

## Profile in Innovation: Rural Hospital Participation in Missouri HealthNet’s Transformation of Rural Community Health (ToRCH) Program

**What:** Six rural hospitals are participating in ToRCH, a new Missouri Medicaid program integrating healthcare and social services in rural areas with hospitals serving as community care hubs, working in partnership with primary care and behavioral health teams and community-based organizations (CBOs). The program provides for a coordinated approach to tackling Health-Related Social Needs (HRSN) at a community level.

**Why:** The program aims to address rural healthcare challenges including unmet HRSN (e.g., housing, transportation) affecting individuals’ ability to maintain their health and effectively manage chronic conditions, and rural hospital financial instability.

**How:** Created through an amendment to Missouri’s Medicaid managed care Section 1915(b)(3) waiver, it employs a funding approach that draws on multiple sources (e.g., Medicaid payment, special state appropriations, social services funding) and evolves over time, initially providing upfront financial resources and gradually transitioning to a performance-based shared savings model.

The ToRCH program officially launched in July 2024. This profile summarizes the early experiences in the program of three participant types – hospitals, primary care teams, and CBOs in the communities of Bolivar, Salem, and Sedalia Missouri.

### Key Features of ToRCH Program

- Rural hospitals serve as community care hubs
- Primary care teams conducting HRSN screenings and providing referrals
- CBOs that receive the referrals provide social services, including new services funded through a Medicaid Section 1915(b)(3) waiver
- Multiple funding streams to support the program
- A technology platform facilitates care coordination and data analytics to guide community strategy
- Other data feeds from the Hospital Industry Data Institute and Missouri HealthNet (MO HealthNet) claims also inform strategy and allow for course corrections

## Overview

Recognizing that medical care alone cannot adequately address the root causes of health issues in rural populations, the MO HealthNet Division (i.e., Missouri Medicaid) developed the ToRCH program to address systemic challenges through a more integrated approach, supporting HRSN assessed through a clinical lens, ultimately aiming to enhance rural healthcare and improve population health throughout the state.<sup>1</sup> The purpose of the ToRCH program is to improve health outcomes and overall well-being in Missouri's rural communities by addressing both medical and HRSN through a comprehensive, integrated care model.

The ToRCH program relies on strong partnerships between three key entities in rural communities - hospitals, primary care teams and CBOs. Additionally, the program incorporates a secure digital technology platform to facilitate care coordination by enabling resource sharing, sending referrals, and tracking activities between hospitals and clinics and CBOs.<sup>1</sup> Six rural hospitals were selected for participation in the pilot based on their ability to create strong community leadership boards consisting of representatives from various domains such as primary care, behavioral health, public health, and CBOs. Participating hospitals include:

### Prospective Payment System (PPS) Hospitals

- Citizens Memorial Hospital - Bolivar, Missouri (Polk County)
- Bothwell Regional Health Center - Sedalia, Missouri (Pettis County)
- Golden Valley Memorial Healthcare - Clinton, Missouri (Henry County)
- Phelps Health - Rolla, Missouri (Phelps County)

### Critical Access Hospitals (CAHs)

- Salem Memorial District Hospital - Salem, Missouri (Dent County)
- Ray County Memorial Hospital - Richmond, Missouri (Ray County)

## Intended Impact of the ToRCH Program

ToRCH seeks to improve population health outcomes for Medicaid enrollees in rural Missouri. The program aims to:<sup>1,2</sup>

- a. Significantly reduce avoidable hospitalizations, including readmissions
- b. Decrease emergency department visits for non-urgent needs
- c. Lower overall healthcare utilization and improved efficiency across the system
- d. Enhance healthcare accessibility by positioning rural hospitals as community care hubs, centralizing access to both healthcare and essential social services like transportation, housing, and food security

According to Kirk Mathews, Chief Transformation Officer at Missouri Medicaid, "The vision for the ToRCH program is to improve population health at the county level, lower healthcare costs, and enhance stability of financially challenged rural hospitals." This initiative, therefore, not only directly addresses immediate healthcare needs but also creates a foundation for continuous improvements by integrating HRSN into the care model.

