STROUDWATER

FUTURE OF RURAL HEALTHCARE: STRATEGIES FOR SUCCESS

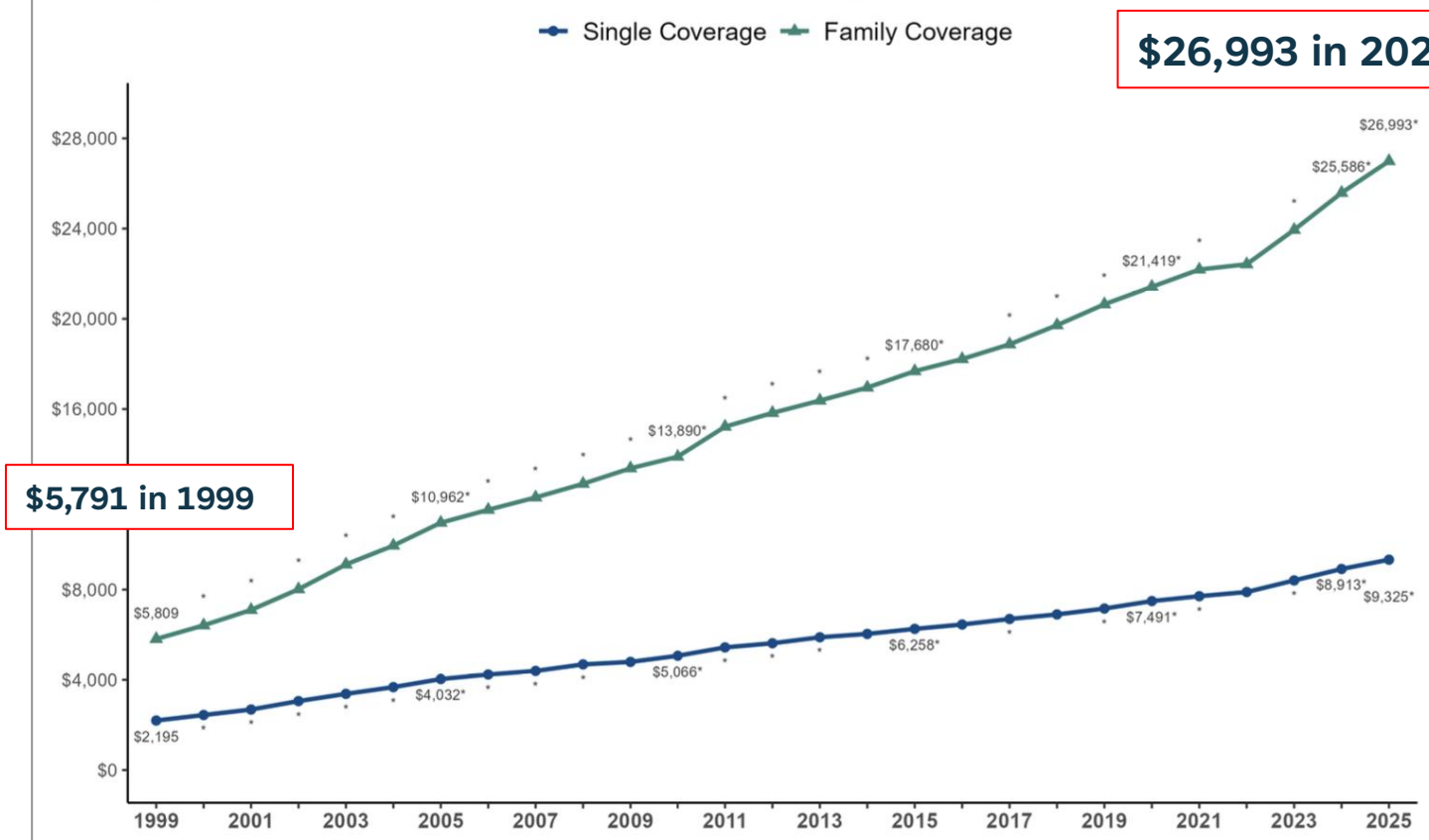
June 9, 2026

THE MARKET IS MOVING

- **Cost of healthcare continues to rise**
  - Kaiser Family Foundation reports 2025 family health insurance premiums have risen again
- **Advances in technology**
  - New market comfort for telehealth has led to an acceleration of new market competition
    - Amazon
    - CVS
    - United Healthcare
    - Risant
  - Artificial Intelligence!
- **Growth in Medicare Advantage**
  - MedPAC reports Medicare Advantage comprises 55% of eligible Medicare beneficiaries
- **Hospital inpatient and outpatient volume declines**
- **Federal government maintains commitment to transitioning payment system**
  - Payment updates
  - Accountable Care Plan growth
  - Budget Reconciliation Act (HR 1)

CALL TO ACTION: KAISER FAMILY FOUNDATION 2025 INSURANCE PREMIUMS

Figure 1.12
Average Annual Premiums for Single and Family Coverage, 1999-2025

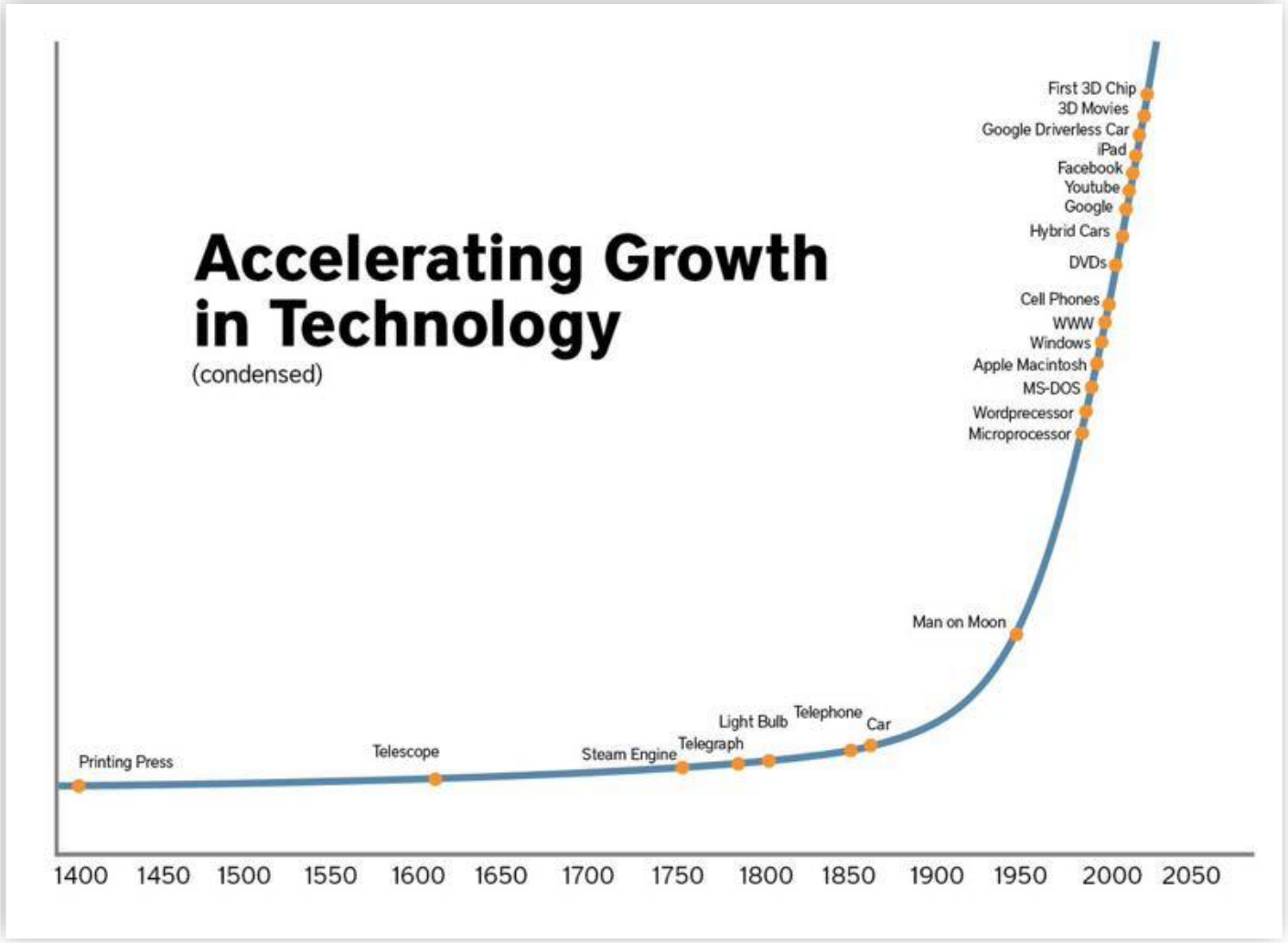


$26,993 in 2025

$5,791 in 1999

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2018-2025; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

CALL TO ACTION: ADVANCES IN TECHNOLOGY



Source: Khalid Hamdan, Accelerating Growth in Technology

CALL TO ACTION: AMAZON'S TRAJECTORY OF HEALTHCARE DISRUPTION*

2018
- Amazon acquires online pharmacy PillPack
- Haven partnership is announced with JPMorgan Chase & Co. and Berkshire Hathaway

2019
- Amazon Care launches

2020
- Amazon Pharmacy rolls out

2021
- **Haven disbands, citing lack of scale to negotiate effectively**

2022
- **Amazon Care shuts down**
- "Virtual healthcare storefront" Amazon Clinic launches

