Kansas Rural Health Transformation Plan Update

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Kansas' Rural Health Transformation Plan is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $221.89 million in Budget Period 1 with 100 percent funded by CMS/HHS.

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Kansas Rural Health Transformation Plan

Overview

- Developed as part of State's application to federal Rural Health Transformation Program
- Meets RHT Program requirements by addressing CMS-specified priorities
  - Make rural America healthy again
  - Sustainable access
  - Workforce development
  - Innovative care
  - Tech Innovation
- To be implemented over 5 years; cannot make significant changes
- Year 1 funding = **$221.89 million**
  - 6th largest award
  - ***Year 2 funding contingent on Year 1 performance***

Governance and Operations

- Governor's Office
- KDHE and KDADS
- Kansas Rural Health Innovation Alliance
- State Legislature (HB 2555)
- UKHS Care Collaborative

Year 1 Schedule

Milestone	Date
CMS Budget Approval + Funds Release	02/17/2026
Deadline to submit Y1 Progress Report + Y2 Budget Request	8/30/2026
End of Y1, Y2 Budget Approval	10/30/2026
Deadline to Expend Y1 Funds	9/30/2027

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5 Initiatives, 24 Programs

Initiative	Program
Expand Primary and Secondary Prevention Programs	1.1 Accountable Food is Medicine + CHW Deployment Program
	1.2 Consumer-Facing Technologies Program
	1.3 Behavioral Health Services Program
	1.4 Integrated Care for Dual Eligible Beneficiaries Program
	1.5 Mobile Cancer Screenings Program
	1.6 Tribal Health Program
Secure Local Access to Primary Care	2.1 Regional Partnerships Grant Program
	2.2 REH Conversion / Transformative Capital Investment Grant Program
	2.3 Revenue Improvement Program
	2.4 Anchor Hospital Advancement Program
	2.5 Mobile Integrated Health Pilot Program
	2.6 Rural Primary Care – Public Health Integration Program
Build a Sustainable Rural Health Workforce	3.1 Physician Pipeline Program
	3.2 Education and Training Program
	3.3 Recruitment and Retention Program
	3.4 Career Exploration Program
Enable Value-Based Care	4.1 Evidence-Based Practice Incentive Program
	4.2 ACO Readiness Program
	4.3 Transportation Program
	4.4 Medicaid Provider Incentive Payment Program
Harness Data and Technology	5.1 Remote Patient Monitoring Program
	5.2 Telehealth Navigator Program
	5.3 Data Infrastructure Program
	5.4 Emerging Technology Program

1. Our current "sick care" system must be transformed into one that enables every rural Kansan to live their healthiest life possible.
2. All rural Kansans should have access to a well-coordinated continuum of care, including local primary care and social services and seamless transitions to regional specialty care.
3. Rural Kansas providers should leverage technology, from telehealth and remote monitoring to data analytics and mobile health solutions, to bridge geographic gaps, enhance care delivery, and empower patients.
4. Kansas should invest Program funds wisely by implementing proven solutions in as efficient a manner as possible to maximize the benefit to rural communities across the state.

1. Grant Programs

5 Grant Programs Distributing $78.8M in Year 1

Program	Details
Regional Partnerships	$44M; State anticipates 5-10 awards of $2M - $10M Applications due April 3; awards announced in mid-May
REH Conversion/Transformative Capital Investments	$15M; State anticipates 15 awards of up to $3M Applications due March 20; awards announced in mid-April
Health Professions Training	$3M to expand or launch allied health training programs RFA to be released later this spring
Non-Emergency Transport	$6M for rural communities to build capacity RFA to be released later this spring
Emerging Technology	$10.8M to expand IT capabilities; RFA later this spring $12M for ambient listening AI acquisition Emerging Technology Committee

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2. Evidence-Based Practice Program

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EBP Program Distributing $33M in Year 1

Infrastructure payments ($22 million)

- Commit to workplan to implement and maintain evidence-based practices
- Funds to offset related expenses
  - ✓ $100K for rural hospitals
  - ✓ $50K for RHCs, rural FQHCs, rural CCBHCs, rural provider-based and independent full-time primary care clinics
- Streamlined documentation requirements

Incentive payments ($11 million)

- Report data on specified performance measures thru QHi
  - ✓ May, June, July performance reported by end of September
- $50K for rural hospitals, $25K for rural clinics

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Commitment to Evidence-Based Practices

