2026 May CMS Webinar
Rural Health Sustainability: RHRC Programs and Approach Transcript

[SLIDE 1]

GHUNNEY: Hello, and thank you all for joining today's CMS webinar. My name is Aya Ghunney and I help coordinate our webinar series. Today's session is on *Rural Health Sustainability: RHRC Programs and Approaches*.

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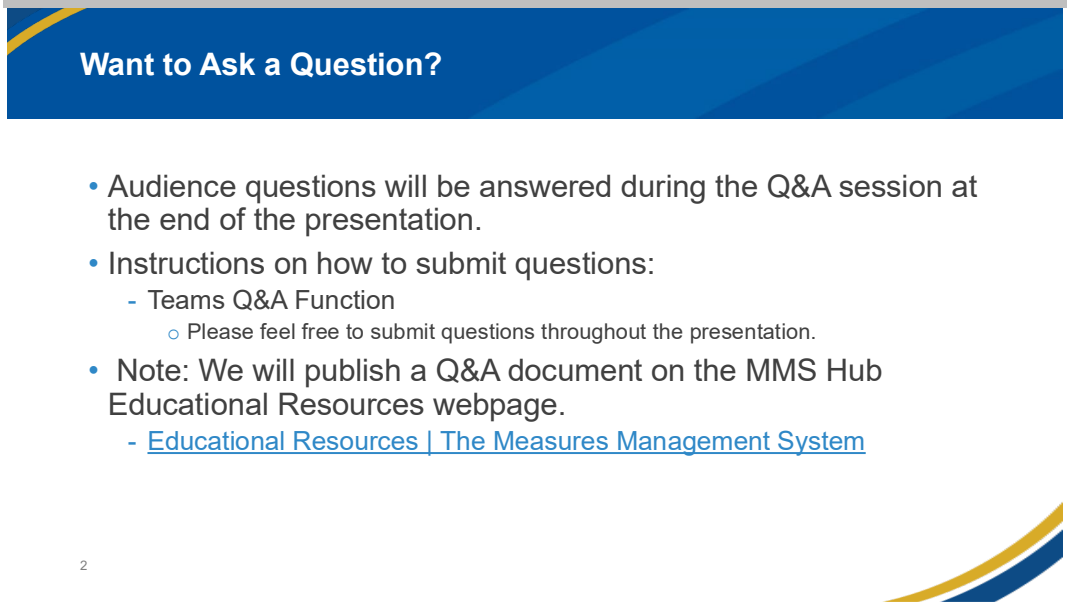

GHUNNEY: So, you're able to ask questions throughout the session. They'll be answered via the Q&A function in Teams. So, once we see your questions come through, we will be selecting them for response at the end of the session. We will publish the materials from this webinar along with the Q&A on the educational resources webpage on the MMS Hub.

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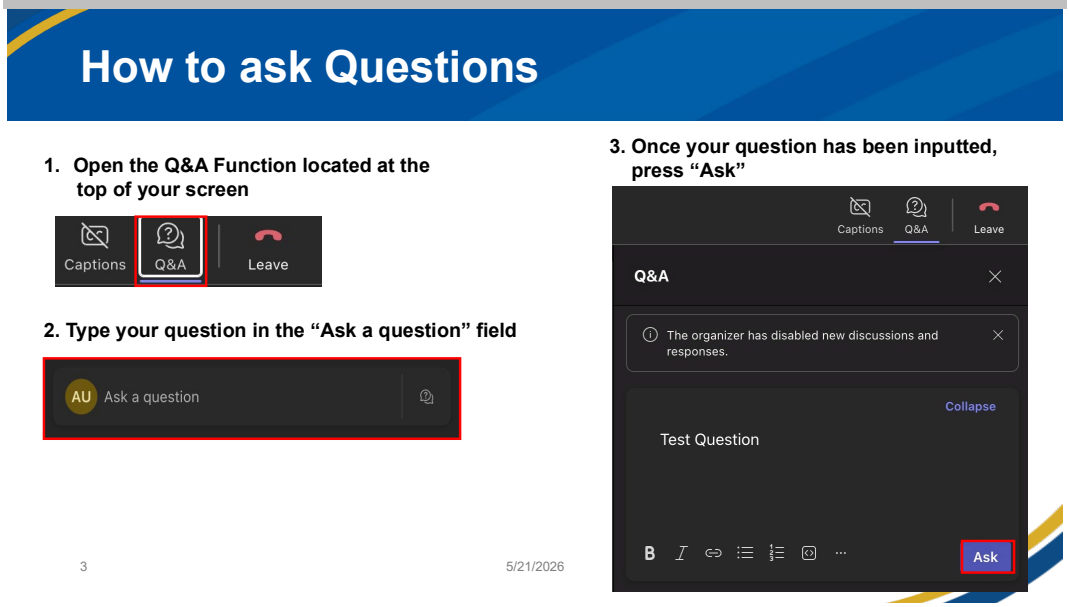

GHUNNEY: So, if you look up at the top of your screen you will see that Q&A button. You can go ahead and click on that and hit "ask"—type your question into the "ask a question" field and just hit "ask," and we will be able to see your question submitted. Again, you can do that throughout the session.

[SLIDE 4]

GHUNNEY: So, without further ado I would like to introduce everyone to our presenter for today. Janice Walters is the CEO of the Rural Health Redesign Center (RHRC), and I will hand it over to you, Janice.

WALTERS: Thank you and certainly appreciate the opportunity to have this conversation with you all today and educate the community as it relates to our services and programs and how we approach rural health sustainability here at the RHRC.

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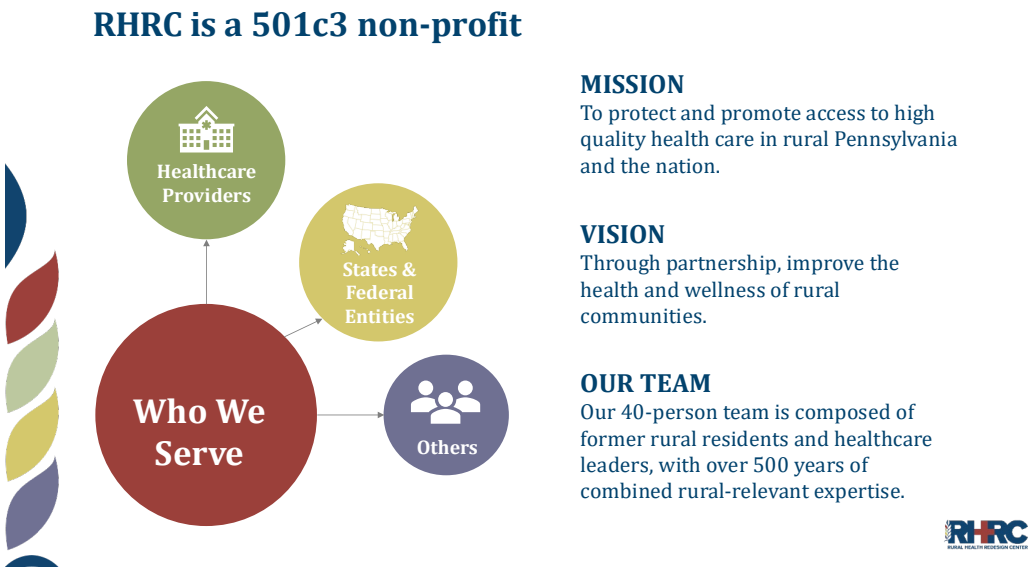

WALTERS: So just a little bit of background about who we are as an organization. So, the RHRC is a not-for-profit organization with a mission to protect and promote access to high quality healthcare in rural Pennsylvania and the nation. Our vision is really to help rural communities thrive, and through partnership improve the health and wellness of rural communities.