2023
- Amazon begins RxPass, a low-cost drug subscription service
- OneMedical is acquired for $3.9B, then partners with Health Transformation Alliance; **now providing primary care to 67 employers and approximately 5m employees**
- Amazon Web Services announces HealthScribe, a new generative AI model to help providers with clinical notes
- Amazon Clinic expands to all 50 states

2024
- Amazon partners with chronic care management company Omada to launch Amazon's health conditions program
- In Q3 '24, virtual mental health provider Talkspace partners with Amazon and joins the health conditions program
- RxPass meets regulatory requirements and becomes available to 50 million Medicare members
- One Medical announces plans to provide primary care through partnering with The Cleveland Clinic
- Amazon launches Hims and Hers-type telehealth service for Prime members

2025
- Amazon One Medical launches pediatric telehealth service for common childhood conditions such as conjunctivitis, hand, foot, and mouth, and diaper rash
- The pay-as-you-go service starts at $29 for message-based visits and $49 for video consultations, and does not require insurance, a Prime membership, or a One Medical membership

2026
- Rush University System partners with Amazon One Medical
- One Medical and Cleveland Clinic open second collaborative primary care office
- One Medical rolls out AI chatbot to assist in patient care and Health Insights feature to interpret blood test results
- Amazon Connect Health, an AI service intended to manage administrative processes and support clinicians through transcription and documentation, launches
- One Medical offers new weight management program using GLP-1 medications

**Please see bibliography on corresponding "Sources" slide in the Appendix*

CVS AND PRIMARY CARE*

CVS continues efforts to expand its primary care presence as competitors such as Amazon, Walmart and Walgreens take major steps forward including its recent major purchase of home health company Signify Health

After losing concierge medicine group One Medical to Amazon, CVS signals it may move forward with multiple smaller, regional acquisitions rather than larger ones as competitors have done

CVS works with Amwell to roll out the virtual care platform it announced in May, which provides virtual access to primary care, on-demand care, chronic condition management and mental health services and to eligible Aetna and CVS Caremark members

In early September 2022, CVS and Signify Health announce that CVS will buy the Dallas-based home health company for $8B. The Signify Health purchase represents a key milestone in CVS's effort to provide comprehensive healthcare offerings, as it now includes home health and value-based care in addition to its retail clinics.

In early May, CVS Health reports that it had finalized the purchases of both private-equity-backed Signify Health and Oak Street Health for a combined $18.6 billion. Oak Street Health, which serves a 42% dual-eligible population, provides primary care that addresses social determinants of health.

CVS's ACO division and Chicago-based Rush University System for Health are now collaborating to coordinate care at area MinuteClinics as participants in the Medicare ACO REACH program

In April 2024, CVS announces plans to add 50 to 60 Oak Street Health clinics within the year, most as stand-alone locations but some within its retail pharmacy stores. Competitors Walmart and Walgreens have both walked back some of their primary care clinics in recent months. [11/24 update: Despite company-wide restructuring, Oak Street Health expansion plans will move ahead]

In October 2024, following other retail giants like Walgreens and Amazon in the healthcare space, CVS announces layoffs of 1% of its workforce as part of a plan to cut $2B in costs, and is reportedly considering a corporate breakup of its retail and insurance arms

As of late October '24, Aetna members in select Texas, Georgia, and Florida locations can use Minute Clinic as their in-network primary care provider, with plans to add North Carolina in the coming weeks

In February '25, in its first primary care partnership with a health system, CVS joins Emory Healthcare Network to offer in-network MinuteClinic services to Emory Healthcare patients at 35 cobranded locations in Georgia

In early March '25, as part of $2B in cuts as insurance subsidiary Aetna continues to struggle, CVS sells its MSSP ACP to care management company Wellvana

**Please see bibliography on corresponding "Sources" slide in the Appendix*

CALL TO ACTION: UNITEDHEALTH BUYS OPTUMCARE AND INVESTS IN HOME HEALTH

> "When you begin to pencil out the math, as we move people into value-based arrangements, that will be a major driver of how we'll move to a $100 billion book of business."

Wyatt Decker, MD
OptumHealth CEO

Managed care company **UnitedHealth Group purchased OptumCare**, comprised of **56,000 physicians and 1,600 clinics,** and **plans to grow it to a $100B business** through value-based arrangements

OptumCare is also launching a virtual care platform – Optum Virtual Care – that supports its plan to integrate virtual care, home care, and care clinics across all 50 states

Per OptumHealth (OptumCare parent) CEO Dr. Wyatt Decker, under the new arrangement physicians will be paid to keep patients healthy

During Q1 2023, purchased home health group LHC for $5.4B, which employs about 30,000 people, operates in 37 states and cares for over 500,000 patients annually

During Q2 2023, outbid competitor to purchase home care company Amedisys for $3.3B, further expanding Home Care services

Sources: Becker's Hospital Review, How UnitedHealth plans to make Optum a $100B business, Ayla Ellison, April 23, 2021, https://www.beckershospitalreview.com/finance/how-unitedhealth-plans-to-make-optum-a-100b-business.html?origin=CIOE; Beckerspayer.com, *UnitedHealth to buy home-health firm LHC Group,* Andrew Cass, 3/29/22 https://www.beckerspayer.com/m-and-a/unitedhealth-to-buy-home-health-firm-lhc-group.html?origin=CFO*; https://www.fiercehealthcare.com/providers/unitedhealth-outbids-option-care-health-amedisys-33b-deal*

CALL TO ACTION: RISANT HEALTH COULD RESHAPE HEALTHCARE, SAYS GEISINGER CEO

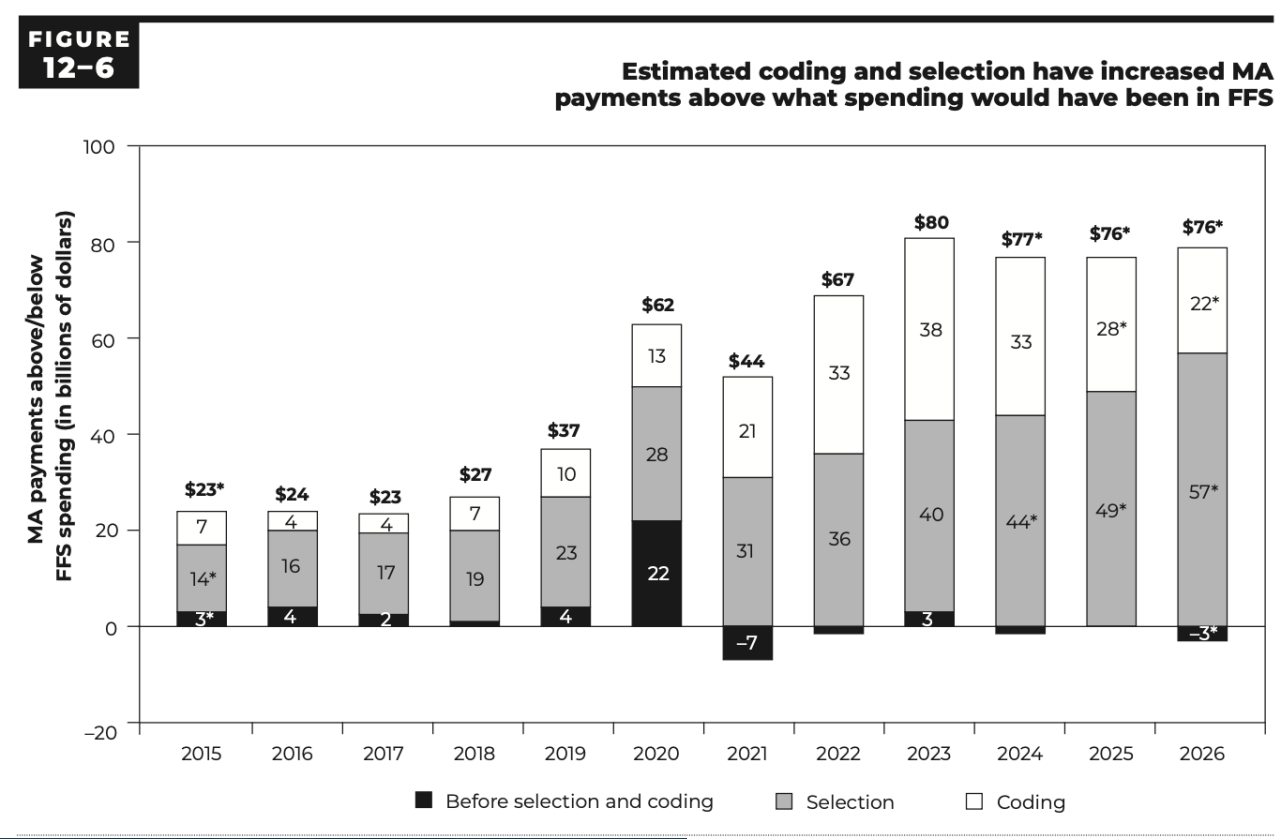
- In April 2024, Kaiser Permanente acquired Geisinger Health and merged it with nonprofit Risant Health to create a national value-based care network. Risant plans to invest at least $100 million in Geisinger through 2028.
- Geisinger CEO Dr. Jaewon Ryu now serves as CEO of Risant Health, which runs a hybrid, pluralistic, multi-payer, multi-provider model
- The Risant group intends to acquire more "like-minded, mission-aligned" health systems that are:
  - Nonprofit
  - Community-oriented
  - Committed to value-based care and health equity
  - Not hospital-centric
- ***Following this model, Risant has moved forward with acquiring NC-based Cone Health, which closed in the summer of 2025***

