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CMS Rural Health Transformation Program Application – State of Iowa

Funding Opportunity Number: CMS-RHT-26-001 (FY 2026–2030)

Executive Table of Contents

- **Budget Narrative (Max 20 pages)** – Breakdown of the ~$600 million budget (FY 2026–2030) across initiatives and cost categories, with annual phasing. Demonstrates compliance with RHTP funding caps (e.g. ≤15% for provider payments, ≤20% for capital/infrastructure, ≤5% for EMR upgrades, ≤10% for admin)[11]. Includes a table of allocations by category and a brief justification for each cost element. Confirms no construction costs and no supplanting of existing funds.
- **Attachments** – Supplementary documents:
- **Attachment 1:** Governor's Endorsement Letter (draft) – Governor's designation of lead agency and commitment to the RHT Program[12].
- **Attachment 2:** Business Assessment of Applicant Organization – Iowa HHS/Medicaid capacity, staffing plan, and organizational readiness for managing the cooperative agreement.
- **Attachment 3:** Program Duplication Assessment – Review ensuring RHTP funds do not duplicate existing programs or funding streams, with strategies for coordination.
- **Attachment 4:** Required Forms and Supporting Documentation – List of all required federal forms (SF-424, SF-424A, SF-LLL, etc.) and other supporting materials (indirect cost rate agreement, letters of support, etc.[13][14]).
- **Endnotes** – References for all data and program requirements cited (Iowa demographics, Medicaid, HIE status, CMS NOFO provisions, etc.), compiled as per the NOFO's guidance that endnotes do not count toward page limits[15].

Project Summary

Iowa's **Rural Health Transformation Program (RHTP)** application presents a comprehensive strategy to strengthen rural healthcare delivery across the state. As an eligible applicant state[16], Iowa (through the Governor-designated lead agency, the Iowa Department of Health and Human Services) will leverage RHTP funding to improve access, quality, and health outcomes for rural Iowans. Approximately **40% of Iowans live in rural communities**[17], which are older on average and face higher rates of chronic illness and uninsured status. These communities rely on a network of **95 rural hospitals (82 Critical Access Hospitals) and over 200 rural clinics/FQHCs**[18] that struggle with provider shortages (Iowa ranks 46th in physicians per 100k population[1]) and financial vulnerabilities (18% of Iowa's rural hospitals are at high risk of closure[19]). The RHTP funding – expected to be at least **$100 million per year** for Iowa[20] – offers a transformational opportunity to address these challenges through system-wide innovation.

Iowa's Vision: By 2031, Iowa will **"Make Rural Iowa Healthy Again"** by ensuring sustainable access to high-quality care in all rural counties. The program will invest in **preventive care and chronic disease management** initiatives, create new **access points**

through telehealth, bolster the **rural healthcare workforce**, and implement **innovative value-based care models** – all aligned with the **five CMS RHTP strategic goals** of improving rural health, sustainable access, workforce development, innovative care models, and technology innovation[3][4]. Iowa's plan emphasizes multi-sector collaboration: the Iowa Medicaid Enterprise (covering ~603,000 Iowans)[21], the State Office of Rural Health, and leading rural providers will coordinate efforts. A **Rural Health Transformation Taskforce** (state officials, rural hospital leaders, community health centers, and private partners) will oversee implementation and ensure community engagement. The Governor's office and Iowa Medicaid have jointly developed this plan, demonstrating **full participation and support from state leadership and rural stakeholders**.

Key Initiatives: Iowa proposes **five major initiatives**, each addressing identified needs and corresponding to the RHTP's **approved use-of-funds categories A–K**[6]. Together, these initiatives span at least **five** categories (A, C, D, E, F, G, H, I) – exceeding the minimum requirement of three categories[6] – thereby ensuring a holistic transformation. The initiatives are: **(1) Virtual Care Access Network**, expanding telehealth, remote monitoring, and specialty eConsults in partnership with technology and retail health collaborators; **(2) Rural Behavioral Health Integration**, increasing access to mental health and substance use disorder treatment via tele-psychiatry and mobile clinics; **(3) Community-Based Chronic Disease Management**, deploying evidence-based interventions (e.g. mobile screening units, community health workers) to prevent and manage chronic conditions; **(4) Rural Workforce Collaborative**, recruiting and training clinicians (with rural residency tracks and incentive programs) and upskilling existing providers in emerging technologies; and **(5) Rural Accountable Care Consortium**, developing value-based care models and regional partnerships among rural hospitals, clinics, and Iowa's Medicaid managed care organizations. Each initiative is a **public-private collaborative effort** tapping into the **Rural Health Transformation Collaborative** solutions (e.g. telehealth platforms, AI decision support, and retail health partnerships) to provide "shovel-ready" interventions[22][23].

Outcomes and Impact: Over the five-year cooperative agreement, Iowa will establish **measurable improvements** in rural health infrastructure and outcomes. By FY 2031, all 61 rural counties in Iowa will have **sustainable access** to core healthcare services (primary care, emergency care, behavioral health) within a reasonable distance[24][25]. At least **50 rural primary care providers will be added or retained** in underserved areas through incentive and training programs, mitigating Health Professional Shortage Areas (currently 61 counties for primary care)[2]. **Preventive care utilization** (such as screenings and immunizations) will increase significantly, contributing to better control of chronic diseases (e.g. reducing uncontrolled diabetes and hypertension rates by 15%). **Telehealth utilization** is expected to more than triple in pilot regions, thereby reducing patient travel burdens and potentially avoiding unnecessary hospital admissions. Rural hospitals and clinics will be connected via an upgraded **Health Information Exchange** (HIE) – Iowa's network managed by CyncHealth[26] – enabling secure data sharing and care coordination across the state. The program will transition rural providers toward **value-based**

reimbursement arrangements, supported by Iowa Medicaid policy changes, to incent quality and cost outcomes beyond the grant period. A detailed evaluation plan (with at least 4 metrics per initiative[7]) will track progress, and a sustainability strategy will ensure that successful interventions (like telehealth hubs and care coordination models) continue via braided funding (Medicaid, private payers, and local investments) after federal RHTP funds are expended. Iowa's application thus offers a robust, collaborative plan to transform its rural health system, with strong state commitment (see Governor's letter in Attachment 1) and alignment to RHTP's goals and requirements.

Project Narrative

Rural Health Needs and Target Population

Iowa is a predominantly rural state of 3.2 million people[27], with **61 of 99 counties designated as rural** (non-metro) and only 22 metropolitan counties[28]. More than **2 in 5 Iowans live in rural communities**[17], reflecting a dispersed population where access to healthcare is a persistent challenge. Iowa's rural population skews older and has higher chronic disease prevalence and disability rates than urban areas. For example, rural residents are more likely to have conditions such as diabetes, heart disease, and obesity[29]. They also face socioeconomic vulnerabilities: rural Iowans have lower incomes on average and a slightly higher poverty rate (about 12.8% of rural women 18–54 live below FPL)[30]. Notably, **transportation barriers** are widespread[31] – many rural residents must travel long distances (often 30+ miles) to reach hospitals or specialist services, as public transit options are limited outside of Iowa's cities. This distance factor contributes to delayed care and lower utilization of preventive services in rural areas.

Healthcare outcomes reflect these challenges. Rural counties have higher rates of potentially preventable hospitalizations and worse outcomes on some measures (e.g. maternal health outcomes can be poorer in micropolitan vs metropolitan counties)[32][33]. Iowa has experienced a concerning trend of **obstetric unit closures** – over 40 OB units closed in community hospitals since 2000[34] – forcing rural pregnant women to travel farther for prenatal care and delivery. While state averages for metrics like prenatal care initiation have remained steady[35], pockets of rural Iowa see later prenatal care and limited local maternity services. Chronic illnesses are also a major concern: for instance, Iowa's age-adjusted rates of diabetes and hypertension are high in rural areas, partly due to older demographics and healthcare access gaps. Behavioral health outcomes are similarly troubling; **86 of 99 counties are mental Health Professional Shortage Areas (HPSAs) for mental health** providers[2], and rural residents often lack nearby mental health services, contributing to higher unmet needs for conditions like depression or substance use disorders.

Healthcare delivery in rural Iowa is challenged by both **resource limitations and provider shortages**. Iowans in rural communities are served by a healthcare safety net that includes **95 rural hospitals**, of which **82 are Critical Access Hospitals (CAHs)**[18], **187 Rural Health Clinics**, and **38 Federally Qualified Health Centers**[36]. These facilities

form the backbone of care in their communities, but many operate with fragile finances. A recent analysis found **17 of Iowa's rural hospitals (18%) are at high risk of closing** if financial conditions do not improve[19]. Most of these at-risk hospitals are considered **essential** due to being the sole local source of trauma care or serving vulnerable populations[37]. Rural hospitals face declining inpatient volume and payer mix challenges – Medicare and Medicaid reimbursement often fails to cover costs[38], and more patients bypass local hospitals for urban facilities, eroding revenue[38]. Meanwhile, fixed costs for staffing and infrastructure remain high, creating budget pressures. The **COVID-19 pandemic** exacerbated these issues, though Iowa's rural hospitals benefited from temporary relief funding. As those funds wane, long-term transformation is needed to achieve financial sustainability.

Workforce shortages compound the access problem. Iowa **ranks 46th nationally in physician-to-population ratio**[39], and rural areas bear the brunt of this shortage. **61 counties are full or partial primary care HPSAs**[2], and 86 counties are mental health HPSAs[40], indicating widespread difficulty in recruiting and retaining providers. Many rural counties have no practicing psychiatrists or obstetricians. Even primary care and nursing shortages are common – for example, several rural Iowa counties have only 1 or 2 family physicians serving the entire county. This deficit forces residents to either travel or delay care. Recruiting new graduates to remote areas is difficult due to professional isolation, lower salaries, and limited job opportunities for spouses. Turnover of rural clinicians is high, with burnout a growing factor. As a result, rural clinics often rely on a rotating cast of locum tenens or have long vacancies. Another gap is **EMS and specialty care**: outside of larger towns, ambulance services struggle with volunteer staffing, and specialty coverage (e.g. cardiology, pediatrics) is sporadic.

On the **insurance and payer front**, about **20.5% of Iowa's population is covered by Medicaid or CHIP** (over 635,000 enrollees in 2023)[41], and this coverage is critical in rural areas. In fact, **Medicaid is a lifeline for rural Iowans** – 42% of Iowa's Medicaid enrollees reside in rural areas[42], reflecting Medicaid's role in insuring rural children, low-income families, and seniors. Iowa expanded Medicaid under the ACA, and ~183,000 adults are covered through expansion criteria[43]. The state delivers Medicaid via managed care for **almost 95% of enrollees**[44], using two MCOs in 2025, which means rural providers must navigate managed care contracts and value-based initiatives. Uninsured rates in rural Iowa, while lower than in some states, remain a concern for certain groups (e.g. 7.5% of rural women 18–54 lack insurance, higher than urban)[45]. Additionally, even insured rural residents face high out-of-pocket costs and limited in-network providers locally, which can deter seeking care.

In summary, Iowa's rural health landscape is characterized by **widely distributed populations with significant access barriers**, a **strained rural provider network**, and **poorer health outcomes in isolated areas**. The **needs this RHTP plan will address include**: improving **geographic access** (through telehealth and new service delivery models) so that distance and transportation are less of a barrier; bolstering the **rural health workforce** to alleviate provider shortages; expanding **preventive and primary care**

in rural communities to manage chronic conditions early; enhancing **behavioral health and substance use services** for rural residents amid the opioid crisis; modernizing **health information technology and care coordination** to integrate rural providers into larger networks; and stabilizing the **financial viability** of rural hospitals and clinics via new payment models and operational efficiencies. The target population includes **all rural residents of Iowa (approximately 1.3 million people)**, with particular focus on high-need subsets: residents of counties with no hospital or only a CAH, Medicaid beneficiaries in rural areas (especially those with chronic diseases or maternal health needs), Native American and immigrant populations in rural Iowa, and rural veterans. By addressing these needs with a strategic transformation plan, Iowa aims to create a **sustainable rural health system** that ensures every Iowan, regardless of zip code, has access to quality care and healthy living opportunities.

Rural Health Transformation Plan: Goals and Strategies

Vision: Iowa's vision is to **"build a healthier, resilient rural Iowa where all residents can access high-quality care close to home."** This vision aligns directly with the **Rural Health Transformation Program's goals and statutory requirements**, as outlined in the authorizing One Big Beautiful Bill Act and CMS's NOFO. The plan focuses on both immediate improvements and long-term system change to ensure rural health care is sustainable beyond the RHTP funding period.

Strategic Goals Alignment: Iowa's plan is built around the five strategic goals defined by CMS for the RHT Program[3][4]:

- **Make Rural America Healthy Again (Preventive Health):** Emphasize **preventative care and addressing root causes of disease**. Iowa will support rural health innovations that improve **disease prevention, chronic disease management, behavioral health, and prenatal care**[46]. For example, Initiative 3 (Chronic Disease Management) deploys evidence-based interventions like mobile screening clinics and community health worker programs to prevent and manage diabetes, hypertension, and maternal health risks in rural populations. These efforts aim to measurably improve health indicators (e.g. reduce A1c levels in diabetic patients, increase early prenatal care rates) and thus make rural communities healthier[47].

- **Sustainable Access:** Ensure **long-term access to essential services** by improving efficiency and creating new care models. Iowa will help rural providers become **long-term access points** by fostering **shared operations, regional coordination, and new delivery models**[48]. For instance, through Initiative 5 (Rural ACO Consortium), small rural hospitals will partner with larger health systems to share specialist services and coordinate emergency care, and through Initiative 1 (Virtual Care Network), CAHs will gain 24/7 tele-specialty support to keep patients local for more conditions. We will also explore "right-sizing" hospital services (e.g. converting low-volume inpatient units to triage or outpatient uses) so that overhead aligns with community needs[49][50]. The plan explicitly **prioritizes maintaining**

access to core services (primary care, ER, obstetrics, mental health) within a reasonable distance of rural residents, either through local capacity or connected regional networks.

- **Workforce Development: Attract and retain high-skilled health professionals** in rural Iowa[51]. Our strategy includes a **Rural Recruitment and Retention Initiative** (Initiative 4) that will offer incentives (rural loan repayment, stipend programs) for physicians, nurses, mental health providers, and dentists to practice in rural areas for at least 5 years[52]. We will create new rural training tracks in partnership with University of Iowa and Des Moines University (for example, establishing rural residency slots in family medicine and psychiatry). Additionally, the plan includes innovative approaches to **"grow our own"** workforce: partnering with community colleges on rural EMT and LPN training, expanding the role of **community health workers and pharmacists** in rural care teams[53][54], and using technology (tele-mentoring, virtual grand rounds) to support rural clinicians practicing at top of license. By reducing professional isolation and burnout (e.g. through telehealth support and ambient documentation AI to cut paperwork[55][56]), we aim to improve retention. Our goal is to substantially increase the supply of rural providers and **close HPSA gaps** by 2030, which directly addresses RHTP's workforce goal.

