Iowa Rural Health Transformation Program (Healthy Hometowns) Project Narrative

Iowa HHS's mission is to provide high quality programs and services that protect and improve the health and resiliency of individuals, families, and communities. The agency's societal vision is that individuals, families, and communities are safe, resilient, and empowered to be healthy and self-sufficient. Its organizational vision is that Iowa HHS is a trusted leader and partner in protecting health and providing high quality services. In line with its mission, Iowa HHS proposes the following comprehensive plan to meet the health needs of rural Iowans through the Rural Health Transformation Program (RHTP). Iowa HHS's plan emphasizes promoting innovation, strategic partnerships, and infrastructure development to support rural population health care, promote preventive care, and address root causes of disease.

Rural health needs and target population

Significant portions of Iowa's population live in rural census tracts. According to the most recent Goldsmith Modification, 47.5% of the state's population resides in rural areas. The proportion is even higher among older adults, with 50.1% of Iowans aged 65 and over living in rural census tracts. For comparison, only about 17% of the total U.S. population and 20% of the elderly population live in rural areas. This relatively high rural population presents major challenges in delivering sustainable, high-quality health care, contributing to differences in health outcomes between rural and urban residents. These differences carry substantial economic costs, including both direct medical expenses and indirect costs from morbidity and mortality, such as lost productivity and future earnings [1].

Chronic diseases, the leading causes of illness, disability, and death, account for an estimated 90% of the nation's $4.9 trillion in annual health care expenditures [2]. In Iowa, the inflation-adjusted direct and indirect costs of chronic diseases are projected to reach $13.82 billion and

$32.24 billion, respectively, in 2025 [3]. Rural communities face disproportionately higher rates of chronic disease and preventable deaths from leading causes, further exacerbating these costs [4]. Addressing the barriers that drive these differences could yield significant economic benefits and improve quality of life. Achieving sustainable change at scale will require a transformation in how rural Iowans engage in healthy behaviors, access preventive and primary care, manage chronic conditions, and receive treatment for acute and emergency needs.

Governor Kim Reynolds has outlined Iowa's strategy through a hub-and-spoke model of care. This approach encourages inter-organizational partnerships, allowing patients to remain in their communities for most care and be transferred only when necessary [5] [6]. It supports new access points for preventive care and promotes healthy behaviors to address root causes of disease. The model also expands health information exchanges and emergency medical services to improve interoperability and care coordination. Crucially, the hub-and-spoke framework enables Iowa to make targeted investments, foster partnerships, and optimize care delivery. By leveraging economies of scale and market forces, the state aims to drive long-term sustainability and improve health outcomes for rural Iowans.

Population Characteristics

Understanding the characteristics of Iowa's rural population and health care landscape is essential for implementing transformational change. Rural Iowans face economic disadvantages compared to those in metropolitan areas, with median household incomes nearly 20% lower at $71,714 versus $85,950 [7]. Twelve of the thirteen Iowa counties where more than 15% of households live below the poverty line are rural [8]. Similar differences appear in employment. While Iowa's average unemployment rate is 3.3%, below the national average of 4%, this masks significant variation [9]. All counties with the highest unemployment rates (ranging from 5.4% to

8.8%) are rural [9]. Insurance coverage also varies geographically. Although 93% of Iowans are insured, above the national average of 89%, every county with coverage rates below the national average is rural [10]. Educational attainment follows the same pattern. Thirteen of the fourteen counties with the highest percentage of residents lacking a high school diploma are rural, affecting 10–20% of their populations [8]. The gap widens at the bachelor's level: all 30 counties with the lowest rates of bachelor's degree attainment are rural [8]. Employment differences between rural and urban areas are most pronounced in agriculture and manufacturing. For example, 6% of the rural workforce is employed in agriculture, compared to just 1% in urban areas [11]. The time-sensitive nature of agricultural work, especially during peak seasons, combined with longer travel times to access care, can result in significant labor losses or operational disruptions for rural farmers [12].

Understanding the insurance mix is also critical to Iowa's transformation plan. Most Iowans (71.8%) have private insurance, while 37.8% have public coverage. Two in five (42%) Medicaid recipients live in rural areas, including those enrolled in traditional Medicaid, the Iowa Health and Wellness Plan (IHAWP), or Healthy and Well Kids in Iowa (Hawki) [13]. Rural Medicaid enrollees often face access challenges, as not all providers accept Medicaid. Children under 17 make up the largest share of rural Medicaid members (46.2%), followed by working-age adults 22–64 (40.1%) [13]. Additionally, 15% of Medicaid enrollees have three or more chronic conditions, higher than the general population [14]. Demographic trends further complicate care delivery. Iowa's fastest-growing age group over the past decade is adults 65 and older, increasing from 14.9% in 2010 to 18.6% in 2023 [15]. Seniors now make up 21% of the rural population, compared to 15.5% in non-rural areas. This growing share of rural Medicare-eligible residents,

combined with the high proportion of rural Medicaid recipients, has serious implications for reimbursement, chronic disease burden, and care demand.

These rural population characteristics pose significant challenges to achieving positive health outcomes. Lower incomes and higher poverty rates create economic barriers to preventive care and healthy behaviors. Lower educational attainment may limit residents' ability to make informed health decisions. The high share of seniors in rural areas also reduces provider margins, as Medicare reimburses at lower rates than commercial insurers [16], potentially threatening long-term financial stability. The hub-and-spoke framework outlined in Iowa's Rural Health Transformation Plan offers a promising framework. It supports rural Iowans in investing in their health and accessing appropriate care, while helping rural providers remain financially viable.

Access to Infrastructure and Care

Although rural households in Iowa are less likely than urban ones to have internet access, approximately 89% still do and thus expanding telehealth services is feasible [8]. Access to vehicles is similar across rural and urban households, but public transportation options are limited in rural areas. Iowa estimated each block group's driving distance and time to the nearest healthcare provider or facility using the road network across the entire state. The results demonstrated that travel distance and time remain significant barriers to in-person care for rural populations. On average, rural residents drive 30 minutes to the nearest hospital, more than twice the time for urban residents. The average drive to the nearest primary care physician is 24 minutes in rural areas, over three times longer than in urban areas.

Access to specialists is even more limited. Most rural census tracts are more than 60 minutes from the nearest cardiologist or urologist, and at least 40 minutes from OB-GYN care. Primary care providers attend 58% of births in rural counties [17], underscoring the shortage of obstetric

specialists. Cancer care is also difficult to access: residents in 38 and 45 counties must drive over 90 minutes to reach the nearest practicing radiation oncologist or medical oncologist, respectively. In emergencies, rural Iowans wait an average of 43 minutes longer than urban residents to reach the most appropriate hospital. These longer travel times impose higher direct and indirect costs on rural residents, including transportation expenses and lost productivity.

Access challenges are also reflected in patterns of rural bypass and emergency department (ED) overuse. Rural bypass occurs when patients travel to metropolitan hospitals instead of using local rural facilities [18]. Iowa's 2024 hospital encounter data shows this is common across both acute and chronic conditions. For example, rural patients are treated for heart attacks at urban hospitals at four times the per capita rate of rural hospitals. Similarly, urban hospitals see two and a half times more rural patients per capita for colorectal and respiratory cancers. Iowa also analyzed avoidable ED visits by mapping admitting diagnoses to ambulatory care-sensitive conditions, those typically preventable with proper primary care [19]. In 2024, rural residents in Iowa had significantly higher ED utilization for these conditions, with some rates more than double those of urban populations (see Appendix 2 for details).

Clearly, geographic and transportation barriers limit rural Iowans' access to critical health care infrastructure. Iowa's hub-and-spoke framework is well-positioned to address these challenges through strategic partnerships, workforce expansion, and care coordination [20]. Identifying which areas will serve as specialty care hubs, and which will operate as spokes for primary and secondary care, will be key to transforming rural health care and improving access across the state.

Provider and Workforce Characteristics

Understanding Iowa's health care market is essential to developing and implementing a sustainable rural health transformation plan. The health care industry employs 210,700 people, 10% of the state's workforce, and contributes $14.3 billion (6%) to Iowa's Gross Domestic Product [21]. While Iowa has a relatively low uninsured rate, this masks important economic dynamics within the insurance market. Health care providers negotiate reimbursement rates with both commercial and public insurers, and the competitiveness of this market directly affects provider payments. Iowa's insurance market is highly concentrated: the top two firms control 93% of the market, giving them significant leverage to set lower reimbursement rates [22]. This disproportionately affects smaller rural providers, who lack the bargaining power of larger systems to negotiate better terms [23].

Iowa's analysis of CMS Hospital Cost Reporting data (2011–2022) highlights the financial strain on rural hospitals. The median operating margin for rural hospitals was nearly -7%, compared to +0.4% for non-rural hospitals. These differences are partly driven by higher overhead and salary costs per patient day, 2.2 and 2.6 times higher, respectively, than in non-rural hospitals. Rural hospitals also face 1.6 times more bad debt per patient day. Their financial position is further weakened by patient mix: 64% of inpatient days in rural hospitals are covered by Medicare, compared to 45% in urban hospitals. Given that commercial payments can be 143% higher for physician services and 199% higher for inpatient care than Medicare rates [24], this payer mix places a disproportionate financial burden on rural hospitals. Workforce data from the Bureau of Labor Statistics (2020–2024) shows significant provider income disparities. Even after adjusting for occupation and geography, rural primary care and specialty physicians earn $24,000 and $14,000 less, respectively, than their urban counterparts. This suggests that substantial financial incentives and strategic partnerships are needed to recruit and retain providers in rural areas.

Provider distribution further illustrates access challenges. According to the Rural Health Information Hub, rural Iowa has 11 physicians per 10,000 residents, below the national rural average of 13 and far below Iowa's urban average of 34. Age distribution compounds the issue: 27% of rural physicians are 75 or older, compared to 17% in metro areas. Lower wages, an aging workforce, and persistent shortages all point to limited access to care for rural Iowans, underscoring the urgent need for transformational change.

Health Outcomes

Chronic disease places a significant burden on Iowa's population, contributing to 8 of the 10 leading causes of death [25]. Heart disease and cancer are the top two. These conditions are not evenly distributed across the state; many disproportionately affect rural residents. While statewide averages suggest similar rates – diabetes at 9% in urban counties and 10% in rural, obesity at 34% and 32%, respectively – these figures obscure important variation [26]. Nine of the ten counties with the highest diagnosed diabetes prevalence (~12%) are rural, as are eight of the ten counties with the highest obesity rates, where over 38% of residents are considered obese [26].This disproportionate burden likely contributes to higher ED utilization in rural areas. All ten counties with the highest age-adjusted ED visit rates for heart attacks and chronic obstructive pulmonary disease (COPD) are rural [27]. This aligns with earlier findings of elevated ED use for ambulatory care-sensitive conditions related to chronic disease management.

According to the Iowa Cancer Registry, Iowa has the second-highest cancer incidence rate in the U.S. [28] Among the six states with rising rates, Iowa's is increasing the fastest, driven largely by lung, skin, breast, and prostate cancers [28]. From 1990 to 2019, Iowa reduced its age-adjusted lung cancer incidence by only 5%, compared to a 23% national decline [28]. The most common cancers, breast, prostate, lung, and colorectal, account for over 10,000 new cases annually, or

half of all new diagnoses. Lung cancer is the leading cause of cancer-related death, responsible for nearly 25% (1,420 deaths), followed by colorectal cancer at 9% (540 deaths) in 2023 [29]. Screenings for colorectal, cervical, and breast cancers are widely recognized as cost-effective secondary prevention strategies [30]. Yet, rural Iowans have significantly lower screening rates. Iowa's analysis of CDC PLACES data confirms this: nine of the ten counties with the lowest colorectal and breast cancer screening rates are fully rural. In these counties, nearly 50% of eligible residents have not received a colorectal screening, and 30% have not received a breast cancer screening [31]. Improving screening rates in these areas could yield substantial health and economic benefits. Additionally, the prevention of lung cancer and melanoma, both with well-known causes, is among the most cost-effective strategies for reducing incidence [30]. A combined approach that promotes preventive behaviors and expands access to screening and treatment is likely to generate significant health gains for rural Iowans while reducing cancer-related health care costs.

Healthy Hometowns – Iowa's Rural Health Transformation Plan: Goals and strategies

Iowa has developed a Rural Health Transformation Plan that meets all requirements of statute in 42 U.S.C. 1397 ee(h)(2)(A)(i). Through the Iowa HHS Strategic Plan and Strategic Plan in Action, Iowa HHS has committed to elevate organizational health, advance operational excellence, and help Iowa thrive. The Iowa Rural Health Transformation Plan, Healthy Hometowns, is in direct alignment with those goals by promoting access to health and human services resources and helping individuals, families, children, and communities thrive.

