Rural
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Rural Value-Based Care and Payment: From Payment Fundamentals to Rural Design

October 20-21, 2026

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Rural Health Value (RHV)

- A collaboration between the RUPRI Center and Stratis Health, funded by the Federal Office of Rural Health Policy
- To facilitate rural health care and community transitions from *volume-based* to *value-based* health care and payment.
- Learn more at ruralhealthvalue.org

Rural Health Value charge:

- Develop tools and resources
- Interpret health policy
- Disseminate best practices
- Provide technical assistance
- Share rural experiences

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Learning Objectives

1. Explain why rural payment systems differ from urban payment systems.
2. Describe the major Medicare rural payment mechanisms.
3. Distinguish fee-for-service from value-based payment.
4. Explain the relationship between payment design and the Triple Aim.
5. Recognize the major value-based care and payment (VBC/P) models and their rural applicability.
6. Recognize factors that influence whether a rural VBC/P approach is likely to succeed.



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Day 1

Rural Healthcare Payment: Why We Get Paid the Way We Do

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Review – Medicare and Medicaid

Medicare

- Started in 1965 as federal health insurance for **people 65 and older**; expanded in 1972 to include people with disabilities and ESRD
- Four Medicare "Parts"
  - *Part A*: Hospital, skilled nursing, hospice, and some home health
  - *Part B*: Physician/provider, other outpatient services
  - *Part C*: Medicare Advantage
  - *Part D*: Prescription drug coverage
- Federal program, primarily federally funded
  - *Part A*: Hospital Insurance Trust Fund, primarily funded by payroll taxes
  - *Parts B and D*: Supplementary Medical Insurance Trust Fund, primarily funded by federal general revenues and beneficiary premiums

Medicaid

- Also started in 1965, a joint federal–state health coverage program primarily serving **low-income Americans** and other eligible populations
- Broader range of covered services than Medicare, including long-term nursing facility care
- Dual eligibles: enrolled in both Medicare and Medicaid
- Federal and state funding
  - Proportion varies by state
  - Overall, approximately 65% federal and 35% state

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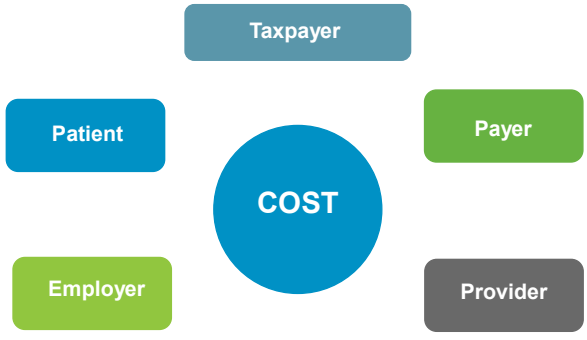
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A Question for You

When we say that "healthcare costs are too high," whose costs are we talking about?

(Recall that one person's cost is another person's profit.)



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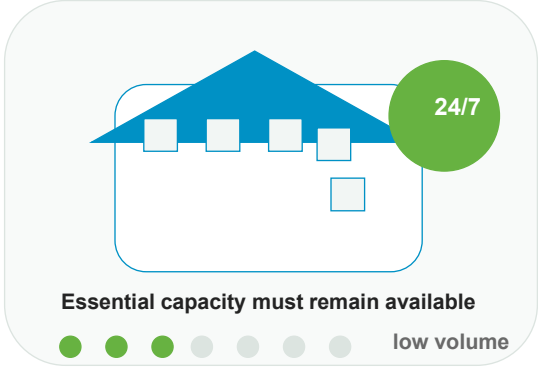
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Setting the Rural Stage

Traditional payment systems do not always generate sufficient revenue to sustain essential rural healthcare services.

- Significant fixed/standby costs
- Limited patient and service volumes
- Essential services must remain available despite low utilization



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Why Rural is Different

Population	**Place**
Organization	**Market**

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Why Rural is Different – **Population** (1/4)

- Older
- Sicker
- Poorer
- Seasonal / Transient



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Why Rural is Different – **Place** (2/4)

- Distance
- Geography
- Weather
- Transportation



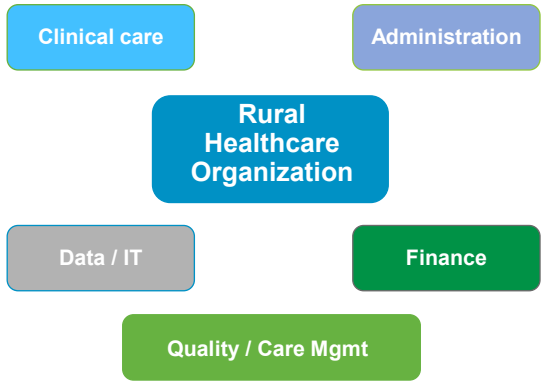
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Why Rural is Different – Organization (3/4)

