types of Essential Services Provided by Rural and Frontier Hospitals Across the Lifespan.

	Perinatal	Early Childhood	Young Adult	Middle Age	Older Age
Emergency and Trauma Care	X	X	X	X	X
Acute Inpatient Care			X	X	X
Skilled Nursing				X	X
Prenatal Care	X				
Labor and Delivery	X				
Laboratory Services	X	X	X	X	X
Imaging Services	X	X	X	X	X
Primary Care	X	X	X	X	X
Infusion Services			X	X	X
Rehabilitation Services			X	X	X
Mental and Behavioral Health Services	X	X	X	X	X
Social Needs Identification and Referral	X	X	X	X	X
Home Health / Hospice				X	X
Long-Term Care					X

When available, rural residents do use rural hospital services. Outpatient laboratory, imaging, and therapy services are core services that rural patients use when a rural hospital provides them. Rural hospital discharges are more likely to be for patients with Medicaid and Medicare coverage. The analysis demonstrates that for some services like obstetric care, a larger proportion of rural patients with government-sponsored insurance, e.g., Medicaid, receive their care in rural hospitals compared to those with commercial insurance.

Patients residing in rural Colorado are traveling to some extent for hospital-based care, though the data used for this study did not identify the location of hospitals, which limits any measurement of the geographic density of service availability across the state. When looking at Health Statistics Region (HSR; a designation made by the Colorado Department of Public Health and Environment (CDPHE) and the only hospital geographic variable available for this analysis), this analysis shows more substantial out-migration for maternity or obstetric care (not only deliveries but any hospital-based care while pregnant; see Figure 3) and chemotherapy (see Figure 4). Differences are observed in out-migration for care across the state, suggesting variation in hospital capacity and/or patient preference. For example, inpatient and outpatient discharges for patients from south and eastern Colorado are more likely to be from a hospital outside the patient's home HSR.

Figure 3. Rural Patients Traveling to Another Health Statistics Region for Hospital-Based Obstetric/Maternity Care.

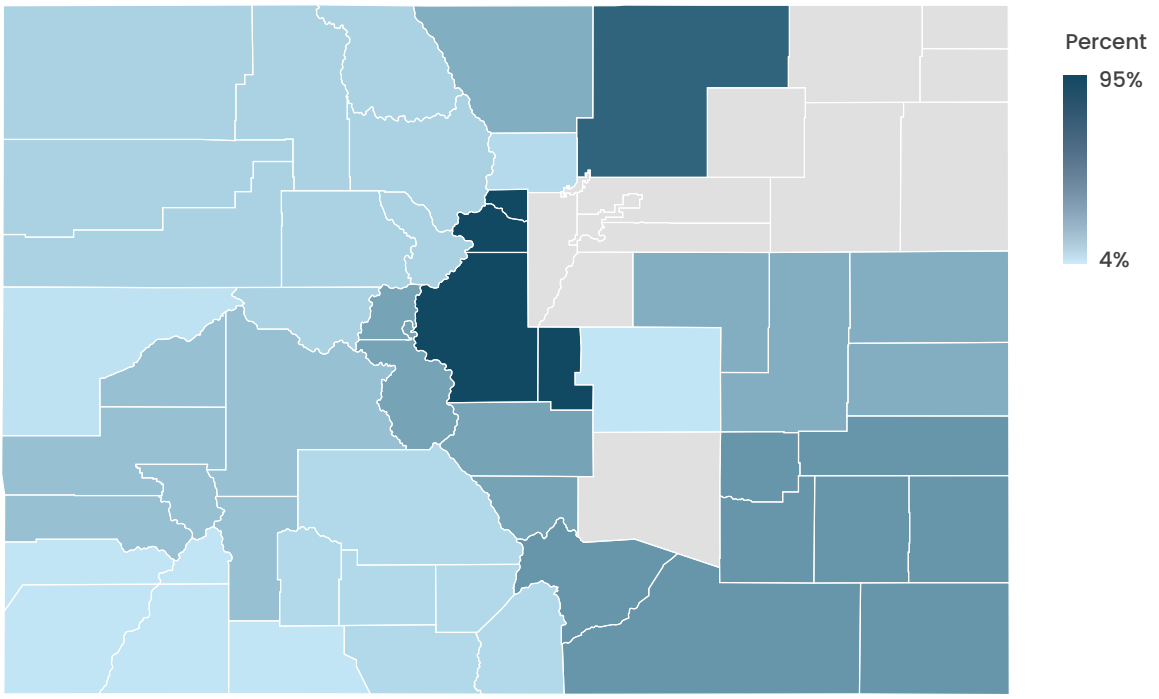
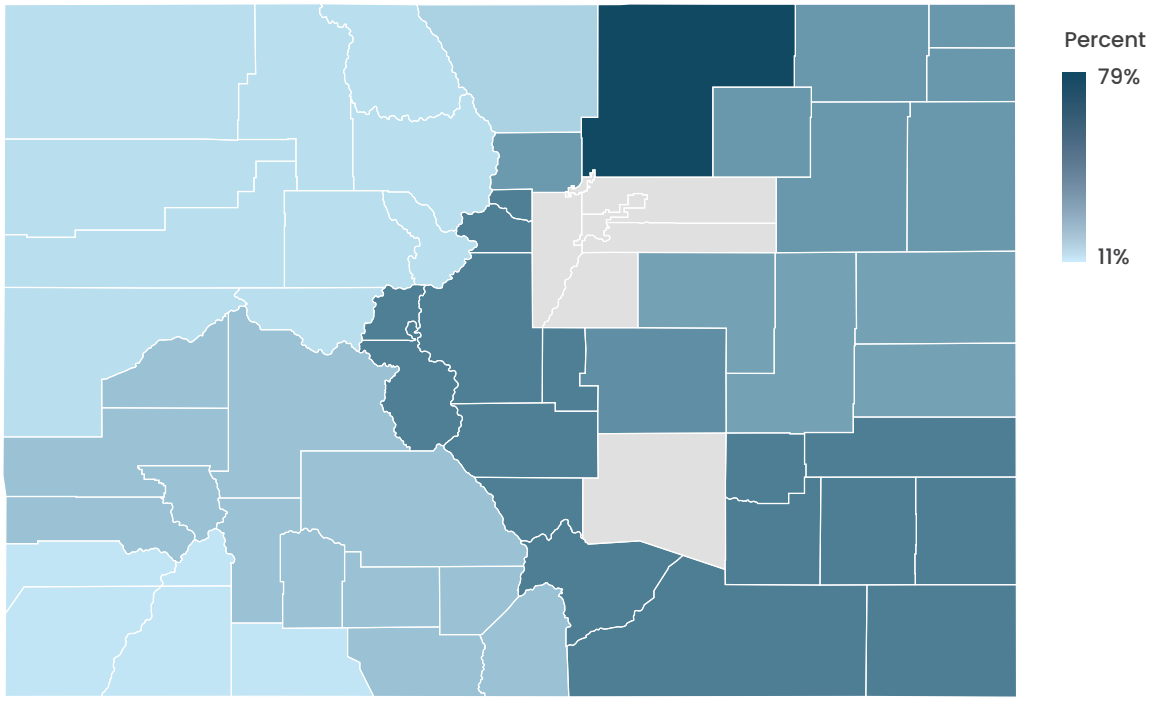


