A Template for

Rural Health System Sustainability

In Colorado

Index

Preamble

In Colorado today, many rural hospitals are teetering on the edge of financial collapse, driven by rising costs, reduced government payment rates, increasing government regulations, growing numbers of uninsured, underinsured, and aging patients, difficulty with staff recruitment and retention, and outdated facilities, among others.

Those same hospitals are often the largest employers and anchors for a small community. They infuse their counties with professionals, well-paid jobs, and community leaders. They are faced now with a choice of closure or consolidation within a large health system, either of which can threaten the mission of the hospital and the vibrancy of the community.

Sustainable rural healthcare impacts all Coloradans – including those in the metro area – because much of the state's unique value (i.e., what makes Colorado "Colorado") is found in the mountains, valleys, ranches, and farmlands through which virtually all residents travel and is a key economic driver for state tourism.

The following principles and strategies were developed by a diverse panel of independent advocates to help communities transform access to health care in rural Colorado to a sustainable future. No advocate has an individual or business incentive for revenue-enhancement or strategic growth. They collectively bring decades of experience and expertise from a broad array of health perspectives and are committed to making Colorado a better place to live, work, and visit.

The following concepts are designed to provide public officials and policymakers with an objective set of lenses with which to evaluate any proposals – including those which come from entities (either for-profit or tax-exempt) that might have a subjective interest which could obscure or outweigh potential adverse ramifications for rural communities in Colorado.

It has taken many years to reach this crisis point; it will take at least five years to solidify the right approach, but that solution must begin to be built without delay. There are few, if any, more critical needs for the future of Colorado.

Proponents: Expertise with Objectivity

The principles, strategies, and realities identified in this document have been crafted by a diverse group of advocates for independent rural health delivery systems whose sole interest is the preservation and enhancement of the non-metro communities throughout Colorado that define much of the character of our state. Each of these Independent Rural Advocates brings decades of experience and insight with very different perspectives. Collectively, they are a unique combination of breadth, depth, and objectivity.

Sue Birch (Steamboat Springs) was the CEO of the Northwest Colorado Visiting Nurse Association for more than 15 years. She was the first Chair of Club 20's Health Care Committee and served as the Executive Director of the Colorado Department of Health Care Policy & Financing (HCPF) under Governor John Hickenlooper. Sue went on to run the State Health Authority for the State of Washington.

Charles Breaux, MD (Grand Junction) worked as the only Pediatric Surgeon in Western Colorado for more than 25 years after receiving his education at Harvard and University of Alabama. He is retired from practice in Colorado but provides locum tenens services in pediatric surgery in Southern Alabama and Northern Nevada.

Bernie Buescher (Grand Junction) served as Executive Director of HCPF under Governor Roy Romer, as a state representative and Chair of the Joint Budget Committee, as Colorado's Secretary of State, as Chair of the St Mary's Hospital Board of Directors, as a Deputy Attorney General (under John Suthers), and as well as legal counsel for numerous physicians.

Karl Gills (Steamboat Springs) has been President or CEO of multiple hospitals and medical centers in Iowa and Northern Colorado, including serving 12 years as the CEO of Yampa Valley Medical Center (before its alignment with UC Health) providing hospital services that included OB, infusion, oncology and had a neonatal intensive care unit and a level 3 trauma center.

Joan Henneberry (Denver) served as the Executive Director of HCPF for Governor Bill Ritter and established the Colorado Center for Improving Value in Healthcare. Before that she served as the Director of Health Policy for the National Governors Association in Washington, DC, spent 13 years at the Colorado Department of Public Health & Environment, and retired as a Vice President for Health Management Associates.

John Hopkins (Grand Junction) is a pharmacist who served as President & CEO of Rocky Mountain Health Plans (before its alignment with United Health Group) running a non-profit health plan that provided access to care for all in the community, including Medicaid, Medicare, and Commercial. RMHP was the only Medicare Managed Care option throughout rural Colorado and its universal access, higher quality with lower costs for government lines of business was validated in numerous external audits and studies including the Dartmouth Atlas.

Kelly Johnston (Grand Junction) is a CPA and President of JFS, LLC which develops financial solutions to rural hospitals and clinics throughout the Western United States.

Gary Knaus, MD (Carbondale) is a retired primary care physician who provided family practice medicine in Carbondale and the Roaring Fork Valley for more than 40 years. He also served as

a founder and first Medical Director for Valley Health Alliance in Aspen.

