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Improving the Value Proposition of Critical Access Hospitals – Lessons from Federal and State Initiatives

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KEY FINDINGS

- Federal and state transformation initiatives commonly focus on improving the value proposition of participating hospitals, increasing their patient centeredness, and, in some cases, implementing elements of payment reform such as global budgets or incentives related to improving hospital performance.
- Interventions from federal and state initiatives can improve Critical Access Hospitals' (CAHs') responses to market demands and demonstrate the value of CAHs by coordinating care, enhancing operational efficiency, expanding access, improving population health, enhancing value, reducing costs, and developing needed services that address local gaps in care.
- State Flex Programs are ideally positioned to assist CAHs in preparing for the value-based health care environment by assessing the readiness of their CAHs to participate in value-based payment models and implementing a series of projects to systematically move CAHs from where they are to where they need to go based on the results of their assessments.

INTRODUCTION

Hospital transformation is the foundation for recent federal and state efforts to reform health care, including those focused on rural hospitals and other providers. The Centers for Medicare & Medicaid Services Innovation Center's (CMMI) transformation initiatives include the Pennsylvania Rural Health Model (PARHM)¹, the Community Health Access and Rural Transformation (CHART) model^{1,2}, the Vermont All Payer Accountable Care Organization model (VT APM-ACO), and the Accountable Health Communities (AHC) model¹. State programs with a focus on transformation include the Georgia Rural Hospital Stabilization Program^{3,4}, the Arkansas Clinical Transformation (ACT) Collaborative⁵, the Colorado Hospital Transformation Program (HTP)⁶, the Oregon Hospital Transformation Performance Program (HTPP)⁷, and the Vermont Green Mountain Care Board's recent work on hospital transformation and development of new payment models for hospitals.⁸

Based on an extensive review of program materials, evaluation reports, and grey literature, this brief identifies lessons learned from efforts to support transformation activities for Critical Access Hospitals (CAHs) and rural hospitals. It offers a practical definition of hospital transformation and identifies strategies (e.g., managing chronic diseases; screening for the social drivers of health (SDOH); working with their communities to address health-related social needs (HRSN); improving access to primary and specialty care, wellness, and mental health and substance use services for use by State Flex Programs (SFPs) to engage CAHs in transformation activities.



BACKGROUND

CAHs and other rural hospitals have long struggled with financial instability and periodic waves of closures.¹ Between January 1, 2005 and July 16, 2025, 196 rural hospitals, 71 of which were CAHs, closed or converted to another provider type.⁹ Included within this group are 42 rural hospitals, 18 of which were CAHs, that converted to Rural Emergency Hospital (REH) status between January 1, 2023 and July 16, 2025.¹⁰ The COVID-19 pandemic exacerbated long-standing challenges impacting CAHs, CAH-based Rural Health Clinics (RHCs), and rural community health systems, including increased risk of hospital closures, loss of essential services, low investment in primary care and public health, payment policies ill-suited to the needs of low-volume providers, and a maldistribution of health professionals and other resources.¹¹ The pandemic also drove changes in the delivery of care by encouraging greater use of telehealth technology to expand access to services.¹² The following enduring trends continue to impact the stability of CAHs and drive federal and state interest in hospital and health care transformation.¹³

Ongoing financial instability of CAHs – The ongoing financial instability of CAHs and rural hospitals is driven by the misalignment between fee-for-service (FFS) payment policies and the long-term financing needs of CAHs and rural hospitals.^{1,14} FFS reimbursement policies do not adequately cover fixed costs and skew the mix of services by encouraging hospitals to focus on volume rather than value. They also encourage hospitals to provide high-margin specialty services rather than low-margin, high-value services that make a greater contribution to health, such as primary care, behavioral health, chronic care management, and preventive services.¹ Additional financial challenges identified by CAH administrators include rising rates of uncompensated care, patient bypass behavior that reduces hospital revenues, and the growth of high-deductible health plans.¹⁴

Declining need for inpatient hospital beds –

Improvements in technology and medical care allow many services to be provided in less restrictive, lower-cost ambulatory, outpatient, and home settings.^{1,15-19} By 2030, inpatient revenues are projected to be 35% lower than in 2020, and the demand for acute care beds will be 44% lower.¹⁹ Experts estimate that the American health care system will have 60% more inpatient beds than needed in 2030 and that many of these beds will be acute care inpatient beds, rather than intensive care, transitional care, or long-term care beds that would better serve the needs of rural populations.²⁰

Growth of managed care, including Medicare

Advantage and Medicaid managed care plans – In 2024, 54% of the eligible Medicare population was enrolled in a Medicare Advantage plan.²¹ Managed care plans can implement their own incentive and reimbursement policies to drive patient-centered care and improve care quality while lowering the overall cost of care, typically by reducing unnecessary inpatient and emergency department (ED) care and increasing use of outpatient, preventive, home, and virtual care.^{15,19,22} The administrative complexity of complying with the variation in reimbursement policies and approaches to improving value across managed care plans can be burdensome for CAHs and other rural providers.

Increased focus on containing health care costs – In 2020, U.S. health care spending accounted for close to 20% of the gross domestic product (GDP), driven primarily by the COVID-19 pandemic.²³ Although the rate of growth moderated in 2021 and 2022, the overall level of spending remains problematic and is expected to rise to 20.3% of GDP by 2033.²³⁻²⁵ Third-party payers are struggling to control health care costs.²⁴⁻²⁶ To combat rising premiums, commercial payers are shifting a higher percentage of costs to patients through high-deductible health plans.²⁷⁻²⁹ Common strategies to control health care costs (e.g., capped payment rates, limitations on enrollment



in contracted provider panels, utilization review processes, and price transparency requirements) have a proportionately higher impact on rural providers than their urban peers given their higher fixed costs, lower patient volumes, and reliance on Medicare enhanced payment methodologies.³⁰⁻³²

METHODOLOGY

To identify lessons learned from federal and state hospital transformation initiatives, the Flex Monitoring Team (FMT) collected and reviewed source documents, including evaluation reports produced for federal and state sponsors of these models and programs, reports to Congress, reports and studies conducted by rural health research centers funded by the Federal Office of Rural Health Policy (FORHP), peer-reviewed literature, and grey literature produced by foundations, consulting groups, and state and national government agencies. The FMT summarized the models and programs and identified key transformation-related themes.

CONTEXT FOR HEALTH CARE TRANSFORMATION

CMMI has been a primary driver of health care and hospital transformation efforts and has implemented more than 50 payment models over the past 10 years, although comparatively few have focused solely on rural providers.³³ CMMI's transformation efforts have focused on value-based models to support care delivery that is person-centered and cost-efficient through expansion of care coordination and management, team-based care, patient engagement, and attention to HRSN and SDOH.³³⁻³⁵

As part of these efforts, CMMI developed two rural innovation models – PARHM^{13,36} and CHART^{13,37} and two models applicable to CAHs and rural providers – Vermont's APM-ACO³⁸ (due to its implementation in a predominantly rural state) and

the ACH model³⁹ (which had rural participants). See Appendix A, Table 1 for an overview of the elements of these models. Several states also undertook their own transformation activities, including Arkansas, Colorado, Georgia, Oregon, and Vermont. Many of these programs mirror the organization of the federal transformation programs through a combination of value-based payment reform and training, technical assistance, and funding to help CAHs and rural providers prepare for value-based payment models (see Appendix A, Table 2).

