STROUDWATER

ABUNDANCE-BASED LEADERSHIP IN RURAL HEALTH: STRATEGIES TO ADDRESS UNCERTAINTY IN THE WAKE OF OB3

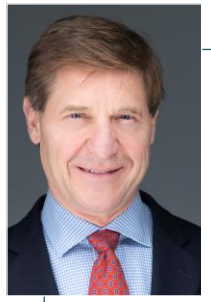
Eric Shell, Chairman

Rural Healthcare Leader Panelists

August 22, 2025

OVERVIEW AND INTRODUCTIONS

PANELISTS



Eric K. Shell, MBA

- Chairman, Stroudwater Associates
- (T) 207-221-8252
- (C) 207-650-2702
- eshell@stroudwater.com

Brock Slabach, MPH, FACHE

- Chief Operations Officer, National Rural Health Association
- (T) 816-756-3140
- bslabach@ruralhealth.us

Kevin DeRonde, MBA, MHM

- Chief Executive Officer, Mahaska Health
- (T) 641-672-3392
- kderonde@mahaskahealth.org

Mary Ellen Pratt, FACHE

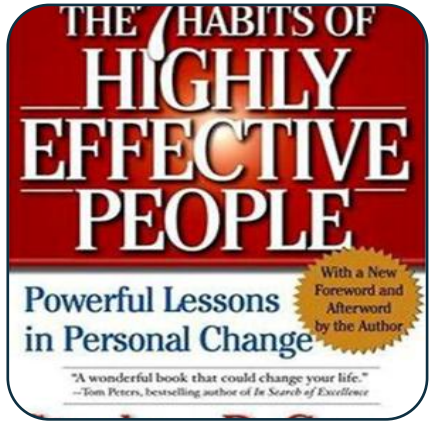
- Chief Executive Officer, St James Parish Hospital
- (T) 225-746-2990
- mpratt@sjph.org

Benjamin Anderson, MBA

- President and Chief Executive Officer, Hutchinson Regional Healthcare System
- (O) 620-665-2001
- andersonbd@hutchregional.com

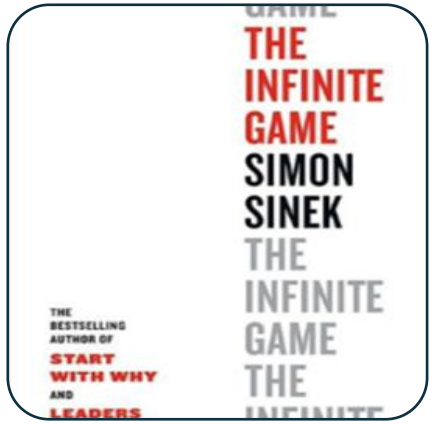
ABUNDANCE (VS. SCARCITY)
INFINITE GAME DECISION-MAKING

ABUNDANCE/INFINITE GAME MINDSET – DEFINED



ABUNDANCE

- Stephen Covey coined the idea of *abundance mentality* or *abundance mindset*, a concept in which a person believes there are enough resources and successes to share with others.
- This is contrasted with the *scarcity mindset* (i.e., destructive and unnecessary competition), which is founded on the idea that, if someone else wins or is successful in a situation, that means you lose; not considering the possibility of all parties winning (in some way or another) in each situation (zero-sum game).



INFINITE GAME MINDSET

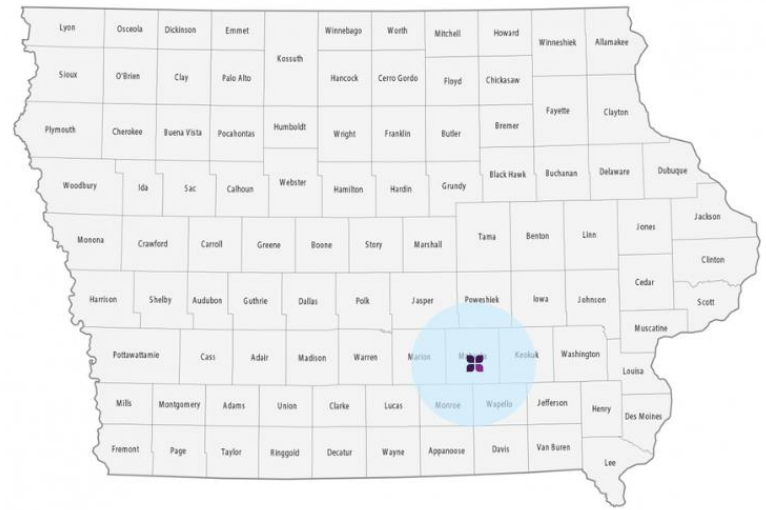
- Simon Sinek developed the concept of the Infinite Game.
- Infinite Games are played by known and unknown players, with no exact/agreed-upon rules, with the primary objective to perpetuate the game.
  - No such thing as winning or losing.
  - The goal is to advance something bigger than ourselves or our organizations.
- We must stop thinking about who wins or who's the best and start thinking about how to build organizations that are strong/healthy enough to stay in the game for generations.