Sources: Modern Healthcare, Risant Health could reshape healthcare: Geisinger CEO, 08/29 https://www.modernhealthcare.com/mergers-acquisitions/risant-health-value-based-care-geisinger-jaewon-ryu?utm_source=modern-healthcare-am-Tuesday; Ibid, *Kaiser-backed Risant Health acquires second hospital system*, Caroline Hudson, 6/21/24 https://www.modernhealthcare.com/mergers-acquisitions/risant-health-cone-health-sale-kaiser-geisinger

CALL TO ACTION: IMPACTS OF AI ON HEALTHCARE PROVIDERS

- **Revenue Optimization/Efficiency**
  - 👍 Automation of scheduling, billing, and admin workflows
  - 👍 Provider documentation assistance, reducing patient throughput time
  - 👍 Improved clinical documentation to reduce denials
  - 👍 Supply chain management
- **Patient Care Benefits**
  - 👍 Enhanced diagnostic accuracy
  - 👍 Personalized treatment plans
  - 👍 Predictive analytics in support of population health
- **Security, Privacy, and Accountability**
  - 👎 Increased exposure to breaches, HIPAA violations, and cyberattacks
  - 👎 Unclear legal frameworks for AI-assisted misdiagnosis
- **Patient and Provider Risks**
  - 👎 Provider de-skilling
  - 👎 Implementation costs
  - 👎 Workforce displacement

CALL TO ACTION: THE MEDICARE ADVANTAGE (MA) PROGRAM: 3/15/2025 REPORT TO CONGRESS

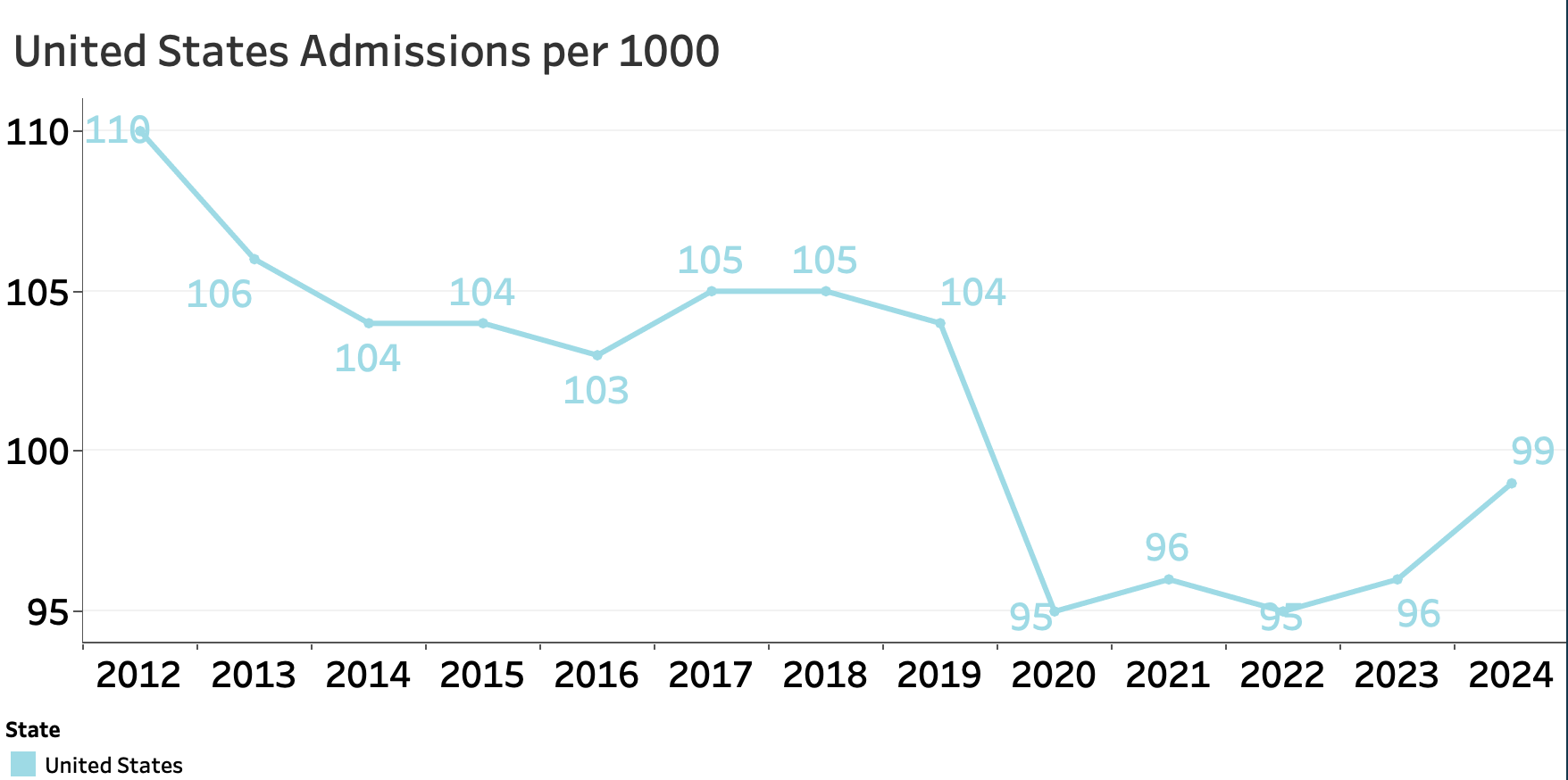


Key findings in the report:

- In 2025, 55% (34.9M) of eligible beneficiaries are enrolled in an MA plan (up from 26% in 2010)
- Risk Scores – Risk scores grew 6% faster than FFS in year one of enrollment and 2% faster in year 2
- MA plans are also estimated to have favorable selection leading to overpayments between 2017 and 2021 of between 6% and 13%
- Overall MA spend relative to FFS is estimated to be over ***$660B*** between 2007 and 2026
- ***Impact to Rural Hospitals***
  - ***Deny payment***
  - ***Delay payment***
  - ***Underpay negotiated rates***

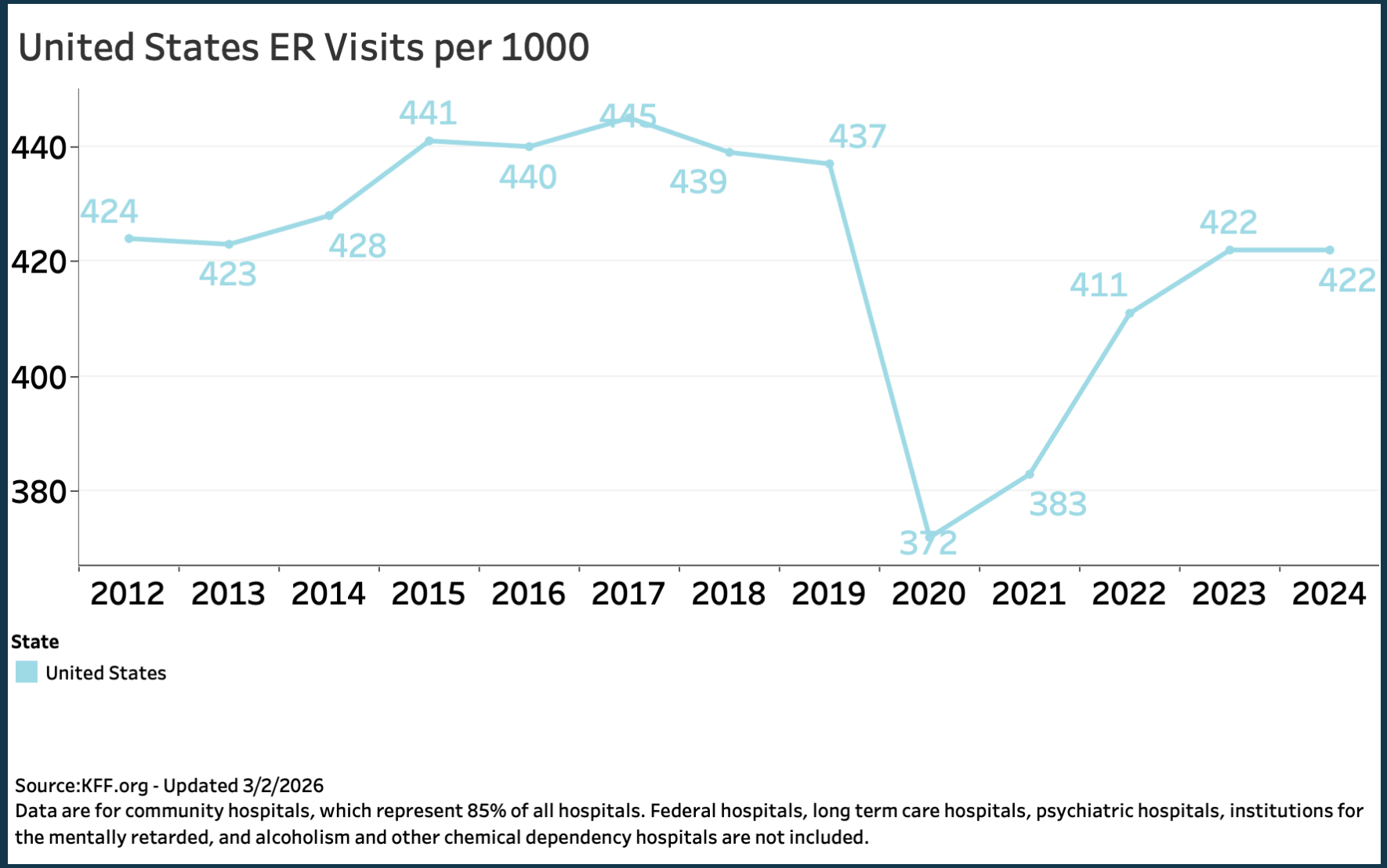
Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2026
https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

CALL TO ACTION: DECLINING IP VOLUME



Source:KFF.org - Updated 3/2/2026
Data are for community hospitals, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.