Iowa Governor Kim Reynolds set the foundation for Healthy Hometowns via House File 972 of the 91st Iowa General Assembly. This legislation, enacted July 1, 2025, establishes a multi-prong strategy for improving rural health care access and health outcomes for rural Iowans. This plan

revolves around the concept that Iowa describes as Health Hubs, often referred to as hub-and-spoke models of care. The **vision** for Healthy Hometowns is to implement a robust hub-and-spoke framework that supports long-term, sustainable and high-quality health care for Iowans living in rural areas.

Healthy Hometowns has three primary **goals**:

1. Iowans will be able to get health care within their rural communities at the most appropriate locations for type and level of care thanks to support from newly developed partnerships, more rural primary care physicians and specialists, and upgraded equipment.
2. Iowans living in rural areas will have improved health outcomes with similar rates of morbidity and premature mortality to those living in Iowa's more populous areas.
3. Iowa will invest in the development and utilization of innovative technology and data infrastructures to support sustainable care options close to home, seamless care partnerships, and data sharing throughout the state.

The **strategies** Iowa will use to implement this plan address each mandatory element.

Improving Access

Iowa will **improve access** to primary care, preventive care, specialty care, behavioral health care, hospital care, and social care for rural residents. Iowa will achieve this through strategies aimed at enhancing care in rural locations, implementing innovative transport solutions when necessary, and co-locating different types of care for ease of access.

Iowa's primary strategy for **improving access** is Hometown Connections. Iowa will enhance hospital centers of excellence that share resources within a network of health systems and care sites. By formally pairing hospitals together to solve access, revenue, and sustainability problems, rural residents can receive primary and preventive care close to home while receiving

access to specialized care at a nearby Health Hub. These formalized partnerships will **improve health outcomes,** reduce costs for rural Iowans, and be supported through the **use of technology,** including the Health Information Exchange Initiative and telehealth solutions. Hometown Connections is supported by the Health Information Exchange Initiative, an innovative **data-driven solution.** The Health Information Exchange Initiative allows sharing of patient records between health care providers across unaffiliated systems and diverse electronic health record systems. This seamless transfer of records removes barriers for both patients seeking care and providers performing referrals, representing a data exchange **partnership** between providers committed to improving care for rural Iowans.

Iowa will **increase access** in rural areas by bringing care directly to where people live, work, and congregate. The EMS Community Care Mobile project upskills Emergency Medical Services (EMS) crews to deliver mobile prenatal care, postnatal care, and chronic disease management. This strategy **uses technology** to outfit existing mobile care units with telehealth capabilities and upskills the Iowa EMS **workforce** by providing specialized training in obstetrics and chronic disease management.

Iowa will also **increase access** to care by co-locating multiple types of healthcare (different service lines) in rural areas. This effort, titled Communities of Care, provides incentives and technical assistance to co-locate public health services, chronic disease care providers, nutrition services, behavioral health providers, Federally Qualified Health Centers (FQHCs), Area Agencies on Aging, and/or other community care providers to allow clients to access multiple types of services in one location. These **partnerships** will involve innovative care models to allow for these services to occur on the same visit. The model also prioritizes scheduling so multiple family members can receive care during one visit, designed to alleviate transportation

barriers and reduce access costs for rural patients. Through the **use of technology**, telehealth services allow these sites to participate in Health Hubs to access specialized care (part of the Hometown Connections). Additionally, the Health Information Exchange Initiative allows these co-located providers to share records about patients, when legal, appropriate, and desired by the client. These co-location sites will employ community health workers to assist with complicated and comprehensive scheduling, service navigation, specialist care referrals, nutrition counseling, and social care. These sites will also provide enhanced services aimed at cancer prevention and early intervention in rural Iowa (Combat Cancer: Prevent and Treat).

Iowa will also employ strategies to transport patients from rural hospitals to specialists in Health Hubs. An example is the High-risk OB and Neonatal Transport Project, a project described in the EMS Community Care Mobile section. In concert with Hometown Connections, this project transports high-risk maternal or infant cases from spokes in rural areas to an appropriate setting with specialized care (for example, a hub) and then back to spokes when possible. This project outfits ambulances with required equipment, including telehealth capabilities, and provides training for the EMS **workforce.** Records for patients will follow patients via the Health Information Exchange Initiative. This intervention **improves access** and **improves outcomes** for rural residents.

Finally, Iowa will increase access to primary and preventive care for rural children via care proposed for school-based services in the Hometown Connections project using telehealth, an innovative **use of technology.** Iowa will work to pursue policy solutions and conduct outreach to increase uptake of these strategies and provide care in schools, when appropriate and consented to by parents.

Improving Outcomes

Healthy Hometowns **improves outcomes** for rural residents through reduced travel to care, fewer emergency department visits, reduced inpatient stay days, reduced chronic disease, increased preventive care and screening uptake, and more primary care visits. While these will take several years to fully realize, Iowa has created an evaluation plan to track proxy measures that are directly related to health outcomes, such as access, utilization, and enrollment in chronic disease management. Some measures, such as avoidable ED visits or maternal inter-facility transfers, will show improvements within five years. Given the scale of Iowa's planned transformation and the necessary implementation duration, the precise measurement and estimation of broad health and financial improvements will continue beyond the five-year grant. Iowa will **improve outcomes** through Combat Cancer: Prevent and Treat. This project will focus on prevention, screening and early detection, and treatment for lung, colorectal, breast, skin, and prostate cancer – the most impactful to rural Iowans. Iowa will also **improve outcomes** by providing tools to Iowans in rural areas for improved self-management of chronic disease. Iowa will provide remote glucose monitoring (a **use of consumer facing technology**) and blood pressure cuffs for home management through existing **partnerships** with local health departments and other contractors. Through simple contract amendments, these strategies can begin improving the health of rural Iowans immediately. Iowa will also deploy these strategies through Hometown Connections, Community Care Mobile's Mobile Integrated Health Care, and Communities of Care.

Technology Use

The use of emerging technologies will be essential to Healthy Hometowns. Iowa will implement telehealth, remote glucose monitoring, and the Health Information Exchange Initiative to advance rural health outcomes. Facilities may invest in state-of-the-art artificial intelligence (AI)

tools, such as for diagnosis, treatment, or revenue cycle management under Hometown Connections.

Partnerships

Iowa will promote **partnerships** among providers through Hometown Connections and Communities of Care by incentivizing agreements and contractual relationships between non-affiliated organizations to improve health outcomes in rural areas. The Health Information Exchange Initiative encourages providers to build data and information sharing **partnerships** that prioritize patients and lower the cost of care.

Workforce

Iowa has made many improvements and commitments to recruiting and retaining healthcare providers. House File 972 of the 91st Iowa General Assembly outlined Iowa Governor Kim Reynolds's vision for transforming health care workforce recruitment and retention in Iowa. The consolidation of grant funds from previous programs, creation of the Health Care Professional Incentive Fund, and vision for Supplemental Enhanced Payment for Graduate Medical Education to increase residency spots in Iowa all work to improve Iowa's rural health care workforce. These strategies are outside the scope of this funding opportunity. Iowa will also support workforce needs via the new Healthy Hometowns supported project, Best and Brightest. Iowa's rural hospitals will have the opportunity to recruit exceptional healthcare talent to Iowa and invest in state-of-the-art health equipment that will make these providers want to stay. Iowa will also invest in the EMS workforce to allow clinicians to practice at the top of their licenses, as described within EMS Community Care Mobile.

Data Driven Solutions

Iowa's strategy to improve data sharing for the benefit of rural Iowans is the Health Information Exchange Initiative. Iowa's rural providers must be connected to this data network to share records between care locations with different electronic health record systems.

Financial Solvency Strategy

The initiatives described within this application will contribute toward financial solvency for rural Iowa providers. Hometown Connections will establish referral agreements, inclusive of telehealth reimbursement terms, that are mutually beneficial to all participants and work to right-size facilities with low utilization. Rural facilities participating across Hometown Connections and Communities of Care will be able to invest in minor space renovations and retrofits, increasing the economic efficiency. These partnerships will also provide enhanced primary and preventive care in rural areas, reducing both emergency department overcrowding in metro areas and length of inpatient stays. The EMS Community Care Mobile will provide care close to home and open bed space in metro areas. The co-location strategies of the Communities of Care will reduce overhead costs and modify the service offerings in rural facilities. Sharing data via the Health Information Exchange Initiative will reduce duplicative care, increase care coordination, and move people through the health care system expediently. As part of Healthy Hometowns, the state is committed to strong evaluation of the health care system. In summer of 2025, Iowa hired the first health economist for the state. Iowa plans to invest in additional high quality, specialized data support to understand and solve rural health care issues.

Causes Identification

Iowa is committed to learning more about the causes of hospital closures. A recent report identified two hospital closures and openings in Iowa from 2008-2023 and over 43 labor and

delivery units have closed since 2000 in Iowa. According to the Center for Healthcare Quality and Payment reform, 18 hospitals in Iowa have low financial reserves and net losses on patient services, indicating a potential risk of closure. Of those 18, three hospitals have reported negative profits over a multi-year period and have more debt than assets, indicating an immediate risk of closure. Generally, hospitals report low patient volumes, staffing challenges, and the inability to recruit and retain nurses and physicians as some reasons for closure. The initiatives described within this application work to address low patient volumes, the bypass of rural facilities, and recruitment and retention. Multiple initiatives provide significant investments to address underutilized facility space, thereby decreasing overhead costs per patient. Employing hub-and-spoke models of care that leverage telehealth integration is expected to reduce rural bypass, with local rural patients having access to virtual specialist expertise at hub facilities, enabling rural patients to receive most care at their local rural facility.

Program Key Performance Objectives

Healthy Hometowns will reduce travel time to access care and the length of inpatient stays while increasing uptake of preventive care and the number of providers in rural areas. These objectives work to reduce health care costs. Iowa will require data sharing agreements with participating facilities to supplement existing state health data. The metrics and evaluation plans describe all performance measures for our initiatives. Iowa's program will achieve the following by 2031:

Significant reduction in ED hospital visits for ambulatory care sensitive conditions (ACSCs) in rural areas.
Increase in the number of rural residents receiving care locally through new or expanded service lines.
Increase provider to population ratios in rural Iowa.
Increase in the number of telehealth consultations delivered to rural residents.
Increase in the number of rural providers or facilities participating in HIE with active data exchange.

Strategic goals alignment

Iowa is committed to aligning all strategies and goals with the following components of the federal Rural Health Transformation Program:

- **Make rural America healthy again:** Iowa will develop new and support existing access points for preventive care, chronic disease management, cancer screening and treatment, prenatal care, other primary care, and specialty care. This work is described within Hometown Connections, Communities of Care, and EMS Community Care Mobile. Iowa will prevent disease and support chronic disease management through Combat Cancer: Prevent and Treat, Communities of Care, and EMS Community Care Mobile.
- **Sustainable access:** Hometown Connections and Communities of Care both form partnerships that allow rural health providers to become long-term access points. The Health Information Exchange Initiative supports sustainability by sharing patient records.
- **Workforce Development:** Hometown Connections and Combat Cancer: Prevent and Treat support the recruitment and retention of providers through the Best and Brightest project. Several pieces of the EMS Community Care Mobile, including Mobile Integrated Health Care and the High-risk OB and Neonatal Project support EMS clinicians practicing at the top of their licenses. Communities of Care will utilize community health workers and care coordinators to help patients navigate care.
- **Innovative Care:** Iowa commits to innovative models of care through Hometown Connections and the Communities of Care. This project is designed to serve rural Iowans in rural areas whenever possible. The projects are strategically designed to shift care to the lowest cost setting and meet patient needs through telehealth. The policy-focused staff person hired will explore potential policy changes for Medicaid billing to support additional

services in schools, reimbursement of care by EMS clinicians, and billing strategies for same-day services provided at co-location sites through Communities of Care.

- **Tech Innovation:** The Health Information Exchange Initiative and the use of telehealth within Hometown Connections, Communities of Care, and EMS Community Care Mobile all align closely with the program's goal to foster innovative technologies. Iowa will also explore remote patient monitoring smart benefit cards, and advanced medical equipment that leverages robotics and artificial intelligence add-ons to advance the state.

Legislative or Regulatory Action

Iowa wishes to address 4 policy scoring factors. Iowa commits to reestablishing the Presidential Fitness Test in a way aligned with Executive Order 14327 prior to December 31, 2028 (B.2). Iowa also commits to including nutrition within continuing medical education requirements for physicians by December 31, 2028 and requests 100 points for this category (B.4) to improve the quality of care provided by physicians in the state. Iowa is participating in all compacts described within this funding opportunity except the PSYPACT compact for psychologists. Iowa commits to joining this network to increase access to and supply of rural health mental health providers. Iowa requests 100 points for this category (D.2). In 2024, via Iowa Senate File 2385, Iowa legislation required the production of a CON report by December 31, 2025. Iowa commits to legislative change for Certificate of Need (CON) (C.3) to remove outpatient behavioral health care from review requirements introduced in early 2026 and enacted prior to December 31, 2026. The implementation plan and timeline for cross-cutting grant activities, including policy changes, can be found on page 60.