Figure 4. Rural Patients Traveling to Another Health Statistics Region for Hospital-Based Chemotherapy Care.



The quantitative data analysis serves as a starting point for defining the core services that rural and frontier hospitals should provide by understanding what they are currently providing.

Additionally, the research team reviewed available community health needs assessments (CHNAs; n=38) to understand the most common health needs rural and frontier hospitals are addressing in partnership with other organizations. Of all the identified needs, these were the most common: 1) Chronic disease management; 2) Mental health and substance use disorder services; and 3) Availability of appointments and services. This analysis highlights opportunities where rural hospitals and community partners can work together to strategically solve problems and prioritize resources.

What are potential policy solutions to strengthen these vital facilities?

Potential policy solutions to address the underlying challenges Colorado's rural and frontier hospitals face were generated from multiple sources, including the literature review and legislative scan, a survey of rural and frontier hospital CEOs across Colorado, key informant interviews of rural health experts outside of the state, five focus groups of rural health stakeholders in the state, and the Core Leadership Team. The full set of recommendations are grouped into three buckets: financial, operational, and clinical services (including the clinical and administrative workforce). These groupings reflect the predominant challenges, e.g., finances and operations, identified in response to the first research question that was asked in this study and what was learned in answering the second research question about essential health services rural and frontier hospitals in Colorado are currently delivering within their communities.

Financial recommendations

- Seek adequate reimbursement from commercial payers for essential services that rural and frontier hospitals deliver within their communities. Incentivize these payers to reimburse at levels more likely to cover high fixed costs in rural facilities.
- Evaluate options to preserve and/or enhance the use of CHASE (Colorado Healthcare Affordability and Sustainability Enterprise) fees for at-risk rural and frontier hospitals across the state.
- Pursue enhanced payment rates for Medicaid for facilities whose payer mix of public payers and uncompensated care represent a significant proportion of their business.
- Design a payer performance scorecard that rates payers on their ability to meet contract requirements, pay rural hospitals promptly, limit denials for payment, etc.
- Create a planning commission that would a) make community health status the basis for payment; and b) provide resources to help rural hospitals transition to a care delivery model focused on improving health status (rather than delivering a greater volume of services).
- Increase Medicaid provider rates and/or preserve or expand health insurance access through Medicaid, e.g., change eligibility or increase benefits.

MOST COMMON IDENTIFIED NEEDS IN THE COMMUNITY HEALTH NEEDS ASSESSMENTS

01

Chronic disease management

02

Mental health and substance use disorder services

03

Availability of appointments and services

- Establish a rural hospital stabilization fund where hospitals can apply for emergency support and/or technical assistance to improve finances, operations, and/or delivery of services, e.g., revenue cycle optimization, cost reporting, leadership coaching, community outreach, strategy development, quality improvement, and workforce retention.
- Equalize reimbursement rates for in-person and telehealth visits.
- Support rural and frontier hospitals to transition from volume-driven to innovative, value-based care models.
- Identify options under the state's authority to improve the utility of MA plans in rural communities, e.g., creating a statewide MA plan, making it easier to switch from MA back to traditional Medicare, and assuring that MA plans cover the total cost of hospital care as a replacement for fee-for-service Medicare.
- Restrict prior authorizations or other administrative activities from insurance companies that can delay or deny payment for services.
- Lower the costs of drugs and insurance products for patients, including protecting the 340B Drug Pricing Program.
- Examine ways to improve SB24-221 (Funding for Rural Health Care). The law created the rural hospital cash fund, and a one-time transfer of just over $1.7 million was distributed in equal amounts to all rural hospitals in the state (approximately $40,000 each). Suggestions were raised to strengthen this fund, including combining funds from other organizations and involving hospitals in the disbursement process.

Operational recommendations

- Create regional collaborations that enhance the ability of rural hospitals to share personnel, data, and technology, engage in group purchasing, coordinate care, and implement population health initiatives, among other activities, while meeting federal anti-trust requirements. The state could leverage SB23-298 (Allow Public Hospital Collaboration Agreements) to advance this goal.
- Decrease barriers and costs for rural hospitals to purchase electronic health record systems.
- Partner with the appropriate agencies to establish a fund to be used by qualifying rural and frontier hospitals for small-scale construction and/or renovation projects, e.g., support hospital equipment updates or replacements.
- Develop a statewide technical assistance program for the use of architects, building planners, and master facility planning consultants, as well as financial counseling and evaluation to inform infrastructure planning and implementation.
- Provide tax breaks for infrastructure improvements for rural facilities, e.g., New Markets tax credits, enterprise zones, and community benefit credits.
- Establish a program to coordinate the planning and purchasing of capital equipment, one that supports hospitals to collectively negotiate purchases and secure favorable financing among available state and federal options.
- Consider developing regional rural hubs and/or rural-urban clinical partnerships to support care delivery where it is most appropriate, with the goal of returning patients as quickly as possible to their originating facility for ongoing care.