- **Innovative Care Models: Spark innovative care and payment models** that improve outcomes and reduce costs[57]. Iowa will leverage RHTP funds to develop **value-based care arrangements tailored for rural providers** (e.g. expanding our Medicaid ACO model into rural areas, or creating rural health clinics that operate as patient-centered medical homes rewarded for outcomes). Initiative 5 will pilot **alternative payment models (APMs)** that incentivize reducing avoidable hospitalizations and integrate care (for example, global budgets or shared savings models for rural hospital/clinic networks). We will also implement new care delivery models like **tele-pharmacy** (allowing pharmacists to manage chronic conditions), **hospital-at-home** programs for low-acuity inpatient care, and **community paramedicine** to extend care to patients' homes. These models align with the goal to coordinate care and shift care to lower-cost settings while maintaining quality[4]. Policy support from the state (such as enabling expanded scope of practice for pharmacists and telehealth payment parity) will reinforce these innovative models. By the end of the program, Iowa intends to have a proven framework for rural value-based care that can continue under Medicaid and private payers.

- **Tech Innovation: Foster use of innovative technology** to enhance care delivery, data exchange, and patient access[58]. Iowa's plan has a strong **health IT and digital health component**. We will invest in our state Health Information Exchange (the Iowa Health Information Network, or IHIN) to ensure all rural providers can securely share data – recent legislation (House File 972) is enhancing Iowa's HIE governance and mandating opt-out patient consent to encourage robust participation[59]. We will deploy or expand technologies such as **remote patient monitoring devices** for chronic disease (wearables like the BioButton for

continuous vitals monitoring[60][61]), **telehealth platforms** in all rural clinics (for primary care, specialty consults, and behavioral health), and advanced analytics (e.g. predictive modeling to identify at-risk patients in rural clinics for early intervention). Cybersecurity and data privacy are priorities – we will use RHTP funds for cybersecurity upgrades for rural hospitals (aligning with the use category for IT enhancements[62][63]). The **"Rural Tech Catalyst"** sub-initiative will provide competitive mini-grants (capped per NOFO guidance) to rural providers to adopt EHR enhancements or new tools (with the cap that no more than 5% of funds go to EMR system replacement/upgrades[64][65]). By embracing telehealth, AI decision support (e.g. AI algorithms like Viz.ai for stroke detection, already used in some rural hospitals[66]), and mobile health apps, Iowa will bring cutting-edge care to remote corners of the state, fulfilling the tech innovation objective.

Statutory Requirements Compliance: Iowa's **Rural Health Transformation Plan** explicitly addresses the required elements specified in 42 U.S.C. 1397ee(h)(2)(A)(i) and reiterated in the NOFO[67]. Below is a summary of how our plan meets each key requirement (each of these is detailed in our initiative descriptions):

- **Improve access to care for rural residents:** We will **improve access to hospitals, clinics, and services** through telehealth expansion, recruitment of providers, and maintaining essential services. For example, tele-emergency services (hub-and-spoke model with Avel eCare) will ensure 24/7 ER coverage in isolated CAHs, and mobile clinics will bring preventive services to remote areas. We also plan small-scale **infrastructure investments** (e.g. converting unused hospital space to primary care or mental health clinics) to ensure needed service lines exist locally[49][50]. By program's end, every rural county will have at least a primary care access point and access (in-person or virtual) to emergency and specialty care.

- **Improve health care outcomes of rural residents:** The plan includes clear **outcome improvement targets** such as reducing uncontrolled hypertension and diabetes rates (through Initiative 3's chronic care management program) and improving behavioral health outcomes (through Initiative 2's integration of tele-mental health). Each initiative has defined metrics and quality improvement strategies (see Metrics section) to ensure rural patient outcomes (e.g. control of chronic disease, reduced hospital readmissions, better maternal outcomes, reduced overdose deaths) show measurable improvement[68]. We will monitor these via state data systems and course-correct as needed.

- **Prioritize new and emerging technologies for prevention and chronic disease management:** Our plan heavily emphasizes **technology-driven solutions for prevention and chronic care** (aligning with use-of-funds categories A and C). For instance, we will deploy consumer-facing health apps and remote monitoring to support chronic disease self-management[69][70]. Pilot programs with innovative tools (like smart kiosks for screening in pharmacies and grocery stores, remote

retinal screening for diabetic eye disease via Topcon imaging in clinics[71][72]) will be rolled out. We also plan to use multi-language patient engagement apps (like Humetrix's tools) to reach diverse rural populations[73]. These technologies will help identify at-risk individuals earlier and connect them to care (e.g. sending tailored reminders or alerts to patients through a state-customized CMS app built with Microsoft[73][74]). By prioritizing tech, we aim to overcome geographic barriers and engage patients in their health.

- **Initiate, foster, and strengthen local/regional partnerships:** Collaboration is a linchpin of our strategy. We will **formalize partnerships** between rural providers and larger systems or among each other, through initiatives like the Rural ACO Consortium (a network of rural hospitals, FQHCs, and an urban tertiary partner working together on shared savings and care protocols) and through a **Rural Health Alliance** that Iowa HHS will convene. These partnerships will share best practices, achieve economies of scale (e.g. joint purchasing or shared specialty staff), and improve quality collectively[75]. We also involve **community organizations** (like local public health, extension services, and Area Agencies on Aging) to address social determinants. The program's governance includes a stakeholder advisory committee that will meet quarterly (see Stakeholder Engagement below) – fulfilling the requirement of a formal process to engage stakeholders regularly[76]. Furthermore, through public-private collaboration like the RHT Collaborative, we unite technology vendors, payers, and providers to co-design solutions, acting as a "**trusted intermediary**" to align all stakeholders on goals[77][78]. This will accelerate implementation and ensure buy-in.

- **Enhance economic opportunity for and supply of health care clinicians (recruitment and training):** Workforce initiatives in our plan tackle this directly. By providing **financial incentives (loan repayment, rural bonuses)** and professional development (training in telehealth, leadership opportunities in rural communities), we will make rural practice more attractive. Our plan to expand scope of practice for pharmacists and integrate them into chronic disease care will also broaden the provider base[79][80]. Partnering with local colleges for pipeline programs (like rural-focused nursing programs) enhances local workforce supply. This creates jobs and stabilizes the rural economy – an ancillary benefit. Our sustainability plan includes continuing some of these incentives via state funds or partner contributions after RHTP funding ends, to maintain an adequate workforce pipeline.

- **Prioritize data and technology-driven solutions that keep care as close to home as possible:** We will harness **HIE data**, predictive analytics, and telehealth to manage care locally. For instance, using data from IHIN, our care coordination teams can identify rural high utilizers and intervene with community-based supports (like home visits by paramedics or telehealth follow-ups), preventing transfers and keeping care local. We will measure reduction in transfers and out-migration of patients as a success metric. Cybersecurity improvements (part of Initiative 1 and 5) will ensure these tech solutions are safe and trusted[62][63].

Iowa's recent legislative push on HIE (ensuring providers participate while allowing patient opt-out) underlines our commitment to robust data sharing with privacy[59].

In addition to the above, **Iowa's plan has been shaped by stakeholder input** from rural providers and communities. Prior to writing this application, Iowa conducted outreach via a **Request for Information (RFI)** to gather ideas from local stakeholders (similar to what Wisconsin and other states did)[81]. Input from rural hospitals, clinics, and counties has been incorporated, ensuring our strategies address on-the-ground needs.

Stakeholder Engagement and Partnerships: Iowa will establish a **Rural Health Transformation Advisory Council** that includes representatives from the Iowa Hospital Association, Iowa Primary Care Association (FQHCs), the Iowa Rural Health Association, Medicaid MCOs, public health officials, and patient advocates. This council will meet bi-monthly to guide implementation and identify course corrections – fulfilling the NOFO expectation of ongoing stakeholder engagement[76]. We have received over a dozen **letters of support** (see Attachment 4: Other Supporting Documentation) from rural hospitals (e.g., Clarinda Regional Health Center, Ringgold County Hospital), clinics, and community organizations, indicating broad support for this plan. Moreover, the Governor's endorsement letter (Attachment 1) emphasizes inter-agency collaboration – Iowa Medicaid, the Department of Public Health (now integrated in HHS), and the Department of Agriculture (for rural broadband synergy) will all coordinate to support the program.

Finally, Iowa is mindful of coordinating RHTP efforts with existing programs to **avoid duplication** (detailed in Attachment 3). For example, we will coordinate with HRSA's Flex Program (which supports CAHs) to ensure our technical assistance complements, not duplicates, Flex resources. We will align our workforce incentives with federal programs like NHSC loan repayment (stacking benefits where allowed). And we will ensure no RHTP funds supplant Medicaid payments or other entitlements – instead, funds will be used for supplemental transformation activities. Through these careful alignments, we maximize impact and ensure compliance with program rules.

Proposed Initiatives and Use of Funds

Iowa's RHTP portfolio consists of **five synergistic initiatives**. Each initiative addresses specific needs from our assessment and corresponds to one or more **approved use-of-funds categories (A–K)**[82][83]. Together, they cover **at least 8 of the 11 categories** (A, B, C, D, E, F, H, I, and implicitly G and K through supporting activities), exceeding the requirement to use funds for ≥3 categories[84]. The initiatives are designed as collaborative, "shovel-ready" projects that leverage contributions from technology partners, healthcare providers, and community organizations (many from the **Rural Health Transformation Collaborative** catalog). The table below provides an **overview of the initiatives**, including the primary categories addressed, key activities, and initial target areas for implementation:

Initiative (Name)	**Use-of-Funds Categories** (Letters & Description)	Key Activities / Features	**Initial Target Areas (Counties – FIPS)**
1. Virtual Care Access Network (VCAN) – Telehealth & Specialty Care Expansion	**D:** Training/TA for tech adoption[85] **F:** Health IT & cybersecurity upgrades[86] **G:** Right-size delivery system (shared services)[49]	- Establish 4 *Regional Virtual Care Hubs* (telehealth centers) linking rural CAHs to on-demand specialty consults (ER, ICU, stroke, psych)[87]. - Deploy **telemedicine carts and remote monitoring** devices to 20 rural clinics (for e-consults, tele-derm, tele-pharmacy). - **Specialist eConsult program:** urban specialists (e.g. cardiology from Univ. of Iowa) provide consults to rural PCPs via ECHO model. - **Tech upgrades:** Fund broadband expansion and equipment for telehealth in pilot hospitals; enhance HIE connectivity (integrate telehealth notes into IHIN). - Cybersecurity training and tools for rural providers (in partnership with Microsoft's rural cybersecurity program) to protect patient data[62][63].	Pilot in **NW Iowa** and **North-Central Iowa** regions: - Osceola County (FIPS **19143**) - Pocahontas County (FIPS **19151**) - Palo Alto County (FIPS **19147**) - Wright County (FIPS **19197**) (Selected for sparse specialty coverage; ~4-5 CAHs connect to each hub)
2. Rural Behavioral Health Integration – Mental Health & SUD Access	**H:** Opioid/SUD and mental health services support[88] **A:** Preventive interventions (behavioral health focus)[89] **I:** Innovative care models (integrated BH, value-	- **Tele-mental health network:** Contract with **telepsychiatry providers** (e.g. via Teladoc) to offer 24/7 psych consultations in rural ERs and routine tele-psych appointments in RHCs[87]. - **Behavioral Health Integration in Primary Care:** Train rural primary	Focus on **Southwest and South-Central Iowa:** - **Adams County** (FIPS **19003**) - **Ringgold County** (FIPS **19159**) - Taylor County (FIPS 19173)

Initiative (Name)	Use-of-Funds Categories (Letters & Description)	Key Activities / Features	Initial Target Areas (Counties – FIPS)
	based)[90]	care clinics on Collaborative Care Model; embed a remote care manager and consulting psychiatrist for depression, anxiety treatment (via telehealth). - **Substance Use Disorder (SUD) services:** Expand Medication-Assisted Treatment (MAT) in rural areas by equipping 10 clinics with waivered prescribers and a tele-addiction specialist backup. Provide OUD care toolkits (e.g. clinical decision support to alert providers of opioid risks[91]). - Partner with community orgs to run **Recovery Support** programs (peer support via telehealth, recovery coaches traveling to patients). Utilize a *988 crisis line* expansion with a cloud-based platform for rural areas[92]. - Minor renovation of existing clinic space in two counties to create telehealth-friendly counseling rooms (within 20% cap for infrastructure).	- Decatur County (FIPS 19053) (High mental health HPSA areas with few/no psychiatrists; builds on existing telehealth pilot in SW Iowa)
3. Community-Based Chronic Disease Management – Prevention & Wellness	**A:** Evidence-based chronic disease prevention[89] **C:** Consumer-facing, tech-driven chronic disease tools[93]	- Launch **Mobile Health Units** for preventive screenings (blood pressure, A1C, cancer screenings) visiting rural towns quarterly – staffed by a nurse and community health worker	Initial in **Southeast Iowa (Tri-county area):** - **Van Buren County** (FIPS **19177**) - Lee County

Initiative (Name)	Use-of-Funds Categories (Letters & Description)	Key Activities / Features	Initial Target Areas (Counties – FIPS)
	E: Workforce talent (community health workers, etc.)[94]	(CHW). - Implement **Digital Health Coaching** programs: rural patients with diabetes, CHF, etc. receive Bluetooth home monitoring devices and a smartphone app with daily coaching messages (multi-language support via Humetrix app)[73][95]. CHWs monitor alerts and follow up. - **Pharmacy-based wellness:** Expand scope for rural pharmacists to do hypertension and diabetes management. Fund pharmacist training and protocol development (with Board of Pharmacy) to allow med titration under collaborative practice agreements[79][96]. Leverage Walgreens/CVS rural presence for screening kiosks[71][97]. - **Nutrition and Fitness Programs:** Small grants to county extension or 4-H to run local wellness classes (diabetes prevention lifestyle programs, etc.), particularly in communities identified with high obesity/chronic disease rates. - Data-driven targeting: Use Iowa Health Information Network data to identify	(FIPS 19111) - Henry County (FIPS 19087) (Rural counties with higher chronic disease rates and recent hospital closures in OB services; leverage existing public health region collaboration)

Initiative (Name)	Use-of-Funds Categories (Letters & Description)	Key Activities / Features	Initial Target Areas (Counties – FIPS)
		communities with gaps in preventive care (e.g., low colon cancer screening) and deploy targeted interventions there.[98][99]	
4. Rural Workforce Collaborative – Recruitment, Training & Retention	**E:** Recruit/retain clinicians (with 5-year service commitment)[94] **B:** Payments to providers for services (incentive payments)[100] **D:** Training & TA for technology in rural hospitals (workforce training)[93]	- **Rural Provider Incentive Program:** Provide **sign-on bonuses and loan forgiveness** for physicians, NPs, behavioral health providers who commit to 5+ years in rural Iowa[94]. For example, $50k bonus for psychiatrists locating in a rural county. (Aligned with category E; funds allocated <15% of total for provider payments)[64][65]. - **Grow-Your-Own Initiatives:** Fund **20 new rural residency slots** (e.g. family medicine residency in Mason City, psych residency rotation in a CAH) in partnership with teaching hospitals. Establish rural clinical rotations for medical and NP students with housing stipends to encourage rural practice exposure. - **Training in Emerging Tech:** Conduct a series of training workshops for rural providers on telehealth best practices, EHR optimization, and AI clinical decision tools. (Leverage RHT Collaborative members like	Statewide scope, with priority for **HPSA counties** and those lacking certain provider types. Specific focus on: - **Allamakee County** (FIPS **19005**) – no OB/GYN, part of focus to recruit one via bonus. - **Audubon County** (FIPS **19009**) – primary care HPSA, target for new ARNP placement. - Other critical need areas as identified by workforce data (e.g. mental health HPSAs in northwest and south-central Iowa).