mahaskahealth

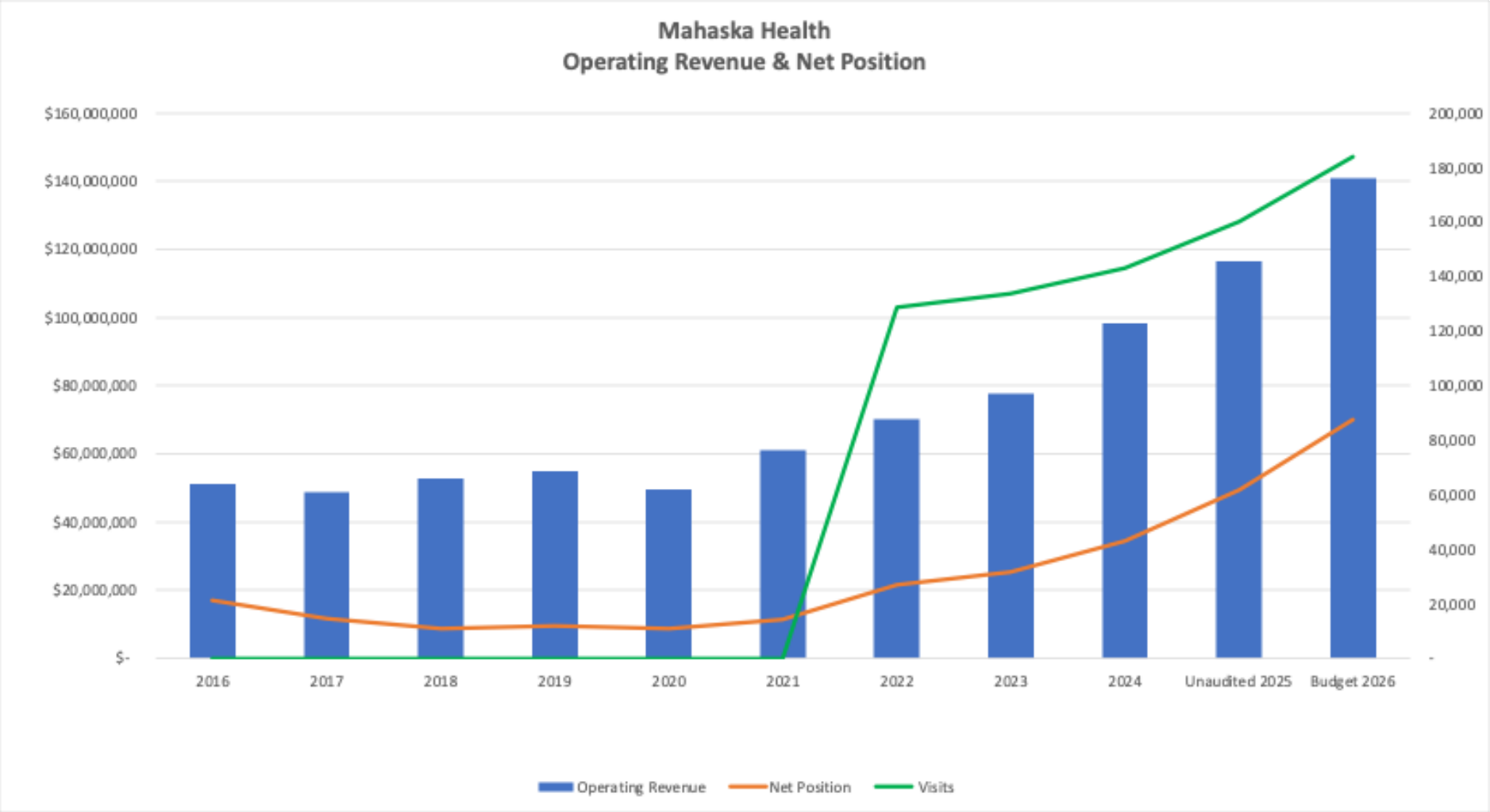
Oskaloosa, Iowa

85+ Medical Specialties
4 Iowa Centers of Excellence

- ✓ 102% increase in births since 2021, with 267 babies born in 2024, on pace to deliver nearly 400 babies in FY 2025. Opened and expanded the first-ever fertility services, providing specialized care for 50 patients. Recruited two OB/GYN specialists, caring for 888 patients from 28 counties in 2024.
- ✓ 1,655 general surgery clinic patient consultations across 26 Iowa counties and 11 out-of-state patients in 2024. Surgery Services team performed 3,928 cases in 2024 across all service lines.
- ✓ 49 cancer cases reviewed in 2024, through the Interdisciplinary Tumor Board, fostering collaborative treatment planning between multiple service lines locally, along with specialists from Des Moines and Iowa City. The only active critical access Tumor Board in Iowa.
- ✓ Welcomed full-time, board-certified, and fellowship-trained Cardiologist, Dr. John Pargulski, alongside an experienced cardiology team. 711 unique cardiology patients treated in 2024 from 17 Iowa counties and five from out of state.



FINANCIAL PERFORMANCE



MAHASKA HEALTH CULTURE

- Need to have the patience to build up a strong organization, and a **strong organization starts with caring for its people**
- It is amazing how much can be accomplished if no one cares who gets the credit
- Physician, provider & nurse-led hospital
- The needs of the patient come first
- Serving is the art and act of focusing on someone else's interest instead of your own
- Teamwork and love for one another, and the team being more important than the individual
- Culture is everything. The result is a culture that continues to attract teammates who share the same values.
- Enjoy serving at work/go home to your families, which drives passionate patient care - Compassion, Kindness, Empathy, and Teamwork
- Empathy and kindness can speed up the healing process and lead to better outcomes for patients and caregivers.
- The number one thing when it comes to change is relationships. How you get somewhere is based on the relationships and trust you garner. That is what will allow you and the team to be successful.
- Press Ganey stated that Mahaska Health is "not normal." Highest employee satisfaction ever recorded at the 96th percentile, ranking in the top 120 out of 4,200 healthcare systems nationwide.