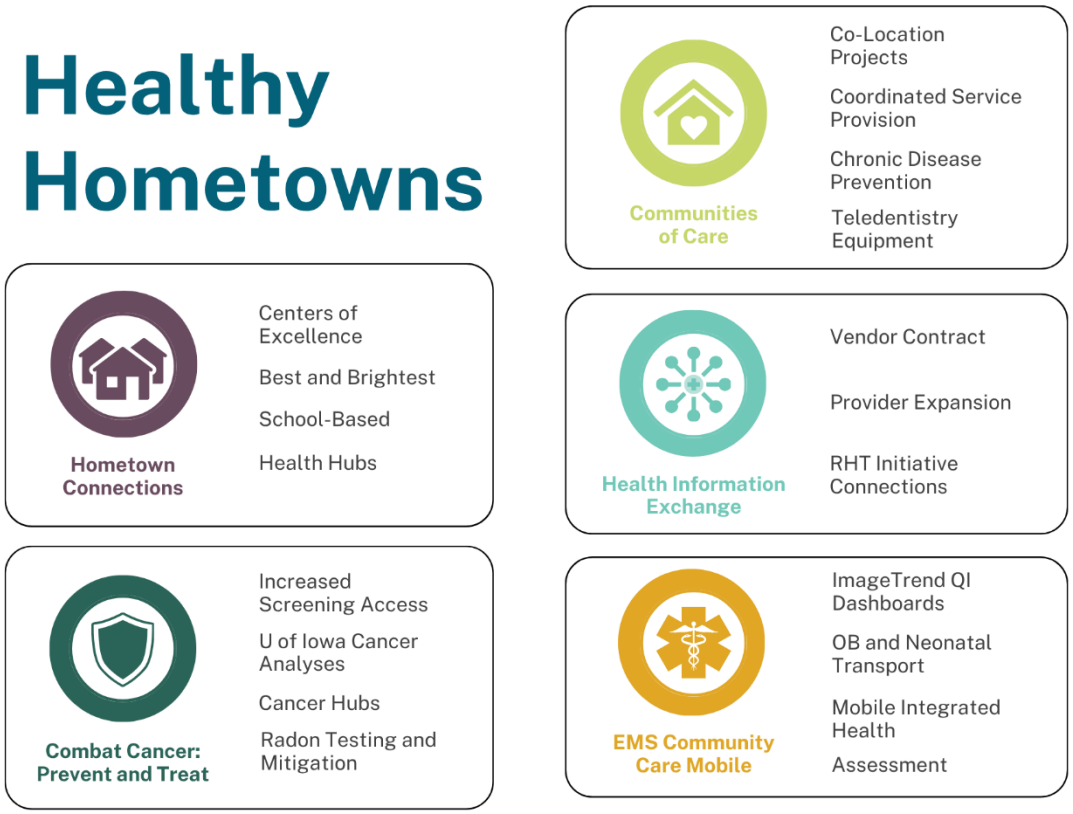
Other required Information

A.2. Proportion of Health Facilities: Hospital Facilities = 98; Other Rural Facilities = 343. List of Certified Community Behavioral Health Centers has been submitted as an attachment.
A.7. No hospitals in Iowa receive DSH payments due to state directed payment programs.

B.2. Health and Lifestyle	**100**
B.3. SNAP waivers	**100**
B.4. Nutrition Continuing Medical Education	**100**
C.3. Certificate of Need (CON)	**50**
D.2. Licensure Compacts-Physician(100), Nurse(100), EMS(100), **Psych(100)**, PA(100)	**100**
D.3. Scope of Practice-PA(100), NP(100),PharmD(100),RDH(50)	**87.5**
E.3. Short-term, limited-duration insurance (STLDI)	**100**
F.1. Remote care services-live video(100), store/forward(100),RPM(100),in-state excep (100),reg process(0)	**80**

Proposed initiatives and use of funds

Iowa's Rural Health Transformation Program application contains five primary initiatives. Each of these initiatives has multiple sub-projects. The visual of the complete program is below.



Initiative 1: Hometown Connections

Description: Iowa will implement Hometown Connections, a statewide initiative designed to strengthen care coordination and service delivery in rural areas through strategic partnerships

among healthcare providers. This initiative is grounded in the evidence-based hub-and-spoke model of care, which Iowa refers to as Centers of Excellence and Health Hubs. This model, widely **supported in healthcare literature**, has demonstrated effectiveness in improving access [32] [33] [34] [35] [36] [37] [38], reducing costs [33] [39] [40] [40] [37] [38], improving hospital financial performance [41] [40] [37], and enhancing health outcomes [6] [40] [37], particularly in rural settings [42] [37] [38]. In this framework, centralized hub facilities offer comprehensive and specialized services, while spoke sites extend access to care within communities. Iowa will utilize RHTP funds to support the development and expansion of Health Hubs, addressing persistent gaps in care coordination and access across Iowa. This initiative exemplifies rural provider strategic partnerships (C.1), talent recruitment (D.1), and remote care services (F.1). Elements of population health clinical infrastructure (B.1), dually eligible services (E.2), health and lifestyle (B.2), data infrastructure (F.2), and consumer facing technology (F.3) are also incorporated. A crosswalk of scoring factors and initiative activities is in the other supporting documentation of this submission.

To **maximize the immediate impact** of this five-year initiative, Iowa will build on prior investments. In 2021, Governor Kim Reynolds awarded *Centers of Excellence* grants to two regional hospitals to enhance maternal care coordination across rural counties. These efforts, examples of **rural strategic partnerships (C.1)**, aimed to ensure adequate staffing and technology, establish referral networks, and promote local utilization of services. In 2023, three additional networks received funding to support maternal care, general surgery, and geriatric services. These networks have demonstrated early success, serving 8,629 individuals and establishing 92 new partnerships. One site has already reported a measurable reduction in rural bypass within three years. To accelerate progress, Iowa will issue immediate amendments to

existing contracts upon receipt of funds, enabling sites to expand service lines and reach new beneficiaries. Iowa certifies that these funds will not supplant existing resources and that all activities will be novel to this grant. Iowa will also re-release the competitive procurement for *Centers of Excellence* to fund up to ten additional centers. These awards will support either new service lines or the geographic expansion of existing services. The application process will require formalized referral agreements, community investment strategies, enhanced outreach, and integration of wraparound social services to **increase coordination among existing rural community providers** (**population health clinical infrastructure, B.1**). Eligible service areas include maternal/child health, cancer, cardiovascular health, mental/behavioral health, and chronic disease prevention and management.

To further accelerate and **maximize immediate impact** in the first year, Iowa will launch competitive grant opportunities focused on workforce development (**talent recruitment, D.1**) and medical equipment acquisition via the novel Best and Brightest Program. In a 2025 survey of Iowa hospitals conducted by the Iowa Hospital Association, clinical workforce recruitment and retention was described as the number one need for investment. Workforce grants will support one-time recruitment and retention incentives, including relocation assistance and bonuses, for positions not subject to non-compete agreements. Recipients must commit to a five-year service term in a rural Iowa community. Equipment grants will fund the acquisition and installation of advanced medical technologies, such as robotic surgical systems, radiotherapy units, CT/PET scanners, and cardiac catheterization equipment. Allowable costs include equipment and *minor* facility modifications necessary for service delivery, in compliance with all infrastructure and capital expenditure requirements. Based on recent Certificate of Need applications, the average cost for equipment procurement and installation is approximately $3.32 million. Iowa anticipates

up to 150 workforce grants in year 1, followed by 17 in years 3 and 4 and 24 in year 5. Iowa will fund up to 34 equipment grants in the first year, 7 grants in years 3 and 4, and 5 in year five. Iowa recognizes that developing and implementing new models of care require specialized expertise in partnership building, agreement negotiation, payment model development, and business planning. To identify this expert knowledge, Iowa will release a competitive grant opportunity in year one to contract with a technical assistance provider. This provider will jumpstart system development by assessing the needs in Iowa's communities and offering personalized assistance to healthcare systems in identifying potential partners, developing draft agreements, and preparing for application for these funds. This contractor will be essential for stakeholder engagement within this initiative and provide the necessary technical assistance for rural facilities with limited resources to navigate the grant process.

After initial planning and expertise provided by the technical assistance provider through the year-one contract, Iowa will significantly scale up the Health Hub model through additional competitive grants that provide *substantial* start-up funds for large-scale service delivery change. These **robust investment plans to transform rural health care delivery** must include one or more of the following service lines: maternal/child health, cancer, cardiovascular care, mental/behavioral health, or chronic disease prevention and management. Some flexibility is required to accommodate the different clinical, infrastructure, and workforce needs across these different service lines under the Health Hub project within the Hometown Connections initiative. The implementation includes early governance and readiness, infrastructure buildout, workforce and telehealth integration, and full program deployment and evaluation.

Iowa commits to using competitive procurement and contracting strategies within Hometown Connections to advance the strategic goals of the federal Rural Health Transformation Program.

In addition to requiring compliance with all terms of the funding opportunity, Iowa will also require that successful applicants connect to and exchange data with the Iowa Health Information Exchange (**data infrastructure, F.2**) and collect and report data on **dually eligible beneficiaries** seen within their practice (**E.2**). This dual eligibility data will be analyzed by Iowa health economists to identify opportunities to improve care.

Under the initial phase of the Health Hub project, the technical assistance contractor has already aided with community assessments and grant preparation. Thus, Health Hub awardees will be expected to have made initial progress in designating the hub and spoke sites, drafting preliminary Memoranda of Understandings, and forming the necessary steering committees. Using cardiovascular as an exemplary service line, a tertiary hospital with existing cardiology, catheterization lab, and surgical capacity may propose to partner with critical access hospitals, rural health clinics, or FQHCs to service as local spoke facilities. RHTP funds are expected to be used to support consultant fees for the drafting and execution of provider service agreements, telehealth service agreements (**remote care**, **F.1**), and transfer/referral protocols. Iowa will require any provider service agreements to explicitly address Stark Law and Antikickback Statutes. RHTP funds may also be used to establish shared quality metrics and any shared-savings models participants wish to pursue, as well as a systematic evaluation of service-line capacity, equipment, and workforce inventories and limitations.

The next phase's objective of the Health Hub project includes infrastructure upgrades and equipment procurement. Spoke facilities will need the physical and digital infrastructure needed to perform routine service-line care and link to hubs for advanced services. For example, a cardiovascular project may require the purchase and installation of 12-lead electrocardiograph (ECG) machines, echocardiogram units, Holter and event monitors, point-of-care troponin

testing, and blood pressure monitors. Contractors may invest in **consumer-facing technology (F.3)** to aid patients with self-management. A maternal/infant project will require different investments, such as the purchase and installation of fetal monitors, portable ultrasound machines, point-of-care hemoglobin and glucose testing devices, neonatal resuscitation equipment, and telehealth-enabled exam rooms for **remote consultations (F.1)** with obstetric specialists. This phase will also include the implementation of telehealth and EHR interoperability through HIE connections. Iowa will allow some RHTP funds to be used for minor building renovations when necessary to provide care along the eligible service lines. Allowable costs may include, for example, refurbishing an existing room for cardiovascular evaluations, installing remote monitoring dashboards, upgrading electrical conduits to support new screening equipment, or necessary upgrades to support advanced HVAC systems for improved infection control. These must be minor, necessary renovations or retrofits that utilize existing underutilized facility space.

In parallel to the infrastructure phase, participating networks will use RHTP funds to build the necessary human capital to provide consistent, quality care for the designated service line. Funds are expected to be used for the recruitment and retention of necessary staff (**talent recruitment**, **D.1**), including salary costs up to the specified salary cap. Positions that require salaries above the cap will need to be supplemented with a different funding source. Funding staff training will also be crucial, such as for new telehealth systems, EHR modules, and remote patient monitoring setup and training. Clinical pathways will need to be finalized, such as for acute coronary syndromes, heart failure, and arrhythmia management in the case of a cardiovascular model. Participating facilities are expected to begin operationalizing care delivery within a hub-and-spoke framework in the next phase of implementation. For example, spoke sites begin

scheduling routine and urgent **remote care tele-consults** with hub specialists. In the case of a cardiovascular project, this may include implementing real-time ECG transmission for emergency cases and remote specialist interpretation. With guidance from hub specialists, local management for hypertension, heart failure, and arrhythmia begins and expands as local patient volume increases. RHTP funds may be used, for example, for rehabilitation and education programs for post-event patients or for establishing and refining rapid transfer protocols for acute events to hub hospitals. In a maternal and infant health project, for example, spoke sites may begin scheduling routine prenatal and postpartum **remote care teleconsultations** with hub-based obstetricians, maternal-fetal medicine specialists, or lactation consultants. This may include remote fetal monitoring interpretation, virtual high-risk pregnancy assessments, and real-time consultation during labor triage. With guidance from hub specialists, local providers begin managing gestational hypertension, diabetes, and postpartum complications, expanding services as patient volume grows. RHTP funds may be used to support start-up investments in remote patient monitoring, childbirth education classes, postpartum depression screening and referral workflows, or to establish and refine emergency transfer protocols for obstetric or neonatal complications requiring higher-level care at hub hospitals. These transfer protocols could be done collaboratively with EMS clinicians participating in the EMS Community Care Mobile Initiative described below.

