Rural hospital payment, models and new venture opportunities: what the RCHD evaluation tells us about healthcare‘s next chapter

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Abstract

The Rural Community Hospital Demonstration (RCHD) represents one of the lo running alternative payment models in Medicare, now covering 26 hospitals acr multiple authorization periods. This evaluation, spanning 2016-2021, provides r longitudinal data on how cost-based reimbursement affects small rural hospital finances, operations, and strategic decisions. For health tech investors, the findi reveal several underexploited opportunities: swing bed utilization as a margin enhancement tool, the outpatient shift creating inpatient volume pressure, geogr market typologies that predict financial performance, and infrastructure gaps th RCHD payments help fill. The data shows new hospitals improved Medicare ma by 8-16 percentage points pre-COVID, though gains disappeared during the pandemic. Continuing hospitals maintained prior improvements without additi gains. Notably, swing bed revenue share increased significantly for new particip suggesting payment design directly influences care delivery patterns. The report identifies specific pain points around base year cost capture, workforce recruitm and service line sustainability that represent investable problems. Market typol analysis (Competitive, Frontier, Isolated) provides a framework for geographic investment targeting, with Frontier markets showing the strongest fundamental COVID period exposed fragility in the model, with cost increases outpacing targ amounts for non-rebase year hospitals. Hospital leaders emphasized the demonstration’s role in maintaining essential services, often unprofitable, that s community anchors. Several recommended expansion of the model or permanen enable long-term capital planning. For investors, the key insight is that payment

model design creates specific operational challenges and opportunities that technology and services companies can address, particularly around cost manage patient flow optimization, swing bed utilization, and workforce solutions tailore rural contexts.

Introduction: Why Rural Hospital Payment Models Matter for Investors

Look, I get it. When you hear "rural hospital demonstration project," your first instinct is probably to skip to the next deal memo. But stick with me here becau CMS evaluation report is basically a treasure map for anyone investing in health infrastructure, services, or technology aimed at the lower-acuity, higher-margin segments of the market.

The RCHD has been running since 2005, covering hospitals that are too big to b Critical Access Hospitals (CAHs) but too small to thrive under standard Medica IPPS rates. These are 50-bed facilities in places like Wyoming, Alaska, and Nebr hospitals that represent the absolute edge case of U.S. healthcare delivery. And e cases, as we know, are where the most interesting business models get built.

This evaluation covers 26 hospitals through FY 2021, which means we have data includes the COVID period, a time when rural hospitals were simultaneously de with workforce shortages, supply chain nightmares, and dramatic swings in utilization. The report separates "continuing" hospitals (those that joined in earl authorization periods) from "new" hospitals (those that joined in 2018 under the Century Cures Act extension). This distinction matters because it lets us see wh happens when hospitals first join the program versus what happens when they continue participation over multiple five-year cycles.

The payment model itself is straightforward, it is cost-based reimbursement in t first year (the base year), then in subsequent years hospitals get the lesser of thei actual costs or a target amount that is inflation-adjusted from the base year. Swi beds, which are acute care beds that can be flexed to skilled nursing facility leve

get special treatment in the cost allocation methodology that makes them more profitable under RCHD than under standard SNF PPS.

Why does any of this matter for investors? Because payment models create incer incentives shape operational decisions, and operational decisions create problem need solving. The RCHD creates a very specific set of problems around base yea optimization, swing bed utilization, outpatient service expansion, workforce recruitment in remote areas, and capital investment timing. Each of these proble an investable opportunity.

Understanding the RCHD Model and Its Market Dynamics

The mechanics of the RCHD payment model are worth understanding in detail because they explain a lot of the downstream business opportunities. In year one base year), hospitals get reimbursed for reasonable costs of care for Medicare beneficiaries. This is pure cost-based reimbursement, the holy grail for hospitals negative margins under IPPS. In years two through five, hospitals get paid the le of actual costs or a target amount calculated from the base year costs, adjusted f inflation using the IPPS market basket update, case mix changes, and discharge volume.

