



Rural

HEALTH VALUE



Collaboration to Contracting: A Guide to Rural Clinically Integrated Networks

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Executive Summary

Rural healthcare organizations (HCOs) face increasing pressure to improve quality, manage population health, and participate in value-based care (VBC) arrangements while maintaining financial viability and local access to care. Individually, many rural hospitals and clinics lack the scale, infrastructure, and resources necessary to succeed in an increasingly performance-driven healthcare environment. Clinically Integrated Networks (CINs) offer a pathway for independent rural HCOs to collaborate strategically while preserving local ownership and community identity.

This Rural Health Value guide provides a framework for developing and operating rural CINs, with particular emphasis on supporting participation in VBC payment and contracting agreements. A CIN is more than a legal structure; it is a coordinated system of healthcare organizations that align clinical, operational, financial, and technological resources to improve patient outcomes, reduce unnecessary costs, and strengthen the long-term sustainability of rural healthcare delivery.

The guide identifies five interdependent pillars that support successful rural CIN development.

- A strong **legal and structural foundation** establishes the governance, agreements, compliance processes, and regulatory safeguards necessary for collective action and payer contracting.
- Effective **governance and leadership** create the organizational alignment, administrative infrastructure, and shared decision-making processes required to manage a network of independent organizations.
- **Clinical integration and care delivery** activities – including care coordination, population health management, and clinician leadership – provide the operational mechanisms through which the CIN improves quality and patient outcomes.
- **Data and technical infrastructure** enable the aggregation, analysis, and secure exchange of clinical and financial information needed to measure performance, support quality improvement, and demonstrate value to payers.
- **Financial sustainability and scale** ensure that the CIN can secure adequate capitalization, negotiate effectively with payers, manage risk, and leverage shared services to create economies of scale.

Throughout the guide, particular attention is given to the unique challenges and opportunities facing rural communities. Successful rural CINs must balance the benefits of collaboration with the desire to maintain local autonomy, physician leadership, and community responsiveness. They must also address rural realities such as geographic isolation, workforce shortages, limited specialty access, and constrained financial

resources. The guide emphasizes practical strategies for overcoming these barriers, including shared administrative services, population health management platforms, centralized and local care coordination models, VBC contracting, group purchasing, and strategic partnerships.

Ultimately, rural CINs provide a mechanism for achieving “independence through interdependence.” By working together through a clinically integrated structure, rural HCOs can gain access to capabilities typically associated with larger health systems while preserving local governance and community-based care. The action steps and contextual information presented in this guide are intended to help rural leaders evaluate, develop, and strengthen CINs that improve health outcomes, enhance organizational sustainability, and support long-term access to high-quality care in rural communities.

Introduction

Rural clinically integrated networks (CINs) are collaborative arrangements designed to improve patient care quality and lower total cost of care through value-based care (VBC) and other operational changes. While CINs among independent rural healthcare organizations (HCOs),¹ are a relatively recent development, the model itself is well-established – many vertically and/or horizontally integrated health systems have operated as CINs for decades. These systems typically own multiple HCOs, employ varied clinical personnel, and may extend their CIN structure to affiliated (not owned) organizations, with whom they share operational practices and accountability to varying degrees.

This Rural Health Value guide provides a framework and resources for developing and operating a CIN comprised of independent rural HCOs, with special focus on how a CIN supports and advances VBC and payment. Readers seeking introductory information regarding rural CINs should refer to the Rural Health Value [Introduction to Rural Clinically Integrated Networks](#) and the Rural Health Value [CIN Readiness Assessment Tool](#).

Clinically Integrated Networks

CINs are incorporated and serve as legal entities, but a CIN is more than a legal arrangement; it is a strategic alliance of HCOs committed to the “Triple Aim”² of better care, improved health, and lower costs. For rural HCOs, the CIN model is not just an administrative option; it offers an approach to address the unique geographic and financial pressures of the rural healthcare landscape. By moving from isolated competition to a model of independence through interdependence, rural HCOs can secure the scale and sophisticated infrastructure necessary to thrive in a value-based payment economy.

Collaboration to Contracting

Developing and operating a CIN involves specific foundational priorities designed for networks seeking to engage in joint contracting with payers and others. This strategy demands a deeper level of structural integration than typical collaborative alliances.

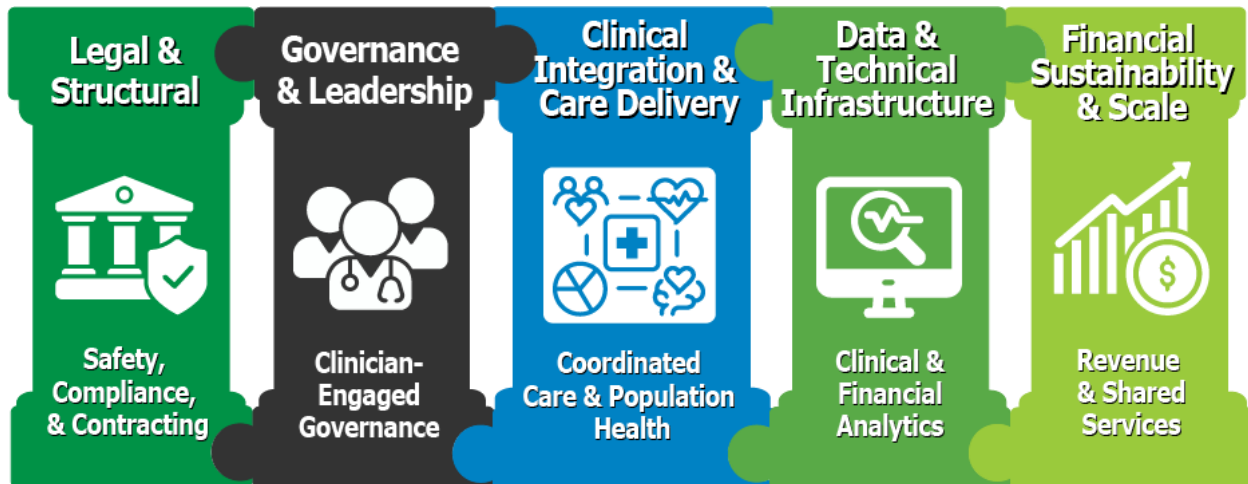
By focusing on the unique characteristics of a CIN, rural leaders can better distinguish between general collaborative alliances and the high-performance models necessary for collective negotiation. Success as CIN relies on shared clinical objectives and a robust legal, financial, and technological infrastructure.

¹ Rural healthcare organizations include Critical Access Hospitals, rural hospitals, independent practices, Rural Health Clinics, Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, etc.

² Berwick DM, Nolan TW, Whittington J. *The Triple Aim: Care, Health, and Cost*. Health Affairs. 2008.

This distinction is critical for rural HCOs already involved in purchasing cooperatives or peer-sharing groups; while valuable, those models lack the legal standing required to negotiate rates with payers. In contrast, a CIN should establish the governance, capital investment, and staffing required for independent rural HCOs to legally present themselves to the market as a single, unified clinical unit.

Five Pillars of Rural CINs



Successful rural CIN development and operation requires navigating five interlocking pillars:

- **Legal & Structural: The Trust Foundation** – This pillar establishes the “safety zones” that allow independent HCOs to collaborate on pricing and quality without triggering antitrust concerns. It is the formal mechanism that transforms a handshake agreement into a protected, single-signature entity.
- **Governance & Leadership: The Alignment Engine** – CIN success depends on a representative governance structure that balances the needs of varied members. This pillar focuses on building a shared culture and developing clinical leaders who can drive Triple Aim performance.
- **Clinical Integration & Care Delivery: The Core Mission** – Clinical integration is the “glue” of the network. It moves beyond financial ties to create a seamless patient experience. By synchronizing care coordination and population health strategies, the CIN ensures high-quality care and minimizes patient leakage from the rural CIN.
- **Data & Technical Infrastructure: The Analytical Brain** – A CIN cannot manage what it cannot measure. This pillar involves building a unified data architecture that aggregates disparate clinical and financial information. It

provides a comprehensive, longitudinal view of the patient, necessary for accurate performance reporting and continuous improvement, the safe application of predictive analytics, and data sharing among CIN members.