SUMMARY OF TRANSFORMATION INITIATIVES

This section describes CMMI and state transformation models that are specifically rural-focused and/or relevant to CAHs and rural providers. These models typically involved payment reform and initiatives to support the value proposition of hospitals and providers by focusing on population health, care management, care coordination, community engagement and collaboration, and operational efficiencies to prepare participants for value-based/advanced payment models. The payment reform strategies do not always directly reimburse hospitals for the transformational activities that improve value. Rather, the underlying logic is that hospital finance improvement can provide hospitals with the opportunity and stability to adopt strategies to improve their value and better serve their communities. As payment reform is beyond the influence of SFPs and the Medicare Rural Hospital Flexibility (Flex) Program, this brief concentrates on the initiatives to prepare CAHs, CAH-based RHCs, and other rural providers to succeed in the evolving value-based payment marketplace, adapt to payment reform as it takes place, preserve and improve access to essential services, and improve population health.

i Rural residents are impacted more heavily by lower incomes, less education, and other SDOH than their urban peers.



Center for Medicare and Medicaid Innovation Models

The Pennsylvania Rural Health Model (PARHM):

PARHM employed two strategies to improve population health outcomes, increase access to high-quality care, strengthen the financial viability of rural acute care hospitals, and reduce the growth of hospital expenditures across all payers.^{40,41} The first strategy involved hospital global budgets with prospectively set payment amounts for hospital services.^{40,41} The second strategy required participants to develop transformation plans that describe their planned activities to address community health needs, attain financial sustainability for the hospital, and achieve savings/budget neutrality for payers.

Evaluation reports covering the first four (2019-2022) of the six performance years identified several key points related to transformation activities.⁴⁰⁻⁴¹

Participating hospitals noted that the model encouraged them to implement strong community engagement activities, including designating staff to facilitate community partnership and engaging new community partners. Hospitals reported that the transformation plans served to accelerate existing community engagement and population health initiatives. Participants also planned service line additions designed to address unmet community needs. While service line additions were driven by their transformation plans, participants explained that these proposed additions were primarily influenced by factors beyond the model, notably the availability of start-up capital and health care professionals to deliver those services.⁴⁰⁻⁴¹

Participating hospitals were required to develop Rural Hospital Transformation Plans that specified how they would redesign the care they provided.⁴⁰ Participants received technical assistance to prepare their plans in accordance with the requirements of the model. Participants reported that their Transformation Plans focused on the needs of their communities and opportunities to improve the health of the residents

of the communities they serve, although many of the issues they identified had previously been raised in their triennial community health needs assessments (CHNAs). Transformation plans developed by participants included strategies to improve:⁴⁰

- Care of patients with chronic illnesses (e.g., addressing SDOH, improving care management/coordination for patients with complex needs, implementing wellness plans, and improving chronic disease screening);
- Access to primary, wellness, emergency, specialty, and diagnostic care (e.g., redesigning primary care; implementing services to meet community needs, and using telehealth technology to expand access to care);
- Access to mental/behavioral health and substance use care (e.g., improving substance use treatment, training, and education; expanding medication-assisted treatment; implementing outreach programs; and developing telehealth services); and
- Operational efficiency (e.g., redesigning space, centralizing internal infection control and dietary policies, improving patient triage and/or ED staffing, and reviewing budgets and service lines).

Many of these initiatives align directly with the goals of the Flex Program and activities undertaken by SFPs (e.g., addressing SDOH, improving quality performance, using telehealth to expand access, or expanding mental health and substance use services). As noted by PARHM participants, they also align with the needs recognized in their triennial CHNAs and related strategy plans. Further, a number of these activities involve the development of reimbursable services (e.g., care management services, integrated mental health services, medication-assisted treatment). Other activities have the potential to control costs and improve operational efficiencies (e.g., redesigning space or reviewing budgets and service lines). As further noted by PARHM participants, they benefited from support and technical assistance provided by members of the



Transformation Team supporting the model. SFPs can focus on providing similar support to CAHs and CAH-based RHCs in their states.

The Community Health Access and Rural Transformation (CHART) Model:

CHART was developed to support rural communities in transforming their health care delivery systems by leveraging innovative financial arrangements and providing operational and regulatory flexibilities.⁴²⁻⁴⁴ CHART planned to:⁴²⁻⁴⁴

- Increase financial stability through payment models that provide up-front investments and predictable, capitated payments and incentivize improvements in quality and patient outcomes;
- Reduce regulatory burden by providing waivers to increase operational and regulatory flexibility for rural providers; and
- Enhance access to services by ensuring rural providers remain financially sustainable and can offer services that address SDOH, including food and housing.

The CHART model experienced a challenging implementation schedule with less interest in participation by states and rural hospitals than expected.⁴⁵⁻⁴⁹ The primary concern expressed by hospital leaders involved the inability of many rural hospitals to participate in risk-sharing arrangements, a theme that was echoed in the Vermont ACO APM model. CMMI eliminated the CHART ACO track in February 2022 and extended the application deadlines for the Community Transformation Track. Despite CMMI's efforts to assist in this process, the four states selected were unsuccessful in recruiting hospitals to participate, primarily due to said concerns about risk-sharing. As a result, CMMI ended the program on September 30, 2023.⁴²

Similar to the expectations under PARHM, the lead organizations for the four participating states were to be responsible for working with participants to develop and implement transformation plans with their community partners. These plans were

expected to describe the participants' health care delivery redesign strategies. Although CHART was ended early and never fully implemented, the focus on developing transformation plans, improving quality reporting, and demonstrating value aligns with Flex Program goals and SFP activities. SFPs can provide similar support and technical assistance to their CAHs to align their activities to support needs identified in CAH CHNAs and encourage activities to improve quality reporting and population health.

The Vermont All Payer Model ACO (VT APM-ACO): The VT APM-ACO included two key elements that sought to shift care from FFS to population-based payments.³⁸ The first involved payment reform through three Medicare, Medicaid, and commercial payers ACO initiatives.⁵⁰ The second element involved three primary population health outcome goals – increasing access to primary care, reducing deaths from suicide and drug overdoses, and reducing the prevalence and morbidity of chronic disease. Primary care visits increased for Medicare ACO beneficiaries between 2014 and 2022. Potential reasons for this success may reflect additional primary care access points, initiatives to connect ED users with a primary care practitioner, and/or increased telehealth use.⁵¹

To address the high rates of deaths from suicide and drug overdoses, Vermont hospitals expanded mental health and suicide screening efforts, embedded mental health clinicians within EDs and primary care offices, and developed initiatives such as walk-in clinics for individuals in crisis. Vermont reported progress toward mental health and substance use performance targets, including high rates of initiation and engagement of alcohol and other substance use disorder treatment and 30-day follow-up after ED discharge for mental health.⁵¹ Vermont also met its performance targets for chronic disease, including diabetes, hypertension, chronic obstructive pulmonary disease, asthma, and tobacco cessation. This was done through existing state and community-level programs.⁵¹



The key lessons learned from the VT APM-ACO include the importance of creating expectations for change as a condition of participation in the overall model, setting measurable performance targets for participants in defined areas of change, and aligning with existing programs to support change and leverage scarce resources. SFPs can adopt a similar approach by identifying common community needs through a review of each CAH's CHNA and strategy plan, identifying existing resources and programs to support hospitals in making the desired changes. One additional lesson was that the use of telehealth and asynchronous screening helped to drive improvements in HRSN screening rates.

