Strategies for CAH Success in the New Healthcare Market

Achieving the Triple Aim in Healthcare

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Overview/Introduction

- In the past 12-24 months, the healthcare field has experienced considerable changes with an increased number of rural-urban affiliations, physicians transitioning to hospital employment models, flattening volumes, CEO turnover, etc.
  - Federal healthcare reform passed in March 2010 with sweeping changes to healthcare systems, payment models, and insurance benefits/programs
    - Many of the more substantive changes will be implemented over the next three years
      - Rural healthcare providers throughout the country are looking out to the future attempting to project what it means to them and how to position themselves for that future
  - State Medicaid programs are moving toward managed care models or reduced fee for service payments to balance State budgets

- Thus, providers face new financial uncertainty and challenges and will be required to adapt to the changing market

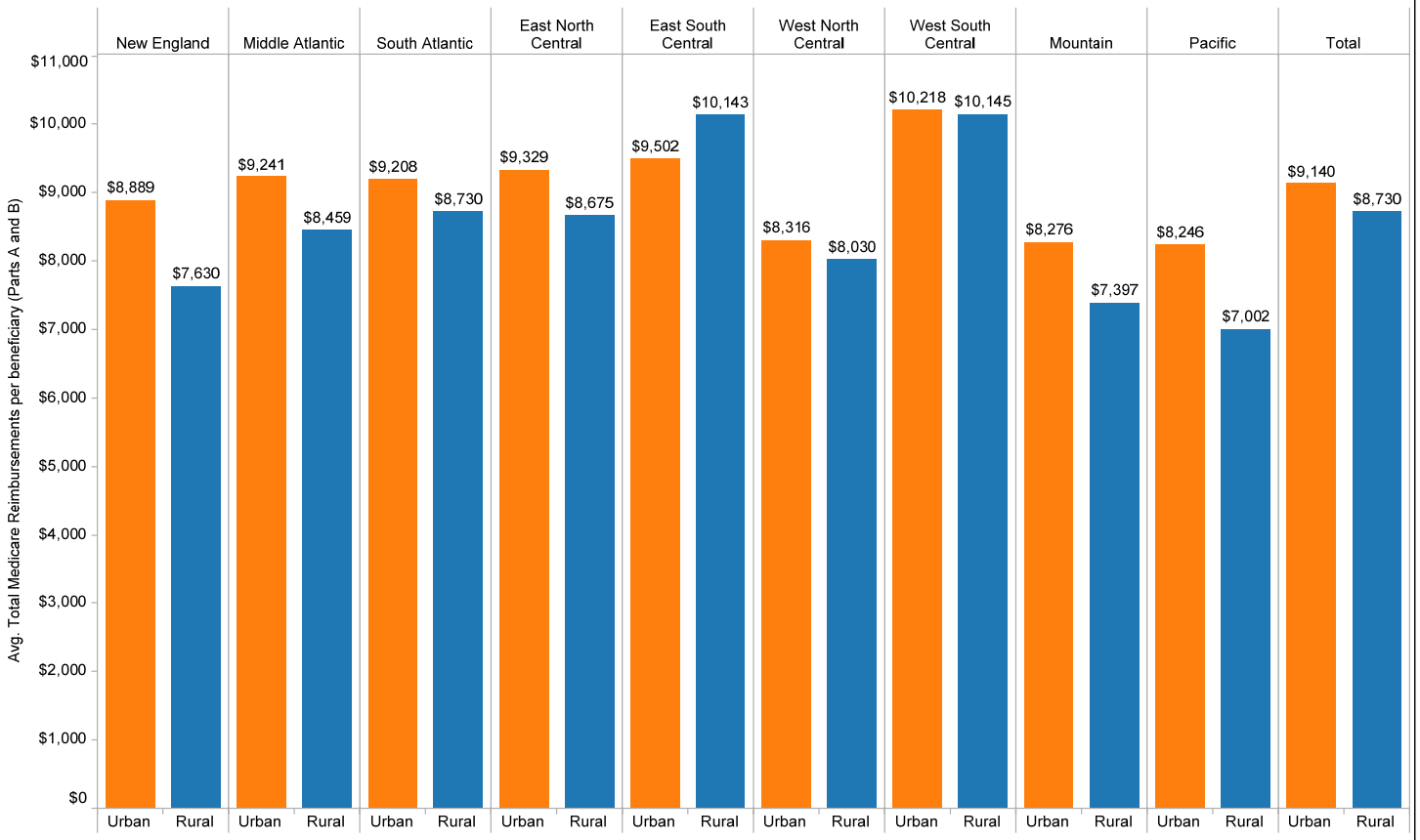
Market Overview - Federal

- Washington Update
  - CBO - January 2011 Report
    - Eliminate the following: Critical Access Hospitals (CAH), Medicare-Dependent Hospital (MDH) and Sole Community Hospital (SCH)
    - Projected Savings over 10 Years, $62.2B
  - MedPAC - September 15, 2011 Presentation
    - CAH conclusions:
      - Keeps hospitals open but not focused on isolated hospitals
      - Keeps neighboring hospitals open, even if there is excess capacity in the market
      - Cost sharing should be reduced, funded through "focusing" the program
  - President's Proposal – September 19, 2011
    - $6 Billion in cuts to rural providers over 10 years
    - Eliminates "higher than necessary reimbursements"
      - Reduce bad debt payments to 25%, down from the current 70%. Save $20 Billion over 10 years
      - Beginning in FY 2013, reduce the IME adjustment by 10%, saving $9 Billion over 10 years.
      - Reduce CAH reimbursement to 100% of cost, down from the current 101%.
      - End CAH reimbursement for facilities located 10 miles or less from another hospital.
      - Limit the use of provider taxes beginning in FY 2015, but do not eliminate them entirely

Market Overview - Federal

- Washington Update (continued)
  - Stroudwater Analysis – November 7, 2011

Medicare Reimbursement (Parts A and B) (2008)



Source: The Dartmouth Atlas (Age, Sex, Race and Price-Adjusted Medicare Reimbursements per Beneficiary), weighted averages by HSA

Market Overview - Federal

- Washington Update (continued)
  - Deficit Reduction – November 23, 2011
    - Sequestration
      - Automatic, across-the-board cuts to specific programs and discretionary accounts