- **Financial Sustainability & Scale: The Defensive Shield** – This final pillar secures the network’s future. By leveraging collective volume for payer negotiations and shared services (like group purchasing), the CIN provides its members with the economic scale of a large system while preserving local autonomy and community identity.

The following sections explore the specific resources and infrastructure required to sustain these five pillars within a resource-limited rural environment.

Action steps are highlighted in bold to help leaders prioritize high-impact decisions. Context and further information to inform discussion follow each action step.

Note on Professional Guidance: While this material aligns with industry standards for healthcare integration, it is intended for informational purposes and does not constitute legal, financial, or clinical advice. Because the regulatory landscape varies by jurisdiction and is subject to change, rural HCOs should consult with qualified legal counsel and professional advisors to ensure full compliance with state and federal regulations before establishing a CIN.

Legal & Structural

Legal and Regulatory Landscape

Proactively monitor the evolving regulatory landscape and establish documented protocols to ensure all activities remain pro-competitive and avoid antitrust violations.

Federal and state regulators grant CINs “safety zones” because their primary goals – improving quality and reducing costs – are considered pro-competitive. These safety zones allow members to negotiate collectively with payers, a practice that would otherwise violate antitrust laws as illegal price-fixing.

For decades, CINs relied on the 1996 Federal Trade Commission (FTC) and the Department of Justice (DOJ) “Statements of Antitrust Enforcement Policy in Health Care.”³ But in 2023, both agencies withdrew these statements, citing them as outdated. CINs are now evaluated on a case-by-case basis by federal and state regulators.⁴ Nevertheless, the core principles of the original 1996 guidelines continue to serve as the functional foundation for modern CIN objectives. Those principles include demonstrable clinical integration, shared financial risk, physician involvement in CIN governance, and avoidance of anti-competitive behavior.

The regulatory transition underscores the importance of documenting that the CIN’s collaborative activities result in measurable improvements in patient outcomes. Antitrust regulators seek a clear link between joint payer negotiations and specific clinical programs implemented by the CIN. For independent rural HCOs, this means that maintaining robust data collection and internal performance monitoring and improvement are no longer just a best practice; it is a critical defensive strategy against potential antitrust scrutiny.

Even without the formal safety zones provided by previous policy statements, a CIN that can demonstrate it reduces unnecessary service duplication, manages chronic diseases more effectively, and shares meaningful clinical data across its members is likely to meet the pro-competitive standards required by federal regulators.

³ Federal Trade Commission and U.S. Department of Justice. *Statements of Antitrust Enforcement Policy in Health Care*. Washington, DC: FTC and DOJ; August 1996.

⁴ Federal Trade Commission and U.S. Department of Justice. *Agencies Withdraw Outdated Enforcement Policy Statements*. February 3, 2023.

Legal and Administrative Expertise and Capacity

Evaluate CIN internal capacity and, where gaps exist, engage external experts with healthcare integration experience to manage the specialized legal and administrative requirements of the startup phase.

Establishing a CIN requires a substantial investment of time, expertise, and financial resources. Prospective CIN leaders should recognize the significant effort required to coordinate schedules, facilitate planning sessions, and develop foundational documents. Beyond these administrative tasks, a CIN should achieve clinical alignment and navigate the complexities of legal, accounting, and insurance requirements. Given these demands, HCO leaders should carefully evaluate their internal capacity to manage this transition or consider contracting with external experts to mitigate risk and ensure the CIN is built on a compliant, sustainable foundation.

This evaluation should also account for the long-term capital required to build the necessary information technology (IT) infrastructure, including interoperable data platforms that enable disparate rural HCOs to communicate seamlessly. Additionally, leaders should be prepared for the cultural shift required to move independent, and sometimes competing HCOs, toward a shared governance model in which clinical performance is transparent and collectively managed.

Legal Counsel

Retain legal counsel with specific expertise in healthcare antitrust law and establish clear internal protocols that govern how leadership directs and utilizes legal advice.

While CINs operate within federal safety zones, they remain subject to ongoing scrutiny for potential antitrust violations. As noted above, the FTC and the DOJ have recently shifted toward a case-by-case enforcement approach, meaning that simply meeting historical risk-sharing benchmarks may no longer provide absolute immunity from investigation. Given this risk, CINs should engage legal counsel with specific expertise in healthcare antitrust law to help the CIN demonstrate true clinical integration. This involves documenting that the collaborative negotiation of payer contracts is secondary to, and necessary for, improving clinical outcomes and reducing per-capita costs.

Additionally, the CIN should retain legal counsel licensed in the state of formation to ensure that all contracts and foundational documents comply with local regulations and are properly prepared for official review. Legal experts can assist in drafting participation agreements that include essential compliance safeguards, such as explicit antitrust

protocols that prevent the unauthorized sharing of competitively sensitive information among independent HCOs. By establishing these legal guardrails early, the CIN can protect itself from allegations of price-fixing or other anti-competitive behaviors while fostering a culture of regulatory accountability.

Incorporation Activity

Designate a responsible party to file the articles of incorporation and secure the necessary state and federal tax-exempt status before entering into binding business agreements.

If not already incorporated, the CIN should establish a formal legal entity in order to enter into binding business agreements.. Most rural CINs choose to organize as a non-profit corporation within their primary state of operation, often aligning with the mission of their founding HCOs. This process requires submitting formal articles of incorporation to the appropriate state agency, as well as federal filings with the Internal Revenue Service to establish tax-exempt status and obtain a federal Employer Identification Number (EIN). The new corporation should also establish a registered business address and the necessary administrative infrastructure to support its identity as an independent, high-functioning organization.

The selection of the legal structure is a critical decision that impacts the CIN's ability to distribute performance bonuses and manage its tax liabilities. While non-profit status is common, leaders should also evaluate the merits of other structures, such as a Limited Liability Company or a Professional Corporation, depending on the ownership group's diversity.

Business and Legal Agreements

Utilize specialized legal counsel to ensure all foundational business and provider agreements reflect jurisdiction-specific requirements and the CIN's clinical integration standards.

The formation of a CIN requires a series of foundational business and legal agreements. At the outset, all participating parties should sign a Non-Disclosure Agreement (NDA) to protect sensitive proprietary information. As the partnership progresses, a Data Use Agreement (DUA) and a Business Associate Agreement (BAA) become necessary for any exchange of clinical or financial information, while a Provider Agreement is essential to codify the specific roles and responsibilities of each CIN member. To formalize the CIN's structure, leaders should also develop Governance

Bylaws that define decision-making processes and shared accountability.

If the CIN utilizes external expertise, an Engagement Agreement or Management Services Agreement (MSA) should be executed. Leaders should anticipate that as the CIN matures, further legal documentation, including value-based contracting frameworks and antitrust compliance protocols, will be required to support its evolving operational needs and protect the organization from regulatory risk.

Participation Agreements

Designate a specific role or team to manage the full lifecycle of participation agreements, from initial drafting and distribution through adjudication and final signature collection.