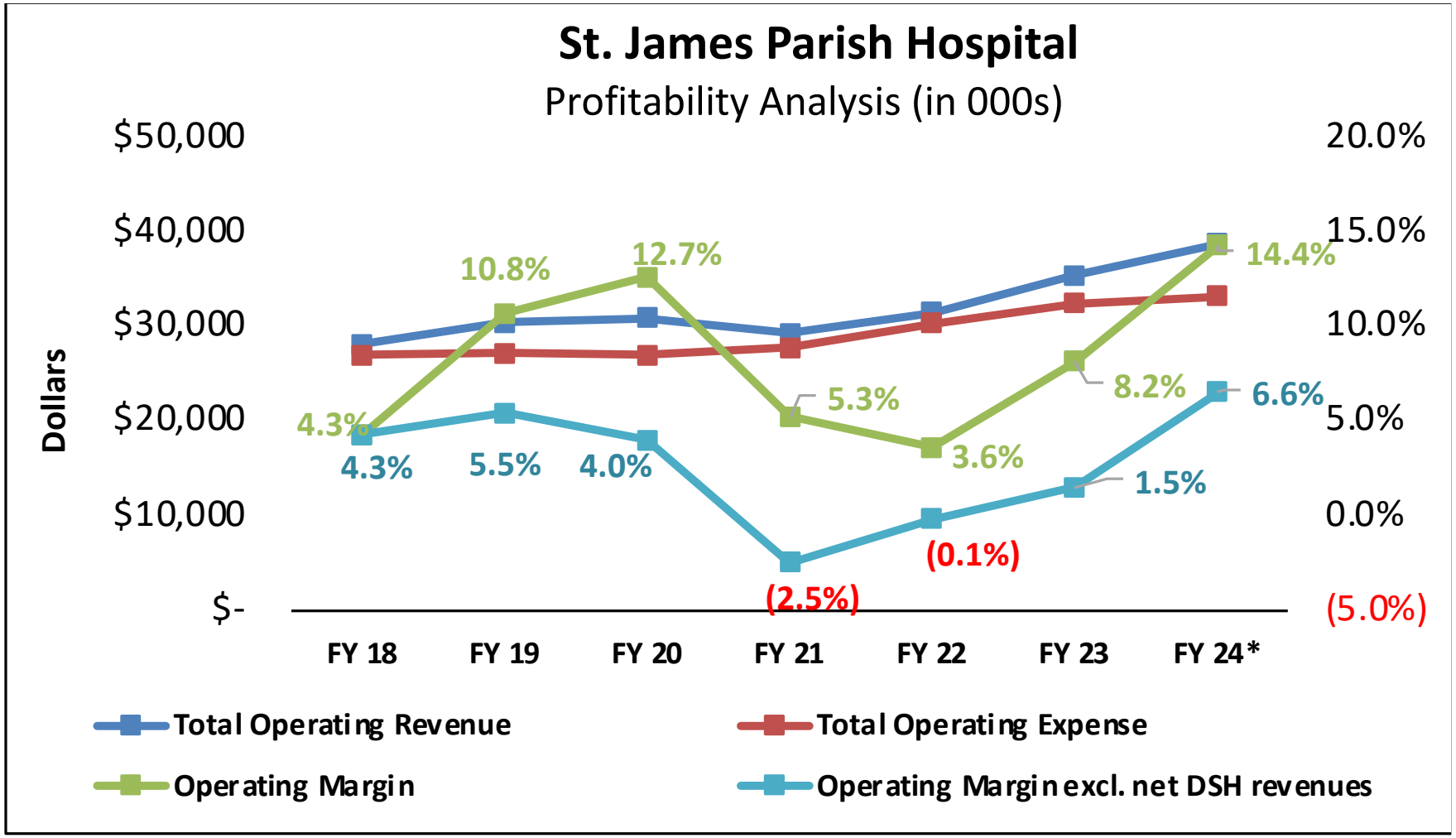
ST JAMES PARISH HOSPITAL

LARGE ENOUGH TO SERVE, SMALL ENOUGH TO CARE.

- Lutcher, Louisiana
- Hospital Service District for Parish St. James (serving 22,000 population)
- Established in 1955, converted to CAH in 2001, relocated to new facility in 2008

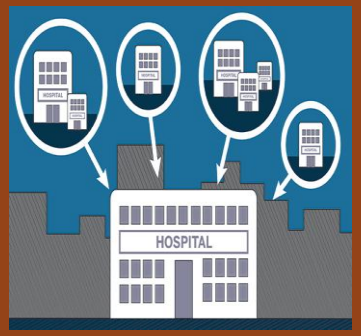
FINANCIAL PERFORMANCE

ST JAMES PARISH HOSPITAL
LARGE ENOUGH TO SERVE, SMALL ENOUGH TO CARE.