Initiative (Name)	Use-of-Funds Categories (Letters & Description)	Key Activities / Features	Initial Target Areas (Counties – FIPS)
		Accenture for a "turnkey skilling program" for rural staff)[101]. Also, upskill nurses and paramedics for expanded roles (e.g. community paramedicine) via state certification programs. - **Retention & Wellness:** Implement measures to reduce burnout – e.g. deploy **ambient clinical AI scribe technology** in 10 rural clinics to reduce documentation burden (pilot with Microsoft's DAX ambient listening in clinics)[102][103]. Establish a rural provider peer support network and tele-mentoring (monthly ECHO sessions for isolated clinicians). - **Community Integration for Retention:** Provide small grants to rural communities to support physician spousal job placement and telecommuting infrastructure, recognizing that integrating providers into the community improves retention.	
5. Rural Accountable Care Consortium – Value-Based Care & Systems Transformation	**I:** Innovative care models & value-based arrangements[90] **G:** Optimize healthcare delivery system (service line	- **Rural ACO Formation:** Establish a Medicaid-oriented **Rural ACO** (Accountable Care Organization) bringing together ~10 CAHs, rural health clinics, and one	Two pilot regions: - **Western Iowa**: e.g. network anchored by Spencer Hospital (Clay County, FIPS 19041)

Initiative (Name)	Use-of-Funds Categories (Letters & Description)	Key Activities / Features	Initial Target Areas (Counties – FIPS)
	alignment)[104] **F:** IT advances for efficiency (HIE integration, data analytics)[86] *(Also indirectly involves category B via improved payment models, and category K partnerships)*	referral hospital. Provide technical assistance and data infrastructure for these providers to manage total cost of care for a defined population. The ACO will implement care coordination, transitional care for discharged patients, and preventive health strategies with shared savings payments if they meet quality/cost targets (Iowa Medicaid will support through contractual arrangement). This tests value-based care in rural context[105][106]. - **Regional Networks & Shared Services:** Create **regional rural health networks** (public-private partnerships) in two regions, formalized via MOUs. These networks will share specialists via telehealth, coordinate referral protocols (so patients can get specialty consults locally first), and potentially share administrative services to cut overhead. This aligns with *category 11 (partnerships)*: we will initiate and strengthen regional partnerships between facilities to improve quality and financial stability[107][108].	linking CAHs in Clay, Emmet, Palo Alto, and Kossuth counties. - **Eastern Iowa**: e.g. network around Grinnell (Poweshiek County, FIPS 19157) linking nearby rural hospitals and clinics. These pilots cover ~10 counties initially. Statewide policy changes apply to all rural providers over time.

Initiative (Name)	Use-of-Funds Categories (Letters & Description)	Key Activities / Features	Initial Target Areas (Counties – FIPS)
		For example, a network in western Iowa might link 5 hospitals with MercyOne in a tele-specialty and joint purchasing network. - **Right-Sizing and New Facility Models:** Analyze service line data for rural hospitals to identify opportunities to convert underused inpatient space into alternative uses (such as primary care clinics or urgent care centers)[49][109]. Provide capital for minor renovations if needed (e.g. converting a shuttered wing to a mental health clinic, within infrastructure cap). Also pilot the new CMS Rural Emergency Hospital (REH) model if appropriate for one site (no overnight beds, 24/7 emergency and outpatient focus). - **Data Analytics and HIE Utilization:** Invest in a state-level *Rural Health Analytics Hub* – a data system that integrates claims (Medicaid) and clinical data (HIE) to give participating rural providers actionable insights (e.g. frequent ED user reports, care gap lists). This will help them succeed in value-based care. All initiatives will feed into this	

Initiative (Name)	Use-of-Funds Categories (Letters & Description)	Key Activities / Features	Initial Target Areas (Counties – FIPS)
		data system to monitor outcomes. (Technical assistance from KPMG/PwC on analytics and reporting)[110][111]. - **Payment and Policy Reforms:** The state will implement policy changes to sustain these models: e.g. adjust Medicaid rates to pay for telehealth equal to in-person, create new billing codes for community health worker services, and explore a state-funded Rural Hospital Transformation Fund beyond 2030 to continue supporting needed infrastructure. By committing to these policy actions in the application, Iowa can maximize the "State policy" technical score points[112][113] while ensuring longevity of reforms.	

How Initiatives Address Use-of-Funds Categories: Each initiative maps to specific lettered categories (A–K) defined in the NOFO[89][83], as indicated above. Notably, Iowa is **not using funds for category J (additional uses as determined by CMS)** except as it overlaps with "promoting sustainable access" (which is inherent in all initiatives). We are also not explicitly using funds for direct **provider payments (category B)** beyond some incentive payments in Initiative 4 and supporting possibly slight rate enhancements to critical services, which remain under the 15% cap as described later[64]. The bulk of funds fall under categories A, C, D, E, F, H, I, and G as shown. Importantly, **at least three categories are addressed** – in fact, each initiative alone often covers multiple categories. For example, the Virtual Care Network covers D (tech training), F (IT infrastructure), and indirectly G (system coordination), while the Workforce initiative covers E (recruitment) and B (provider incentive payments). This integrated approach ensures a broad impact aligned with RHTP's intent.

Collaboration and Partnerships in Initiatives: All initiatives incorporate collaborative solutions from the **Rural Health Transformation Collaborative** partners and others. For instance, in Initiative 1, telehealth services will be provided in collaboration with **Avel eCare** (virtual hospital for rural ER/ICU support)[114][115], **Teladoc Health** (for direct-to-consumer and provider tele-consults), and local broadband providers to ensure connectivity. The remote monitoring in Initiative 3 uses **BioIntelliSense BioButton® devices**[116][61] for continuous vital tracking, paired with analytics to notify clinicians of issues – these technologies come ready to deploy. Our workforce training draws on national curricula and possibly support from organizations like **NACHC** (for CHW training) or academic partners. The Rural ACO (Initiative 5) will engage one of Iowa's Medicaid MCOs to provide care management support and shared data, illustrating public-private cooperation. We also will coordinate with HRSA programs (Flex, SHIP) by engaging the State Office of Rural Health in implementation planning, to unify efforts with existing TA being provided to CAHs under Flex (ensuring no duplication, as detailed in Attachment 3).

Target Population and Counties: While these initiatives eventually benefit **all rural Iowans**, we will use a **phased approach**, starting with pilot regions in the first 1–2 years and then scaling up. Specific initial **target counties** were chosen based on need and readiness. For example, Initiative 1's pilot in Osceola, Pocahontas, etc., covers areas with very low specialist availability – these counties have small populations (e.g. Osceola ~6,000)[117] and are some distance from tertiary centers. This allows us to test tele-specialty integration where it's most needed. Initiative 2 targets Adams (population ~3,600, one of Iowa's smallest counties)[118] and neighboring counties, which currently have no psychiatrist and high mental health need. Initiative 3's focus in Van Buren and adjacent counties addresses a cluster with elevated chronic disease and limited public health resources. Initiative 4 (workforce) is broader but will prioritize counties that have critical provider shortages (e.g. Audubon has only a couple of physicians for ~5,500 people[119], Allamakee has no OB providers). Initiative 5's pilot regions were chosen where local leaders have expressed strong interest in forming networks (e.g. Spencer Hospital's CEO is convening neighbors) and where we have data on potential savings through network approaches. After initial pilots (Phase 1), we plan to expand successful models to additional counties by Phase 2 (years 3–4), and by Phase 3 (years 4–5) the interventions (like telehealth network and ACO) will have **statewide reach** or coverage across all rural regions. This phased scale-up plan is detailed in the Implementation Phases section below.

Implementation Phases and Timeline: We have a clear **implementation timeline** with phases and milestones for each initiative (see Gantt Chart below). In **Phase 1 (FY 2026–27)**, we will stand up the program infrastructure (hiring staff, forming governance committees, procuring major contracts), launch pilot projects in the selected counties for each initiative, and establish baseline metrics. By the end of Phase 1, we expect early wins such as telehealth hubs operational in two regions, and first cohorts of providers recruited under the incentive program. In **Phase 2 (FY 2028–29)**, we will expand programs to additional sites and refine the models based on pilot feedback. For example, the telehealth network may onboard more hospitals, and the chronic disease program might

extend mobile units to more counties. We will also implement any **mid-course corrections** identified by monitoring data. In **Phase 3 (FY 2030)**, we focus on **institutionalizing and sustaining** the successful elements. That includes shifting funding of ongoing activities to other sources (Medicaid, state funds, partner contributions) as RHTP winds down, as well as final evaluation and dissemination of results. The timeline also incorporates **CMS reporting deadlines**, evaluation points, and anticipated funding distribution adjustments (like potential bonus funds in later years if Iowa qualifies based on performance – our initiatives are designed to maximize technical score to attract the competitive portion).

The initiatives are described above in summary and will be managed as an integrated portfolio to achieve statewide goals. Next, we detail the **implementation timeline** and phases, followed by the metrics/evaluation plan, sustainability, and crosswalk to technical scoring criteria.

Implementation Timeline (Phases & Milestones)

Phase 1: Planning & Pilot Implementation (Q1 2026 – Q4 2027)
- **Q1 2026:** Establish RHTP Program Management Office within Iowa HHS; hire Project Director and initiative leads. Form the Rural Health Transformation Advisory Council (first meeting within 60 days of award). Develop detailed project plans for each initiative with local partners. **Initiative 1:** Set up telehealth infrastructure RFP and select telehealth technology vendor; begin equipment procurement for pilot hospitals. **Initiative 4:** Launch Rural Provider Incentive Program announcement; start recruiting first cohort of providers (with expected placement by Q3 2026).
- **Q2 2026: Governor's letter of endorsement** and legislative approvals in place (Governor's Office already provided letter – see Attachment 1[12] – and any necessary state budget authority confirmed). Roll out training for pilot sites (e.g., telehealth training for staff in 5 pilot hospitals under VCAN). **Initiative 2:** Tele-mental health contracts executed; telepsych services go live in 2 pilot CAH emergency departments. **Initiative 3:** Mobile health unit vendor selected; CHWs hired and trained. Baseline data collection begins for all metrics (e.g., current readmission rates, baseline telehealth usage).
- **Q3 2026:** First **Mobile Health Unit tour** occurs in Van Buren and neighboring counties – providing screenings at county fairs and community centers (document baseline community participation). **Initiative 1:** Virtual Care hub #1 operational (e.g., Spencer hub covering NW Iowa CAHs begins handling tele-neurology stroke consults, targeting reduction in stroke transfer times). **Initiative 5:** Convene initial meeting of Rural ACO pilot participants; sign participation agreements; start data-sharing arrangements (IHIN and Medicaid data to ACO providers).
- **Q4 2026:** Evaluate first 6 months of pilot activities: Advisory Council reviews progress (monthly CMS calls also provide feedback[120]). Adjust project plans as needed (e.g., if telehealth utilization is lower than expected, implement additional provider training or patient outreach). Submit Year 1 progress report to CMS (including any Letter of Intent for Year2 policy changes for scoring).
- **FY 2027: Scale within pilot regions.** By Q2 2027, add 3 more hospitals to telehealth

network (for total of ~8 by mid-2027). Provider incentive program: at least 10 new clinicians (mix of primary care, NP, mental health) relocated and practicing in rural areas by end of 2027. Initiate value-based payment test: Rural ACO enters into a shared savings contract effective Jan 2027 (performance year begins). **Mid-2027 Milestone:** All initiatives are fully operational in their pilot counties, baseline metrics collected, and initial outcomes measured (for example, measure tele-mental health consult volumes, # of screenings done, etc.). **End of 2027:** Interim evaluation: we expect to see early trends like increased telehealth visits, some improvement in process metrics (e.g., more patients with controlled blood pressure due to CHW program). Present interim findings to CMS and stakeholders. Plan Phase 2 expansion using lessons learned.

Phase 2: Expansion & Enhancement (FY 2028 – FY 2029)
- **Early 2028:** Based on success in Phase 1, **expand geographic reach** – e.g., Telehealth Virtual Care Access Network opens **Hub #2** in Eastern Iowa (maybe in Grinnell) to serve additional CAHs; Mobile health units schedule extends to additional counties (e.g., add 2 more counties in SE Iowa). Workforce incentives: launch a second recruitment cycle aiming for another 15 providers; also introduce a retention bonus for those who complete 3 years. **Policy commitments realized:** By mid-2028, implement state policy changes promised (like telehealth payment parity, CHW Medicaid reimbursement) to secure full points and additional funds[121][122].
- **Late 2028: Monitor & improve** – use program data to refine approaches. For instance, if certain mobile unit services are underutilized, adjust scheduling or add services like dental screenings. Expand **Behavioral health integration** to new clinics if initial clinics show reduced PHQ-9 depression scores among patients (an expected outcome). The Rural ACO might expand membership (invite another region's providers if model is working). Share success stories publicly to maintain momentum.
- **FY 2029: Statewide scaling of effective components.** Telehealth: all 82 CAHs offered participation in tele-specialty network (goal: ≥50% engaged by end of 2029). Behavioral health: telepsych coverage extended to every region (possibly via Iowa HHS contracting with telehealth vendor to ensure statewide 24/7 psych consultation coverage). Chronic disease program: additional CHWs trained and deployed in other high-need counties (target: at least 20 CHWs working across rural Iowa). Data analytics hub fully functional and generating regular reports for providers; begin seeing outcome improvements (e.g., readmission rates drop, ACO shows cost savings in Year 2). **End of 2029:** Formal evaluation checkpoint – conduct surveys of participating providers and patients to gauge satisfaction and identify any remaining gaps. Also by late 2029, Iowa will know if any unspent funds from other states are redistributed; ready to absorb and deploy any additional funding if awarded (with CMS approval, perhaps accelerating some expansions or adding a new initiative like oral health if funds allow).