      - Medicare reimbursements will be cut 2%
      - Medicaid and Social Security will not be part of the automatic cuts

Market Overview - Federal

- Healthcare Reform
  - Coverage Expansion
    - By 1/1/14, expand Medicaid to all non-Medicare eligible individuals under age 65 with incomes up to 133% FPL based on modified AGI
      - Currently, Medicaid covers only 45% of poor (≤ 100% FPL)
      - 16 million new Medicaid beneficiaries; mostly "traditional" patients (vs. disabled, elderly)
      - FMAP for newly eligible: 100% in 2014-16; 95% in 2017; 94% in 2018; 93% in 2019; 90% in 2020+
    - Establishment of State-based Health Insurance Exchanges
    - Subsidies for Health Insurance Coverage
    - Individual and Employer Mandate
      - Requires all American citizens not covered by an employer-based or governmental plan to purchase health insurance
      - U.S. Supreme Court will review the constitutionality of these mandates
  - Provider Implications
    - Insurance coverage will be extended to 32 million additional Americans by 2019
      - Expansion of Medicaid is major vehicle for extending coverage
    - May release pent-up demand and strain system capacity
    - Traditionally underserved areas and populations will have increased provider competition
    - Have insurance, will travel!
    - States will have to fund unmatched Medicaid expenditures further straining state budgets

Market Overview - Federal

- Healthcare Reform (continued)
  - Medicare and Medicaid Payment Policies
    - Medicare Update Factor Reductions
      - Annual updates will be reduced to reflect projected gains in productivity which will produce $895B over 10 years (.25% in 2010-2011; .35% in 2012-2013; .45% in 2014; .35% in 2015-2016; 1% in 2017-2019)
    - Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment Reductions
      - Medicaid (2013) $14B reduction over 10 years
      - Medicare (2013) $22B reduction over 10 years
    - Medicare Hospital Wage Index
      - Likely redefinition of wage areas – projected savings $2.3B over 10 years
    - Independent Payment Advisory Board (IPAB)
      - Charged with figuring out how to reduce Medicare spending to targets with goal of $13B savings between 2014 and 2020
        - ➢ 0.5% in 2014 increasing to 1.5% in 2018 and beyond
  - Provider Implications
    - Payment changes will increase pressure on hospital margins and increase competition for patient volume
    - "Do more with less and then less with less"
    - Medicaid pays less than other insurers and will be forced to cut payments further
    - Medicare cuts of 8% ($155 billion over 10 years) intended to be offset by increased payment for previously uninsured patients ($170 billion over 10 years)
    - Bad debt reduction

