VA Rural Vitality - Project Narrative

The Commonwealth of Virginia is home to more than 1.5 million rural residents spread across many different geographies, including regions spanning from Appalachia to the Eastern Shore and Southside. Governor Youngkin and the Secretary of Health & Human Resources (HHR) submit this Cooperative Agreement Funding Application, with the Department of Medical Assistance Services (DMAS) as the designated submitting entity, to invest in rural communities to innovate, improve health care access, and achieve better health outcomes across the lifespan – from infants and children, to their hardworking parents, to older adults who are the bedrock of their communities. Virginia proposes the "VA Rural Vitality" a series of transformational initiatives to target health and lifestyle challenges in rural communities, implemented in collaboration with trusted Commonwealth partners to effectively execute work of this magnitude and importance. Initiatives are directly aligned to the CMS Strategic Goals articulated in the Notice of Funding Opportunity for the Rural Health Transformation Program (RHTP).

VA Rural Vitality builds on Virginia's long-standing commitment to high-quality and sustainable rural healthcare, leveraging existing programs and partnerships as its foundation. The Commonwealth has strong experience in implementing large-scale health transformation projects, as outlined in the example existing state-funded initiatives in Table 1.

Table 1. Key statewide initiatives made by the Youngkin administration

Program	Description
Right Help, Right Now: *Transforming Behavioral Health*	**Governor Youngkin's ambitious transformation of Virginia's behavioral health system** that has invested over $1.4B to improve mental health & substance use care and outcomes. Key achievements include over 100 mobile crisis teams operating statewide 24/7, and an expansion of crisis-receiving units from 216 to 663 across crisis receiving centers, stabilization units and therapeutic homes.

Reclaiming Childhood Taskforce: *Improving Youth Mental Health*	**Governor Youngkin's statewide effort to protect children from the addictive effects of social media and excessive screen time**, engaging families, educators, and experts to develop solutions. Commits to reduce screen time by 25% in 2025.
It Only Takes One: *Preventing Fentanyl Overdoses*	**A statewide initiative to drive awareness around the risks of fentanyl among Virginia's youth.** Since implementation in 2024, fentanyl deaths in Virginia are down 44% - the largest year-over-year percentage decline in the nation.
Healthy Moms, Healthy Families, Healthy Communities: *Enhancing Maternal Health*	**A series of statewide efforts to enhance maternal health services and supports**, including increased postpartum visits for Medicaid members, expanded access to Doula services, and improved maternal health data and best practices.

The Commonwealth engages closely with rural communities and has made rural-specific investments, as captured in the Virginia Department of Health (VDH) Virginia Rural Plan 2022-2026 – but considerable challenges remain. Rural Virginians face barriers to health, including higher rates of chronic disease and substance use, limited access to services, workforce shortages and outdated technologies. These challenges were reinforced in twelve listening sessions held throughout rural Virginia by the Secretary of HHR, DMAS Director, and VDH Director (who is an OB-GYN residing in rural Southwest VA). In response, Virginia proposes four key initiatives: CareIQ; Homegrown Health Heroes; Connected Care, Closer to Home; and Live Well, Together.