Annie Lee (Denver) is the President & CEO of Colorado Access, providing physical and behavioral health care to the Medicaid and CHP+ recipients in the Metro area. Annie brings a diverse background in health plan administration to the group, having worked at HCPF, Kaiser Permanente, and Colorado Children's Hospital. Annie is currently the Vice-Chair of the Board of Directors for Connect for Health Colorado.

Steve Reynolds (Glenwood Springs) is a small business owner and current Co-Chair of the Health Committee for Club 20. As a gym owner, Steve is committed to individual responsibility, wellness and preventive care, and supporting local health care delivery systems that work for both consumers and small businesses. Steve was instrumental in crafting the Club 20 proposal for health care reform for the 208 Commission for Health Care Reform, promoting many of the innovations adopted by the state over the past 20 years.

Arnold Salazar (Alamosa) has spent more than 40 years working in Behavioral Health in rural Colorado, including 15 years as CEO of the San Luis Comprehensive Community Mental Health Center. His work in Value Options and Colorado Health Partners addressed the behavioral health needs in 43 counties in Colorado, from New Mexico to Wyoming.

Steven Summer (Denver) was the President & CEO of the Colorado Hospital Association from 2006 to 2019. He also served as President & CEO of the West Virginia Hospital Association and worked at the Maryland Hospital Association. Steven is currently President & CEO of the Healthcare Institute, comprised of 45 CEOs of large nonprofit health systems in the country.

Dick Thompson (Grand Junction) served for 17 years as the President & CEO of Quality Health Network, a health information exchange which linked medical behavioral and human services providers, enabling them to coordinate care, avoid duplication, identify individuals at risk, and provide faster emergency services treatment throughout Western Colorado. Dick currently serves as Chair of the Board of Directors for Connect for Health Colorado.

Reginald Washington, MD (Denver) is a retired Pediatric Cardiologist who served as Chief Medical Officer at Presbyterian St. Lukes Medical Center and the Rocky Mountain Hospital for Children. Reggie is an advocate for fitness and personal responsibility and served as Co-Chair of the Task Force on Obesity and Chair of the Committee on Sports Medicine & Fitness for the American Academy of Pediatrics.

Jay Want, MD (Denver) is a retired Internal Medicine physician, and served as President & CEO of Physician Health Partners, a multi-practice organization with 300 primary care physicians serving 60,000 patients in Colorado. Jay has also served as the Executive Director of the Peterson Center on Health Care in Manhattan and as Chief Medical Officer for the Colorado Center for Improving Value in Health Care.

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Steve ErkenBrack (Grand Junction) is the President & CEO of the Buell Foundation, which has funded more than a quarter of a billion dollars supporting services for young children in every county of Colorado. Prior to Buell, Steve served as President & CEO of Rocky Mountain Health Plans, as Colorado's Chief Deputy Attorney General, as Chair of the Club 20 Health Committee, as Vice Chair of the Board of Directors for Connect for Health Colorado, and on the Boards of Directors of America's Health Insurance Plans and the Alliance for Community Health Plans. Steve has helped organize this effort, recognizing the acute need to preserve health services for

children and families throughout rural Colorado.

Preparation: Assessing the Current Landscape

The Proponents realized from the outset that the value of their objective assessment had to be grounded in both their collective expertise AND a thorough understanding of the current delivery system, including the changes, whether improvements or not, that have evolved in recent years.

Individual organizers met with leadership of the Colorado Rural Health Center and dozens of rural hospital executives through both Rural Futures and the Western Healthcare Alliance. Thereafter, for more than six months, the proponents met as a group for formal presentations from stakeholders, providers, insurers, and other organizations currently active in the delivery of services in rural Colorado – including the leadership of the Department of Health Care Policy & Financing (HCPF) – from September, 2025 to April, 2026.

Those presentations and analyses included:

Clinical Integration of Primary Care in rural Colorado (Marnell Bradfield - Western Health Alliance/Community Care Alliance);

Medicaid PRIME (Patrick Gordon – Rocky Mountain Health Plans)

Mountain Family Health Centers (Dustin Moyers in Roaring Fork Valley)

Valley-Wide Health Systems (Jania Arnold & Kristina Daniel in San Luis Valley)

Rural Hospital Funding Solutions (Kelly Johnston of JHC)

Rural Futures (Lauren Hughes & Kevin Stansbury)

Colorado Department of HCPF (Kim Bimestefer & senior leadership team)

Following those assessments and analyses, the Proponents determined that rather than create an independent proposal or white paper that might be unduly influenced by transitory policies or short-term funding realities, they would try to develop a consensus around principles and strategies by which all proposals could be evaluated to build the optimal approach to rural health and rural communities over the long term.