In the final stage, full implementation is achieved, and changes to health and financial outcomes are expected to begin accruing. Iowa will allocate up to $20 million annually for individual Health Hub projects under the Hometown Connections initiative. The heavy subsidization of the start-up costs is expected to free up internal cash flows, enabling rural facilities to expand capacity and right-size their care delivery among affected service lines. One study found

significant cost savings of over $350,000 for the facilities participating in a hub-and-spoke network [37], implying the investment in such models for rural providers is likely to improve financial sustainability. The **impact on rural residents is also expected to be structurally transformative**. Some recent studies have found cost savings from reduced travel costs and recovered labor productivity between $147 and $187 per visit for patients utilizing telehealth [43]. If Iowa's rural population with atherosclerotic cardiovascular disease were to substitute an in-person visit for a telehealth visit, this population could save $17-$21 million for each substituted visit. Other research has found significant increases in treatment initiations among hub-and-spoke programs and extrapolating to the rural Iowa population implies 95% more patients may see treatment started for chronic diseases [44].

To further expand access and improve outcomes for Iowa's youth, the State will also implement a targeted school-based services strategy under the Hometown Connections initiative. According to 2025 data from the Iowa Department of Education, nearly 42% of the student population attends school in a rural area, underscoring the potential for **significant and transformational impact**. Expanding school-based health services offers evidence-based benefits, including increased access to care, early identification and intervention for chronic conditions, improved school attendance, and enhanced continuity of care. Partnerships between rural clinical providers and schools provide examples of both **population health clinical infrastructure** (**B.1**) and **rural provider strategic partnerships** (**C.1**).

These outcomes are particularly critical in rural areas, where limited access to comprehensive care can have long-term implications for both childhood and adult health. Iowa will issue a Request for Proposals to hospitals, rural health centers, FQHCs, local public health departments, and community health centers to establish partnerships with schools for the

delivery of clinical services. Funding may be used to support staffing, mobile health units, telehealth infrastructure, training, medical equipment and supplies.

Eligible expenses include telehealth-enabling technologies (**remote care, F.1**), electronic health record modules tailored for school-based care, and tools that facilitate remote parental engagement. Applicants must demonstrate a formal partnership with at least one rural school district and commit to providing regularly scheduled clinical services. Contractors may subcontract with schools to fund minor infrastructure modifications necessary to accommodate healthcare delivery. They may offer grants or supply health-related equipment to incentivize school participation. To further support **health and lifestyle (B.2)**, Iowa will require school-based contractors to incorporate evidence-based nutrition and physical activity education into their care delivery. Contractors can use limited funds to provide physical activity equipment to schools as incentives for participation.

Main Strategic Goals of the <u>Hometown Connections</u> initiative:

Improving access: Iowa will develop Health Hubs to provide care within rural communities to address cardiovascular health, cancer, mental and behavioral health, maternal and child health, and chronic disease prevention and treatment. Iowa will increase providers in rural areas, leverage telehealth, and identify transportation solutions to enhance access to care.

Improving outcomes: Iowa will improve outcomes by increasing access to preventive care, care coordination, screenings for earlier detection or disease, and visits to manage chronic disease.

Technology use: Iowa will use telehealth services and remote patient monitoring to support care.

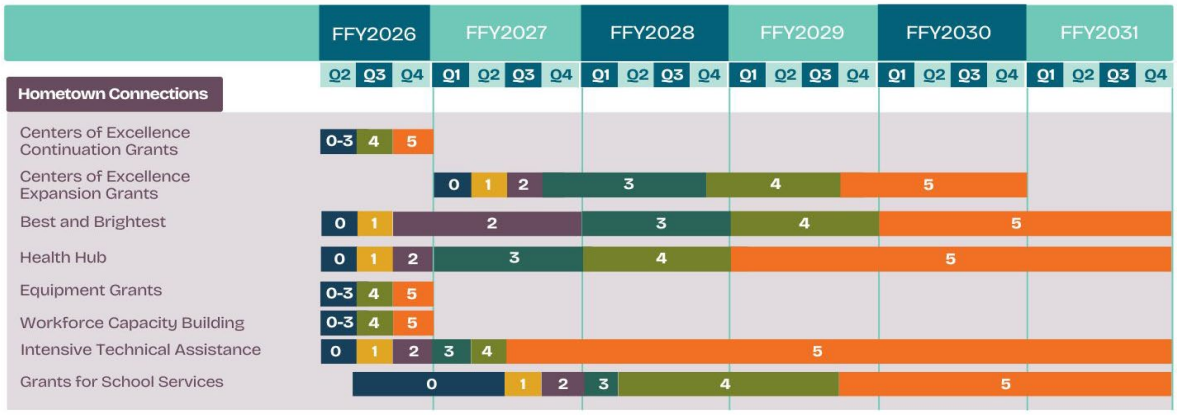
Partnerships: Iowa will prioritize partnerships between healthcare systems (rather than within existing affiliations) to ensure patients receive the right care, at the right time, in the right place, while preserving patient choice.

Workforce: Iowa plans salary enhancements, workforce recruitment strategies, and rural facility equipment upgrades to entice providers to join rural practices as part of Best and Brightest.

Data-driven solutions: Iowa will connect rural providers to the Health Information Exchange.

Use of funds: A,B,C,D,E,F,G,J,K	**Technical score factors: B.1, B.2, C.1, D.1, E.2, F.1, F.2, F.3**
Key stakeholders	Hospitals (including rural, critical access, and large systems), tertiary care hospitals, rural clinics, primary care providers, federally qualified health centers, community-based organizations, colleges and universities
Outcomes	These can be found within the Metrics and Evaluation Plan section below.
Impacted Counties	For existing Centers of Excellence: FIPS: 001, 003, 007, 009, 025, 027, 029, 047, 051, 073, 095, 099, 101, 107, 111, 117, 123, 125, 127, 135, 137, 157, 161, 171, 177, 179, 183. For new grants, unknown (competitive).
Est. Required Funding	**$535,538,157** over 5 years

Implementation plan and timeline:



Stage	Milestone	Description	Timing
Stage 0	Program launch and planning complete	Staff hired **(see page 58 for complete details)**, RFPs released for all sub-projects; feasibility studies completed; governance structures established; TA contract executed;CoE contracts signed	FY26
Stage 1	Initial awards and contracts executed	Contracts signed for Centers of Excellence expansion, Best and Brightest, and Hometown Connections; workforce recruitment begins	FY27
Stage 2	Infrastructure and workforce readiness	Majority of COEs operational; transformational tech equipment installed; spoke sites identified and telehealth buildout underway	FY28
Stage 3	Service delivery initiated	Telehealth services launched at spoke sites; new services operational at COEs; workforce fully deployed	FY29
Stage 4	Network integration and scale-up	Hub-spoke referral pathways active; specialty services available locally; data-sharing and cybersecurity protocols in place	FY30
Stage 5	Full implementation and evaluation	All sub-projects fully implemented; measurable outcomes accrue (e.g., telehealth consults, local care delivery, financial sustainability indicators)	FY31

Stakeholder Engagement: Iowa is committed to engaging rural stakeholders throughout the RHTP initiative. Stakeholder input began in July 2025 through weekly partner meetings and hospital roundtables with Iowa's congressional delegation. These sessions helped identify the needs of rural Iowans and healthcare providers. Key contributors to the planning process included the Iowa Hospital Association (IHA), which conducted a statewide hospital needs survey; the Iowa Primary Care Association (IPCA), which supports health centers and safety net providers; two major health systems; the University of Iowa College of Public Health; and the Iowa Insurance Division. Iowa HHS assembled a cross-divisional planning team with leadership from Medicaid, Public Health, Compliance and Administration, the State Office of Rural Health, Data Strategy, Health Economics, Communications, Government Relations, and Fiscal teams. This team will continue to guide implementation throughout the grant period.

Stakeholder engagement within this initiative will be maximized by leaning on the expertise of the technical assistance vendor described above. The statement of work for this vendor will include hosting in-person and virtual collaboration sessions, implementing robust communities of practice for problem solving, and connecting state staff and policy makers to the feedback of providers giving care in rural communities.

Iowa will also leverage its extensive network of local contractors and service providers, including public health agencies, EMS programs, WIC clinics, community action agencies, Area Agencies on Aging, and university partners, to support implementation and evaluation. These partners, along with advisory committee members, will help assess community needs and monitor program success. As a unified Health and Human Services agency, Iowa brings deep internal expertise across public health, chronic disease management, data analytics, Medicaid policy, rural health, EMS, and lifespan-focused services.

Iowa will build on existing governance frameworks to support stakeholder engagement. The *Healthy Iowans* initiative, a statewide health improvement plan, provides a strong foundation through its **steering committee**, which includes payers (e.g., Wellmark Foundation, Iowa Medicaid), providers (e.g., IPCA, Iowa Rural Health Association), nonprofits (e.g., Food Bank of Iowa), government agencies (e.g., Iowa Department of Education), and academic institutions (e.g., University of Iowa, Iowa State University).

In addition, Iowa has convened targeted workgroups, such as those focused on behavioral health access, that include representatives from payers, providers, community health programs, advocacy organizations, local governments, and rural policy experts. Iowa will also engage with an existing partner, the Great Plains Tribal Epidemiology Center, to ensure that evaluation work on this grant considers the unique needs of Iowa's tribal-affiliated residents. These groups offer established venues for collaboration, information sharing, and coordinated implementation. Many of these partnerships are already formalized through contracts or agreements, which can be amended to incorporate RHTP-specific workplans and deliverables. This structure ensures that stakeholder input remains central to the initiative's success.

Metrics and Evaluation Plan: Hometown Connections includes three sub-projects that each contribute to the overall goal of improving access, financial sustainability, and health **outcomes** of rural populations. The selected performance metrics reflect this initiative's phased implementation strategy, with early infrastructure and workforce investments aimed at increasing service delivery over a short time. In these early stages, the initiative will track the first performance metric: (1) the percentage of Centers of Excellence that have launched new services and hired workforce positions, such as OB navigators, midwives, or mental health providers. Simultaneously, the second performance metric, (2) the percentage of equipment that has been

installed and is operational across participating facilities, will be monitored. These two metrics demonstrate early progress in expanded workforce, diagnostic, and treatment capacity at rural facilities. As Health Hubs mature, metric (3) will report on the percentage of rural spoke facilities with telehealth infrastructure operational *and* connected to hub specialists, ensuring readiness for virtual care delivery and access to advanced specialist expertise. Finally, metric (4), the number of telehealth consultations delivered between hub specialists and spoke facilities will be reported to demonstrate increased utilization of specialist services provided to rural patients. This metric will be calculated at the county-level. Overall, these metrics can be reliably measured and illustrate the initiative's trajectory from early implementation to impact. The data sources for these metrics include a combination of reporting requirements and required data sharing agreements to be conditional on being awarded RHTP funds. Reporting requirements will provide the data for metrics (1), (2), and (3). Encounter data will be submitted to Iowa HHS at least monthly for evaluation by internal Health Economists for metric (4). The milestones are given in the implementation table above.

Sustainability Plan: The Hometown Connections initiative is designed to create long-term impact through strategic, one-time investments that build rural healthcare capacity. Start-up funding for major medical and telehealth equipment will enable rural providers to offer services that would otherwise be cost-prohibitive. Once operational, these services can generate sustainable revenue through reimbursements, while also attracting more patients and providers to rural facilities. Similarly, recruitment and retention incentives are structured to establish long-term provider presence. As providers and their families integrate into rural communities, many are expected to remain beyond the incentive period, contributing to workforce stability. The business partnerships developed and solidified by legal agreement will last long beyond this

funding. The technical assistance provider will offer this assistance to all rural hospitals, not just those involved in forming Health Hubs. This will further enhance sustainability. Iowa will embed a robust evaluation framework into the RHTP initiative to monitor improvements in rural health outcomes and population health. This data-driven approach will help identify effective strategies for continued investment and scale. Anticipated cost savings, such as reduced emergency department use, improved chronic disease management, and earlier disease detection, will further support sustainability. These savings, realized through improved care coordination and contractual provider partnerships, can be reinvested to strengthen rural healthcare delivery statewide. Iowa acknowledges that these outcomes and cost savings are more likely to be realized after these programs reach maturity.