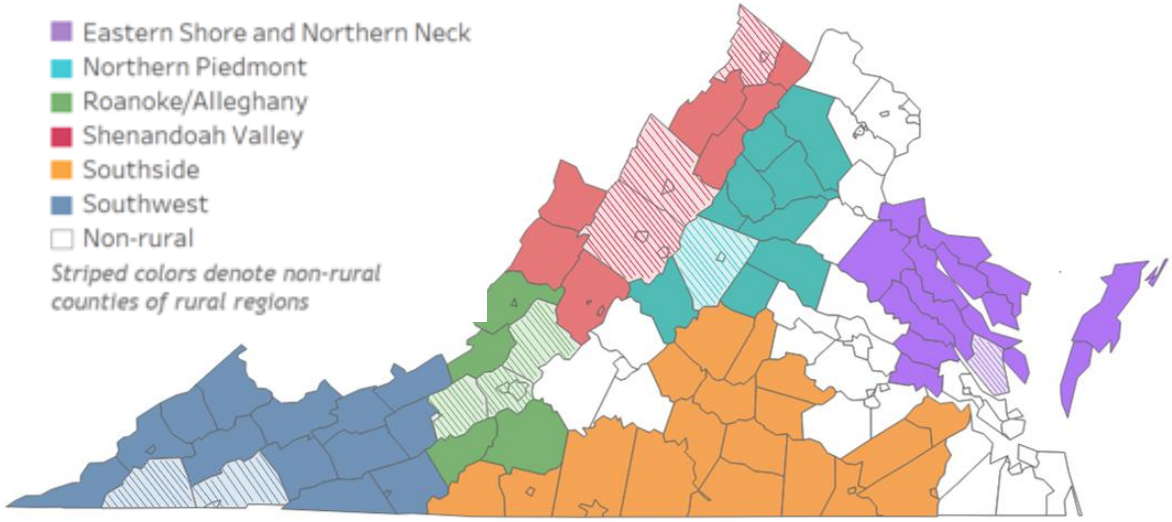
Figure 1. VA Rural Vitality Initiatives

1. Allied health professionals are specialized healthcare workers, such as physical therapists, radiologic technicians, and dental hygienists, who are not doctors or nurses but play a vital role in diagnosing, treating, and rehabilitating patients, complementing the work of clinicians

Rural Health Needs and Target Population

Often referred to as the 'rural horseshoe,' Virginia's 76 rural counties (as defined by the Federal Office of Rural Health Policy (FORHP)) represent 57% of the total counties in Virginia. Virginia's six rural regions include: 1) Southwest, 2) Roanoke/ Alleghany, 3) Southside, 4) Northern Piedmont, 5) Shenandoah Valley, and 6) Eastern Shore and Northern Neck.

Figure 2. Map of Virginia's rural regions



While each region has its own character and history, they share common needs including broad health care challenges, and decades of economic decline and a shift away from traditional industries (e.g., mining, farming) driving high poverty rates (typically above the state average of 9%). The table below provides a snapshot of these regions and their unique characteristics.

Table 2. Overview of Rural Virginia Regions

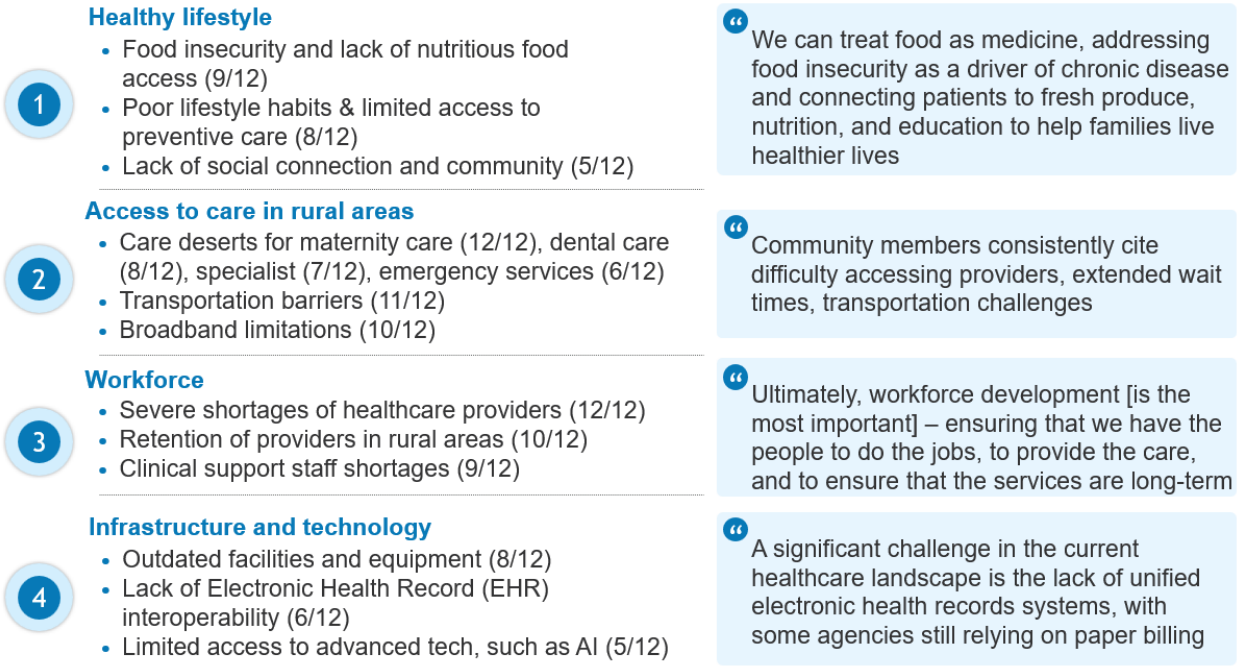
Region	Description
Southwest Virginia	Covers the Appalachian Mountains in the southwest corner of the Commonwealth, bordering West Virginia, Kentucky, and Tennessee. This is Virginia's most rural region, with communities that share many characteristics with neighboring Appalachian states. • **Economy:** Historically dependent on coal mining, timber, and manufacturing, economic shifts have tested the resilience of these communities. • **Demographics:** Approximately 57,000 people live in poverty, with rates ranging from 11 percent in Washington County to 27.6 percent in Lee County. Eleven out of thirteen counties have poverty rates over 15 percent.[1]