Melissa Hope, Project Coordinator for the Missouri Department of Social Services, highlighted this aspect, noting, "We're building local leadership boards to foster collaboration among healthcare providers, public health agencies, and CBOs to address community-specific needs." Moreover, the

long-term viability of the program is ensured through the shared savings model, wherein reduced healthcare costs can be reinvested into expanding community services. Abigail Barker, a Rural Policy Research Institute (RUPRI) researcher and Economic Consultant for Missouri Medicaid, emphasized that “Sustainability is built into the program through shared savings, ensuring hospitals and CBOs have the funds to continue operating and reinvest in social services.”

Further information on the development of the ToRCH program is provided in Appendices A and B.

## Program Implementation

### Setting Up Community Care Hubs and Developing Information Infrastructure for ToRCH Entities

The core of the ToRCH program is its hospital hub which bring together the hospital, primary care teams, and local CBOs also known as ToRCH entity. A ToRCH entity is a hospital, a federally qualified health center, a rural health clinic, or a local public health agency that leads the program.<sup>3</sup> Jenna Hicks from Citizens Memorial Hospital, a prospective payment system (PPS) hospital, shared that one of their first infrastructure changes was adding new staff roles such as community resource specialists to manage the integration of the closed loop referral technology platform. These specialists manage responses to patients’ social care needs and ensure seamless referrals to CBOs through the technology platform. The hospital also implemented a single sign-on system to integrate the technology platform into their existing workflows and is working with its electronic medical records (EMR) vendor to serve as the first beta site for the technology platform/EMR integration in the nation. The CEO of Bothwell Regional Health Center, another rural PPS hospital, Lori Wightman, noted that the technology platform was more of a “plug-and-play” solution for her facility, requiring no major infrastructure changes. However, they faced challenges related to staff training and data entry, particularly in ensuring the technology platform was effectively used across the organization.

In contrast, Salem Memorial Hospital, a Critical Access Hospital (CAH), had to build its infrastructure for ToRCH from the ground up. Tabitha Stanfast, Director of Quality Improvement, and Brooke Bollman, CEO of Salem Memorial Hospital, shared that their hospital formed a “Community Leadership Board,” which brings together local constituent groups to guide the program. Salem Memorial has focused on integrating HRSN screenings into the hospital’s workflow and coordinating services through the technology platform, which has been critical in centralizing community resources.

A senior customer success manager from the technology platform organization noted that the platform plays a critical role in facilitating communication between hospitals and CBOs, tracking referrals and ensuring that patient needs are addressed in a timely manner. This manager stated that one of the significant challenges faced by CBOs is limited staffing capacity, especially since many rural CBOs are volunteer-run or operate with minimal resources. To address this, funding through the ToRCH program can be funneled to CBOs to hire additional staff and manage the increased workload of processing and fulfilling referrals. The senior manager added that building trust in rural communities is key, and having hospitals like Citizens Memorial, Bothwell, and Salem Memorial leading the communication across community partners has been an effective strategy to engage the local population and service providers in the program.

*“Building trust in rural communities is key... having hospitals lead the communication has been an effective strategy”*

## Staff Training in Hospitals and CBOs

Training has been a significant focus during the implementation of ToRCH. Hospitals and CBOs required training on how to use the technology platform effectively. Hicks mentioned that while the platform provided basic training, there were ongoing gaps in staff understanding, especially between administrative and clinical perspectives. Many of the hospital staff required additional support to integrate it into their workflows, and training continues to be an evolving need as new challenges arise. The senior manager from the technology platform organization emphasized that it provides a structured environment for managing referrals and communication, but for many rural hospitals and CBOs, change management and ongoing training remain essential for ensuring smooth operations and full integration of the system.

Wightman noted that despite the ease of integrating the technology platform, there remains a need for continuous staff development, particularly in handling the manual processes involved with entering data into the platform. At Salem Memorial Hospital, where staffing resources are more limited, the challenges are even more pronounced. The hospital's leadership shared that they have a social worker managing care coordination but lack a dedicated care management team, which makes ongoing training and infrastructure development critical to their success in the program.