The Accountable Health Communities (AHC)

Model: The AHC Model was developed to test whether connecting Medicare and Medicaid beneficiaries to community resources for HRSN would improve quality of care outcomes and reduce costs.³⁹ The AHC Model mandated screening all FFS Medicare and Medicaid beneficiaries for core HRSN (i.e., food insecurity, housing instability, transportation problems, utility difficulty, and interpersonal violence).³⁹

The model paired bridge organizations (e.g., hospitals, health systems, health departments, universities, non-profit organizations, third-party payers, local or state government entities, health information technology firms, and consulting firms) with clinical delivery sites and community service providers in 29 communities.⁵²⁻⁵⁵ Bridge organizations served as 'hubs' in their communities, forming a coordinating consortium to partner with clinical delivery sites to conduct HRSN screenings and make referrals to community services, connect beneficiaries and providers through community service navigation, and align model partners to optimize community capacity.⁵²⁻⁵⁵ The model provided funds to support the infrastructure and staffing needs of bridge organizations and did not pay directly or indirectly for any community services.

The AHC model was successful in reducing health care expenditures, improving quality of care, reducing total expenditures, and increasing beneficiaries' connection to community services and HRSN resolution overall. This model provided evidence that navigation can transform the delivery of care to address HRSN-related barriers to health. Key elements of the AHC model included:⁵²⁻⁵⁵

- Universal screening of all beneficiaries who sought care from participating clinical delivery sites or other sites using a standardized screening tool for the core HRSN to determine eligibility;
- A patient-specific community referral summary, a list of resources tailored to the beneficiary's unmet HRSN, populated from the Community Resource Inventory, a database of community service providers updated at least every 6 months; and
- Navigation involving in-depth assessment, planning, referral to community services, and follow-up until needs were resolved or determined to be unresolvable.⁵²⁻⁵⁵

The community and population health improvement initiatives from the AHC model align closely with the Flex Program and are similar in many ways to current SFP initiatives. SFPs can undertake efforts to improve screening for HRSN, encourage the development of resource and referral directories, encourage greater engagement with community agencies, and provide support and technical assistance to help CAHs implement these strategies.

State Hospital Transformation Initiatives

The Georgia Rural Hospital Stabilization Program

(RHSP): In March 2014, the Georgia Department of Health and the Georgia Office of Rural Health (GORH) implemented the RHSP, which finished its seventh year of funding on August 31, 2023.⁵⁶⁻
⁵⁹ In 2024, RHSP was folded into a new dual track funding program – (1) the Rural Hospital Support Grant for Hospital Stabilization and (2) Graduate Medical Education with grantees eligible to apply



for one but not both of the funding tracks.⁶⁰ RHSP was established to support the development of an integrated ‘hub and spoke’ model to prevent the over-utilization of EDs as primary care access points, promote greater community engagement among local providers and service agencies, and use technology to treat patients in the most appropriate setting to relieve cost pressures on rural EDs.⁵⁶⁻⁵⁹ The State of Georgia allocated grant funding, which was provided to participating CAHs and prospective payment system hospitals. The core objectives of the RHSP were to increase access to primary care, increase market share, reduce potentially avoidable readmissions, and reduce inappropriate utilization of the ED.⁵⁶⁻⁵⁹

Over time, grantees expressed a desire for more flexibility with the use of RHSP funds to allow a tailored approach to address individual needs.⁵⁹ To address this desire for greater flexibility, the RHSP was modified based on recommendations of GORH leadership. The program maintained the hub and spoke framework and community engagement mandates and required a portion of funds to be directed to at least one ‘traditional’ project.⁵⁶⁻⁵⁹ In addition to supporting at least one traditional project, grantees were allowed to use funds to support costs associated with program administration. Each project was required to meet one or more of the identified core objectives and support the “right care, at the right time, and in the right setting” philosophy of the RHSP.

In the final year of original RHSP funding (2023), eight rural hospitals, including four CAHs were funded.⁶¹ Examples of funded projects during the multiple rounds of funding included development of new service lines; expansion of primary care and other services to surrounding communities; replacement of equipment; renovations of clinical space; implementation of programs to improve operational efficiencies; and development of transportation, care coordination, telemedicine,

and behavioral health care programs. According to participants, care coordination projects were the most impactful and telemedicine projects were the least impactful.⁵⁶

While initiatives related to renovating clinical space or the purchase of equipment are outside of the funding requirements for the Flex Program, SFPs can still benefit from the lessons learned regarding expansion of community engagement and collaboration between community and regional partners, implementation of programs to improve operational efficiency, and implementation of programs to support care coordination, telemedicine, and behavioral health care programs.

The Arkansas Clinical Transformation (ACT)

Collaborative: In recognition of its high rates of chronic diseases, the Arkansas Department of Health implemented the ACT Collaborative to assist hospital-based and independent primary care clinics in improving chronic disease management.⁶² The program created and continues to create partnerships between primary care clinics, the University of Arkansas for Medical Sciences, quality improvement consultants, and subject matter experts to improve the delivery of care, outcomes, and quality of life for chronic disease patients. ACT provides clinics with funding and technical assistance to support their work in the following areas:⁶²

- Quality improvement training and support (e.g., mapping current clinical processes, assessing a clinic’s capability to report data, and/or recommending electronic health record [EHR] modifications to build patient registries);
- Implementing the Chronic Care and Institute for Healthcare Improvement models;
- Enhancing data management and reporting; and
- Preparing primary care practices to implement the National Committee for Quality Assurance Patient-Centered Medical Home (PCMH) accreditation.⁶²⁻⁶³



The ACT program is still in operation, although it is currently undergoing changes. Based on a conversation with the staff from the Arkansas Department of Health, the program is being revised to incorporate a chronic care-focused patient registry. Participants will continue to have access to training and technical assistance to support their engagement in the ACT Collaborative.

As with other initiatives, the focus on chronic care management aligns with the goals of the Flex Program and suggests an opportunity to provide education, training, and support to their CAHs to enhance their chronic care management efforts.

The Colorado Hospital Transformation Program (HTP): Colorado's HTP is centered around the value-based principles of improving patient health and reducing costs while encouraging collaboration among providers.⁶⁴ Program success is measured by Medicaid cost savings, reductions in hospital readmission rates and ED visits, and improvements in special population patient outcomes (i.e., pediatric and behavioral health patients) and in the coordination of their care.⁶⁴ The HTP is a five-year program that began in 2021. The first year, CAHs and other acute care hospitals developed their plans to meet the HTP goals and develop metrics for the actions taken to meet the goals.⁶⁴⁻⁶⁷ The second and third years of the program expanded the special populations to include end-of-life patients and patients prescribed opiates.⁶⁵ The fourth and fifth years are when the changes in payments occur for the participants.⁶⁴⁻⁶⁷

All Colorado hospitals, including CAHs, were required to participate in the HTP, while CAHs were given extra financial support via the Rural Support Fund.⁶⁸⁻⁶⁷ CAHs that did not engage in the HTP forfeited their Supplemental Medicaid Payments. If CAHs were unable to fully meet their program demands, the percentage of funds distributed to them was reduced based on their HTP performance.⁶⁵⁻⁶⁷ CAHs that reduced Medicaid costs received financial awards.⁶⁵⁻⁶⁷

Participants were required to conduct a Community and Health Neighborhood Engagement process.⁶⁴ CAHs within the HTP noted that the increase in communication with community stakeholders was beneficial and brought insights to patient needs, delivery of care, and resources.⁶⁵ Key features of the HTP included the intentional partnership approach built into the process at the community and state levels, the provision of support and resources to participants, and building trust and engagement with small rural hospitals by the state.^{65,66}

Although the provision of financial awards related to performance improvement is outside of the scope of Flex Program activities, SFPs can work with and support their CAHs in efforts to better engage community partners and stakeholders and improve coordination of care.