Here is where it gets interesting for investors. The target amount calculation cre very specific incentives. If your costs go up faster than the inflation adjustor (wh they often do in rural areas with workforce shortages), you are leaving money on table. If you can keep costs flat or growing slower than inflation, you are printin money relative to IPPS. The swing bed methodology adds another layer because for swing beds are blended with acute care costs, and since acute costs are much higher, this results in substantially higher reimbursement for swing bed days tha would get under SNF PPS.

The evaluation identifies three market typologies that are useful for thinking ab investment targeting. Competitive markets have three or more hospitals within 3 miles. Frontier markets have fewer than three hospitals within 35 miles and stab

growing county populations. Isolated markets have fewer than three hospitals w 35 miles and declining county populations. These categories are not just academ they predict financial performance and investment opportunity.

Frontier market hospitals showed the strongest fundamentals. They have limitec competition, stable or growing populations, and often serve as the only facility i service area. These are hospitals in places like Jackson, Wyoming, where one administrator noted they regularly draw patients from 80-100 miles away for inp surgery and diagnostics. For investors, Frontier markets represent the sweet spo enough volume to support services, limited competition, and growing populatio that can sustain new service lines.

Competitive markets, counterintuitively, do not necessarily mean better financia performance. More hospitals means more competition for both patients and workforce. Several Competitive market hospitals reported challenges with physi groups opening competing outpatient surgery centers or other hospitals recruiti away their specialists.

Isolated markets are the toughest. Declining populations, often economically disadvantaged, with limited room for growth. The RCHD helps these hospitals a closure but the multiplicative effect is limited. Two continuing hospitals mentio that declines in coal mining negatively impacted their local economies. These ar great investment targets for growth-oriented ventures, but they might be interes for cost-reduction or efficiency plays.

Key Financial Findings and What They Mean for Startups

Let us talk numbers because this is where the rubber meets the road. New hospi joining the RCHD improved Medicare inpatient margins by 16 percentage point average during the demonstration period. Medicare combined margins (inpatien outpatient) improved by 11 percentage points. These are huge swings. We are ta about hospitals going from deeply negative margins to approaching break-even c their Medicare business.

But here is the catch, all of these gains happened in the pre-COVID period (rela
years one and two). By relative years three and four, which coincided with the pandemic, the margin improvements disappeared. New hospitals were back to negative Medicare margins despite being in the demonstration. Why? Because tl were in non-rebase years, meaning they were getting paid the lesser of actual cos their target amount, and COVID drove costs up dramatically while volumes dro

Continuing hospitals did not see additional margin improvements during the C extension beyond what they already achieved during the prior ACA extension. T maintained their gains but did not build on them. Pre-COVID, continuing hospi saw statistically significant improvements in Medicare inpatient margins, likely the rebase year when they went back to cost-based reimbursement. But during COVID, those gains evaporated.

Total profit margins (which include all payers and non-operating revenue) tell a different story. New hospitals saw significant improvements in total profit margi during the demonstration. But this is probably not because of the RCHD directl since Medicare margins did not consistently improve. More likely, total profit m improvements came from other sources like COVID relief funds, Paycheck Prot Program loans, or improved performance with other payers.

Here is what this means for investors. First, the cost-based reimbursement mod really fragile during periods of rapid cost inflation. Hospitals on cost-based reimbursement in their base year do fine. Hospitals in years two through five wi target amount that does not keep pace with actual cost increases get squeezed. T creates a huge opportunity for cost management tools specifically designed for r hospitals.

Second, the swing bed methodology creates an arbitrage opportunity that hospit are definitely exploiting. New hospitals increased their Medicare swing bed reve share by 7 percentage points during the demonstration. This was not accidental, was a strategic response to payment incentives. More on this below, but the key is that payment design is directly influencing clinical operations in predictable v

Third, the outpatient shift is killing these hospitals. Almost every hospital interviewed mentioned the trend toward outpatient procedures reducing their inpatient volumes. One administrator said it "forces hospitals to have to compet for-profit, oftentimes physician-owned, outpatient surgery centers." Another not that many orthopedic trauma cases from outdoor activities in their mountain tov now treated outpatient, limiting inpatient revenue. This is the big secular trend working against the RCHD model, and it is accelerating.