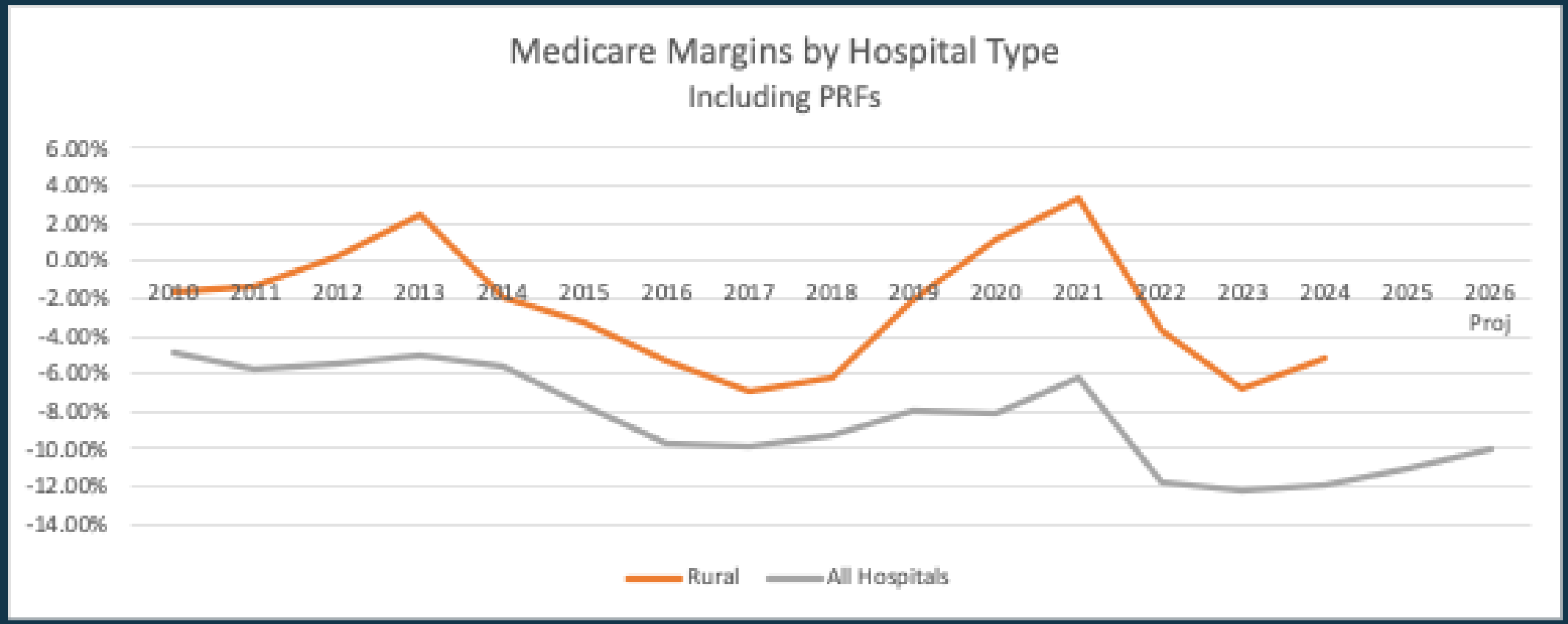
CALL TO ACTION: DECLINING ER VOLUME



Source:KFF.org - Updated 3/2/2026
Data are for community hospitals, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.

CALL TO ACTION: DECLINING MEDICARE MARGINS

- Medicare Margins by Provider Type – Including Provider Relief Funds



Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 12, 2026
https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_SEC.pdf

FORMER CMMI DIRECTOR DR. LIZ FOWLER ON "STRATEGIC REFRESH"

"WE NEED TO FIND A WAY TO BRING EVERYONE ALONG. WE CAN'T HAVE FEE-FOR-SERVICE REMAIN A COMFORTABLE PLACE TO STAY."

"We need to have a clear path for the innovators who are ready and willing and able to take on…risk, but I think we also need to push the laggards and then we need to reach those who have challenges participating….It may not be one-size-fits-all."

On CMMI innovation models: "A lot of what we've done has been aimed toward certification of models to become a permanent part of Medicare….In trying to get a model certified, it really does suggest a very specific model and a very specific way of thinking about evaluations and the assessment by actuaries. I wonder if we can instead think about the overall goal being transformation of the system instead of certification, or both."

Source: HFMA.org, *Why the federal agency that oversees healthcare payment innovation is rethinking its approach,* Nick Hut, 4/26/21
https://www.hfma.org/topics/news/2021/04/why-the-federal-agency-...utm_source=rasa_io&PostID=29248522&MessageRunDetailID=5032322143

CMS 2022 INPATIENT PERSPECTIVE PAYMENT PROPOSED RULE 4/27/21, FINALIZED 8/2/21

- Payment Rate Update

PROPOSED FY 2022 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS				
FY 2022	**Hospital Submitted Quality Data and is a Meaningful EHR User**	**Hospital Submitted Quality Data and is NOT a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User**
Proposed Market Basket Rate-of-Increase	2.5	2.5	2.5	2.5
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-0.625	-0.625
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-1.875	0	-1.875
Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.2	-0.2	-0.2	-0.2
Proposed Applicable Percentage Increase Applied to Standardized Amount	**2.3**	**0.425**	**1.675**	**-0.2**

Source: CMS Fact Sheet, 4/27/2021; NRHA Summary of 2022 IPPS Final Rule 8/2/2022

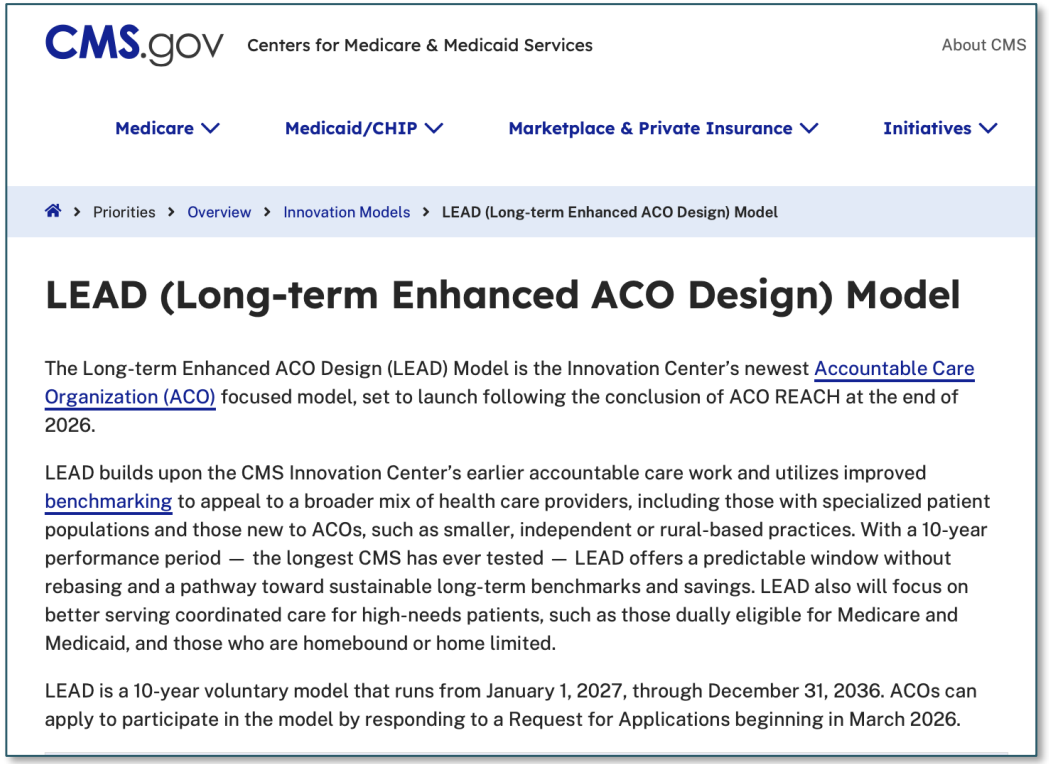
CY2023 MEDICARE PFS – MEDICARE SHARED SAVINGS PLAN FINAL RULE (11/1/2022)

- CMS issued a proposed rule that announces and solicits public comments on proposed policy changes for Medicare payments under the PFS, and other Part B issues, on or after January 1, 2023 (continued)
  - ***Rule was finalized on 11/1/2022***
- Key elements related to MSSP include:
  - Finalized proposal to provide advance investment payments (AIPs) to low-revenue ACOs, inexperienced with performance-based risk Medicare initiatives, that are new to the program
    - **One-time fixed payment** of **$250K** with **quarterly payments** for the first two years of the 5-year agreement period
    - Requirement that advanced payments be used for improving health care provider infrastructure, increasing staffing, or providing accountable care to underserved beneficiaries
    - Application period during CY23 for 1/1/24 start
    - Advanced payments would increase with higher levels of dual eligible beneficiaries
    - Advance payments would be paid back from future shared savings
  - Expand opportunities for certain low-revenue ACOs participating in the BASIC track to share in savings, even if they do not meet the minimum savings rate