Relationships between a CIN and its participating hospitals, clinics, and practitioners are formalized through Hospital Participation Agreements and Affiliated Practitioner Participation Agreements. Participation agreements serve as the foundational legal contracts that define the terms of CIN membership. These documents are essential for demonstrating active clinical integration to regulators, as they explicitly grant the CIN the single-signature authority required to negotiate and bind hospitals and practitioners to contracts with payers. To function effectively, the agreements should be accompanied by a BAA and a DUA, which establish the legal framework for the Health Insurance Portability and Accountability Act (HIPAA)-compliant exchange of Protected Health Information (PHI) and the aggregation of clinical data across the CIN's various electronic health records (EHRs), population health management (PHM) platforms, and other shared data sources.

The core provisions of participation agreements focus on shifting hospital and practitioner roles from independent actors to collaborative partners held to specific performance standards. This includes adherence to evidence-based clinical protocols, timely data submission for population health analytics, and participation in the CIN's quality improvement initiatives. The contract should outline clear accountability measures, such as remediation processes or potential termination for failing to meet cost and quality benchmarks. Finally, the agreement defines the financial relationship between the parties, detailing how performance bonuses or incentive payments are distributed and ensuring that all arrangements comply with federal regulations like the Stark Law and the Anti-Kickback Statute.

Advanced Regulatory Protections

Conduct a jurisdiction-specific regulatory review to ensure full compliance with Corporate Practice of Medicine and Any Willing Provider mandates while strategically maintaining high-performance CIN membership standards.

To ensure a robust regulatory posture, the CIN should first align with Corporate Practice of Medicine regulations, which prevent non-clinical entities from exerting undue influence over professional medical judgment or clinician employment. This foundational oversight extends to mandatory jurisdiction-specific licensing, where the CIN should determine whether it is classified as an Independent Practice Association or a managed care entity requiring formal registration with the State Attorney General or the Insurance Commissioner.

As the CIN defines its membership, it should navigate Any Willing Provider mandates, which may require accepting any HCO or clinician who meets established terms, a requirement that should be strategically balanced with the CIN's goal of maintaining a selective, high-performance CIN. To maintain the integrity of these clinical operations, the CIN should establish strict ethical guardrails and anti-manipulation protocols. These internal controls are designed to prevent “cherry-picking” or “lemon-dropping,” ensuring that value-based incentives do not inadvertently reduce medically necessary care or reduce appropriate access to care. Finally, the CIN should conduct periodic analyses of exclusivity and market concentration to mitigate antitrust risks and determine the strategic value of exclusive versus non-exclusive participation agreements for its members.

Accreditation

Consider pursuing formal accreditation from a recognized body such as URAC or NCQA to validate clinical integration, strengthen legal standing, and accelerate negotiations with national payers.

Pursuing formal accreditation from organizations such as URAC⁵ or the National Committee for Quality Assurance (NCQA)⁶ is more than a branding exercise; it is an important strategic maneuver. While CIN accreditation currently is not required by payers or regulators, and the accreditation process is expensive and time-consuming, accreditation acts as a “seal of approval” that validates the CIN's maturity, providing a rigorous framework that ensures the CIN is not just a network on paper, but a high-functioning system in practice.

⁵ URAC. Clinically Integrated Network (CIN) Accreditation Standards. Washington, DC: URAC.

⁶ National Committee for Quality Assurance. *Clinically Integrated Network Accreditation Standards*. Washington, DC: NCQA.

A critical advantage of accreditation is its role in providing legal and regulatory security. Accreditation serves as objective, third-party evidence that the CIN has met the high standards of integration required by the FTC and the DOJ. It demonstrates that the CIN has established the active supervision and interdependence necessary to negotiate payer contracts collectively, significantly reducing the risk of price-fixing allegations. This legal safe harbor is the foundation upon which the financial viability of a rural CIN is built.

Payers are often hesitant to enter into complex value-based or risk-sharing agreements with unproven entities. A formal accreditation signals to commercial and government payers that the CIN has been vetted for its data integrity, clinical governance, and quality improvement processes. Accreditation can accelerate contract negotiations, help the CIN secure higher base fee schedules, and unlock access to pay-for-performance programs that might otherwise be reserved for larger, urban systems.

Beyond the external benefits, the accreditation process compels a rural CIN to conduct a comprehensive internal audit. To meet accreditation standards, the CIN should formalize its governance, standardize its clinical pathways, and harden its data security protocols. This creates a roadmap for operational maturity, ensuring the CIN moves beyond its initial phase into a disciplined, data-driven entity. Furthermore, because accreditation requires ongoing monitoring and periodic recertification, it embeds continuous quality improvement (CQI) into the CIN's culture. This ongoing commitment ensures that the CIN remains agile and able to adapt to the ever-shifting requirements of federal health policy and VBC.

Governance & Leadership

Governance Structure

Establish a formal governance structure, including a Board of Directors with diverse clinical and administrative representation, clearly defined decision processes and voting rights, and a multi-tiered committee structure to ensure cross-member collaboration.

Establishing a CIN requires creating a new legal entity with a formal governance structure that fosters cross-provider collaboration. In the initial stages, a Board of Directors should be established, typically consisting of founding HCO leaders and a representation from physicians and/or advanced practice provider champions to ensure clinical input at the decision-making level. The Board of Directors is responsible for developing corporate bylaws and defining essential protocols, including organizational authorities, decision processes and voting rights, and a multi-tiered committee structure focused on clinical quality, finance, and IT interoperability. Additionally, leaders should prioritize establishing a clear evaluation and admission process for new CIN member entry, as well as current CIN member exit. This framework should define objective performance benchmarks and participation requirements, ensuring that the CIN remains a high-performance organization capable of delivering measurable value to payers and patients alike.

Executive Team and Staff

Develop a structured recruitment, onboarding, and funding plan for a dedicated administrative team with expertise spanning healthcare delivery, data science, legal compliance, and financial management.

To operate effectively, a CIN requires an administrative team capable of managing the complex intersection of healthcare delivery, data science, and legal compliance. At the executive level, a CIN typically requires a dedicated Chief Executive Officer (CEO) to manage strategic relationships, a Chief Medical Officer (CMO) to lead clinical committees and drive practitioner engagement, a Chief Financial Officer (CFO) to provide strategic oversight of CIN financial health, and a Chief Information Officer (CIO) to lead IT evaluation and operation.

The CEO serves as the primary visionary and strategic leader of the rural CIN. While the CMO, CIO, and CFO manage their respective technical domains, the CEO is

responsible for harmonizing these efforts to ensure the CIN remains focused on its dual mission of clinical excellence and financial viability. The CEO acts as the essential link between the Board of Directors and the operational staff, translating high-level governance decisions into actionable CIN strategies. In a rural context, this role is uniquely outward-facing; the CEO should be an expert at managing the complex interpersonal dynamics among independent HCOs while simultaneously representing the CIN's single-signature authority in negotiations with payers and external partners.

Effective CIN implementation and operation require additional support across a variety of roles and responsibilities. A data and analytics team aggregates clinical information from disparate electronic health record systems and other data tools and platforms to produce actionable performance reports. Care coordinators or population health managers track high-risk patient populations across various care settings, ensuring that the CIN's clinical goals are translated into actual patient outcomes. A provider relations team facilitates seamless onboarding and credentialing while serving as the primary communication link between the CIN and its participants. Strategic partnership experts develop and manage vendor (including IT) relationships. Insurance specialists manage the complexities of value-based contracting, including contract negotiation and performance bonus distribution plans. Administrative support staff handle the day-to-day logistics of governance, including organizing board meetings, maintaining the electronic policy guidebook, and ensuring compliance documentation is updated for regulatory review. Administration funding and staffing should scale with the size and scope of the CIN. Executive and leadership supporting roles may be part-time or full-time, and the administrative team may be built internally or outsourced.

Administrative Support

Assign clear responsibility, whether internal or outsourced, for meeting coordination, secure document management, and version control to ensure operational continuity and audit readiness.