- Workforce
- Resources
- Expertise
- Scale
- Risk Aversion

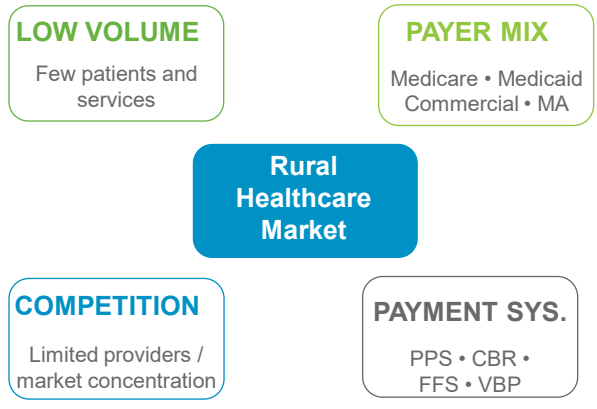


Fewer people • Fewer resources • Broader roles

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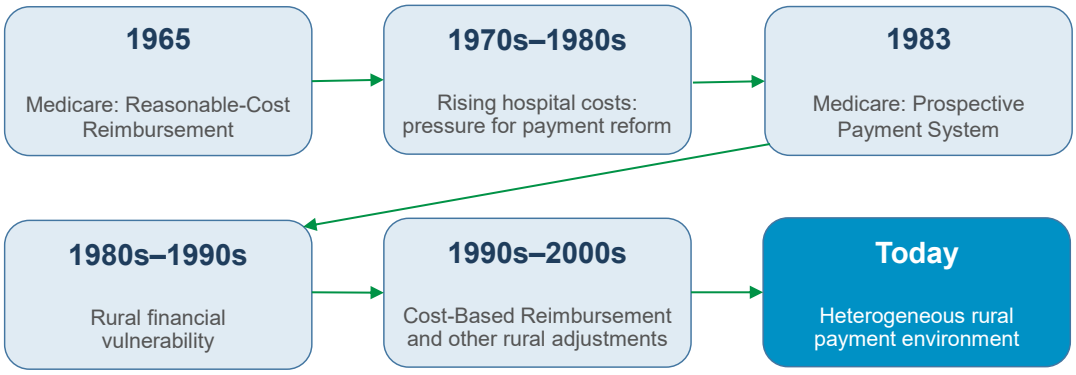
Why Rural is Different – Market (4/4)

- Low Volume
- Payer Mix
- Competition
- Multiple Payment Systems



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Very Short History of Rural Medicare Payment



The story is how Medicare payment policy adapted to different rural circumstances.

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Prospective Payment Exposed a Rural Challenge



The Prospective Payment System was designed to encourage efficiency; rural circumstances made that objective difficult to achieve.

Rural hospitals must keep essential services available, even when few patients need them.

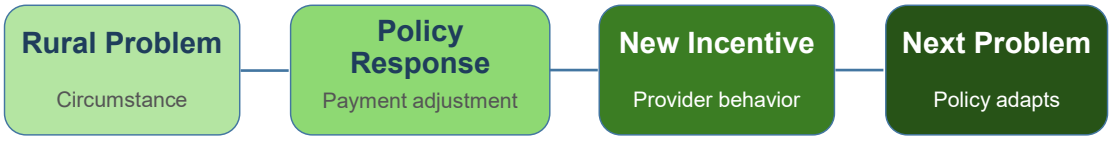
The cost of maintaining those services remains, regardless of how many patients use them.

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The Historical Pattern

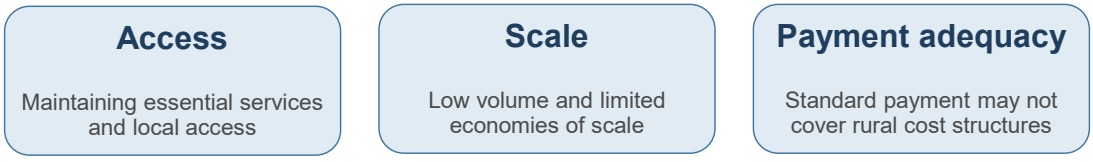


Rural payment policy has evolved through a series of targeted responses rather than a single, integrated rural payment strategy.