One of the things that we pride ourselves on here at the RHRC is the lived experience that many of our team have as it relates to rural healthcare and leading rural healthcare organizations. So, our 40+ member team is composed of former rural residents, as well as healthcare leaders, and collectively we have over 500 years of combined rural relevance experience. So, we approach all of our work through a lens of applicability and practicality based on our lived experience in rural healthcare and as rural residents.

So, who we serve at the highest level, we serve healthcare providers directly. We also support states and federal entities, and then other types of partners and clients as well.

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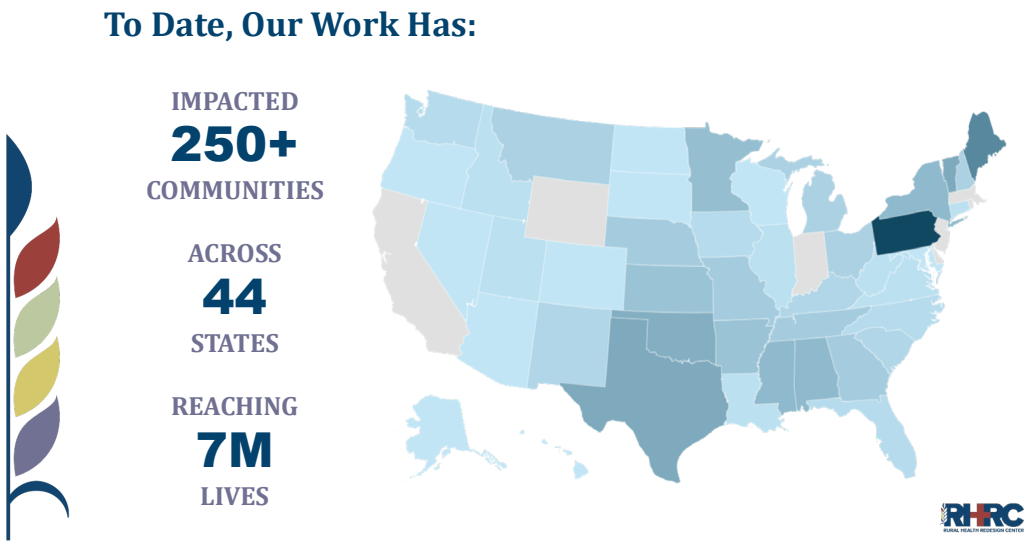

WALTERS: Our footprint across the country, this slide represents where we have a presence and the work that we've done since its inception. So, since we came into existence in 2020, we've impacted more than 250 rural communities across 44 states with an anticipated reach of over seven million (7M) lives. Transparently this was our 2025 data, and so as shared as part of our annual report. So there again, if you'd like more information on our organization, we do have our annual reports on our website for you to go and see, but we do pride ourselves in terms of our ability to support rural healthcare providers and bring about meaningful change and sustainability.

In rural communities we certainly know with some of the developments within the RHTP that rural health is certainly getting a lot of attention, but our mission has been about preserving access to rural healthcare even before the RHTP existed.

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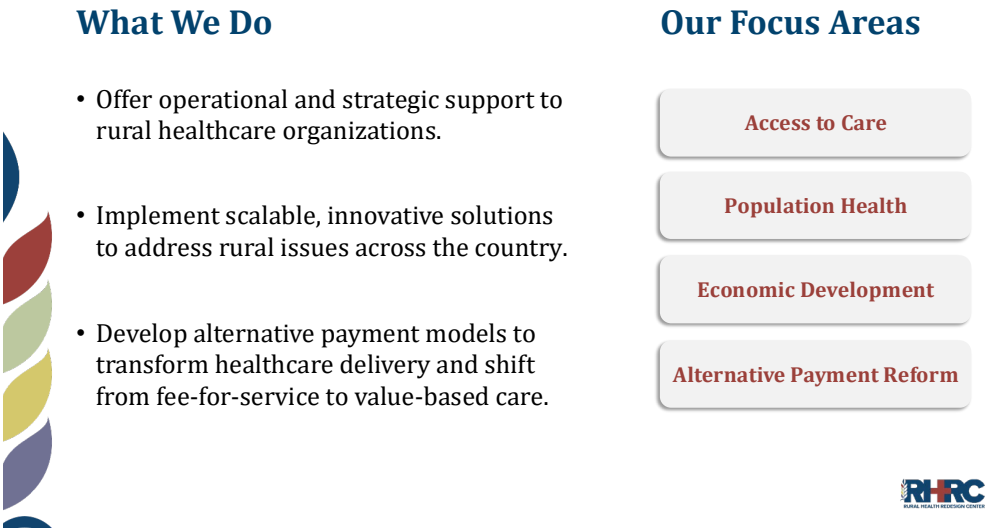

WALTERS: So, we offer operational and strategic support to rural healthcare organizations. We also implement scalable and innovative solutions to address rural issues across the country. So really, we develop relevant alternatives with the goal of transforming the healthcare delivery ecosystem really shifting from fee-for-service (FFS) to value-based care.

Our focus areas within our programs, and I'll share a little bit more information about our programs, but really it is about preserving and expanding access to care — all through the lens of population health and wellness and trying to improve the lives of rural communities so that they do become thriving broad communities and understanding the implications

of healthcare and the role that healthcare plays within the broader ecosystem to achieve those objectives and really improve the lives of the people that we serve, which ties into economic development. We recognize the backbone that the healthcare delivery system plays as it relates to broader economic development issues, and preserving access to healthcare is a building block for broader economic developments. Again, reinvigorating rural communities and helping them to thrive.

And, as I've already mentioned, alternative payment. We firmly believe that in order for healthcare to be robust in our rural communities we have to develop different approaches to paying for healthcare and certainly recognize now within the rural health transformation program, there is a focus on alternative payment. But in order for any of these to be sustainable in the future, we have to figure out how to pay for healthcare differently, and drive better, improved outcomes through the dollars we're spending.

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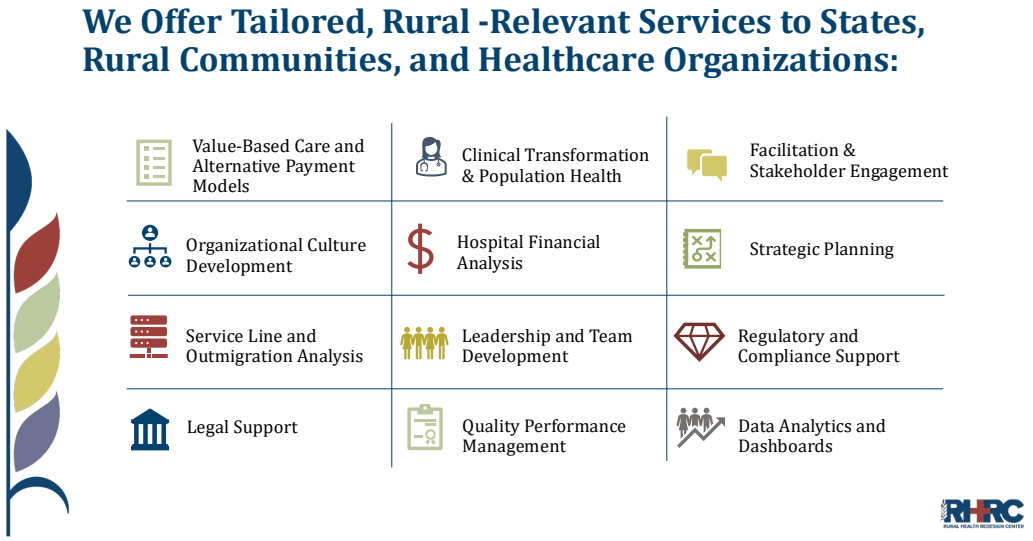

WALTERS: So, our team, as I've already mentioned, here at the RHRC, is well-versed in rural healthcare, but we do offer tailored rural-relevant services, as stated previously, to states, rural communities and healthcare organizations. I'm not going to speak to each one of the bullets on this slide, but it's just representative of the vast amount of expertise and experience that we have here at the center in terms of working with healthcare organizations to sustain what they have in order to transform for the future, as well as then working with states and other organizations that can get value from our knowledge here at the center.