Growth

Be Bigger



Hospital Partnerships

Physician Recruitment

New Services

Quality

Be Better

Reduce Harm

Best practices

Just Culture

TeamSTEPPS

People

Be Brilliant

Goals/Alignment

Empowerment

Change Management

Reward/Recognition

Service

Be Beneficial

Pt Satisfaction

Access

Community

Technology

Finance

Be Bountiful

Revenue Cycle

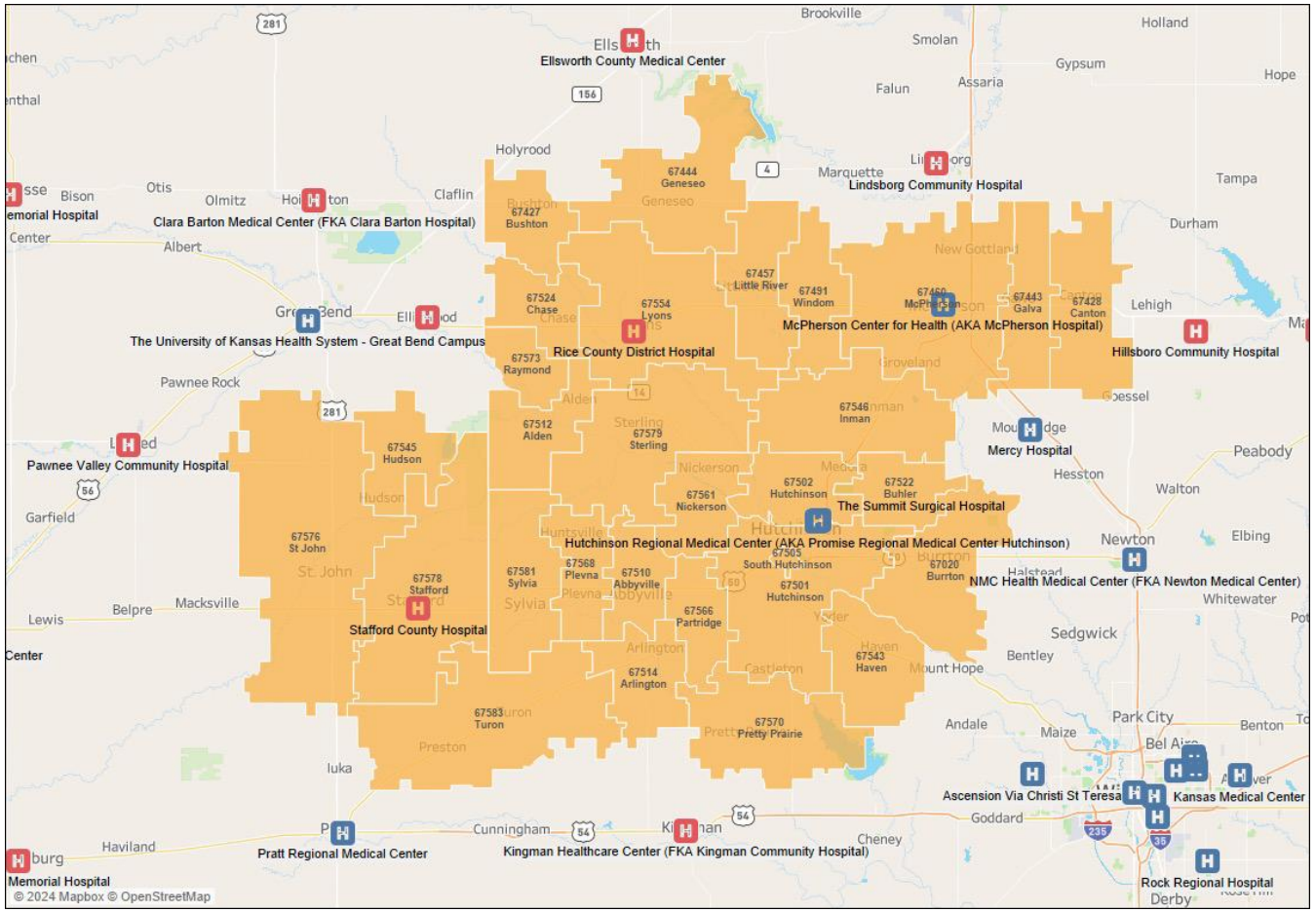
Efficiency/Lean

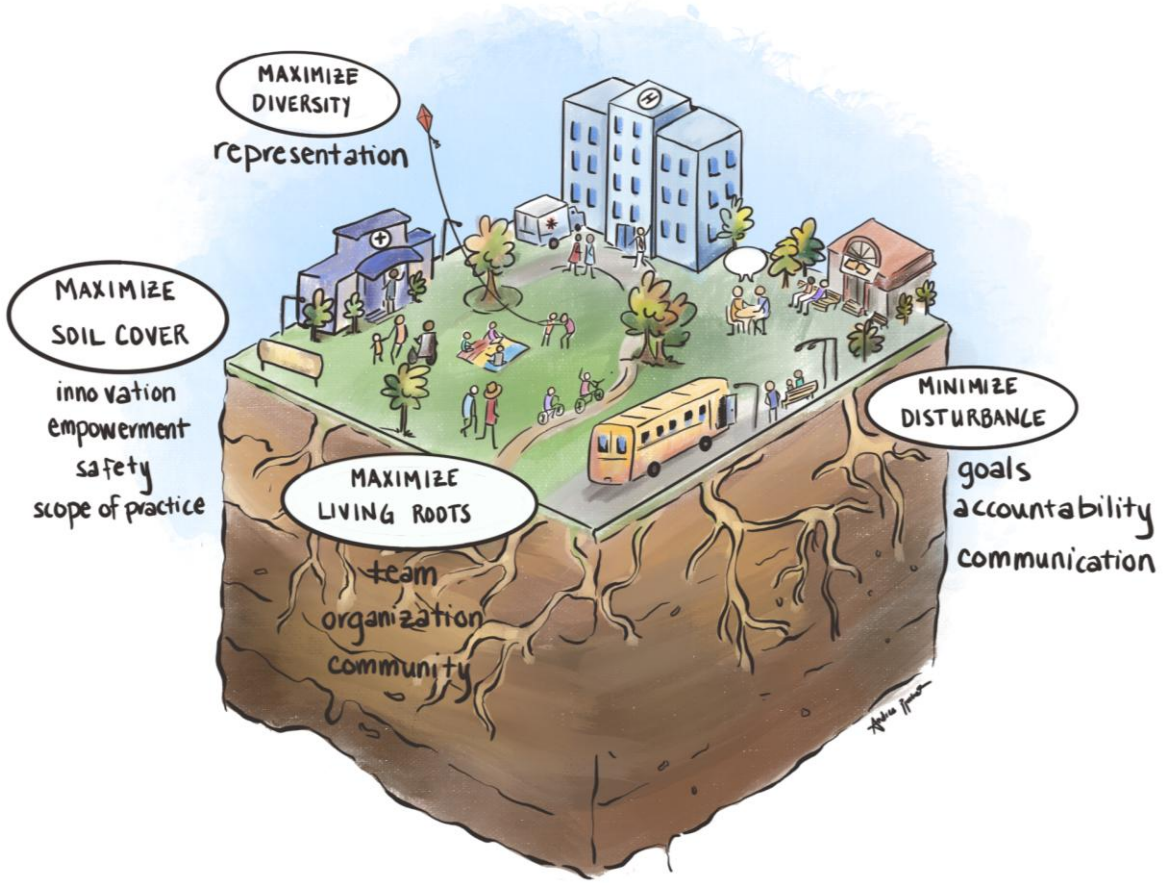
Grants

Supply Chain

HUTCHINSON REGIONAL MEDICAL CENTER

- 190-bed, independent Sole Community Provider
- Serves a 30-zip-code area with nearly 100K population
- Hutchinson, KS