Those incremental responses produced the collection of special rural payment arrangements we have today.

Addressing Rural Payment Challenges

Rather than one rural payment system, Medicare uses multiple approaches to address different **rural circumstances**.



The policy question is not simply “What designation is this?” but “What rural problem was the policy designed to address?”

Rural Hospital Payments: Problem → Policy Response

Designation / Approach	Rural Circumstance	Payment Response	Current Status
Critical Access Hospital	Low volume; access to essential services	Cost-based reimbursement (101% of allowable costs for covered services)	Separate Medicare provider type
Sole Community Hospital	Sole or essential hospital in the area	Higher of federal IPPS rate or hospital-specific rate for payments	IPPS hospital designation
Rural Referral Center	High-volume rural referral hospital	Special IPPS classification / payment treatment	IPPS hospital designation
Low Volume Hospital	Low inpatient volume and geographic isolation	IPPS low-volume payment adjustment	Criteria and adjustment change over time
Rural Emergency Hospital	Access to emergency services required	Enhanced fee-for-service payment and grant	New hospital designation disallowing inpatient care
Rural Community Hospital	Small rural hospitals too large for CAH	Cost-based reimbursement under demonstration	Demonstration; limited number of participants

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See: https://www.medpac.gov/document-type/payment-basic/

Outpatient Rural Payment Approaches

Rural Health Clinics (RHCs)

All-Inclusive Rate (AIR) which may be cost-based for covered encounters; additional payment policies apply to some services.

Federally Qualified Health Centers (FQHCs)

Prospective Payment System (PPS), with specific payment adjustments and additional services paid under defined rules.

Private Practices in Health Professional Shortage Areas

10% quarterly bonus to certain health care providers who furnish services in HPSAs.

(The list here and on the previous slide are intentionally not exhaustive; the purpose is to illustrate the patchwork of rural payment approaches.)

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Determining Medicare Payment Amounts

Prospective Payment System (PPS)	Cost-Based Reimbursement (CBR)
• Larger hospitals • Federally Qualified Health Centers	• Critical Access Hospitals • Rural Health Clinics
• Prospective payment • Payment ≠ actual cost	• Retrospective payment • Payment ≈ allowable cost

Low volume challenges both approaches, but low volume is especially consequential in rural health care.

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Basic Economics of Healthcare Payment

Price x Volume = Revenue

Revenue – Costs = Margin

Payment Approach	Changes to Price	How Revenue Responds
Prospective Payment System	Price is established prospectively.	Revenue increases with increasing volume.
Cost-Based Reimbursement	Payment reflects allowable costs.	Payment generally follows allowable costs.

Ultimately, we're interested in a positive margin.

To realize a positive margin, revenue must be greater than cost.

All organizations require a positive margin to remain viable.

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Not All Costs Change With Volume

Costs that rise and fall with activity

Variable Costs

- Food, laundry, and supplies
- Medications
- Some contracted services
- Other costs directly associated with providing care

Costs of being ready to provide care

Fixed/Standby Costs

- Building and equipment
- Core staffing
- Emergency/clinical capacity
- IT, administration, infrastructure, and other essential capabilities

Low volume creates a rural financial challenge.

Low volume → less revenue while substantial standby costs remain.

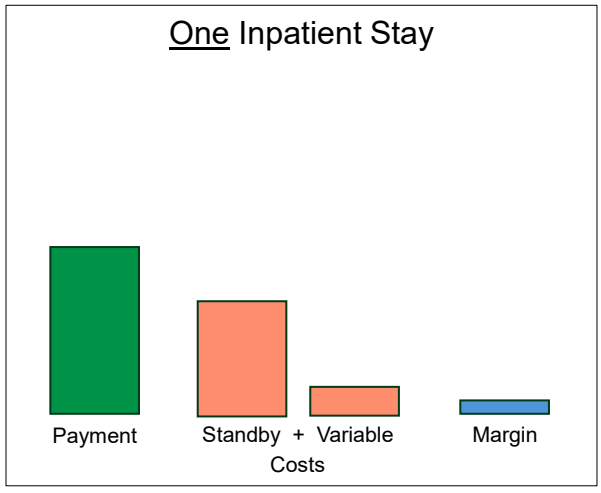
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Prospective Payment System – One Inpatient Stay