So, really as we think about our work, I think about it in two *pillars*. We focus on preserving what we currently have in order to have an infrastructure by which to transform, and so it's really a twofold approach as it relates to our services here at the center. We'll get into each pillar and our approach to preserving, as well as in our approach to transforming, but really starting with that preserving access through tailored technical assistance (TA) and then working across the continuum to define the new infrastructure and the new delivery system for the future.

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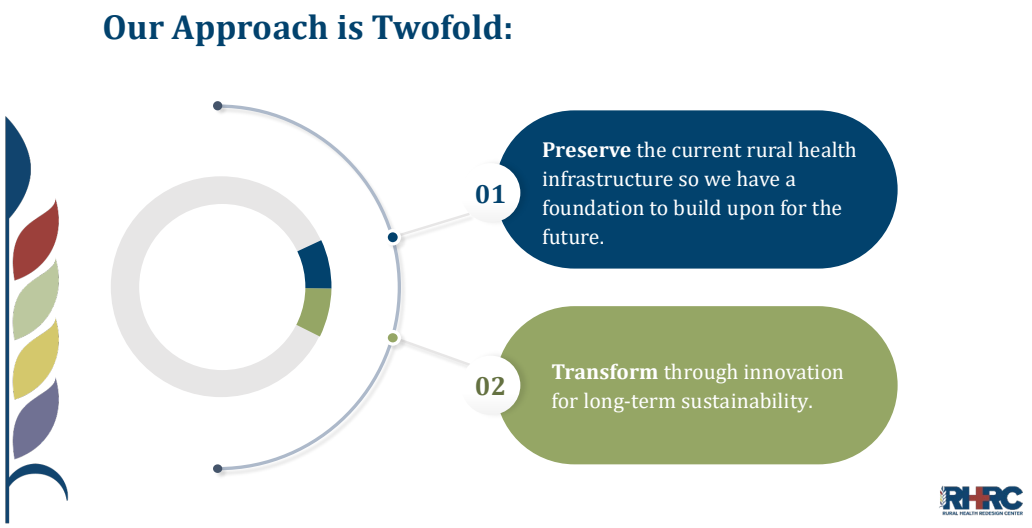

WALTERS: Again, just touching on the points that I made. Our approach is really twofold. It's *preservation*, preserving the current rural health infrastructure so that we have a foundation to build upon for the future. And then transforming through innovation for long-term sustainability.

I want to recap a point I've already made as it relates to economic development; I would say reinvigorating rural communities. We understand that healthcare is a fundamental backbone. So, if we want to attract businesses and we want economic development and broader reach within our rural communities, we have to preserve what we have. There's a lot of data to show that once rural healthcare organizations close, it's almost *impossible* or very difficult to get those services back.

So, preserving through the lens of keeping what we have in order to innovate is really our focus here at the center. It's not to preserve what we

have and expect to continue into perpetuity, but it's more about preserving so that we can then innovate.

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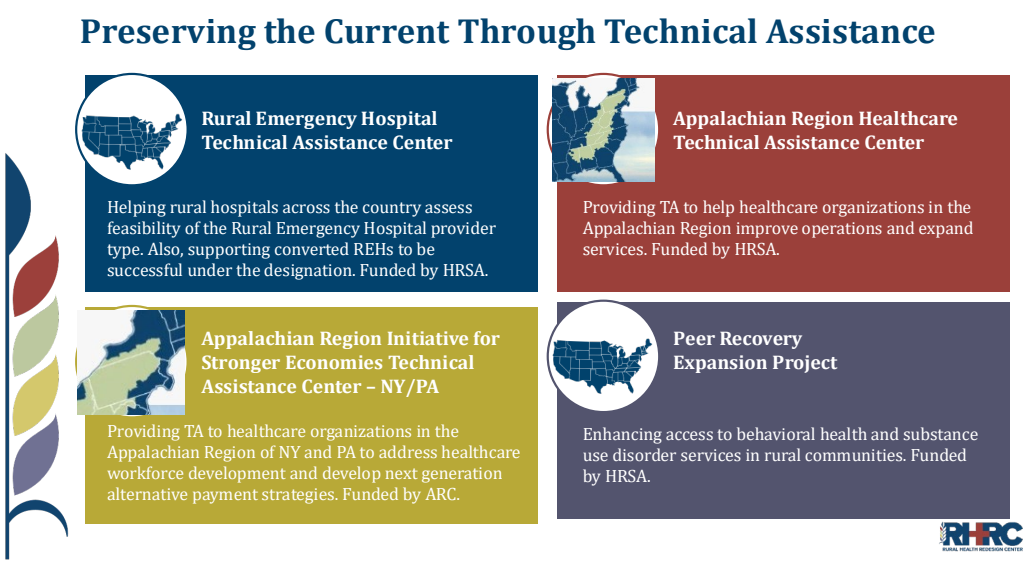

WALTERS: A lot of our preservation really is focused on providing robust technical assistance (TA) to rural health providers across the country. One of the main mechanisms that we have to do this work is through offering technical assistance through formal technical assistance (TA) centers that have been stood up either through federal partners, such as the Federal Office of Rural Health Policy (FORHP) and HRSA, or other funders such as the Appalachian Region Healthcare Technical Assistance Center (ARH-TAC).

So, on the slide right now, it's really just showing you some of the breadth of TA centers that we're offering and working to provide our services through. We do run the national Rural Emergency Hospital Technical Assistance Center (REH-TAC), and really the focus of that TA process is

working with organizations, hospitals in particular across the country, to assess the new REH designation and licensure to understand if that licensure provides a more stable path forward for that entity in order to preserve access to healthcare for their community.

We start that process with understanding, as I like to say it, “does the math work, and does the financial arrangement within that designation provide a more predictable and stable revenue stream for the hospital?” And for those that do convert, we then get to walk with them in the post-conversion space to continue to provide robust TA services to them — again, helping them improve their operations and expand access to care within that new licensure type.

Within the Appalachian Region we’re actually running two TA centers — one directly with the Appalachian Region commission, and then one in partnership with HRSA, but there again providing robust technical assistance (TA) to healthcare organizations, again looking to sustain and improve their operations with the goal of providing a pathway to get them to a more sustainable infrastructure, which we believe at the Rural Health Redesign Center (RHRC) is directly tied to alternative payment, and paying for healthcare services differently within a transformed ecosystem.

So again, Appalachian Region, two separate TA centers where hospitals have the opportunity to work with us directly. And then we provide them a pathway of technical assistance (TA) to improve their operations.