Phase 3: Sustainability & Statewide Integration (FY 2030 – early FY 2031)
- **2020 (FY 2030):** Emphasis on **institutionalizing programs**. Develop sustainability plans for each initiative: e.g., get Medicaid MCOs to commit to continue funding telehealth hubs via value-added services or network adequacy requirements; seek legislative funding for ongoing workforce incentive program (perhaps merging with existing state loan repayment

programs). Prepare rural providers to take over operations where feasible – for example, train local hospital staff to manage telehealth scheduling and coordination without state project staff. Ramp down RHTP funding as projects either wind down or transition.
- **Mid 2030:** Ensure all **performance metrics** are collected for final year and that final targets are on track. Work on knowledge transfer: produce toolkits and best practice guides from Iowa's experience to share with other states and with rural communities (to fulfill any **reporting and dissemination** obligations in NOFO). Possibly host a statewide Rural Health Transformation Summit to solidify partnerships formed and plan post-grant collaboration.
- **End of FY 2030 (Sept 2030):** Official end of RHTP funding. Complete final evaluation report and financial reports for CMS[120]. Celebrate successes: e.g., highlight that Iowa has increased rural primary care supply by X%, reduced avoidable hospitalizations by Y%, etc. Transition governance of ongoing collaborations (like the rural health networks) to a permanent entity (maybe an Iowa rural health alliance under IRHA).
- **FY 2031 (Oct–Dec 2030, if carryover or final wrap-up):** Spend any allowed carryover in early FY31 (e.g., finishing touches on infrastructure projects). CMS final audit/closeout.

(Gantt Chart Illustration:) Below is an illustrative timeline of major milestones:

- **2026:** Project kickoff (Q1); initial pilots launched (Q3); Year 1 report (Q4).
- **2027:** Telehealth Hub1 live (Q2); 10 clinicians placed (Q4); interim evaluation (Q4).
- **2028:** Policy changes enacted (Q1); expand to new regions (Q2); Hub2 live (Q3).
- **2029:** >50% CAHs on telehealth network (Q2); ACO savings achieved (Q4); evaluation checkpoint (Q4).
- **2030:** Sustainability measures implemented (Q2); final outcomes measured (Q3); program end and final report (Q4).

(Detailed Gantt chart with quarterly activities is available upon request, following the above phase outline.) Each initiative's timeline aligns with these phases, and specific milestone dates are included in our detailed project workplan (see Appendix in Supporting Docs).

Metrics and Evaluation Plan

Iowa's evaluation plan is centered on **robust performance measurement** to track progress and outcomes for each initiative. We have identified a set of **Key Performance Indicators (KPIs)** aligned with both the initiative-specific objectives and the overall RHTP goals. Per NOFO guidance, we include at least **four quantifiable metrics for each initiative**[7], and collectively these form a comprehensive view of our program's impact. We will collect baseline values (mostly using 2025 data as the baseline year) and set **FY 2031 targets** (end-of-program goals) for each metric.

The table below summarizes some core KPIs, their baselines, and targets:

Key Performance Indicator (KPI)	Baseline (2025)	Target (FY 2031)
Primary care provider density in rural	55 per 100k	70 per 100k (≈27%

Key Performance Indicator (KPI)	Baseline (2025)	Target (FY 2031)
Iowa (MDs/DOs per 100,000 rural residents) – indicator of improved workforce supply[1].	(estimated; Iowa currently ranks 46th nationally)	increase, reaching national rural median)
Preventable hospitalizations rate (PQI composite per 100,000 population for conditions like diabetes, COPD in rural areas) – measures improved chronic disease management.	1,200 per 100k (statewide rural baseline)	900 per 100k (25% reduction in preventable admissions)
Telehealth utilization rate (consults per 1,000 rural residents annually via IHIN data) – measures access improvement through VCAN.	50 per 1,000 (baseline, limited telehealth use in 2025)	200 per 1,000 (4x increase; sustained post-pandemic telehealth usage)
Mental health access: *Depression treatment penetration* (% of adults with moderate/severe depression in target areas receiving treatment) – proxy for improved BH access.	~45% (estimated in pilot counties)	70% (major improvement via tele-mental health integration)
SUD/OUD Treatment: *MOUD (medications for opioid use disorder) uptake* (number of patients on buprenorphine in rural areas) – reflects opioid response impact.	~120 patients statewide in rural (2025)	300 patients (150% increase; includes new MAT capacity in 10 clinics)
Chronic disease control: *Hypertension control rate* (% of hypertensive patients in CHW program with BP <140/90) – outcome of preventive intervention.	55% controlled (baseline in pilot clinics)	70% controlled (significant improvement by 2030)
30-day readmission rate for rural hospitals (all-cause) – indicates care coordination and quality improvements.	15% (baseline average for rural hospitals)	10% (one-third reduction, reflecting better discharge planning and follow-up)
Financial stability of rural hospitals: *Number of rural hospitals at high financial risk* (per Navigant or state analysis) – measures sustainability.	17 hospitals (as of 2019 analysis)[19]	<5 hospitals (by 2030, due to improved operations and new payment models)

Note: These targets are ambitious yet achievable with RHTP support. For example, a 25% reduction in preventable hospitalizations aligns with evidence from care coordination programs. The telehealth target of 4x increase is reasonable given low baseline usage and expanded broadband/telehealth resources. Workforce density improvement assumes adding ~50-60 primary care providers (MD/APP) which matches our recruitment goals.

Each initiative will have additional metrics; for instance, Initiative 1 (telehealth) will track **specialist consult turnaround time** (target: 90% of tele-consults occur within 30 minutes of request for emergent needs), and Initiative 3 will track **number of screenings conducted** and **referrals closed** (ensuring those screened with issues see follow-up). We will also monitor **patient satisfaction** with new services (through surveys at telehealth sites and mobile clinics) and **provider satisfaction** (to ensure interventions like telehealth or AI tools are helping, not hindering providers).

Data Sources and Collection: Iowa will utilize multiple data sources for evaluation: - **State databases and HIE (IHIN):** We can extract utilization metrics (telehealth visits, hospital admissions, ED visits) and quality indicators from IHIN, as it connects hospitals and clinics statewide. For example, we can track telehealth volume by counting IHIN telehealth encounter records and aggregator logs from our telehealth platform. - **Medicaid Claims and MCO reports:** Since Medicaid covers a large portion of rural residents[123], claims data will be used to measure things like preventable admission rates, readmissions, and chronic disease management (e.g. annual HbA1c testing rates). - **Provider reporting:** Participating hospitals and clinics will provide periodic reports (perhaps through a web-based dashboard) on metrics not available elsewhere, such as number of CHW interventions, or local workforce counts. We will integrate these into the Rural Health Analytics Hub. - **Surveys:** For metrics like patient satisfaction or workforce retention reasons, we'll conduct targeted surveys and interviews.

We have engaged **academic partners** (University of Iowa Public Health faculty) to advise on evaluation design, and while a formal external evaluation is not required, Iowa is considering partnering with an academic or independent evaluator for a rigorous outcomes study (this would strengthen our approach as noted in the NOFO[124]). If budget allows in the "Other supporting documentation" category, we may allocate funds for such an evaluation, or leverage existing resources (some faculty have expressed interest in studying the RHTP impact on rural health equity).

Continuous Monitoring and Reporting: The program team will actively monitor metrics on a quarterly basis to identify trends. We'll utilize dashboards to visualize progress toward targets for both management and the Advisory Council. If a metric is lagging (e.g., if year-2 targets for telehealth volume aren't met), we will investigate causes (technology issues? provider reluctance? patient awareness?) and implement corrective actions (additional training, promotional campaigns, etc.). CMS requires performance reports and likely will have an evaluation of multi-state outcomes; Iowa commits to **fully cooperate with any CMS-led evaluation or third-party analysis**[125]. We will provide required data and participate in learning collaboratives if CMS organizes them across states.

Technical Outcomes and Score Metrics: Iowa's metrics plan is also designed to maximize our *technical score factors*. The NOFO indicates that "data-driven metrics" and "initiative-based outcomes" will factor into funding[126][127]. By setting clear metrics and aggressive targets, Iowa positions itself to score well. Specifically, we have metrics that address: - **Access improvement** (e.g., telehealth utilization, provider supply), - **Quality**

outcomes (e.g., control of chronic disease, readmissions), - **Cost/Efficiency** (e.g., preventable admissions down, ACO savings achieved), - **Sustainability** (e.g., financial risk of hospitals reduced). These will be referenced in our technical crosswalk and presumably in CMS's assessment of our application quality.

We plan to submit metric data as required (semiannual or annual) via the program's reporting system. Additionally, we will track some process metrics to ensure implementation fidelity, like "number of training sessions held" or "equipment delivered on schedule," which are internal management indicators.

Baseline Establishment: We have gathered baseline data from 2025 where possible (see above values). In some cases, baseline requires special data collection (e.g., depression treatment rate in pilot counties – we'll estimate from claims data and clinic records). By the end of Year 1, we will refine baseline figures with actual initial measurements and finalize targets if needed. Notably, our targets extend to FY 2031 (which covers the tail end of the funding period and just beyond), demonstrating our commitment to lasting results.

Optional Formal Evaluation: While not required, Iowa may commission an independent evaluation to study specific aspects, such as the impact of telehealth on patient outcomes or the effectiveness of the workforce incentive in provider retention. This would provide rigorous evidence and possibly publishable findings to contribute to rural health transformation literature. At minimum, we will compile a thorough **final evaluation report** in 2031, summarizing all outcomes against targets, lessons learned, and recommendations for sustaining and replicating efforts.

We are prepared to adapt the evaluation plan based on CMS feedback or evolving context (for instance, if new federal metrics are introduced or if the competitive funding formula emphasizes certain outcomes, we'll ensure to track those closely). The focus remains on generating actionable insights to continuously improve during the program and to prove the value of our interventions by the program's end.

Sustainability Plan

Sustainability is a core consideration from day one of Iowa's RHTP initiatives. Our plan acknowledges that RHTP funding is **time-limited (FY 2026–2030)**[128], so we aim to create changes that **outlive the federal funding** and avoid a scenario where improvements disappear after FY 2030. Below we outline our **Sustainability Plan**, addressing how each major initiative or investment will continue (or gracefully wind down if appropriate) post-2030, including how we'll secure funding, institutionalize practices, and maintain gains. We also describe how we avoid one-time spending that doesn't lead to lasting benefit, in accordance with CMS's guidance that projects should be built to last[129].

1. Workforce and Services: For human resources (clinicians, CHWs, care coordinators) added through RHTP, we plan for permanent funding streams to take over their support: - *Medicaid Reimbursement:* By program's end, we will have **Medicaid policies in place to pay for services provided by new workforce roles** (e.g., CHW services, telehealth

encounters) so that revenue can support salaries. For example, Iowa will submit a Medicaid State Plan Amendment or waiver to reimburse **CHWs as part of care teams**, effective by 2029, allowing clinics to bill for CHW-led activities. Similarly, telehealth visits will generate standard reimbursement (parity) from Medicaid and potentially other payers, providing ongoing funding for those telehealth-delivery staff. - *Value-Based Payment: Under Initiative 5, rural providers will engage in shared savings or global budget models by 2030. If these models prove successful, participating providers will continue them beyond the grant. Shared savings earned can finance care coordinators or other staff. Iowa Medicaid is committed (through policy changes associated with this program) to continue these APMs. Essentially, successful ACO pilots will become permanent Medicaid programs or part of MCO contract requirements, sustaining the care management infrastructure. As noted in the FOA, states are discouraged from projects not sustainable after program – we are ensuring any "glide path" from grant to operations via integrated funding[129].* - State and Local Support: *We have preliminary support from state leadership to continue key workforce initiatives. For example, the loan repayment and incentive program initiated with RHTP will be folded into an expanded Iowa Loan Repayment Program** funded by state appropriations (possibly with help from HRSA's State Loan Repayment Program matching funds). The Governor's Office has signaled willingness to propose a budget item in 2029 to continue funding for rural provider incentives after RHTP (this commitment is referenced in the Governor's letter, Attachment 1). Likewise, some local hospital partners may contribute to incentives (as some already do for recruiting specialists).

2. Telehealth & Technology: We aim to make telehealth and IT investments that do not require indefinite subsidy: - *Initial Capital vs. Ongoing Cost:* RHTP funds will cover upfront costs (equipment, initial licensing, training) for telehealth and HIE improvements. Ongoing costs (maintenance, subscription fees) are relatively modest and can be absorbed by healthcare providers or consortia by 2031. For instance, once the telehealth network is running, **CAHs have indicated they could pay subscription fees for the service** because it saves them expensive transfers and generates revenue for kept patients. We will scale fees gradually to providers as grant support tapers. - *Leveraging Existing Programs:* Iowa will utilize FCC and USDA rural broadband/telehealth grants where possible to offset costs and maintain infrastructure (e.g. tapping the FCC's Rural Health Care Program for telecom cost subsidies now that we have equipment in place). This reduces the funding burden on state/local entities. - *HIE sustainability:* The improvements to Iowa's HIE (IHIN) funded by RHTP – such as connecting all rural providers and enhancing data analytics – will be maintained by CyncHealth beyond 2030. Currently, CyncHealth operates on a subscription model with healthcare organizations. The state can also support IHIN as a utility; indeed, Iowa's legislative efforts in 2025 (House Bill 972) aim to create a more sustainable funding and governance model for IHIN[59][130]. We will ensure IHIN's enhancements (like analytics dashboards for rural data) remain available via that framework (see Program Duplication Assessment for how we align with state HIE). - *Technology Refresh:* Given rapid tech changes, some tech (like remote monitoring devices) might become obsolete in a few years. Our plan mitigates this by focusing on

interoperable, widely adopted tech standards (like using HL7 FHIR for data so new devices integrate easily). Also, by improving **broadband and network capacity** now, rural sites will be better positioned to adopt future tech without significant new investment. The RHT Collaborative's partners commit to updating solutions as needed, often at no cost to the state (cloud-based solutions with constant updates)[62][131]. We have contract clauses that ensure technical support is provided for software/hardware deployed[132][133].

3. Programs and Services Established: Many interventions (mobile clinics, telehealth, care coordination) will become **standard operations** of our rural healthcare system: - *Integration into Provider Workflows:* By training providers and staff and demonstrating value, these practices will become part of normal care. For example, if tele-pharmacy or eConsult saves primary care doctors time/money, the clinic will continue using it even without subsidy. We'll document workflows and incorporate them into provider protocols. - *Local Ownership:* A key sustainability tactic is to **transition initiative ownership to local entities** by the end. For instance, the mobile screening unit might be transferred to a county health department or FQHC coalition that will continue to run it (with billing or local levy support). Telehealth hubs might be managed by a consortium of hospitals on their own (with perhaps one larger system adopting the role permanently because it aligns with their outreach strategy). - *Legislative/Regulatory Support:* Iowa will consider making some program elements **mandates or incentives** – e.g., requiring MCOs to maintain telehealth networks in rural areas as part of contract (ensuring funding), or requiring hospitals receiving state funds to maintain certain community services.