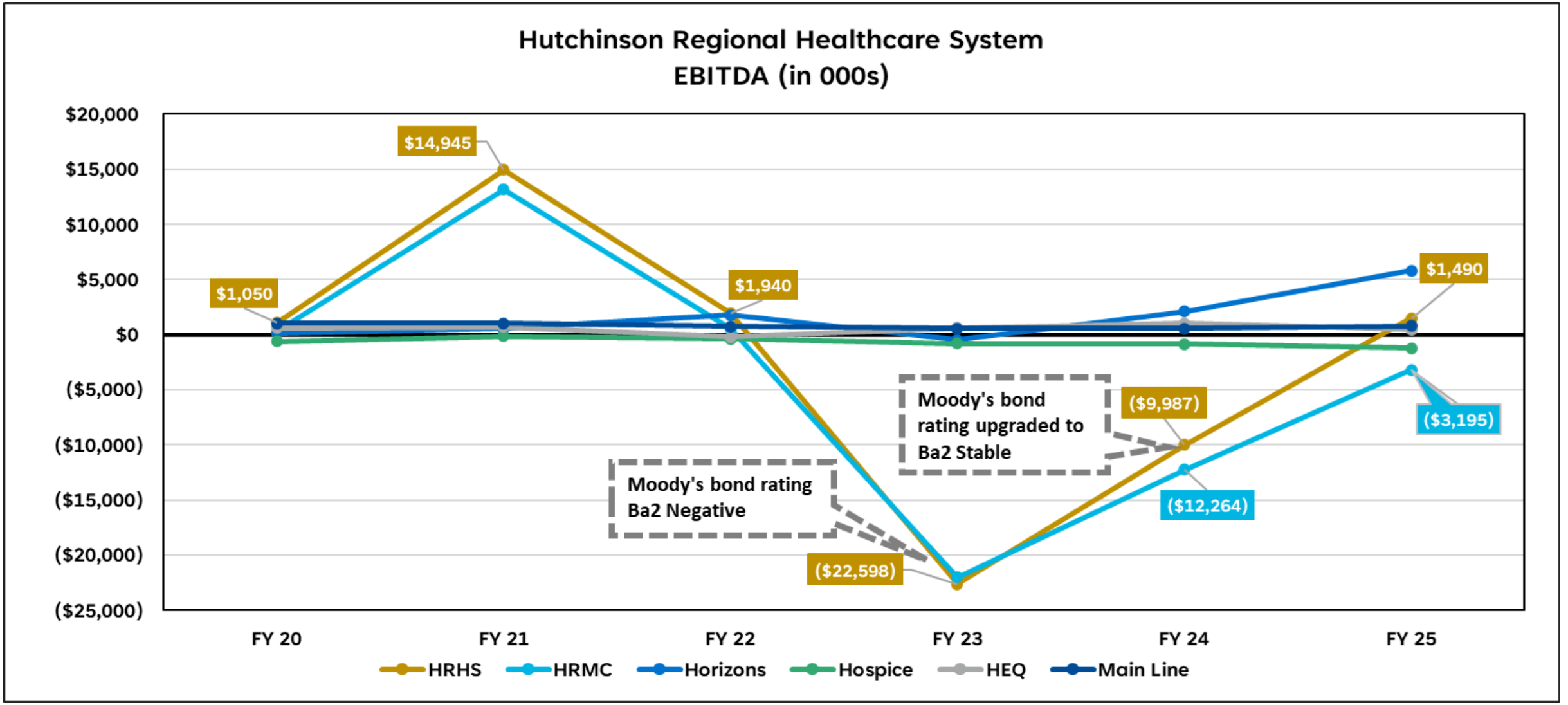
LEADING SYSTEMIC CHANGE

Identify the “right thing” to do by asking the right questions.

Hack the system, bootleg the funding to do the “right thing.” (starts with leadership)

Track the outcomes for doing the “right thing.”

Leverage the outcomes and tell the story to scale the intervention and change policy.


Hutchinson Regional Healthcare System
EBITDA (in 000s)
$20,000
$15,000
$10,000
$5,000
$0
($5,000)
($10,000)
($15,000)
($20,000)
($25,000)
$14,945
$1,050
$1,940
$1,490
Moody's bond rating upgraded to Ba2 Stable
($9,987)
($3,195)
Moody's bond rating Ba2 Negative
($12,264)
($22,598)
FY 20
FY 21
FY 22
FY 23
FY 24
FY 25
HRHS
HRMC
Horizons
Hospice
HEQ
Main Line

National Rural Health Association

Overview of OB3

bslabach@ruralhealth.us
X: @bslabach
#ruralhealth
August 7, 2025

Brock Slabach, MPH, FACHE
Chief Operations Officer

OBBBA Impact

- Net increase in unified budget deficit of $4.1T between 2025 and 2034
  - New CBO estimate released today
