



# Rural Health Value Virtual Summit

## Designing Rural Value-Based Care for the Future

### February 2026

#### Key Points

The purpose of the Summit was to identify strategies and ideas which accelerate rural healthcare organization participation and success in value-based care and payment.

- Value-based care (VBC) success depends on thoughtful design, aligned incentives, and targeted investment.
- Rural healthcare organizations (HCOs) face persistent structural and financial barriers, including workforce shortages, fragmented data systems, unpredictable financial returns, and heavy administrative burdens that impede VBC adoption.
- Simplifying performance metrics, funding up-front infrastructure, recalibrating financial risk, and aligning payment models with the realities of rural care will facilitate VBC adoption and success.
- The future of rural VBC relies on empowering local healthcare leaders to drive meaningful transformation – without their organizations bearing disproportionate financial risk.

#### Introduction

In June 2025, during two virtual sessions, the Rural Health Value (RHV) team convened a group of rural value-based care (VBC) thought leaders to discuss the current state and future opportunities of rural VBC and payment. The purpose of the convening was to identify strategies and ideas to accelerate rural healthcare organization (HCO) participation and success in VBC and value-based payment (VBP), that is, payment for delivering VBC. The June 2025 Summit is the latest in the series of Rural Health Value convenings and briefs since 2020 that have offered insight, strategies, and recommendations for those implementing VBC and those designing VBP programs. The June 2025 participants were selected to represent a broad range of perspectives, including front line care delivery, accountable care organization (ACO) leaders, and health systems and networks involved in VBC and VBP.

## Today's Rural Value-Based Care Experience

### Background

The rural VBC and VBP environment and experience have changed dramatically over the past decade. In 2012, the Affordable Care Act created the Medicare Shared Savings Program (SSP), also known as the Medicare ACO Program. Many rural health care organizations now participate in the Medicare SSP, in part due to additional models and changes encouraging rural participation. Launched in 2016, the Center for Medicare and Medicaid Innovation (CMMI) ACO Investment Model (AIM) provided support for necessary ACO infrastructure. Beginning in 2024, Advance Investment Payments (AIP) serve as a payment option within Medicare SSP designed to help small, rural, and underserved providers participate successfully in Medicare SSP. Starting in 2027, CMMI's LongTerm Enhanced ACO Design (LEAD) will help lower Medicare SSP participation barriers and likely attract organizations new to ACOs, including small, independent, and rural practices.

In addition to federal VBP models and programs, Medicaid and private payer models have emerged that provide an array of opportunities for rural HCOs to participate in VBP programs. This changing environment provided the context for the Summit.

### Summit Participant Experiences

While the growth of VBP opportunities across multiple payer types is helpful for rural organizations with small patient volumes, it also brings with it challenges; for example, several participants noted that the administrative burden experienced by providers is multiplied, and quality measurement becomes more complicated (one participant cited 127 different quality measures across different payer platforms).

Throughout the Summit, all participants noted that rural HCOs face distinct challenges adopting VBC, such as limited financial resources, workforce shortages, underdeveloped information technology infrastructure, and fragmented electronic health record (EHR) systems. Furthermore, post-pandemic recovery efforts shifted focus away from long-term transformation initiatives like VBC.

Administrative and data burdens compound these challenges. Managing multiple payers and submitting complex reports continues to discourage even more expansive participation. Participants noted that many rural organizations simply do not have the staff or expertise to manage VBC metrics and the data reporting responsibilities that span various platforms and programs. The complexity of quality measures often leads to care team fatigue, while persistent issues with EHR interoperability and payer data sharing undercut transparency. These problems highlight the critical need for standardization across reporting requirements.

Financial risk and sustainability remain a significant concern for participation in VBC models. Although pooled population health budgets and community-based allocation frameworks can offer some support, implementation has been inconsistent. High upfront investments with uncertain or delayed returns – often stretching beyond 18 months – make engagement risky. Several participants noted CFO lack of confidence that shared savings will actually materialize. For smaller HCOs especially, the absence of scale to absorb financial risk poses a serious obstacle. Smaller HCOs often struggle to maintain sufficient reserves within ACO structures. Payer adoption of electronic clinical quality measures (eCQMs) has introduced additional HCO operational and financial strain. Some rural HCOs report struggling to make eCQMs work because many EHR systems do not integrate well or use inconsistent data standards. Furthermore, implementing eCQMs requires staff time, training, and workflow redesign – or hiring vendors to complete these tasks. One participant noted that eCQMs aggregated across multiple EHR platforms has been a significant challenge. Another reported that all-patient reporting is expensive and burdensome.