Fourth, workforce is the number one cost pressure. Multiple hospitals reported staffing challenges that forced them to use expensive travel nurses or offer reten bonuses. One hospital lost staff to higher-paying travel jobs during COVID. Anc lost staff due to vaccine and mask mandates. Staffing challenges existed pre-pan but worsened dramatically. This is a massive investment opportunity for workfo solutions tailored to rural contexts.

The Swing Bed Opportunity: A Case Study in Payment Design

Let me dive deeper into swing beds because this is probably the most interesting finding in the entire report from a business model perspective. Swing beds are a care beds that can be used for either acute care or skilled nursing facility level c Under the RCHD, swing bed costs are calculated separately but using a methodc that blends acute and swing bed costs together. Since acute costs are much high this results in substantially higher reimbursement for swing beds under RCHD under standard SNF PPS.

The data shows that new hospitals increased their Medicare swing bed revenue s by 7 percentage points during the demonstration. This is statistically significant economically meaningful. One new hospital reported that "the swing-bed portio this demonstration makes it work for us." Another got a waiver to bypass the thr day stay rule through its ACO, which increased swing bed payments even more.

Continuing hospitals did not increase their swing bed revenue share during the extension, they maintained the relatively high share (around 16 percent) that the

already achieved during the prior ACA extension. But interviews revealed that s
bed volume is highly dependent on local competitive dynamics. One hospital sav
swing bed payments drop when a nearby SNF opened, then rise again when it cl
Another hospital reported competition with nearby facilities for swing bed patie

Here is the business model opportunity. Swing bed utilization is clearly profitab
under the RCHD payment structure, but hospitals struggle with optimizing
utilization for several reasons. First, physician preference and habits play a big r
One hospital noted that physicians prefer to send patients home with home heal
rather than use swing beds. Second, local competition from SNFs and long-term
facilities affects referral patterns. Third, staffing challenges make it harder to
maintain swing bed programs.

There is a clear opening here for a swing bed optimization platform tailored to F
hospitals. This would include clinical decision support to identify patients
appropriate for swing bed placement, care coordination tools to compete effecti
with local SNFs, financial modeling to show physicians the margin impact of swi
bed utilization, and potentially even a shared staffing model to address workforc
constraints.

Beyond the financial opportunity, several hospitals reported that swing beds imp
patient outcomes by reducing readmissions and maintaining continuity of care.
hospital said swing beds help stabilize bed utilization and staffing. So there is a
quality story here too, not just a margin story.

The key insight is that payment model design creates clinical and operational
behaviors that would not otherwise exist. Swing bed utilization under RCHD is
than it would be under IPPS or SNF PPS because the payment model makes it
profitable. This is not cynical, it is just rational behavior responding to incentive
And wherever you have rational behavior responding to incentives, you have an
opportunity to build tools and services that help organizations optimize their
response.

Market Typologies and Geographic Investment Theses

The market typology framework in this report (Competitive, Frontier, Isolated) i actually a really useful investment screening tool. If you are building a company sells to small rural hospitals, you should absolutely be segmenting your target m along these lines because the financial profiles and operational challenges are dramatically different.

Frontier market hospitals are your best targets. These are hospitals in areas with fewer than three hospitals within 35 miles and stable or growing county populat They have limited competition, often serve as the only facility in their service are and benefit from population growth. The evaluation shows that new hospitals wi higher Medicare inpatient acute care discharges during their base year received higher additional RCHD payments in future years. Discharge volume drives fina performance under the RCHD, and Frontier markets have the volume and growt support new service lines.

Several Frontier market hospitals in the evaluation reported limited competitior said "there is no competition up here, there is more work than all of us can accomplish." Another noted it has "no real significant competition" because the nearest large hospitals are over an hour away. A third hospital in Jackson, Wyom said they regularly draw patients from 80-100 miles away. These are hospitals wi real market power and the ability to expand services without fear of being under by competitors.