Initiative 2: Combat Cancer: Prevent and Treat

Description: Cancer is the second leading cause of death in Iowa, following heart disease, and remains a critical concern for rural communities. As Iowa's rural population continues to age, the burden of cancer, particularly lung, breast, colon, and skin cancers, is expected to increase. The Combat Cancer: Prevent and Treat initiative will invest in prevention, screening, and treatment strategies to reduce this burden, with a focus on expanding access to care through a statewide Health Hub model. Similar to Initiative 1 above, Combat Cancer advances rural provider strategic partnerships (C.1), talent recruitment (D.1), and remote care services (F.1). It also incorporates the exchange of data with the Iowa Health Information Exchange (data infrastructure, F.2), strategies to address the health and lifestyle related risk factors for cancer (B.2), collection of data on dually eligible beneficiaries within practice sites (E.2), population health clinical infrastructure improvements (B.1), and consumer facing technology (F.3).

To maximize the **immediate impacts** of this award, Iowa is prepared to release a competitive grant application for cancer-focused Hometown Connections sites within the first year of funding. Development work is already underway, guided by experienced Iowa HHS leadership with deep procurement expertise. In addition, Iowa will competitively procure a technical assistance vendor to support hospitals and rural providers throughout the application and implementation process. The initiative will address longstanding gaps in rural cancer care by establishing a hub-and-spoke network. Regional hub hospitals will offer advanced services such as radiation therapy, surgical oncology, and subspecialty care. Local spoke facilities will provide diagnostics, chemotherapy and infusion services, and follow-up care, all under shared clinical protocols. This model, made up of **rural provider strategic partnerships** (**C.1**), expands access while avoiding the high costs of duplicating full oncology services at each site. **Credible literature** has shown that hub-and-spoke networks providing cancer care results in increased access, particularly to specialists [45]. Additionally, research shows that reduced travel time to cancer care improves outcomes and getting care closer to home and existing social networks may also reduce risk for cancer mortality [46] [47]. Thus, Iowa expects this initiative to be **structurally transformative and of high projected impact** [48].

Implementation will follow a phased approach, beginning with Stage 0, which focuses on governance, planning, and partnership development. Participating providers will form inter-organizational steering committees to define service areas, establish referral protocols, and develop data-sharing agreements. Legal and regulatory frameworks will be established to address telehealth licensure (including for out-of-state providers), pharmacy compliance, provider credentialing, and electronic health record interoperability. Iowa anticipates that some oncology practices may partner with Critical Access Hospitals to renovate underutilized space for

outpatient infusion clinics. These partnerships may also include tertiary cancer centers to support shared savings models and coordinated care delivery. RHTP funds will support the legal and operational infrastructure needed to formalize these sustainable collaborations.

In Stage 1, rural hospitals and clinics will assess and prepare physical spaces to support cancer care delivery. This includes renovations to accommodate infusion services, tele-oncology consult rooms (**remote care**, **F.1**), and pharmacy infrastructure retrofits that meet USP 797/800 standards. RHTP funds may be used to purchase infusion chairs, pumps, temperature-controlled storage, and other essential equipment. Telehealth infrastructure, including hardware, software licenses, and cybersecurity upgrades, will also be supported to enable early tele-oncology consultations and virtual tumor boards.

Stage 2 will focus on workforce planning and **talent recruitment** (**D.1**), which will begin early and may overlap with infrastructure development. Iowa recognizes that oncology workforce shortages, non-compete agreements, and competition from neighboring states may pose challenges. RHTP funds will be used to recruit and retain medical and radiation oncologists, oncology-certified advanced practice providers and nurses, oncology pharmacists, and technicians. Funding will also support the hiring and training of local navigators and community health workers to coordinate care (**population health clinical infrastructure, B.1**). In addition, Iowa will support training and certification for existing staff to expand local capacity for oncology care. Tele-oncology agreements and chemotherapy supply chain logistics will be formalized during this stage.

Once infrastructure and staffing are in place, Stage 3 will initiate service delivery. Patients will begin receiving diagnostic testing, chemotherapy, follow-up care, and tele-oncology consultations at participating rural sites. RHTP funds may support the implementation of

oncology-specific EHR modules, scheduling software, and AI-enabled diagnostic tools. To reduce barriers to early utilization, limited transportation assistance may be provided. Iowa will monitor key metrics such as reduced travel burden, increased rural cancer screenings, and tele-oncology visit volumes to evaluate early impact.

In Stage 4, the network will mature and expand its scope of services. Referral agreements will be executed for advanced treatments such as radiation therapy and surgical oncology at hub facilities. RHTP funds may support minor renovations to diagnostic and operating rooms, as well as the purchase or upgrade of advanced medical equipment. Rural providers will also begin developing survivorship and palliative care programs in collaboration with hub specialists. This final stage ensures that the network becomes fully operational and sustainable, with improved access, better outcomes, and more efficient use of resources. Proposals that include the formation of Accountable Care Organizations (**E.1**) will be prioritized for funding, as these models support long-term financial sustainability and coordinated care delivery.

In addition to supporting the development of Health Hub partnerships focused on rural cancer care, Iowa will invest in prevention and screening efforts for lung, colorectal, and skin cancers with broader geographic impact. Iowa will enlist the assistance of a contractor to conduct cancer screening outreach, purchase and distribute screening tests and equipment. Because 1 in 5 cancers are linked to obesity, physical inactivity, poor diet, and alcohol consumption [49], this contractor will provide outreach and marketing materials specific to the **health and lifestyle (B.2)** factors that increase risks for certain cancers. Iowa rural areas have some of the highest radon levels in the country, radon being the second leading cause of lung cancer. To address this preventable risk, Iowa will fund 30,000 radon tests annually, subsidize mitigation for 500 rural homes per year, and support the training of additional radon mitigation professionals to expand

service availability in rural areas. Iowa will also evaluate the program's effectiveness, including rural residents' willingness to invest in mitigation without public subsidies.

To increase colorectal cancer screening, Iowa will expand access to FIT testing via existing contractors and the Communities of Care initiative. Funding will also support follow-up diagnostic colonoscopies for uninsured rural adults with positive FIT results. This represents a significant expansion beyond Iowa's current programming. Iowa certifies that no funds will be used to replace reimbursable clinical services.

Skin cancer, one of the most prevalent cancers in Iowa, will be addressed through the purchase and distribution of dermatoscopes to rural providers. These handheld devices use polarized light to reveal skin structures not visible to the naked eye, improving early detection of melanoma and other skin cancers. Providers will receive training and educational materials to support early identification and referral to dermatology specialists.

To further expand access, Iowa will distribute telehealth-enabled tablets to pharmacies and libraries across rural counties to advance **remote care services (F.1)** and **consumer-facing technology (F.3)**. These devices will support virtual cancer screening appointments and integrate FIT testing into telehealth workflows, allowing patients to order tests, complete them at home, and review results online. This builds on Iowa's telepharmacy regulations and successful pilots, such as the Storm Lake Public Library's telehealth room (Telehealth Room | Storm Lake, IA - Official Website), positioning trusted community spaces as access points for preventive care.

As described above within Hometown Connections, Iowa will also require successful applicants connect to and exchange data with the Iowa Health Information Exchange (**data infrastructure, F.2**) and collect and report data on **dually eligible beneficiaries** seen within their practice ore

receiving screening or other services (**E.2**). This dual eligibility data will be analyzed by Iowa health economists to identify opportunities to improve care.

Iowa will also partner with the University of Iowa to conduct a study examining environmental, diagnostic, and genetic risk factors contributing to cancer in Iowa. The study will use statistical modeling and spatiotemporal analysis to evaluate population-level interventions and tailor behavioral and educational strategies for rural populations. Findings will inform future messaging, screening efforts, and potential policy or legislative changes to reduce cancer burden.

Additionally, Iowa's university partner will identify three clusters of rural counties, each with elevated cancer rates and multiple risk factors, to receive intensive cancer prevention and control consultation. Each five-county cluster will engage in participatory planning with university consultants and local stakeholders to implement evidence-based screening and intervention.

Finally, Iowa will expand support for the Iowa Cancer Affiliate Network (I-CAN), which currently assists seven rural hospitals in delivering high-quality cancer care. I-CAN provides strategic planning and technical assistance to enhance services such as survivorship care, nutrition, rehabilitation, palliative care, and psychosocial support. RHTP funds will be used to expand I-CAN's reach to additional rural facilities and may connect to any Hometown Connections or Center of Excellence site. All work with the University of Iowa can begin in the first year of funding due to an existing contractual relationship, **maximizing immediate impacts** of the funds. No funds will supplant existing costs. These robust investment plans into cancer prevention and treatment will be structurally transformative for the 21,200 Iowans [50] expected to have been diagnosed with cancer in 2025 and to prevent future cancer.

Main strategic goals of the Combat Cancer: Prevent and Treat:

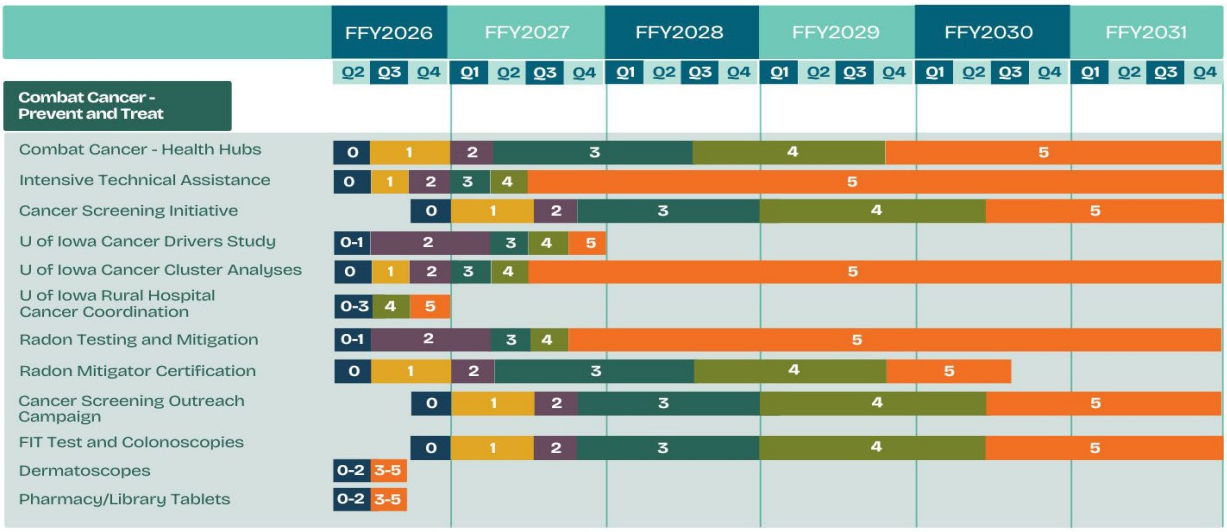
- **Make rural America healthy again:** Providing cancer prevention and screening are evidence-based approaches for improving disease prevention and treatment. Expanding access to cancer care will enable rural Americans to receive the care they need for cancer through treatment to survivorship.
- **Sustainable Access:** Providing investment capital to fund start-up and implementation costs for oncology Health Hub partnerships, investing in telemedicine expansion, and increasing interoperability through the HIE will result in sustainable access to cancer care by subsidizing start-up costs and operational efficiencies.
- **Workforce Development:** Workforce education and credentialing in oncology care, recruitment and retention of oncology workforce, and training radon mitigators.
- **Tech innovation**: Oncology care modules, telemedicine (tele-oncology, tele-pharmacy)

Use of funds: A,B,C,E,F,G,J,K	**Technical score factors: B.1,B.2,C.1,D.1,E.2,F.1,F.2,F.3**
Key stakeholders	Hospitals (including rural, critical access, and large systems), tertiary care hospitals, rural clinics, primary care providers, federally qualified health centers, community-based organizations, and universities
Outcomes	These can be found within the Metrics and Evaluation Plan section below.
Impacted Counties	Unknown, competitive procurements
Est. Required Funding	**$183,052,239** over 5 years

Implementation plan and timeline:

Stage	Milestone	Description	Timing
Stage 0	Program planning and RFPs released	**Hire staff (see page 58 for full details),** RFPs for screening, prevention, and oncology hub-spoke networks released; governance and implementation planning initiated; and University of Iowa partnership	FY26
Stage 1	Contracts executed and early implementation begins	Awards made for screening and hub-spoke infrastructure; workforce recruitment begins; screening tools and outreach materials developed; University begins data analysis and county cluster identification	FY27
Stage 2	Screening and infrastructure buildout underway	FIT, radon, and dermatoscope screenings launched; spoke site renovations and equipment procurement initiated; I-CAN expansion planning begins	FY28
Stage 3	Treatment infrastructure and referral pathways operational	Infusion chairs installed; tele-oncology consults initiated; tumor boards established; radon mitigation underway; I-CAN services expanded to new sites	FY29

Stage 4	Integrated cancer care delivery in rural communities	Local cancer treatment available at spoke sites; screening data integrated into prevention strategy; referral networks fully functional	FY30
Stage 5	Full implementation and measurable outcomes	All sub-projects fully implemented; measurable outcomes available (e.g., local cancer care delivery, screening follow-up rates)	FY31



Stakeholder Engagement: As described above, the RHTP core planning team and external engagement sessions also contributed toward this initiative and will continue to meet quarterly throughout the duration of this funding opportunity. The existing **steering committees and advisory councils** described within Hometown Connections above will also provide input on the implementation of this initiative. Iowa will leverage existing partnerships with the State Health Registry of Iowa (cancer registry), the University of Iowa College of Public Health, and the internal Iowa HHS Comprehensive Cancer Control Program and their local contractors already located within Iowa rural communities to implement this work.