The Oregon Hospital Transformation Performance Program (HTPP): In July 2014, Oregon established the HTPP to support hospital engagement with their Coordinated Care Organizations (CCOs), which are essentially Medicaid ACOs.⁶⁸ On January 12, 2017, Oregon's 1115(a) Medicaid demonstration waiver, which created the CCOs, was extended through June 30, 2022.⁶⁸ As part of this process, the HTPP was extended through June 30, 2018, at which point hospital pay-for-performance incentive payments were transitioned under the CCO contracts.⁶⁹ Based on the 2018 recommendations of the Oregon Health Policy Board, Oregon implemented CCO 2.0, which built on lessons learned from the first five years of work with CCOs. Specific CCO 2.0 goals included improving behavioral health systems, increasing value/pay for performance, focusing on SDOH, and maintaining sustainable cost growth.⁷⁰⁻⁷³

The HTPP was a hospital incentive pool, created to issue incentive payments for adopting quality improvement activities and the measurement of resulting performance improvement.⁷⁰⁻⁷² The Oregon Health Authority streamlined the approach to health transformation by having CCOs



coordinate and align their transformation and quality work through the Transformation and Quality Strategy.⁷⁰⁻⁷²

The HTPP offered incentive payments to hospitals to improve the patient experience of care, enhance quality and satisfaction, improve the health of the covered populations, reduce the per capita cost of care, and focus on value rather than volume.⁷⁰⁻⁷¹ The legislatively established Hospital Performance Metrics Advisory Committee selected 11 outcome metrics and benchmarks covering six domains.^{68,70-72} Hospitals earned incentive payments by achieving the targets associated with these measures.^{68,70-72} The HTPP also encouraged enhanced collaboration between participating non-profit hospitals, accredited health departments, and CCOs to coordinate and leverage their required CHNAs (hospitals and accredited health departments) with the required CCO community health improvement plans.

Although it is outside of the scope of the Flex Program to provide direct incentives for performance improvement, SFPs can focus on efforts to encourage and support collaboration between their CAHs, other providers, health departments, and other key players to implement strategies to mitigate gaps in local delivery systems, better use scarce resources, and improve the health of their communities.

Vermont Act 167 - Hospital System Transformation and Community Engagement Process: In 2022, the Vermont Legislature passed Act 167 to fund an investigation on how to improve health system sustainability and hospitals' financial health.⁸ Act 167 recognized that Vermont's hospitals, particularly its rural hospitals, were in poor and continuously deteriorating financial health.^{8,74} It also acknowledged that increasing commercial prices to sustain hospitals was no longer a viable option, given the affordability crisis in Vermont.^{8,74} The goals for this effort included:

- Working with communities, providers, and insurers to improve outcomes and control costs;

- Helping hospitals and communities to make decisions about their systems to remain fiscally sustainable and provide the care Vermonters need; and
- Pursuing federal funding sources to support transformation activities, including addressing affordability, access, and workforce development.⁷⁴

Although this study is not a model focused on immediate hospital behavior change, it highlights the importance of encouraging hospitals to become more patient-centered and adopt strategies to succeed under value-based payment systems. It also mirrors similar strategies discussed in the federal and state models and programs discussed earlier in this brief.

DISCUSSION

The transformation initiatives we reviewed shared two common features. The first was an element of payment reform, most commonly focused on stabilizing hospital finances and incentivizing hospitals to improve their value proposition. The Health Care Transformation Task Force, a collaborative of providers, payers, purchasers, and patient advocates, has described value-based care as the best current option for improving high-quality, person-centered care delivery; moderating health spending; and making health care more affordable for patients.⁷⁵ PARHM highlighted the importance of preparing a formal transformation report, an exercise that was new to many of the participants.⁷⁶

The second feature of these models and programs involved the provision of resources, technical assistance, and support to CAHs and other providers to deliver patient-centered care, improve the quality of care, and reduce the cost of care by eliminating unnecessary inpatient admissions and ED use. The intent of these efforts is to improve the capacity of hospitals, including CAHs, to succeed under new payment models, including global budgets, ACOs, and other value-based advanced payment models.



The models and programs varied in the extent to which they approached the concept of transformation; however, there were significant commonalities in the strategies and activities undertaken. Common strategies across the nine models and programs included encouraging participants to:

- Coordinate and manage care of patients with chronic diseases;
- Address HRSN and SDOH;
- Improve access to primary care, wellness, and specialty services;
- Improve the collection, sharing, and reporting of quality data;
- Improve quality of care;
- Expand the availability of mental health and substance use services;
- Encourage greater use of telehealth to improve access to care;
- Expand community engagement and collaboration; and
- Improve hospital operational efficiency.

The payment reform strategies implemented by the nine models and programs did not directly pay participants to engage in these activities; rather, they provided incentive payments or bonuses for improving performance on key measures related to controlling costs, improving population health, or reducing unnecessary inpatient admissions or ED utilization. The underlying logic is that the financial stabilization of rural hospitals and providers will provide them with the opportunity and flexibility to undertake these efforts. It should also be noted that some of these strategies are reimbursable by third-party payers (e.g., implementing or expanding primary care, chronic care management, and/or integrated behavioral health services) or can have a direct impact on improving operational efficiencies or reducing the cost of care.

It is important to acknowledge that the focus on chronic care management, patient and community engagement, the importance of population health, the

need for expanded primary care, mental health, and substance use services, and the focus on value are not new concepts. These strategies have been reflected in numerous projects implemented by SFPs over the current and past funding cycles. SFPs are thus well-positioned to work with their CAHs and related partners on similar initiatives.

It is clear, however, that many CAHs struggle with implementing these types of initiatives. The efforts of CMMI and state transformation models attest to the ongoing need to support CAHs to succeed in value-based care. It is important to note that CAHs and CAH-based RHCs can be reimbursed by third-party payers for the expansion of essential services, including primary care, chronic care management, and integrated behavioral health, either in office or through telehealth. Improving operational efficiency, the use of data to improve and demonstrate quality, and the ability to share data with clinical partners will benefit CAHs and other providers that are struggling to remain financially viable. It is also important to note that the concepts of engaging communities in supporting their local health systems and collaborating with local partners to address community needs are tied closely to the Internal Revenue Service's (IRS's) hospital accountability efforts (i.e., community benefit reporting, CHNAs, and CHNA-related implementation/strategy plans).

CONCLUSION

Federal and state transformation models and programs are typically focused on preparing hospitals and providers for value-based care in response to market forces that demand evidence of quality and the ability to reduce the costs of care. Common areas of activity include expanding primary care, implementing care management programs, addressing chronic diseases, implementing integrated behavioral health services, developing collaborative community partnerships to address HRSN, and improving quality management and reporting. These activities closely align with the goals of the



Flex Program and are areas in which a number of SFPs are currently engaged. They also directly align with the expectations established by the IRS's hospital accountability requirements.