Establish a rural hospital stabilization fund

Equalize reimbursement rates for

In-person and telehealth visits

Support rural and frontier hospitals

To transition from volume-driven to value-based care

Clinical services and workforce recommendations

Clinical services:

- Build upon research done in this project to further characterize essential services that should be made available in rural and frontier communities statewide.
- Allocate more resources to prevent mental health crises and suicides among farmers, ranchers, and agricultural producers, as well as other at-risk groups in rural communities.
- Increase investments in preventive care across the lifespan.
- Improve availability and comprehensiveness of care for aging adults in rural areas.
- Form regional collaborations to improve access to care, e.g., rural obstetrics coalitions to share resources and provide preparedness training for obstetrical emergencies.
- Broker partnerships between rural hospitals and other community providers, e.g., public health, federally qualified health centers, and human service organizations, to improve health and health care locally.
- Explore innovative strategies to bridge gaps in access to mental health, primary care, and specialty services in rural areas.
- Support more robust remote patient monitoring services so that patients can remain closer to home, as well as mobile units and home visiting nurse programs.
- Invest more consistently in broadband and high-speed internet so that telehealth is more readily available statewide. Telehealth should support, not supplant, in-person care.
- Consider more formal partnerships with urban facilities to provide specialty services.
- Explore urban-rural transfer agreements or partnerships regarding patient care and how to help offload volume at urban facilities.
- Consider strategic opportunities to ensure preservation of hospital service lines such as long-term care, hospice, and home health where they are the only provider in the community.
- Reform emergency medical transport services so that they are more available and affordable, while being mindful of the high fixed costs rural and frontier hospital incur to provide these services.

Clinical workforce:

- Enhance existing rural rotations for medical students, resident physicians, and other clinicians, so they become more familiar with a team-based approach to caring for rural communities.
- Change state laws and regulations to make it easier for out-of-state clinicians to offer telehealth services in Colorado.
- Offer broader student loan forgiveness or interest rate decreases for health care workers and administrators choosing to work in rural hospitals, across multiple roles and specialties.
- Provide tax credits to specific types of providers that are highly needed in certain rural communities.
- Ease state licensure requirements to allow health care professionals licensed in other states to "fast track" for Colorado state licensure.
- Implement restrictions against non-compete clauses.
- Expand scope of practice for different types of medical professionals to increase access to care and mitigate workforce shortages, e.g., physician associates, nurse midwives, and psychologists.
- Adjust minimum staffing, training, and equipment regulatory requirements that may adversely impact rural health care providers, e.g., nursing and emergency medical services.
- Encourage partnerships with local school districts to create pathways for interested traditional and non-traditional students entering health care occupations.
- Create opportunities for the state's community colleges to work collaboratively with rural hospitals to develop more robust training programs for ancillary professions, e.g., medical assistants, lab technicians, and certified nursing assistants.

Administrative workforce and governance:

- Fund development of training programs for hospital administrators within Colorado's higher education institutions.
- Help fund the participation of hospital leaders in existing executive leadership programs, e.g., Dartmouth Master of Health Care Delivery Science and University of Colorado Denver Executive MBA in Health Administration, among others.
- Modify HB22-1005 (Health-care Preceptors Tax Credit) to allow rural and frontier hospital CEOs and other executive leaders, e.g., CFOs and COOs, to qualify for tax credits for mentoring or precepting health care administration students and/or early career professionals.
- Partner with a state agency or organization to develop or expand training materials and programs for hospital governing board members.

Conclusion

Colorado's rural and frontier hospitals face numerous challenges, including ensuring adequate reimbursement, acquiring needed capital, and recruiting and retaining a robust workforce, among others, in their efforts to protect and expand access to essential clinical services in their communities. This roadmap details a prioritized list of state-level policy recommendations designed to address these challenges. This list is based on extensive findings from the Colorado Rural Futures mixed methods research study analyzed through the lens of the state's rural leaders and hospital executives. As a result, these recommendations are evidence-based and highly relevant to rural Colorado. This roadmap can serve as a tool to inform and align advocacy efforts among rural health stakeholders to strengthen rural and frontier hospitals in Colorado over the next three years and beyond.

What comes next: The Core Leadership Team will disseminate this roadmap to key stakeholders and meet with health systems and payer leaders, peer rural hospitals, rural health associations, project funders, and state policymakers to discuss the recommendations and formulate an implementation plan. The results of these discussions will make subsequent stakeholder interactions and policy momentum more focused and productive. These discussions serve as an opportunity to test whether these specific policy strategies are the right fit for Colorado at this time, given myriad policy changes at the state and federal levels, calls for reform by prominent national organizations, and the new RHTP. The state has an incredible opportunity to use these new federal dollars to ensure sustainable rural health policy change, leveraging the synergy between RHTP plans and Colorado Rural Futures recommendations. As implementation moves forward, the Core Leadership Team will call upon peers to get involved by providing feedback on potential solutions, reaching out to elected officials, engaging in ongoing stakeholder work, responding to data and media requests, and more.

Building on this work: The Colorado Rural Futures project was scoped to focus on strengthening rural and frontier hospitals as a first step to expanding and protecting ongoing access to needed health and health care services and maintaining financially viable anchor institutions that are critical to their local economies. However, rural and frontier hospitals are not the only health care providers in their communities, and they frequently participate in partnerships to improve local and regional health care infrastructure. The research and recommendations of the Colorado Rural Futures project serve as a starting place to engage other key rural health stakeholders (e.g., Colorado Rural Health Center, Western Healthcare Alliance, Eastern Plains Healthcare Consortium, Colorado Hospital Association, Pro 15 Northeast Colorado, Colorado Health Foundation, and Colorado Health Facilities Authority) in creating a collective vision and partnership to ensure more vibrant and thriving rural communities across the state.