The other program that we’re currently running — and it is in its final year but we’re looking for a path forward — is the work that we’ve done specific to payer recovery. Expansion and substance use treatment. So within this program we’ve actually embedded peer recovery specialists (PRSs) within

emergency rooms within our—there's a number of Pennsylvania hospitals that we're working with specific to this program, but embedding peer recovery specialists (PRSs) within emergency rooms to walk with folks that have substance use conditions that want to recover, and really getting them connected with somebody that's been in their shoes and walked that road with them to help get them on that recovery journey.

Also, within this program we have developed a mental health first aid training program that we are making available to clients that we serve as well. So really a lot of our technical assistance (TA) is done through these TA centers, again with the goal of preserving so that we have infrastructure to transform in future years. Again, the services that we provide through these TA centers go back to the slide I shared previously, that robust service listing or the services that we look to provide our client organizations, our hospitals, through the various TA centers.

I will make note that a couple of our programs do allow us to work with more than hospitals. So, some programs allow us to actually work with FQHCs and other types of providers like dental clinics and behavioral health organizations as well. Who we can work with is really program-specific. So, if you're interested in learning more, please do visit our website where we have more information on each of these programs.

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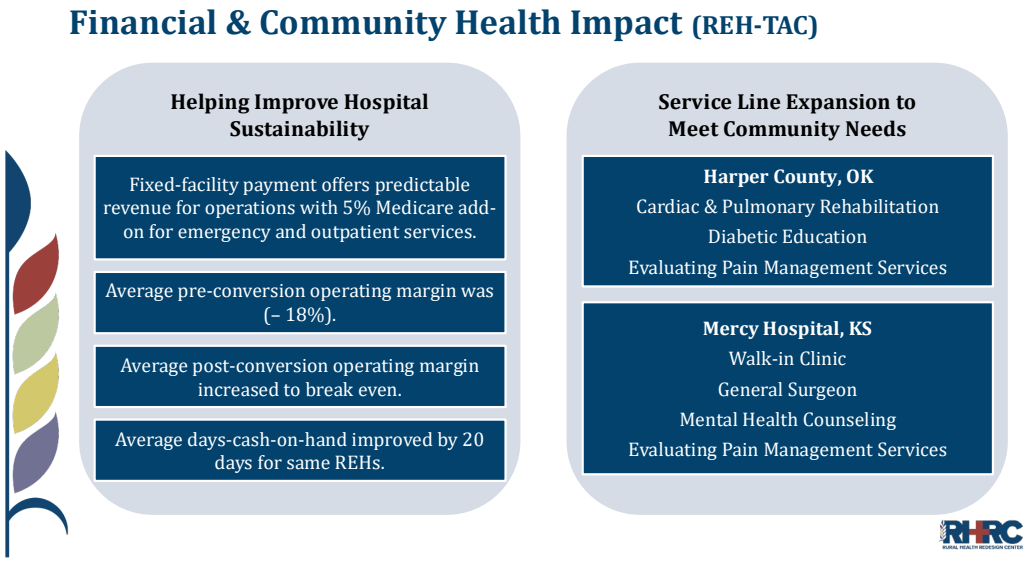

WALTERS: I'm just sharing some early information as it relates to our largest TA center that we're running currently, the Rural Emergency Hospital (REH-TAC). So early learnings from our engagements so far have shown that the fixed-facility payment being paid to these new organizations is very meaningful and has brought forth a transformative solution as it relates to their operating margins. So certainly, most of the organizations that have converted were experiencing extreme losses prior to conversion, and now a lot of these organizations are moving to close to break even, if not better than break even specific to their operating performance.

What's really exciting for us to see here at the center is that as this payment paradigm has changed for these early adopters of the REH licensure, we naturally see them moving into population health and wellness efforts as they think about what they can do within that rural

emergency hospital (REH) licensure and really meet the needs of their community.

So, one of the fundamental things that we believe in here at the center is the changing of the payment paradigm. I think we now have two reference points — the rural emergency hospital (REH) as well as the Pennsylvania Rural Health Model (PARHM), which I'll talk a little bit more about in a few slides.

But really, if we change the payment paradigm and we get the payment right — and we get the incentives aligned — hospital leaders, industry leaders naturally step into population health and wellness, once the incentive is aligned in order to do so. So just sharing with you some of the early things with some of our REH hospitals, our early adopters. Harper County and Mercy Hospital, some of the first REHs that we had in the country and now some of the things that they're doing to step in this space and start addressing population health and wellness within their communities as part of being a rural emergency hospital (REH).

So exciting stuff to see and certainly we count it a privilege to be able to be in this space and walk with these early adopters. I have a lot of respect for the people that are willing to go first and provide the opportunity for us to learn across the industry in terms of what works and what doesn't work as it relates to rural health payment reform and transformation.

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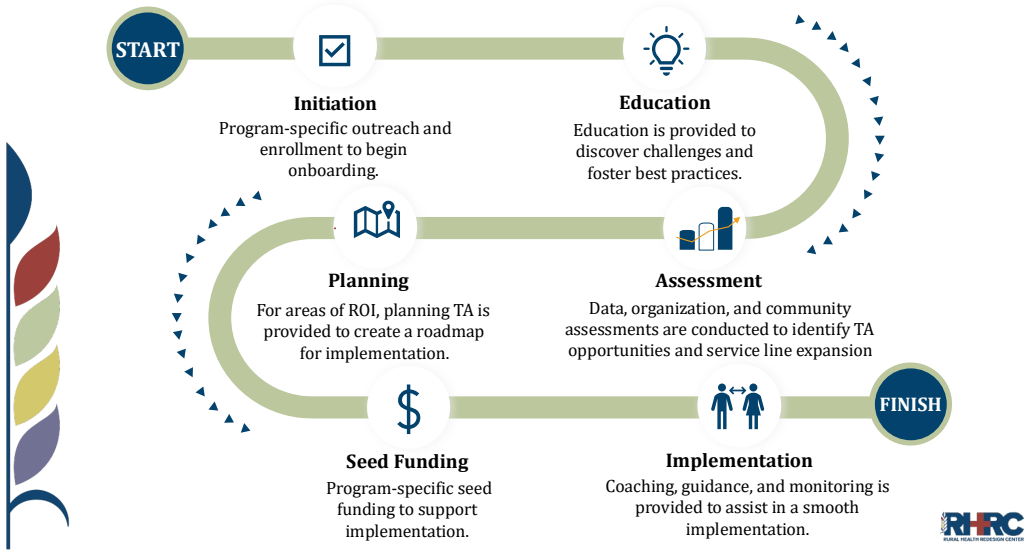

WALTERS: As we think about our TA journey and how we approach our work, specific in the TA space and in our TA centers, I'm just showing you an overview for organizations that might be interested in engaging with us, both with at the hospital level through our TA centers, and then as far as broader engagement at the state and federal level. Certainly, our programs start with initiation where we really work to understand and build relationships with folks that we are privileged enough to work with.

We spend a lot of time educating on what resources we have available. So, we educate to our clients. And then we also are educated, because we enter all of our engagements seeking to understand and really understanding the starting point for all of the clients and all of the folks that we get to support through our work. So, education both ways where we're learning from them and they're learning from us.

We spend a lot of time doing assessments. So again, as part of that learning we do a lot of assessments to try to understand the current landscape — what's working at the community level, what's not working at the community level, what's working within the organization, what's not working within the organization — to identify where best to start the technical assistance (TA) journey. We recognize that every organization is very unique, and so we do allow a lot of customization as it relates to our approach in terms of where we start. We're trying to address the burning issues first but then provide a lot of training as well as planning.