Market Overview - Federal

- Healthcare Reform (continued)
  - Medicare and Medicaid Delivery System Reforms
    - Expansion of Medicare and Medicaid Quality Reporting Programs
      - Jan. 2012 Medicaid quality measures defined and used to compare provider quality
      - Jan. 2013 a Physician Compare website that provides comparative quality and pt. satisfaction data for all Medicare par physicians
    - Medicare and Medicaid Healthcare-Acquired Conditions (HAC) Payment Policy
      - By Oct. 2014, the 25% of hospitals with the highest HAC rates will get a 1% overall payment penalty
    - Medicare Readmission Payment Policy
      - Hospitals with above expected risk-adjusted readmission rates will get reduced Medicare payments
        - Max. reduction is 1% in 2013 and 3% 2015 and after
    - Value based purchasing
      - Medicare will reduce DRG payments to create a pool of funds to pay for the VBPP
        - 1% reduction in FFY 2013
        - Grows to 2% by FFY 2017
      - Hospitals will be scored based on quality measures from three domains
        - Clinical Process
        - Patient Experience
        - Outcomes (beginning in 2014)
      - Hospital DRG payments will be adjusted based on a composite score calculated from all results

Market Overview - Federal

- Healthcare Reform (continued)
  - Medicare and Medicaid Delivery System Reforms (continued)
    - Bundled Payment Initiative
      - "Invited providers to apply to help and develop four different models of bundling payments….three of which would involve a retrospective bundled payment, with a target payment amount for a defined episode of care"
      - Target amount defined by a discount off of historical FFS payments
    - Comprehensive Primary Care Initiative (CPC) – 4-year pilot demonstration program
      - "CPC initiative will seek to strengthen free-standing primary care capacity by testing a model of comprehensive, accountable primary care supported by multiple payers"
      - "CMS seeking to collaborate with other payers in 5-7 markets, with approximately 75 practices in each market"
      - Payment Model
        - Monthly care management fee paid to PCPs (approximately $20 per member per month) on behalf of FFS Medicare beneficiaries and in years 2-4, potential to share in any savings to the Medicare program

Market Overview - Federal

- Healthcare Reform (continued)
  - Medicare and Medicaid Delivery System Reforms (continued)
    - Accountable Care Organizations
      - Requirements
        - "have established a mechanism for shared governance"
        - "have in place a leadership and management structure that includes clinical and administrative systems"
        - "define processes to promote evidence-based medicine and patient engagement," quality reporting, and care coordination
        - "have a formal legal structure…to receive and distribute payments for shared savings…."
      - Three-year commitment
      - Each ACO assigned at least 5,000 Medicare beneficiaries
        - Prohibitions on cherry picking and lemon dropping
      - Providers continue to receive usual fee-for-service payments
      - Compare expected and actual spend for specified time period
      - If meet specified quality performance standards AND reduce costs, ACO receives portion of savings
    - CMS Center for Medicare and Medicaid Innovation (CMMI)
      - Created in 2011 to test innovative payment and delivery models
      - $10B in funding for 8 years, and then $1B year ongoing
      - Idea is to test innovative ideas, and if they work, implement them nationwide

Market Overview - Federal

- Healthcare Reform (continued)
  - Medicare and Medicaid Delivery System Reforms (continued)
    - Provider Implications
      - Acute care hospitals with higher than expected risk-adjusted readmission rates and HAC will receive reduced Medicare payments for every discharge
      - Value based purchasing program will shift payments from low performing hospitals to high performing hospitals
      - Physician payments will be modified based on performance against quality and cost indicators
      - Hospitals will be allowed to take the lead in forming Accountable Care Organizations with physician groups that will share in Medicare savings
      - There are significant opportunities for demonstration project funding

Market Overview - Other

- State Budget Deficit

- High Deductible Health Plans

Rural Challenges

- Market challenges affecting rural hospitals over the next five to ten years
  - Factors that will have, or continue to have, a significant impact on rural hospitals over the next 5-10 years
    - Payment systems transitioning from volume based to value based
      - FFS → Value Based Payment / Accountable Care
    - Increased emphasis of Quality as payment and market differentiator
      - Measurable and comparable
      - Must be meaningful
    - Reduced payments that are "Real this time"
      - Healthcare providers will have to do more with less
      - CCN – Medicaid underpayment
    - Increased burden of remaining current on onslaught of regulatory changes
      - Regulatory Friction / Overload
    - Continued difficulty with recruitment of providers to rural areas
    - Increasing competition from other hospitals and physician providers for limited revenue opportunities
    - Requirement that rural information technology is on par with urban hospitals
    - Rural hospital governance members without sophisticated understanding of rural hospital strategies, finances, and operations
    - Consumer perception that "bigger is better"
    - Severe limitations on access to capital of necessary investments in infrastructure and provider recruitment

New Environment Challenges

- New Environment Challenges
  - Subset of most recent challenges
    - Payment systems transitioning from volume based to value based
    - Increased emphasis as Quality as payment and market differentiator
    - Reduced payments that are "Real this time"
  - New environmental challenges are the Triple Aim!!!