  - Increase cost of debt financing of $718B
- Congressional/media focus on rural healthcare was unprecedented
- Senate proposed the Rural Health Transformation Program (RHTP) as a sweetener to coax leery Republicans to support the Bill
- Started at $25B, and was raised to $50B
- This fund was meant for **rural** communities!

OBBBA Medicaid Cuts

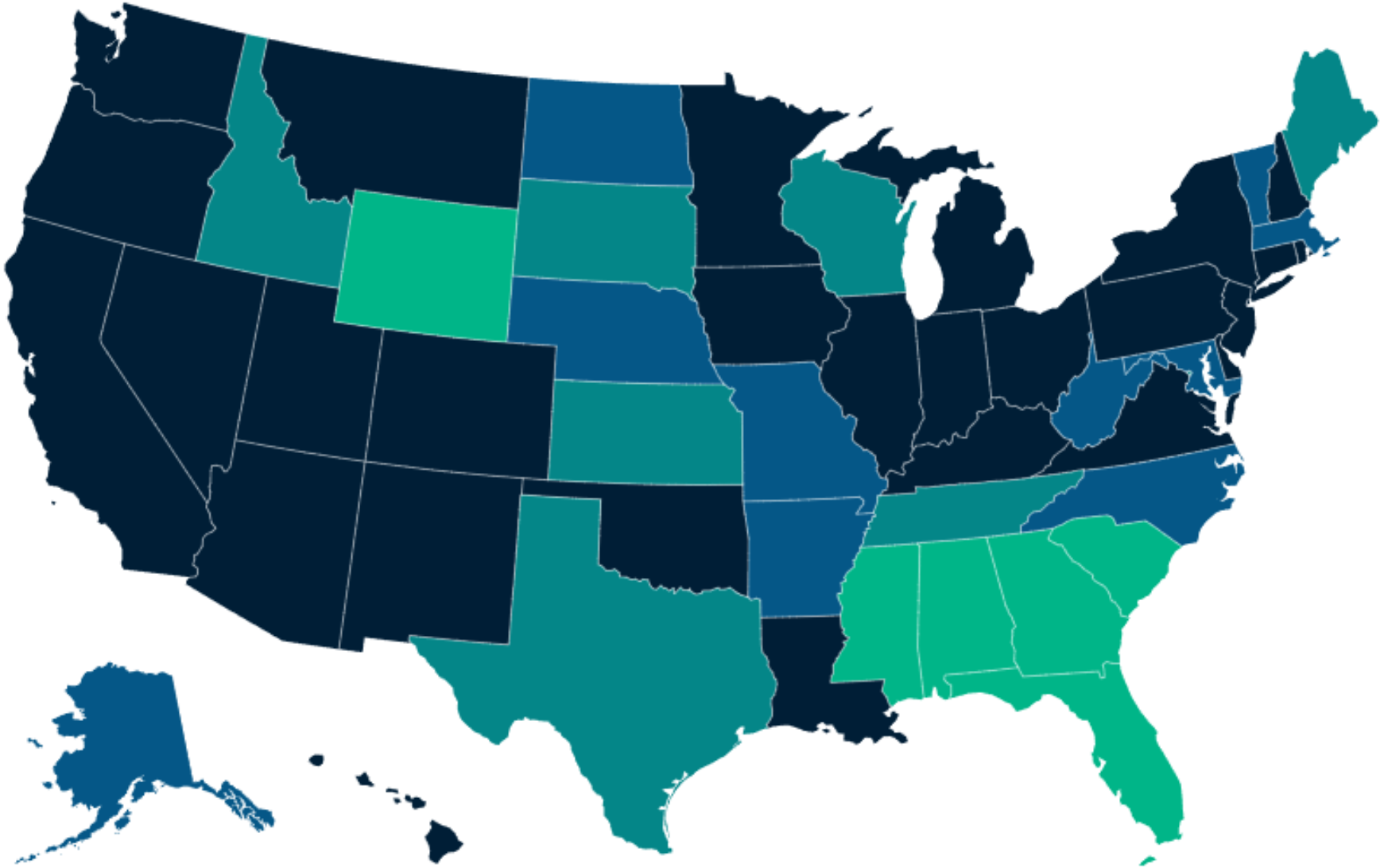
- Mandating that adults who are eligible for Medicaid through the ACA expansion meet **work and reporting requirements** ($326 billion)
- **Repealing the Biden Administration's rule** simplifying Medicaid eligibility and renewal processes ($167 billion)
- Establishing a moratorium on new or increased **provider taxes** and reducing existing **provider taxes** in expansion states ($191 billion)
- Revising the payment limit for **state-directed payments** ($149 billion), and
- Increasing the frequency of **eligibility redeterminations** for the ACA expansion group ($63 billion).
- NRHA Govt. Affairs team full OBBBA update on July 30