So, we then enter a planning process. A number of our TA centers actually allow for service line expansions and depending on the program, there's actually seed funding. So really helping organizations understand what their communities need, and then in some programs — not all programs — being able to provide seed funding to actually get that new service line off the ground. And then we work with the organizations through implementation, providing coaching and guidance and monitoring to ensure that the plans we've collectively developed are executed and that we actually drive to the outcome and anticipated finish that we have collectively built together.

So, it's a pretty robust process again from initiation, relationship building, education, assessment, planning, providing seed funding if and where we can, and then walking with organizations through implementation. So, this is our overall process. The only thing that makes this unique is the seed funding. Again, not all programs allow for seed funding, but this is a general process of what folks can expect to get as it relates to our service line offerings and how we deliver our products across all of our programs.

[SLIDE 13]

Pursuing Long-Term Sustainability & Transformation

- Systematic change to the healthcare ecosystem is needed to truly preserve and revive rural health.
- In leading programs such as the Pennsylvania Rural Health Model (PARHM) and running various Technical Assistance Centers including the Rural Emergency Hospital Technical Assistance Center, our team has been on the frontlines of innovation since the organization's inception.
- We serve as a central convenor of hospitals, payors, state and federal officials, contractors, and other relevant partners to drive stakeholder engagement that delivers transformative solutions.
- Our work continues to serve as a learning lab, influencing national policy across industries.

WALTERS: So really who we are, where the RHRC sees itself fitting within the broad ecosystem is really the convener. So, we certainly recognize that in order to bring about sustainable change, it requires a broad involvement across all different types of stakeholders and partners. So, where we see ourselves is that convener sitting in the middle bringing folks together and then providing frameworks by which to work through to build solutions.

So as we think about pursuing long-term sustainability and transformation, again we see ourselves as the convener to drive systematic change across the healthcare ecosystem and leading programs such as the Pennsylvania Rural Health Model (PARHM) and our technical assistance center, sharing with you some insights to the Rural Emergency Hospital Technical Assistance Center (REH-TAC) in particular in some prior slides.

We really do see ourselves as an entity that's been on the frontline of innovation since our organization's inception.

So, this is what we are here for; this is what we do. This is our only focus area, which is sustaining access to rural healthcare and then innovating the delivery system. Again, as I've already mentioned, we see ourselves serving as the central convener of all of the different stakeholders that it takes in order to bring about meaningful change. It is nothing that any one entity can do on its own. We need government, we need providers, we need the payer communities, and other broader partners such as hospital associations as well as other community-based organizations (CBOs) coming together to really define and transform the rural heath landscape.

So, we also believe that our work here at the center, one of our goals is to serve as a learning laboratory — not only for the state of Pennsylvania, but for the country. So, we've been blessed with the opportunity to be on the frontlines, and one of the goals of what we're hoping to achieve is to allow us to share our lessons learned with all of you across the country so that folks don't necessarily make the same mistakes we did.

We did make some mistakes and have identified those, and we really want to be able to share that with all of you and serve as a catalyst to be able to reach our goals sooner and share our lessons learned wherever we can — again, to help folks avoid pitfalls, but then also share our lessons learned in terms of what has worked well and how we continue to build out what's worked well and help folks avoid what didn't work so well.

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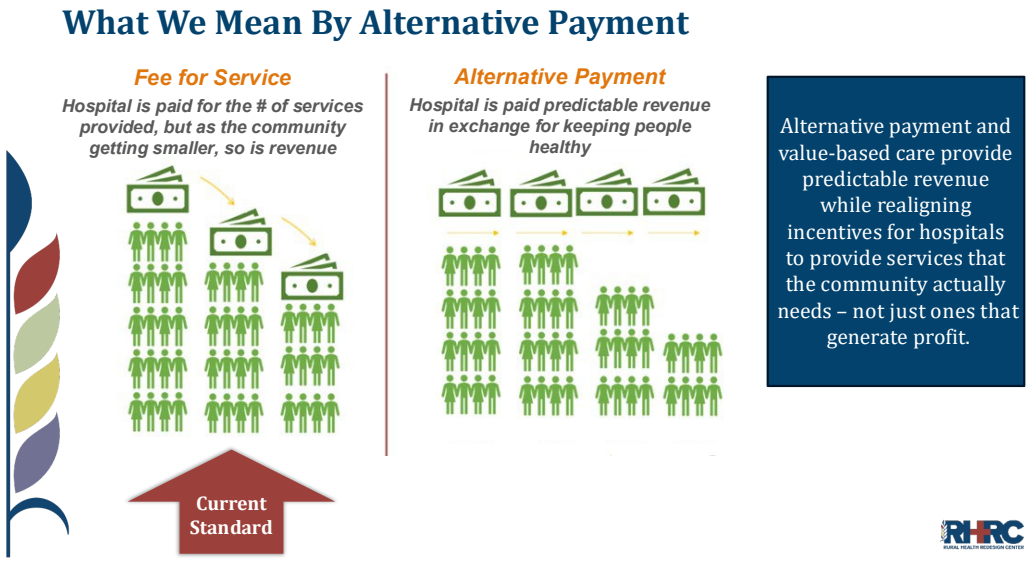
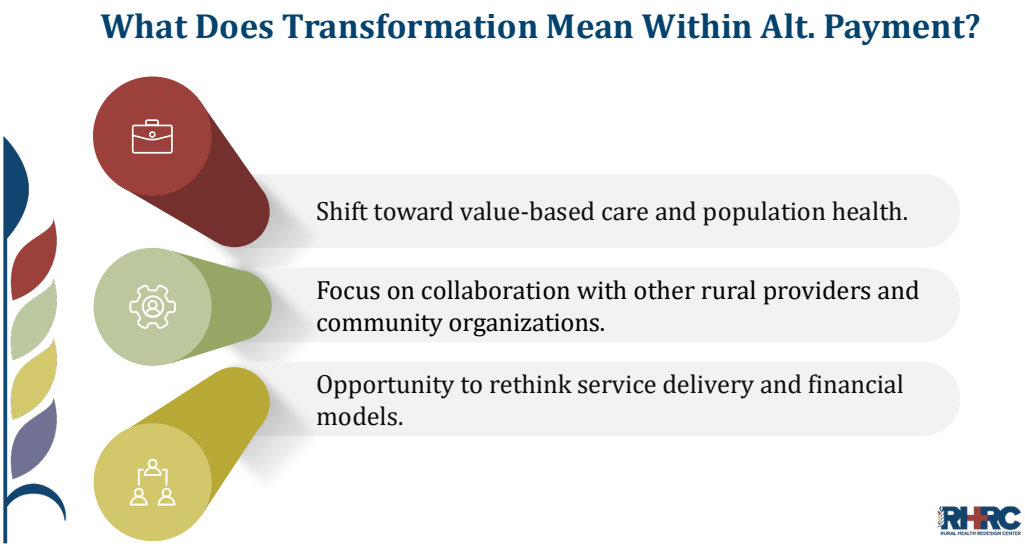


WALTERS: Moving into alternative payment, so one of the things I've already spoken to is our sustainability. So really understanding that sustainability and preservation of what we have has to be the starting point, but that's not where we want to stop. We don't want to stop there. We actually want to evolve into something different for the future. So, when we talk about alternative payment here at the RHRC, it's really through this lens of moving away from fee-for-service (FFS), moving away from I would say activity-based payment, volume-based payment, and moving into predictable revenue.