- Investments in infrastructure needed to implement and maintain evidence-based practices
  - Formally adopt written protocols tailored to provider's needs and circumstances
  - Adapt workflows to incorporate best practices
  - Provide training to all relevant staff
  - Track performance and engage in continuous quality improvement
  - Collect and report data on performance measures evaluating compliance with evidence-based practices
- Available capacity-building resources
  - Dedicated Learning Management System (LMS) accessible through www.ukhscarecollaborative.com (launching in April) – videos and examples of protocols, policies and procedures, order sets, checklists, flow charts, internal training materials, and internal audit tools
  - Dedicated hospital and clinic performance improvement specialists

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Hospital Attestation Form

	Infrastructure Development Task	Supporting Documentation? (Yes/No)	Primary Responsible Party	Date Completed
1	Management has reviewed Program requirements and benefits with governing body and has established process for providing regular updates to governing body regarding Program participation			
2	Management has reviewed Program requirements and performance measure specifications with Medical Staff (including, but not limited to, Emergency Department Medical Director, Hospitalist Medical Director, and/or Chief Medical Officer)			
3	Management has reviewed Program requirements and performance measure specifications with clinical leadership (including, but not limited to Chief Nursing Officer, Emergency Department Director, and Inpatient Unit Director and/or Nursing Supervisor)			
4	Hospital has executed QHi Participation Agreement			
5	Each designated program liaison has successfully completed QHi training			
6	Each designated program liaison has successfully completed virtual learning series on performance measure reporting			
7	Hospital has developed and tested data collection processes to report on EBP Program measures			
8	Medical Staff have approved relevant evidence-based protocols relating to EBP Program measures			
9	Clinical leadership has evaluated and modified clinical workflows to comply with approved protocols			
10	Quality Committee has initiated ongoing improvement projects relating to performance on EBP Program measures			
11	Hospital commits to having clinical staff successfully complete a two-hour course on evidence-based practices on an annual basis to be documented within Care Collaborative's learning management system			
12	Governing body has established process to review at each regular meeting most recent data on EBP Program measures and status of related improvement projects			
13	Hospital has scheduled annual on-site visit with designated Care Collaborative performance improvement specialist			
14	Hospital commits to providing in a form and manner specified by the Care Collaborative on an annual basis (a) the number of individual patients screened or treated under evidence-based practices, and (b) information regarding Hospital's participation in a Medicare or Medicaid accountable care organization.			

Hospital has completed each task specified on this Attestation Form. I understand Hospital may be required to return any payment it receives under the EBP Program if the Care Collaborative later determines one or more of these tasks was not completed.

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Clinic Attestation Form

	Infrastructure Development Task	Supporting Documentation? (Yes/No)	Primary Responsible Party	Date Completed
1	Management has reviewed Program requirements and performance measure specifications with practitioners			
2	Management has reviewed Program requirements and performance measure specifications with nursing and support staff leaders			
3	Clinic has executed QHi Participation Agreement			
4	Each designated program liaison (2) has successfully completed QHi training			
5	Each designated program liaison (2) has successfully completed virtual learning series on performance measure reporting			
6	Clinic has developed and tested data collection processes to report on EBP Program measures			
7	Clinical leaders have approved relevant evidence-based protocols relating to EBP Program measures			
8	Clinical leaders have evaluated and modified clinical workflows to comply with evidence-based protocols relating to EBP Program measures			
9	Clinic has initiated ongoing quality improvement projects relating to performance on EBP Program measures			
10	Clinic commits to having clinical staff successfully complete a two-hour course on evidence-based practice on an annual basis to be documented within Care Collaborative's learning management system			
11	Clinic commits to making key leadership available for annual on-site visit with designated Care Collaborative performance improvement specialist			
12	Clinic commits to providing in a form and manner specified by the Care Collaborative on an annual basis (a) the number of individual patients screened or treated under evidence-based practices, and (b) information regarding Clinic's participation in a Medicare or Medicaid accountable care organization.			

Clinic has completed each task specified on this Attestation Form. I understand Clinic may be required to return any payment it receives under the EBP Program if the Care Collaborative later determines one or more of these tasks was not completed.

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Hospital Performance Measures

- Chest Pain - STEMI and NSTEMI Patients
- Stroke – Ischemic and Hemorrhagic Stroke Management
- Sepsis with Hypotension – Timely Vasopressor Utilization
- Diabetes Hospital Discharge Checklist
- Heart Failure Hospital Discharge Checklist
- ED Arrival to Contact with Qualified Medical Provider*
- Discharge Medication Reconciliation Checklist*

*Measures applicable for REHs where DC Checklists may not. Also applicable for CAHs with no eligible cases to report in a quarter for another measure