Future Healthcare Environment

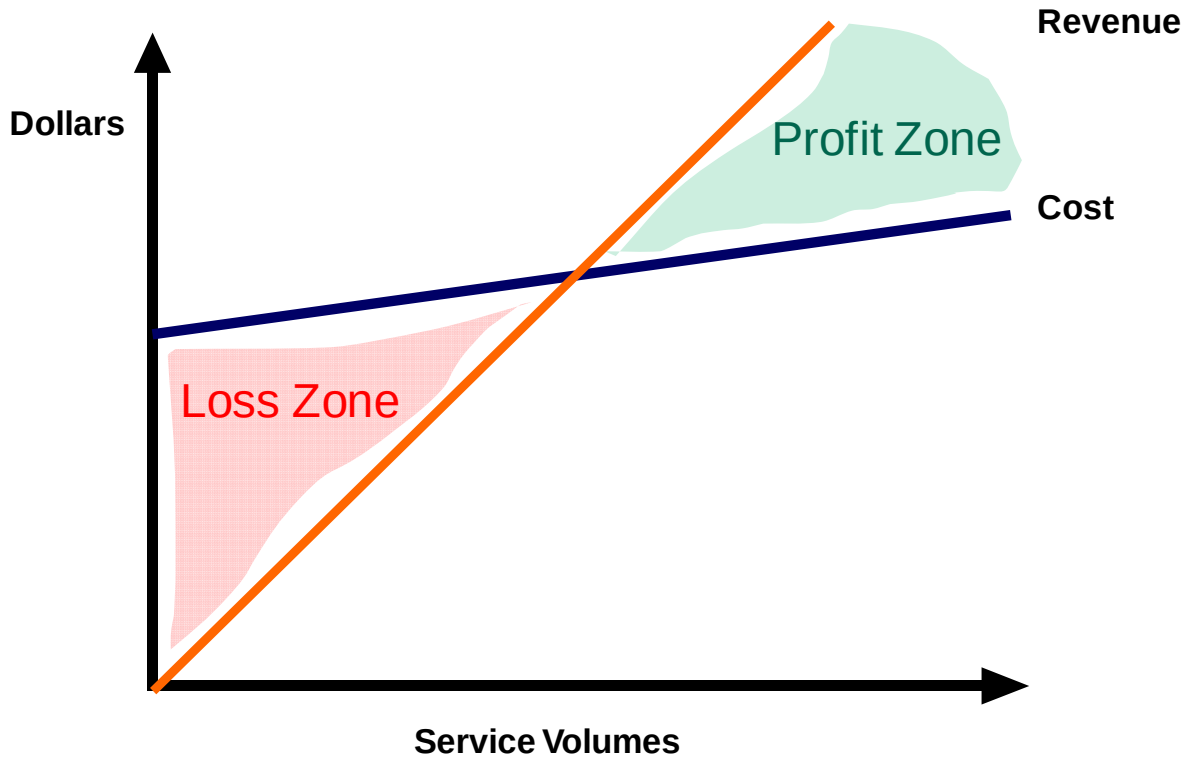
- Future Hospital Financial Value Equation
  - Definitions
    - Patient Value

$$\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}}$$

    - Accountable Care:
      - A mechanism for ***providers to monetize the value derived from increasing quality and reducing costs***
        - Accountable care includes many models including bundled payments, value-based payment program, provider self-insured health plans, Medicare defined ACO, capitated provider sponsored healthcare, etc.

Future Healthcare Environment

- Future Hospital Financial Value Equation
  - Economics
    - As payment systems transition away from volume based payment, the current economic model of increasing volume to reduce unit costs and generate profit is no longer relevant
      - New economic models based on patient value must be developed by hospitals but not before the payment systems have converted
    - Economic Model: FFS Rev and Exp VS. Budget Based Payment Rev and Exp



Prioritized Challenges

- Volume Based to Value Based Payment Systems
  - Important elements of Challenge
    - Hospital acquired condition penalties (beginning 2013)
    - 30-day Readmission Penalties (beginning 2013)
      - Readmissions – how does hospital manage behavior of patient population
        - Incentive to affect change now resides with providers
    - Value Based Purchasing
      - VBP – 2013 withhold for PPS Hospitals
    - Bundled payment initiative
    - Self funded health plans
      - Efficiencies around self funded benefit plan to drive savings to hospital bottom line
        - Incent employees to make better choices
          - Ex: Higher premiums for smoking, obesity, etc.
        - Align with Community Partners
          - Nursing Home
          - Home Health
          - Etc.
    - Medicare ACOs