Metrics and Evaluation Plan: Combat Cancer: Prevent and Treat combines three complementary projects, prevention and screening, Health Hubs for oncology care, and a data-driven cancer prevention strategy. Performance metric (1) reports the number and percentage of cancer screenings, including radon tests, FIT tests, and dermatoscope screenings at the county-

level, demonstrating progress in early detection and prevention for the rural population. The second metric (2) will monitor the percentage of high radon test results that result in subsidized and non-subsidized radon mitigation installations at the county-level, highlighting the effectiveness of radon testing on environmental risk reduction. As treatment infrastructure is developed, the third (3) performance metric will include the percentage of rural spoke facilities with outpatient chemotherapy infusion infrastructure progress, including renovation progress, equipment procurement and installation, and staffing. The final performance metric (4) to be reported will be the number of tumor boards or tele-oncology consultations conducted between rural spoke facilities and hub specialists, indicating increased access to specialist cancer care for rural patients. Iowa's complete Healthy Hometowns Implementation Plan can be found above. Iowa will require data-sharing agreements with the awarded contractors to provide the necessary data for Iowa HHS to calculate and report these metrics.

Sustainability Plan: Combat Cancer: Prevent and Treat has been intentionally designed to be sustainable as it aligns improved access to cancer care with efficient resource utilization and allocation. By developing routine chemotherapy, diagnostic, screening, and follow-up services to outpatient hospital centers already located in rural areas, rural facilities can generate high-margin encounters while improving the utilization of any underused clinical space. Cancer treatments, including chemotherapy, have high reimbursement rates and can improve the financial viability of rural facilities. Partnerships between different providers and facilities can also create opportunities to leverage 340B drug pricing once provider service agreements are in place and cost reports have been submitted. Thus, participating CAHs and affiliated rural hospitals may acquire oncology pharmaceuticals at significantly lower costs while maintaining standard reimbursement rates. These savings can be reinvested in the facility, such as in additional staff

recruitment, equipment, or enhanced patient navigation or survivorship programs. The initiative's design also generates additional revenue via increased volume of telehealth encounters for both the spoke and hub locations. The upfront capital investment provided through the RHTP funds effectively removes some of the financial barriers of innovation, including renovation, IT upgrades, and equipment procurement. Participating rural hospitals can then free up existing operating cash flows to be directed toward efficiency investments, such as AI-enabled revenue cycle management or claim denial tools to further improve financial performance. Additionally, the services of the TA provider will be available for all Iowa rural hospitals. The resulting partnerships and legal agreements will survive beyond the five-year grant period.

The sustainability of the other cancer projects within this initiative is based on initial investments and informing policy decisions. Distributing and tracking radon tests will allow Iowa HHS to understand the distribution of indoor radon risk and the rural population's willingness to mitigate. Mitigating homes will create long-lasting lung cancer prevention. Purchasing telehealth tablets and dermatoscopes are one-time costs intended to improve cancer screening and care coordination. These supplies will likely be used for several years and generate sufficient revenue to cover replacements. Funding the cancer study at the University of Iowa will result in actionable insights into the determinants of cancer and help inform necessary policy changes while the work to identify cancer clusters will allow Iowa to effectively target cancer interventions among the rural populations with the highest cancer burden.

Initiative 3: Communities of Care

Description: Rural Iowans face persistent challenges in accessing coordinated, person-centered care. Health and social services are often limited and geographically dispersed, and chronic disease remains a significant burden. To address these issues, Iowa will implement a structural

transformation strategy centered on two core activities: (1) piloting co-located service delivery sites and (2) embedding Community Health Workers (CHWs) to enhance care coordination and chronic disease prevention. This initiative exemplifies an investment in population health infrastructure (B.1) and rural provider strategic partnerships (C.1), while also incorporating elements to contribute toward health and lifestyle improvements (B.2), assistance for dually eligible beneficiaries (E.2), remote care services (F.1), data infrastructure enhancements (F.2), and consumer facing technology strategies (F.3).

Through a competitive grant process, Iowa will fund up to seven geographically diverse projects that co-locate at least three distinct provider types at a single rural site (**population health clinical infrastructure, B.1 and rural provider strategic partnerships, C.1**). These may include local public health agencies, Federally Qualified Health Centers, hospitals, behavioral health providers, substance use treatment programs, pharmacists, oral health providers, aging and disability service organizations, and other healthcare or social service entities committed to reducing chronic disease. Co-locating providers together has been shown to improve provider communication and patient outcomes, and depending on the types of services located together could reduce hospitalizations, lengths of stay, and hospital readmission [51] [52]. Iowa will take this concept, often used to co-locate primary care and specialty care, to structurally transform care provision in rural Iowa to combat chronic disease [51].

RHTP funds may be used for a range of allowable and sustainable investments, including:

- Shared technology infrastructure (e.g., telehealth equipment, scheduling systems, data-sharing tools),
- **Consumer-facing tools (F.3)** (e.g., blood pressure monitors, glucose monitors, fitness trackers),

- Workforce costs (e.g., CHW salaries, training, cross-training for integrated care),
- Non-reimbursable service delivery for uninsured individuals,
- Preventive screening materials and patient engagement incentives (e.g., transportation vouchers),
- **Partnership development** and coordination **(C.1)** (e.g., stakeholder convenings, outreach materials),
- Sustainability planning (e.g., shared savings model design, reimbursement alignment, billing workflow development).

Co-location offers operational efficiencies and improved patient experience. Shared facilities reduce overhead costs and allow for joint use of administrative, janitorial, and IT staff. Cross-training enables staff to coordinate both clinical and social care, reducing duplication and improving continuity. For patients, co-location allows for multiple appointments across service lines in a single visit, reducing travel time and time away from work or school. This convenience is expected to increase uptake of preventive services and chronic disease management.

The model also builds on existing infrastructure. In FY 2024, 30 rural county boards of health contracted with hospitals or health systems, often co-locating public health offices within healthcare facilities. These hospitals, which averaged over 33,000 patient visits annually, represent strong candidates for pilot sites. Embedding preventive and chronic disease services into these high-traffic locations could yield **transformative health outcomes**.

Each site will also employ Community Health Workers to support care coordination, system navigation, and chronic disease prevention. CHWs will manage complex scheduling across co-located services and provide real-time referrals (**B.1)**. At least one CHW per site will receive specialized training in Medicare and Medicaid benefit enrollment to support **dually eligible**

individuals (E.2), a population that stands to benefit significantly from integrated care. Sites will be required to collect and report data on the number of dually eligible individuals served through the program and information regarding their unique needs.

These co-located sites will maintain a strong focus on chronic disease prevention and management, with primary prevention efforts targeting cardiovascular disease, obesity, diabetes, and cancer. Early intervention services will address emerging health concerns to prevent progression and reduce long-term health impacts. These may include referrals, cancer screenings, and diabetes management services. **Credible literature** has identified that co-located care reduces appointment wait times, increases outpatient visits, reduces costs, improves life quality, and improves access to services and equipment for management of chronic disease [53] [54].

Successful applicants will be required to offer or refer clients to a broad range of evidence-based preventive services that focus on chronic disease and **health and lifestyle factors** (**B.2**), including Diabetes Self-Management Education and Support (DSMES), the National Diabetes Prevention Program (NDPP) [55], Chronic Disease Self-Management Education [56], Walk With Ease (WWE) [57], Self-Measured Blood Pressure (SMBP) Monitoring [58], and Fecal Immunochemical Test (FIT) screening with follow-up colonoscopy [59]. Clients will also be eligible for subsidized radon testing and mitigation, as outlined in Combat Cancer.

In addition to clinical services, applicants must promote **healthy lifestyle (B.2)** changes. Required offerings include nutrition education [60], lactation support [61], and access to donor milk for breastfed infants [62]. Sites must also provide no-cost or discounted gym memberships (if not already available), on-site exercise classes, or walking groups [63]. To support self-management, patients may receive home blood pressure monitors, continuous glucose monitors, or smart benefit cards (e.g., Evermore) to encourage healthy decision-making. **Credible**

literature has found that cash benefits, such as through smart benefit cards, have reduced ED visits that result in an inpatient stay, reduced ED visits related to behavioral health and substance abuse, and increased access to subspecialists [64].

To **maximize immediate impact**, Iowa will amend existing contracts with statewide vendors to expand chronic disease-related services. For example, Iowa will purchase 18 portable dental x-ray units and related equipment to support school-based dental care. Dentists will review x-rays remotely via telehealth and refer children for restorative care as needed. Iowa will also expand its contract with the University of Iowa's Child Health Specialty Clinics to provide telehealth equipment for managing chronic conditions in children with special healthcare needs in rural counties. Additional contract amendments with Title V-funded agencies will support cancer prevention services, including colonoscopies, mammograms, high-density MRIs, and prostate cancer screenings for uninsured individuals.

This initiative will also align with other components of Healthy Hometowns. Co-located sites will be equipped with telehealth infrastructure (**remote care, F.1**) and serve as both community hubs and satellite sites within the broader Health Hub network described in Hometown Connections. When appropriate and with client consent, records will be shared across providers through the Iowa Health Information Exchange (**data infrastructure, F.2**), enabling robust care coordination without requiring new electronic health record systems.

Main Strategic Goals of the <u>Communities of Care</u> initiative:

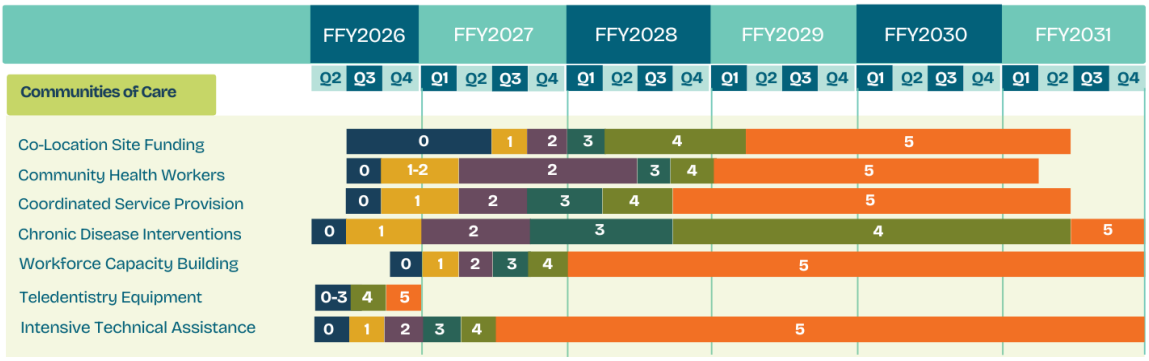
- **Make rural America healthy again:** This initiative supports rural health innovations through co-located access points to promote preventive health, address root causes of diseases, and provide wrap around social care. It implements evidence-based, outcomes-

driven interventions to improve chronic disease prevention and management through community-based access points offered in a community care Health Hub system.

- **Sustainable access:** This initiative provides innovative funding and support to encourage co-location models for providers in rural areas for multiple service lines at one location.
- **Innovative care:** Rural health care co-location partnerships will involve innovative care models to allow for these services to occur on the same visit if preferred by the patient. Iowa will expand innovative care by creating these rural chronic disease prevention and management hubs to improve health outcomes, coordinate care, promote flexible care arrangements and provide greater access to chronic disease prevention for rural Iowans.