But in exchange for that predictable revenue expectation of improved population health and wellness outcomes. So alternative payment through the lens of the RHRC is really about providing predictable revenue that's tied to population health and wellness and payment that aligns the incentives, not only for hospitals, but really all providers across the

continuum to really align the incentive and focus on population health and wellness. Here at the center, we do tend to work with hospitals first, but as we think about where healthcare needs to go, we know that most of the care is going to be needed in order to improve population health and wellness at the communities. It's going to happen outside the walls of the hospital. It's starting with preserving access to care, because we certainly do understand that for many rural communities the rural hospital is the backbone of the healthcare delivery system. So, ensuring that that's preserved, but with the vision of transforming. It's not keeping what we currently have but sustaining it so that we have the infrastructure to transform.

[SLIDE 15]



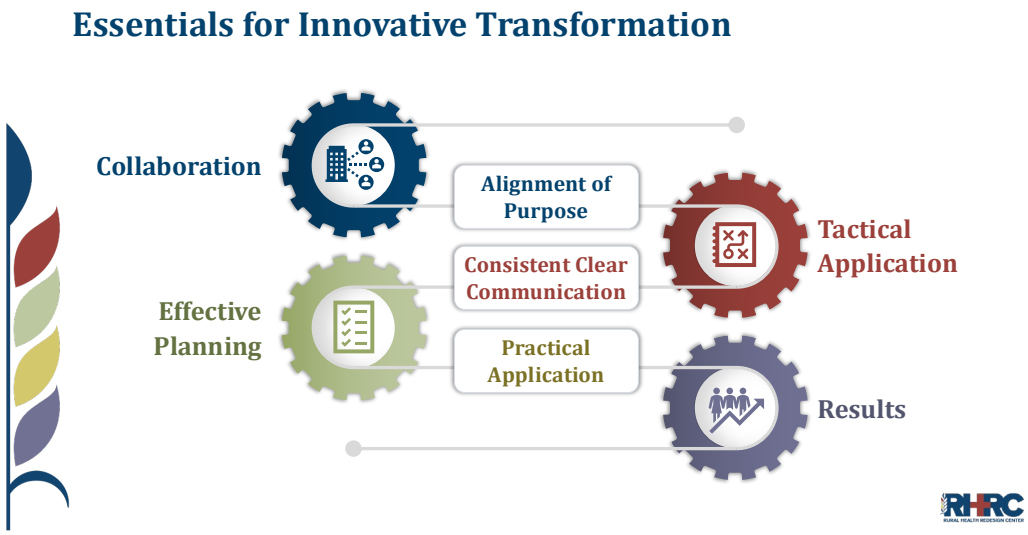
WALTERS: What do we mean by transformation with an alternative payment? As I've already stated, it's really the shift toward value-based care and population health. Paying for good health outcomes and quality

play a very important role to assess the quality of healthcare that's coming out of the redefined payments mechanism.

We also focus on collaboration. We certainly recognize that in order for us to be successful long-term, hospitals are not the folks that are going to be able to do this by themselves, but it really is asking our hospitals to serve as the convener. Because of the role that they play in a lot of these communities, we believe they are centrally located and ideal to serve as the transformative engine by asking them to serve as collaborators and conveners amongst other rural healthcare providers but recognizing they can't do it by themselves. We can ask them to be the collaborators and the conveners to truly drive the transformation within their communities.

Again, what does transformation mean for us here at the center? It's really the opportunity to rethink service delivery and financial models. We're now in the 21st century. We need to make sure that we're bringing forth 21st century technology and that our payment systems are situated and built to actually pay for what is needed within that transformed and new delivery system.

[SLIDE 16]



WALTERS: Certainly, recognizing the only way that any of this will be successful is through robust collaboration, and again asking leaders in healthcare to play a different role than maybe they historically have. Again, we truly believe that if we get the payment paradigm right and we get the incentives aligned, our rural healthcare leaders will have the freedom and the brainpower and capacity to actually serve as the convener to drive the change within their communities.

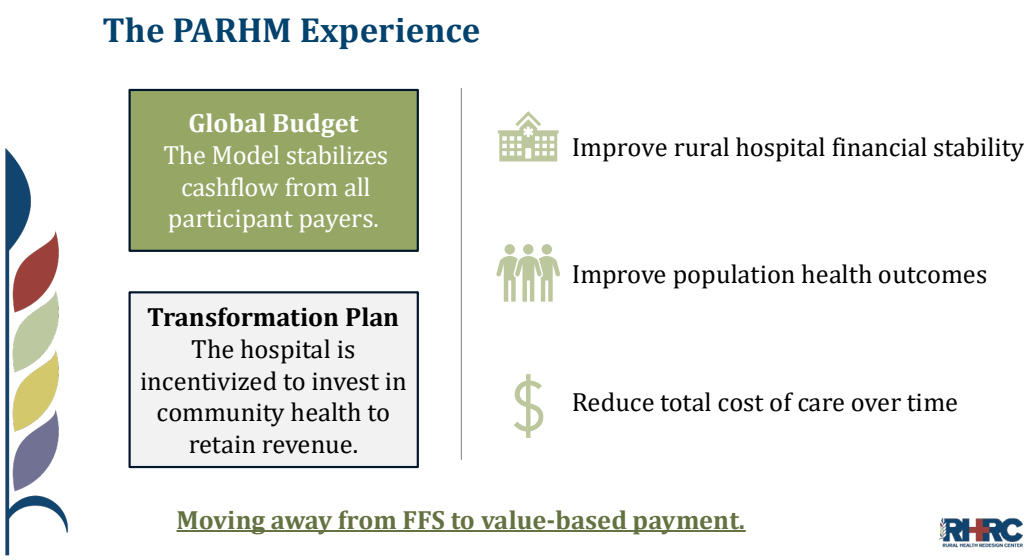
The essential elements for innovation, obviously, it's robust collaboration and alignment of purpose. We all have to understand what the vision is, and so how do we co-create the vision of what we think rural healthcare should look like for the 21st century? Align on that purpose and then identify the tactical application. What are the tactics that we need? But then also develop the pathway for consistent and clear communication. How do we plan well?

I think that’s one of the things within the RHTP. The timeline by which this has had to be rolled out has not allowed for a lot of effective planning, and I'm certainly hoping that through some of the service offerings and some of the work that’s happening we’ll be able to maybe take a breath and do some effective planning so that we can then get to the practical application to yield the results we’re hoping for and want to see achieved within the RHTP opportunity that we have.

So, these are not my words. I've heard lots of folks say that we believe the RHTP is a once-in-a-lifetime opportunity, and so I remain optimistic that we collectively have enough knowledge and resource — not only here at the center but across the healthcare continuum, across the state policy organizations and across CMS.

We have the knowledge. It’s a matter of how do we get it aligned to really drive meaningful results, you know, through this opportunity that’s presenting itself.

[SLIDE 17]



WALTERS: I want to share a few lessons learned from the Pennsylvania Rural Health Model (PARHM) experience. Again, going back to where we want to serve as a learning laboratory. We have learned a lot, and we want to share those lessons learned with whoever we can, whoever will listen. We certainly want to be a partner on this journey, but there were basically two pillars within that program — the global budget and then the transformation plan.

The vision was that the global budget would stabilize cash flow from all of the participant payers. And then really an exchange for that predictable payment we were asking our hospitals to develop transformation plans that would incentivize them to move to community health and wellness. Really that's how you retain your revenue was actually driving improved population health and seeing that within the data.