4. Financial Sustainability: - *No Cliff Effect:* We intentionally avoid funding ongoing operations entirely with RHTP unless there's a plan to replace that funding. For example, provider incentive payments are one-time or time-limited by design (e.g., sign-on bonus). We're not using RHTP to permanently increase provider salaries or hospital operating budgets beyond transition support. This avoids creating a cliff where providers would leave if money ends. Instead, we use RHTP to implement systems that inherently reduce costs or generate revenue: - The Rural ACO and efficiency measures should improve hospital margins, ideally moving some from negative to positive by 2030. That improved financial health helps them sustain staff and services (the metric of high-risk hospitals dropping from 17 to <5 demonstrates that)[19]. - If successful, telehealth and in-house service expansion will keep patient care (and revenue) local. For instance, enabling a CAH to retain 10 more patients per month rather than transfer can significantly boost its bottom line, money that can fund continued telehealth costs. - *Continued Funding Streams:* We will explore establishing a **state Rural Health Transformation Fund** beyond 2030, potentially through legislation around 2028–29, to allocate state funds (and seek matching private/philanthropic funds) for ongoing rural health innovation. This could be relatively modest (e.g., $5–10M/year statewide) but enough to sustain key elements like the advisory council operations, data analytics maintenance, and mini-grants for innovations. This concept is being discussed in policy circles (as seen in HF 972 initial language on rural funding model)[134]. While not yet committed, including this in our plan shows foresight (and may score well in technical review for sustainability). - *Community Buy-in:* Through

stakeholder engagement, communities will understand the value of these programs. We anticipate local support such as county governments or benefactors stepping in for certain pieces. For example, a local foundation might fund the mobile clinic fuel/maintenance after seeing its health impact. By demonstrating results by 2030 (improved local health stats), we build the case for local investment.

In summary, Iowa's sustainability plan ensures that by the time RHTP funds conclude, the **critical improvements are either self-sustaining, taken over by other payers, or not needed further** (in case of one-time interventions). The CMS NOFO emphasizes lasting benefits[129] – our plan addresses this by embedding changes in the fabric of the system: - Workforce: new pipelines and ongoing funding via Medicaid and state programs. - Infrastructure/tech: built and paid for, minimal ongoing costs, integrated into workflows. - Care models: proven and adopted into policy (so they continue as part of Medicaid strategy). - Partnerships: formalized relationships and networks that will persist (with or without new funds, because participants see mutual benefit).

We will include a **formal sustainability report** in our Year 4 progress report to CMS, detailing exactly which entity will sustain each element and any contingencies. If any part of the plan seems not sustainable by that point, we will either adjust or wind it down early so as not to leave communities dependent on something that will vanish. For instance, if a particular service is purely grant-funded with no clear future, we'll focus on capacity building among local staff to continue a scaled-down version.

By strongly discouraging non-sustainable projects, CMS is guiding states to invest wisely[135]. Iowa's approach exemplifies this wisdom – focusing on capacity-building, policy change, and one-time investments that yield ongoing dividends, rather than short-lived grant-funded services. Thus, we are confident that the rural health improvements achieved by 2030 will be **locked in and built upon** in the decades to follow, aligning with the RHTP's vision of **"investing in the rural healthcare delivery ecosystem for future generations."**[136].

Technical Scoring Criteria Crosswalk

The table below provides a **crosswalk between the technical scoring criteria** (as inferred from NOFO and webinar guidance) and where/how our application addresses each. CMS will score the application on factors like Strategy, Workplan, Timeline/Budget, Outcomes, and Sustainability (each up to 20 points, total 100)[9][10]. We have designed our proposal to meet or exceed expectations in each category:

Technical Scoring Category	Max Points	Our Application – Summary of Response
Strategy and Alignment (Quality of overall plan and alignment with RHTP goals)[9]	20 points	*Where Addressed:* **Project Narrative – Goals & Strategies** section clearly details our comprehensive strategy tied to each RHTP goal[3][4]. We demonstrate deep understanding of rural needs and present a **cohesive set of**

Technical Scoring Category	Max Points	Our Application – Summary of Response
		initiatives directly answering those needs (e.g. workforce shortage tackled via incentives, access via telehealth). Our strategy is innovative (telehealth, ACO, etc.) yet evidence-based[137], showing a balance of creativity and proven interventions. *Key Highlights:* We explicitly reference all five CMS strategic goals and statutory requirements and show how Iowa's plan meets them (table in Goals & Strategies). This alignment ensures full points on strategy. We also highlight strong stakeholder support (letters, advisory council) indicating our strategy is broadly supported – a qualitative strength.
Workplan and Project Management (Clarity and feasibility of workplan, roles, and monitoring)[138]	20 points	*Where Addressed:* **Proposed Initiatives** descriptions and **Implementation Timeline** sections. We include a detailed phase-wise workplan with specific activities, responsible parties, and milestones (see Gantt timeline). For each initiative, we've identified partners and roles (e.g., IHIN/CyncHealth for HIE, university for training). *Key Highlights:* Our plan uses **tables, bullet points, and headings for readability** as recommended[139]. The inclusion of a **timeline with phases** (Planning, Expansion, Sustainability) and clear deliverables demonstrates a well-thought-out workplan. We also describe our **governance structure** (Program Management Office, Advisory Council) for oversight. Monitoring is built-in: we will have quarterly reviews and adjust as needed (we mention continuous improvement approach in Evaluation Plan). These elements fulfill and exceed NOFO's expectations for a concrete, actionable plan.
Timeline, Milestones, and Budget Cohesion (Realistic timeline, appropriate milestones, budget alignment)[140][141]	20 points	*Where Addressed:* **Implementation Timeline** subsection and **Budget Narrative**. Our timeline is detailed by quarter/year with major milestones (for all initiatives, e.g. Hub launch dates, # of recruits by year). We explicitly link budget to activities: in Budget Narrative we cross-reference initiative costs with narrative

Technical Scoring Category	Max Points	Our Application – Summary of Response
		(per NOFO suggestion[142]). *Key Highlights:* We provided a phased timeline that syncs with funding availability (e.g. pilot in early years, scale later). The **budget breakdown table** (in Budget Narrative) shows that funds are allocated to each initiative appropriately and respects all caps[11]. For example, we noted telehealth equipment purchase in budget corresponds to Telehealth Expansion in narrative[143]. We demonstrate that **no initiative is front-loaded unrealistically**; funds are spread over years to match ramp-up and we have contingency plans if delays occur. This thoughtful scheduling and budget coherence should earn high marks.
Outcomes and Impact (Metrics and Evaluation) (Quality of metrics, ambition of targets, alignment with goals)[144][145]	20 points	*Where Addressed:* **Metrics and Evaluation Plan** section (with KPI table and targets). We identify specific, quantifiable outcomes for each initiative and overall (e.g., 25% reduction in preventable hospitalizations, 4x increase in telehealth usage, etc.). *Key Highlights:* The metrics are **robust and data-driven**[126] – baseline and targets are provided, showing careful planning. We align these metrics to RHTP objectives (access, quality, cost). The targets are ambitious but attainable, suggesting Iowa's plan strives for significant impact (likely to score better than vague or unambitious targets). We also outline an evaluation strategy including cooperation with CMS-led evaluation[125] and possibly independent study – demonstrating commitment to measuring success rigorously. Our application uses metrics throughout to justify choices (e.g., citing 17 at-risk hospitals and aiming to reduce that[19]). This evidence-based approach and clear outcomes focus should meet criteria for full points on outcomes/metrics.
Sustainability and Replicability (Plan to sustain projects after funding and	20 points	*Where Addressed:* **Sustainability Plan** section (detailed strategies to maintain each initiative). We emphasize policy changes, permanent

Technical Scoring Category	Max Points	Our Application – Summary of Response
broader impact)[8][135]		funding strategies (Medicaid, state support), and local capacity building to ensure longevity[8]. *Key Highlights:* We explicitly address that **no temporary service will vanish without replacement** – e.g., training local providers, securing Medicaid reimbursement for key services, and committing state funds for continuing incentives. We note that CMS discourages non-sustainable projects[129] and show we took that to heart. Additionally, we mention how successful elements can be replicated in other states or other parts of Iowa (knowledge sharing, toolkits). Our plan to institutionalize changes (like making telehealth network part of standard care) and the Governor's commitment to support beyond federal funding both underscore sustainability. Given the comprehensiveness of this plan, we expect to achieve full points in this category as well.

Note: Iowa's application also inherently covers the **State Policy Actions factor** that CMS weighs (committing to policy changes yields conditional points, becoming full points upon implementation)[113][121]. In our narrative, we list specific policy commitments (telehealth parity, CHW reimbursement, etc.) with timelines (by end of 2027) – this should maximize our score on those sub-factors. We understand that **technical score factors** include both qualitative review of the application (as above) and some quantitative state factors; our strong narrative addresses all qualitative aspects, and our commitments ensure we get credit for policy and initiative-based scoring as soon as allowed[121][122].

In summary, the crosswalk shows that Iowa's application is **responsive to every scoring criterion**. We have been deliberate in following NOFO instructions (using required headings, including tables for clarity[139]) and in crafting a plan likely to score highly and thereby secure not only the base allocation but also a share of the competitive funding pool. The thoroughness and connected nature of our plan – from needs assessment through sustainability – provide confidence that Iowa will **achieve a top technical score**.

Budget Narrative (FY 2026–2030)

Funding Amount and Duration: Iowa is requesting RHTP funding for the full five-year period (FY 2026–2030). Based on the allocation formula, if all states participate, Iowa expects a base award of **$100 million per year** (total **$500 million**)[20]. With competitive factors (rural population ~43% of state, robust application), Iowa may receive additional

funds; for planning, we assume a total of **~$600 million** over 5 years. The budget is presented in **FY 2026 dollars** and we expect to utilize funds fully by the end of FY 2030 (with any small remainder by Sept 2031 for final closeout). No state matching funds are required or included[146], but Iowa will contribute in-kind resources (staff time, office space) and may supplement program aspects with state funds if needed for sustainability in later years.

Summary Budget by Initiative: We have allocated the funding across the five initiatives and supporting activities as follows (total may not sum exactly due to rounding):

- **Initiative 1: Virtual Care Access Network (Telehealth) – $120 million (20%)** over 5 years. This covers telehealth equipment purchases (telemedicine carts, peripherals) for ~50 sites (approx. $15M), development of two telehealth hub centers (facility upgrades, $5M), contracting tele-specialist services (~$50M across years, as ongoing cost), IHIN integration and cybersecurity upgrades ($20M), training and technical assistance ($5M), and project management and evaluation for this initiative ($5M). This substantial investment reflects the high priority of telehealth in improving access. *Note:* Equipment and infrastructure costs here will be one-time primarily, with maintenance later picked up by hospitals – currently, these capital costs are within the allowed **<20%** infrastructure cap overall[11] (specific breakdown below).

- **Initiative 2: Rural Behavioral Health Integration – $90 million (15%)**. Major components: tele-mental health contracts (psychiatrists, counselors – ~$30M), training primary care for Collaborative Care Model (~$5M), establishing two mobile clinics for SUD (vehicle purchase, minor renovation – $8M, counted in infrastructure cap), funding community-based recovery supports ($5M), and covering costs for MAT expansion (e.g. induction clinic support, $4M). Also includes funding for integrating BH into HIE/analytics ($3M) and evaluation ($1M). About $10M reserved for contingency or scale-up to more sites if initial uptake is high. Behavioral health is resource-intensive (specialist time), hence a significant allocation.

- **Initiative 3: Chronic Disease Management & Prevention – $80 million (13.3%)**. This funds mobile screening units (2 units @ ~$1.5M each plus operating costs ~$15M over 5 years for staff, travel), community health worker workforce expansion (50 CHWs over 5 years scaled up, including training and salaries partly grant-funded – ~$20M), remote patient monitoring devices and digital app platforms (~$10M including devices like BioButtons and license fees for ~1000 patients/year), pharmacist upskilling and integration (training, protocol development, ~$2M), local wellness program grants ($5M), and data collection/evaluation ($2M). The remainder (~$25M) covers program management and expansion to more counties in later years (e.g., adding units or sustaining CHWs until other funding takes over). Many of these costs support prevention efforts that don't generate immediate revenue, so RHTP covers them initially.

- **Initiative 4: Rural Workforce Collaborative – $60 million (10%)**. Breakdown: direct provider incentive payments (sign-on bonuses, loan repayments) – **$30M** allocated (e.g., 60 providers x $500k average package over time, including physicians, NPs, etc.). This stays within **15% provider payment cap**: $30M is 5% of $600M total, well under 15%[64]. We will ensure these payments "for provision of services" (i.e., retention incentives tied to serving rural patients) remain within allowed uses[100]. Training costs (residency programs, tele-education, faculty support) – ~$15M, which includes establishing new residency rotations and possibly funding residency slots. Telehealth training and provider well-being programs – $5M. Recruitment program administration and marketing – $2M. Contingency $8M that could go to additional bonuses if needed to attract high-need specialists or to extend program length for some participants. Note: We anticipate using external match if possible (e.g., NHSC or employer contributions) to extend these funds further, but budget shows full amounts to be safe.

- **Initiative 5: Rural ACO & System Transformation – $120 million (20%)**. This is a broad category that includes: seed funding for two rural networks (startup costs like legal, governance, IT – $10M), ACO care coordination funding (e.g., hiring care coordinators, data analysts for network – $20M over 5 years), performance-based payments to providers (if needed to simulate shared savings early or to invest in quality improvement – $15M, this could be considered provider payment but we classify as part of model development; counted within 15% cap together with Initiative 4 provider payments), HIT/analytics infrastructure – $25M (this overlaps with HIE improvements and analytics hub, covering software, data warehousing, reporting tools etc.), minor capital or renovation projects for right-sizing – $20M earmarked (e.g., repurposing spaces or upgrading facilities to be tech-ready). Importantly, per NOFO, **capital expenditures/infrastructure across whole program cannot exceed 20%**[11], i.e., $120M if total $600M. We have infrastructure elements in initiatives 1, 2, and 5 primarily (telehealth equipment, mobile clinics, facility conversions). Summing those: Telehealth equip $15M + mobile clinic/renovation $8M + facility conversions $20M = $43M, ~7.2% of total, well under 20%. Even including all IT hardware as "infrastructure," we remain below 20%. Administrative costs for network convening and technical assistance – $10M (including contracts with consultants like KPMG/PwC for specialized expertise in modeling, as referenced in narrative[147][110]). We also set aside $20M for a "Rural Transformation Reserve" which might fund additional projects or bolster others depending on performance (or potentially the Tech Catalyst which NOFO caps at lesser of 10% or $20M[148] – we adhere to that by capping at $20M). This reserve gives flexibility to respond to emerging needs or scale successful interventions further in years 4-5. Any use of this reserve will be within allowed categories and likely require CMS approval via budget modification.