## Implementing Primary Care Case Management (PCCM) Model

The PCCM model is integral to ToRCH's approach, as it focuses on coordinating care across both medical and social services. Primary care teams, within Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and private practices in the program are responsible for conducting HRSN screenings and making referrals to CBOs for non-medical services. Dr. Barker noted that these screenings are reimbursed based on the volume of referrals and services completed, ensuring that primary care teams are financially supported for their expanded role in managing both clinical and HRSN. At Bothwell Regional Health Center, primary care teams work closely with CBOs to ensure that the needs of people who are at

*"Primary care coordination is focused on keeping patients in the community... which is critical for patient retention"*

- Tabitha Stanfast, Salem Memorial

higher risk are addressed, helping to reduce emergency room visits. In Salem Memorial Hospital, primary care teams are focused on keeping patients in the community and avoiding referrals to larger urban hospitals (unless medically necessary), which is critical for patient retention and the hospital's growth.

## Funding the ToRCH Program

The main funding agency supporting the ToRCH program is the MO HealthNet Division, i.e. Missouri Medicaid.<sup>4</sup> The program is designed to evolve over time, initially providing upfront financial resources and gradually transitioning to a performance-based shared savings model. All funds for the ToRCH program flow through the hospital hub, with the hospital hub developing contracts and agreements with CBOs and providers. The following are components of the funding strategy:

**Community Strategy Services:** In the first two years, quarterly Medicaid payments based on the number of Medicaid enrollees in the ToRCH area will support the development and implementation of community strategy services, including population health strategies and collaboration among hospitals, primary care teams, and CBOs. This funding also covers leadership and coordination efforts, screening activities, and relationship building, and can only be used to support ToRCH objectives.

**Capacity Building Funds:** Administered by the ToRCH leadership board in each county, these funds are intended to build the capacity of CBOs for new services by enhancing infrastructure, training, and technology to enable their full participation in ToRCH. For the first two years, hospitals in larger counties have \$320,000 per year and those in mid-sized counties have \$240,000 per year to distribute to local CBOs.<sup>1</sup> This amount will be gradually reduced by one-third in year three and by two-thirds in year four, eventually phasing out in year five. These Medicaid dollars are not federally matched.

Capacity building funds are not designated for existing expenses. However, Medicaid will reimburse new services established through the Medicaid Section 1915(b)(3) waiver (waivered B3 services such as supplemental health-related transportation, food and nutrition education, home-delivered medically appropriate meals, housing remediation to address health risks) on a per-service basis, and those funds may help support new positions. Agreements between ToRCH hubs and CBOs can facilitate referrals for these services, and delivering new services could potentially fund new staff. Justin Clutter, Project Manager at the MO Department of Social Services, explained that “ToRCH is funded through a combination of state Medicaid and federal matching funds, with a total budget of approximately \$15 million.”

**Waivered B3 Services:** Medicaid will reimburse waivered B3 Services during the first two years. Any additional funding beyond the budgeted amount for B3 services will be structured as a quality performance-based shared savings by year five.

**Incentive Payments:** Incentive payments are provided to hospitals for meeting population health targets based on specific performance metrics, such as lower rates of avoidable hospitalizations and readmissions, avoidable emergency department use, and all-cause hospital utilization for all Medicaid recipients in the community. The first incentive payments are scheduled to be paid out in January 2026, and annually in January thereafter.

**Shared Savings Model:** In the context of ToRCH, a shared savings model is a healthcare reimbursement strategy that incentivizes hospitals to reduce healthcare costs while maintaining or improving the quality of care. Under this model, hospitals are rewarded for lowering overall hospital utilization among their Medicaid patient populations, regardless of location. Medicaid shares a portion of the resulting savings with the hospitals, creating a financial incentive to promote efficient and effective care. . Specifically in ToRCH, shared savings will become the primary funding mechanism for waivered B3 services by year five of the program. The model year is July-June, corresponding to the state fiscal year. Shared savings are paid to the hospitals in January of model year three. and are phased in. Only one-third of the total to run the model is based on the shared savings earnings, which increases to two-thirds for model year four, and is then based entirely on the shared savings calculation for model year five and onward.

Mathews emphasized the importance of these shared savings: “The vision for the ToRCH program is to improve population health at the county level, lower healthcare costs, and enhance the financially challenged rural hospitals.” Through shared savings, ToRCH aims to ensure the financial stability of rural hospitals while simultaneously improving health outcomes in Missouri’s rural communities. These shared saving payments increase if the goals are exceeded, with the incentive structure transitioning entirely to a shared savings model by year five. Shared savings are earned by achieving population health goals and reducing emergency department and hospitalization rates, allowing hospitals and CBOs to expand their services over time.