The CIN CEO is ultimately responsible for organizational oversight and strategic direction and should ensure that adequate administrative support is in place. Effective CIN management demands significant coordination, including numerous meetings and extensive documentation, reflecting the complexity of aligning multiple healthcare stakeholders. Thus, to function efficiently, the CIN requires dedicated support, whether internal or outsourced, to manage meeting logistics including scheduling, agenda development, preparation, and timely follow-up. This administrative backbone ensures that committee members, who are often busy clinicians and executives, can focus on strategic decision-making rather than coordination hurdles. Effective follow-up is particularly vital in a clinically integrated environment, as it ensures that action items

related to quality improvements or contract negotiations move forward between formal sessions.

Robust document management is essential for creating, distributing, and securely filing records, as well as for the formal process of acquiring and tracking required signatures. Given the sensitive nature of clinical and financial data, these systems should provide a high degree of security and version control to maintain a clear audit trail. This infrastructure should also support participation agreements and business associate agreements, ensuring that all credentials and contracts remain up to date. As the CIN grows in size and complexity, the transition from manual tracking to automated project management and electronic signature platforms becomes essential to maintain organizational momentum. By centralizing these functions, the CIN can minimize the risk of compliance gaps and ensure that the foundational legal and operational paperwork is always accessible for regulatory review or board reporting.

Policy Compendium

Establish and maintain an electronic policy compendium that allows all CIN members immediate access to current clinical protocols, governance documents, and compliance standards.

To provide an accessible and comprehensive administrative framework, a CIN should designate a responsible party to maintain an electronic policy compendium that serves as a central resource for members, regulators, and reviewers. This digital compendium documents the formal rules, policies, and clinical expectations of the CIN, ensuring that all participating providers have immediate access to the most current protocols – a critical requirement for demonstrating active clinical integration during regulatory audits. A robust manual should include detailed governance documentation, such as board structures and committee charters, as well as a library of evidence-based clinical protocols and disease-management guidelines.

Beyond clinical standards, the policy compendium should define the operational mechanics of the CIN, including policies for quality performance monitoring, data collection methodologies, and the specific benchmarks used to measure member success. It should also clearly outline the due process for remediation and sanctions when providers fail to meet these standards, as well as the transparent methodology used for financial distributions and incentive payments. The compendium should incorporate essential compliance and regulatory standards, including HIPAA, the Anti-Kickback Statute, and conflict-of-interest disclosures. Finally, the compendium should also detail specific criteria for CIN participation, credentialing, and membership termination.

Strategy

Formalize an objective evaluation process for assessing growth opportunities, such as geographic expansion or technology investments, to ensure new initiatives align with the CIN's clinical mission and financial sustainability.

As the CIN matures, it requires a process for developing and evaluating growth, investment, and partnership strategies to ensure long-term sustainability and market relevance. This includes identifying opportunities for geographic expansion and evaluating investments in advanced population health technology or care coordination services that enhance preventive health and chronic disease management. The CIN should also establish criteria for pursuing strategic partnerships, such as joint ventures with various vendors or service providers.

By formalizing this evaluation process, leadership can objectively determine if a new initiative or partner aligns with the CIN's core mission of improving quality and reducing costs. These structured assessments allow the CIN to pivot toward high-value investments while avoiding partnerships that could dilute the clinical focus or create unnecessary financial risk for its independent members.

Communication and Culture

Develop a comprehensive change management strategy that cultivates a culture of “independence through interdependence,” aligning the goals of potentially competitive organizations through shared accountability, clear communication, and regular face-to-face engagement.

While this document addresses the technical, financial, and structural elements of CIN development, successful formation also depends on the interpersonal dynamics required to bring together independent, and at times competitive, HCOs. For a CIN to thrive, participants should adopt a mindset of “independence through interdependence.” This perspective recognizes that each organization retains its unique identity while becoming stronger and more resilient through collaboration toward shared goals. Cultivating this collaborative culture involves moving beyond transactional relationships to a model based on shared accountability and clinical vision. Leaders should invest in a comprehensive change management strategy that addresses the cultural shifts needed to align providers' clinical workflows and financial incentives. This often includes establishing clear communication channels and frequent opportunities for face-to-face engagement, which help to humanize the data-driven objectives of a CIN. By prioritizing the human element of integration, the CIN can transform from a mere legal entity into a

cohesive clinical community. The long-term viability of a CIN depends as much on the strength of professional relationships as it does on the technical infrastructure; true integration is only possible when members are fully committed to a common standard of excellence for the populations they serve.

Leadership and Infrastructure Development

Develop a robust leadership and administrative infrastructure capable of managing the complex operational and financial demands of VBC and payment.

Clinical leadership provides medical support for a rural CIN, while administrative leadership serves its operational requirements. In a rural landscape, where independent HCOs often lack the back-office scale of large urban systems, the CIN should develop an administrative infrastructure capable of managing the complex business of VBC and payment. This requires a unique leadership profile, one that balances the potentially competing interests of independent entities with the collective financial goals of the CIN.

The leadership of a rural CIN should be adept at navigating the dual reality of the current healthcare economy, managing the transition from traditional fee-for-service (FFS) to risk-based payment models. Administrative leaders are responsible for critical negotiations with payers, ensuring the terms of the agreements are realistic for a rural population. Beyond contracting, they provide the essential legal and compliance oversight required to maintain the CIN's clinical integration status, shielding the CIN from antitrust scrutiny.

Another compelling rural CIN value proposition is its ability to provide shared services that individual members could not afford on their own. This administrative support often includes centralized human resources, group purchasing power, and managed IT services. By centralizing these functions, the CIN allows local hospital and clinic managers to focus less on “keeping the lights on” and more on patient experience and clinical quality. Additionally, the CIN provides a vital layer of support through unified marketing and patient outreach, helping rural HCOs maintain patient volume and brand identity in an increasingly competitive market. This collective administrative support reduces the overhead of operating independently, making the CIN attractive to HCOs that wish to remain autonomous yet need support from a larger system.

Clinical Integration & Care Delivery

Clinical Integration

Establish ongoing collaborative processes, including shared clinical protocols, performance monitoring and improvement, and peer accountability mechanisms, to demonstrate true clinical interdependence to governmental regulators and accrediting bodies.

Clinical integration is a structured, ongoing collaboration between healthcare providers that aims to improve patient care quality and operational efficiency while controlling costs. To be recognized by regulators and accreditors as a legitimate CIN, independent rural HCOs should move beyond simple financial cooperation and establish a high degree of clinical interdependence. This is achieved through the implementation of evidence-based protocols, shared data analytics for performance monitoring, and accountability and improvement mechanisms for providers who do not meet established benchmarks. Central to this effort is the CMO, who serves as the primary architect of the CIN's clinical vision. The CMO ensures that evidence-based protocols are not merely administrative mandates but are clinically relevant and adopted by frontline practitioners across the CIN. By investing significant capital into shared infrastructure and leadership, the CIN can demonstrate that joint activities provide genuine value to patients.

Care Coordination

Implement a care coordination model that combines centralized data analytics and oversight with locally embedded staff, balancing operational efficiency with the relational trust essential to rural patient engagement.

Care coordination serves as the operational bridge between fragmented clinical services and cohesive population health management. In rural environments, patients frequently face geographic barriers, a scarcity of locally available specialists, and complex transitions between small community hospitals and distant urban healthcare centers. Effective care coordination mitigates these rural challenges by ensuring that clinical information follows the patient, thereby reducing redundant testing and closing gaps in preventive and chronic disease care.

Local care coordination programs rely on coordinators who are physically located within individual clinics or hospitals. The primary advantage of this approach is the high

degree of relational coordination. In tight-knit rural communities, trust is a significant factor in patient compliance; a patient is far more likely to engage with a care plan managed by a familiar face at their local clinic than by a stranger on the phone. Furthermore, local coordinators possess an intimate knowledge of regional social supports, such as which local churches provide food assistance or which neighbors provide informal transport. However, this model is often difficult to scale and incurs higher overhead, requiring the duplication of staff across multiple small sites.