Principles and Realities for Rural Health Care Delivery Systems

Fundamental Facts

1. Any approach to rural healthcare must fit within the broader health delivery models for all of Colorado. However, the challenges faced by rural communities are different and distinct.

2. Any effective health care system should be "person-centered" and affordable, built around the best interests of the residents of the community, in cooperation with the providers, hospitals, doctors, government, or any private-sector business, and not driven primarily by profit, margin, or the growth of a provider system.

3. Health care systems and components are interrelated. Medicaid and Medicare policies and payments impact commercial insurance costs and effectiveness, and vice versa, because providers have business models for all patients, with diverse funding streams.

4. Innovation can be found in both the private and public sectors but requires insight and adjusting to new data and changing environments. Innovations and efficiencies have been adapted in public programs like Medicaid through collaboration and effective "public-private" partnerships.

5. 50% of health care expenses are incurred by 5% of the population. The healthiest 50% of the population incurs 3% of the cost.
   - (source - https://meps.ahrq.gov/data_files/publications/st556/stat556.shtml)

   Corollary: Current JBC estimates that more than 75% of Medicaid costs are expended on less than 15% of the patients. Note: these are not patients who are abusing the system, they are people with significant health care needs and include premature babies, the disabled, and the elderly, often with co-morbidities.

6. High performing private systems create efficiencies by managing the care of the most needy, improving health outcomes, minimizing expense over the long term, and strategically managing payer contracting relationships, with a focus on outcomes and total cost of care.

7. A key to minimizing costs is to keep people as healthy as possible through preventive care, primary care, prenatal care, palliative care, etc. An effective health care system helps patients transition to and/or remain in the least expensive 50% of the population.

8. Core efficiencies can be adapted from delivery systems with proven effectiveness and sustainability over many years; models with a dominant focus on primary care, a medical home, and integrated behavioral health have thrived in Colorado when focused

primarily on the collective interests of patients, not profit margins or corporate growth strategies.

Community versus Remote Decision-Making

9. The most effective decision-maker for a patient in rural Colorado is a local provider or care team who is familiar with local resources, can monitor what does and does not work, and has the flexibility to adjust care. It is NOT a government employee in Denver or Washington (or a private sector employee in a distant corporate headquarters).

10. Recent Medicaid and Medicare decisions concerning rural Colorado patients have been dictated by government officials since the dollars spent – although originating from the taxpayers in communities – flow through such government offices. Colorado's next Governor should replace "the golden rule" (he who has the gold, makes the rules) with "the knowledge rule" (he who knows the most about the patient makes the decisions, with government support and oversight).

11. "One-size-fits-all" does not work well in health care. What works in Denver may not work in Durango. What works in Steamboat may not work in Alamosa. Each locality has distinct resources, strengths, and needs. That said, effective models developed in rural Colorado might be replicated and adjusted to fit other rural communities.

12. Communities should be empowered to create their own solutions to fit the resources of the community. Local creativity should not only be allowed but should be encouraged and supported by government. But the community must accept the responsibility to "own" its decisions on the allocation of resources, including the denial of care, and be held to the same performance measures.

13. Generally, rural communities have fewer resources than are available in metro areas. But there can be a strong tradition of collaboration born of necessity and a mutual commitment to view the underserved as "neighbors in need of help" rather than "strangers spending tax dollars". Since this is not universally true, and government must differentiate between communities that will work together and those that won't.

Primary and Preventive Care

14. Efficient use of available resources and locally controlled care management is an essential part of any sustainable model of care. Not all models identified as "managed care" currently in use are equally effective.

15. Advanced Primary Care – i.e. a proactive, patient-centered approach – with clinical integration of care is an essential part of a rural solution, both to efficiently address the needs of high cost patients and to help others remain healthy. Every $1.00 spent in primary care creates $13 of savings in the system.

- (Source - https://www.commonwealthfund.org/blog/2024/increasing-investment-primary-care-lessons-states

16. An effective rural health solution requires a robust data platform that enables the identification of high utilizers and the assessment of their treatment, taking advantage of the increasing deployment of Artificial Intelligence in medical diagnosis and care.