Prioritized Challenges

- Volume Based to Value Based Payment Systems (continued)
  - Market Symptoms/Response
    - Generally agreed that fertile market for ACOs occur due to relatively low margins and need to transition from volume payment models due to reduced levels of fees
    - In 10 years likely that 90% of hospitals will be aligned (10% will be truly independent)
      - Shift at accelerated pace of independent physicians to employed physicians
    - Concern of task force members is that transitioning of the delivery system functions must coincide with transitioning payment system or rural hospitals, without adequate reserves, will be a financial risk
      - "Stepping onto the shaky bridge" analogy
    - Non-ACO accountable care initiatives will require increased integration between medical staff and rural hospitals

Prioritized Challenges

- Volume Based to Value Based Payment Systems (continued)
  - ACO Relationship to Rural Hospitals
    - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
      - ACO language: PCP can belong to one ACO. Hospitals and specialists can belong to several
        - Cost centers will become bricks and mortar, technology, and specialists
    - Rural hospital will not likely have the scale to form their own ACO and thus must consider their relationship with forming regional ACOs
      - Regional ACOs will look to increase number of covered patients to generate additional "revenue" and dilute fixed costs
    - Rural hospitals bring value / negotiating power to affiliation relationship as generally PCP based
      - Rural has value through alignment with revenue drivers (PCPs) rather than cost drivers but must position themselves for new market:
        - Functional alignment with PCPs in local service area
        - Develop a position of strength by becoming highly efficient
        - Demonstrate high quality through monitoring and actively pursuing quality goals
      - Rural hospital must better understand their value proposition to forming networks and **NOT** perceive themselves as approaching urban for a "hand out / bailout"

Prioritized Challenges

- Volume Based to Value Based Payment Systems (continued)
  - Provider Strategies
    - Necessary for Hospitals to survive the gap between pay-for-volume and pay-for-performance
      - Delivery system has to remain aligned with current payment system while seeking to implement programs / processes that will allow flexibility to new payment system
        - Delivery system must be ready to jump when new payment systems roll out
      - Engage commercial payers in conversation about change in payment process
      - Engage all forming regional ACOs in discussions
      - Develop clinical integration strategies with medical staff that increase likelihood of successfully implementing "non-ACO" accountable care programs
      - Evaluate all opportunities to increase efficiency and improve quality
      - Engage employers in wellness programs
    - Hospital Affiliation Strategies
      - Understand that revenue streams of the future will be tied to primary care physicians, which often comprise a majority of the rural healthcare delivery network
        - Thus rural hospitals, through alignment with PCPs, will have extraordinary value relative to costs

Prioritized Challenges

- Volume Based to Value Based Payment Systems (continued)
  - Provider Strategies (continued)
    - Hospital Affiliation Strategies (continued)
      - Evaluate 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 option for rural hospitals that want to remain "independent"
        - Integration of services where it makes sense
      - Explore / Seek to establish interdependent relationships among rural hospitals understanding unique value of rural hospitals relative to future revenue streams
    - Physician Relationships
      - Hospital align with employed and independent providers to enable interdependence with medical staff and support clinical integration efforts
        - Contract (e.g., employ, management agreements)
        - Functional (share medical records, joint development of evidence based protocols)
    - Governance/Structure
      - Educate Board members about new market realities to both open eyes and influence decision makers in positive direction
        - Goal is to take local politics out of major strategic decisions including affiliation strategies, medical staff alignment, in increasing hospital efficiency

Prioritized Challenges

- Quality as Payment and Market Differentiator
  - Important elements of challenge
    - Value based payment program
      - Hospitals will be scored based on quality measures from three domains compared against peers (outcome score) and yourself (improvement scores)
        - Clinical Process
        - Patient Experience
        - Outcomes (beginning in 2014)
    - Educated Consumers / Transparency
      - Hospital quality data available publicly
        - Hospital Compare
        - Health Leaders
        - Hospital websites
    - Rural hospitals that lack sophisticated technology must combat negative market perceptions
    - Federal Office of Rural Health Policy initiatives MB-QIP program encouraging CAHs to report rural relevant quality measures

