May 4, 2026

Kansas Rural Health Transformation Plan
Evidence-Based Practice Program
Frequently Asked Questions

What is the Evidence-Based Practice (EBP) Program?

The EBP Program is part of the State's Rural Health Transformation (RHT) Plan, funded by the federal government's RHT Program. Its purpose is to help rural hospitals and clinics build and maintain the infrastructure needed to implement and sustain evidence-based practices. Rural hospitals and clinics will report on performance measures to demonstrate continued compliance with these practices. Rural providers' scores on these measures will demonstrate the quality of care they provide to their communities.

Who will operate the EBP Program?

The State has contracted with the UKHS Care Collaborative Association (Care Collaborative) to operate the EBP Program. Rural hospitals and clinics will be required to sign a Participation Agreement (including a HIPAA business associate agreement and acceptance of required federal terms) with the Care Collaborative. The Participation Agreements are available now on the KDHE RHT Program webpage, https://www.kdhe.ks.gov/2361/Rural-Health-Transformation-Program.

The Care Collaborative will make available a wide range of resources to support rural providers in implementing evidence-based practices and reporting on specified measures. The Care Collaborative also will monitor providers' compliance with the requirements specified in the Participation Agreement and will make payments to qualifying hospitals and clinics.

What are the benefits of participating in the EBP Program?

In Year 1 of the RHT Plan, April to September 2026, rural Kansas hospitals will receive $100,000, and rural Kansas clinics will receive $50,000 as infrastructure payments. To receive these payments, providers must attest to having made specified investments to support evidence-based practices, including staff training, workflow modifications, and data collection and reporting processes. The Attestation Form attached to the Participation Agreement lists the necessary investments.

Also in Year 1, rural hospitals will receive an additional $50,000 and rural clinics will receive an additional $25,000 for successfully reporting data on the performance measures for the period July, August, and September by October 31, 2026.

Which Kansas providers are eligible to participate in the EBP Program?

To determine eligibility, the EBP Program uses the Federal Office of Rural Health Policy's definition of "rural" as reported on Am I Rural? Tool - Rural Health Information Hub.

Hospitals: The following facilities are eligible to participate in the EBP Program as hospitals: (a) a facility located in a rural area listed under the Facility Type "**Accredited Hospital/Critical Access Hospital**" in the Directory of KDHE Regulated Health Care Facilities at the time the Participation Agreement is signed (use the online tool available at https://www.kdhe.ks.gov/612/Directory-of-Regulated-Health-Care-Facil); (b) a facility that is licensed by the State as a rural emergency hospital; and (c) a facility located in a rural area that at any point during the period beginning on January 1, 2015, and ending on December 26, 2020, was a facility described in K.S.A. 65-484(a) or became a department of a provider or provider-based entity.

Rural Health Clinics: Any entity listed under the Facility Type "**Rural Health Clinics**" in the Directory of KDHE Regulated Health Care Facilities at the time the Participation Agreement is signed. Use the online tool available at https://www.kdhe.ks.gov/612/Directory-of-Regulated-Health-Care-Facil.

Federally Qualified Health Centers: Any facility located in a rural area providing primary care services furnished by a practitioner (physician, advance practice registered nurse, clinical nurse specialist, physician assistant) at least 32 hours per week that is approved by the Health Resources Services Administration (HRSA) as a Federally Qualified Health Center at the time the Participation Agreement is signed with the exception of mobile clinics, school-based clinics, dental clinics, and walk-in/urgent care clinics. The Care Collaborative is presently using a list generated by the Community Care Network of Kansas to confirm eligibility under this criteria.

Certified Community Behavioral Health Centers: Any facility listed under "Kansas Community Mental Health Centers" on the document maintained by KDHE at https://www.kdhe.ks.gov/DocumentCenter/View/15100/FQHCs-Safety-Net-Clinics-CHMCs-PDF at the time the Participation Agreement is signed.

Other Full-Time Primary Care Physician Practices: A full-time provider-based or independent primary care physician practice located in a rural area. To qualify as full-time, a practice must operate at least 32 hours per week in one or more rural locations. To qualify as a primary care physician practice, the practice must include at least one full-time physician with one of the following five specialty designations in their Medicare enrollment: Family Practice, General Practice, Internal Medicine, Geriatric Medicine, or Pediatric Medicine. (This list is based on the definition of primary care physicians used in the Medicare Shared Savings Program for purposes of beneficiary attribution.) If an independent practice operates in multiple rural locations under the same Taxpayer

Identification Number or a provider-based practice operates in multiple locations under the same name, the practice will execute a single Participation Agreement covering all locations (i.e., it will not receive multiple payments for multiple locations).