Region	Description
	• **Health status:** Low population density and provider shortages contribute to longer travel times and limited access to care. Rates of chronic disease and premature mortality remain above the state average.[2]
Roanoke/Alleghany	Includes counties surrounding the cities of Blacksburg, Roanoke, and Salem, as well as Craig and Alleghany counties that border West Virginia. • **Economy:** The railroad was historically central to the region's development. Today, key industries include education, healthcare, and advanced manufacturing.[3] • **Demographics:** The area's median income has increased since 2013, but the 17.5% poverty rate remains higher than the state average.[4] Residents of this region are more likely to be publicly insured. • **Health status:** Residents report more mentally and physically unhealthy days than the state average. Rates of obesity, depression, and smoking are also elevated.[5]
Southside Virginia	Refers to the south-central region of the Commonwealth bordering North Carolina. • **Economy:** A historically low-density, agricultural region centered on tobacco. The economy has diversified but still includes agriculture, timber & manufacturing. • **Demographics:** Poverty rates range from 7.7% in Cumberland County to 24.6% in Charlotte County, with just under 50 thousand people living in poverty. • **Health status:** Danville and Martinsville both have life expectancies roughly a decade shorter than the statewide average (68.3 years and 65.8 years, respectively). Chronic disease and adult obesity rates remain among the highest in the state.[6]
Northern Piedmont	Represents the rural areas between the urban centers of Richmond and Northern Virginia, including the Piedmont rural counties around Richmond. • **Economy:** The economy includes forestry, manufacturing and warehousing logistics near the I-64 and route 29 corridors. • **Demographics:** Moderate poverty rates range from 5.1% in Fauquier County to 14.4% in Nelson County. Rising housing and living costs create affordability challenges for lower-income households. • **Health status:** Health indicators are generally stronger than in more remote regions but still lag non-rural regions of the Commonwealth.
Shenandoah Valley	Represents counties west of the Blue Ridge Mountains. • **Economy:** Agriculture, livestock, and light manufacturing are core industries. • **Demographics:** Poverty rates in the region range from around 7% in Frederick County to more than 15% in remote counties, with an aging population driving higher demand for healthcare services. • **Health status:** Health indicators are generally stronger than in more remote regions but still lag non-rural regions of the Commonwealth
Eastern Shore & Northern Neck	Comprises remote coastal regions separated from mainland Virginia by the Chesapeake Bay, where distance and broadband limitations affect access to care and employment. • **Economy:** Agriculture, poultry, seafood, and tourism play central roles, though seasonal employment and weather disruptions can affect stability. • **Demographics:** Countywide poverty rates range from 9.3% to 18.5%, and broadband access remains limited (less than ~80% in Accomack and Northampton counties have broadband access) • **Health status**: Uninsured rates range between 15-19% for nonelderly adults and 10-13% for children, as compared to 11% and 5% respective rates statewide.[7]

Rural Health Needs Analysis

Qualitative Stakeholder Feedback. To design a transformational program and application that reflects the needs and goals of rural communities themselves, the HHR Secretary, DMAS, and VDH leadership hosted twelve listening sessions across the Commonwealth in September 2025. These sessions demonstrated that residents, providers, and other stakeholders are acutely aware of rural health challenges – ranging from limited access to preventive care to workforce shortages to outdated technology – and engaged with innovative efforts to address them. The themes heard in the listening sessions were broadly in line with the challenges the Commonwealth has sought to address through programs such as the *It Only Takes One* and *Healthy Moms, Healthy Communities, Healthy Babies* described above. The figure below shows the most common themes heard during these sessions.