Appendices

Appendix A – Detailed Methodology

The creation of the Colorado Rural Futures policy roadmap was informed by a mixed methods research study as summarized in the table and further detailed below. This study was found to be exempt from review by the Institutional Review Board (COMIRB #24-0300). The authors analyzed data derived from all aspects of the research study, iteratively discussing findings and insights with the Core Leadership Team for feedback and refinement, to produce the final policy recommendations, e.g., state, federal, organizational, included in this roadmap. The methods are summarized below.

Quantitative methods:	Qualitative methods:
Analyzed hospital-level data to understand variation in rural hospital characteristics across Colorado	Conducted an environmental scan of nearly 150 peer-reviewed and lay media articles to identify the root causes of distress facing rural and frontier hospitals
Analyzed discharge-level data to understand the types of services rural hospitals provide and where rural patients go for hospital-based care	Conducted a legislative scan of nine states, including CO, ID, KS, MT, NM, OR, UT, WA, WY, to source ideas for legislative solutions for rural and frontier hospitals' most common challenges
Fielded a survey of rural and frontier hospital CEOs in Colorado to understand their perspectives on recent policies enacted at the state level, as well as the most pressing challenges they face	Reviewed 38 Community Health Needs Assessments to determine the most common health priorities in Colorado's rural and frontier communities
Examined build and renovation dates for Colorado's rural and frontier hospitals to assess capital needs	Interviewed 23 key informants representing rural health policy, research, and administrative leaders outside of Colorado to gather ideas for policy solutions to common challenges rural and frontier hospitals face
	Hosted 10 focus groups (six virtual and four in-person) involving 77 Colorado stakeholders, including clinicians, hospital administrators, board members, elected officials, and business owners, to discuss proposed policy solutions

QUANTITATIVE METHODS

Analysis of hospital- and discharge-level data

Several key data sources were used to complete our quantitative analyses. Each source and the associated statistical methods are summarized below.

1. The American Hospital Association (AHA) Annual Survey, 2009-2022. The AHA Annual Survey database includes hospital- and health system-level data on utilization (admissions, births, surgeries, emergency department visits, and staffing), physician arrangements, hospital service lines and facilities, organizational structure and affiliations, alternative payment models, telehealth, and behavioral or social determinants of health services. Given large amounts of missing data in earlier years, the analysis only reports on data from the 2022 survey year. Descriptive analyses are provided for rural hospitals (n=43) in the state.
2. The Colorado Hospital Discharge data, 2017-2023, made available by the Colorado Hospital Association (CHA). These data are provided to CHA from hospitals across the state and include information about patient demographics, diagnoses, and place of service as well as the health statistics region for both the patient and the hospital. Place of service is used to identify if a hospital visit was inpatient, emergency, or outpatient. Where possible, diagnostic (International Classification of Diseases or ICD) codes were used to determine if a person presented to a hospital for obstetric care or for chemotherapy. ICD codes were also used to identify if a hospital visit was related to substance use or mental or behavioral health needs. Of importance in interpreting these findings, the team did not have access to hospital identifiers and therefore is unable to definitively determine hospital location. Instead, hospital region and type were used to determine that a hospital is likely in a rural community. All descriptive summaries provided are at the patient-discharge level. Multivariable logistic regression was also conducted to test associations between key demographics and use of certain types of hospital-based services (e.g., obstetric care and chemotherapy) by rural patients.
3. CMS Hospital Cost Report data was used to determine hospital bed size and to calculate hospital operating margin. Operating margin was calculated using net revenue from patient care to ensure COVID-19 relief dollars were excluded from the calculation.

To view the chartbook with detailed findings from analysis of hospital- and discharge-level data, *please see this QR code.*

Survey of rural and frontier hospital CEOs in Colorado

In September and October 2024, the Core Leadership Team and the Farley Center fielded an online survey of all 43 rural and frontier hospital CEOs in Colorado to better understand their perspectives on the most pressing challenges they face, as well as their thoughts about possible solutions. The survey questions (n = 28), a mix of multiple choice, Likert scale, and open-ended prompts, were jointly developed by the Core Leadership Team and the Farley Center and loaded into the online platform Qualtrics. The Core Leadership Team promoted the survey via different channels, e.g., email, personal outreach, and stakeholder calls. Results were exported for analysis by the Farley Center.

Examination of build and renovation dates for Colorado's rural and frontier hospitals

For all 43 hospitals classified as rural by CHA, the Farley Center team reviewed publicly available data sources to determine the build dates of their current facility. Additionally, all renovations for each hospital were confirmed. This data was used to create a map to illustrate the age of all rural hospitals statewide that is described above in the main report.

QUALITATIVE METHODS

Environmental scan of peer-reviewed and lay media

Understanding the root causes of distress the state's rural and frontier hospitals face was largely accomplished through a focused environmental scan of the extant peer-reviewed literature and media that resulted in an annotated bibliography and informed answers to the two other research questions. The purpose of this annotated bibliography was to conduct a thorough review of the current rural hospital distress literature and condense it into a useful resource. Multiple sources were utilized to identify the core articles for review. First, a literature review was conducted from the online database PubMed.gov, accessed through the CU Anschutz Strauss Health Sciences Library. The initial search criteria of "rural hospitals" yielded 18,000 individual publications. The search was sequentially and independently narrowed using specific research terms with "rural," including "economy," "closure," "critical access," "transfer," and "bypass." Each specific search yielded 25-500 articles. The articles were further narrowed to "English language" and published between 2015-2024. Additional articles were identified through the references and endnotes of published manuscripts and reports, suggestions from colleagues, and recommendations from experts. Finally, these same search terms were cross-referenced for additional scholarly articles and non-peer reviewed literature in search engines such as Google and for the larger news and media outlets in Colorado, e.g., The Colorado Sun, The Denver Post. The combined searches included over 1,000 articles on rural hospitals. The authors reviewed these to identify seminal papers, those essential to rural hospital administrators, policymakers, and state agency leaders.