- **Program Administration and Evaluation: $60 million (10%)**. This covers the central program management, staff, evaluation activities, and indirect costs. We

are **limiting administrative and indirect expenses to 10%** of total funding[149]. For instance, Iowa HHS will hire approximately 8-10 FTEs for the RHTP PMO (Project Director, financial manager, data analyst, initiative coordinators, etc.) at an estimated $15M over 5 years (salary, benefits). Another $5M is for contractual support staff (e.g., an external evaluator contract if pursued, or specialized data analysis). Indirect costs (overhead) applied to federal funds at our negotiated indirect cost rate (we will include the Indirect Cost Rate Agreement in Attachment 4) are expected to be ~$5M (under 1% of total, because many costs are pass-through to subrecipients). The remaining admin budget (~$35M) is primarily for **evaluation and monitoring**, including building data systems, conducting surveys, and reporting. If we involve an academic partner for evaluation, part of that budget goes there (we estimate ~$5M for a multi-year comprehensive evaluation study). Travel and meeting costs for stakeholder engagement (rural summits, site visits) are also included here (~$1M over 5 years). We confirm that administrative expenses will **not exceed 10%** of the state's allotment each budget period[149].

Budget by Category (aggregate): To ensure clarity and compliance, we present the budget in key categories relative to total (using $600M as reference):

- **Provider Payments (direct)** – approx. **$30M** in workforce incentives + maybe up to $10M performance payments in ACO = **$40M** (≈6.7% of total). **Compliance:** *Cap 15%* – we are well under at ~6.7%[64]. These are funds that go directly to providers for services or as incentives; all are tied to program goals (e.g. retention bonuses requiring service years).
- **Capital Expenditures & Infrastructure** – approx. **$100M** earmarked across initiatives (telehealth hardware, mobile units, facility reno, IT infrastructure hardware). This is ~16.7% of total. **Compliance:** *Cap 20%* – we are under at ~16.7%[11]. We will track this category carefully to ensure we never exceed 20% in any budget period either[150].
- **EMR/HIT systems replacement** – We do not plan any wholesale EHR replacement using RHTP (most rural providers have EHRs). If a small EHR upgrade is needed for integration, we allocate a maximum of **$20–$25M** to any EMR-related spending, which is ~4% of total. **Compliance:** *Cap 5% if replacing existing EMR* – we are within at ~4%[65]. (And this may not be fully utilized; if no EMR replacements, funds go to other IT which counts under general infra).
- **Administrative/Indirect** – **$60M** (10%). **Compliance:** meets the *10% cap* exactly[149]. We will ensure strict accounting so that overhead is tracked and not exceeded.
- **Programmatic (Everything else)** – The remainder, roughly **$370M (61.7%)**, is programmatic spending on services, contracts, training, personnel delivering care, etc., which directly contribute to initiatives. This includes things like telehealth service contracts, staff like CHWs (not counted as admin because they deliver program services), etc.

The budget is phased over years roughly as: Year 1 ~$100M (ramp-up, lots of one-time equip purchase), Year 2 ~$110M, Year 3 ~$130M (peak as expansions happen), Year 4 ~$130M, Year 5 ~$130M (including sustaining costs and final eval). We anticipate possibly front-loading some capital costs early (to deploy tech ASAP), and reserving more service delivery funds for later years as programs scale. However, any large unspent in a year can carry to next (the NOFO indicates funds remain available through next FY)[20]. Iowa will monitor spend rate and adjust to make full use of funds within allowed timeframe (ensuring no funds expire unused – with flexibility that CMS will redistribute unused from others, Iowa stands ready to utilize any reallocated funds due to our robust pipeline of activities).

Cost Reasonableness & Efficiency: Each budget line was developed with cost estimates from vendors or past programs: - Telehealth costs draw on known costs from IRHTP (Iowa Rural Healthcare Telecommunications Program) and market quotes (e.g., tele-ICU program costs). - Workforce incentives are benchmarked against NHSC and state programs to ensure they are competitive but not excessive (e.g. $50k bonus is on par with existing signing incentives in rural Iowa). - We leverage *in-kind contributions*: e.g., many training activities will use existing curricula from partners like University of Iowa, saving development costs. - Bulk purchasing and phased rollouts will yield savings (we might get volume discounts on equipment, etc.). We also co-align with other funding (like leveraging HRSA grants where applicable – e.g., using Flex grant TA for some hospital quality improvement instead of duplicating spend).

Other Federal Funding Considerations: We affirm that RHTP funds will **not duplicate** other federal funds (see Attachment 3 for duplication assessment). For budget, this means if an activity could be billed to another source (Medicaid, Medicare, HRSA grant), we plan accordingly: - Medicaid-covered services (clinical services delivered) ideally will be billed to Medicaid rather than paid by grant, except where we explicitly use grant to test enhancements or increase payments up to cap. For instance, telehealth visits for Medicaid patients post-policy change will generate Medicaid claims revenue that sustains telehealth operations; RHTP might fund initial deficit but not pay double for each visit. - Construction of new facilities is **prohibited** and not in our budget[150]. We only have minor renovations within 20% cap. No RHTP funds go to building new buildings. - We also avoid using RHTP to fund ongoing costs that could be covered by other existing programs during the grant. Example: leveraging HRSA's SHIP grant for small hospital EHR training means we won't use RHTP for the exact same training, freeing those dollars for something else.

Budget Forms and Documentation: In Attachment 4, we include the **SF-424A** form showing budget breakdown by year and object class categories (Personnel, Fringe, Travel, Equipment, Supplies, Contractual, Other, Indirect). We also provide a narrative by object class here for further detail: - *Personnel:* A portion of funds will support salaries for time spent on program by state staff or contracted staff engaged in direct program activities (e.g., CHWs, project coordinators) – these are detailed under each initiative and in admin section, summing to ~$50M. - *Fringe Benefits:* Calculated at standard rates for personnel (approx. 30% for state employees, included in above). - *Travel:* Includes travel for mobile

units, staff site visits, training events – estimated $2M total (mostly under initiative budgets). - *Equipment:* Major equipment purchases (telehealth, mobile clinics, IT hardware) – ~$40M, under initiatives 1,2,5 budgets, clearly within infrastructure plan. - *Supplies:* Minor supplies (e.g., medical supplies for mobile clinics, educational materials) – a small portion (~$3M). - *Contractual:* Largest share – contracts with vendors (telehealth service providers, training partners, technical consultants) – likely $200M+ aggregated in initiatives. Each major contract will be competitively procured following state procurement rules. - *Other:* This includes incentives to providers (which are like sub-awards or other costs), community grants, etc. – perhaps $50M. - *Indirect:* As noted, ~ $5M using our approved rate (we will attach the Indirect Cost Rate Agreement as required, showing our federally negotiated rate, which we will apply only to eligible direct cost base).

Cost Cap Compliance Summary: To reiterate important compliance points, Iowa's budget adheres to all RHTP restrictions: - **Capital/Infrastructure ≤ 20%:** We allocated ~16.7% to such costs[11]. For example, if Iowa receives exactly $500M, we would ensure ≤$100M on capital; our plan with $600M still stays ~<$100M on capital. - **Provider Payments ≤ 15%:** We have ~6.7% in direct provider payments (incentives, etc.)[64]. If new needs arise (e.g., deciding to use funds to supplement Medicaid hospital payments temporarily), we would ensure total still under 15%. We currently do not plan a broad provider payment increase with RHTP (some states might, but Iowa focuses funds on transformation projects). However, if Iowa later opts to use some funding for one-time stabilization payments to, say, those 17 at-risk hospitals, we will keep it within the remaining margin under 15%. That flexibility is noted but not in current budget. - **EMR Replacement ≤ 5%:** We budget ~4% for EMR/HIT upgrades and will cap any single hospital EHR replacement support well below the 5% threshold[65]. Our focus is more on integration and add-on tools, not full EHRs. - **Admin/Indirect ≤ 10%:** We exactly meet this[149]. Iowa will carefully segregate admin costs in accounting to not exceed this each year as well. - **No Construction:** Confirmed, no new construction of buildings, only minor alterations within existing facilities (e.g., partitioning a space for a clinic, which falls under allowed minor renovations and within the 20% capital cap)[150]. - We also note the NOFO mention that something like a "Rural Tech Catalyst Fund" initiative should not exceed the lesser of 10% or $20M[148]. In our context, any such tech innovation pot is limited to $20M (as we set aside). So we comply with that as well (since $20M is ~3.3% of $600M, under 10%). - **Lobbying:** No RHTP funds will be used for lobbying activities (we will submit SF-LLL as "None" in Attachment 4). - **Maintenance of Effort:** RHTP is new, but Iowa will ensure we maintain our state spending on existing rural health programs (not cut them because of this influx). We may redirect some state funds to other gaps since RHTP covers certain areas, but not in a way that violates any MOE requirements (the NOFO didn't specify MOE, but we commit to augment, not replace, state effort).

Financial Management: Iowa HHS's fiscal division will manage the grant funds with oversight from our Department's CFO and the State Auditor as needed. We have experience managing large federal grants (e.g. the State Innovation Model (SIM) test grant of $43M in 2015–2019, multiple CMS Medicaid grants, HRSA grants). Systems are in place

for tracking, federal reporting (likely via PMS and quarterly reports), and auditing. We will follow 45 CFR 75 (Uniform Guidance) for cost principles and procurement.

Sub-awards (like funds to hospitals or local organizations) will be given with clear performance contracts and reporting requirements. We anticipate some RHTP funds will effectively flow to subrecipients (e.g., hospitals participating in ACO may receive some funding to hire care coordinators). Iowa will monitor subrecipients per federal regs (including single audit requirements if they exceed threshold, etc.).

Budget Risks and Mitigation: The primary budgetary risk is that some initiatives might underspend or overspend relative to plan: - *Underspend risk:* If, for example, workforce incentives uptake is slower (fewer providers sign up initially), we might not use allocated funds early. To mitigate, our budget is flexible – funds can shift between initiatives with CMS approval, or timeline extended. We built in a reserve (unallocated $20M tech fund) that can be tapped for other uses or not spent if not needed, to ensure we don't scramble to spend unwisely. Also, Iowa can absorb redistributed funds from other states in later years – our plan has room to expand successful programs if extra funds come in 2028-2030 due to other states not using theirs (we mention readiness in timeline). - *Overspend risk:* Conversely, if certain costs run higher (e.g. more providers than expected sign on for bonuses – a good problem), we will prioritize within the plan or seek other funding. Because we have multiple funding categories, we can adjust. For instance, if telehealth usage and demand is huge, requiring more state investment, we might allocate a bit more to that and less to something with slack. Our robust monitoring (financial reports monthly) will catch deviations early.

Conclusion of Budget Narrative: Iowa's budget is carefully crafted to support a **broad yet integrated set of initiatives**, with prudent reserves and compliance with all federal requirements. It strikes a balance between investing in long-term capacity (infrastructure, workforce development) and short-term boosts (incentives, new services) that together drive transformation. We are confident the funding requested is **sufficient and necessary** to achieve the ambitious outcomes in our project narrative. If only the minimum $500M becomes available to Iowa, we can still execute the core of this plan (we would scale down some expansions or intensity). The above plan assumes a slightly higher figure to be prepared for best-case scenario. In any case, Iowa will ensure that **every federal dollar** is used for its intended purpose – transforming rural health – and tracked with transparency and accountability. Detailed line-item budgets and justifications by object class and initiative are provided in the appended budget documents (SF-424A and supplementary Excel, included in Attachment 4), and a high-level required form SF-424 is submitted with this application.

Attachments

Attachment 1: Governor's Endorsement Letter (Draft)

(Drafted on State of Iowa letterhead, to be signed by Governor Kimberly Reynolds upon submission.)

Date: October 30, 2025

To: The Selection Committee, CMS Rural Health Transformation Program (CMS-RHT-26-001)
Centers for Medicare & Medicaid Services

Re: State of Iowa's Application for the Rural Health Transformation Program

Dear Selection Committee,

As Governor of the State of Iowa, I am proud to endorse Iowa's application for the CMS Rural Health Transformation Program (RHTP) and to designate the **Iowa Department of Health and Human Services (Iowa HHS)** as the lead agency to develop and implement this program[12]. This letter serves as Iowa's formal commitment to the goals and requirements of the RHTP, as well as my personal assurance of full state support for the proposed initiatives.

Designation of Lead Agency: Iowa HHS – specifically, its Division of Medicaid Services in partnership with the Office of Rural Health – will be the prime awardee responsible to CMS for the cooperative agreement[12]. Iowa HHS has the authority and expertise to manage this program, having successfully administered Medicaid and numerous federal grants. The Department will coordinate across relevant state agencies, including the Department of Agriculture (on rural broadband) and the Department of Workforce Development (on health workforce initiatives), to ensure a whole-of-government approach. I have directed these agencies to cooperate fully with Iowa HHS in this endeavor.

State Commitment and Support: Rural health is a top priority for my administration. The Iowa Legislature and I have taken steps in recent years to address rural healthcare needs – for example, passing laws to improve our health information network and proposing a new rural emergency hospital licensure. In fact, House File 972 introduced in 2025 underscores our focus on rural health funding and HIE modernization[151][59]. Through this RHTP application, we seek to amplify and accelerate these efforts with federal partnership. I am committed to providing any necessary state resources, including: - Aligning state policies with the RHTP plan (as noted in the application, Iowa will pursue telehealth payment parity, support expanded scope of practice for pharmacists, and other policy actions by 2027 to facilitate transformation). - Ensuring **continued funding** for effective programs post-grant. I will work with our legislature to establish sustainable funding (state or private) for critical elements like provider incentive programs, telehealth networks, and care coordination, so that these innovations can continue beyond FY 2030. - Engaging Iowa's Congressional delegation and federal partners to support flexibility and waivers needed for our model. If any Medicaid waivers or plan amendments are needed (e.g., to implement value-based payment models or new service reimbursements), my administration will prioritize those.

Governor's Rural Health Task Force: Upon award, I will convene a Governor's Rural Health Transformation Task Force, which I will chair on a quarterly basis, to receive

progress updates and assist with high-level problem-solving. This Task Force will include legislative leaders, ensuring bipartisan support and awareness. Iowa has a strong history of bipartisan backing for rural healthcare (e.g., telehealth legislation in 2019 had unanimous support). I anticipate continued collaboration across branches to make this program a success.

Stakeholder and Provider Support: I have spoken with many rural hospital CEOs, clinicians, and community leaders. There is widespread excitement for Iowa's RHTP initiatives. Enclosed in our application are letters of support from key stakeholders (hospitals, clinics, associations), demonstrating the unity behind this effort. As Governor, I will champion this program in communications with communities – to ensure local buy-in, patients' awareness, and provider engagement.

Accountability: I assure CMS that Iowa will comply with all terms and conditions of the award. Iowa HHS has robust financial management capabilities (as evidenced by clean audits on federal programs like Medicaid). We will provide the required performance reports, financial reports, and participate in RHTP learning networks facilitated by CMS[120]. I personally will expect regular reports from Iowa HHS to my office on milestones and will intervene if any obstacles require executive action. For instance, if regulatory waivers at the state level are needed to implement a component, I will work to expedite those.

In conclusion, the State of Iowa is fully committed to **"transforming the rural healthcare ecosystem"**[136] through this program. We view it not only as funding, but as a partnership with CMS to create lasting change. Our rural communities are counting on these innovations – from telehealth to workforce initiatives – to secure their healthcare future. I firmly believe Iowa's proposed plan meets and exceeds the RHTP goals and will serve as a model for rural health transformation nationally.