For more information regarding the funding specifics, see the ToRCH website and the ToRCH Participation Agreement that is available on the website.

---

<sup>1</sup>Small counties have < 15K population, medium have 15K-30K, and large are over 30K in total population

## What's Next

Implementation of ToRCH began July 2024 after a planning period of more than one year. The evaluation plan is also in place, beginning with the initial calculations of shared savings as determined by the change in Medicaid costs in participating rural counties compared to the costs of non-participating rural counties. Dr. Barker noted that an ongoing evaluation will address the most fundamental questions in real time to allow for course corrections.

Evaluation of ToRCH will ultimately allow its participating community care hubs to adapt, leaning into strategies that show the most evidence of success, while also providing insights more broadly about how to solve rural population health challenges that sit at the intersection of the clinical and social realms.

ToRCH is set to evolve significantly in the coming years as the program plans to expand to additional rural hospitals and their respective communities. Mathews highlights the long-term goal of adding more hospital cohorts every two years. "Our ultimate aim is to have all rural hospitals participating, showing that improving population health and reducing healthcare costs can be financially stable." This growth is intended to be supported by scaling the shared savings model and gradually expanding services to address broader needs within rural communities through the Section 1915(b)(3) waiver. The technology platform also plays a key role in the future direction of ToRCH. The senior customer success manager from the technology platform organization emphasized their plans to refine the platform further: "We're continuously evolving our platform based on feedback, with future enhancements including deeper integrations with EMR systems and more robust reporting features."

*"We need to add more services as we encounter real-world needs, particularly non-medical transportation and home modifications"*

- Lori Wightman, Bothwell Regional Health

Hospitals involved in ToRCH are equally committed to the program's future. Wightman expressed a desire to expand services under the Section 1915(b)(3) waiver as the program scales. "We need to add more services as we encounter real-world needs, particularly in non-medical transportation and home modifications." Bothwell's leadership board will continue to focus on improving care coordination and reducing emergency department visits by addressing the needs of people with chronic conditions like diabetes and hypertension. Hicks highlighted plans to expand their infrastructure for better community care management. "We're building capacity to provide social care not just inside the hospital but across the broader community." For Salem Memorial Hospital, future growth involves building from the ground up. Tabitha Stanfast stressed the importance of patient retention and care coordination. "We're focused on bringing more patients back to the community and improving follow-up care after discharge." Salem Memorial plans to further develop its leadership board and strengthen partnerships to address HRSN more effectively, ensuring the sustainability of its rural healthcare services.

*"We're building capacity to provide social care not just inside the hospital, but across the broader community"*

- Jenna Hicks, Citizen's Memorial

CBOs in the pilot program committed to ensuring the success of ToRCH. United Way of Pettis County continues to play a key role fostering collaboration between healthcare providers and nonprofits. Rachelle Simon from United Way of Pettis County highlighted the program's potential for long-term change by addressing critical non-medical needs like housing and transportation. "Many hands make light work," reflecting her optimism that the program will alleviate the burdens on individual



organizations by fostering stronger partnerships. Together, these efforts reflect a shared commitment to making ToRCH a transformative force in rural healthcare.

By expanding services, enhancing collaboration through technology, and strategically scaling the program, ToRCH is positioned to not only improve health outcomes but also ensure the sustainability of rural hospitals for the future. The collaborative and adaptive nature of ToRCH will help ensure that all participants, from hospitals to technology partners and community organizations, are prepared to address the unique needs of rural Missouri while continuously refining their strategies to improve health outcomes and reduce costs. The program's future direction is driven by the collective vision of creating a model of healthcare that not only serves but thrives in rural communities.