The final selection in this annotated bibliography includes 146 articles and 80 news stories that provide the reader with a broad understanding of the current state of the science in rural hospital finance, clinical operations, workforce, and the local economy. The annotations include an analysis of the research, ideas, and recommendations to inform the reader about clinical care, research gaps, and best practices for rural hospital management, clinical care, and finance. Additionally, the articles provide a basis for potential state policy solutions that may support rural hospitals and communities. By selecting and describing a collection of articles that includes a mix of general and specific topics, this bibliography provides a guided tour through the topic of rural hospital distress.

Legislative scan of nine states

The authors conducted a review of enacted and proposed legislation in multiple states (CO, ID, KS, MT, NM, OR, UT, WA, and WY) to identify approaches Colorado and peer states have pursued in the past to improve the rural health care workforce, financial operations of rural hospitals, and delivery of clinical services. These nine states were selected for several reasons, including similar rural geographic and political makeup compared to Colorado. This legislative scan provided a range of potential solutions the state's stakeholders can consider, as well as a benchmark for comparison regarding proposals Colorado's General Assembly has introduced.

Review of Community Health Needs Assessments

The team reviewed community health needs assessments (CHNAs) to identify key community needs that the state's rural hospitals and their partners face. Of the 43 rural hospitals in Colorado, 38 had CHNA reports available for review with data ranging from 2018 to 2024. The remaining hospitals were either not required to complete a CHNA based on their ownership status or the study team was unable to acquire the CHNA. These reports were collected from hospital websites and through direct requests. Each report was reviewed to document the community needs identified, each of which was compiled into a list. Community needs were categorized based on similarity to help understand the most common needs across the state.

Key informant interviews of rural health experts

Twenty-three key informant interviews of experts outside of Colorado were conducted and analyzed, including a mix of rural and frontier hospital CEOs, association executives, innovators, researchers, and federal officials, as well as financial, workforce, and policy experts. All interviews were conducted virtually via Zoom, recorded, and transcribed for later analysis. The key informants were chosen through purposeful sampling to achieve a balance across selection criteria, including geography, type of leader and role, and national versus frontline perspective. Two members of the Farley Center research team participated in each interview. The results were summarized, anonymized, and shared with stakeholders during the focus groups. Interviewees were also asked to share key documents with the team for review, including reports, briefs, legislation, and regulation, among other materials.

Focus groups

In June and July 2025, the Farley Center facilitated 10 focus groups with Colorado stakeholders (n = 77 individuals engaged across six virtual and four in-person focus groups [held in Alamosa, Craig, Gunnison, and Hugo]) for two purposes: 1) to identify a range of state-level policy recommendations to the most common challenges rural and frontier hospitals in Colorado face (first five focus groups); and 2) to review the recommendations based on feasibility and impact (second five focus groups). The stakeholders included community leaders, hospital board members, local employers, clinicians, payers, elected officials, state agency leaders, rural health association representatives, and philanthropy and health systems leaders. The focus group participants were chosen through purposeful sampling to achieve a balance across all ten groups in terms of geography, role, and lived experience. Two members of the Farley Center participated in each focus group. All focus group discussions were recorded and transcribed for later analysis. The results of the focus group discussions, plus findings from other aspects of the research project, underwent subsequent iterative analysis and refinement to produce the final set of policy recommendations detailed in the Policy Recommendations section of this roadmap.

Appendix B – Detailed Findings by Data Source and Method

This appendix contains detailed findings by data source and method for all phases of this mixed methods study according to the methods summary table in Appendix A. For an overall synthesis of study findings, please see the Research Findings section earlier in this roadmap.

QUANTITATIVE METHODS:

Analysis of hospital-level data to understand variation in rural hospital characteristics across Colorado:

The review of hospital-level characteristics shows some variability in financial, capital, and service line infrastructure. Based on the definition of rural hospital used by CHA, 43 rural and frontier hospitals in Colorado were identified based on critical access hospital designations/status and location in a rural or frontier county. Overall, rural hospitals in the state are diverse in geography (e.g., Eastern Plains, Western Slope, and resort town), size, and ownership. Over 70% of rural hospitals are critical access hospitals and have 25 or fewer beds. The operating margin for rural hospitals over the last several years varies widely (-44% to 32%) with a mean and median value less than 0, demonstrating substantial variation in financial stability and resources for patient care. This shows that Colorado's rural hospitals are generally small and at risk of or in financial crisis, but that varying organizational locations (e.g., resort towns with a large tax base) and sizes may influence financial performance.

Hospital-level data analysis: The analysis of service lines used data from the American Hospital Association (AHA) Annual Survey from 2022 and 2023 and included 29 (2023) and 30 (2022) rural Colorado hospital responses. While a powerful source of hospital-level information, the survey is voluntary, and there are rural hospitals that did not respond to the 2022 or 2023 surveys.

All rural hospitals responding to the survey report operating an inpatient general medical surgical unit for adults and emergency departments. Most rural hospitals have infrastructure for trauma care and the availability of swing beds to allow for flexibility in the type of care delivered using those beds. Approximately 60% of rural hospitals (90% of the larger rural hospitals and 50% of the smaller rural hospitals) that responded to the survey report having a labor and delivery unit.

Rural hospitals serve community needs for inpatient care and provide extensive outpatient and ancillary services that are not traditional hospital roles. For example, almost all rural Colorado hospitals report providing primary care services (76%), and half report operating a rural health clinic. There is also evidence of infrastructure in rural hospitals for delivering physical rehabilitation, chemotherapy, ambulance services, case management and social work services, skilled nursing, chaplaincy, and home health care. A majority of rural hospitals responding to the survey also have imaging services (e.g., CT, MRI, and ultrasound) available in their community. Notably, rural hospitals play an important role in providing screening and social services, including breast cancer screening, diabetes prevention programs, health screenings, community health education, and community outreach. Social needs screening for housing needs, food insecurity, utility needs, interpersonal violence, transportation needs, employment or income support, and social isolation is also a critical service provided by rural hospitals. Related, a majority of rural Colorado hospitals report having a program or strategy to address needs identified through social needs screening.