Sources: CMS.gov Calendar Year 2023 Medicare Physician Fee Schedule Proposed Rule Fact Sheet, July 7, 2022; CMS.gov Calendar Year 2023 Medicare Physician Fee Schedule Final Rule Fact Sheet, November 1, 2022; NRHA Summary of Final CY 2023 Medicare Physician Fee Schedule and other Changes to Part B Payment and Coverage Policies

LEAD (LONG-TERM ENHANCED ACO DESIGN)

- On 12/18/25, CMMI announced a 10-year, voluntary model, replacing the ACO REACH Model, using:
  - Improved benchmarking;
  - Flexible, capitated population-based payments to support team-based care; and
  - 10-year performance period offering a predictable window without rebasing for sustainable long-term benchmarks and savings.
- LEAD aims to:
  - ***Increase the scope of ACOs — to include more small, more rural, and more independent health care providers and Community Health Centers.***
  - Enhance evidence-based prevention and care coordination for more patients, including those with high-needs.
  - Empower patients to be more actively involved in their care.
- LEAD includes key design features:
  - **Integration of high-needs patients**: Support for high-needs patients, including more accurate risk adjustment and benchmarking
  - **Two voluntary risk-sharing options:**
    - **Global Risk:** Eligible to receive up to 100% of their savings and liable for up to 100% of total losses relative to their established performance benchmark.
    - **Professional Risk:** Eligible to receive up to 50% of total savings and liable for up to 50% of total losses relative to their established performance year benchmark.



Sources: 12/18/2025 https://www.cms.gov/priorities/innovation/innovation-models/lead

MEDICARE ACOS 2026 UPDATE: **CMS FAST FACTS**

- On 1/26/26, 14.3M Medicare beneficiaries are estimated to receive care coordinated through ACOs, up from 13.7M in 2025
- During 2024, Shared Savings ACOs earned shared savings of $4.1B and saved Medicare $2.5B
- ***"ACOs represent a critical component of CMS's comprehensive strategy to increase value-based care for people with Medicare and Medicaid."***

Shared Savings Program Fast Facts – As of January 1, 2026

CMS MEDICARE SHARED SAVINGS PROGRAM

PROGRAM CHARACTERISTICS (as of Jan 1) / PERFORMANCE YEAR RESULTS

Performance Year	ACOs	Assigned Beneficiaries	Total Earned Shared Savings	Quality Score
2026	511	12.6 million	TBD	TBD
2025	476	11.2 million	TBD	TBD
2024	480	10.8 million	$4.1 billion	81%*
2023	456	10.9 million	$3.1 billion	82%*
2022	483	11.0 million	$2.5 billion	81%*
2021	477	10.7 million	$2.0 billion	91%
2020	517	11.2 million	$2.3 billion	97%
2019	487	10.4 million	$1.5 billion	92%
2018	561	10.5 million	$983 million	93%
2017	480	9.0 million	$799 million	92%
2016	433	7.7 million	$700 million	95%
2015	404	7.3 million	$645 million	91%
2014	338	4.9 million	$341 million	83%
2012 / 2013	220	3.2 million	$315 million	95%

*The elimination of MIPS bonus points resulted in lower MIPS Quality performance category scores for ACOs

ACOs BENEFICIARY ASSIGNMENT METHODOLOGY

	ACOs	Percent
Prospective	129	25%
Preliminary Prospective with Retrospective Reconciliation	382	75%

ADVANCE INVESTMENT PAYMENTS (AIP)

Participating ACOs	36
Beneficiaries assigned to ACOs participating in AIP	442,315

PREPAID SHARED SAVINGS (PSS)

Participating ACOs	4
Beneficiaries assigned to ACOs participating in PSS	51,005

ACO Tracks	ACOs	Percent
One Sided (24% of ACOs)		
BASIC Track Levels A&B	121	24%
Two Sided (76% of ACOs)		
BASIC Track Levels C&D	12	2%
BASIC Track Level E	82	16%
ENHANCED Track	296	58%

HIGH / LOW REVENUE ACOs

	ACOs	Percent
High Revenue	186	36%
Low Revenue	325	64%

Enrollment Type	Percent
Aged Non-Dual	87.7%
Disabled	6.6%
Aged Dual	5.3%
End Stage Renal Disease (ESRD)	<1%

ACO PARTICIPANT LIST COMPOSITION

Participant TINs	15,353
Physicians and non-Physicians	687,739
Hospitals	1,539
Federally Qualified Health Centers (FQHCs)	8,840
Rural Health Clinics (RHCs)	3,109
Critical Access Hospitals	590

Skilled Nursing Facility (SNF) AFFILIATES & SNF 3-DAY RULE WAIVER

ACOs approved for a SNF 3-Day Rule Waiver	183
Total number of SNF affiliates	3,196

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Sources: https/www.cms.gov/files/document/2026-shared-savings-program-fast-facts.pdf; https://www.cms.gov/newsroom/fact-sheets/2026-medicare-accountable-care-organization-initiatives-participation-highlights

CALL TO ACTION: BUDGET RECONCILIATION ACT

- Rural hospitals will be impacted significantly by the Budget Reconciliation Act
  - Up to 15M additional uninsured people, placing further pressure on the FFS payment model
    - *Effective January 2026, Healthcare Exchanges lost 1.5M (5.1%) covered lives through the discontinuation of enhanced premium tax credits and more restrictive enrollment criteria*
  - Health sector to lose $1.1T over 10 years, primarily through reduced Medicaid coverage and direct provider payments
  - $50B Rural Health Transformation Program
    - $10B per year for 5 years beginning 2026
    - States were to submit a rural transformation plan by December 31, 2025, to include:
      - Improve access
      - Improve health outcomes for rural residents
      - Prioritize new and emerging technologies that emphasize prevention and chronic disease management
      - Improve the financial solvency of rural hospitals
- **Rural health systems must proactively position themselves for the new market reality**

CALL TO ACTION: IN SUMMARY

Traditional fee-for-service payment will continue to transition to value-based payment

Pressure for operational efficiencies and human and capital resources will continue to accelerate

Flexibility must be ingrained into any short- to medium-term strategies as a direct result of increased regulatory and environmental uncertainty

FUTURE HOSPITAL FINANCIAL VALUE EQUATION: DEFINITIONS

PATIENT VALUE

$$\frac{\text{QUALITY}}{\text{COST}} \times \text{POPULATION} = \text{PATIENT VALUE}$$

ACCOUNTABLE CARE

- A mechanism for ***providers to monetize the value derived from increasing quality, reducing costs, and applying value to larger populations***
  - Accountable care includes many models, including bundled payments, value-based payment programs, provider self-insured health plans, Medicare-defined ACOs, capitated provider-sponsored healthcare, etc.
- Different “this time”
  - Providers monetize value
  - Government “all in”
  - New information systems to manage costs and quality
  - Agreed-upon evidence-based protocols
  - Going back is not an option

FUTURE HEALTHCARE PROVIDER FINANCIAL VALUE EQUATION

- ACO Relationship to Small and Community Healthcare Providers
  - Revenue stream of the future tied to Primary Care Physicians (PCP) and their patients
  - Small and community healthcare providers bring value / negotiating power to partner relationships as generally PCP based
    - Smaller community healthcare providers have value through alignment with revenue drivers (PCPs) rather than cost drivers, but must position themselves for a new market:
      - Alignment with PCPs in the local service area
      - Develop a position of strength by becoming highly efficient
      - Demonstrate high quality through monitoring and actively pursuing quality goals

THE PREMISE

Finance

- Macro-economic payment system
  - Government payers changing from fee-for-service (FFS) to population-based payment system (PBPS)
  - CMMI is considering making value-based payment models mandatory
  - Private payers follow government payers