- A Prospective Payment System (PPS) Hospital receives a single preset Medicare payment (determined by the primary inpatient diagnosis) per inpatient stay.
- Length-of-stay and costs-of-care do not change the payment (revenue).
- Revenue – Costs = Margin



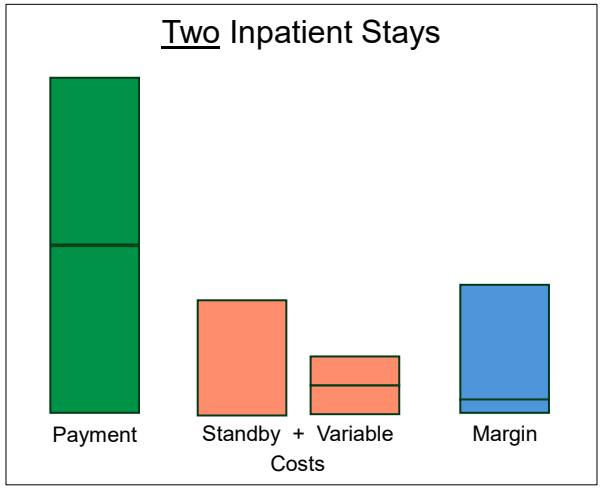
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Prospective Payment System – Two Inpatient Stays

- A Prospective Payment System (PPS) Hospital receives a single preset Medicare payment (determined by the primary inpatient diagnosis) per inpatient stay.
- Length-of-stay or costs-of-care do not change payment (revenue).
- Revenue – Costs = Margin
- How does a PPS hospital increase its inpatient margin?
  - (Hint: Recall the basic economics of healthcare payment.)



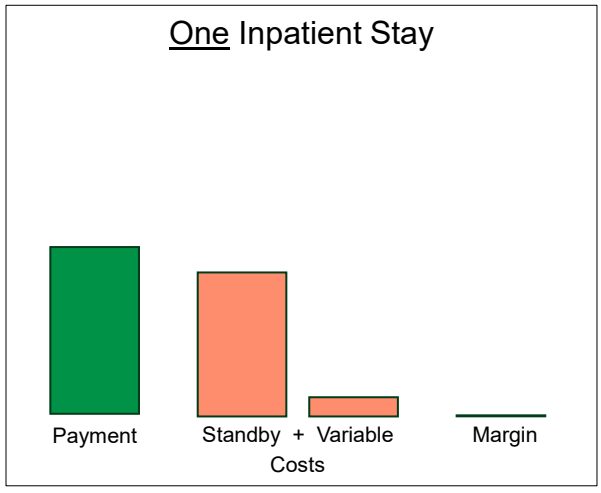
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Cost-Based Reimbursement – One Inpatient Stay

- A Critical Access Hospital (CAH) receives Medicare payment based on *allowable* costs (standby + variable) for an average inpatient stay.
- Payment (revenue) increases as costs increase.
- Revenue – Costs = Margin



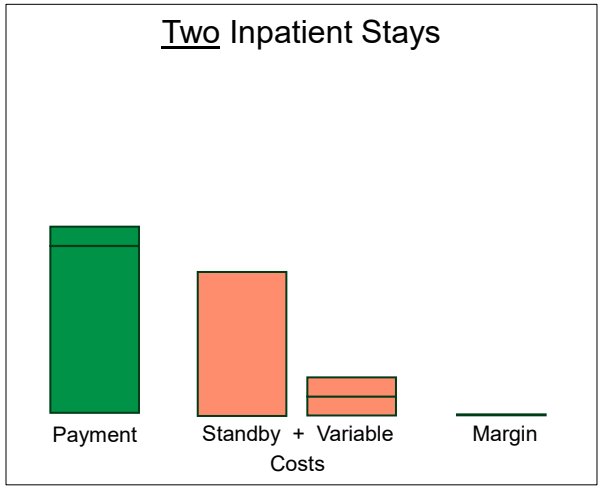
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Cost-Based Reimbursement – Two Inpatient Stays

- A Critical Access Hospital (CAH) receives Medicare payment based on *allowable* costs (standby + variable) for an average inpatient stay.
- Payment (revenue) increases as costs increase.
- Revenue – Costs = Margin
- How does a Critical Access Hospital increase its inpatient margin?
  - (Hint: Commercial insurance contracts *should* contribute to the margin.)



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Medicare Advantage

- Medicare Advantage (MA) is an increasingly important part of the rural payment environment.
- Payment to rural healthcare organizations is determined by the MA plan – not necessarily Original Medicare rates.
- Contracting, network, authorization, and payment terms matter.