## **APPENDIX A: Development of the ToRCH Program**

### **Conceptualization and Planning**

The conceptualization and planning of the ToRCH program was driven by the need to address the unique challenges in Missouri’s rural healthcare landscape. Justin Clutter, Project Manager at the Department of Social Services, explained that the program was conceptualized to combat the financial struggles of rural hospitals, which were exacerbated by many residents bypassing rural hospitals to seek care in urban hospitals. This situation not only weakened the role of rural hospitals but also left rural communities with inadequate access to medical care. Clutter emphasized that the aim of ToRCH was to empower local hospitals by integrating social care into healthcare, providing financial support for essential services like transportation and primary care access, and reducing reliance on emergency care. Abigail Barker, a RUPRI researcher and Economic Consultant for Missouri Medicaid, highlighted that ToRCH was designed from the outset with rural needs in mind, making it distinct from other health policies that are often adapted from urban models. Dr. Barker explained that ToRCH strategically positioned rural hospitals as community care hubs, not only addressing medical needs but also targeting HRSN such as housing and transportation.

During the planning phase, Kirk Mathews, Chief Transformation Officer at Missouri Medicaid stressed the alignment of ToRCH with broader Medicaid transformation goals, including improving population health, reducing costs, and ensuring the financial sustainability of rural hospitals. Mathews noted that a key strategy was fostering collaboration between hospitals, primary care, social service agencies and Medicaid, through shared savings initiatives, which incentivized hospitals to reinvest savings into their services. Hope highlighted the vital role of technology in planning, particularly the use of the technology platform. This software facilitated coordination between hospitals and CBOs, ensuring timely referrals and a seamless care experience for patients. Overall, ToRCH was conceptualized as a program where financial support and strategic partnerships would lead to long-term health improvements for rural communities in Missouri.

### **Approval and Support**

On March 29, 2024 the Missouri Department of Social Services (DSS) HealthNet Division, which administers MO HealthNet, announced the approval of a 1915(b)(3)waiver amendment from the Centers for Medicare & Medicaid Services (CMS), allowing for the full deployment of the ToRCH program.<sup>1,3</sup> The development and implementation of ToRCH required significant approval, including securing an amendment to the existing Section 1915(b)(3) waiver from CMS . This waiver is a section of the Social Security Act that allows states to offer Medicaid managed care services in a more flexible manner. It is commonly used for states to implement managed care delivery systems, but it can also provide authority for Primary Care Case Management (PCCM) models that direct Medicaid services more effectively and provide cost-saving measures by coordinating care.<sup>5</sup> Under the Section 1915(b)(3) waiver for ToRCH, the Missouri Medicaid Transformation Office was able to secure federal approval for ToRCH hubs to provide “community strategy services” (i.e., the coordination work of aligning partners), analyzing data, and running the model. The waiver also allowed individual-level coverage of non-traditional services targeting specific HRSN, with the aim of reducing avoidable hospital admissions and emergency department visits and ultimately reducing all-cause hospital utilization among Medicaid enrollees of the community. These services, which typically fall outside the scope of standard medical care, are seen as crucial to improving population health outcomes and reducing healthcare costs in rural areas.

In the first two years of the program, a budgeted amount is allocated to the hospital for providing services 1915(b)(3) waiver . These services include addressing HRSN such as transportation, food and nutrition education, home-delivered medically appropriate meals, and housing remediation to