Thank you for your consideration of Iowa's application. We are enthusiastic about the opportunity to collaborate with CMS on this landmark investment in rural health. Please feel free to contact my office or Iowa HHS for any clarifications during the review process.

Sincerely,

Kim Reynolds
Governor of Iowa

Enclosures: Designation of lead agency documentation (State of Iowa Executive Order 2025-… designating Iowa HHS for RHTP), Letters of Support (see Attachment 4).

Attachment 2: Business Assessment of Applicant Organization

Applicant Organization: Iowa Department of Health and Human Services (Iowa HHS), designated by the Governor as lead agency for RHTP[12]. Iowa HHS is a consolidated agency (as of 2022) that includes the former Department of Public Health and Department of Human Services (which encompasses the Medicaid agency). This structure uniquely

positions us to deliver a coordinated rural health transformation program, combining public health expertise, healthcare financing (Medicaid), and human services under one umbrella.

Organizational Capacity and Experience: Iowa HHS has extensive experience managing large-scale health programs and federal grants. The agency administers the ~$6 billion Iowa Medicaid program serving ~20% of Iowans[17][41], indicating strong fiscal handling capacity. We have successfully implemented complex multi-year initiatives: - *State Innovation Model (SIM) Grant:* Iowa received a $43 million CMS SIM grant (2015–2019) to advance value-based care. Iowa HHS (then DHS) led that program, meeting all milestones (establishing community care teams, developing value-based ACO arrangements) and properly stewarding funds. We applied lessons from SIM in crafting our RHTP approach (e.g., need for robust stakeholder engagement and data analytics). - *Medicaid Modernization:* Transition to managed care in 2016 was a major operational project, involving network development and beneficiary support, achieved under Iowa HHS's management. While challenging, it demonstrates our ability to implement systemic changes affecting rural providers (95% of Medicaid enrollees are in managed care now[44]). - *HRSA Grants:* The Iowa Office of Rural Health (within HHS) manages HRSA's Medicare Rural Hospital Flexibility (Flex) Program (around $500k/year) and Small Hospital Improvement Program (SHIP). We routinely work with 82 CAHs on quality improvement and finance projects[18]. This provides a foundation for delivering technical assistance under RHTP – we have established relationships with all rural hospitals in Iowa. - *Public Health Programs:* Iowa HHS handles CDC and HRSA public health grants (immunization, maternal health, etc.), often focusing on rural needs. We have Title V Maternal-Child Health block grants reaching rural counties, and our staff are adept at building community-based services. - *Behavioral Health Initiatives:* The agency oversaw the expansion of mental health regions and a recent ~$30M federal grant for substance abuse prevention, demonstrating capacity to manage behavioral health projects across rural areas.

Key Personnel and Staffing Plan: We have identified a strong team for RHTP: - *Executive Sponsor:* Iowa Medicaid Director (name to be provided) will serve as executive sponsor, ensuring integration with Medicaid's strategic direction, especially for value-based payment alignment. - *Project Director:* **[Jane Doe, MPH]** – a seasoned program manager in Iowa HHS with 15 years' experience in rural health (current Director of Iowa Office of Rural Health). She will dedicate ~100% effort to RHTP, overseeing daily operations, inter-agency coordination, and CMS liaison. She successfully managed the Flex Program and has relationships with rural providers statewide. - *Deputy Director/Finance Manager:* **[John Smith, CPA]** – Iowa HHS Bureau Chief of Finance will ensure financial compliance, manage budget tracking, and coordinate with the State's accounting system for federal reporting. He has overseen multi-million federal grants including the CARES Act provider relief funds distribution in Iowa, ensuring timely and correct use. - *Initiative Leads:* Each of the five initiatives will have a designated lead: - Telehealth Lead: **[Dr. Alice Nguyen]**, MD – Clinical lead for telehealth at University of Iowa Hospitals, contracted part-time to advise and coordinate specialty telehealth integration. - Behavioral Health Lead: **[Sara Thompson, LISW]** – current Rural Mental Health Services Coordinator at Iowa HHS, with

experience expanding tele-psychiatry in Iowa. - Chronic Disease/Prevention Lead: **[Mark Patel, MPH]** – Chronic Disease Director at Iowa HHS, has run statewide diabetes prevention programs. - Workforce Lead: **[Karen Miller]** – Director of Healthcare Workforce at IA Workforce Development (will collaborate via MoU), experience with NHSC programs and state residencies. - ACO/Transformation Lead: **[David Chen]** – Iowa Medicaid innovation program manager, who worked on SIM and value-based purchasing, knowledgeable about ACO models. - *Data Analyst/Evaluation Lead:* **[Analyst TBD, PhD]** – We plan to hire or contract a lead evaluator (potentially through an academic partner like University of Iowa College of Public Health). This person will design the monitoring system, analyze metrics, and produce evaluation reports. Our budget covers this position. - *Support Staff:* Administrative assistants (2 FTE for scheduling, communications), a communications specialist (1 FTE) to manage stakeholder comms and telehealth adoption campaigns, and regional outreach coordinators (we plan 3 FTE, each covering ~33 counties to liaise with local partners). - *IT Support:* We will leverage the State's Office of the Chief Information Officer (OCIO) and CyncHealth for health IT expertise rather than hire separately. The budget includes contractual funds for IT integration tasks.

All key personnel have been identified in our application forms, and resumes can be provided. We will ensure any future hires meet qualifications and will seek CMS approval if required for key roles. We will also engage consultants as needed for specialized knowledge (e.g., KPMG/PwC mentioned for network design). Iowa HHS's HR process is ready to quickly recruit any unfilled roles upon award, given the tight implementation timeline.

Organizational Structure: Iowa HHS will manage the RHTP under its organizational hierarchy. The RHTP Project Director will report to the **Deputy Director of Public Health** within HHS (who in turn reports to the HHS Director). The Project Director will also have a dotted-line report to the Iowa Medicaid Director for any components intersecting Medicaid. This dual-report ensures high-level oversight. The Governor's Task Force (as per her letter) provides top-level governance, but day-to-day will be handled within HHS. We have attached an **organization chart** illustrating RHTP governance: it shows the Project Director overseeing initiative leads and support staff, coordinating with Iowa Medicaid, and the Advisory Council feeding input (Attachment 4 includes this chart).

Financially, funds will be managed through Iowa HHS's grants management division using existing financial systems (Iowa's central accounting), assigning a unique program code for RHTP to track all expenditures. We have the capability to generate required financial reports (SF-425, etc.) quarterly.

Systems and Processes: - *Financial Management:* We follow Iowa's financial policies and federal Uniform Guidance. We have internal controls for approving expenses, a procurement bureau for competitive bids (we will use state contracts or RFPs for major purchases like telehealth vendor, following state procurement law to ensure cost-effectiveness). We maintain documentation for all spending, making us audit-ready (the State Auditor or CMS could audit, and we welcome that). - *Program Management:* We will

utilize project management software (Microsoft Project or similar) to track tasks and timelines of each initiative. Weekly team meetings will review status, and we'll escalate issues to leadership promptly. - *Risk Management:* We will maintain a **risk register** (as also described in our application risk section below) to manage programmatic and financial risks, updated monthly. The Advisory Council will also play a role in identifying external risks (e.g., policy barriers). - *Subrecipient Monitoring:* Many RHTP funds will be disbursed to subrecipients (like sub-grants to hospitals, contracts to FQHCs). Iowa HHS has a Bureau of Contract Management that will assist in drafting agreements with clear deliverables and reporting requirements. We will conduct desk audits and some on-site monitoring for subrecipients annually per our risk-based monitoring plan. Entities receiving >$750k in federal funds will be required to submit Single Audits to us and we'll follow up on any findings. - *Data Systems:* We will track performance metrics in our **Iowa Health I-O (Innovation Outcomes) Dashboard**, an internal tool HHS is developing for this and similar projects, using Tableau or PowerBI. This will allow near real-time views of key metrics for decision-makers. - *Privacy & Security:* Because we will handle PHI in evaluation (like Medicaid data, IHIN data), we will ensure all data use is compliant with HIPAA. Iowa HHS has data use agreements with CyncHealth (HIE) and appropriate security protocols (the state's systems are compliant with federal NIST standards for Medicaid info). Evaluators or partners will sign Business Associate Agreements if needed. House File 972's emphasis on HIE patient consent will be followed – giving patients opt-out rights[59] – but since this is population-level improvement, patient-level consent is not typically required beyond existing law for analysis.

Past Performance and Readiness: Iowa HHS has a track record of launching new initiatives quickly when needed (e.g., the COVID-19 vaccination campaign was rolled out statewide by the department within weeks of vaccine availability, leveraging local public health and providers effectively). For RHTP, we have already started preparatory work: we conducted an RFI in September (like Wisconsin did[81]) to gather partner interest, we have an inventory of rural health programs in Iowa (so we know where duplication might occur or where synergy is possible), and we have drafted an implementation manual for internal use. This demonstrates our readiness to hit the ground running by the time awards are announced (we anticipate December 2025 approvals[152][153]).

Inter-Agency Coordination: As noted, Iowa HHS will coordinate with other agencies. Notably, Iowa Medicaid (which is part of HHS) and the Iowa Insurance Division (for private insurer engagement in rural ACO), as well as Iowa Department of Inspections & Appeals (for any regulatory changes like licensing Rural Emergency Hospitals), and Iowa Workforce Development (for workforce data and initiatives). We have established points of contact in each and will formalize working groups. For example, the Iowa Medicaid Enterprise will dedicate actuary/finance staff to adjust MCO contracts to incorporate RHTP changes (with timeline to avoid delays in negotiation cycles).

Business Assessment Summary: In conclusion, Iowa HHS has the **organizational capacity, infrastructure, and expertise** to successfully carry out the RHTP project and manage a $500M+ cooperative agreement. We have experienced leadership, a solid

financial system, and relationships at state and local levels crucial for success. The agency's consolidation has actually strengthened our ability to break silos – under one roof we have Medicaid and Rural Health working hand in hand (which will be a key advantage in integrating financing and public health interventions). Our risk in undertaking this is mitigated by our experience and proactive planning. We are confident in our ability to **meet program requirements, achieve proposed outcomes, and responsibly manage public funds**. CMS can trust that Iowa HHS will be a **reliable steward** of the RHTP funding, delivering transformative results for rural Iowans.

(Additional documents such as the organizational chart, resumes of key personnel, and the indirect cost rate agreement are included in Attachment 4 as part of the Business Assessment.)

Attachment 3: Program Duplication Assessment

The State of Iowa has thoroughly reviewed existing federal, state, and local programs to ensure that the activities and funding in our RHTP proposal **complement rather than duplicate** other initiatives. This attachment summarizes potential areas of overlap and how we will avoid duplication or supplantation of funds, in accordance with RHTP requirements and sound grants management practices.

1. Avoiding Duplication with Existing Federal Programs:

- **Medicaid and Medicare Payments:** The RHTP allows up to 15% for provider payments[64], but those funds cannot duplicate payments already available through Medicaid/Medicare for services. *Assessment:* We will not use RHTP to pay for any medical service that could be billed to Medicaid, Medicare, or other insurance. For example, telehealth clinical encounters will be billed to insurance; RHTP funds will only cover setup costs or uncovered services (like a specialist consult that isn't billable). Similarly, RHTP will not fund ongoing salaries for clinical staff who deliver billable services (beyond initial incentive periods). We will coordinate with Iowa Medicaid's rate and payment policies – any supplemental payments from RHTP will be structured as time-limited bonuses or tied to transformation activities (e.g., quality performance) to avoid being seen as duplicative of regular claims reimbursement.
- *Medicare Rural Programs:* Medicare has some rural hospital support (Critical Access Hospital cost-based reimbursement, etc.). Our RHTP funds used for hospital sustainability (if any) will be for transformation (like system redesign or new service development), not to pay for services Medicare already reimburses. For instance, if a CAH qualifies for Medicare bonuses (e.g. value-based purchasing incentives), we won't replicate that – rather we might fund a quality improvement coach to help them achieve those bonuses.
- *Supplantation Concern:* We confirm RHTP funds won't replace state Medicaid funds. Iowa will maintain effort on Medicaid rates. For example, if we consider a short-term enhanced payment to rural hospitals via RHTP, it will be clearly separate

from Medicaid's base payments and not reduce what Medicaid would otherwise pay (no double-dipping via CPE or such).

- **HRSA Programs:**

- *Flex Program (Critical Access Hospitals):* Iowa receives ~$800k/year for the Flex program to support CAH quality improvement, financial consulting, and EMS integration. *Avoidance:* We will align RHTP-funded TA for CAHs with Flex activities. For instance, Flex funds currently support some quality reporting training – RHTP will not duplicate that, instead it might fund complementary areas (like telehealth training which Flex doesn't cover). The Iowa Office of Rural Health (which runs Flex) is internal to our team, so we will coordinate scopes. If RHTP provides consultant assistance to CAHs, we'll ensure it goes beyond what Flex's contractor already does (Flex has limited hours, RHTP can scale it).
- *SHIP (Small Hospital Improvement Program):* Grants ~$9k to each rural hospital for small projects (EHR, quality). *Avoidance:* If a hospital is using SHIP for, say, an EHR module purchase, we won't use RHTP to fund that same module. We'll actually encourage hospitals to use SHIP first for smaller needs and reserve RHTP for larger transformation efforts.
- *Community Health Center (FQHC) grants:* Some RHTP initiatives involve FQHCs (e.g., CHWs, integration). We will coordinate with the Primary Care Association to ensure we're not duplicating HRSA Health Center Program funding. For instance, if an FQHC already gets HRSA funds for a behavioral health integration project, RHTP might supplement by adding telehealth equipment or linking it with hospitals, but not duplicate funding of the same personnel.
- *NHSC and other workforce programs:* Iowa leverages NHSC for loan repayment to clinicians in HPSAs. Our RHTP workforce incentives will be designed to **supplement, not duplicate** NHSC. E.g., a doc could get NHSC loan repayment (federal) and additionally a state RHTP bonus for extra commitment years, but we won't pay off loans that NHSC is already covering. We'll coordinate through the Bureau of Health Workforce representative to possibly combine efforts (maybe using RHTP funds for providers not eligible for NHSC or to extend service beyond NHSC terms).
- *Telehealth Resource Centers (TRC):* HRSA funds a Regional TRC that covers Iowa for telehealth TA. We'll consult them for expertise, but RHTP's telehealth work is implementation, not just TA, so no duplication of funding streams (TRC is separate technical assistance resource).
- *Other HRSA grants:* e.g., Iowa's Maternal Health Innovation grant which addresses maternal healthcare in rural areas. We will ensure RHTP's maternal telehealth or mobile prenatal care work aligns with and fills gaps not addressed by that grant. Similarly, if any HRSA Rural Communities Opioid Response Program (RCORP) grants are active in Iowa counties, we will coordinate opioid use disorder activities

to complement those (RCORP might fund local coalition work while RHTP funds teleMAT expansion, for example).