The breadth of initiatives implemented by federal and state transformation models and programs suggests opportunities for SFPs to develop an integrated approach to supporting hospital preparation for value-based care across the Flex Program's distinct program areas.

As noted in our discussion of the selected transformation models and programs, payment reform is an important element of hospital transformation; however, these new payment models may not be sufficient to incentivize the level of change necessary to transform health care delivery systems. This reality provides an opportunity for SFPs to leverage their resources to support CAHs to participate and succeed in federal and state models and programs and encouraging them to become more patient-centered, engage in population health improvement activities, improve quality reporting and performance, improve operational efficiency, and work with payers to moderate rising health care costs. To encourage SFPs to think about their role in supporting CAHs to succeed in a value-focused health care environment, we offer the following practical definition of hospital transformation:

Hospital transformation involves efforts to encourage hospitals to become more patient-centered by reorienting hospital delivery systems around patients, in response to evolving care paradigms, reimbursement policies, market forces, and the health care environment.

CAH transformation may seem like a lofty goal for SFPs, as it sounds more intimidating than it needs to be. It is easy to fall into the trap of promoting radical change and expecting immediate, "big" results. In reality, CAHs can be moved towards patient-centered hospital transformation and value through a series of

sequential steps that move them closer to where they need to go. CAH transformation involves starting from where they are and moving one project at a time to the point where they can demonstrate their value to patients and payers. Under this definition, transformation is an outcome that is realized step-by-step, through the implementation of targeted projects. Transformation in CAH performance is produced by the accumulation of actions and adjustments resulting from implemented projects.

As a starting point, SFPs can support CAHs by assessing their readiness to participate in value-based payment models. While different consulting firms and professional organizations have developed assessment tools for this area of work, access to them is typically fee-based or dependent on membership in the sponsoring organizations. As an alternative, Rural Health Value offers an assessment tool that can be used by SFPs to assess the readiness of their CAHs to participate in value-based payment models.⁷⁷ We encourage SFPs to consider modifications of the assessment tool to reflect the value-based payment models or programs and related payment reforms underway in their states.

Upon completion and analysis of the readiness assessment data from their CAHs, SFPs can begin to develop a strategic plan to improve the capacity of CAHs to participate in value-based payment models and demonstrate their value to patients, their communities, and third-party payers. Their ability to demonstrate their value can improve their negotiating power with ACOs, Medicare Advantage plans, and managed care plans. Rural Health Value has produced a companion document to their assessment tool - [Using the Value-Based Care Tool – Prioritizing Capacities and Planning for Action](#), which provides examples of a priority analysis and action plan for a hospital that has completed the assessment tool.⁷⁸

SFPs may use the results of the assessments for multiple CAHs to identify and develop a funding cycle cohort-based project to improve the capacity of



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participating CAHs to demonstrate their value in their local markets. Past FMT studies in the Quality Improvement and Population Health Program Areas suggest strategies to assist SFPs with developing a cohort-based project to help CAHs succeed in the value-based marketplace based on the results of their readiness assessments (Appendix B).

For example, SFPs may work with a cohort of CAHs to improve their collection and reporting of Medicare Beneficiary Quality Improvement Project (MBQIP) data under the QI Program Area. Under the QI and Financial and Operational Improvement Program Areas, SFPs may work with CAHs to streamline clinical and financial operations, reduce hospital costs, improve patient care quality, minimize waste, streamline how they work, and maximize value for patients and payers by implementing LEAN or Six Sigma-based interventions. Depending on the focus of their LEAN or Six Sigma interventions, outcomes of these efforts may be reductions in wait times, medication errors, or unnecessary transports. Under the Population Health Program Area, SFPs may work with a cohort of participating CAHs to implement HRSN and SDOH screening protocols; develop referral programs for patients with HRSN; implement integrated behavioral health and primary care services; or encourage substantive collaboration with local and regional health departments, providers, social service agencies, schools, governments, and businesses.

SFPs are ideally positioned to assist CAHs with demonstrating their value by coordinating care, enhancing operational efficiency, expanding access, improving population health, enhancing value, reducing costs, and developing services that address gaps in local care (e.g., implementing chronic care management, collaboratively addressing HRSN, expanding primary care, and developing integrated behavioral health and primary care services). Doing so will assist CAHs by helping them to demonstrate their value in a value-based payment environment and, as a result, improve their ability to negotiate with third-party payers.

For more information on this report, please contact John Gale, john.gale@maine.edu.

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REFERENCES

1. Gale JA. (2023, September). Twenty-five years of the Medicare Rural Hospital Flexibility Program: The past as prologue. *J Rural Health*, 39(4):691-701. doi: 10.1111/jrh.12754. Epub 2023 Mar 15. PMID: 36922153.
2. Centers for Medicare and Medicaid Services. (2023, September 30). CHART Model. <https://www.cms.gov/priorities/innovation/innovation-models/chart-model>
3. State Office of Rural Health, Georgia Department of Community Health. (2019, December). The rural hospital stabilization program: A comprehensive report. https://dlg.galileo.usg.edu/data/dlg/ggpd/pdfs/dlg_ggpd_s-ga-bc900-pr8-bm1-b2019-bh6-belec-p-btext.pdf
4. State Office of Rural Health, Georgia Department of Community Health. (2022, November). The rural hospital stabilization program: A comprehensive report. Addendum 1: Rural hospital stabilization grant program, phase five. <https://dch.georgia.gov/document/document/rhs-phase-5-comprehensive-report-addendum-nov-2022/download>
5. Arkansas Department of Health. (N.D.) Arkansas clinical transformation (ACT) collaborative. <https://healthy.arkansas.gov/boards-commissions/committees/arkansas-clinical-transformation-act-collaborative/>
6. Colorado Department of Health Care Policy & Financing. (2025). Colorado hospital transformation program 101 - Hospital transformation program overview. <https://hcpf.colorado.gov/colorado-hospital-transformation-program-101>
7. Kushner J, Young J, Chan B, McConnell J, Broffman L, Royal N, Wright B, & Weller M. (2016, June 29). Hospital transformation performance program (HTPP) evaluation report. <https://digitalcollections.library.oregon.gov/nodes/view/139774>
8. Vermont Green Mountain Care Board. (2024, June 19). Act 167 (2022): A brief history & why hospital system transformation is necessary to preserve Vermonters' access to essential services. <https://gmcboard.vermont.gov/sites/gmcb/files/documents/167-brief-history-and-motivation-6.19.pdf>
9. Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. (2025, March 20). 196 rural hospital closures and conversions since January 2005. Accessed March 27, 2025. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>
10. Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. (2025, March 13). 42 hospitals have converted to rural emergency hospitals since January 2023. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-emergency-hospitals/>
11. Gale J, Knudson A, Popat S. (2020, September 17). Rebuilding the foundation of rural community health after COVID-19. 2020. <https://www.themedicalcareblog.com/covid-19-impact-rural-community-health/>
12. Jazieh AR and Kozlakidis Z. (2020). Healthcare transformation in the post-coronavirus pandemic Era. *Front. Med.* 7:429. doi: 10.3389/fmed.2020.00429
13. Center for Medicare and Medicaid Innovation. (2024, November 12). CMS Innovation Center Report: Re-imagining rural health: Themes, concepts, and next steps from the CMS Innovation Center "hackathon" series. <https://www.cms.gov/files/document/reimagining-rural-health-strategy.pdf>
14. Thomas S, Thompson K, Knocke K, G. P. (2021, February). Health system challenges for critical access hospitals: Findings from a national survey of CAH executives. <https://www.shepscenter.unc.edu/download/22078/>
15. Prevost T, Skillrud I, Gerhardt W, Mukherjee D. (2020). The potential for rapid consolidation of health systems: How can hospitals use M&A to innovate for the future? Deloitte Center for Health Solutions. https://www2.deloitte.com/content/dam/insights/us/articles/6616_CHS_Great-consolidation-refresh/6616_CHS_Great-consolidation-refresh.pdf
16. Singhal S, Radha M, Vinjamoori N. (2022, March 24). The next frontier of care delivery in health care. McKinsey & Company. <https://www.mckinsey.com/~media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/the%20next%20frontier%20in%20health%20care/the-next-frontier-of-healthcare-delivery.pdf>