If a hospital or health system owns or operates one or more hospitals, rural health clinics, and/or full-time primary care physician practices, it must execute a separate Participation Agreement for each eligible hospital and/or clinic.

The Care Collaborative anticipates there will be unique cases requiring additional analysis to determine eligibility. If you are unsure whether your organization qualifies, please email care.collaborative@rhtp.net with details of your specific circumstances. As the Care Collaborative addresses such circumstances, it will update these FAQs to ensure providers in similar circumstances are treated consistently.

Also note: the Participation Agreement requires that a provider be presently enrolled in the Medicare program and not excluded or suspended from participation in any federal healthcare program to receive any payment under the EBP Program.

Are you forcing "cookbook" medicine on rural providers?

Evidence-based guidelines are not fixed protocols or rigid rules, but recommendations that must be applied using clinical judgment. They are intended to support clinical decision-making, not to supplant a practitioner's expertise or an individual's unique needs.

Evidence-based practice means adapting existing workflows to incorporate the latest research regarding safe and effective treatment of specific conditions. For more than a decade, the Care Collaborative has helped rural providers implement evidence-based practice by customizing protocols to their specific circumstances. This includes engaging with medical staff members to solicit input and address their concerns.

What resources will be available to assist providers in implementing and maintaining evidence-based practices?

One of the required investments listed on the Attestation Form is completion by at least two designated program liaisons of a virtual learning series on performance measure reporting.[1] Each series includes multiple webinars detailing the relevant performance measure specifications. These webinars will be presented live in May and early June with recordings available on the Care Collaborative's soon-to-be-launched learning

[1] Each clinic and each hospital must have two designated liaisons. The same two individuals can serve as the designated liaisons for multiple hospitals and/or clinics operating under the same TIN. The role of the designated liaisons is not limited to reporting; the liaisons manage the hospital's or the clinic's implementation and maintenance of evidence-based practices.

management system (LMS). Attendance at live sessions and access to the recorded webinars will be tracked for verification purposes.

Rural Hospital Virtual Learning Series

Date	Title	Zoom Registration Link
May 6	Implementing and Sustaining Evidence-Based Practices in Rural Hospitals and Clinics	https://zoom.us/webinar/register/WN_[illegible]
May 8	Rural Hospital Quality Improvement Measures for EBP Program: Chest Pain; Stroke; Sepsis with Hypotension	https://zoom.us/webinar/register/WN_[illegible]
May 22	Rural Hospital Quality Improvement Measures for EBP Program: Discharge Checklists for Diabetes and Heart Failure; ED Arrival to Contact with QMP; Medication Reconciliation Checklist	https://zoom.us/webinar/register/WN_[illegible]

Rural Clinic Virtual Learning Series

Date	Title	Zoom Registration Link
May 6	Implementing and Sustaining Evidence-Based Practices in Rural Hospitals and Clinics	https://zoom.us/webinar/register/WN_[illegible]
May 21	Rural Clinic Quality Improvement Measures for EBP Program: Abnormal Waist-to-Height Ratio; Cardiovascular-Kidney Metabolic Syndrome	https://zoom.us/webinar/register/WN_[illegible]
June 3	Rural Clinic Quality Improvement Measures for EBP Program: Dementia Screening	https://zoom.us/webinar/register/WN_[illegible]
June 4	Rural Clinic Quality Improvement Measures for EBP Program: Prenatal Care in First Trimester; Postpartum Depression Screening; Medication Reconciliation Between Primary Care and Behavioral Health; Medication Reconciliation Less Than 30 Days Post-Discharge	https://zoom.us/webinar/register/WN_[illegible]
June 11	Rural Clinic Quality Improvement Measures for EBP Program: Lung Cancer Screening, Part I	https://zoom.us/webinar/register/WN_[illegible]
June 25	Rural Clinic Quality Improvement Measures for EBP Program: Lung Cancer Screening, Part II (optional)	https://zoom.us/webinar/register/WN_[illegible]

Additionally, the Care Collaborative will produce multiple resources available to providers at no charge including additional in-person, virtual, and on-demand presentations; virtual and in-person expert consultations; and examples of protocols, policies, and procedures; order sets; checklists; flowcharts; internal training materials; and internal audit tools. The Care Collaborative will communicate with rural providers regularly regarding available resources.

How were the performance measures selected?

The Care Collaborative's medical director, Dr. Bob Moser, worked with experts across the State to identify relevant measures with straightforward reporting requirements that demonstrate a provider's successful implementation of evidence-based practices. Dr. Moser tailored the measures to ensure compliance with the federal rule prohibiting the use of measures for which providers are presently eligible for payments.