And so again, the two pillars were looking to achieve three objectives, which was to improve rural hospital financial stability, improved population health outcomes, and then reduce the total cost of care over time with the overall goal of moving away from fee-for-service (FFS) to value-based payment (VBP).

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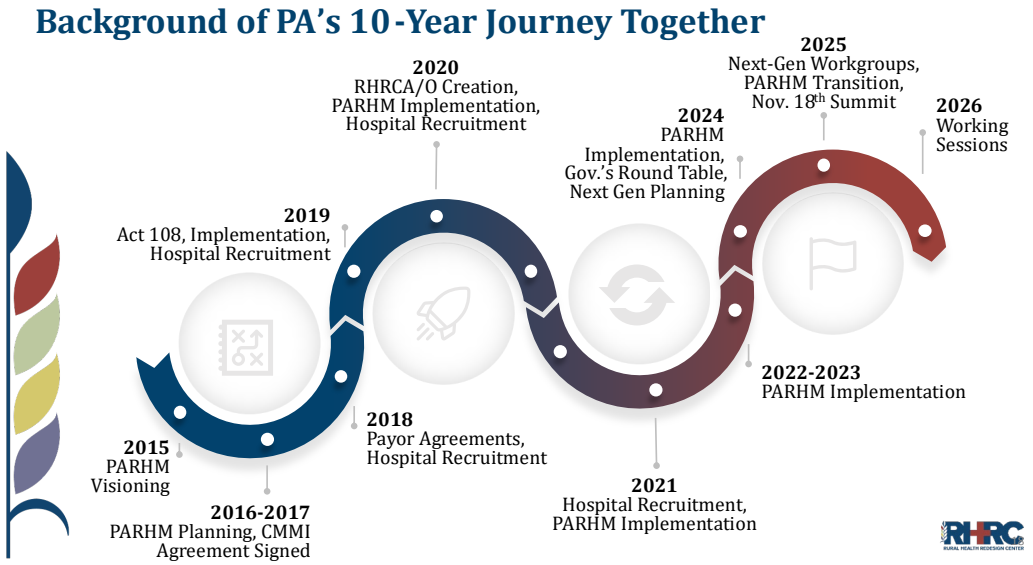
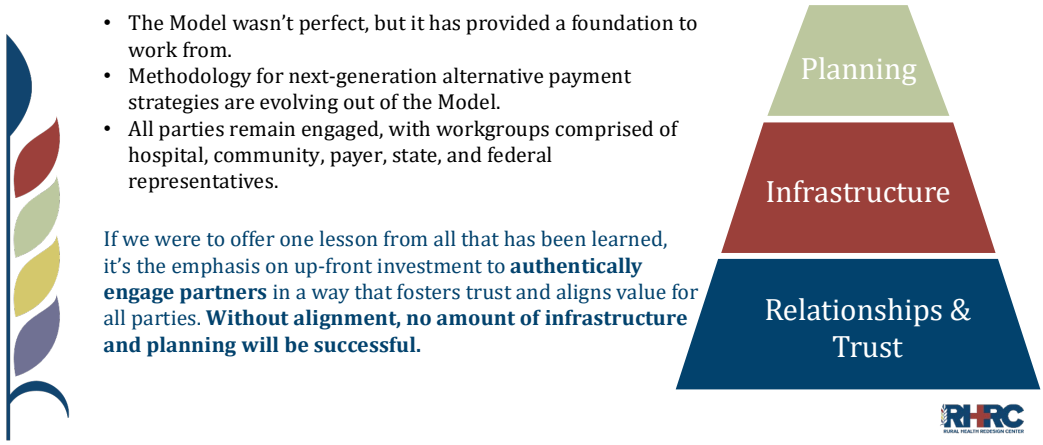


WALTERS: This work did not happen overnight, and so the state of Pennsylvania has actually been on this journey now for almost ten years. So again, a lot of knowledge to share with folks in terms of how to do this work, how to stand up programs, how to develop governance structures, and how to engage stakeholders on this journey. None of this happens overnight. It's a marathon, not a sprint. Again, we have a lot of knowledge and framework that we're hoping to be able to share with folks in terms of how to achieve these objectives and how to approach this work to drive towards the results that we're all looking for and hoping for.

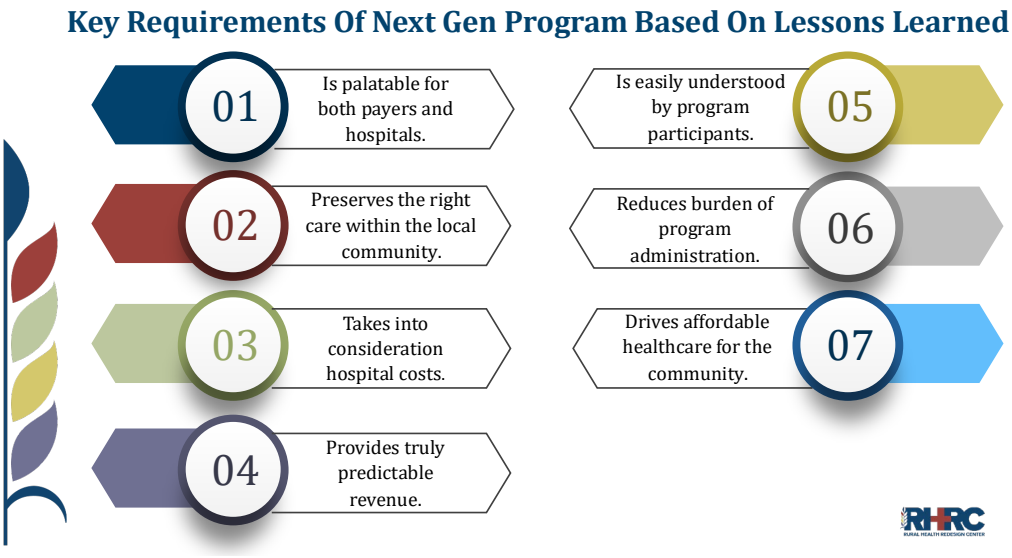
[SLIDE 19]



WALTERS: One of the most important lessons that we learned through all of this work is the importance of *relationship* and *trust*. This goes back to one of the fundamental principles that's needed in terms of alignment of purpose. We have to all understand what the goal is and how we all plug into that to achieve the objectives, but relationships and trust is the building block and the foundation that allows any of this work to be done.

Certainly, on that foundation of relationship and trust we then have to identify and build infrastructure and then do effective planning, but the most important thing that we've learned is really the need to authentically engage partners in a way that fosters trust and aligns value for all parties. Without alignment and finding what I like to call the WIIFM — the "what's in it for me" or the value proposition for every stakeholder on the journey — there's no amount of infrastructure and planning that will be successful, if we don't start with that alignment and trust in relationship.

[SLIDE 20]



WALTERS: Sharing again some key lessons learned from the Pennsylvania Rural Health Model (PARHM) experiment. The learning laboratory of what was built and what we've done. Some of the key requirements of a next-generation program based on our lessons learned is what I'm sharing with you on this slide. In the interest of time I can't speak through each one of those, but again there were a lot of things that we got right within the first demonstration program, but then there were also a number of things that we know need to be improved as we are putting pen to paper to develop our next generation strategies.