Conversely, centralized care coordination services utilize a dedicated hub to coordinate care across the entire CIN via telephonic or digital platforms. This approach often provides economies of scale, greater depth and breadth of services, standardized protocols, and data-tracking tools. While efficient and easier to manage, the centralized approach risks feeling impersonal. To build trust and maintain continuity, centralized care coordination services should align with local care coordinators. Key strategies include using local area codes for patient outreach, identifying as part of the local care team, making timely EHR entries, and maintaining an up-to-date knowledge of local social supports.

A hybrid strategy can often be most effective, combining centralized data analytics and high-level administrative oversight with local staff empowered to manage direct, person-centered patient relationships. Thus, the centralized service amplifies local care coordination. The success of this hybrid strategy depends on the CMO's clinical oversight, which harmonizes centralized data insights with local clinical workflows. By providing a single point of clinical leadership, the CMO ensures that care coordination remains patient-centered and responsive to each member site's unique resource constraints.

Population Health

Integrate systematic care gap identification and health-related social needs (HRSN) screening into standard clinical workflows, using aggregated population health data to proactively address the root causes of poor health outcomes.

Adopting a population health approach involves transitioning from treating the individual patient to managing the collective health of an entire community. This shift is essential because rural health outcomes are often dictated as much or more by environmental and socioeconomic factors than by clinical interventions alone. By focusing on population health, a rural CIN can proactively identify high-risk cohorts, standardize preventive care, and address the root causes of poor health, thereby driving down the total cost of care and improving the CIN's performance in value-based contracts.

The primary mechanism for improving population health within a CIN is the systematic identification and closure of care gaps. A care gap occurs when there is a discrepancy between the evidence-based recommended care and the care the patient actually receives, such as a missing annual wellness visit, an overdue colonoscopy, or a lack of consistent A1c monitoring for a diabetic patient. By aggregating data across the CIN, the CIN can generate care gap lists that allow care coordinators to proactively engage patients before they fall into a health crisis.

A truly effective rural CIN recognizes that clinical care accounts for only a fraction of health outcomes, with the remainder driven by HRSN,⁷ also known as upstream drivers of health. In rural communities, these factors may include food deserts, unreliable (or nonexistent) public transportation, substandard housing, or energy insecurity. To become more efficient, the CIN should integrate social risk screening and referrals to community resources into its standard clinical workflow. Furthermore, the CIN may link members and their patients to community resources through organizations such as Findhelp.org.

Clinician Leadership Development and Support

Integrate systematic care gap identification and HRSN screening into standard clinical workflows, using aggregated population health data to proactively address the root causes of poor health outcomes.

The cornerstone of any CIN is the inclusion of physicians and/or advanced practice providers in governance, which is not only a strategic advantage but a regulatory necessity to demonstrate clinical integration for antitrust purposes. Effective leadership in a rural CIN involves empowering local practitioners to serve on boards and clinical committees, where they take ownership of the CIN's quality standards and care pathways. This fosters a culture of peer-to-peer accountability, where clinical performance is managed by fellow practitioners rather than administrative executives. By engaging rural practitioners as developers of CIN clinical protocols, the CIN ensures that the strategies implemented are culturally relevant to their specific patient populations and logistically feasible within their local resource constraints.

While the Board of Directors provides oversight, the CMO serves as the vital link between governance and practice. The CMO is responsible for cultivating a culture of peer-to-peer accountability and mentoring local practitioners to take on leadership roles within clinical committees. This leadership ensures that the CIN's quality standards are driven by clinical reality rather than purely financial targets.

⁷ National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care into the Delivery of Health Care*. Washington, DC: National Academies Press; 2019.

Workforce development in a rural CIN should focus on upskilling current staff to thrive in a VBC environment. Rural clinics often operate with lean teams, requiring role transformation of existing personnel. This means training medical assistants and nurses to act as care coordinators and population health managers who can proactively close care gaps rather than just assisting with the current patient. The CIN should also invest in ongoing education regarding the business of medicine, helping clinicians understand the nuances of risk-based contracts, Hierarchical Condition Category (HCC) coding,⁸ and quality reporting metrics. This educational support is vital to transforming a traditional FFS workforce into a team capable of effectively managing population health.

⁸ Hierarchical Condition Category (HCC) coding is a risk-adjustment methodology used by the Centers for Medicare and Medicaid Services to estimate the expected healthcare costs of individual patients based on their diagnosed conditions. By mapping diagnosis codes to clinically meaningful categories, HCC coding assigns each patient a risk score that reflects their health complexity, enabling more accurate and equitable payments to providers caring for high-need populations. Source: Centers for Medicare & Medicaid Services. *CMS-HCC Risk Adjustment Model*.

Data & Technical Infrastructure

Data Aggregation, Management, and Analysis

Select and implement a population health management (PHM) platform capable of aggregating disparate clinical and financial data from member EHRs, payer systems, and other data sources into a single, comprehensive, and longitudinal patient record.

Clinical and financial data serve as the CIN backbone, providing the structural integrity needed to support complex decision-making. Without a robust data architecture, a CIN is merely a collection of independent providers; with it, the CIN gains the analytical insights necessary to drive joint clinical, financial, and operational strategies. The CIO serves as the lead strategist in this transformation, responsible for designing a data environment that balances the autonomy of independent rural sites with the need for interoperability across IT systems – scaled, priced, and maintainable in ways appropriate to a rural care delivery setting. The CIO selects and manages the PHM and business intelligence platforms that serve as the CIN's single source of truth, translating raw clinical and financial data into actionable executive insights. This intelligence enables the CIN to move beyond anecdotal evidence toward a high-performance model in which objective metrics validate strategic decisions.

Clinical data represents the primary clinical intelligence of the CIN, requiring the aggregation of information from disparate EHRs into a single, longitudinal patient view. This unified record is vital in a rural setting where a patient may see a primary care provider in one town and a specialist in another. By centralizing clinical data, the CIN can identify chronic care gaps, track quality outcomes, and utilize risk stratification to identify the most vulnerable patients before they require expensive emergency interventions. A PHM platform is a critical tool that aggregates, manages, and analyzes data from multiple sources: clinical data from EHRs, health information exchanges, and national data aggregators; financial and utilization data from payer claims; HRSN data from EHRs and national data sources. Unlike standard EHRs, a PHM platform provides a holistic view of the population's health. It identifies rising-risk patients and automates the workflows for care coordinators, making it an essential tool for proactive wellness.

Financial data provides the economic insight required to prove the CIN's value to payers and maintain its long-term viability. This is more than simple billing; it encompasses the analysis of total cost of care and leakage (when patients seek services outside the CIN). By integrating claims data with clinical performance, the CIN can more accurately manage risk-adjusted coding and monitor distributions of shared savings, ensuring it is appropriately reimbursed for the complexity of its rural patient population. Business and

performance software provides the executive-level oversight needed to manage the CIN as a commercial entity. This includes business intelligence dashboards that synthesize clinical and financial trends into high-level reports for the Board of Directors, as well as referral management tools to facilitate high-quality, low-cost referrals.

Data Security

Require all data platforms and vendors to meet rigorous third-party security certifications, such as HITRUST or SOC 2, and implement technical safeguards including encryption and access controls to protect patient data from unauthorized access and cyber threats.

In addition to population health and financial tools, the integrity of a rural CIN rests on its ability to safeguard the massive volume of data flowing through its own and its vendors' data platforms. Because the CIN model relies on the consistent exchange of PHI between independent entities, the CIN's data backbone should be hardened against both accidental disclosure and malicious cyberattacks.