Medicare beneficiary choice
↓
MA plan receives risk-adjusted payment from CMS
↓
Rural healthcare organization negotiates/receives payment from the MA plan

For rural healthcare organizations, "Medicare payment" increasingly means more than just Original Medicare.

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What Do We Expect of the Healthcare System?

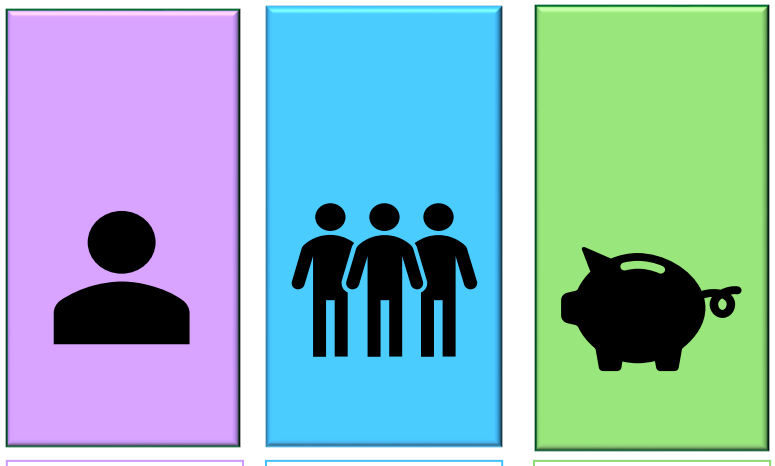


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Triple Aim



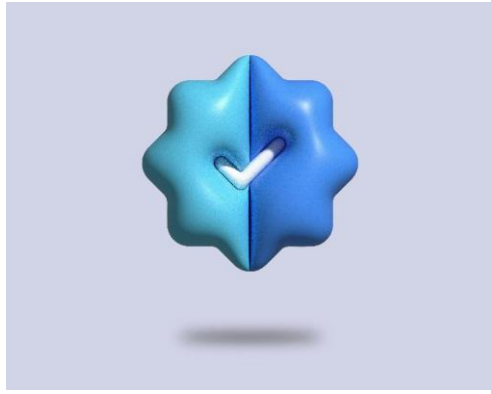
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Value-Based *Care* (VBC)

- The Triple Aim defines what we want the healthcare system to accomplish.
- VBC delivers the outcomes we desire relative to the resources we use.
- VBC is proactive, comprehensive, coordinated, person-centered, and outcomes-focused.
- "Value" depends on perspective.
  - Patient, provider, taxpayer, employer, or insurer



Value = Outcomes ÷ Resources

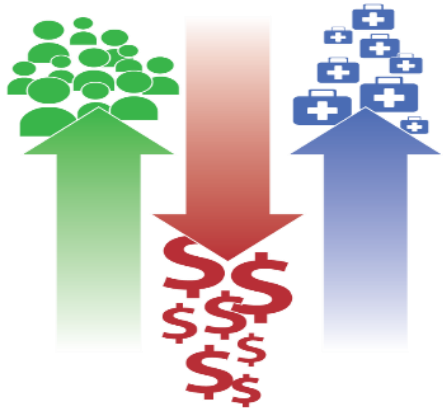
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Value-Based *Payment* (VBP)

- VBP financially rewards desired outcomes – not simply the delivery of services.
  - Better care
  - Improved health
  - Smarter spending
- Fee-for-service pays for units of service (volume) while VBP adds incentives for outcomes.
- VBP generally does not eliminate fee-for-service but is often layered on top.



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Payment Design Shapes How Care Is Delivered

- How we deliver care depends, in great part, on how we are paid for care.
- "Form follows finance."
- If we desire Triple Aim outcomes, we must pay for Triple Aim outcomes.
- VBP helps move the needle from Volume → **Value**.
- Thus, care delivery and payment are linked – value-based care and payment (**VBC/P**).



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Operating in Two Payment Systems

- FFS and VBP operate simultaneously.
- The incentives often conflict.
  - FFS → volume
  - VBP → value
- VBP requires investment in new capabilities.
  - e.g., data aggregation and analysis, care management, quality improvement
- Grants can help bridge the transition.
- Grant objectives should align with the predominant payment environment, or counterbalance negative financial impacts.



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Key Take-Home Points



- **Rural is different.** Population, place, organization, and market matter.
- **Rural payment policies are responses to rural circumstances.** They solve some problems but may create new unintended consequences.
- **Payment design shapes provider behavior.** Good design aligns incentives with the Triple Aim. Poor design does not.