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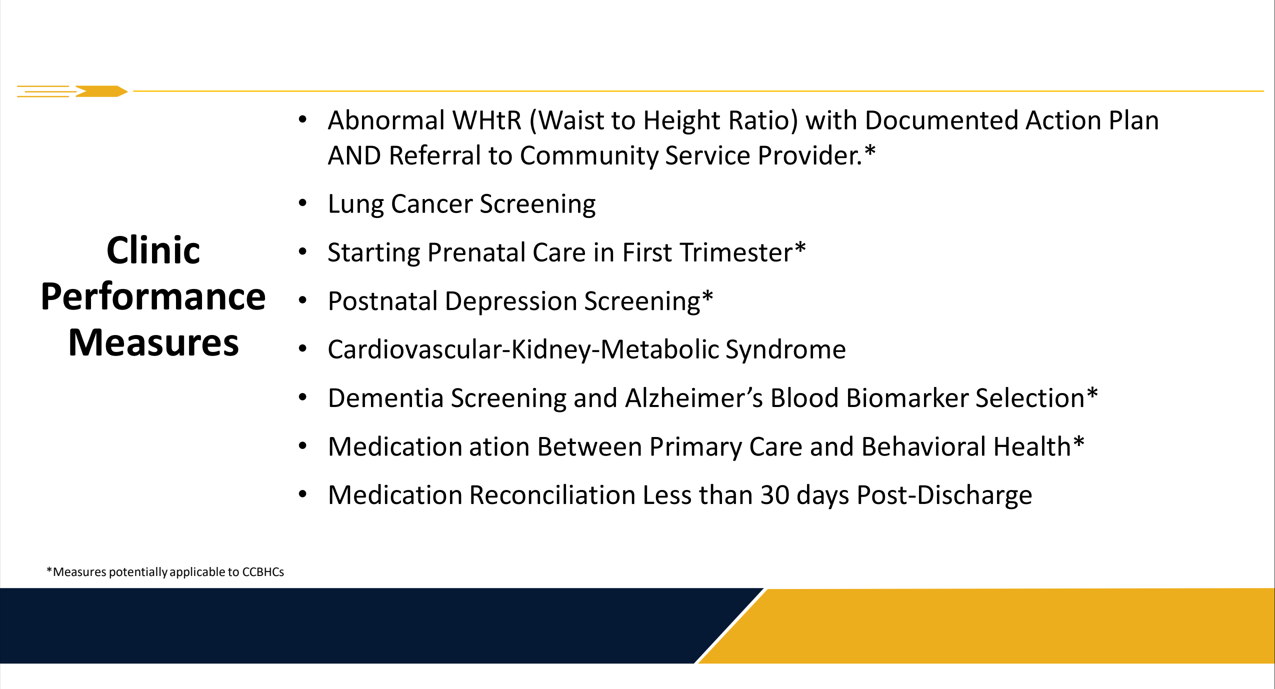

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EBP Program Next Steps

- March 30 webinar recording, Frequently Asked Questions, and hospital and clinic Participation Agreements now available on KDHE RHT Program webpage
  - https://www.kdhe.ks.gov/2361/Rural-Health-Transformation-Program
  - New Care Collaborative website launching soon
- Review, execute, and return signed Participation Agreement
- Begin work on Attestation Form requirements
  - Governing body, medical staff, and clinical leadership engagement
  - Adoption and implementation of evidence-based protocols
  - Performance measure reporting and QHI training

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3. Anchor Hospital Advancement Program

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- Objective: Keep care close to home by elevating identified anchor hospitals' ability to provide specialty care and support rural health systems in their region
- Action Plan: Deliver curated services and IT funding to reinforce anchor hospitals' capabilities and capacity to serve their respective regions
  - Establish board with anchor hospital participation
    - Initial work facilitated by joint venture between Ascension Via Christi and the University of Kansas Health System
  - Anchor hospitals required to formally commit to regional service
  - Not intended to implement/enforce hub-and-spoke model for care delivery

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Identifying Eligible Hospitals

Criterion	Hard screen
Coverage contribution (60-min proxy)[1]	
Discharges	>= 1,000
Population of hospital city	>= 9,000
Operating rooms	>= 2
Total surgeries	>= 1,500
Outpatient Visits	>= 25,000
Births (OB proxy)	>= 100
ED visits	>= 3,000
Net patient revenue	>= 60,000,000
Affiliated physicians	>= 40

Anchor Hospital	Hospital Type	City
A01 Citizens Medical Center	CAH	Colby
A02 Salina Regional Health C	PPS	Salina
A03 HaysMed AKA Hays Medical	PPS	Hays
A04 Ascension Via Christi Ho	PPS	Manhattan
A05 Great Bend TUKHS	PPS	Great Bend
A06 St Catherine Hospital	PPS	Garden City
A07 Newman Regional Health	CAH	Emporia
A08 Labette Health	PPS	Parsons
A09 Southwest Medical Center	PPS	Liberal
A10 Hutchinson Regional Medi	PPS	Hutchinson