The standard for security in healthcare is no longer just HIPAA compliance, which is a legal baseline rather than a technical seal of approval. For a CIN to demonstrate that its infrastructure is truly resilient, third-party certifications are necessary. The most rigorous of these is the Health Information Trust Alliance (HITRUST) Common Security Framework (CSF),⁹ which provides a certifiable framework that integrates HIPAA, National Institute of Standards and Technology (NIST),¹⁰ and other regulatory standards. Achieving HITRUST certification is often a prerequisite for a CIN to sign contracts with major national payers. Similarly, System and Organization Controls (SOC) 2 reports are crucial for evaluating the operational effectiveness of a vendor's security controls over time. These certifications serve as trust signals, allowing independent rural HCOs, payers, and other entities to feel confident that sharing patient data with a centralized hub will not result in a catastrophic breach.

The CIO oversees this security structure, ensuring that the CIN's defense-in-depth strategy remains resilient against evolving cyber threats. By managing these rigorous third-party certifications, the CIO provides the technical assurance that enables independent HCOs to trust that their local data is handled with institutional-grade security.

The core challenge for a rural CIN is protecting PHI while simultaneously making it accessible for care coordination. Under HIPAA's Security Rule,¹¹ the CIN should

⁹ Health Information Trust Alliance. HITRUST Common Security Framework (CSF).

¹⁰ National Institute of Standards and Technology. *Cybersecurity Framework (CSF) 2.0*. Gaithersburg, MD: NIST; 2024.

¹¹ U.S. Department of Health and Human Services. Health Insurance Portability and Accountability Act (HIPAA) Security Rule.

implement technical safeguards, including encryption for data at rest and in transit. However, in a CIN, the “Minimum Necessary” rule becomes a complex balancing act. The CIN should ensure that while a care coordinator has enough information to assist a patient, they do not have unfettered access to the entire medical record unless clinically required.

Artificial Intelligence

Leverage artificial intelligence (AI)-driven predictive analytics to identify rising-risk patients while maintaining human-in-the-loop oversight protocols that guard against algorithmic bias, particularly in rural demographic contexts.

To move beyond serving as a passive data repository, a CIN can leverage artificial intelligence (AI) as a strategic asset for its clinical and administrative staff. In a rural context, defined by scarce human resources and vast patient geography, AI transitions from a technological luxury to an essential infrastructure that drives efficiency across several domains.

While traditional population health tools primarily identify historical gaps in care, modern PHM and care coordination platforms utilize AI-generated predictive analytics to provide a forward-looking perspective. By aggregating thousands of data points from EHRs, insurance claims, and HRSN data, AI algorithms can identify rising-risk patients. These are individuals who may not currently present as acutely ill but are statistically predisposed to high-cost clinical events. Furthermore, AI may assist centralized care coordination systems determine how (e.g., text or phone call) and when (e.g., time of day or day of week) human care coordinators can best engage patients. For a rural CIN, this targeted intelligence allows care coordination teams to focus on intensive interventions where the clinical and financial risks are highest.

Despite these efficiencies, implementing AI requires rigorous governance. Implementing AI is not merely a clinical decision but a technical one, led by the CIO, who should ensure these models are seamlessly integrated into existing workflows. The CIO is responsible for the technical vetting of AI vendors to ensure their models are transparent and adaptable to rural demographics, preventing the “black box” effect that can lead to unintended biases. For example, rural CINs should remain vigilant about algorithmic bias; for example, models trained exclusively on urban data may fail to accurately reflect the specific health challenges and lifestyle factors of rural populations. To maintain safety and trust, the CIN should uphold a human-in-the-loop philosophy, meaning AI-generated insights serve as expert recommendations to support a clinician’s or care coordinator’s professional judgment rather than replacing it.

Performance Measurement and Reporting

Implement a structured performance measurement and reporting framework, including standardized quality measures and federal reporting protocols such as QRDA and FHIR, to ensure regulatory compliance and the accurate distribution of shared savings.

To establish legal and operational legitimacy, a rural CIN should implement a rigorous framework for data collection and reporting. This requirement serves as a formal mechanism by which the CIN demonstrates its interdependence to regulatory bodies such as the FTC and DOJ, ensuring that the CIN can negotiate payer contracts jointly without violating antitrust laws. Data collection should be comprehensive, capturing a longitudinal view of patient experience across disparate HCOs to prove that the CIN is successfully reducing clinical variation and managing the total cost of care.

In addition to supporting direct patient care, clinical data should be used to measure quality outcomes across the population. HCOs should report, or the PHM should gather data relative to a standardized set of clinical quality measures, such as cancer screening rates and chronic disease management metrics. In a rural setting, this often necessitates that the CIN (often via the PHM) aggregate data from multiple independent EHRs into a centralized platform. Reporting should be frequent and transparent, allowing the CIN to provide peer-to-peer feedback to clinicians.

A rural CIN should adhere to standardized federal reporting protocols to participate in Medicare quality incentive programs and value-based models. The primary vehicle for this currently is Quality Reporting Document Architecture (QRDA), a standard based on the Health Level Seven (HL7) Clinical Document Architecture. QRDA files enable the CIN (or the PHM platform) to transmit electronic Clinical Quality Measures (eCQMs) to the Centers for Medicare & Medicaid Services (CMS) in a structured format that ensures data consistency and machine-readability across different healthcare systems. CMS has indicated it will shift to Fast Healthcare Interoperability Resources (FHIR)¹² in the near future. This modern technical standard for health information exchange supports seamless data sharing through Application Programming Interfaces (APIs). The CIO manages this technical evolution, directing the transition to FHIR-based standards and Application Programming Interfaces (APIs). By staying ahead of CMS technical mandates, the CIO ensures the CIN remains an organization capable of participating in the most sophisticated value-based payment models.

While Medicare often drives CIN quality initiatives, clinical performance data collection and reporting should also account for commercial payer and state Medicaid program

¹² Health Level Seven International. *FHIR Release 5*.

requirements, each of which may utilize distinct metrics and benchmarks. Aligning reporting infrastructure across all payer types ensures the CIN can meet its contractual obligations and accurately demonstrate value across its full patient population.

Financial data collection enables the CIN to monitor its economic performance and accurately distribute shared savings. The CIN should collect and analyze payer claims data to calculate the total cost of care for attributed patient lives. High-functioning rural CINs also require granular cost data to manage risk-based contracts effectively. By linking financial data with clinical outcomes, the CIN can perform risk-adjustment and actuarial modeling, which are essential for predicting future expenses and ensuring the CIN remains solvent while taking on value-based risk. This integrated reporting serves as evidence that the CIN is delivering a more efficient, lower-cost alternative to the fragmented FFS model.

Performance Improvement

Develop and deploy a clinical and financial performance improvement strategy that closes care gaps, reduces unwarranted practice variation, and positions the CIN to meet the quality benchmarks and cost targets required to realize VBC contract revenue.

For a CIN to fulfill its mission, measuring performance is necessary but not sufficient – the CIN should also act on what the data reveals. Performance improvement is the bridge between measurement and meaningful change, translating metrics into better clinical outcomes, healthier populations, and sustainable financial performance. CINs that implement performance improvement processes are better positioned to close care gaps, reduce unwarranted clinical practice variation, and deliver consistently high-quality care across their member sites. A commitment to continuous improvement also enables CINs to respond more effectively to changes in community conditions, patient needs, payer priorities, and evolving research and best practices.

A population health focus is particularly necessary in rural CINs, where chronic disease burden is often high and access to specialty care limited. By systematically identifying patients who are overdue for preventive services, experience poorly controlled chronic disease, or are at elevated risk for avoidable hospitalizations, a CIN can direct resources where they will have the greatest impact. Over time, these efforts compound, reducing downstream costs, improving patient outcomes, and building a record of measurable quality gains that strengthens the CIN's relationships with payers and community stakeholders alike.