Funding Approaches

17. A fee-for-service model of payment promotes overutilization and inefficiency; it has been a major factor in the financial unsustainability of the status quo; payment reform is essential... but it is not enough by itself. Systemic and structural reform resulting in the transformation of rural health care is required.

18. Value based payment models that incentivize value (defined by cost, quality, patient satisfaction and provider satisfaction) should be encouraged.

19. Community health and healthcare is a common good. Innovative models could include the creation of "public health districts" akin to other special districts for essential public needs such as utilities, power, water. These could also entail "sub-districts" with local control and broad community support. (Such models can be seen in other contexts, such as how the San Luis Valley manages its water.)

    Such districts could most effectively look beyond the limitations of reactive healthcare and incorporate a proactive approach to the social determinants of health, including housing, environment, substance abuse, and other impacts that change patient outcomes.

Future Realities

20. The sustainable transformation of rural health systems – which could encompass local decision-making instead of centralized control in Denver – will require the next governor of Colorado to comprehend, prioritize, and champion this effort. It will likely require fundamental changes in state laws and (potentially) federal rules and policies.

21. Traditional hospitals may not be viable or sustainable for some rural communities in the future. Some areas should focus on rightsizing truly essential services, triage, transportation, and public health.

22. Any solution for rural communities requires the collaboration of all health-related components of the community (hospitals, physicians, mental/behavioral health, public health, home health, hospice and palliative health, community health workers). State support for innovation should focus on communities with such a collaborative approach.

Proposed Strategies for Sustainable Rural Health Delivery in Colorado

A sustainable rural health system must function not as a collection of independent providers, but as a coordinated delivery system—leveraging partnerships, optimizing scarce resources, and maintaining essential local access while delivering care more effectively and efficiently.

The following are a set of strategies to guide evaluation of proposals for rural change. They emphasize improving community health outcomes, reducing total cost of care, aligning with government payer realities, right-sizing services, strengthening workforce models, and advancing regional and community collaboration. They support aligned decision-making among health system leaders, policymakers, and community stakeholders.

1. Community Health Impact First (Not Just Margin)

Key Consideration: Improve outcomes aligned with local disease burden.

- Chronic disease focus for all ages (e.g., obesity. diabetes, COPD, heart disease)
- Imbed value of upstream programs (e.g. prenatal care)
- Address aging-related needs (mobility, cognition, isolation)
- Reduces avoidable ED visits and hospitalizations

A financially sustainable model in rural Colorado must *lower total cost of care by improving health*, not just adjust revenue streams.

2. Total Cost of Care Orientation

Key Consideration: Create value-based reimbursement.

- Operate within a global budget
- Reward prevention and care coordination
- Shift hospitals and providers from volume-driven to value-driven revenue

If it only works when beds are full, it is not sustainable.

3. Align with the current rural reality of Government Payer Dominance

Key Consideration: Work within Medicare and Medicaid realities.

- Account for lower payment levels
- Leverage waivers and supplemental funding
- Align with CMS innovation models

Commercial payer–dependent strategies designed for large population centers are unrealistic in these communities.

4. Right-Sizing of Services

Key Consideration: Align services with local capability and safety.

- Determine what services should be local based on community need, not income stream
- Define process for partnering or transferring services
- Avoid unsustainable service expansion
- Demand efficient, high-quality delivery

Sustainability often requires *strategic subtraction*, not expansion.

5. Workforce Realism and Sustainability

Key Consideration: Operate within achievable workforce constraints.

- Team-based care models (NPs, PAs, community health workers)
- Reduced dependence on scarce specialties
- Use of telehealth and virtual support
- Focus on "home-grown" workforce, retention, and burnout reduction

If it assumes ideal staffing, it will fail.

6. Regional Collaboration Over Independence

Key Consideration: Strengthen partnerships across systems.

- Formal incentivized affiliations with regional providers
- Shared services (both professional and operational)
- Coordinated referral pathways

Independence is often financially unsustainable; **interdependence is the model.**

7. Preservation of Local Access

Key Consideration: Maintain meaningful local access to care.

- Sustain emergency and urgent care services
- Preserve primary care presence
- Minimize unnecessary travel burden
- Expand safety net providers including FQHCs to cover all of rural Colorado

Community trust is a financial asset—losing it accelerates decline.

8. Evidence-Based Policy and Regulatory Alignment

Key Consideration: Align with external policy environment.

- Leverage CMS rural models
- Align with Medicaid innovations
- Utilize grants and demonstration programs

The model should **ride policy tailwinds**, not fight them.