- **SAMHSA and CDC Grants:** Iowa has SAMHSA grants for opioid response (State Opioid Response, SOR) and others for mental health. RHTP behavioral health integration will be coordinated so that, for instance, SOR funds medication-assisted treatment startup in some clinics (with its own funding), whereas RHTP might fund telepsych and integration efforts – they enhance each other. We have internal crosswalks listing current grants by county; our project leads will ensure if an SOR grant is paying for a peer recovery coach in County X, RHTP won't double-fund another for same tasks, but could fund additional coaches where SOR doesn't reach. Many CDC grants (diabetes prevention, heart disease control) also channel into rural health programs; we plan to align RHTP's chronic disease efforts with those. Actually, we see synergy: RHTP can scale up pilots from those grants. No RHTP funds will be used to continue an activity currently funded by an active CDC grant unless that grant ends and the activity is crucial (in which case, it's arguably sustaining rather than duplicating, but we will check with CMS in such cases).

- **FCC/USDA Broadband Programs:** Our telehealth expansion needs broadband; FCC's Rural Health Care (RHC) program subsidizes connectivity for rural providers. We will utilize FCC RHC for ongoing connectivity costs rather than use RHTP dollars, thus no duplication (RHC is underutilized in Iowa; we'll actually enroll more hospitals in it). If we do any broadband infrastructure (like purchasing hotspot devices or supporting a network upgrade), we'll confirm it doesn't overlap with USDA's ReConnect grants or others in that area. The Governor's Office has a broadband grant program (Empower Rural Iowa); if they fund the same areas, we'll adjust. Essentially, RHTP tech funds focus on medical devices and IT integration, not core broadband cables if others cover that.

2. Avoiding Duplication with State Programs and Private Initiatives:

- **Iowa State Programs:**
- *Iowa's existing loan repayment program (PRIMECARRE):* Iowa runs a modest state-funded loan repayment for rural providers. RHTP workforce incentives will be coordinated with PRIMECARRE so that a provider doesn't receive duplicate awards for the same service period. We may stack or sequence them: e.g., PRIMECARRE might cover first 2 years, RHTP covers years 3-5 for a provider. We have staff overseeing both, so this will be managed.
- *Mental Health Regions funding:* Iowa's regional mental health system provides funds to counties for services like mobile crisis. If RHTP funds a tele-crisis service, we'll integrate it with region services and ensure region dollars can be used for ongoing operations after RHTP starts it. No double-funding: if a region already funds a tele-mental health line, RHTP would enhance or expand it rather than fund the exact same hours.

- *Iowa Health Information Network (HIE/IHIN):* The state has contracted with CyncHealth to operate HIE. There is some state funding and participant fees supporting it. RHTP will invest in IHIN upgrades. To avoid duplication, we will coordinate budget with CyncHealth's existing funding. For instance, if state HIE funding already covers basic connection for all hospitals, RHTP will focus on advanced analytics on top of it. If any of our RHTP HIE enhancements are something CyncHealth already planned with other funds, we'll shift RHTP to unmet needs. We have representation from CyncHealth on our team to manage this.
- *State Innovation Alliance (if any):* While SIM ended, Iowa still has an Iowa Healthcare Collaborative working on quality improvement. We'll ensure our quality efforts in RHTP (like hospital QI coaching) complement IHC's ongoing work funded by other grants (like HQIC). Possibly we'll route RHTP QI support through IHC to leverage their network rather than duplicate establishing a parallel network.

- **Private/Foundation Initiatives:**

- There are initiatives by health systems (e.g., MercyOne's rural tele-stroke program, University of Iowa's tele-specialty outreach). We'll partner rather than duplicate – e.g., UIHC's tele-stroke (part of a grant or their budget) will be integrated into our telehealth hub rather than RHTP creating a new stroke service.
- Some local hospitals have foundation grants for equipment or mobile clinics; we will coordinate at local level to complement. For example, if a county hospital foundation bought a mobile mammography van, RHTP's mobile unit might schedule around it or focus on other screenings, not duplicating mammography that's already covered.
- The Iowa Primary Care Association might have a grant to put CHWs in clinics; RHTP CHW deployment will fill gaps in clinics without that resource, not double-place CHWs where one is already funded.

3. Complementarity and Layering of Funding:

Our approach is often to **layer RHTP funding on existing structures to amplify impact**: - Example: The **Iowa Health Careers Program** (state) exists to encourage rural youth into health professions. It's small scale; RHTP's workforce initiative can complement by offering those participants eventual incentives and positions. Not duplication, but pipeline alignment. - The RHTP **value-based care** push aligns with Iowa Medicaid's own programs. If Iowa Medicaid introduces a new ACO arrangement statewide around 2028, RHTP funds will be used to help rural providers participate (technical assistance, temporary financial support) but not to pay for things Medicaid or MCOs are funding. We have MCO representatives engaged to ensure we differentiate funding responsibilities.

4. Ensuring No Double Billing or Double Dipping:

We will implement internal controls: for any subrecipient or contractor, we will require certification that **RHTP funds will not be used for costs covered by another**

federal/state funding source. For instance, if a hospital receives both RHTP subgrant and a HRSA grant, we'll have them submit a cost allocation plan or separate accounting to clearly delineate which personnel/activities each covers. Our contract language will include prohibition of supplanting and require notification if other funds are received for similar purposes.

Iowa HHS's grant management system can flag similar expenditures. We'll also coordinate with our Single Audit process: auditors will look for duplicative funding issues – we will actively provide clarity in documentation to avoid findings.

5. Addressing Areas of Potential Overlap Identified by CMS FAQ:

(Though at the time of writing, CMS's FAQ (if released) likely emphasizes integration with existing efforts.) Based on common guidance: - *Electronic Health Records (EHR):* If EHR incentive funds (HITECH from past) already paid for systems, RHTP should not simply replace those. We heed the 5% EMR cap[65]. Our budget for EHR is targeted to integration or upgrades not previously funded. And if any hospital qualifies for remaining Meaningful Use incentives (unlikely now), we won't use RHTP where MU funds could be used. - *Capital Projects:* Some rural hospitals may concurrently pursue USDA loans or other funding for facility upgrades. We'll coordinate so RHTP doesn't pay for something financed elsewhere. E.g., if a hospital got a USDA Community Facilities loan to update its clinic, RHTP may instead fund equipment inside that clinic or other needs, not the construction which loan covers. - *Telehealth overlap:* If another program (e.g. USDA DLT grant) gave telemedicine equipment to a site in 2024, we'll verify what's still needed. RHTP might focus on connecting those sites into networks or adding new specialties rather than buying duplicate equipment. Also, the VA has telehealth programs in rural Iowa for veterans – RHTP telehealth can coordinate with those (maybe share infrastructure). We won't duplicate VA's effort for veteran patients but complement by ensuring civilian providers and VA can coordinate via HIE etc.

6. Unique Additions of RHTP (What would not happen otherwise):

To emphasize, RHTP will enable projects that **do not have other funding sources**: - For example, there is no existing program paying rural hospitals to collaborate or share services at this scale – RHTP provides that catalytic funding for networks. We are confident this is additional, not redundant. - Workforce: current programs (NHSC, small state program) are insufficient; RHTP adds value by increasing the number of slots/incentives, not duplicating existing ones (which cover only a fraction of need).

7. Coordination Mechanism:

We will maintain a **Program Matrix** of funding sources vs activities to track overlaps. The Project Director and initiative leads will update this quarterly. We'll consult with federal project officers if any question arises about overlap. Additionally, the Advisory Council includes representatives from major programs (e.g., Flex, PCA, MCOs) who can spot if something we plan is already being done and direct us to adjust.

8. Future Flexibility:

If during implementation an opportunity arises to leverage another funding (say CMS announces a new demo for rural hospitals or we get a new grant), we will pivot RHTP funds if appropriate so that combined funds extend reach rather than double-fund. For instance, if Iowa gets selected for a CMMI pilot on global budgeting, we might use RHTP funds to help hospitals transition, while CMMI pilot provides payment, ensuring each covers different facets.

Conclusion: Iowa's RHTP plan is designed to be **complementary** to all known programs. We have cross-checked each initiative element against current funding streams. By doing so, we ensure that RHTP funds will fill gaps and **accelerate transformation** without wasting resources on duplicative efforts. This approach not only meets compliance but also maximizes the impact of every dollar by aligning with other initiatives (the sum being greater than parts). We will remain vigilant throughout the project to continue avoiding duplication as programs evolve and new funding emerges, and will document in progress reports how we are coordinating (CMS likely will appreciate evidence of coordination rather than siloed use of funds).

(Detailed crosswalk tables and a list of known programs in Iowa with brief descriptions, which we used for this assessment, can be found in the Appendix of this attachment. For brevity, not all are listed here, but examples were provided as above.)

Attachment 4: Required Forms and Supporting Documentation

This section includes a list of required forms and additional supporting documents accompanying Iowa's RHTP application. All standard forms are completed and submitted in grants.gov as part of the application package, and key supporting documents are provided to strengthen our proposal.

A. Required Forms (Grants.gov Submission) – *completed and attached in application package:*

1. **SF-424: Application for Federal Assistance** – Signed by Iowa's Authorized Official (Director of Iowa HHS). This form provides general information including DUNS/UEI, Congressional Districts (IA-ALL for state programs), and funding request ($600,000,000).
2. **SF-424A: Budget Information – Non-Construction Programs** – Our detailed budget by object class and by year is filled in this form (Sections A-F). It reflects $120M each year across five years (subject to final award). This aligns with the narrative, and Section B shows the breakdown across the five initiatives (we treated each initiative as a "component" for clarity, although not required).
3. **Grants.gov Lobbying Form (Certification and SF-LLL)** – We have no lobbying activities to disclose. The SF-LLL is submitted indicating "No lobbying to report," and a certification is included that Iowa will not use federal funds for lobbying.

4. **Project/Performance Site Location(s)** – Identifies the primary location (Iowa HHS, Des Moines, IA 50319) and notes that project activities occur in multiple rural counties (we attached a table listing all 61 rural counties as secondary sites).
5. **Key Contact Form (if applicable)** – Included via Grants.gov form, listing Project Director (Jane Doe, MPH) as program contact, and an alternate contact (John Smith, CFO for financial matters).
6. **SF-424B: Assurances – Non-Construction** – Since this is a non-construction project, we have signed SF-424B to assure compliance with all applicable requirements (Uniform Administrative Requirements, etc.). Iowa abides by these assurances.
7. **Grants.gov Attachment Form** – used to upload this combined application document and supporting PDFs as needed.

(Note: The NOFO references an "Other Attachments Form"[13]. We have used that to attach this consolidated application and the attachments as one file in Markdown/PDF as per instructions. Each attachment component here aligns with NOFO's list[13].)

B. Other Supporting Documentation (Included in this Attachment):

- **Indirect Cost Rate Agreement:** Iowa HHS's federal Negotiated Indirect Cost Rate Agreement (NICRA) is attached (dated July 1, 2025) showing an approved indirect rate of 19.0% of salaries and wages. We apply this rate (de minimis for some subrecipients if they lack a rate). Our budget's indirect cost line was calculated using this, which is within the 10% admin cap as explained[149].
- **Organizational Charts:** We include two charts – (1) Iowa HHS high-level org chart highlighting the divisions involved in RHTP, and (2) the RHTP Project structure chart (as mentioned in Business Assessment) showing governance, reporting lines, and initiative teams.
- **Resumes of Key Personnel:** Short bios or CVs for Project Director (Jane Doe), Initiative Leads, and Evaluation Lead (to be hired – we included a draft position description in lieu of resume). These demonstrate the qualifications we summarized.
- **Letters of Support:** We have compiled letters from major stakeholders (submitted as a single PDF):
- Iowa Hospital Association (statewide hospital membership organization) – letter expressing support and willingness to coordinate, highlighting how our plan aids Iowa's rural hospitals.
- Iowa Primary Care Association – letter supporting our collaboration with FQHCs and confirming non-duplication with their programs.
- 5 Individual Rural Hospitals – e.g., MercyOne Siouxland (covering NW Iowa), Ringgold County Hospital, Van Buren County Hospital, Pocahontas Community Hospital, and Audubon County Memorial Hospital. Each letter details the needs in

their community and endorses specific relevant initiatives (telehealth, workforce, etc.). They commit to participating and sustaining efforts.

- University of Iowa Health Care – letter from the CEO pledging specialty support and involvement in telehealth/ACO efforts.
- Iowa Department of Agriculture (Office of Broadband) – letter indicating partnership on broadband and that our telehealth goals align with their broadband expansion and will not duplicate funding.
- Iowa Workforce Development – letter supporting workforce initiative and confirming data sharing and coordination on incentive programs.
- CyncHealth (HIE operator) – letter of support confirming technical partnership and that RHTP funds will be effectively used to enhance HIE and analytics, dovetailing with state HIE enhancements.
- Others: e.g., Iowa Rural Health Association letter praising inclusion of community voices and offering to assist with outreach, and an Iowa Health Care Association (covers rural nursing homes) letter supporting telehealth for post-acute linkages (not a primary focus but they appreciate system approach).
- **Governor's Executive Order (if applicable):** If available by submission, we include the Executive Order or official designation from the Governor naming Iowa HHS as lead (or a memo to that effect) to reinforce Attachment 1.
- **Technical Supporting Details:** A brief methods paper on how we calculated baselines and targets for metrics (for evaluators' reference, not required by NOFO but provided for transparency). For example, calculation of rural preventable hospitalization baseline from our hospital discharge data 2024, etc.
- **Risk Register (detailed):** While we summarize risk in narrative below, here we attach a table of top 10 risks, their scores (likelihood, impact), owner, and mitigation actions. This shows CMS we proactively manage risks.

All attached files are clearly named (e.g., "IA_RHTP_OrgChart.pdf", "IA_RHTP_LOS.pdf" for letters). The Governor's letter and these attachments collectively demonstrate Iowa's readiness and broad support.

C. Compliance Checklists: (if provided in NOFO or requested) - We have completed any **NOFO compliance checklist** ensuring page limits (Project Narrative 60 pages, Budget Narrative 20 pages) are met – *note: as an example application, our narrative is richly detailed; in actual submission we will format accordingly and not exceed limits, using endnotes outside page count as allowed[15].* - **Page Limit Attestations:** Governor's letter is 2 pages (under 4-page limit[154]), Business Assessment is ~10 pages (under 12-page limit[155]), Duplication Assessment is ~5 pages (within 5-page limit[156]).

D. SF-424A Section F (Budget Justification) or additional budget details: We included the Budget Narrative in the application body per guidance, but if a separate detailed budget justification by object class is needed beyond SF-424A, we provide an expanded breakdown in this attachment (e.g., a table showing costs by initiative by year and by

category). This essentially mirrors the content of the Budget Narrative in tabular form for clarity.

By providing all the above forms and documents, we ensure a complete and compliant application. The letters and supporting materials reinforce the credibility and preparedness of Iowa to undertake the RHTP. We kindly request CMS to review these attachments alongside our narrative; they offer evidence of our planning and partnerships which will drive our success in transforming rural health in Iowa.

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