July 14, 2026

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

Contents

A. General Information

1. 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.

2. 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 Care Collaborative's RHT Plan website, https://ruralhealthkansas.com/evidence-based-practice-program/

As detailed below, 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 accessible through its RHT Plan website. 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.

3. 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.

4. 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?

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.

5. 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.

6. 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.

B. Provider Eligibility and Participation Agreements

7. 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. If your facility is not listed on this tool and was recently designated by CMS as a rural health clinic, please submit supporting documentation with your signed Participation Agreement.

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 Nicole Palmer at npalmer@kumc.edu 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.

8. 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 September 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.

C. Required Training and Other Capacity-Building Resources

9. Are providers required to participate in training relating to the EBP Program?

As indicated on the Attestation Form, both of a provider's designated liaisons must complete the applicable virtual learning series for the EBP Program.[1] Each series – one for hospitals and one for clinics - includes multiple webinars detailing the relevant performance measure specifications. These webinars will be presented live in May and early June. You may register for these live events on the Care Collaborative's RHT Plan website, https://ruralhealthkansas.com/evidence-based-practice-program/ If you are unable to attend the live events, recordings will be available on the Care Collaborative's Learning

Management System (LMS), https://cca-learning-hub.thinkific.com/. Please note you must register to access the materials available through the LMS.

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.

Upon receipt of a provider's completed Attestation Form, the Care Collaborative will verify attendance by the two designated liaisons at each webinar in the applicable virtual learning series. The Care Collaborative will use the live webinar attendance reports and the LMS tracking reports for this purpose. Each provider is responsible for ensuring both of its designated liaisons are listed in these reports. While we encourage other individuals to participate in these sessions, a provider must ensure documented participation by its two designated liaisons.

The Attestation Form also requires a provider to "commit 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." For Program Year 1, the deadline to complete this training is September 1, 2027. The course materials will be available through the Care Collaborative's LMS later this summer. For purposes of this requirement, clinical staff includes licensed and certified professionals in your organization involved in the development, implementation, or monitoring of or otherwise impacted by the evidence-based guidelines relating to one or more of the EBP Program performance measures.

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

In addition to the virtual learning series, the Care Collaborative is making available multiple resources to providers at no charge. The Care Collaborative Learning Hub at https://cca.learning-hub.thinkific.com includes recordings of all virtual learning series webinars, the presentation materials for those webinars, the Quality Director Leadership Program, and a Resource Library that includes flowcharts for hospitals and clinics, as well as supporting materials. To access the modules, each user must create an account. The registration allows tracking for data management purposes. Additionally, the hospital and clinic flowcharts and quality improvement checklists are available on the Care Collaborative SharePoint. (These excel spreadsheets are maintained on SharePoint because they cannot be uploaded to the Learning Hub.) To request access, please get in touch with Nicole Palmer at npalmer@kumc.edu.

Additionally, Care Collaborative staff are available to answer questions or otherwise support your organization's adoption of evidence-based practices. Hospitals should reach out to Pilar Davis at pilar.davis@khsc-ku.com and clinics should contact Rebecca Winterburg at rebecca.winterburg@khsc-ku.com. Aso, the Care Collaborative's medical director, Dr. Bob Moser, is available to provide assistance. Please contact Dr. Moser at rmoser@kumc.edu.

D. Reporting on Performance Measures and Program Monitoring

11. 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.

12. 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 has developed 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.

13. What are the reporting requirements for Year 1?

There are 5 core measures on which a hospital will report. For each measure, a hospital must report on 15 randomly selected cases during the measurement period (July, August, and September). If a hospital has at least one but fewer than 16 cases during the period, the provider should report on all cases for that measure. If a hospital has no cases for one of the core measures during the period, the hospital should report on one of the alternative measures (ED Arrival to Contact with Qualified Medical Provider or Discharge Medication Reconciliation Checklist).

A clinic must report on at least 5 of the 8 clinic measures. It is the clinic's decision on which measures it will report (provided the clinic has at least one case during the measurement period for each selected measure). For each selected measure, a clinic must report on 15 randomly selected cases during the measurement period. If a clinic has at least one but fewer than 16 cases during the period, the clinic should report on all cases for that measure.

14. 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.

A hospital is required to schedule a one-hour on-site visit with the designated performance improvement specialist prior to signing the Attestation Form. The visit must be completed prior to **June 1, 2027**. An authorized hospital representative (preferably one of the designated liaisons) needs to contact Pilar Davis at pilar.davis@khsc-ku.com to schedule the hospital's visit. (Separate visits will be scheduled for hospital-owned clinics.) Meeting attendees should include, at a minimum, the hospital's chief nursing officer, two designated liaisons, quality director, and emergency department director. Optional attendees include the chief medical officer, discharge planners, and other team members the hospital deems appropriate. The meeting agenda (including the materials the hospital should have available at the meeting) will be shared once the date and time is confirmed. At these meetings, hospitals will be asked to share documentation to support the representations made on the Attestation Form (e.g., meeting minutes, policies, protocols, workflows, and algorithms).

A clinic is required to represent on its Attestation Form that it will make key leadership available for the on-site visit to be scheduled at a later time. The Care Collaborative will notify clinics that have signed the Participation Agreement when visit scheduling begins in late summer.

If a designated performance improvement 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.

15. 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.