Use of funds: A,B,C,E,F,G,I, J,K	**Technical score factors: B.1, B.2, C.1, E.2, F.1, F.2, F.3**
Key stakeholders	Local public health, Federally Qualified Health Centers, hospitals and healthcare systems, substance use providers, mental and behavioral health providers, social care providers, pharmacies, oral health providers, aging and disability service providers, community action agencies, and other healthcare providers.
Outcomes	These can be found within the Metrics and Evaluation Plan section below.
Impacted Counties	Unknown, competitive procurements
Est. Required Funding	**$175,935,156** over 5 years

Implementation plan and timeline:



Stage	Milestone	Description	Timing
Stage 0	Program planning and RFP release	**Hire staff (see page 58 for full details),** RFPs for co-location sites developed and released with technical assistance; governance and implementation planning initiated	FY26
Stage 1	Site selection and workforce recruitment	Co-location sites identified; legal agreements executed; CHW recruitment and training begins	FY27

Stage 2	Infrastructure and IT readiness	Renovations and upgrades completed at initial sites; telehealth and cybersecurity infrastructure installed	FY28
Stage 3	Service integration begins	Co-location sites begin offering multiple lines of service; CHWs deployed and care coordination workflows operational	FY29
Stage 4	Program expansion and optimization	Additional service lines added; workflows refined; outreach and patient engagement scaled	FY30
Stage 5	Full implementation and measurable outcomes	All co-location sites fully operational; measurable outcomes available (e.g., service utilization, care coordination metrics)	FY31

Stakeholder Engagement: As described above, the RHTP core planning team and external engagement sessions also contributed toward this initiative and will continue to meet quarterly throughout the duration of this funding opportunity. The existing **steering committees and advisory councils** described within the Hometown Connections above will also provide input on the implementation of this initiative. Iowa will also leverage existing partnerships with local boards of health in areas where public health and hospital care are co-located and the expertise of the Iowa HHS Chronic, Congenital and Inherited Conditions Bureau to achieve success.

Sustainability: Iowa anticipates that the Communities of Care initiative will have a lasting impact on rural healthcare delivery. Many of the upfront costs, such as relocating services and establishing legal agreements for shared staffing and space, are one-time investments. Over time, cost savings from co-location and shared staffing models can be reinvested into sustaining the rural healthcare workforce and expanding services. Most direct services offered through this initiative are already reimbursable by insurance. However, Iowa recognizes that multiple same-day visits across providers can create reimbursement challenges. To address this, Iowa will contract with subject matter experts in the first year to explore solutions. The Iowa Health Economist will analyze denied claims data from participating sites, and Iowa HHS leadership will use these findings to engage with the Iowa Insurance Division, Medicaid, and private insurers to inform potential policy changes. All competitive procurement applicants will be required to submit sustainability plans. Proposals with more detailed and actionable strategies

will receive higher scores. One recommended approach is to map payer responsibilities, across Medicare, Medicaid, commercial insurance, grants, and philanthropy, and develop shared savings agreements and value-based care pathways to support long-term viability.

A core sustainability mechanism is the reduction in disease burden. By increasing access to preventive care and early intervention, the initiative reduces the need for costly treatment of advanced conditions. This shift allows healthcare systems to reallocate resources more efficiently, supporting ongoing operations and reducing overall expenditures.

To further support sustainability, Iowa HHS will coordinate a community of practice among funded sites. This forum will facilitate peer learning, sharing of best practices, and collaborative problem-solving to strengthen the long-term durability of these new care models.

Metrics and Evaluation Plan: Communities of Care is designed to reduce administrative duplication and increase access to coordinated care and preventive services in rural areas by leveraging co-location to provide services in one location. This initiative invests in workforce development, focused on the recruitment and training of CHWs to support care coordination and chronic disease management. Our performance **outcomes**/metrics reflect the implementation trajectory, beginning with infrastructure and workforce development and ending with integrated services being delivered. Early in the implementation, the first performance metric will report (1) the percentage of co-location sites that have completed space renovations/retrofits and technology infrastructure (shared data systems, telehealth infrastructure), demonstrating progress towards site readiness. Simultaneously, this initiative will monitor and report (2) the number and percentage of CHW positions filled, reflecting progress towards building the necessary care coordination workforce. As the initiative progresses and co-location sites become operational, the third performance metric will report (3) the percentage of sites offering multiple lines of

service, capturing the extent of care integration. Finally, as patient volume increases the final performance metric will capture (4) engagement and utilization by reporting the percentage of patients participating in chronic disease management programs at co-location sites by county of residence and county of service. These metrics are selected for their feasibility, with the initiative's goals, and ability to demonstrate both early implementation progress and long-term impact on access and care coordination. Iowa will require detailed data-sharing agreements between contractors and Iowa HHS to report on these metrics. The Milestones are provided under the implementation section above.

Initiative 4: Health Information Exchange Initiative

Description: Iowa proposes to sustain and expand the Iowa Health Information Exchange as a foundational strategy to structurally transform rural healthcare delivery. Established in 2008, Iowa's HIE has onboarded 115 of the state's 118 hospitals, along with a limited number of other provider types, including behavioral health providers, Federally Qualified Health Centers (FQHCs), local health departments, payers, laboratories, and physician clinics. Currently, 94% of hospitals use the HIE to submit electronic public health lab reports, and 97% use it for syndromic surveillance reporting. This initiative highlights Iowa's commitment to **data infrastructure** (F.2), while supporting **rural provider strategic partnerships** (**C.1**) and **population health clinical infrastructure** (**B.1**) by allowing providers to share information and coordinate care. Despite this robust infrastructure, only 25% of hospitals use the HIE to access longitudinal patient records for care coordination. Recent reductions in federal funding, including cuts from the CDC, have left Iowa without a funding source to maintain and expand this critical system. Through Healthy Hometowns, Iowa will preserve existing HIE functionality, expand connectivity to rural providers, and increase provider access to longitudinal patient data.

Effective rural healthcare requires seamless information sharing across hospitals, specialists, primary care providers, and other care settings. A 2023 U.S. Government Accountability Office report found that only 26.6% of rural hospitals nationwide receive patient records via electronic exchange, while over half still rely on mail or fax [65]. This gap undermines care coordination and increases costs. **Credible literature** has shown that HIE use reduces hospital admissions [66], reduces inpatient length of stay [67], especially for patients with chronic conditions [67], and lower costs by avoiding duplicate procedures and imaging [68] [69].

RHTP funding will support Iowa's ability to connect rural providers to patient data across disparate systems, regardless of their electronic medical record platform. This investment will enhance care coordination across all major initiatives, Hometown Connections, Combat Cancer: Prevent and Treat, and Communities of Care, by enabling providers to access complete patient histories, reducing duplication, and improving outcomes.

Iowa will engage a vendor to maintain the HIE's core infrastructure, including cloud-based data hosting, clinical data repositories, data standardization services, interoperability support, data quality review, security, and governance. A competitive procurement was released in September 2025, with an anticipated start date of February 2026, pending funding, positioning Iowa to act quickly and maximize the impacts of this funding in the first year. Additional RHTP-supported enhancements will include:

- Longitudinal patient record exchange, enabling access to comprehensive patient data (e.g., history, medications, labs, imaging).
- Bed availability dashboard to support EMS Community Care Mobile and patient flow.
- Electronic lab reporting to meet public health requirements and reduce provider burden.
- Syndromic surveillance reporting for near real-time emergency department monitoring.

- Public health registry reporting to automate legally required submissions.
- Admission, Discharge, and Transfer (ADT) notifications to improve care coordination and reduce readmissions for Medicaid members.
- Direct secure messaging to replace fax and email with secure, electronic communication.
- Fee offsets for providers that actively use the HIE to improve care quality and reduce costs.
- Expanded connectivity to additional rural provider types, including primary care, long-term care, behavioral health, FQHCs, local health departments, durable medical equipment providers, home health agencies, and independent practices. These provider types often operate on different electronic systems. By enabling comprehensive data sharing and interoperability, Iowa will improve care coordination, reduce duplication, and support better health outcomes across rural communities.

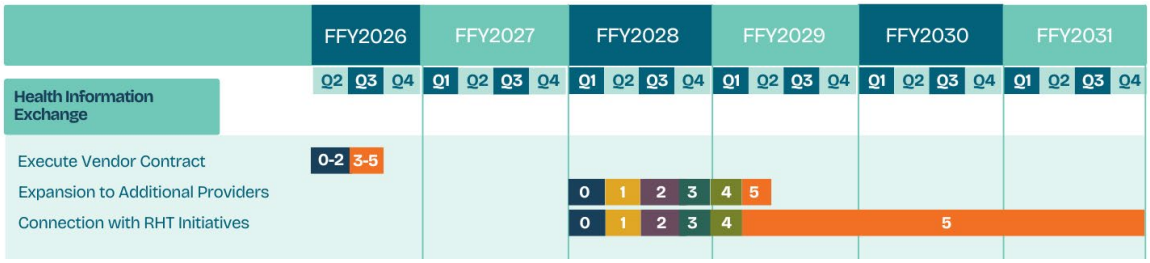
Main Strategic Goals of the Health Information Exchange Initiative:

- **Make rural America Healthy Again:** The health information exchange (HIE) supports innovations and new access points by providing a mechanism to provide health records across care providers. This is particularly impactful in Communities of Care and Hometown Connections.
- **Sustainable Access:** The HIE helps rural providers become long term access points by allowing for record sharing with other providers when needed. Rural facilities are better able to work together when they use coordinated technology.
- **Tech Innovation:** The ability to securely share data across provider types and care settings promotes efficient care delivery.

Use of funds: D, F, K	**Technical score factors: B.1, C.1, F.2**
Key stakeholders	Primary care providers, nursing homes, long term care facilities, skilled nursing facilities, behavioral health and mental health providers, federally qualified health centers, local health departments, durable medical equipment

	providers, home health agencies, independent medical practices, hospitals, rural health clinics, FQHC/CHC, CCBHC, Iowa HHS, EMS clinicians, and dentists.
Outcomes	These can be found within the Metrics and Evaluation Plan section below.
Impacted Counties	All
Est. Required Funding	**$56,926,944** over 5 years

Implementation plan and timeline:



Stage	Milestone	Description	Timing
Stage 0	Planning and vendor selection complete	**Hire staff (see page 58 for full details),** vendor selected, contracts executed, and outreach strategy finalized	FY26
Stage 1	Initial onboarding and infrastructure setup	First wave of rural facilities onboarded; HIE infrastructure installed and tested at pilot sites	FY27
Stage 2	Expansion to priority rural facilities	Majority of target rural hospitals and clinics connected; training and onboarding complete	FY28
Stage 3	Active data exchange and dashboard use	Longitudinal patient records in use; dashboards operational; providers accessing and using HIE data	FY29
Stage 4	Full rural integration and optimization	All target facilities connected; interoperability scores improve; duplicate testing reduced	FY30
Stage 5	Evaluation and sustainability planning	Utilization metrics reported; HIE supports care coordination and quality improvement; sustainability plan in place	FY31

Stakeholder Engagement: As described above, the RHTP core planning team and external engagement sessions also contributed toward this initiative and will continue to meet quarterly throughout the duration of this funding opportunity. Additional partnership work for this initiative is mandated in Iowa statute. In chapter 135D of the state code, Iowa is mandated to provide a health information network that is patient-centered and market-driven (135D.4 1.a), represents the interests and meet the needs of consumers and the health care sector (135D.3 1.d), and constitutes a public and private collaborative effort to promote the adoption and use of health information technology of the state to improve health care quality, increase patient safety, reduce health care costs, enhance public health, and empower individuals and health care professionals

with comprehensive, real-time medical information to provide continuity of care and make the best health care decisions (135D.6 3.d). This chapter also mandates the convening of a stakeholder advisory council that includes at least one member who is a consumer of health services and a majority of voting members representative of participants in the health information network.

Metrics and Evaluation Plan: The Health Information Exchange (HIE) initiative is designed to expand interoperability across rural and underserved healthcare providers, enabling timely access to patient information and improving care coordination. The selected performance metrics reflect the initiative's progression from onboarding new provider types to demonstrating use of the HIE infrastructure. Early in the implementation, the (1) number of new HIE agreements signed (by county of provider site) with non-hospital providers, including clinics, behavioral health, home health, and specialty care, will be tracked to demonstrate the expansion beyond traditional hospital systems that have participated in Iowa. As onboarding progresses, the (2) percentage of rural facilities (based on county) with active HIE accounts will be monitored and reported to assess readiness and system engagement. To capture actual system utilization, the initiative will report (3) the number of rural facilities (based on county) provisioned to use the longitudinal health record and (4) the number of queries made to the longitudinal health record each month, in rural counties and all counties, reflecting how often providers are accessing comprehensive patient data to inform care. These metrics are selected for their feasibility, alignment with the initiative's goals, and ability to show both infrastructure maturity and clinical impact, while ensuring that progress is measurable and non-duplicative across initiatives. Milestones are above.

Sustainability Plan: Investing in Iowa's HIE aligns with the economic principle of addressing under-provisioned goods, where large-scale coordination can overcome market limitations.