Despite these hurdles, innovative programs and expanded resources are creating fresh opportunities for rural VBC engagement. Encouragingly, the rise of new models, such as those driven by CMMI, has introduced greater support for small and rural Medicare SSP participants. Distinct from federal support, rural HCOs are developing experience with Clinically Integrated Networks (CINs) and ACO aggregators (organizations that aggregate Medicare beneficiaries into Medicare SSP ACOs and Medicare Advantage plans), which enhance small HCO capacities and bargaining power. One participant noted that participation in a CIN supports shared resources and investments – and helps smooth financial gains and losses. Electronic tools, such as population health management platforms and artificial intelligence (AI)-supported care coordination support, are helping streamline workflows and data sharing, enabling broader provider participation in VBC efforts. Participants noted that HCO leadership is increasingly advocating on behalf of primary care providers (PCPs), acknowledging long-standing issues with staffing and technology gaps. Tiered financial models and preventive care strategies, such as Annual Wellness Visits and transitions of care initiatives, are showing promise as potential solutions to improve sustainability and impact.

As value-based care continues to evolve, the emphasis has shifted from merely incentivizing participation to tackling administrative complexity and strengthening recruitment and clinician support. However, these changes carry significant financial implications, raising sustainability concerns, especially for smaller and independent HCOs operating on thin margins.

## Navigating Financial Risk in Rural Value-Based Payment

Multiple participants commented that VBP financing remains particularly challenging in rural areas, where tight provider budgets and delayed returns on investment make participation risky. For example, performance bonus and shared savings payments often do not occur until 18+ months after the start of the contract and are not guaranteed. Yet investment in VBC infrastructure (e.g., care management expenses, health information technology, and population health initiatives) must be made throughout the contract period. One participant noted that the HCO hired an actuarial firm to justify VBC investments to organizational financial planners. Gaining governing board approval for VBC expenses, technology investments, and risk assumption is especially difficult when performance bonuses (or shared savings) are uncertain or difficult to predict.

To overcome these challenges, participants highlighted several financial strategies.

- Shared Expenses and Savings: health systems, CINs, and ACO aggregators may group patients and pool resources within networks. The participants related varying methods for distribution of expenses – from expenses pooled at a network Population Health Team to all expenses managed at the local level. Aggregating expenses functions best when all partners align goals, performance metrics, and revenue/expense distributions. Summit participants did not discuss performance bonus (or shared savings) distributions in detail. But all mentioned distributions to participating providers and organizations are based on performance and attributed patients. Furthermore, several participants commented that the performance bonus (or shared savings) and losses (if subject to downside risk) allocation process is crucial for maintaining trust and ensuring that all participants are aligned with the goal of improving care while controlling costs.
- Achieving Cost Reductions: In rural healthcare settings, achieving reductions in cost of care often requires focusing on chronic disease management, reducing care variation, prioritizing preventive care, and improving the efficiency of care delivery to curb overall costs. For governing boards weighing VBC decisions, the participants noted that it is important to present VBC's long-term benefits of improved patient outcomes and community health, not just financial metrics. It was also critical to emphasize long-term savings, such as those resulting from fewer emergency department visits and specialist referrals, over immediate financial returns. One participant commented about the power of stories to make a compelling argument for VBC.
- Cost and Risk of Implementation: Implementing VBC demands substantial upfront investment, with performance bonuses (or shared savings) not guaranteed, or distributed until up to 18+ months after contract initiation. This

delayed return fosters skepticism, particularly among smaller HCOs and their governing boards. The participants noted that HCO financial planners need better forecasting tools to model potential gains and accurately assess risk, helping rural leaders make more informed decisions about VBC participation.