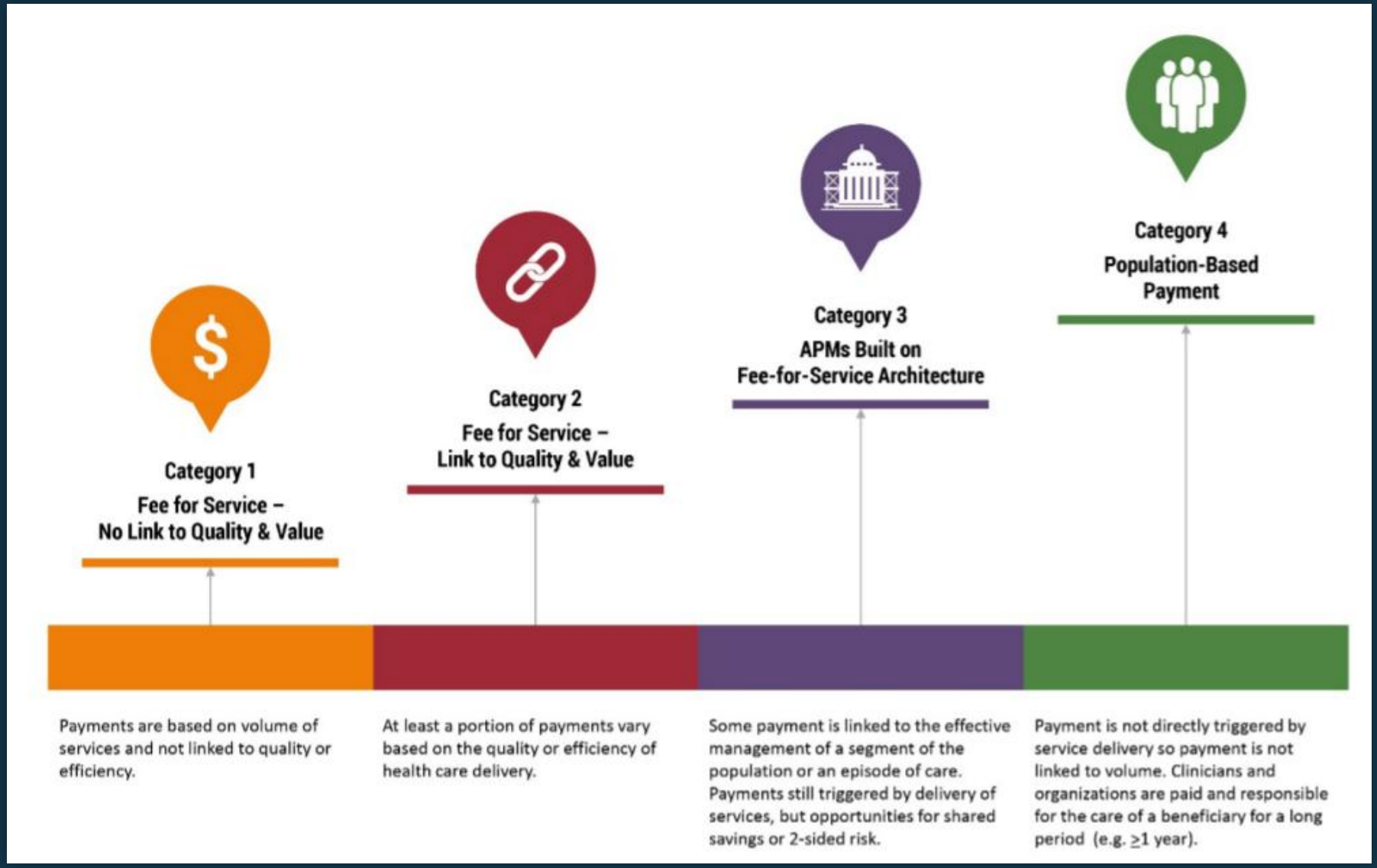
Function

- Provider imperatives
  - Fee-for-service (FFS):
    - Maximization of price and utilization
    - Management of costs
  - Provider Based Payment System (PBPS):
    - Management of care of a defined population
    - Providers assume risk

Form

- Provider organization evolution from:
  - Independent organizations competing with each other for market share →
  - Aligned organizations competing with other aligned organizations for covered lives based on quality and value
- Network and care management organization must develop new competencies:
  - Network development
  - Care management
  - Risk contracting & management

TRANSITION FRAMEWORK VALUE-BASED JOURNEY



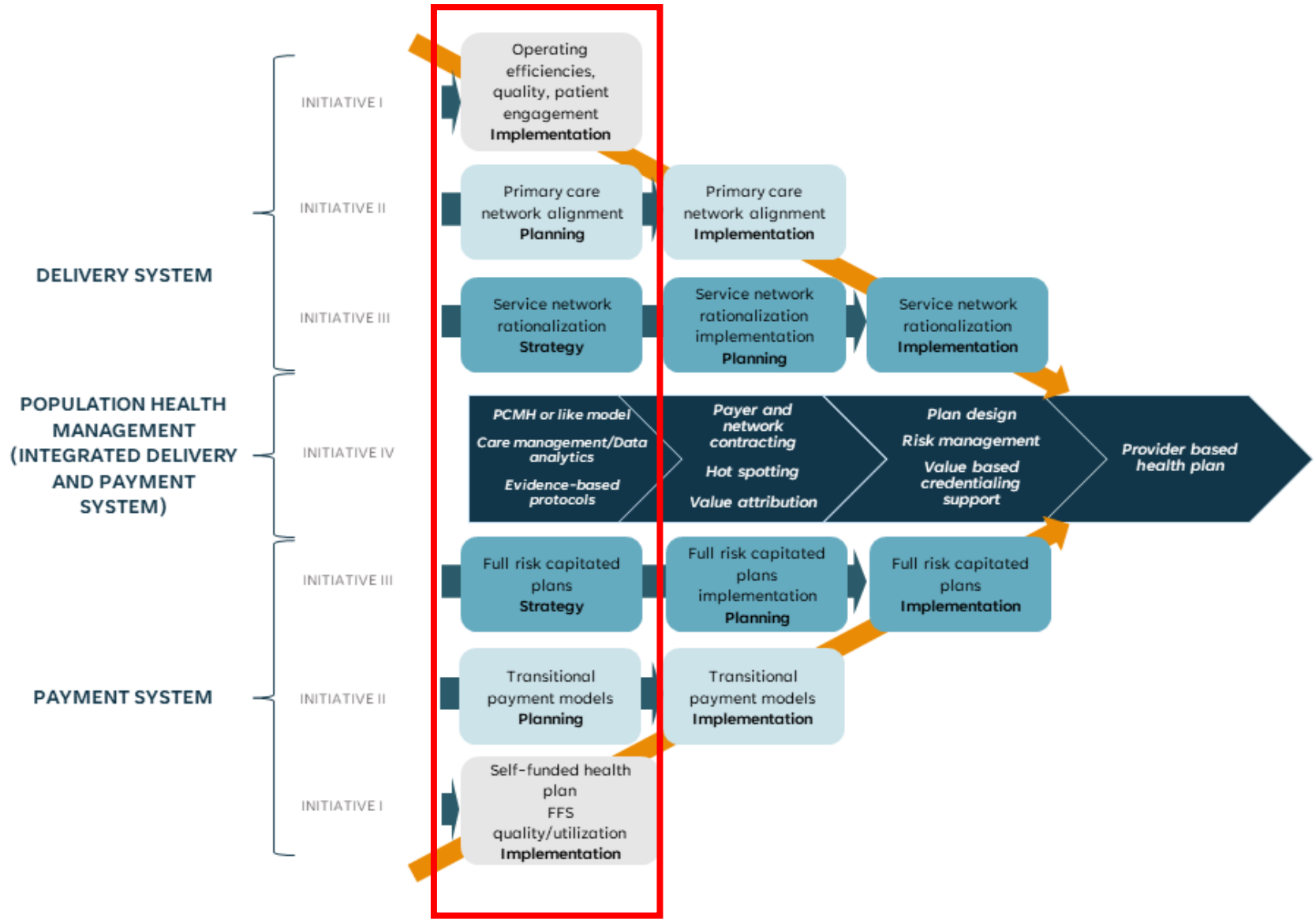
THE CHALLENGE: CROSSING THE SHAKY BRIDGE

Fee for Service Payment System

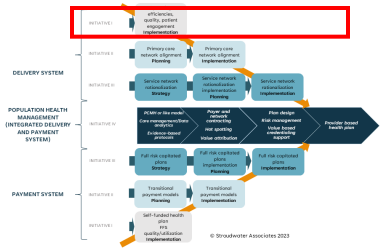
Population Based Payment System

2014 2020 2024 2028 2032 2036

TRANSITION FRAMEWORK



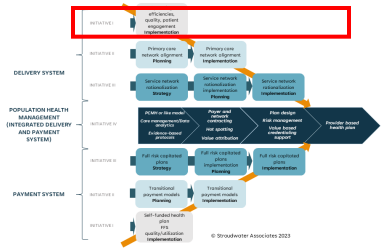
INITIATIVE I – OPERATING EFFICIENCIES, PATIENT SAFETY AND QUALITY



- Hospitals not operating at efficient levels are currently, or will be, struggling financially
- "Efficient" is defined as
  - Appropriate patient volumes meeting the needs of their service area
  - Revenue cycle practices operating with best practice processes
  - Expenses managed aggressively
  - Physician practices are managed effectively
  - Leverage AI to improve operational efficiency and third-party reimbursement
- Patient Engagement
  - Proactively engaging patients in care
    - Annual physicals and wellness visits, well-child visits, etc.

Graphic: National Patient Safety Foundation

INITIATIVE I – OPERATING EFFICIENCIES, PATIENT SAFETY AND QUALITY



- RUPRI studied the fixed-to-total cost ratios for hospitals of different sizes
  - Current Study reviewed cost report data between 2011 and 2020 for 4953 hospitals
  - This model estimated fixed and variable costs using the simple definition of a variable cost as one that varies with volume
    - Costs that tracked with adjusted patient days were considered variable
- Important Findings:
  - The median ratio for all hospitals in metropolitan UICs is 0.733, while the median ratios in all other UICs are markedly higher and increase as hospital locations become more rural
- Conclusions:
  - Hospital payment policy and payment model development may benefit from considering hospital fixed-to-total-cost ratios, particularly in places where economies of scale are unattainable

RUPRI Center for Rural Health Policy Analysis

Rural Policy Brief

Brief No. 2025-3 JUNE 2025 http://www.public-health.uiowa.edu/rupri/

The Impact of High Hospital Fixed-Cost Ratios on Rural Populations

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Purpose

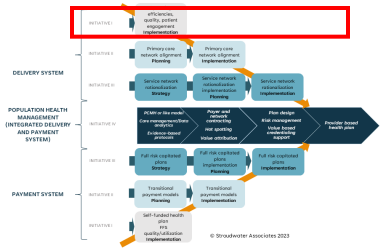
This brief focuses on rural hospitals with high fixed-to-total-cost ratios and describes characteristics of those hospitals and the communities they serve. The brief extends a recent RUPRI Center analysis[1] of whether hospitals in rural areas have higher fixed-to-total-cost ratios, a characteristic that has implications for financial stability under different payment models. We describe how this measure varies across the United States, the demographic characteristics associated with hospitals at different ratio levels, and the share of nonmetropolitan hospitals that have Critical Access Hospital (CAH) or Low-Volume Hospital (LVH) designations.