RHTP funding will be used to strategically expand HIE access, particularly in rural areas, while enabling Iowa to evaluate the impact of expanded connectivity on patient outcomes and potential cost savings for payers and providers. To ensure long-term sustainability, Iowa will pursue multiple strategies. This includes identifying cost-sharing opportunities across Iowa HHS programs that rely on HIE functionality or data and demonstrating the system's value to payers and providers to encourage broader adoption. Iowa will also work to integrate additional HIE use cases into Medicaid operations, further embedding the exchange into routine care delivery. Evaluation activities supported by RHTP funding will quantify cost savings and care improvements, strengthening the case for continued investment. Iowa HHS will use stakeholder feedback to identify and prioritize new functionalities that add value to users. These insights will inform future pricing models and ensure that the HIE remains a cost-effective, high-value tool for providers, payers, and patients across the state.

Initiative 5: EMS Community Care Mobile

Description: Iowa will implement a robust strategy to transform prehospital care through three coordinated sub-initiatives: (1) EMS System Development and Sustainability Assessment, (2) Mobile Integrated Health Care, and (3) High-risk OB and Neonatal Transport Project. Together, these efforts will strengthen the EMS workforce, integrate telehealth and home-based care, and reduce unnecessary ED visits and hospital transports. In 2024, over 320,000 Iowans interacted with the EMS system, with approximately 35% residing in rural areas. These initiatives will structurally transform rural health care delivery with a large projected impact on rural. This initiative primarily addresses EMS (C.2), remote care services (F.1), and improvements to population health clinical infrastructure (B.1), while also containing components of data

infrastructure improvements (F.2), data collection for dually eligible individuals (E.2), rural provider strategic partnerships (C.1), and talent recruitment (D.1).

Iowa will conduct a statewide EMS system assessment to inform the development of a district-based hub-and-spoke model for prehospital care. The assessment, beginning early in the first budget year to maximize the immediate impact of this work, will include coverage mapping, call volume analysis, workforce distribution, and financial modeling. Predictive analytics and scenario testing will identify opportunities to optimize deployment, improve coordination, and ensure each district can support efficient operations. While implementation of the hub-and-spoke EMS model is outside the scope of this funding, the assessment will guide future system design, workforce strategies, payer engagement (including Medicaid and MCO reimbursement), and technology investments. The assessment will be paired with data infrastructure system upgrades, quality improvement dashboards, and annual evaluations. A reassessment in Year 4 will measure progress toward sustainability and system efficiency goals.

Iowa will also establish Mobile Integrated Health (MIH) demonstration projects to deliver care directly to rural Iowans through home visits and community-based services. This community-based care initiative will outfit ambulances and existing vehicles with the technology needed for telehealth and direct care provision (**remote care services**, **F.1**), particularly in chronic disease prevention and management. MIH teams will provide post-discharge follow-up, chronic disease and cancer management, acute care, and preventive services. The services provided use expanded scopes of practice for EMS clinicians to improve the **population health clinical infrastructure** (**B.1**) in rural Iowa by focusing on technological innovation, primary care, and chronic disease prevention and management. MIH is an evidence-based strategy to reduce ED

utilization and hospital readmissions by addressing health concerns before they escalate [70]. Services provided will be entered within the Iowa HIE (**data infrastructure, F.2**).

At least one MIH project will serve a three-county rural area, fostering regional collaboration and **rural provider strategic partnerships** (**C.1**). Services will include treatment-in-place, resource navigation, and chronic disease management for conditions such as diabetes, COPD, and heart failure. MIH teams will also integrate prenatal and postpartum care, using telehealth to close maternal health gaps in rural areas. These services are supported by strong evidence and have been shown to reduce costs and improve outcomes [71], though they are not currently reimbursable in Iowa. Data from these projects will support efforts to establish treat-in-place services as a reimbursable benefit (**remote care, F.1**).

Iowa will use this opportunity to further advance the goals of the Rural Health Transformation Program by collecting data on individuals receiving services from MIH units to determine how many beneficiaries are **dually eligible (E.2)**. This data, following analysis by Iowa's Health Economist, will help Iowa develop future strategies to improve care for this population. This project also supports a path for non-physician health care in rural areas and provides enhanced training for EMS clinicians (**talent recruitment, D.1**).

Iowa will fund demonstration projects to enhance maternal and neonatal transport capacity. Existing ambulances and helicopters will be upgraded with OB-specific equipment, monitoring devices, and telehealth connectivity (**remote care, F.1**) to enable specialist-guided care during transport. EMS clinicians will receive advanced training (**talent recruitment, D.1**), including high-fidelity simulation, to manage complex deliveries and neonatal emergencies. This intervention, often referred to as teletransport, has been shown through early trials to improve outcomes for critical neonatal cases [72].

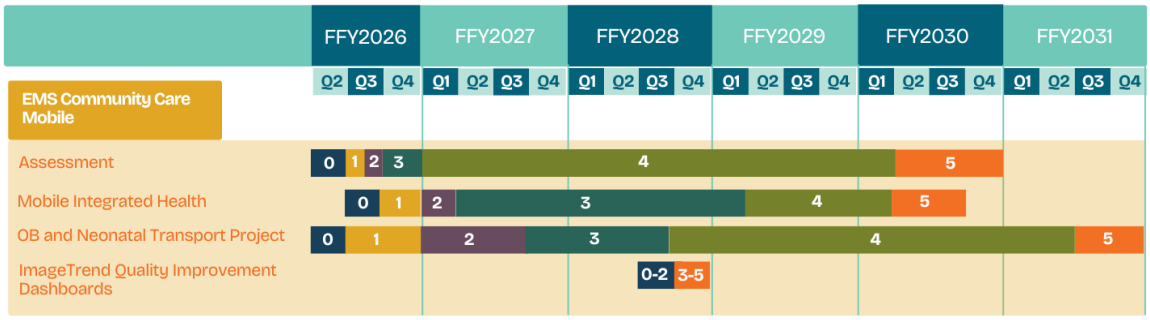
These transport projects will integrate with the Hometown Connections network as part of **rural provider strategic partnerships (C.1)**, ensuring timely access to perinatal hubs while preserving continuity of care by returning patients to local facilities when appropriate. This approach maximizes existing EMS assets, avoids the cost of new fleet purchases, and supports a scalable, cost-effective system for improving maternal and neonatal outcomes.

Main Strategic Goals of the EMS Community Care Mobile:

- **Make rural America healthy again:** Support rural health innovations through new care access points with mobile integrated health care units serving patients in their homes or at other community sites. Implement evidence-based, outcomes-driven interventions to improve chronic disease prevention and management through MIH units.
- **Sustainable access:** Help rural hospital OB units remain operational by providing access to High-Risk OB and Neonatal transport when needed. Offer tele-health through Mobile Integrated Health units within High-risk OB and Neonatal transport vehicles.
- **Workforce Development:** Expand training for EMS clinicians, creating career pathways and improving retention.
- **Innovative care:** High-risk OB and Neonatal Transport involve coordinated care and flexible care arrangements. High-risk OB and Neonatal Transport and Mobile Integrated Health projects make EMS providers a larger part of the care team and allow them to practice at the top of their licenses.

Use of funds: A,C,D,E,F,G,K	**Technical score factors: B.1, C.1, C.2, D.1, E.2, F.1, F.2**
Key stakeholders	EMS Service Programs, Hospitals, Public Safety, Department of Transportation, Iowa Homeland Security and Emergency Management, Telehealth Providers, EMS Training Programs
Outcomes	These can be found within the Metrics and Evaluation Plan section below.
Impacted Counties	Unknown, Competitive Procurements
Est. Required Funding	**$44,924,208** over 5 years

Implementation plan and timeline:



Stage	Milestone	Description	Timing
Stage 0	Program planning and RFP release	**Hire staff (see page 58 for full details),** Internal EMS staff hired; RFPs for MIH, OB, and assessment sub-projects released	FY26
Stage 1	Statewide registry and initial awards	Patient registry launched; contracts awarded for demonstration programs	FY27
Stage 2	Equipment and staffing readiness	Vehicles equipped; staff hired and trained; MIH and OB programs begin setup	FY28
Stage 3	Service delivery begins	Community visits and transports begin; EMS teams operational in rural areas	FY29
Stage 4	Expansion and integration	Geographic coverage expands; EMS integrated with telehealth and hospital systems	FY30
Stage 5	Evaluation and impact reporting	Utilization and outcome metrics reported; reduced readmissions and improved maternal outcomes documented	FY31

Stakeholder Engagement: As described above, the RHTP core planning team and external engagement sessions also contributed toward this initiative and will continue to meet quarterly throughout the duration of this funding opportunity. Iowa is well-equipped to deploy RHTP with rural stakeholders through an existing network of contractors and local EMS providers.

Metrics and Evaluation Plan: The EMS initiative is designed to modernize and expand emergency medical services in rural areas through a combination of internal capacity-building, demonstration program deployment, and expanded service delivery. The selected performance metrics reflect this phased approach, beginning with foundational administrative and planning activities and progressing toward infrastructure readiness and measurable service impact. Early in the program, the time required to hire internal EMS staff and release RFPs for sub-projects will be tracked to demonstrate administrative readiness and the ability to launch key components

of the initiative. As demonstration programs are awarded and implemented, the percentage of EMS programs that are fully equipped and staffed will be monitored, capturing progress in vehicle procurement, equipment installation, and workforce deployment. Once operational, the initiative will report the number of community visits and non-emergency transports conducted per month (at the county level), reflecting the volume and reach of expanded EMS services. To ensure equitable access, the geographic distribution of EMS services will also be tracked (at the county level) relative to rural population coverage, helping to demonstrate alignment with the initiative's access for rural residents. These metrics are selected for their feasibility, alignment with the initiative's objectives, and ability to show both early implementation progress and long-term service delivery outcomes. The Milestones are given in the implementation section above.

Sustainability Plan: Iowa's sustainability plan ensures that the investments made in the EMS Community Care Mobile create a long-lasting, self-sustaining prehospital care system for the State. Investments in telehealth equipment and project-specific upgrades to existing emergency transport vehicles are one-time costs. The Iowa EMS Program will work collaboratively with Iowa Medicaid to add Mobile Integrated Health treat-in-place services as reimbursable benefits. Iowa HHS will also partner with birthing hospitals, health systems, and insurers to co-fund OB-capable transport teams as part of maternal health quality initiatives. Costs can be integrated into regional perinatal quality collaboratives to share expense burdens. Iowa will implement a robust evaluation component to explore improvements in population-level health and rural health outcomes throughout the grant award period and demonstrate cost savings from this initiative.

Iowa HHS Governance and Project Management Structure

The Iowa Department of Health and Human Services (Iowa HHS) will serve as the lead agency for this initiative, with the Medicaid Division partnering with the Compliance and

Administration Division to coordinate implementation. The authorizing official is Lee Grossman, Iowa Medicaid Director, and the Principal Investigator is Kelsey Feller, Chief Data Officer and Division Administrator for Data Privacy and Strategy. Mr. Grossman has multiple years of experience leading Medicaid programs, and Ms. Feller has over ten years of grant management, procurement, contracting, quality improvement, and data project oversight experience.

A cross-sector steering committee will guide implementation and includes leadership from Iowa HHS divisions, including Public Health, Compliance and Administration, Communications, and Government Relations, as well as external partners such as the Iowa Hospital Association and the Iowa Primary Care Association. Iowa's strategies will have foundations in the fields of both public health and health economics, with expertise from both disciples on the planning committee and within project leadership roles.

Iowa will dedicate 14 full-time equivalent (FTE) positions to support this work. These positions, along with associated fringe, supplies, in-state travel, and indirect costs, represent a 0.98% administrative rate retained by the state. Iowa will hire initiative leads for each of the six major components of the proposal, as well as a coordination lead to ensure alignment across initiatives. Three additional staff will manage contracting and budgeting. The EMS Community Care Mobile initiative will include a staff member focused on policy, system development, and outreach. Iowa will hire a policy specialist to support long-term system change and two data analysts to work with the Chief Data Officer and Health Economist on continuous evaluation and system assessment. No staff funded through this project will participate in any lobbying activities or do any work to influence the enactment of legislation, appropriations, regulations, or administrative actions before Congress or any state legislature or other governing body.

Senior Iowa HHS leadership members have been assigned to oversee each initiative and will manage early implementation and hiring. These leaders will reassign existing staff as needed to ensure timely launch of each initiative. Leadership assignments are below and can be viewed on the organizational tables submitted within the other supporting documents section:

- Lee Grossman – Medicaid Director, Overall project oversight
- Kelsey Feller – Chief Data Officer, Principal Investigator
- Dr. Lachlan Watkins – State of Iowa Health Economist, Hometown Connections Lead
- Marisa Roseberry and Jill Lange – Division Administrators for Performance and Operations and Public Health Promotion and Prevention, Communities of Care Leads
- Kelsey Feller – Chief Data Officer, Health Information Exchange Lead
- Margot McComas – Division Administrator for Public Health Protection, Community Care Mobile Lead
- Jill Lange – Division Administrator for Public Health Promotion and Prevention, Combat Cancer: Prevent and Treat Lead

The **implementation plan and timeline** for cross-cutting grant activities is below.