## Designing Payment Models for Rural HCOs

Rural HCOs would be better served by VBP contracts that prioritize simplicity and consistency. Smaller HCOs face disproportionate challenges due to administrative burdens such as claim denials, appeals, and changes in contract language. To support successful VBP participation, participants suggested that payers streamline processes by ensuring prompt payments, unifying rules across payers, and delivering accurate, timely financial reports that allow HCOs to track performance and fiscal health.

The participants recommended specific improvements to VBP design that could ease rural VBC and VBP participation and boost its impact:

- **Simplify Metrics**: Reducing the number of required performance metrics – and keeping them consistent year over year – would allow HCOs to focus more on care delivery than on constantly adjusting to evolving benchmarks. Aligning measure requirements across payers would also minimize duplicative work and lower administrative costs.
- **Enhance Flexibility**: Payment models should give rural HCOs more room to adapt without facing destabilizing financial risks.
- **Invest in Infrastructure**: Financial support for the upfront costs of technology and data systems is essential. Without it, rural HCOs struggle to meet the reporting and data-sharing requirements of VBP contracts.
- **Rebalance Risk**: Risk-sharing structures should be refined to reflect the financial realities of small, independent, and/or rural HCOs. Subjecting small HCOs to the same risk-sharing models used in large organizations can limit a rural HCO's ability to succeed under these models.
- **Account for Pharmacy Spend**: Pharmacy-related costs and utilization patterns should be integrated into VBP design, recognizing their influence on both outcomes and total cost of care.

## Innovative Pathways to Value-Based Care in Rural Communities

Participants have adopted a variety of strategies to support VBC and VBP success. Important among them is greater transparency in performance data, especially when identifying care gaps and facilitating peer-to-peer comparisons. Technology has also played a pivotal role, enhancing both data collection and care management. Streamlining the focus on a few essential performance metrics across contracts has

proven effective, with measures and interventions like annual wellness visit rates and transitions of care practices emerging as particularly valuable performance levers. Establishing clear expectations for contract start dates and building robust, data-driven reporting systems are also critical steps in maintaining effective VBC programs.

Still, implementing VBC in rural environments presents unique hurdles, many of which were highlighted by the participants. Administrative complexity and the excessive cost of patient “churn” (i.e., when patients cycle in and out of systems and health plans) can lead to fragmented care and reduced continuity, increasing emergency department use and compromising health outcomes. Accurate performance reporting is essential, but it demands internal expertise to validate data – a resource many rural HCOs struggle to secure. Nevertheless, building strong collaborative relationships and ensuring that payers are aligned with HCOs’ goals can help reduce financial and operational strain.

In many successful rural models, clinical care has expanded to include non-clinical services, such as housing, food assistance, and other social services. Some participants noted that their HCOs have moved beyond a purely medical approach to support the broader needs of their patients, incorporating mental health services, social support, and community-based resources. This holistic model not only enhances outcomes but also reduces unnecessary medical utilization. By acknowledging that patients often require non-medical assistance, clinicians can more effectively manage their caseloads, directing resources to where they are most needed, whether physical, psychological, or social. However, a key challenge remains: payment structures often do not account for non-clinical services, making it difficult to sustain these critical components of care delivery.

## **Future Outlook for Value-Based Care in Rural Communities**

Rural HCOs continue to face significant barriers in adopting VBC due to the complexity of care models, administrative burdens, and financial uncertainty. These persistent challenges have sparked concern about the long-term viability of VBC, particularly for smaller HCOs, where the assumption of financial risk could lead to devastating outcomes such as clinic or hospital closure.

Despite these challenges, the participants remained excited about the promise of VBC. One area of optimism lies in the growing potential of AI to support rural clinicians by enhancing operational efficiency, streamlining workflows, and improving care coordination. They cited bipartisan support for VBC is another encouraging sign. However, inconsistent policies and regulatory frameworks, including those governing telehealth, continue to create friction for rural adoption. Further, the participants stated that there is a pressing need to re-evaluate financial risk structures in VBC, particularly

for rural organizations serving older and medically complex populations that often lack the resources to manage those risks effectively.