Table 1. Average County Population Density, Median, 25th and 75th Percentiles of Fixed-to-Total-Cost Ratios for all Hospitals by UIC Group

UIC Group	Number of Hospitals	Average Population Density	Median Ratio of Hospitals in UIC Group	25th percentile	75th percentile
Metropolitan (UIC = 1,2)	2,976	671.7/mi²	0.733	0.602	0.861
Micropolitan (UIC = 3,5,8)	797	69.8/mi²	0.847	0.778	0.895
Noncore adjacent to large metro or with town of 2500+ (UIC = 4,6,9,11)	857	40.1/mi²	0.901	0.866	0.929
Noncore without town of 2500+ (UIC = 7,10,12)	332	13.3/mi²	0.933	0.886	0.957

Source: http://www.public-health.uiowa.edu/rupri/

OPERATING EFFICIENCIES, PATIENT SAFETY AND QUALITY



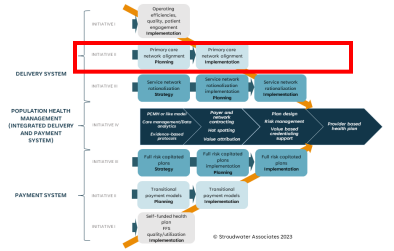
- **Focus on Quality and Patient Safety**
  - As a strategic imperative
  - As a competitive advantage

U.S. HHS Hospital Compare Measures	National Avg.	MA Average	Fairview Hospital	Berkshire Medical Center	Baystate Medical Center	Columbia Memorial Hospital	Sharon Hospital	Saint Peter's Hospital	Bringham and Women's Hospital	Mass General Hospital	Albany Medical Center	Charlotte Hungerford Hospital
Patient Survey Summary Star Rating:			**5**	**3**	**3**	**2**	**4**	**3**	**3**	**4**	**2**	**3**
Patient Satisfaction (HCAHPS) Average:	**71%**	**70%**	**84%**	**68%**	**66%**	**61%**	**73%**	**67%**	**71%**	**74%**	**64%**	**65%**
Nurses "Always" communicated well:	80%	80%	92%	81%	75%	73%	84%	77%	80%	83%	75%	77%
Doctors "Always" communicated well:	82%	81%	90%	78%	77%	74%	84%	76%	80%	82%	70%	75%
"Always" received help when wanted:	68%	66%	88%	64%	59%	58%	71%	59%	69%	65%	62%	60%
Pain "Always" well controlled:	71%	71%	83%	73%	68%	70%	72%	70%	69%	72%	65%	69%
Staff "Always" explained med's before administering:	65%	64%	78%	64%	61%	56%	69%	59%	61%	66%	58%	58%
Room and bathroom "Always" clean:	74%	72%	86%	73%	67%	63%	78%	63%	66%	72%	66%	72%
Area around room "Always" quiet at night:	62%	53%	68%	46%	48%	45%	60%	47%	56%	54%	43%	40%
YES, given at home recovery information:	87%	89%	94%	89%	88%	83%	85%	87%	89%	90%	83%	91%
"Strongly Agree" they understood care after discharge:	52%	53%	70%	50%	49%	41%	51%	49%	51%	59%	46%	47%
Gave hospital rating of 9 or 10 (0-10 scale):	72%	70%	88%	65%	65%	53%	73%	69%	80%	82%	65%	60%
YES, definitely recommend the hospital:	71%	74%	91%	65%	73%	50%	72%	76%	84%	90%	70%	61%

Source: www.hospitalcompare.hhs.gov

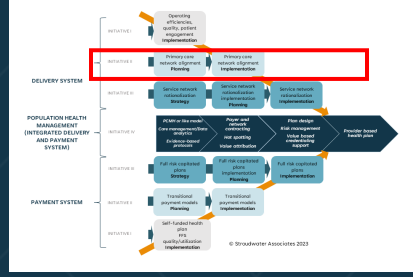
Highest Score
Above State Avg.
Below State Avg.
Lowest Score

INITIATIVE II – PRIMARY CARE ALIGNMENT

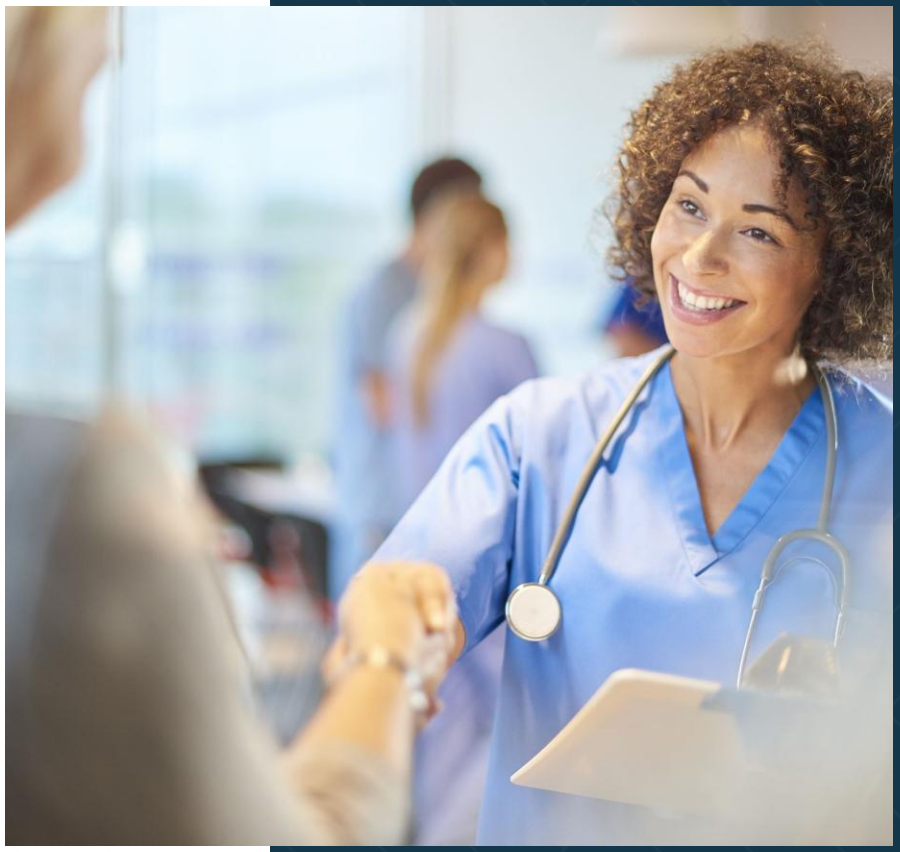


- Understand that revenue streams of the future will be tied to primary care physicians, who often comprise a majority of the rural and small hospital healthcare delivery network
  - Thus, small and community hospitals, through alignment with PCPs, will have extraordinary value relative to costs
- Physician Relationships
  - Hospitals align with employed and independent providers to enable interdependence with medical staff and support clinical integration efforts
    - Contract (e.g., employment, management agreements)
    - Functional (share medical records, joint development of evidence-based protocols)
    - Governance (Board, executive leadership, planning committees, etc.)
  - *Potential Model for rural and community health systems:*
    - *New PHO/CIN/IHN*

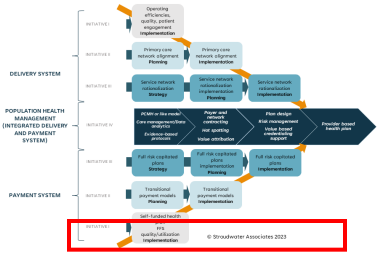
INITIATIVE III – RATIONALIZE SERVICE NETWORK



- Definition
  - Coming together in larger systems to reduce future fixed costs
    - Fixed costs include Bricks and Mortar, specialists, and technology
- Develop system integration strategy
  - Evaluate a wide range of affiliation options, ranging from network relationships to interdependence models to full asset ownership models
    - Interdependence models through alignment on contractual, functional, and governance levels may be an option for community hospitals that want to remain “independent”
  - Explore / Seek to establish interdependent relationships among small and community hospitals, understanding their unique value relative to future revenue streams
- Identify the number of providers needed in the service area based on population and the impact of an integrated regional health care system



PAYMENT SYSTEM STRATEGY – INITIATIVE I



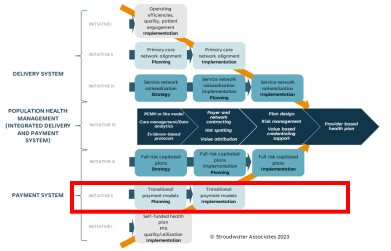
Develop self-funded employer health plan

- Hospital is already 100% at risk for medical claims thus no risk for improving health of employee "population"
- Change benefits to encourage greater "consumerism"
  - Differential premium for elective "risky" behavior
- "Enroll" employee population in health programs – health coaches, chronic disease programs, etc.