For investors, Frontier markets represent the opportunity to build growth-orien businesses. These hospitals have positive tailwinds (growing populations, limited competition) and can invest in new service lines, technology, and infrastructure. are selling something that requires upfront capital investment or multi-year con Frontier market hospitals are your buyers.

Competitive market hospitals are trickier. More competition means pressure on patient volumes and workforce. The evaluation found that continuing hospitals

(which were more likely to be in Competitive markets) had higher total profit an operating margins at baseline but still faced challenges with negative Medicare margins. Competitive markets also tend to have slightly younger, less educated, less affluent populations compared to Frontier markets, though the differences a small.

The opportunity in Competitive markets is cost reduction and efficiency. These hospitals cannot compete on volume or market power, so they need to compete c operational excellence. This is where you sell care coordination platforms, worki optimization tools, revenue cycle management, and other "take cost out of the sy solutions. Competitive market hospitals are also more likely to be part of health systems, which changes the sales motion but potentially makes implementation

Isolated market hospitals are the tough ones. Declining populations, economical disadvantaged areas, limited growth prospects. The RCHD helps prevent closure does not create growth opportunities. New hospitals from Isolated markets recei lower additional RCHD payments in non-base years, likely because they have lov discharge volumes and fewer opportunities to grow revenue.

That said, Isolated markets are not necessarily bad investment opportunities, th just different. If you are building something around care delivery for underserve economically disadvantaged populations, Isolated market hospitals are your idea partners. If you are building telemedicine or remote monitoring solutions that e the reach of small hospitals, Isolated markets are where the need is greatest. If y building workforce solutions for areas with severe shortages, Isolated markets h the most acute pain.

The key is to match your business model to the market typology. Growth plays g Frontier markets. Efficiency plays go to Competitive markets. Access and unders plays go to Isolated markets. Do not try to sell a growth-oriented, capital-intensi solution to an Isolated market hospital. They do not have the volume or the capi make it work.

COVID's Impact and the Resilience Question

The COVID period (FY 2020 and 2021 in this evaluation) is really revealing abou fragility of the RCHD model and rural hospitals more broadly. All of the margin improvements that new hospitals achieved during their first two years of partici disappeared during COVID. Continuing hospitals also saw their pre-COVID gai erased. Why?

Hospital leaders reported three main challenges during COVID. First, costs wen dramatically. PPE, disinfectants, ventilators, and other equipment were purchas reduce transmission risk. Staffing costs exploded as hospitals competed for scar workers and relied on expensive travel nurses. Some hospitals reported unused medications and temporary testing spaces as additional cost pressures.

Second, service utilization shifted dramatically. Elective procedures were reduce postponed due to COVID risks and supply shortages. Some hospitals saw lower demand from reduced tourist populations (think ski resort towns or other recrea destinations). Others had to divert patients due to staffing shortages, they literal could not accept transfers because they did not have nurses to staff the beds.

Third, and this is the payment model issue, hospitals in non-rebase years were g paid based on target amounts set in their pre-pandemic base years. So if your ba year was FY 2018 and you are in FY 2020 or 2021, your target amount reflects 2(cost levels adjusted only for inflation, case mix, and volume. But COVID drove c up way faster than the inflation adjustor, and volumes dropped, so you are gettir squeezed on both sides.

The hospitals that did okay during COVID were either in their rebase year (getti paid on cost) or had access to COVID relief funds like CARES Act money that bolstered total profit margins even if Medicare margins suffered. Several hospita explicitly mentioned that CARES funding helped mitigate the cost burden of C(related activities.

Here is the investment thesis. The RCHD model is fragile during periods of rapi inflation or utilization shocks. Hospitals cannot adjust their target amounts mid cycle, they are locked in for five years. This creates a huge opportunity for finan planning and forecasting tools that help hospitals model out different cost and v scenarios over their five-year participation period.

It also creates an opportunity for flexible cost management solutions. During CC hospitals tried to cut costs by minimizing quality improvement efforts unrelated the pandemic, delaying facility renovations, and deferring equipment purchases. these are blunt instruments. What they really need are tools that let them dial cc up or down quickly in response to external shocks while maintaining quality and access.