9. Financial Durability

Key Consideration: Require a 5-8 year commitment.

- Viable beyond short-term funding
- Path to stable or positive margins
- Account for payer mix and demographictrends

Sustainability means surviving beyond the pilot phase.

10. The Art of Creating Integrated Community-Based Care Coordination

Key Consideration: Must result in a coordinated local delivery system... or failure

- Align hospitals, physicians, home health, EMS, FQHCs, behavioral health, LTC, and social services
- Shared accountability for high-risk populations
- Improved care transitions
- Shared care plans and communication pathways

Coordinated care will maximize available resources.

The Promise & Peril of Artificial Intelligence for Rural Communities

AI has great potential to improve quality, affordability and access in rural Colorado if developed and deployed smartly. Providers and patients, however, are likely to adopt these tools at a rate that make regulation durability difficult. What is appropriate today may become obsolete in a few months. Therefore, we recommend a few guiding principles by which to judge current and future applications.

To effectively guide the deployment of Artificial Intelligence in Colorado's rural communities, the Governor should frame policy, funding, and regulation around four core principles.

1. The Principle of Augmented Capacity

AI should not be used to replace localized human care or justify the reduction of physical healthcare infrastructure. Instead, it must serve as a workforce multiplier. AI ideally should make people more effective and efficient, not replace them.

- **Focus first on administrative applications:** Prioritize AI applications that absorb administrative burdens (like ambient scribing) and expand the capabilities of existing rural clinicians, maximizing the time they spend in face-to-face patient care. Other examples of such administrative applications include discharge planning, community resource coordination, discharge follow-up, and readmission risk stratification.

2. The Principle of Technological Robustness

Rural technology must be built for rural realities. Cloud-dependent solutions are fragile in areas with inconsistent broadband or cellular coverage.

- **Recognize the existing digital divide for rural areas:** Direct state investments toward "Edge AI"—technologies with localized, on-board processing power that can perform advanced diagnostics and imaging completely offline or via mobile health clinics.
- **Tools should be otherwise appropriate to rural environments.** AI tools should be appropriate to the literacy level of the users involved, including the patients. They should also reflect the technology available to rural populations, who may not have as much access to computers other than their cell phones.

3. The Principle of Regulatory Equity

Stringent consumer protection laws should protect rural citizens without inadvertently starving rural facilities of innovation due to legal overhead.

- **Give them the answers proactively:** Accompany every new AI regulation with state-backed compliance toolkits, boilerplate disclosure templates, and technical assistance. Small, critical-access hospitals must be insulated from legal friction, ensuring that a lack of legal budget doesn't translate to a lack of modern technology.
- **Avoid overregulation:** National bodies are actively articulating standards that encompass HIPAA and other regulations for these applications. Colorado should be

cautious of enacting one-off regulation; the state should wherever possible attempt to future-proof by aligning with existing national standards.

4. The Principle of Human Accountability

AI must never operate as a closed-box final authority in clinical or financial decision-making.

- **Maintain human oversight:** Enforce a strict "human-in-the-loop" standard across all deployments. Rural clinicians must be trained not only to use AI but to critically evaluate, challenge, and override algorithmic outputs that fail to account for the unique socio-economic realities of rural living. Humans with knowledge of local special circumstances must always be the final decision-maker.

CONCLUSION and A CALL TO ACTION

The most effective government innovations in health care have been bipartisan which enables processes to evolve to best serve the public, based on medical and pharmacological improvements as well as market changes, not calcify due to political conflict. This is increasingly difficult because the intensity of the divide between the parties creates profound challenges to find common ground.

With strong leadership, sustainable healthcare for rural Colorado could be a goal that bridges very diverse political perspectives. The best person to lead this effort is the next Governor of Colorado, with the support of key legislators, policy-leaders, the business community, consumers, and advocates from all sectors.

To date, the problem has been framed as the survival of rural hospitals because they are indeed "on the ropes" and their closure or absorption into a large metro-based system would transform a rural community with the removal of local health professionals and community leaders.

But a sustainable solution cannot be found in just the hospital silo of the health system. Any viable long-term approach must entail a system-wide restructuring of the health care landscape within a community, built on the principles and strategies set forth above. This must in turn fit within the health delivery systems for all of Colorado: urban, suburban, and rural. It can be done … but only with visionary and informed state leadership as well as a robust and realistic community commitment.