How will hospitals and clinics report data?

The Care Collaborative is partnering with Kansas Healthworks to use its online quality reporting tool, Quality Health Indicators (QHi), for the EBP Program. Most rural hospitals presently use QHi to report data. Kansas Healthworks is developing specific tools for reporting on the EBP Program measures. As part of the infrastructure requirements, providers will participate in QHi training, including one introductory webinar and one focused on EBP Program reporting. One-on-one assistance will be available for providers experiencing any difficulties with reporting.

Participating providers will be required to sign a separate agreement with Kansas Healthworks to ensure all data is properly safeguarded. A provider will receive the Kansas Healthworks agreement after it submits its signed Participation Agreement to the Care Collaborative; unlike the EBP Program Participation Agreements, the QHi agreement is not available online. A provider will not be able to submit data through QHi unless and until it returns the signed agreement to Kansas Healthworks and its designated liaisons complete the required QHi training.

Is there a deadline for signing the Participation Agreement?

To receive a Year 1 infrastructure payment ($100,000 for hospitals, $50,000 for clinics), a rural provider must submit to the Care Collaborative all required documentation (including the executed Participation Agreement (with signatures on the HIPAA Business Associate Agreement and Appendix 1 to Exhibit D), a signed and dated W-9, banking information, and contact information for those individuals responsible for the provider's participation in the EBP Program) and the provider's completed Attestation Form by no later than October 1, 2027.

To receive a Year 1 incentive payment ($50,000 for hospitals, $25,000 for clinics) in addition to a Year 1 infrastructure payment, a rural provider must submit all required documentation referenced above (including the provider's completed Attestation Form) to the Care Collaborative by October 1, 2026, and then report on the performance

measures for the period July, August, and September through QHi by no later than October 31, 2026. Keep in mind that a provider must return a signed agreement to Kansas Healthworks and complete required training as a condition of submitting data through QHi.

The Care Collaborative encourages rural providers to return their signed Participation Agreements as soon as possible, as a provider will not receive the QHi agreement until it returns the signed Participation Agreement. As noted above, a provider cannot participate in QHi training until it returns the signed QHi agreement to Kansas Healthworks.

What will the EBP Program look like in future years?

All future RHT Program funding is dependent on CMS approval and funding levels. The State will work with CMS to define the scope of the EBP Program in Year 2 and beyond. CMS rules place limits on the amount the State can spend on payments to providers for clinical services, and CMS treats pay-for-reporting and pay-for-performance incentives as such payments. Thus, for Year 1, two-thirds of EBP Program payments are for infrastructure, and the rest is for pay-for-reporting incentive payments. Year 2 will include quarterly pay-for-performance incentive payments, hopefully at levels similar to the Year 1 pay-for-reporting incentive payments.

How will providers' performance be monitored?

To receive the infrastructure payment, a provider must submit a completed Attestation Form demonstrating that the provider has made, or will make, certain investments in support of evidence-based practices. Also, when submitting data to QHI, a provider will attest to the accuracy and completeness of that data.

Within 12 months following a hospital's submission of its Attestation Form, a Care Collaborative performance improvement specialist will conduct an on-site visit to verify these attestations and to provide assistance based on the provider's performance on the specified measures. Clinic site visits will occur within 18 months following submission of the Attestation Form. If the specialist identifies any potential issues with the Attestation Form or the data submitted to QHi, the Care Collaborative will investigate, including requesting additional information from the provider. If the Care Collaborative determines the provider made intentional and material misrepresentations on the Affirmation Form or purposefully submitted inaccurate information relating to the measures, the Care Collaborative may recoup payments made to the provider.

Will information regarding a provider's participation in the EBP Program be reported publicly?

The Care Collaborative will post on its website a list of providers that have received infrastructure payments and incentive payments. This information will also be included in the State's report to CMS on RHT Plan implementation.

Are there any restrictions on hospitals and clinics' use of infrastructure payments, or is it flexible as long as the expenditures support the EBP Program's goals? Does a hospital or clinic need to submit any documentation to justify specific expenditures?

The infrastructure payments are intended to fund the investments a hospital or clinic has determined are necessary to implement and sustain evidence-based practices. All hospitals and clinics will need to engage leaders and educate staff, modify workflows, engage in continuous performance improvement, and develop reporting capabilities. These activities will require significant investments in time and effort. A hospital or clinic may need to hire additional staff or make investments in technology or data infrastructure to support expanded quality improvement activities. The completed Attestation Form documents those investments for which a hospital or clinic will be compensated.