The resilience question is also a workforce question. Almost every hospital ment staffing as their biggest COVID-related challenge. Some reported burnout leadi early retirements. Others lost staff to higher-paying travel jobs. Vaccine and mas mandates caused some departures. And the competition for staff intensified as la hospitals and other industries started competing for the same workers.

For investors, this points to workforce solutions as a category with huge tailwind But not generic workforce solutions, we are talking about solutions specifically designed for rural contexts. Think retention and engagement tools that address unique challenges of working in a small town. Telehealth and remote support m that let rural hospitals access specialists without having to recruit them full-tim Training and upskilling programs that let existing staff take on expanded responsibilities. Shared staffing models that let multiple rural hospitals pool resources.

The COVID period also exposed the importance of the RCHD as a financial back Many hospitals said the demonstration helped prevent even greater losses durin pandemic. One hospital noted that without the RCHD, they would have been at operating loss. Another said the demonstration remained essential for "tweener" hospitals that do not qualify for CAH status but cannot thrive under IPPS.

New Business Models Enabled by Cost-Based Reimbursement

Let us talk about what new business models become possible when you have cos based reimbursement as the underlying payment structure. The RCHD is intere because it creates a very specific environment where certain activities that woul unprofitable under IPPS become profitable or at least less unprofitable.

First, swing beds, as discussed above. But let me extend the swing bed thesis a b Under cost-based reimbursement, swing beds are not just a margin enhancemen they are a patient flow optimization tool. Several hospitals mentioned that swing reduce readmissions and maintain continuity of care. One hospital said swing be help stabilize bed utilization and staffing. What if you built a platform that opti patient flow across acute, swing bed, and outpatient settings to maximize both c outcomes and financial performance under cost-based reimbursement?

This platform would include predictive analytics to identify patients at risk of readmission who would benefit from swing bed placement. Care coordination to manage transitions between acute and SNF-level care. Financial modeling to sho hospitals the margin impact of different patient flow scenarios. Integration with SNFs and home health agencies to coordinate care across settings. This is basica patient flow optimization layer specifically designed for the unique incentives of based reimbursement.

Second, service line expansion for unprofitable but essential services. Multiple hospitals mentioned using RCHD payments to support service lines that would otherwise be unprofitable, things like obstetrics, behavioral health, ICU, dialysis ambulance services. Under IPPS, these services are often money losers. Under co based reimbursement, they are fully reimbursed in the base year and then factor into the target amount for future years.

This creates an opportunity for service line as a service models tailored to rural hospitals. Imagine a company that provides turnkey behavioral health services to small rural hospitals, staffing, protocols, technology, everything. The hospital ca

the cost-based reimbursement in their base year, the service line gets built into t target amount, and the service company takes a percentage of the revenue or a management fee. This works for any high-need, low-margin service line that is important for community health but tough to sustain financially.

Third, capital investment timing. The evaluation found that hospitals have older capital infrastructure than comparison hospitals. RCHD hospitals also reported demonstration payments to fund infrastructure upgrades. One hospital credited demonstration with enabling facility renovations and equipment purchases. This creates a very specific business opportunity around capital financing and equipn leasing structured around the RCHD payment cycle.

Here is how it works. A hospital in its base year has an incentive to make capital investments because those costs will be reimbursed and will increase their targe amount for future years. But small rural hospitals often struggle to access capita markets or get favorable financing terms. What if you built a financing vehicle specifically for RCHD hospitals that provides capital during base years with repayment terms structured around the five-year RCHD cycle?

This is basically project finance meets healthcare policy arbitrage. You are takin advantage of the payment model to provide capital to hospitals at attractive rate because you understand their cash flows better than traditional lenders. You cou extend this to equipment leasing, real estate development, even recruiting and retention incentives for key staff.

Fourth, cost management as a service. The big challenge for RCHD hospitals is keeping cost growth below the inflation adjustor during non-rebase years. This i hard because rural hospitals face structural cost disadvantages like workforce shortages, lack of economies of scale, and supply chain inefficiencies. What if yo built a platform that provides comprehensive cost management across all the ma categories (labor, supplies, facilities) specifically tailored to small rural hospitals

This would include group purchasing for supplies, shared services for back-offic functions, workforce optimization to reduce reliance on expensive travel staff, ar

financial analytics to identify cost reduction opportunities. The value propositio simple, we help you keep your cost growth below your target amount growth, an take a percentage of the savings.