17. VenDenBoom L. (2021, December 10). 10 health care industry trends to watch in 2022. <https://hc1.com/blog/10-healthcare-trends-2022>
18. Zimlichman E, Nicklin W, Aggarwal R, Bates D. (2021) Health care 2030: The coming transformation. *NEJM Catalyst*. 2021. doi: 10.1056/CAT.20.0569.
19. Gerhardt W, Arora A. (2020, February 21). Hospital revenue trends: Outpatient, home, virtual, and other care settings are becoming more common. Deloitte Insights. <https://www2.deloitte.com/us/en/insights/industry/health-care/outpatient-virtual-health-care-trends.html>
20. Javanmardian M, Tomczyk T, Bach B, Doria S. (2020). Health care supply will be right sized. How health care supply can better fit demand. *Oliver Wyman Health Innovation Journal*, 4:24-30.
21. Freed M, Biniek J, Damico A, Neuman T. (2024, August 8). Medicare Advantage in 2024: Enrollment update and key trends. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>
22. Centers for Medicare and Medicaid Services. (2024, April 1). 2025 Medicare Advantage and Part D rate announcement. <https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-rate-announcement#:~:text=CMS's%20goals%20for%20MA%20and,selecting%20%E2%80%9C2025%20Announcement.%E2%80%9D&text=The%20chart%20below%20indicates%20the,plan%20payments%20relative%20to%202024>
23. Taylor T. (2025, July 1). US health care expenditures: An ominous trend returns? <https://conversableeconomist.com/2025/07/01/us-health-care-expenditures-an-ominous-trend-returns/>
24. Centers for Medicare and Medicaid Services. (N.D.) National health expenditure projections – 2023-2032. Forecast summary. <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>
25. Keehan S, Madison A, Poisal J, Cuckler G, Smith S, Sisko A, Fiore J, & Rennie K. National Health Expenditure Projections, 2024–33: Despite Insurance Coverage Declines, Health to Grow as Share of GDP *Health Affairs* 2025 44:7, 776-787.
26. Aron-Dine A, Hayes K, Broaddus M. (2020, July). With need rising, Medicaid Is at risk for cuts - Center on Budget and Policy Priorities. <https://www.cbpp.org/sites/default/files/atoms/files/7-22-20health.pdf>
27. Manatt Health, The Robert Wood Johnson Foundation. (2021, October 5). The Manatt state cost containment update: Accountability and consumer affordability. <https://assets-us-01.kc-usercontent.com/9fd8e81d-74db-00ef-d0b1-5d17c12fdda9/6df1538a-d236-4aa7-a46a-81c216572771/The-Manatt-State-Cost-Containment-Update-PDF-10-04-2021-v2.pdf>
28. Chernew C, Cutler D, & Shah S. (2021, August 18). Reducing health care spending: What tools can states leverage? <https://www.commonwealthfund.org/publications/fund-reports/2021/aug/reducing-health-care-spending-what-tools-can-states-leverage>
29. Young G, Rae M, Claxton G, Wager E, Krutika A. (2022, March 10). How many people have enough money to afford private insurance cost sharing? <https://www.healthsystemtracker.org/brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-in-typical-private-health-plans/>
30. Starner T. (2021, November 21). Here's why health care costs will be volatile in 2022 and beyond. <https://hrexecutive.com/heres-why-healthcare-costs-will-be-volatile-in-2022-and-beyond/>
31. Walker E. (2024, July 8). Nine reasons for rising health care costs. <https://www.peoplekeep.com/blog/nine-reasons-for-rising-health-care-costs>
32. Chernew M, Dafny L, Pany M. (2020, March). A proposal to cap provider prices and price growth in the commercial health-care market. https://www.hamiltonproject.org/assets/files/CDP_PP_WEB_FINAL.pdf
33. Fowler E, Rudolph N, Davidson K, Finke B, Flood S, Bernheim S, Rawal P. (2023). Accelerating care delivery transformation — The CMS Innovation Center's role in the next decade. *NEJM Catalyst Innov Care Deliver*, 4(11).
34. Center for Medicare and Medicaid Services. (N.D) The CMS Innovation Center's transformation initiative at-a-glance. <https://www.cms.gov/files/document/transformation-initiative-2pager-aag.pdf>



35. Centers for Medicare & Medicaid Services. (2022, November). Person-centered innovation — An update on the implementation of the CMS Innovation Center’s strategy. <https://innovation.cms.gov/data-and-reports/2022/cmimi-strategy-refresh-imp-report>
36. Center for Medicare and Medicaid Services. (N.D.) Pennsylvania rural health model. <https://www.cms.gov/priorities/innovation/innovation-models/pa-rural-health-model>
37. Center for Medicare and Medicaid Services. (N.D.) Chart model. <https://www.cms.gov/priorities/innovation/innovation-models/chart-model>
38. Center for Medicare and Medicaid Services. (N.D.) Vermont all-payer ACO model. <https://www.cms.gov/priorities/innovation/innovation-models/vermont-all-payer-aco-model>
39. Center for Medicare and Medicaid Services. (N.D.) Accountable health communities model. <https://www.cms.gov/priorities/innovation/innovation-models/ahcm>
40. NORC at the University of Chicago. (2024, December). The Pennsylvania rural health model (PARHM) fourth annual evaluation report. <https://www.cms.gov/priorities/innovation/data-and-reports/2024/parhm-ar4>
41. NORC at the University of Chicago. (2023, September). The Pennsylvania rural health model (PARHM) third annual evaluation report. <https://www.cms.gov/priorities/innovation/data-and-reports/2023/parhm-ar3>
42. Center for Medicare and Medicaid Services. (N.D.) Chart model. <https://www.cms.gov/priorities/innovation/innovation-models/chart-model>
43. Center for Medicare and Medicaid Services. (2020, August 11). Community health access and rural transformation (CHART) model fact sheet. <https://www.cms.gov/newsroom/fact-sheets/community-health-access-and-rural-transformation-chart-model-fact-sheet>
44. Rural Health Value. (Updated 2021, March 2). CHART community transformation track – Q&A. <https://ruralhealthvalue.public-health.uiowa.edu/CHART/CHART%20QAs.pdf>
45. American Hospital Association. (2021, May). Future of rural health care task force. Final recommendations. <https://www.aha.org/system/files/media/file/2021/05/final-recommendations-future-of-rural-health-care-task-force-may-2021.pdf>
46. Borumand S. (2022, June). Profiling rural regions for CHART expansion. Harvard Kennedy School, Mossavar-Rahmani Center for Business & Government, M-RCBG Associate Working Paper Series No. 188. https://www.hks.harvard.edu/sites/default/files/centers/mrcbg/files/188_AWP_final.pdf
47. Karle A, Coakley Stowe E. (2020, December 11). CHART model community transformation track: Value proposition for states. <https://www.shvs.org/chart-model-community-transformation-track-value-proposition-for-states/>
48. Miller HD. (2020, October). Why the CMS CHART model will hurt rural hospitals. https://chqpr.org/downloads/Problems_With_CMS_CHART_Model.pdf
49. Center for Health care Quality and Payment Reform. (N.D.) Rural hospitals at risk of closing. https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
50. Lunge R. (2018, June). An early look at Vermont’s rollout of its value-based, multi-payer “next gen” model to lower costs and improve population health. https://nashp.org/wp-content/uploads/2018/06/NASHP-ACO-Model-Issue-Brief-final-6_8_2018.pdf
51. NORC at the University of Chicago. (2024, June). Evaluation of the Vermont all-payer accountable care organization model: 2018–2022. <https://www.cms.gov/priorities/innovation/data-and-reports/2024/vtapm-4th-eval-full-report>
52. Center for Medicare and Medicaid Services. (2024, November). Accountable health communities (AHC) model evaluation: Third evaluation report. <https://www.cms.gov/priorities/innovation/data-and-reports/2024/ahc-3rd-eval-report>
53. Center for Medicare and Medicaid Services. (2023, May). Accountable health communities (AHC) model evaluation: Second evaluation report. <https://www.cms.gov/priorities/innovation/data-and-reports/2023/ahc-second-eval-rpt>