Financial sustainability increasingly depends on demonstrated results. As VBC contracts tie reimbursement to quality benchmarks and cost efficiency, CINs that show

continuous improvement may be rewarded with shared savings, performance bonuses, and preferred contracting relationships. Conversely, CINs that lack the organizational capacity to improve performance risk leaving revenue unrealized. Performance improvement is therefore not merely a clinical imperative; it is a core business strategy that underpins the CIN's long-term viability and growth.

Financial Sustainability & Scale

Revenue Source Identification

Develop a diversified capitalization strategy, drawing on member dues, grants, and payer partnerships, to finance initial startup costs and ensure long-term liquidity without compromising clinical mission or organizational autonomy.

The formation of a rural CIN is a resource-intensive process that requires considerable time, expertise, and financial investment. Consequently, identifying sustainable revenue sources is a critical early step in bridging the gap between initial development and long-term operational stability. Initial funding may come from founding HCO capital contributions, member dues, grants, or venture capital. These resources are typically used to support the substantial costs associated with health IT infrastructure, data analytics platforms, and the administrative personnel required to manage CIN operations.

As the CIN develops, additional revenue sources should be explored. These may include federal grants and loans through the U.S. Department of Agriculture and network grants through the Health Resources and Services Administration. Given the emphasis many states place on maintaining and improving access to healthcare services in rural communities, CINs should also consider opportunities for direct state investment. Local, state, and regional foundations with a focus on rural health care may provide additional support. Thus, CIN leadership should consider engaging these organizations as potential funding sources.

As the CIN matures, potential revenue sources may expand to include payer investments, VBC payments, and private equity funding. Payer-supported funding may take the form of care coordination fees or infrastructure grants designed to support the transition to risk-based contracting. Importantly, a successful CIN can generate performance bonus revenue by meeting payer-specific quality and/or cost-control benchmarks established in value-based payment contracts.

Throughout CIN growth, CIN leaders should carefully weigh the advantages of external capital against potential disadvantages, such as a loss of autonomy or a shift in organizational priorities. Relying heavily on private equity, for example, may introduce performance timelines that conflict with a CIN's clinical mission or its commitment to physician-led governance. Strategic financial planning should focus on diversified capitalization that balances immediate liquidity needs with the preservation of the CIN's core values and strategic independence.

The CFO plays a central role in implementing this financial strategy. Responsibilities

include developing the CIN's capital structure, evaluating financing alternatives, monitoring financial performance, and ensuring that investment decisions support the organization's operational and strategic objectives. Through ongoing financial stewardship, the CFO helps position the CIN for long-term sustainability and growth.

Accounting and Financial Management

Implement an integrated financial management platform and designate a qualified CFO to provide strategic oversight of shared savings distributions, audit readiness, and long-term fiscal accountability.

To manage revenues, expenses, and budgets effectively, a CIN requires an integrated financial platform that streamlines accounting and financial operations. Implementing a centralized system is especially important for managing the complex flow of funds unique to CINs. These software-driven platforms should accurately track performance-based incentives and distribute performance bonus revenue with precision and transparency across multiple independent healthcare organizations.

Complementing this technology, a CFO provides the oversight and strategic leadership needed to ensure fiscal accountability, regulatory compliance, and long-term financial stability. Beyond daily operations, the combination of robust financial systems and CFO oversight ensures audit readiness and maintains transparency for all stakeholders. This dual approach – sophisticated software paired with executive expertise – enables the CIN to move beyond basic bookkeeping toward proactive financial management.

The CFO also plays a critical role in evaluating the financial viability of value-based contracts, assessing risk across payment models, and ensuring that the CIN maintains adequate capital reserves to support future growth. Establishing this level of fiscal rigor early on strengthens the CIN's credibility, enabling it to negotiate more favorable terms with payers and attract high-quality HCOs who value organizational stability. A strong financial foundation protects the CIN from market volatility and supports reinvestment in clinical quality and patient care initiatives.

Establishing a CIN requires a robust suite of business functions and administrative infrastructure. The CIN should secure comprehensive business insurance, including professional liability, cybersecurity, and Directors and Officers (D&O) policies, to protect its leadership and participating entities.

Marketing and Outreach

Develop and sustain a comprehensive marketing and outreach strategy that communicates CIN value across all key audiences including prospective members, patients, and payers, through both traditional outreach and a consistent digital presence.

A rural CIN's long-term sustainability depends not only on its clinical and operational performance, but also on its ability to communicate its value to key audiences including prospective members, patients, and payers. A deliberate marketing strategy is essential to building the CIN's reputation, growing its network, and securing the contracts that make VBC viable in a rural setting.

Attracting new members requires the CIN to clearly articulate its value proposition to rural independent hospitals, physician practices, and other healthcare organizations considering affiliation. Marketing efforts directed at prospective members should emphasize the CIN's shared services, collective contracting power, and operational support – benefits that are particularly compelling to rural organizations operating with limited administrative infrastructure. Targeted outreach by current members to regional healthcare associations, state hospital associations, and local health system leaders can help the CIN identify and recruit aligned partners.

For patients, the CIN's marketing mission is one of awareness and trust. Rural communities often have deeply rooted relationships with local providers, and the CIN should position itself as an extension of that trusted care, not a distant corporate entity. Community outreach efforts should communicate the CIN's commitment to local, coordinated, high-quality care. Health fairs, community events, and partnerships with local organizations can reinforce the CIN's presence and accessibility. Unified branding across member organizations helps patients recognize and navigate the network with confidence.

Marketing to payers requires a data-driven approach. The CIN should be prepared to present compelling evidence of its clinical performance, cost efficiency, and population health capabilities. Quality metrics, outcomes data, and demonstrated experience managing risk all serve as marketing tools in payer negotiations. Establishing the CIN as a credible and capable partner positions it to secure favorable value-based contracts and preferred network status with both commercial payers and Medicaid managed care organizations.

A strong digital presence is increasingly essential for CINs, even in rural communities where broadband access remains uneven. A professional website and active social media channels, including Facebook, LinkedIn, and Instagram, allow the CIN to reach

patients, prospective members, and community stakeholders efficiently and cost-effectively. A consistent and authentic digital voice reinforces the CIN's brand identity and keeps all audiences informed of network updates, quality achievements, and community initiatives.

Payer Relationships

Develop a payer relations strategy that leverages aggregated performance data and single-signature authority to move beyond transactional FFS negotiations toward collaborative, long-term VBC contracting partnerships.

A rural CIN's strategic approach to payer negotiations hinges on transitioning from a price-taker in a FFS environment to a value partner in a risk-based economy. Administrative leadership should leverage the CIN's single-signature authority, which allows the CIN to negotiate on behalf of its independent members as a single entity. This collective bargaining power is legally defensible only if the CIN can prove it is a truly clinically integrated system rather than a loose affiliation. Consequently, the primary administrative strategy is to use aggregated data to demonstrate that the CIN's coordinated care models effectively improve clinical quality and lower the total cost of care. By presenting a unified front, backed by validated performance metrics, administrative leaders may secure higher base rates and more favorable incentive structures than any single rural provider could achieve on its own.

When approaching commercial payers, the initial goal may be to secure care management fees (typically on a per-member-per-month basis) to provide the upfront capital needed to fund the CIN's infrastructure, such as the population health platform and care coordination staff. The CIN should then pursue long-term strategic partnerships with payers that are aligned to improve clinical quality and reduce total cost of care. Shared savings generated through these partnerships benefit both parties – helping payers manage premium growth while providing the CIN with resources to fund future VBC initiatives and strengthen the financial stability of its rural member organizations.