Fifth, base year optimization. Several new hospitals reported concerns that their year costs did not fully reflect their ongoing operations. One hospital's base year not include costs for a recently hired clinician. Another had added rural health c that shifted cost allocation away from inpatient care. This creates a consulting opportunity around base year planning and optimization.

A base year optimization service would help hospitals plan their base year to maximize their target amount for future years. This includes timing capital investments, staffing additions, service line expansions, and other cost-increasin activities to occur during the base year when they will be fully reimbursed and factored into the target. It is basically tax planning but for hospital payment mo

Infrastructure Plays and Capital Investment Opportunities

The evaluation found that RCHD hospitals have significantly older capital infrastructure than comparison hospitals (measured by average age of plant). Th not surprising given that small rural hospitals struggle to access capital markets often defer infrastructure investments. But it creates a really interesting opportu for infrastructure-focused investors.

Several hospitals mentioned using RCHD payments to fund infrastructure upgra One hospital credited the demonstration with enabling recruitment of specialist implying they used the payments to build out facilities or equipment needed to support those specialists. Another mentioned delaying planned facility renovatio during COVID but implied they would resume those projects post-pandemic.

Here is the infrastructure thesis. RCHD hospitals have a stable, predictable reve stream (their target amount) that grows with inflation, case mix, and volume. Th makes them attractive borrowers for infrastructure projects if you structure the

financing correctly. But traditional healthcare lenders often do not understand t
RCHD payment model or are too conservative to lend to small rural hospitals.

This creates an opening for a specialized infrastructure fund that provides capit
RCHD hospitals for facility upgrades, equipment purchases, and technology
investments. The fund would take security interests in the hospital's RCHD pay
and structure repayment terms around the five-year participation cycle. You cou
potentially even get creative with rebase year payment waterfalls where the fund
paid back accelerated amounts during rebase years when hospitals are getting cc
based reimbursement.

The types of infrastructure projects that make sense include electronic health re
upgrades (many rural hospitals are still on old systems), facility renovations to su
new service lines, medical equipment for diagnostic or surgical capabilities, and
real estate development for clinician housing in areas where affordable housing
recruitment barrier.

Four new hospitals mentioned struggling with affordable housing and childcare
their communities, which made recruiting staff difficult. What if you built a real
estate development company that partners with RCHD hospitals to build clinici
housing near their facilities? The hospital could potentially pay below-market re
the development company using RCHD payments, and the development compan
would own the asset and get tax benefits from the project.

There is also an opportunity in technology infrastructure. Multiple hospitals
mentioned the rapid growth of telehealth during COVID and expectations that i
would remain a key service going forward. But telehealth requires technology
infrastructure (broadband, EHR integration, specialty platforms) that many rura
hospitals lack. A specialized telehealth infrastructure fund could provide capita
expertise to help RCHD hospitals build out their capabilities.

The key insight is that RCHD hospitals have deferred infrastructure investment
years because of financial constraints. The demonstration payments give them a
revenue base to support debt service, but they need lenders who understand the

payment model and are willing to take on the policy risk (what happens if the demonstration ends?). There is a real opportunity for a fund or lender that can b this gap.

The Permanence Problem and Policy Ri

Let me talk about the elephant in the room, policy risk. The RCHD has been ext three times now (ACA in 2010, CCA in 2016, CAA in 2021), but it is still a demonstration project, not a permanent payment model. This creates real uncer for hospitals and for investors.

Multiple hospitals mentioned wanting the demonstration to become permanent. said permanence would enable long-term planning. Another noted they lack a contingency plan if the demonstration ends, they might face ownership changes service cuts without continued support. A third said the temporary nature of the program makes it hard to justify long-term capital investments.

From an investor perspective, this is a classic policy risk problem. You are build business that depends on a specific payment model that could go away if Congre does not reauthorize it. This limits your exit options (strategic buyers will discou for policy risk) and makes it harder to raise capital (investors want stable, predic markets).