Source: KFF Analysis

Federal Medicaid Cuts in the Enacted Reconciliation Package, By State

As a % of 10-year baseline federal spending (2025-2034)

< 7% 7%–10% 10%–13% ≥ 13%



Rural Health Transformation Program Requirements

NRHA
Your voice. Louder.

RHTP Overview

- Rural Health Transformation Program (RHTP): $50 billion to all 50 states over 5 years
  - 50% of funds distributed equally to all states with an application approved by CMS
  - The remaining 50% distributed based to states with an approved application in an amount determined by the CMS Administrator. Criteria for CMS Administrator to follow:
    - %age of state's population located in a rural census tract of an MSA, proportion of RH facilities in the state relative to the number of RH facilities nationwide, the situation of hospitals in the state, and any other factors that the CMS Administrator finds appropriate
  - States must apply prior to December 31, 2025 by submitting "rural health transformation plan." CMS must approve applications by Dec. 31, 2025.
  - One-time application for all five years of the program.

RHTP—Application Requirements

A detailed rural health transformation plan. The plan must outline how the state will:

- Improve access to hospitals and other providers for rural residents;
- Improve health care outcomes of rural residents;
- Prioritize use of new and emerging technologies that emphasize prevention and chronic disease management;
- Initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other providers to promote quality improvement, increase financial stability, maximize economies of scale, and share best practices;
- Recruit and retain clinicians;
- Prioritize data and technology-driven solutions that help rural providers furnish health care services as close to the patient's home as possible;
- Outline strategies to manage long-term financial solvency and operating models of rural hospitals; and
- Identify specific causes that are driving standalone rural hospitals to close, convert, or reduce service lines.

RHTP—Uses for Funding

- Allowable Uses of Funds and Conditions:
  - Promoting evidence-based interventions to improve prevention/chronic disease mgmt.
  - Payments to providers
  - Promoting technology-driven solutions for prevention and mgmt.
  - Training/TA for developing and adopting technology-enabled solutions that improve care delivery in rural hospitals
  - Recruiting and retaining clinical staff to rural areas with a 5-year obligation to stay
  - TA, software, hardware for significant tech advances to improve efficiency, cybersecurity, and patient outcomes
  - Assisting rural communities to right-size health care delivery by identifying needed services, facilities, etc.
  - Supporting access to OUD/SUD treatment
  - Projects that support value-based care
  - Additional uses “designed to promote sustainable access to high-quality rural health care services” as determined by CMS Administrator
- States must plan to carry out at least 3 of these activities
- Funding **cannot** be used as non-federal Medicaid share

RHTP—Eligible Facilities

- Hospitals:
  - Located in a rural area (which is defined as outside of a Metropolitan Statistical Area per 42 U.S.C. § 1395ww(d)(2)(D))
  - Treated as being located in a rural area*
    - *This captures many large, urban hospitals that have "reclassified" to rural for inpatient prospective payment system purposes, i.e., urban located rural reclassified hospitals.*
  - Located in a rural census tract of an MSA
- Critical access hospitals
- Sole community hospitals
- Medicare-dependent hospitals
- Low-volume hospitals
- Rural Health Clinics
- Rural emergency hospitals
- Federally qualified health centers (FQHCs) and health centers receiving Section 330 grants
- Community mental health centers (CMHCs)
- Opioid treatment programs located in a rural census tract of an MSA
- Certified community behavioral health clinics located in a rural census tract of an MSA

NOTE: FQHCs and CMHCs do NOT have to be located in a rural area

*Sharp Rise In Urban Hospitals With Rural Status In Medicare, 2017–23, Health Affairs, Aug. 4, 2025

Strategic and Operational Dimensions for Hospitals and Clinics

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OBBBA—Reframing Our Response