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Day 2

Rural Value-Based Care and Payment: Designing for Value

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Review: Rural Healthcare Payment Policy Basics

- Payment policy responds to unique rural circumstances and market forces, often resulting in unintended consequences.
- Fundamental rural market forces include inadequate patient and service volumes in a fee-for-service payment environment.
- Every payment system creates incentives. Good payment design aligns incentives with the Triple Aim.



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A Question

What are the unintended consequences of Cost-Based Reimbursement relative to value-based care and payment?

(Recall that rural healthcare organizations are risk-averse.)

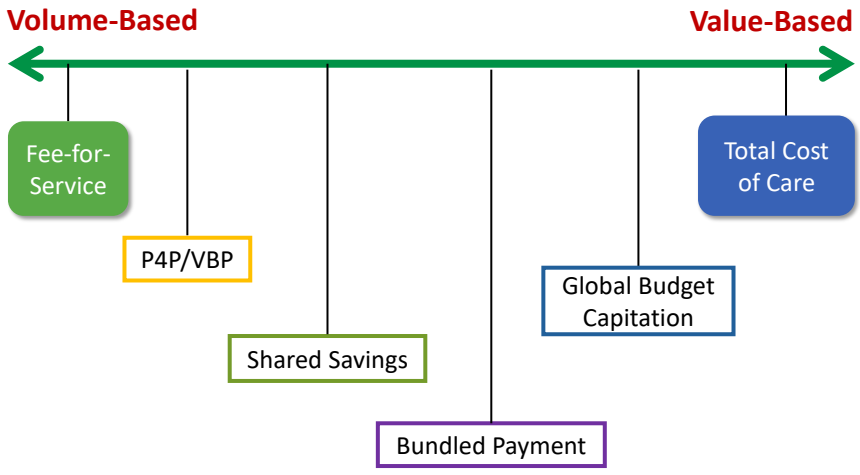


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The Evolution of Value-Based Payment



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Alternative Payment Model (APM) Framework

- **Health Care Payment Learning and Action Network** developed the Framework to accelerate the transition from FFS to VBP models.
- Framework aligns public and private payers, providers, and purchasers around the Triple Aim.
- On average, where on the Framework are rural healthcare organizations now?

HCPLAN. https://hcp-lan.org/apm-framework/

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	FEE FOR SERVICE – LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION – BASED PAYMENT
	A **Foundational Payments for Infrastructure & Operations** (e.g., care coordination fees and payments for HIT investments)	A **APMs with Shared Savings** (e.g., shared savings with upside risk only)	A **Condition-Specific Population-Based Payment** (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B **Pay for Reporting** (e.g., bonuses for reporting data or penalties for not reporting data)	B **APMs with Shared Savings and Downside Risk** (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B **Comprehensive Population-Based Payment** (e.g., global budgets or full/percent of premium payments)
	C **Pay-for-Performance** (e.g., bonuses for quality performance)		C **Integrated Finance & Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)

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Current VBC/P Model Examples

Accountable Care

- Medicare Shared Savings Program (MSSP)
- ACO REACH – concludes December 2026
- LEAD – launches January 2027

Hospital Programs

- Hospital Value-Based Purchasing
- Readmissions Reduction
- Hospital-Acquired Conditions Reduction

Clinical Payments

- Merit-based Incentive Payment System (MIPS) remains in 2026.
- CMS proposed moving traditional MIPS to MIPS Value Pathways (MVPs) after 2028.

State Innovation

- AHEAD – Five participating states; opportunity for up to two additional states
- Medicaid VBC/P programs such as ACOs and managed care organization plans

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Accountable Care Organizations (ACOs)

- ACOs are groups of healthcare providers that are jointly accountable for the quality and cost of care for a defined population.
- ACOs may participate in Medicare, Medicaid, and commercial payment arrangements.
- Financial rewards (and, in some models, financial losses) are tied to performance.
- In shared-savings arrangements, the payer *shares* a portion of savings when the ACO meets quality and cost targets.

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Medicare Shared Savings Program (MSSP)

- Medicare establishes a benchmark for expected spending for an ACO's **attributed population**.
- The benchmark accounts for historic spending and patient characteristics, including health status.
- **Hierarchical Condition Categories (HCCs**) help quantify differences in patient health status.
- Actual Medicare spending is compared with the **risk-adjusted benchmark** to determine savings or losses.