Analysis of discharge-level data to understand the types of services rural hospitals provide and where rural patients go for hospital-based care:

Discharge-level data analysis: Discharge-level analyses explored these key questions:

1. What does hospital-based care look like in Colorado and specifically in rural Colorado?
2. What are the characteristics of rural Coloradans seeking hospital-based care in Colorado, and where are they going for certain types of services?

The goal was to identify the essential services rural Coloradans seek from their local rural hospitals and to identify alignment or misalignment between core services offered by rural hospitals and those that patients need and demand. Of note, these analyses were supplemented by focus group participant feedback on their own experiences or expertise in seeking care in rural Colorado.

Rural patients in Colorado are using rural hospitals but that varies by both type of care (e.g., inpatient, emergency, and outpatient) and type of need as determined by diagnosis (e.g., pregnancy/postpartum care, cancer care, and behavioral health). The study's findings offer evidence that rural hospitals serve both essential needs of those living in their communities and that they serve in a critical safety-net role.

When available, rural residents do use rural hospital services. Outpatient laboratory, imaging, and therapy services are core services that rural patients use when a rural hospital provides them. Rural hospital discharges are more likely to be for patients with Medicaid and Medicare coverage. The analysis demonstrates that for some services like obstetric care, a larger proportion of rural patients with government-sponsored insurance, e.g., Medicaid, receive their care in rural hospitals compared to those with commercial insurance.

Patients residing in rural Colorado are traveling to some extent for hospital-based care; however, the data used for this study did not identify the location of hospitals, which limits any measurement of the geographic density of service availability across the state. When looking at Health Statistics Region (HSR; a designation made by the Colorado Department of Public Health and Environment and the only hospital geographic variable available for this analysis), this analysis shows more substantial out-migration for maternity or obstetric care (not only births/deliveries but any hospital-based care while pregnant; see Figure 3) and chemotherapy (see Figure 4). Differences are also observed in out-migration for care across the state, suggesting variation in hospital capacity and/or patient preference. For example, inpatient and outpatient discharges for patients from south and eastern Colorado are more likely to be from a hospital outside the patient's home HSR.

Survey of rural and frontier hospital CEOs in Colorado: Hospital administrators responding to the survey identified the following challenges facing their institutions:

- Fifteen CEOs shared their thoughts about the root causes of distress facing Colorado's rural and frontier hospitals, most commonly payer reimbursement, staffing challenges, costs of resources, isolation due to distance, state legislation and regulation, low volume, and administrative burdens.
- The most pressing issues for the respondents' hospitals (n=16) are regulation and legislation, insurance challenges, cybersecurity, infrastructure, and workforce concerns. The respondents would like to see less overwhelming and fewer regulations and more reimbursement for services.
- Overall, recent Medicaid redeterminations or disenrollments have negatively impacted hospitals by causing self-pay rates to increase, decreasing cash flow and causing delays, and increasing bad debt and uncompensated care (n=16).
- On a scale of one to five, with five being the most negative impact, 18 CEOs indicated that Medicare Advantage is having a negative impact on their facilities, with an average rating of 3.56. This response was largely driven by low reimbursement for provided services.
- Among the 17 CEOs who responded to a question about the specialty services their hospitals provide, the top three specialties are physical or occupational therapy, orthopedics, and cardiology.
- Eighteen CEOs reported they most commonly provide the following types of services to support their board of directors: education in hospital financing, education in staffing a rural hospital, and sharing success stories about their hospital.
- Of the 18 respondents from special district or county hospitals, 56% rely on property taxes to support their hospitals.

Respondents also shared their suggestions about potential solutions to address the challenges they identified:

- When asked what options are being considered related to SB23-298 (Allow Public Hospital Collaboration Agreements), the CEOs (n=16) responded that their top opportunities for cross-hospital collaboration included provider recruitment, shared business services, joint purchasing of insurance, and supporting ancillary clinical services.
- If policies and regulations permitted, 17 CEOs would consider the following additional collaborations or network opportunities: negotiating reimbursements, sharing IT services, and staffing collaborations.
- The Rural Support Fund is complementary funding to the Hospital Transformation Program to prepare critical access and other rural hospitals for future value-based payment environments. Sixteen CEOs indicated they have primarily used the funding to establish or augment services lines, improve HIE connectivity, and offer employee training.
- SB24-221 (Funding for Rural Health Care) created the rural hospital cash fund (total amount available for the program = just over $1.7 million) for the purposes of distributing money in equal amounts (approximately $40,000 each) to rural hospitals across the state.
  - For the 14 CEOs who have received funding from this appropriation, the dollars were primarily utilized for cybersecurity, strategic planning, community health needs assessments, IT, education, and for general funds.
  - Eleven CEOs shared their ideas for strengthening the impact of the rural hospital cash fund, including combining funds from other organizations, involving hospitals in the disbursement process, collaborating with universities, and ensuring sustainability.
- The state-level policies most frequently mentioned (n=15) as helping rural hospitals and systems include the Rural Support Fund, SB23-298, and CHASE. Improvements could be made by maximizing the usage and distribution of these funds.

Examination of original build dates for Colorado's rural and frontier hospitals: For all 43 hospitals classified as rural by the Colorado Hospital Association (CHA), the Farley Center team reviewed publicly available data sources to determine the build dates of their original facility. Additionally, all renovations for each hospital were confirmed (not visualized in Figure 1). The oldest building, East Middle Park Health in Kremmling, was constructed in 1933 while the newest building, St. Vincent Health in Leadville, was completed in 2021. Some hospitals had no recorded renovations, while the most recent renovations or additions occurred in 2025. Of these hospitals, 24 were built through 1975, when the Hill-Burton Act was amended and incorporated into the Public Health Service Act, and 28 were built before 1997, when the program stopped receiving federal financial support. See Figure 1 in the main report.