Figure 3. Themes from Listening Sessions



These sessions also reinforced the importance of partnerships between rural providers and community organizations, the need for dignity and respect for rural residents and providers, and an overall frustration with current state of rural healthcare. This qualitative feedback was combined with research and quantitative data analysis to inform the overarching goals VA Rural Vitality seeks to address.

Demographic Data Relative to the statewide average, rural communities experience lower median household incomes, higher unemployment, and lower educational attainment.[2] These demographic and economic characteristics create heightened vulnerability to health care access challenges as well as health outcomes that lag statewide measures. In addition, higher uninsurance rates lead to delays in care and increase the financial burden of uncompensated care on rural safety net providers.

Table 3: Virginia Demographics, Rural vs Non-Rural[1]

Metric	Rural VA	Non-rural VA
Population size	1,579,035 (17.9% rural)	7,242,389
Median household income	$63,535	$84,654
Uninsured rate (%)	8.4	7.4
Unemployment rate (%)	3.3	3.0
High school completion (%)	87.0	91.3
Food insecurity (%)	13.3	11.2

Chronic Disease. The burden of chronic disease is a challenge across the country, in rural and non-rural areas alike. However, rural Virginia's rates for diabetes, high blood pressure, and high cholesterol exceed those in rural counties nationwide. Rural communities in Virginia also struggle with a pervasive shortage of dental care. Beyond the challenges poor dental care poses for oral

Table 4. Chronic Conditions Rural Prevalence[8]

Metrics	Rural VA	Rural US	US
Adult diabetes	16%	14%	13%
Adult obesity	40%	39%	38%
Adult high cholesterol	41%	38%	37%
Adult high blood pressure	42%	39%	37%
Children overweight/ obese	26%[9]	n/a	31%
Children 'flourishing'[2]	64%[10]	n/a	66%

health, it is also associated with chronic diseases such as diabetes and cardiovascular disease.[11] These chronic diseases can be managed and effectively addressed by a combination of behavioral change (e.g., better diets and more active lifestyles), education and health literacy, and medical intervention. A 2022 University of Florida study found that life expectancy increased 3.8 years when someone with poorly controlled diabetes improves their A1c biomarker from an average of 9.9% down to the normal level of 5.9%.[12] The American Diabetes Association estimates the total annual cost of diabetes in the United States to be over $400 billion.[13] Given its prevalence, as well as the potential for health outcome improvements, chronic disease management is a key focus for this effort.

Another important focus is Virginia's rural children. Over 25% of Virginia children are overweight or obese – potentially setting them up for a lifetime of chronic disease. Also concerning, fewer Virginia children are noted as 'flourishing' than national averages – meaning that they do not show signs of affection, resilience, curiosity, or interest in learning.[14]

Substance Use Disorder (SUD): In Virginia, 17.06% of adults and 8.69% of youth 12-17 were diagnosed with SUD in 2024.[15] A recent $1.4 billion investment as part of the *Right Help, Right Now* program seeks to increase access to timely SUD care, increase assistance to individuals experiencing SUD-related crises, and reduce rates of relapse. Further investment and innovation will help continue improvement for rural communities.

Maternal and Infant Health: Access to adequate maternal and infant health care was noted as an issue in all twelve stakeholder listening sessions. Across the Commonwealth in 2023, 13.9% of births had inadequate prenatal care, and 3.2% had no prenatal care.[16] Additionally, infant mortality rates are higher than national averages – rural Virginia has a rate of 6.7 per 1k births, compared to US average of 6.1.[17] Neonatal abstinence rates were also higher than US averages in

rural Virginia – 8.2 babies were born with NAS in 2022 per 1k births, 39% higher than the US average of 5.9[18]. Ongoing efforts, such as Governor Youngkin's 2024 Executive Order re-establishing Virginia's task force on maternal health data and quality measures, are supporting the Commonwealth's understanding of maternal health needs, but additional investment is needed to improve and enable access, especially in rural communities. Twenty-two percent of rural Virginians must drive more than forty minutes to the nearest labor and delivery (L&D) unit, and in five rural counties, drive times exceed 75 minutes[19]. Sixty-three percent of Virginia counties have no OB-GYN.[20]

Access to Care. Lack of access is a pervasive challenge and was one of the most frequently cited issue in stakeholder listening sessions, particularly access to primary, specialty, dental, and emergency care. Closely tied with the challenges of a constrained health workforce, rural Virginia only has 163 Primary Care Providers per 100k residents, compared to 252 in non-rural counties, a difference of ~35%. In 2023, only 44% of all Virginians utilized primary care[21]. In 2021, the median drive time for rural Virginians to substance use services was over 51 minutes[22]. Stakeholders also frequently cited transportation and lack of broadband access as barriers to care.