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AHAP Year 1 Goals and Workstreams

1. On-Demand and Consultative Resources - $250,000
   - Make available subject matter experts to assist with location-specific needs, e.g., cybersecurity, long-term site planning and mechanical assessment, quality & safety assessments, managed care contracting
2. Artificial Intelligence and EHR optimization - $9.8 million
   - Form committee to identify and prioritize operational challenges that have viable technology solutions for rapid and broad implementation
   - Deploy solutions across anchor hospitals to help with efficiency, patient safety, and experience
3. Remote Patient Monitoring - $9.75 million
   - Deploy wearables for continuous inpatient monitoring to decrease length of stay, reduce complication rates, and reduce hospital staff workloads
4. Rural Residency Programs - $8.5 million
   - Expand/develop programs in 5 high-need specialties: OB/GYN, Behavioral Health, Family Medicine, General Surgery, Psychiatry, and Orthopedics.

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4. Revenue Improvement Program

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New Services Coordinated by Healthworks

- Centralized credentialing organization
  - Primary source verification
  - Plan enrollment
  - Background checks
- Revenue cycle support organization
  - Best practices
  - Staff training and ongoing support
  - Assistance with specific claims

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5. Workforce Programs

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Multi-Pronged Approach

- Healthworks leadership
  - Medical student rural rotation housing (payments to hospitals to secure local housing)
  - Rural nurse residency program
  - Clinical preceptor and instructor incentive payments
  - K-12 career exploration
- Additional opportunities
  - Expansion of Kansas Bridging Program (KUMC Institute for Community Engagement)
  - Health professions service educational awards (Kansas Board of Regents)
  - Mobile simulation lab (Care Collaborative)

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6. Accountable Food Is Medicine Community Health Worker Deployment

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New Resources To Meet Community Needs

- Non-clinical staff deployment
  - KDHE placing 20 CHWs/year in rural primary care clinics and CCBHCs + 6 practice facilitators
  - K-State placing 20 CHWs/year in regional extension offices + 29 nutritionists and 4 agricultural specialists
- Responsibilities
  - Identify and recruit FIM-eligible individuals
  - Screen individuals for upstream drivers of health and connect to community resources
    - Charitable food distribution system
  - Engage families in healthy eating education
  - Enroll FIM participants in remote monitoring
  - Connect individuals to consumer-facing technologies for primary and secondary prevention
    - Computerized cognitive behavioral health therapy
    - Alzheimer's Disease prevention and resource coordination
    - Lifestyle, fitness, and nutrition
    - Asynchronous Diabetes Prevention Program

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7. Behavioral Health Programs

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Expanding Capacity to Meet Behavioral Health Needs

- Behavioral health integration in primary care
  - Funds for up to 70 practices to evaluate opportunity, develop implementation plan
  - Support to launch in-person and virtual services
- Pediatric psychiatric access
  - Support for PCPs in diagnosing and managing pediatric behavioral health issues
- Emergency Department behavioral health intervention hubs
  - Establish and operate 6 regional hubs to support rural EDs with behavioral health cases
- Behavioral health crisis transport
  - 24/7 access to patient assessments, coordinated services, and transport to appropriate level of care
- Statewide SUD referral and stabilization network
  - Single point-of-contact for SUD crises

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8. Transportation Programs

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Right Heads in the Right Beds

- Interfacility Transport Teams
  - Dedicated teams in 8 locations with centralized dispatch
- Non-Emergency 911 Calls
  - Transfer non-emergent 911 calls to 24/7 nurse navigators to guide patients to most appropriate level of care
- EMS Reimbursement for Treat-in-Place and Transport to Alternative Location
- Mobile Integrated Health Pilot Program (5 participating communities)
  - Specially-trained CMAs to provide at-home supportive services

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9. Medicaid Provider Incentive Payment Program

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New KanCare Reimbursement for Care Coordination

- $1,000 incentive payment to providers who successfully connect Medicaid beneficiaries to MCO care coordination services
- Care Collaborative to provide on-the-ground support to help providers identify and connect Medicaid beneficiaries
- Demonstrate value in paying providers for care coordination services (KanCare 4.0)

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10. Program Administration

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Maximizing Provider Payments

- RHT Program permits states to spend up to 10% of total award on administrative expenses
- Kansas' Year 1 administrative budget of $7.2M = 3.3% of total award
  - KDHE staff/related resources = $470K
  - Consultant (Boston Consulting Group) = $2.3M
  - Fiscal agent (BDO Government Services) = $3M
  - Grant assistance (Care Collaborative) = $1.2M
  - Evaluation (KHI/FHSU) = $240K

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