54. Center for Medicare and Medicaid Services. (2020, December) Accountable health communities (AHC) model evaluation: First evaluation report. <https://www.cms.gov/priorities/innovation/data-and-reports/2020/ahc-first-eval-rpt>
55. Alley D, Asomugha C, Conway P, Sanghavi D. (2016, January 7). Accountable health communities — addressing social needs through Medicare and Medicaid. *N Engl J Med* 2016;374 (1):8-11. DOI: 10.1056/NEJMp1512532.
56. State Office of Rural Health, Georgia Department of Community Health. (2019, December). The rural hospital stabilization program: A comprehensive report. <https://dch.georgia.gov/divisionsoffices/stateoffice-rural-health/rural-hospital-stabilization-program/rhs-reports>
57. State Office of Rural Health, Georgia Department of Community Health. (2022, November). The rural hospital stabilization program: A comprehensive report. Addendum 1: Rural hospital stabilization grant program, phase five. <https://dch.georgia.gov/document/document/rhs-phase-5-comprehensive-report-addendum-nov-2022/download>
58. Georgia Department of Community Health. (2022, December 31). Rural hospital stabilization grant program - Phase 6 program report. <https://dch.georgia.gov/divisionsoffices/state-office-rural-health/rural-hospital-stabilization-program/rhs-reports>
59. England T. & Lucas D. (2015, February 13). Rural hospital stabilization committee final report to the governor. <https://dch.georgia.gov/document/document/rural-hospital-stabilization-committee-report-022315-final/download>
60. Georgia Department of Community Health. (2023, November 16). Request for grant application - dual track rural hospital support grant for hospital stabilization or graduate medical education. <https://dch.georgia.gov/document/document/dualtrackrfgafinal111523/download>
61. Georgia Department of Community Health, (2023, July 5). Notice of award - Rural hospital stabilization grant program 2023. <https://dch.georgia.gov/document/document/noarfgaruralhospitalstabilization2023/download>
62. Arkansas Department of Health. (N.D.) The Arkansas clinical transformation (ACT) collaborative. Accessed March 18, 2025.
63. Arkansas Center for Health Improvement. (2015). Case study patient-centered medical homes: Using data to improve population health. <https://achi.net/wp-content/uploads/2018/01/PCMH-Case-Study-Using-Data-to-Improve-Population-Health.pdf>
64. Colorado Department of Health Care Policy and Financing. (2025). Colorado hospital transformation program. <https://hcpf.colorado.gov/colorado-hospital-transformation-program>
65. Rural Health Value. (2023, October and revised 2025, March 6). Rural innovation profile: Rural hospital experiences in the Colorado hospital transformation program. https://ruralhealthvalue.public-health.uiowa.edu/files/Colorado_Hospital_Transformation.pdf
66. Colorado Health Institute. (2019, October). The hospital transformation program - What we know so far about Colorado's latest value-based care initiative. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/HTP%2520Primer_2.pdf
67. Colorado Department of Health Care Policy and Financing. (2023, October 19). Colorado hospital transformation program - Frequently asked questions. https://hcpf.colorado.gov/sites/hcpf/files/HTP%20Frequently%20Asked%20Questions%20%28FAQ%29_10.19.23.pdf
68. Starr J. (2015, June 5). Proposal To extend the Oregon Health Authority's hospital transformation performance program through June 30, 2017. <https://www.thelundreport.org/content/proposal-extend-oregon-health-authoritys-hospital-transformation-performance-program>
69. Centers for Medicare and Medicaid Services. (2017, January 12). Approval of Oregon's extension of section 1115(a) Medicaid demonstration, entitled "Oregon Health Plan (OHP)" (Project Number 21-W-00013/10 and 11-W-00160/10). <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/or/or-health-plan2-ca.pdf>
70. Oregon Health & Science University, Center for Health System Effectiveness. (2016, June 29). Hospital transformation performance program (HTPP) evaluation report. <https://digitalcollections.library.oregon.gov/nodes/view/139774>



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71. Shenoy S & Mickey Rork M. (2018, February). Oregon Medicaid transformation - Is coordinated care the answer? <https://www.theactuarmagazine.org/oregon-medicaid-transformation/>
72. Oregon.Gov. (2022, June). Paying for value in health care: A roadmap for implementing the Oregon value-based payment compact. <https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20Meeting%20Documents/6.-VBP-Compact-Roadmap.pdf>
73. Sherwood C. (2014, July 2). Hospitals worry about competition, reimbursement by CCO. <https://www.thelundreport.org/content/hospitals-worry-about-competition-reimbursement-cco>
74. State of Vermont Agency of Human Services. (2025). Health care transformation. <https://humanservices.vermont.gov/health-care-transformation>
75. Health Care Transformation Task Force. (2024, January 9). Celebrating ten years in value-based care – Reflections and foresights. <https://hcttf.org/the-task-force-releases-celebrating-ten-years-in-value-based-care-reflections-and-foresights/>
76. Raths D. (2025, February 28). What's the future of value-based care for rural hospitals? <https://www.hcinnovationgroup.com/policy-value-based-care/alternative-payment-models/article/55271566/whats-the-future-of-value-based-care-for-rural-hospitals>
77. Rural Health Value. (2024, February). Value-based care strategic planning tool, V4. <https://ruralhealthvalue.public-health.uiowa.edu/vbc/VBCsurvey.pdf>
78. Rural Health Value. (2024, February). Using the value-based care tool – Prioritizing capacities and planning for action. Accessed March 31, 2025. <https://ruralhealthvalue.public-health.uiowa.edu/vbc/VBCActionPlan.pdf>