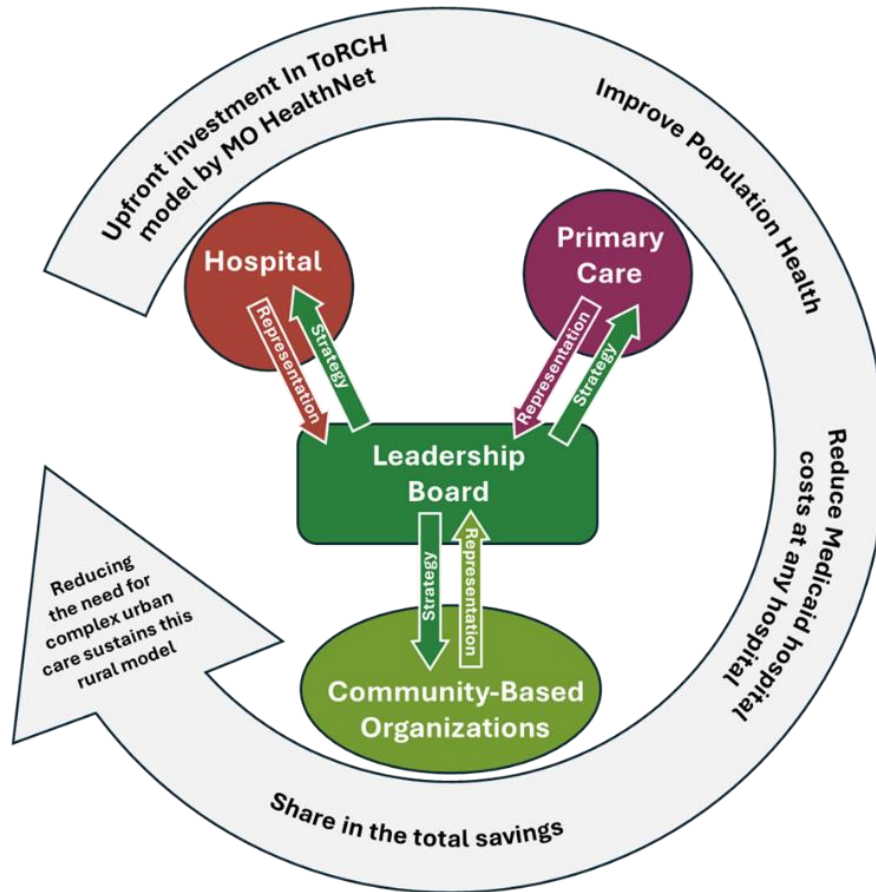


address health risks.<sup>6</sup> The funding from Medicaid for these services will gradually transition into a shared savings model for hospitals over five years, with the amount decreasing by one-third each year starting in year three. By year five, the funding for waived B3 services will rely entirely on savings generated by improved health outcomes and reduced healthcare utilization.<sup>7</sup>

## APPENDIX B: Key Entities of the ToRCH Pilot Design

# TRANSFORMATION OF RURAL COMMUNITY HEALTH (ToRCH) PROGRAM

*Understanding how hospitals, primary care providers and community-based Organizations can work together to improve community health*



Source: Missouri Medicaid Transformation Office

## References

1. New Rural Health Program Directs Resources to Rural Communities to Improve Health | DSS Press Release. Accessed September 12, 2024. <https://dss.mo.gov/press/03-29-2024-torch-pilot-project.htm>
2. Missouri HealthNet's New ToRCH Model Addresses Social Care Challenges For Chronic Health Conditions & Creates Sustainability For Rural Hospitals. OPEN MINDS. Accessed September 12, 2024. <https://openminds.com/market-intelligence/news/missouri-healthnets-new-torch-model-addresses-social-care-challenges-for-chronic-health-conditions-creates-sustainability-for-rural-hospitals/>
3. 13 CSR 70-94.030 Transformation of Rural Community Health (ToRCH) - PROPOSED RULE. Accessed September 12, 2024. <https://dss.mo.gov/proposed-rules/13-csr-70-94.030.pdf>
4. ToRCH FAQs | mydss.mo.gov. Accessed September 12, 2024. <https://mydss.mo.gov/torch-faqs>
5. 1915(b) waivers. MACPAC. May 9, 2022. Accessed September 16, 2024. <https://www.macpac.gov/subtopic/1915b-waivers/>
6. dianawinder. Missouri Medicaid Tests New Transformation of Rural Community Health (ToRCH) Model. Rural Spotlight. April 25, 2024. Accessed September 16, 2024. <https://ruralhealthinfocenter.health.mo.gov/missouri-medicaid-tests-new-transformation-of-rural-community-health-torch-model/>
7. Section 13 CSR 70-94.030 - [Effective until 11/1/2024] Transformation of Rural Community Health (ToRCH), Mo. Code Regs. tit. 13 § 70-94.030 | Casetext Search + Citator. Accessed September 16, 2024. <https://casetext.com/regulation/missouri-administrative-code/title-13-department-of-social-services/division-70-mo-healthnet-division/chapter-94-rural-health-clinic-program/section-13-csr-70-94030-effective-until-1112024-transformation-of-rural-community-health-torch>

(April 2025)

For more information about the Rural Health Value project, contact:  
University of Iowa | College of Public Health | Department of Health Management and Policy  
[www.RuralHealthValue.org](http://www.RuralHealthValue.org) | [cph-rupri-inquiries@uiowa.edu](mailto:cph-rupri-inquiries@uiowa.edu) | (319) 384-3831

*This resource was developed with funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$500,000 with 0% financed with non-governmental sources. The contents are those of the author(s) do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.*