But here is the contrarian take. The RCHD has now been running for 20 years a been extended three times under administrations of both parties. The evaluation shows it has achieved its core goal of improving Medicare margins for participat hospitals, even if the effects are fragile during external shocks like COVID. Hosp uniformly support the program and there is bipartisan interest in rural hospital sustainability. The policy risk is real but probably lower than it appears.

Also, the RCHD is a laboratory for testing alternative payment models that coul apply more broadly. Cost-based reimbursement with inflation-adjusted targets i model that could potentially be extended to other hospital categories (CAHs, sol community hospitals, etc.). If you build a business that works for RCHD hospita

you are building something that could scale to a much larger market if the paym model expands.

The other policy risk to consider is what happens during reauthorizations. The (extension in 2021 did not make major changes to the program structure, but it c have. Future reauthorizations might change eligibility criteria, payment methodologies, or add quality requirements that alter the economics. This is anc reason to build businesses that are not solely dependent on the RCHD payment but provide value under multiple reimbursement schemes.

The policy risk also creates an opportunity for consulting and advisory services t help hospitals navigate the demonstration's requirements and optimize their participation. Several hospitals expressed confusion or concern about how their year costs were calculated or whether they were maximizing their payments. A specialized advisory firm that understands the RCHD payment methodology and help hospitals optimize their participation would have a clear value proposition.

Conclusion: Building for the Margins

Here is my bottom line. The RCHD evaluation reveals a set of small, rural hospit that are financially fragile, operationally constrained, and dependent on a payme model that provides just enough support to keep them afloat but not enough to t These hospitals face structural disadvantages around workforce, capital, scale, a market power. The secular shift to outpatient care is eroding their inpatient volu which is the foundation of the RCHD payment model. COVID exposed how vulnerable they are to external shocks.

But these challenges are opportunities. Every constraint that RCHD hospitals fa problem that needs solving. Workforce shortages need workforce solutions. Cap constraints need creative financing. Swing bed utilization needs optimization platforms. Cost management needs specialized tools. Service line sustainability r new business models. Infrastructure gaps need infrastructure funds.

The key is to build businesses that are tailored to the specific context of small ru hospitals operating under cost-based reimbursement. Generic solutions will not because these hospitals face unique challenges that are different from large urba systems or even from CAHs. You need to understand the payment model, the ma dynamics, the operational constraints, and the policy environment to build some that actually works.

The market typology framework (Competitive, Frontier, Isolated) is a useful scre tool for targeting your go-to-market. Frontier markets are your best opportuniti growth-oriented businesses. Competitive markets are where you sell efficiency a cost reduction. Isolated markets are where you focus on access and underserved populations.

The swing bed opportunity is probably the most immediately actionable insight this report. New hospitals are clearly increasing swing bed utilization in respons payment incentives, and there is room for optimization tools, care coordination platforms, and even shared staffing models to help hospitals capture this opport more effectively.

The infrastructure opportunity is longer-term but potentially larger. RCHD hos have deferred capital investments for years and now have a revenue base to supp debt service. The right infrastructure fund with the right financing structure co unlock a lot of pent-up demand.

The policy risk is real but manageable. The RCHD has been extended three time has broad support. It is also a laboratory for alternative payment models that cou scale beyond the current 26 hospitals if it proves successful. Building businesses work for RCHD hospitals positions you to capture a larger market if the paymer model expands.

The COVID period was brutal for these hospitals but also revealed their resilien and the importance of the demonstration as a financial backstop. Hospitals that have closed without the RCHD managed to survive the pandemic. That is worth

something, both to the communities they serve and to investors looking for busi
with a mission-driven component.

In summary, if you are investing in health tech or services aimed at small rural hospitals, the RCHD evaluation is required reading. It provides detailed data on financial performance, operational challenges, payment model mechanics, and hospital leader perspectives that you cannot get anywhere else. And it reveals sp investable opportunities that are underexploited by the current generation of healthcare startups. Go build something for the margins. The opportunity is the

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