FFS Quality and Utilization Incentives

- Maximize FFS incentives for improving quality or reducing inappropriate utilization (e.g., inappropriate ER visits, re-admissions, etc.)
- Annual Well visits, Chronic Care Management (CCM) and Transitional Care Management (TCM) FFS payments
- Maximize MIPS incentive payments
  - MIPS ACO

PAYMENT SYSTEM STRATEGY – INITIATIVE II

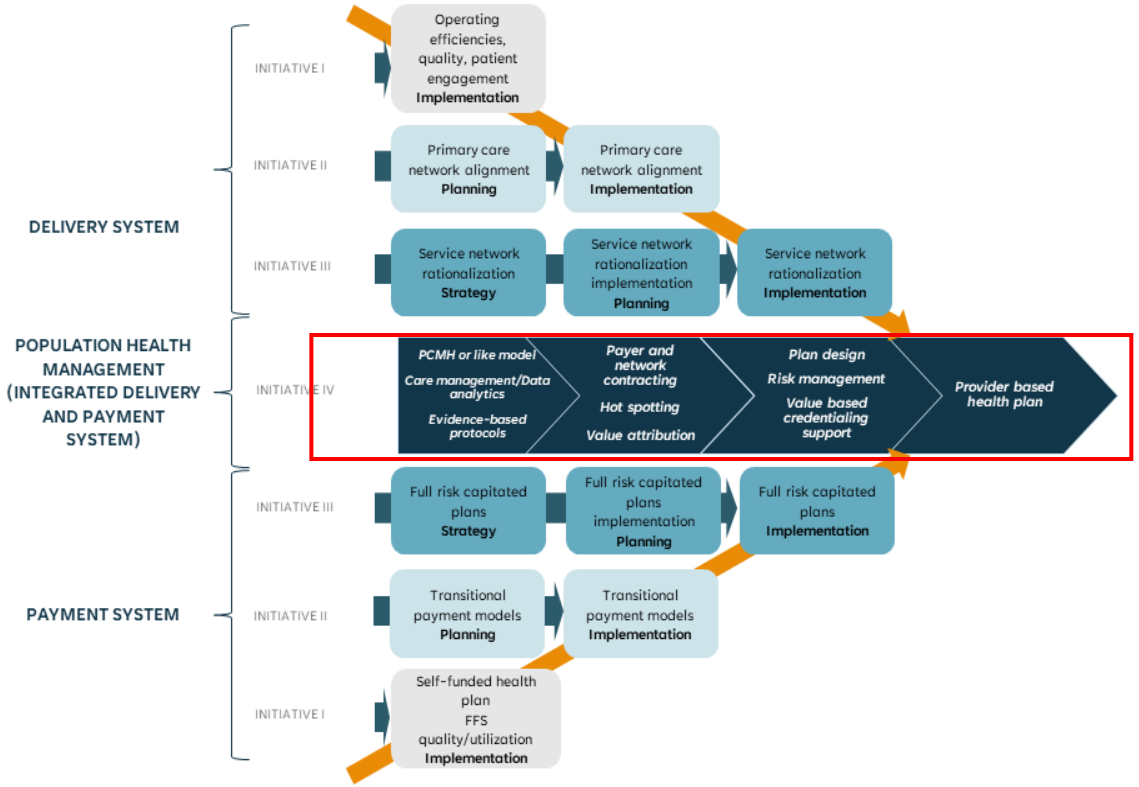


Initiative II: Implementation planning for transitional payment models

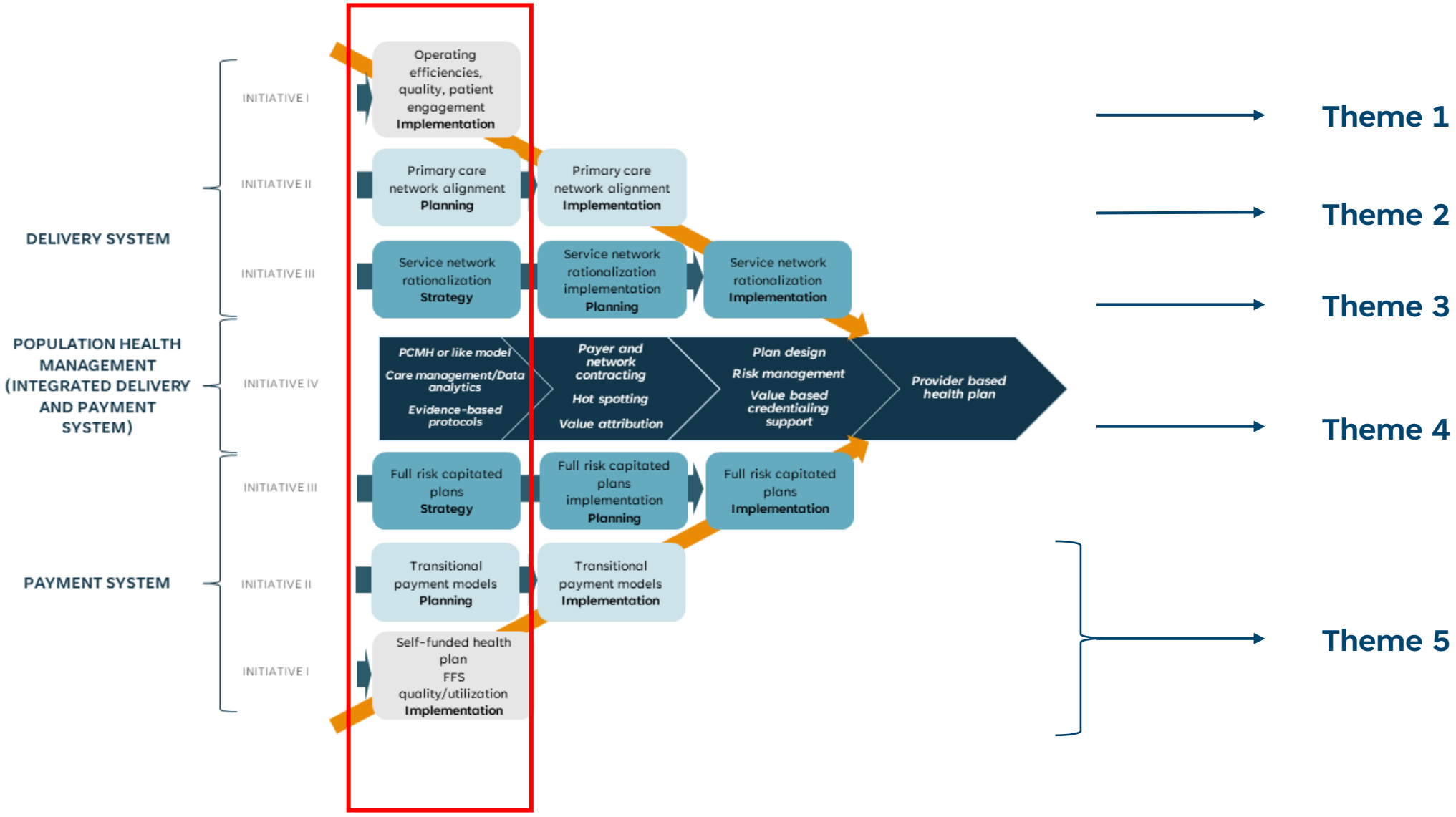
- Transitional payment models include:
  - FFS against capitation benchmark w/ shared savings
  - Shared savings model Medicare ACOs
  - Shared savings models with other governmental and commercial insurers
  - Partial capitation and sub-capitation options with shared savings
- Prioritize insurance market opportunities
- Take the initiative with insurers to gauge interest and opportunities for collaborating on transitional payment models
- Explore direct contracting opportunities with self-funded employers

POPULATION HEALTH STRATEGIES – PHASE I

- Phase I: Develop Population Health building blocks
  - Goal: Infrastructure to manage self-insured lives and maximize FFS Utilization and quality incentives
  - Initiatives:
    - PCMH or like structure
    - Care management
      - Discharge planning across the continuum
        - Transportation, PCP, meds, home support, etc.
      - Transitions of care (checking in on treatment plan)
        - Medication reconciliation
        - Post-discharge follow-up calls (instructions, teach back, medication check-in)
        - Identifying community resources
        - Maintain patient contact for 30 days
    - Develop claims analysis capabilities/infrastructure
    - Develop evidence-based protocols



TRANSITION FRAMEWORK IN REVIEW



CONCLUSIONS/RECOMMENDATIONS

The current environment, driven by health care reform and market realities, offers a new set of challenges. Many health care providers have not yet considered either the magnitude of the changes or the required strategies to appropriately address the changes.

Locally delivered health care (including rural and community hospitals) has high value in the emerging delivery system

"Shaky Bridge" crossing will require planned, proactive approach

Critical to maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system

CONCLUSIONS/RECOMMENDATIONS (CONTINUED)

Important strategies for providers to consider include:

- Increase leadership awareness of new environment realities
- Strategic plan to incorporate new strategic imperatives – “Bridge Strategy”
- Improve operational efficiency of provider organizations
- Adapt effective quality measurement and improvement systems as a strategic priority
- Align/partner with medical staff members contractually, functionally, and through governance where appropriate
- Seek interdependent relationships with developing regional systems
- Develop strategies to proactively move towards value-based payment

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Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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APPENDIX

AMAZON'S TRAJECTORY OF HEALTHCARE DISRUPTION: SOURCES

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