Prioritized Challenges

- Quality as Payment and Market Differentiator (continued)
  - Market Symptoms/Response
    - Rural hospitals have varying degree of acceptance as to rural relevant measures
      - Often unwilling to report (CAHs) as measures "not relevant to us"
      - Hospitals that have accepted measures are aggressively seeking to improve scores
    - Increasingly, patients have easy access through internet to hospital quality information (Healthgrades.com; Hospital Compare)
      - Hospital administration often not aware of their scores or do not believe their scores reflect the quality provided in their institutions
        - Unfortunately, perception often drives reality
    - Rural hospitals that have performed well on quality scores are beginning to promote quality and safety of their hospitals
    - Loss of market share due to perceived or real quality deficiencies is much more serious threat to rural hospitals that potential loss of 1-3% Medicare inpatient reimbursement
    - Increasingly, quality will be differentiator in future provider recruitment

Prioritized Challenges

- Quality as Payment and Market Differentiator (continued)
  - Provider Strategies
    - Increase Board members understanding of quality as a market differentiator
      - Move from reporting to Board to engaging them (i.e. placing board member on Hospital Based Quality Council)
      - Quality = Performance Excellence
      - Increase level of Board training, awareness, comprehension
    - Publicly report quality measures
      - All CAHs to begin reporting to Medicare Beneficiary Quality Improvement Program (MBQIP)
      - Increase internal awareness of internet based, publicly available, quality scores
      - Develop internal monitor systems to "move the needle"
      - Monitor data submissions to ensure reflect true operations
      - Consider reporting quality information on hospital website or direct patient to LA Hospital Compare
      - Staying current with industry trends and future measures
      - Educate staff on impact of how actual or perceived quality affects the hospital image
      - Must develop paradigm shift from quality being something in an office down the hall to something all hospital staff responsible for
        - ➢ Shift from being busy work to being integrated in business plan

Prioritized Challenges

- Quality as Payment and Market Differentiator (continued)
  - Provider Strategies (continued)
    - Partner with Medical Staff to improve quality
      - Restructure physician compensation agreements to build quality measures into incentive based contracts
      - Modify Medical Staff bylaws tying incentives around quality and outcomes into them
    - Ensure most appropriate methods are used to capture HCAHPS survey data
      - Consider transitioning from paper survey to phone call survey to ensure that method has increased statistical validity
    - Electronic Health Record (EHR) to be used as backbone of quality improvement initiative
      - Meaningful Use – Should not be the end rather the means to improving performance

Prioritized Challenges

- Payment Cuts "Real this time"
  - Important elements of challenge
    - Failure of Super Committee to reach agreement thus -2% sequestration impact beginning in 2013
    - Uncertainty related to future of state UPL and DSH programs
    - Value Based Payment Program with 1% maximum cuts beginning in 2013 and 2% in 2017 and after
    - Re-admission payment with max. reduction of 1% in 2013 and 3% 2015 and after
    - RACs, MICs, etc
    - High deductible commercial health plans (e.g., HSAs)
    - Commercial contract with insurers (not willing to cost share)
    - Healthcare Reform
      - Cuts in Update factors for PPS
      - ACOs – potential reduction in volume
      - DSH Dollars / UPL
      - Limitation on Provider assessments
      - 133% Federal Poverty Level eligible for Medicaid 2014
    - Potential physician pay cuts

Prioritized Challenges

- Payment Cuts "Real this time"
  - Market Symptoms/Response
    - Hospitals not operating at efficient levels are currently or will be struggling financially
      - Efficient being defined as
        - Appropriate patient volumes meeting needs of their service area
        - Revenue cycle practices operating with best practice processes
        - Expenses managed aggressively
        - Physician practices managed effectively
        - Effective organizational design
    - Resources available for necessary investments in plant, technology, and recruitment are becoming increasingly scarce when required the most
    - Providers hospitals increasingly seeking affiliations primarily as a safety net strategy

Provider Strategies

- Payment Cuts "Real this time" (continued)
  - Increase efficiency of revenue cycle function
    - Adopt revenue cycle best practices
      - Effective measurement system
      - "Super charging" front end processes including online insurance verification, point of service collections
      - Education on necessity for upfront collections
      - Ensure chargemaster is up to date and reflects market reality
  - CAHs to ensure accuracy of the Medicare cost reports
    - Improving accuracy of Medicare cost reports often results in incremental Medicare and Medicaid revenue to CAHs
  - Review profitable / non-profitable service lines to determine fit with mission and financial contribution to viability of organization
    - Define who you are and be good at it
  - Continue to seek additional community funds to support hospital mission
    - Increase millage tax base where appropriate
    - Ensure ad valorem tax renewal

Provider Strategies

- Payment Cuts "Real this time" (continued)
  - Increase monitoring of staffing levels staffing to the "sweet spot"
    - Staffing education for DONs/Clinical managers
    - Salary Survey / Staffing Levels / Benchmarks that are relevant