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Why HCCs Matter

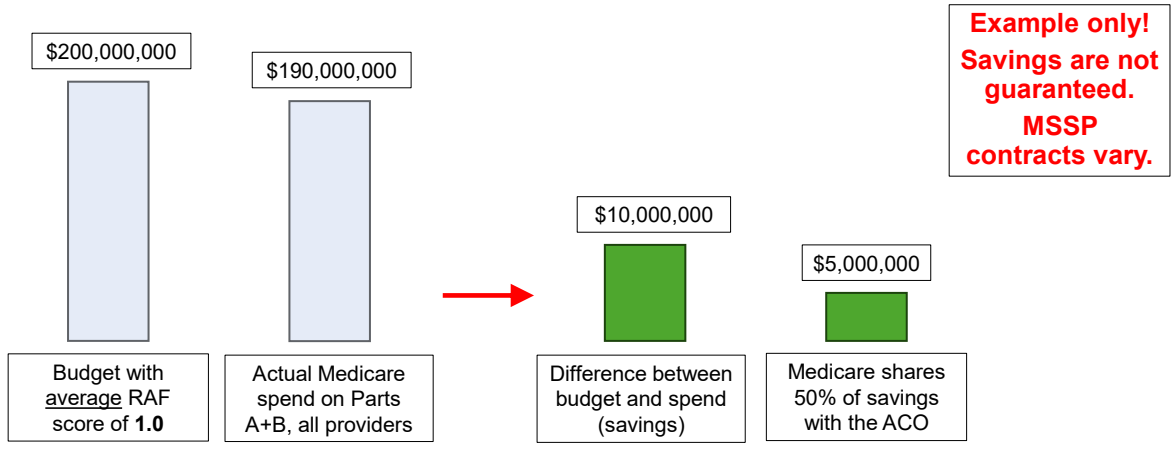
- HCCs are one component of the risk-adjustment methodology.
- The Risk-Adjustment Factor (RAF) reflects predicted healthcare spending based partly on documented health status; a lower score generally indicates lower predicted spending.
- Incomplete documentation can underestimate a population's illness burden, and therefore its predicted spending.
- Accurate documentation → accurate risk assessment → appropriate spending benchmark

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MSSP Risk-Adjustment Factor Score = **1.0** (Average)

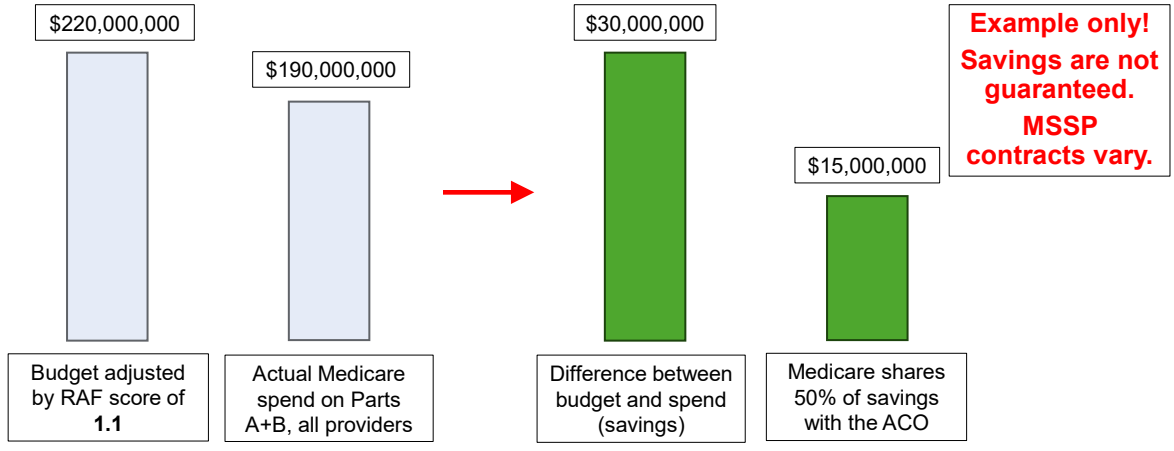


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MSSP Risk-Adjustment Factor Score = **1.1**