VBC Contracting

The CIN should develop a payer relations strategy that leverages aggregated performance data and single-signature authority to move beyond transactional FFS negotiations toward collaborative, long-term VBC contracting partnerships.

Successfully operating a rural CIN requires a strategic departure from urban-centric VBC models, which often overlook the leaner administrative structures and narrower margins inherent in rural health care. To maintain financial viability, CINs should initially prioritize a “risk-aversion first” strategy, favoring upside-only contracts that shield member HCOs from downside volatility. The CFO leads financial underwriting for VBC contracts, performing simulations to ensure the CIN can withstand fluctuations in patient volume and high-cost clinical outliers. This CFO oversight ensures that the CIN enters into agreements only when the clinical targets are financially achievable within the constraints of a rural budget. Initial agreements should focus on predictable, non-visit-based revenue, such as pay-for-performance (P4P) bonuses or per-member-per-month (PMPM) care management fees, to provide the essential capital needed for care coordination and data analytics. As the CIN matures, it may transition to shared-savings models, in which the CIN receives a portion of the savings generated by meeting quality benchmarks and controlling total cost of care.

The clinical efficacy of a rural CIN depends on a rural-relevant performance framework that minimizes administrative burden. Rather than adopting an exhaustive metric list, CINs should strive to limit the number of quality measures per contract, ensuring each is clinically important, rural-relevant, evidence-based, and highly feasible to yield consistently accurate data. Measures should account for geographic realities. Performance should be measured by proactive access to primary care rather than reactive indicators such as emergency department utilization, which often reflect lack of local after-hours care options rather than poor clinical management. By using risk-adjusted thresholds and simple measurement criteria, the CIN can align payer expectations with the rural workforce’s actual capabilities and constraints.

Operational sustainability is further predicated on the seamless integration of population health data. VBC contracts with payers should mandate automated, electronic data exchange to facilitate real-time performance tracking without overwhelming staff with manual reporting or antiquated claims processing. Negotiations should explicitly target reducing administrative burdens, such as complex prior authorizations, credentialing, and mid-contract policy shifts, which disproportionately affect resource-constrained organizations. By codifying these protections, rural CINs ensure that leadership remains focused on improving patient and community health outcomes rather than navigating the complex requirements of traditional payer bureaucracy.

Fee Schedule Negotiation

Pursue a dual-track payer strategy that simultaneously optimizes traditional FFS base rates through collective negotiation while building the infrastructure and performance data needed to transition to VBC contracts.

A rural CIN's payer strategy should be a dual-track approach. While the long-term goal is to thrive under VBC, the short-term survival of rural HCOs often depends on optimizing the traditional FFS payment schedule. By negotiating both simultaneously, a CIN ensures that it is rewarded for its current volume while being incentivized for its future outcomes.

In a traditional healthcare environment, small rural hospitals and practices are often price-takers, forced to accept whatever rates a dominant payer offers. However, by obtaining legal CIN status, these independent entities can engage in collective fee-schedule negotiation.

Administrative leaders may leverage the CIN's geographic necessity as a primary negotiation tool. Many payers are required to maintain network adequacy, meaning they should have a certain number of providers within a specific radius of their insured members. In many rural areas, CIN members are the only healthcare providers available. By presenting a unified front, the CIN can secure market-competitive base rates that reflect the higher cost of delivering care in isolated areas, ensuring that foundational FFS revenue remains high enough to cover the CIN's operational overhead.

By balancing sophisticated VBC incentives with a strong, negotiated FFS baseline, the CIN creates a resilient financial model that helps protect its members from the volatility of either reimbursement system alone.

Procure aggregate and specific reinsurance and maintain adequate capital reserves to buffer against the financial volatility inherent in risk-based contracts.

Mitigating Volatility

To further manage the inherent financial volatility of VBC and payment, the CIN should

implement catastrophic loss protection, specifically by procuring aggregate and specific reinsurance.¹³ These stop-loss mechanisms are essential to shield rural HCO members from the devastating financial impact of high-cost clinical outliers. The CFO is responsible for procuring and managing stop-loss and reinsurance policies, serving as the final safeguard against insolvency. By maintaining a risk-adjusted perspective on the balance sheet, the CFO ensures that the CIN remains solvent even during years of high clinical utilization or shifting payer attribution. This protection is further reinforced by ensuring actuarial soundness through strict population minimums. By maintaining a sufficient volume of “covered lives,” the CIN achieves the statistical stability necessary to prevent natural variations in patient health from causing disproportionate financial swings.

Operational accuracy in this model relies heavily on transparency in payer attribution, requiring the CIN to maintain a detailed registry of how each commercial and government payer assigns patients – whether via historical claims, primary care selection, or geographic algorithms. Finally, to navigate the complexities of the Stark Law and the Anti-Kickback Statute, the CIN should subject all incentive distributions and shared savings payments to independent Fair Market Value (FMV) compliance audits. These third-party reviews confirm that all payments are based on performance rather than the volume or value of referrals, thereby preserving the CIN’s legal and financial integrity.

Shared Services and Group Purchasing

Build internal capacity to identify share service opportunities and leverage collective volume to negotiate superior pricing through a group purchasing organization (GPO).

A foundational value of a rural CIN is its ability to aggregate the purchasing power and operational needs of its members, effectively creating economies of scale that would be unattainable for an independent rural hospital or clinic. Shared services within a CIN encompass a broad range of essential but expensive services that are more cost-effective when maintained collectively. Shared services may include CIN leadership and operational staff, financial management, accreditation, policy development, and compliance oversight. This centralized approach not only ensures a higher standard of operational excellence but also provides a buffer against the high costs of specialized talent, which may be difficult to recruit in rural markets. By spreading the cost of high-

¹³ Reinsurance, also known as stop-loss insurance, protects CINs from catastrophic financial exposure by covering claims that exceed a predetermined threshold. It is a critical risk management tool for organizations assuming financial responsibility for a defined patient population under VBC arrangements.

level administrators, technical experts, and services across the entire CIN, each member gains access to a system-level experience at a fraction of the market rate.

Complementing shared services is the GPO strategy, which leverages the collective volume of the CIN to negotiate discounts on medical supplies, pharmaceuticals, capital equipment, and more. By aggregating the purchasing volume of multiple HCOs, a rural CIN can command pricing tiers usually reserved for large urban health systems. This leverage extends beyond physical goods to include service contracts, such as insurance, accounting, recruitment and retention, and laboratory. For a rural facility operating on thin margins, the immediate reduction in supply chain costs can provide the financial liquidity necessary to reinvest in new clinical technologies or infrastructure.

Shared services and group purchasing lower costs, enabling independent CIN members to remain viable in an increasingly consolidated market. This collective strength allows rural HCOs to enjoy the benefits of a large corporate system, such as advanced analytics and discounted supplies, without sacrificing local identity or community-focused mission. It transforms the CIN from a mere clinical partnership into a robust economic alliance that protects the region's financial health.

Conclusion

The formation of a rural CIN is a complex undertaking – one that demands alignment across governance, clinical operations, data infrastructure, financial management, and culture, each responsive to the unique characteristics and needs of the rural environment. Yet for rural healthcare organizations facing the dual pressures of declining reimbursement and rising patient complexity, the CIN model offers a compelling path forward. By building shared administrative infrastructure, adopting value-based care contracts, and cultivating a culture of interdependence, rural HCOs can achieve together what few could accomplish alone; that is, preserving local access to care while competing on quality in an increasingly performance-driven healthcare economy. The information, decision points, and action steps outlined in this guide provide a framework for a rural CIN journey, recognizing that success will require not only technical and financial rigor, but the sustained commitment of clinical and administrative leaders who share a common vision for the health of their rural communities.