Sample of Selected Departments

Department	Performance Indicator	FY 2011 Volume	Hourly Standard (1)	FTEs @ Standard	Actual FTEs (2)	Variance
Nursing - Med Surg	Per Patient Day	4,981	10.00	23.95	33.99	10.04
Nursing - Obstetrical/Postpar	Per Patient Day	1,375	10.00	6.61	12.35	5.74
Nursing - Nursery	Per Patient Day	757	5.00	1.82	4.43	2.61
Nursing - ICU/CCU	Patient Day	1,376	20.75	13.73	8.84	(4.89)
Nursing - Surgery - Major	Per Case	353	11.00	1.87	9.93	8.06
Nursing - Other OP Proc	Per Case	749	1.60	0.58	8.37	7.79
Nursing - Recovery Room	Per Case	1,507	3.30	2.39	1.97	(0.42)
Surgery Subtotal				7.31	10.34	3.03
Emergency Room	Per Case	13,315	2.40	15.36	19.16	3.80
UR/Case Mgr/Soc Ser	Patient Days	6,357	0.75	2.29	0.80	(1.49)
Nursing Administration	Per Adj. Admissions	7,327	1.75	6.16	5.57	(0.59)
Subtotal Nursing				68.80	78.70	9.90
Radiology	Per Procedure	19,901	1.44	13.77	18.34	4.57
Lab/Blood Bank	Per Test	147,566	0.25	17.88	16.39	(1.49)
Physical Therapy	Per Treatment	21,629	0.50	5.20	4.00	(1.20)
Cardio/Pulmonary	Per Procedure	16,981	0.86	7.04	6.00	(1.04)
Pharmacy	Per Adjusted Day	25,055	0.60	7.23	2.54	(4.69)
Subtotal Ancillary				51.11	47.27	(3.84)
Subtotal - Clinical				119.91	125.97	6.06
Hospital Administration	Per Adj. Admissions	7,327	1.65	5.81	5.00	(0.81)
Information Systems	Per Adj. Admissions	7,327	1.00	3.52	2.00	(1.52)
Human Resources	Per Adj. Admissions	7,327	1.10	3.88	3.09	(0.79)
Patient Accounting	Per Adj. Admissions	7,327	3.00	10.57	19.60	9.03
Medical Records	Per Adj. Admissions	7,327	3.50	12.33	9.88	(2.45)
Cent Supply/Mtl Mgmt/Sterile	Per Adjusted Day	25,055	0.30	3.61	4.03	0.42
Housekeeping	Net Square Feet	79,876	0.31	11.98	12.14	0.16
Dietary	Meals Served	96,122	0.25	11.55	11.94	0.39
Plant Ops/ Maintenance	Gross Square Feet	111,826	0.12	6.45	3.93	(2.52)
Laundry and Linen	Lbs of Laundry	349,015	0.02	3.36	2.93	(0.43)
Subtotal Support				98.34	74.54	(23.80)
				218.25	200.51	(17.74)