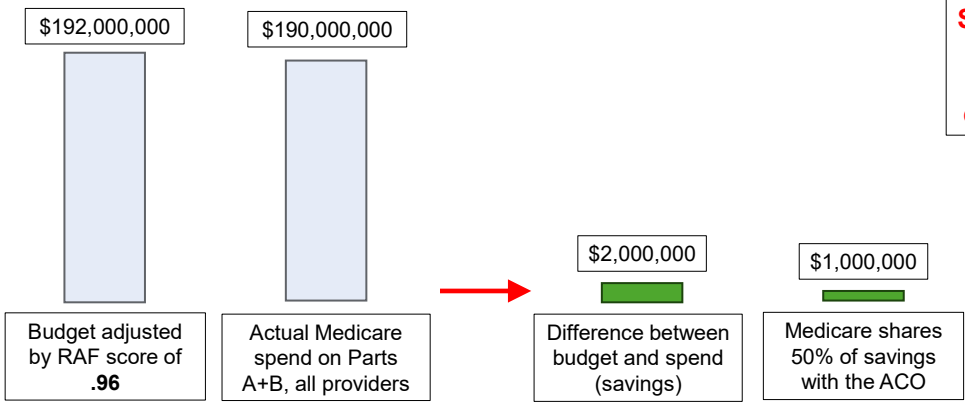


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MSSP Risk-Adjustment Factor Score = **.96**



Example only!
Savings are not guaranteed.
MSSP contracts vary.

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HCC Risk Adjustment May Not Accurately Reflect Rural Risk

- Rural beneficiaries have:
  - Higher mortality
  - Greater chronic disease burden
  - Significant access barriers
  - Yet, lower average HCC risk scores
- Therefore, lower HCC scores do not necessarily mean lower clinical risk.
- Why might that be true?
- What does this mean for rural VBC/P participation?

Location	Mean HCC risk score
Urban	1.11
Rural micropolitan	1.09
Rural adjacent	1.08
Rural nonadjacent	1.04
Frontier	0.97

MedPAC. Medicare and the Health Care Delivery System. June 2021.

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Risk Adjustment Is Important. Quality Is the Goal.

- Accurate risk adjustment ensures a fair spending benchmark.
- Quality performance ensures savings aren't achieved at the expense of care.
- The objective remains the Triple Aim
  - Better Care
  - Improved Health
  - Smarter Spending



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Rural VBC/P: Barriers and Opportunities

Barriers	Opportunities

• Scale and infrastructure
  • Small populations, limited analytic/data capacity
• Operational complexity
  • FFS and VBP operating simultaneously
  • Multiple contracts, measures, reporting requirements
• Financial transition risk
  • Up-front investment, delayed returns, downside risk
	• Align payment with mission
	  • Reward better care, health, and value
	• Build rural capability
	  • Data, care coordination, quality improvement
	• Create resources for reinvestment
	  • Potential shared savings and other VBP payments
	• Prepare for the future

Rural Health Network Development Planning Program addresses the scale problem through network development.

RHPTP provides technical assistance to small rural hospitals and RHCs to prepare for and succeed in value-based care models

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Rural-Sensitive VBP Contracts

- **Is it clinically meaningful?**
  - Rural clinician input
  - Measures relevant to rural health care
  - Providers can directly influence performance
- **Is it statistically fair?**
  - Sufficient volume to reduce statistical noise
  - Appropriate comparison group
  - Both achievement and improvement can demonstrate success
- **Is it operationally feasible?**
  - Minimal data collection and reporting burden
  - Transparent, auditable performance data
  - Measures that are understandable and consistently defined
- **Is the financial risk appropriate?**
  - Clear, feasible path to reward
  - Risk matched to rural organizational capacity
  - Incentive large enough to justify investment

A rural-sensitive contract recognizes that small volume, limited capacity, and relatively high fixed/standby costs change the economics of VBP.

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The Rural VBP Financial Test

- Can the organization afford to participate?
  - Up-front investment in people, data, care management, etc.
- Can the organization realistically earn the incentive?
  - A clear and feasible path to reward.
- Is the reward worth the investment?
  - The potential incentive should exceed the cost of the activities required to achieve it.
- What happens when utilization (volume) falls?
  - Savings from reducing utilization may be accompanied by fixed/standby costs that do not disappear.



Reducing utilization is not necessarily financially beneficial to a rural organization.

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Key Take-Home Points – Day 2



- **VBC/P is a continuum.** FFS will remain part of the payment system indefinitely.
- **Rural participation is different.** Scale, workforce, data, and financial risk matter.
- **Rural economics matter.** Low volume and standby costs change the VBP equation.
- **Payment shapes behavior.** Good VBP aligns incentives with the Triple Aim.
- **Rural providers need support.** FORHP can help build capacity and reduce barriers.

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Thank You!

You do important work.

From rural healthcare organizations, rural communities, and nearly 70 million rural Americans – thank you.



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