QUALITATIVE METHODS:

Environmental scan of the peer-reviewed literature and lay media articles: A comprehensive environmental scan of published literature and public media identified the following broad themes:

- Administrative and contracting elements of financial success
- Inadequate opportunities for access to capital
- Breadth of clinical services provided
- Workforce, including clinicians, nursing, ancillary, and administrative staff
- The impact of the local community economy on hospital distress

Additional policy-relevant ideas that emerged in the scan included networking among rural hospitals, partnership with urban hospitals, workforce training incentives, marketing of local services, identifying non-clinical revenue opportunities, maximizing private and public payer contracts, and potential subsidies or other direct financial support.

Several specific topics were found frequently in the environmental scan, such as maternal health, consolidation of health systems, payers, Medicare Advantage, clinical services, and financial viability of a small rural hospital. Hospital finance was a common topic within the health services research literature, and quite a few articles about rural hospital financial stability were found in the lay media. Both in the peer-reviewed literature and media were examples of hospitals unable to acquire adequate capital to renovate, expand, or build a new facility. Individual examples punctuated the robust data on rural hospital aging and attempts to capitalize facilities. The literature included numerous articles about the clinical services provided at rural hospitals. Maternity care topped the list of clinical services studied; however, there were many articles about surgery, cancer care, primary care, and emergency care.

A ubiquitous theme emerged from both the peer-reviewed literature and lay media review regarding whether rural hospitals were financially viable, stable, secure, and/or had a future. It was not clear from the literature whether there was a standard pathway to financial stability for rural hospitals. Without significant state and/or federal policies that stabilize and support rural hospitals, no standard local process to assure rural hospital financial viability emerged from the literature. Infused throughout was the idea that while the critical access hospital legislation was initially a stabilizing factor, it was no longer sufficient to protect many rural hospitals from closing. The environmental scan also provided a robust review of the negative impacts that Medicare Advantage has on rural hospitals. Medicare Advantage carriers advertise widely to potential beneficiaries, including those living in rural communities. However, these plans do not adequately contract with rural facilities including hospitals, outpatient clinics, laboratory and imaging services, and/or subacute care and swing beds, leading to access challenges related to narrow networks. Rural patients often do not understand that their Medicare Advantage plan may not adequately cover local rural facility fees, nor allow for care in the local swing bed. The rise of Medicare Advantage has also been associated with increased administrative burdens, lower reimbursement rates, and delays and denials in payment.

The fields of addressing health equity and the social determinants of health appeared frequently throughout the rural hospital literature and media stories. There seemed to be no common theme on how rural hospitals could serve as a model for health equity and a vehicle to address social drivers. The articles were dominated by epidemiological analysis of social determinants of health and demographic variation faced by rural communities that tend to have lower income, higher poverty, fewer goods and services, and geographic isolation. There was no answer in the literature except for a few individual hospital examples. Research articles, commentaries, and anecdotes on telehealth were common in the peer-reviewed literature but not in the lay media.

While there remains ongoing literature about the rural health care workforce, the topic no longer dominates the literature or media as it once did. There were a few new and long-term studies on the rural health care workforce, often including the broader team of nurses, ancillary personnel, and administrative staff, rather than only the physician workforce. There was very little analysis or literature on the benefit that rural patients provide to urban hospitals through transfer and referral of clinical cases.

There were limited examples of rural hospitals working with local community organizations to share resources, space, and programs, e.g., how might a rural hospital offer social services, house local health or public health organizations, and deliver educational programs. However, there was solid literature on the interaction between economic sectors and the crucial symbiosis between the rural community economy and the financial stability of the local hospital. The overall health of a community, from physical health to financial health, social services, and education was closely tied to the stability of the local hospital.

There was not much about how a local hospital might build a brand, market its services to the community, tell its story, deliver positive content to local newspapers, or highlight hospital staff, services, or programs. Rural mobility and technology make it possible to bypass the local clinic and hospital, and there are competitive, for-profit, companies actively marketing for rural patient market share.

While the environmental scan identified numerous topics that may have policy implications, the two major themes that arose were financial and clinical services. Identifying a successful path to financial stability may require federal, state, and local policy efforts. Securing capital funds for renovation and expansion requires creative options, many unique to a particular community. Recognizing the appropriate clinical services for an individual hospital requires understanding the regional and state landscape and cultural expectations of patients and policymakers.

To review the annotated bibliography, *please see this QR code.*

Legislative scan of nine states: This scan showed:

- Workforce initiatives aim to strengthen the workforce by reducing educational costs through loan forgiveness, grants, and tax credits, particularly for providers in underserved areas. Legislators in these states have also supported the establishment of training programs in rural settings and expanded scopes of practice for various medical professionals to further address workforce shortages, e.g., physician extenders, nurse midwives, and medical assistants. States have also explored restrictions against non-compete clauses and adjusted minimum staffing requirements.
- Financial measures include Medicaid provider rate increases, enhanced health insurance benefits/eligibility through Medicaid or other means, tax incentives for rural hospital infrastructure development, and group purchasing strategies to lower costs of equipment, supplies, insurance, and other services.
- Clinical care service improvements focus on easing licensing barriers to fill open positions more easily, especially for out-of-state providers, and expanding tele-medicine access through regulatory changes and investments in broadband internet. Clinical care solutions also include simplifying prior authorization requirements, addressing health insurance affordability so people can more easily seek care, and expanding Medicaid eligibility and benefits to enhance patient access to essential services.

Review of Community Health Needs Assessments to determine common health priorities in Colorado's rural and frontier communities: A review of 38 CHNAs identified multiple community needs, including:

- Affordability of services
- Aging services
- Availability of appointments and services
- Improved care coordination
- Chronic disease management care
- Climate change action
- Community engagement
- COVID-19
- Family planning and support services
- Mental health and substance use disorder services
- Safety
- Various social determinants of health
- Workforce development and retention

Of these needs, the most common were: 1) Chronic disease management; 2) Mental health and substance use disorder services; and 3) Availability of appointments and services. This analysis highlights opportunities where rural hospitals and community partners can work together to strategically solve problems and prioritize resources.

While an important source of information, CHNAs can be limited in their utility given methodological, resource, and other challenges. Given small population sizes, acquiring high-quality and reliable data that can produce statistically significant results can be difficult. Limited staff and funding can impact the ability of a hospital to conduct a comprehensive assessment and truly engage the local community.