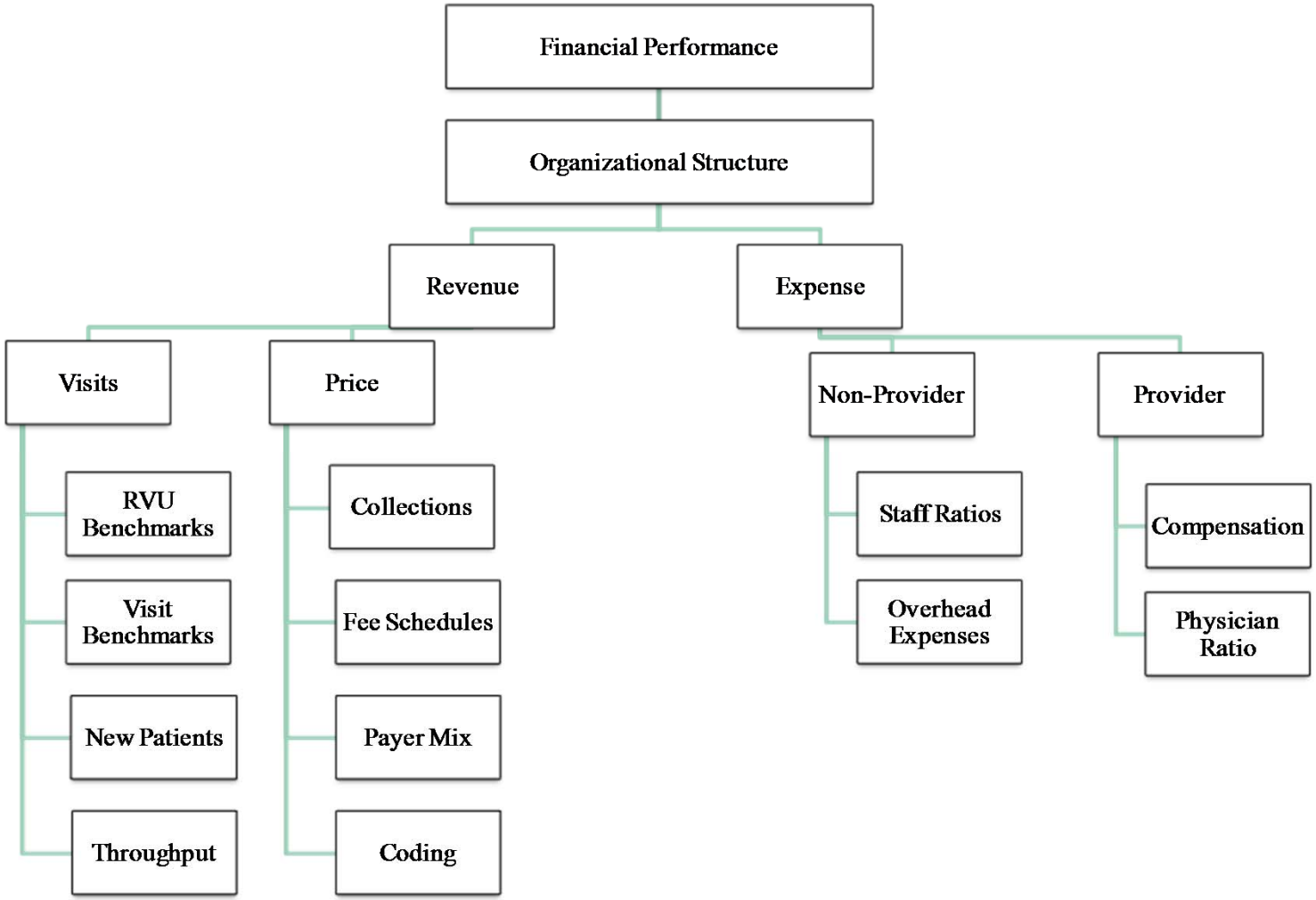
(1) Hourly Standards based on Stroudwater sample of hospitals

Provider Strategies

- Payment Cuts "Real this time" (continued)
  - Develop LEAN production practices that consider the expenditure of resources for any goal other than the creation of value for the end customer to be wasteful
    - Preserving value / quality with less processes
    - Workflow redesign
    - Inventory Levels / Standardization
    - Response Times
    - Replicating Successes among all hospitals
    - C-Suite training on LEAN / Six Sigma
  - Evaluate self funded health insurance plans for optimal plan design
    - Self funded health insurance plans offer often overlooked opportunity to develop accountable care strategies for a defined patient base through aligning employee incentives through improved benefits design and more effective care management processes
  - Evaluate 340B discount pharmacy program as an opportunity to both increase profit and reduce costs
    - Often 340B only looked upon as an opportunity to save costs not considering profit potential

Provider Strategies

- Payment Cuts "Real this time" (continued)
  - Develop physician practice expertise



Provider Strategies

- Payment Cuts "Real this time" (continued)
  - Have an effective organizational design that drives accountability into the organization
    - Decision Rights
      - Drive decision rights down to clinical/operation level
      - Education to department managers on business of healthcare
        - Avoid separation of clinical and financial functions
    - Performance Measurement
      - Department managers to be involved in developing annual budgets
      - Budget to actual reports to be sent to department managers monthly
        - Variance analysis to be performed through regularly scheduled meetings between CFO/CEO and department managers
    - Compensation
      - Recognize performance in line with organizational goals

Conclusions/Recommendations

- For decades, rural hospitals have dealt with many challenges including low volumes, declining populations, difficulties with provider recruitment, limited capital constraining necessary investments, etc.
  - The current environment driven by healthcare reform and market realities now offers a new set of challenges. Many rural healthcare providers have not yet considered either the magnitude of the changes or the required strategies to appropriately address the changes
- Core set of new challenges
  - Payment systems transitioning from volume based to value based
  - Increased emphasis on Quality as payment and market differentiator
  - Reduced payments that are "Real this time"
- Important strategies for providers to consider include:
  - Increase leadership awareness of new environment realities
  - 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
  - Maintain alignment between delivery system models and payment systems building flexibility into the delivery system model for the changing payment system