So, while the Pennsylvania Rural Health Model (PARHM) program in and of itself is officially winding down, the work here in the state of Pennsylvania continues as we continue to work with our partners. Our payer community is still with us at the table. So, all of the payers that we were able to engage as part of the first program are still sitting at the table with us evolving saying "how do we keep this work going? How do we

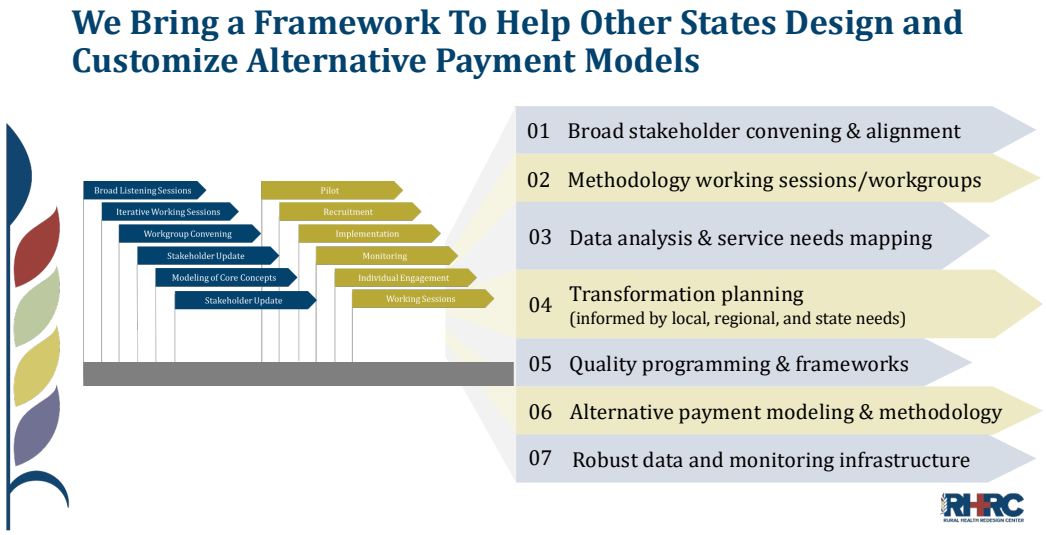
build on the ten years of experience that we've had and continue to iterate on this?"

We all recognize the need to continue to stay at the table and drive improvement. So again, the seven things that I shared are really the must-haves. It's got to be palatable for both payers and hospitals. We've got to ensure it's preserving the right care within each community. We recognize that we can't have cookie-cutter approaches, and so it's customizable frameworks that allow us to customize the program based on the needs of the individual community.

We know it has to take into consideration provider cost. The only way anything is going to be sustainable is if revenue exceeds expenses. It's a basic business principle, and so we understand that during the first model we had the COVID pandemic. We certainly recognize that our first model was just revenue-only, and so we have to have mechanisms to address cost. We know it has to provide truly predictable revenue. It's easily understood by program participants.

One of the things that we heard from our participants at first, based on the first program, was there are just a lot of black box calculations. So, we want to try to simplify that and have different approaches and also reduce administrative burden. And then at the end of the day what we develop has to drive affordable healthcare for the community. So, these are the I would say seven must-haves of the next generation work that we continue to lead here at the center, obviously being informed by Pennsylvania and the Pennsylvania stakeholders.

[SLIDE 21]



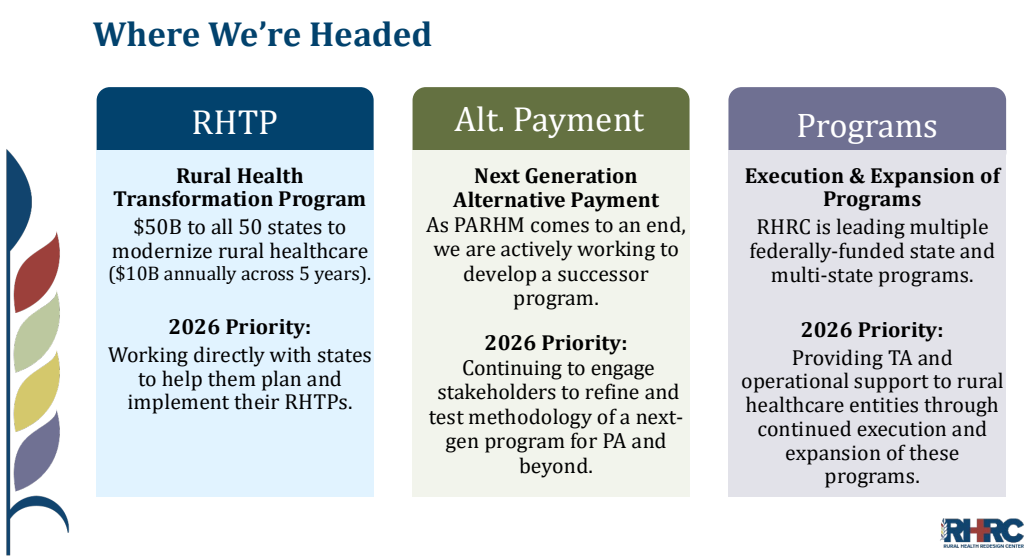
WALTERS: So really what we believe we can offer to again, any potential folks that want to work with us is we bring frameworks to help other states and providers co-create and design and customize APM payment models. So again, we're not developing or proposing to bring the Pennsylvania program to you. What we've recognized through the work here at the Rural Health Redesign Center (RHRC) is the need to provide planning frameworks. And then working with states, working with providers to really co-create for their state and their community.

We certainly recognize that all states are different, and I've heard that a lot as I spoke nationally that Pennsylvania is not necessarily reflective of other rural states, and that is absolutely true.

So again, what we've developed is a framework that we believe can help states accelerate. If there's interest in accelerating APM frameworks,

especially within the RHTP opportunity that's now been presented, we believe that we have frameworks that will help get states there quicker, and again leveraging the ten years of experience and knowledge that we have on this journey thus far.

[SLIDE 22]



WALTERS: So really going to my last formal slide, and then I believe we'll open it for Q&A, is our focus areas here at the center are obviously the RHTP. We want to help all states and anybody that has interest in working with us a leverage to funding that's coming into their states. So certainly that's one of our 2026 priorities is to work directly with states to help them plan and implement their RHTPs.

Obviously, we're advancing alternative payment next-generation strategies. I've already provided a little bit of insight into some of the must-have things that we're thinking about here in the state of Pennsylvania. Again, looking to share these lessons learned and really help accelerate

APM design across the country. And then continuing to execute our various TA programs and do that well, and certainly expand our technical assistance (TA) and operational support to rural healthcare entities through continued execution and expansion of programs.

And then the last thing I'll say is again, we're here to work with whoever. Going back to one of my earlier slides, we work with individual providers. We work with states, and then we also do work on behalf of the federal government. Our goal here is that five years from now within the RHTP to say that we've done something super meaningful and changed the trajectory of rural health infrastructure, rural health delivery across the country. That's the big hairy audacious goal that we have, and we certainly want to help wherever we can to achieve that objective. So, with that, I'm going to turn it back to our host for Q&A.

[SLIDE 23]

Contact Information

Reach out to RHRC, if you have questions or would like to learn more.

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[SLIDE 24]

Q&A Portion Not Included in Transcript

[SLIDE 25]

GHUNNEY: So just a reminder that you may contact the Measures Management System (MMS) at our help desk: MMSsupport@battelle.org, and please visit the MMS Hub for the latest news and announcements. We've got a news item right now on the updated eCQM specifications and resources for 2027, and also information about joining the Partnership for Quality Measurement (PQM) committee. So, you can go and look to see how to get engaged. Thank you again for joining us today.

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