Another area of optimism expressed at the Summit is in the continued growth of network approaches to VBC and VBP. A variety of network types, such as ACO aggregators and CINs, have emerged among rural health care organizations organizing to participate in VBP programs. CINs allow patient aggregation across organizations to meet VBP program participation criteria; and they offer shared services and support, such as data analysis, joint negotiations and contracting, and shared learning.

## Conclusion

VBC offers promise to enhance health outcomes and rural HCO sustainability, but its success depends on thoughtful design, aligned incentives, and targeted investment. This RHV report highlights comments shared during the Summit regarding persistent structural and financial barriers to rural HCO participation in VBC and VBP including workforce shortages, fragmented data systems, unpredictable financial returns, and heavy administrative burdens. Yet within these challenges lie actionable opportunities. Participants identified simplifying performance metrics, funding upfront infrastructure, recalibrating financial risk, and aligning payment models with the realities of rural care as essential steps forward.

Innovative approaches – such as integrating clinical and non-clinical services, leveraging technology for care coordination, and strengthening payer/provider relationships – are already demonstrating what is possible. But for rural HCOs to fully engage and succeed in VBP, care models must evolve to reflect their specific context. That includes designing contracts that are clear, consistent, and fair, with achievable timelines for return on investment and greater recognition of the value rural organizations bring to population health.

According to the participants, the future of rural VBC relies on empowering local healthcare leaders to drive meaningful transformation without bearing disproportionate financial risk. Doing so will not only improve access and quality of care for rural populations but also ensure that the broader shift toward value is both inclusive and sustainable.

## Summit Discussion Questions

### Welcome and Introductions

- Briefly share your experience with value-based care and payment.

### Experience

- In your experience, what has been the most meaningful change in value-based care and payment over the past decade?
- Which elements of value-based care and payment models support and hinder rural engagement and success?

### Financial Considerations

- How do value-based care participants share expenses associated with managing value-based care programs and payment contracts?
- How are value-based savings (or losses) managed among contract participants (HCOs or individual HCOs)?
- In a rural context, what strategies do you use to achieve reductions in total cost of care? How do you explain this to governing boards, especially in relation to the risk of decreasing a rural HCOs organization's fee-for-service revenue?
- What value-based care and payment costs and risks (for example, operational changes, infrastructure investment, and downside risk contracts) do you consider?

### Payment Design

- How would you advise payers to design value-based payment contracts and programs to help rural HCOs deliver high quality care at lower cost?

### Actions

- What have been the most impactful changes that you have implemented to foster value-based care and payment success?
- How are you addressing challenges or hinderances to implementing value-based care and payment changes in rural settings?
- How do you incorporate your relationships across the continuum of care and services in your VBC arrangements? For example: (1) non-clinical services (e.g., food, transportation, housing) and/or non-clinical supports (e.g., community health workers and health coaches) and (2) long-term care and post-acute care, home care, hospice, etc.?

### Rural Future

- What are you most concerned about, and most enthusiastic about, for the future of value-based care and payment?

## Summit Participants

1. Shannon Banks – MaineHealth ACO
2. Sherry Clouse Day – Mercy (MO, OK, AR, KS)
3. Jackie Costley-Reviel – Allen Parish Community Healthcare
4. David Dirks – Intermountain Healthcare
5. Elizabeth Foster – One Community Health
6. Jason Gaines – Honest Health
7. John Henderson – Texas Organization of Rural & Community Hospitals (TORCH)
8. Casey Korba – Aledade
9. Zack Royston – University of Maryland Shore Regional Health
10. Todd Searls – Illinois Rural Community Care Organization
11. Aaron Todd – Iowa Primary Care Association
12. Janice Walters – Rural Health Redesign Center
13. Naomi Wedin – Cibolo Health
  
14. Lawrencina Afagbedzi – HRSA Federal Office of Rural Health Policy
15. Craig Caplan – HRSA Federal Office of Rural Health Policy
  
16. Jennifer Lundblad – Rural Health Value
17. Clint MacKinney – Rural Health Value
18. Keith Mueller – Rural Health Value
19. Kelly O’Neill – Rural Health Value
20. Fred Ullrich – Rural Health Value
21. Karla Weng – Rural Health Value
22. Kristin Wilson – Rural Health Value
23. Whitney Zahnd – Rural Health Value