Key informant interviews of rural health experts outside of Colorado: The goal of the key informant interviews (n = 23) was to better understand challenges rural and frontier hospitals face and to identify potential state-level policy solutions from experts outside of the state. Informants emphasized numerous challenges facing rural and frontier hospitals, including:

- Current payment models are often not suitable or adequate in rural areas
- Payer mixes with a greater reliance on public insurance
- High amounts of uncompensated care
- Medicare Advantage, including lack of transparency about delays and denials
- Patients with lower median income levels and higher uninsured rates that can lead to bad debt as patients are unable to pay
- Lower reimbursement rates
- Recruiting and retaining the rural health care workforce
- Resources required to maintain compliance, engage in innovative care delivery models, and maintain diverse service lines
- Impact of rural hospitals on the local economy
- Access to capital
- Financially unstable hospitals facing potential closure
- Changing demographics of rural patients, caregivers, and clinicians
- Concerns with the new Rural Emergency Hospital designation; while it still allows a facility to provide emergency and outpatient care, the model eliminates the possibility to provide inpatient services

Informants shared several policy and programmatic examples of potential solutions to consider pursuing in Colorado and to continue advocating for at the federal level:

- Areas ripe for advocacy include proposing changes to Medicaid rates and higher reimbursement from commercial payers, providing more assistance for rural and frontier hospitals to participate in care delivery innovation, expanding access to preventive care, sustaining availability of and payment for telehealth services, investing more in loan repayment programs for clinicians, and enhancing emergency preparedness in rural areas.
- Creating alliances or regional collaborations among hospitals to share resources, engage in group purchasing, and improve quality of care was mentioned frequently. The Community Care Alliance was cited as a model Colorado could consider expanding for building a statewide clinically integrated network to better share data, analytics tools, technology, and more among collaborating providers.
- Consider developing regional rural hubs and/or rural-urban clinical partnerships to support care delivery where it is most appropriate, with the goal of returning patients as quickly as possible to their originating facility for ongoing care.
- Leverage tools akin to the Community Apgar Project to assist rural hospitals with tailoring their approaches to recruiting and retaining different members of their health care workforce.
- Explore mechanisms to provide robust technical assistance in Colorado to rural and frontier hospitals, e.g., strategy development, revenue cycle optimization, quality improvement, cost reporting, leadership coaching, community outreach, and workforce retention. The Targeted Technical Assistance for Rural Hospitals Program was cited as an example of services that could be offered.
- The Office of Rural Prosperity in Wisconsin was specifically mentioned for their work in creating the Thrive Rural Wisconsin Initiative that offers "project management, financial support, and technical assistance to advance housing, community economic development, community facilities, and sustainable energy projects."
- The University of North Dakota provides the opportunity to participate in the Rural Opportunities in Medical Education (ROME), a 5- to 6-month program that supports students rotating through rural primary care training opportunities in North Dakota and Minnesota.
- The Rural Hospital Stabilization Pilot Program led by the Health Resources and Services Administration (HRSA) provides technical assistance to rural hospitals to tailor their service lines locally to meet community health needs and keep care local.
- HRSA's Rural Residency Planning and Development Program provides support to create new rural residency training programs.

Conducting focus groups of Colorado stakeholders: The first five focus groups yielded the following list of policy recommendations that were iteratively discussed with the second set of five focus groups, the Core Leadership Team, and the Farley Center before arriving at the final set detailed in the Policy Recommendations section:

- Work with the appropriate agency to establish a fund to be used by qualifying rural hospitals for construction and equipment acquisition, including for smaller scale projects.
- Develop a technical assistance program through an appropriate organization for the use of architects, building planners, and master facility planning consultants.
- Establish a formal capital planning program through a state association to coordinate planning and purchasing of capital equipment, one that supports hospitals to collectively negotiate purchases and arrange for favorable financing among available state and federal options.
- Ensure adequate reimbursement for services that rural and frontier hospitals provide across different payers.
- Consider enhanced payment rates for Medicaid for facilities whose payer mix of public payers, e.g., Medicaid and Medicare, and uncompensated care are greater than 50%.
- Incentivize commercial payers to reimburse at levels more likely to cover high fixed costs in rural facilities.
- Design a payer performance scorecard that rates payers on their ability to meet contract requirements, pay rural hospitals promptly, limit denials for payment, etc.
- Enhance the ability of rural hospitals to develop collaborative agreements to procure or purchase needed equipment, insurance, or information technology services, share a clinical workforce, and permit greater price negotiation with commercial payers.
- Explore whether telehealth, mobile units, and/or regional hospital collaborations could bridge gaps in access to mental health services in rural areas.
- Allocate more resources to prevent mental health crises and suicides among high-risk populations, including farmers, ranchers, and other groups.
- Consider developing a regional alliance of rural hospitals, where one hospital may focus on providing maternity care, for example, and the other hospitals prioritize other service lines.
- Invest more consistently in broadband and high-speed internet so that telehealth is more readily available statewide.
- Support more robust remote patient monitoring services so that patients can remain closer to home, as well as home visiting nurse services.
- Lower the costs of drugs and insurance products for patients. This includes maintaining or strengthening existing programs such as the 340B Drug Pricing Program and the WHA Community Care Alliance Pharmacy Benefit Management Program for rural hospital employees.
- Create opportunities for the state's community colleges to work collaboratively with rural hospitals to develop more robust training programs for ancillary professions, e.g., medical assistants, lab technicians, and certified nursing assistants.
- Enhance existing rural rotations for medical students, resident physicians, and other clinicians, so they become more familiar with a team-based approach to caring for rural communities.
- Change state laws and regulations to make it easier for out-of-state clinicians to offer telehealth services in Colorado.
- Encourage partnerships with local school districts to create pathways for interested traditional and non-traditional students entering health care occupations.
- Offer broader student loan forgiveness or interest rate decreases for health care workers and administrators choosing to work in rural hospitals, across multiple roles and specialties.

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