APPENDIX A: Features of CMMI and State Transformation Models

TABLE 1. Features of CMMI Transformation Models

Purpose	Payment Approach	Transformation Activities
<i>Pennsylvania Rural Health Model (PARHM)</i>		
Tested whether access to high-quality care in rural Pennsylvania could be improved through care delivery transformation and hospital global budgets	Hospital Global Budgets	Participants prepared transformation plans that described activities to address community health needs, attain financial sustainability, and achieve savings/budget neutrality for payers
<i>Community Health Access and Rural Transformation (CHART)</i> ACO track terminated from CHART in 2/22; CHART ended early on 9/30/23		
Designed to test a way for rural communities to transform their health care delivery systems by leveraging innovative financial arrangements and operational and regulatory flexibilities	Developed new ways of reimbursing providers that provided upfront investments and capitated payments to pay for quality and patient outcomes	Focused on activities to improve value and reduce unnecessary hospital admissions and ED use
<i>Vermont All Payer Accountable Care Organization (VT APM-ACO)</i>		
Tested whether the health of Vermont’s population could be improved by transforming the relationships between care delivery and public health systems	Capitated payments to ACOs, risk-based payments under Medicare, negotiated payments under Medicaid and commercial payers	Focused on activities to improve value, reduce unnecessary admissions and ED use, increase access to primary care, reduce deaths from suicide and drug overdoses, and reduce the prevalence and morbidity of chronic disease
<i>Accountable Health Communities (AHC)</i>		
Tested whether systematically identifying and addressing the health-related social needs (HRSN) of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services could reduce health care costs and utilization	Funded infrastructure and staffing needs of the community bridge organizations	Focused on building collaborative relations at the community level to address HRSN



TABLE 2. Features of State Transformation Programs

Purpose	Payment Approach	Transformation Activities
Georgia Rural Hospital Stabilization Program		
Supported development of an integrated hub and spoke model to prevent overutilization of EDs as a primary care access point	Provided grant funding to support stabilization at the hospital level	Supported hub and spoke models to increase access to primary care, increase market share, reduce potentially avoidable admissions, and reduce inappropriate ED use
Arkansas Clinical Transformation (ACT) Collaborative		
Supported improvement and expansion of chronic care management by hospital-based and independent clinics	Provided incentive payments for improved performance	Provided training and technical assistance for quality improvement, implementation of chronic care models, improvements to data management capacity, and designation as a patient-centered medical home
Colorado Hospital Transformation Program (HTP)		
Provided support and resources to assist hospitals to participate in a Medicaid value-based payment model	Provided incentives to hospitals participating in Medicaid value-based payment models	Provided technical assistance, education, and funding to support participation in value-based models
Oregon Hospital Transformation Performance Program (HTTP)		
Supported hospitals to successfully engage in the Community Care Organizations (CCOs) (geographically defined Medicaid ACO)	Provided incentives to hospitals to prepare for participation in CCOs and risk sharing between CCOs and participants	Supported improvements to the behavioral health system, increased value performance of hospitals participating in CCOs, improved efforts to address SDOH, and maintained sustainable cost growth
Vermont Act 167 - Hospital System Transformation and Community Engagement Process*		
Funded a three-part investigation on how to: (1) improve health system sustainability and hospitals' financial health, (2) develop an advanced payment model, and (3) conduct a hospital budget review	Payment model development has not yet begun as of September 2025	Formed planning groups to: (1) regionalize specialty care, (2) regionalize and professionalize EMS, (3) improve care coordination and management for heavy utilizers, (4) improve services to dual eligible individuals, and (5) coordinate and optimize EHRs

*Although Vermont's Hospital System Transformation and Community Engagement Process was not immediately focused on changing hospital behavior, it highlights the importance of encouraging hospitals to become more patient-centered and adopt strategies to succeed under value-based payment systems by improving efficiency, slowing cost growth, managing care, reducing health imbalances, and increasing access to essential services.



APPENDIX B: FMT Resources on Improving the Value Proposition of Critical Access Hospitals

1. Pick M, Hamdi A, Larh M. Rural Resource: Availability of Obstetric Simulation Training by State. University of Minnesota, Flex Monitoring Team. September 2025.
2. Harr B, Stearns R, Gale J. An Evaluation of State Flex Program Initiatives to Support Critical Access Hospital-Based Rural Health Clinics. University of Southern Maine, Flex Monitoring Team. September 2025.
3. Gale J, Pearson K, Stearns R, Croll Z. Characteristics and Trends of Critical Access Hospitals That Own or Operate Ambulance Services. University of Southern Maine, Flex Monitoring Team. May 2025.
4. Croll Z, Jewell C, Gale J. Critical Access Hospital-Local Health Department Partnerships to Address Rural Community Needs. University of Southern Maine, Flex Monitoring Team. January 2024.
5. Gale J, Jewell C, Kahn-Troster S. Population Health Outcome Measurement Strategies for State Flex Programs. University of Southern Maine, Flex Monitoring Team. July 2023.
6. Lahr M, Santana X, Bean N, Parsons H, Moscovice I. Care Coordination and Community Partnerships for Cancer Care in Critical Access Hospitals. University of Minnesota, Flex Monitoring Team. January 2023.
7. Budko A, Pink G, Gurzenda S, Howard A, Reiter K. Financial Characteristics of Critical Access Hospitals (CAHs) Participating in Accountable Care Organizations (ACO). University of North Carolina at Chapel Hill, Flex Monitoring Team. November 2022.
8. Lahr M, Santana X, Parsons H, Bean N, Moscovice I. Delivery of Cancer Screening and Treatment in Critical Access Hospitals. University of Minnesota, Flex Monitoring Team. October 2022.
9. Gale J, Jewell C, Kahn-Troster S, Croll Z. Evaluating State Flex Program Population Health Activities. University of Southern Maine, Flex Monitoring Team. March 2022.
10. Lahr M, Chantarat T, Quick M, Pick M, Moscovice I. How Critical Access Hospitals Are Addressing the Social Needs of Rural Populations. University of Minnesota, Flex Monitoring Team. November 2021.
11. Pick M, Lahr M, Moscovice I. Rural Initiatives Addressing Community Social Needs. University of Minnesota, Flex Monitoring Team. March 2021.
12. Gale J, Kahn-Troster S, Pearson K, First N. Addressing Opioid Use in Rural Communities: Examples from Critical Access Hospitals. University of Southern Maine, Flex Monitoring Team. Briefing Paper #46 August 2020.
13. Gale J, Croll Z, First N, Kahn-Troster S. Provision of Mental Health Services by Critical Access Hospital-Based Rural Health Clinics. University of Southern Maine, Flex Monitoring Team. Briefing Paper 45. June 2020.
14. Gale J, Kahn-Troster S, Croll Z, First N. Engaging Critical Access Hospitals in Addressing Rural Substance Use. University of Southern Maine, Flex Monitoring Team. Briefing Paper #44. June 2020.
15. Gale J, Croll Z, Zoll L, Coburn A. Critical Access Hospitals' Community Benefit Activities: An Updated Review. University of Southern Maine, Flex Monitoring Team. Policy Brief 40. December 2018.
16. Gale J, Coburn A, Pearson K, Croll Z, Shaler G. Population Health Strategies of Critical Access Hospitals. University of Southern Maine Flex Monitoring Team. Briefing Paper 36. August 2016.
17. Croom J, Croll Z, Gale J, Coburn A. Community Benefit Activities of Critical Access, Other Rural, and Urban Hospitals: National Data. University of Southern Maine, Flex Monitoring Team. February 2014.
18. Gale J, Coburn A. Collaborative Community Health Needs Assessments: Approaches and Benefits for Critical Access Hospitals. University of Southern Maine, Flex Monitoring Team. Policy Brief 36. May 2014.