- Feelings and opinions aside on OBBBA, what we do now will either set the stage for survival…or closure
- Re-read the OBBBA as a strategist
- Bottom line: How will you prepare for the cuts and benefit from RHTP?
- Preparation begins NOW

Strategic Implications

- Decreased Medicaid-covered patients—**increase in bad debt/charity**
  - Work requirements for the expansion population will need **recertification assistance**
  - Expiring **Enhanced Premium Tax Credits** (EPTC) Dec. 31, 2025—4M people uninsured (disproportionately rural enrollment)
  - **Care will shift to EDs and FQHCs** (330B Grant for uncompensated)
- Funding cuts will hit your hospital/clinic balance sheets
  - **Provider Tax limits** decrease from 6% to 3.5% by 2032
  - **State Directed Payments**—limited to Medicare rates/110% non-expansion states
  - Rural Hospital Transformation Program (RHTP) with $50B may help, must **assess the gaps now…remember, RHTP ends just after cuts get started**
  - Increasing federal deficits expected to be over $3T could invoke the 2010 Pay as You Go Act (PAYGO)…a **4% sequester** of all Medicare revenue as early as FY2026

Hospital Leadership—What To Do Now

- Model your hospital's exposure to the following:
  - Provider Tax/SDP cuts between FY28 and 32—quantify the decrease
  - Model the impact of the individuals in your community that stand to lose Medicaid coverage and a potential decrease in volume/revenue—estimates
  - Quantify the impact of a potential 4% sequester of Medicare revenue (addition to existing 2%)
- Share the impact with State leadership—let them know your gaps
- Review and update your charity care policies, anticipating an increasing number of uninsured in your community

Hospital Leadership—What To Do Now

- Procedures and Staffing Analysis:
  - Establish procedures to determine eligibility and ensure compliance for individuals losing Medicaid coverage
  - Allocate staffing resources to support eligibility re-certification and assist with claims appeals, noting additional costs associated with each
- Communicate the outcomes of these efforts to your State Leaders—noting gaps
- Monitor your State's application process for the Rural Health Transformation Plan Funding to CMS, advocating for equitable treatment and involvement of your facility—actively participate in the State-led development of the CMS application
- Ensure your rural health system is operating at maximum efficiency from both volume/revenue-generating and expense perspectives
  - Consider a third-party external review of strategic, financial, and operational performance

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Thank you.

bslabach@ruralhealth.us
@bslabach
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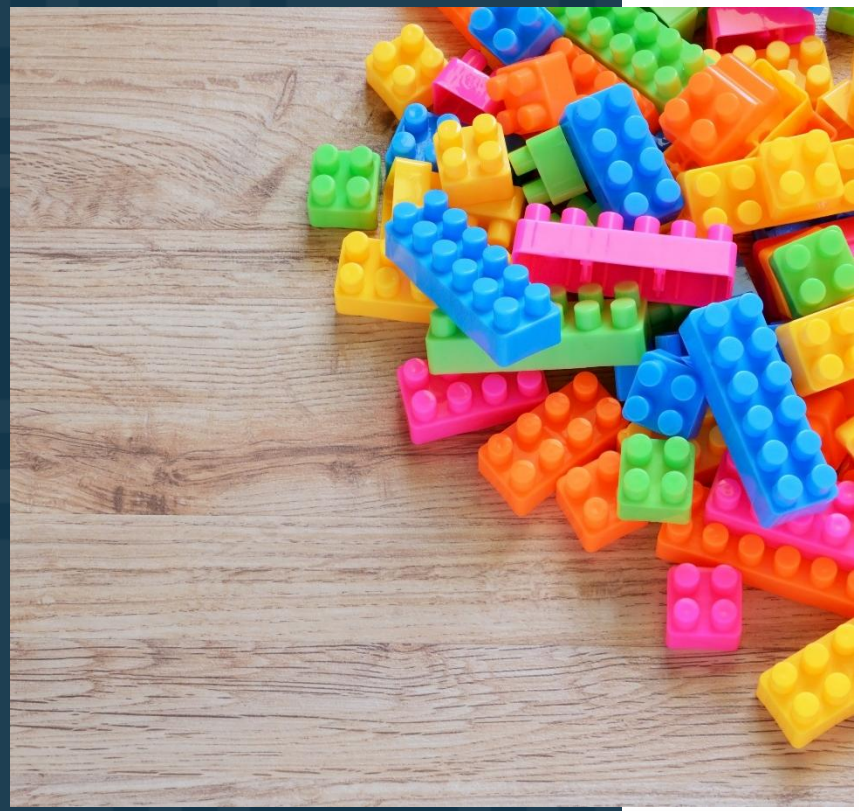
CEO ROUNDTABLE QUESTIONS/ DISCUSSION POINTS



- Given the anticipated impacts of OB3, how will your Abundance/Infinite Game mindset influence your hospital's strategies/finance/operations over the next 24 months?
  - Revenue cycle
  - Staff recruitment
  - Medical staff recruitment
  - Economic uncertainty
  - Volume growth
  - Expense management
  - Team/Medical Staff Internal Culture
  - Community engagement
- As a result of OB3, what are your top 1-2 recommendations for leaders to ensure the long-term viability of their rural health system, given future uncertainty?

QUESTIONS AND DISCUSSION