Health Workforce. Workforce shortages are an underlying driver of health system challenges. Primary care shortages are pervasive, with nearly 55% of rural localities in Virginia designated as Primary Care Health Professional Shortage Areas (HPSAs)[23]. In addition, 28% of rural counties had zero behavioral health prescribing practitioners in 2022[24]. Dental providers are also lacking, with rural Virginia having 40% fewer dentists per capita than non-rural areas[25].

Table 5. Healthcare Access Snapshot: Rural vs Non-rural Virginia[26]

Metrics		Rural VA	Non-Rural VA
Access to care	Primary care providers per 100k	**163**	252
	Driving Time ≥ 45 minutes from L&D unit	**13%**	2%

Workforce challenges	Dentists per 100k	**23**	38
	Counties with no OBGYN	**63%**	19%
	Registered Nurses per 100k	**903**	1041
	Radiology Technicians per 100k	**49**	58

Financial Solvency. Rural providers are often the main or only access points for care, yet many operate on narrow margins, reflecting lower patient volume, higher Medicaid patient mix, and higher uncompensated care burdens. The Center for Healthcare Quality and Payment Reform noted in an August 2025 report that seven rural Virginia hospitals have reduced services in the last decade, with an additional two rural hospitals closing altogether.[27] The report also states that of the thirty-one open rural inpatient hospitals in Virginia, nine are at risk of closing, of which six are at immediate risk of closure. An analysis of 2022 CMS cost reports showed that Virginia's hospitals generally operate at lower margins than hospitals in other states. Virginia's rural hospitals operate at an average margin of -1.2%, with 26% operating with margins less than -10%[28].

Table 6. Comparison of Virginia hospital performance in rural vs non-rural hospitals[29]

Financial measure	Rural VA	Rural US	Non-rural VA	Non-rural US
Bad debt as % of patient revenue	1.0%	1.0%	1.0%	1.1%
Operating margin (%)	-1.2%	-1.7%	-0.9%	2.0%
Medicaid revenue as % of patient revenue	3.9%	3.1%	3.4%	2.8%

Identifying Rural Areas

To identify eligible rural areas for subaward funding, the Commonwealth proposes to use the Federal Office of Rural Health Policy (FORHP) definition. Subrecipients should be located in rural counties as defined by FORHP, or they must demonstrate that the project being funded will effectively target residents of rural counties. Additional initiative-specific criteria will be included, such as a requirement for an on-the-ground implementation partner in FORHP-designated counties.

Target Populations

Consistent with the Governor's letter, Virginia is committed to improving healthcare access and outcomes for all rural residents – supported by the broad scope of proposed initiatives within VA Rural Vitality complementing this broad focus, data and stakeholder feedback highlight vulnerable populations where targeted interventions will drive greatest impact.

Table 7. Target Populations for VA Rural Vitality

Target Populations	Population-Specific Sub-initiative
Rural adults with/at risk of chronic conditions and substance use disorders	Food as medicine, Consumer tech for education and lifestyle change, Remote Patient Monitoring (RPM)
Rural pregnant women and as well as those less than one year post-partum	Innovative maternal care
Rural children and adolescents already at risk of chronic conditions & behavioral health challenges	Active kids
Low-income rural seniors	Integrated care for duals

The Commonwealth will collaborate with rural hospitals, FQHCs, RHCs, free clinics, federally recognized Tribes, other local providers, innovative health tech partners, community-based organizations (e.g., AAAs), and others as a critical part of this effort.

Target Geographies

Most or all initiatives will provide benefits across Virginia's rural counties detailed in Table 2. In the first year, pilot efforts will launch first in a 'test and learn' approach prior to scaling. In years 2-3, competitive grant processes will expand and scale those initiatives to other rural areas throughout the state. Further detail on initiatives is available in the Proposed Initiatives section of this application.

Section 2: Rural Health Transformation Plans: Goals and Strategies

Virginia proposes a bold vision for rural health transformation where rural Virginians lead the way to better health through innovative tools, effective prevention strategies, and new care

delivery models, supported by providers coming from their own communities. This approach expands access to quality care and equips rural Virginians with tools and information to thrive.

Figure 4. Overarching Goals of VA Rural Vitality

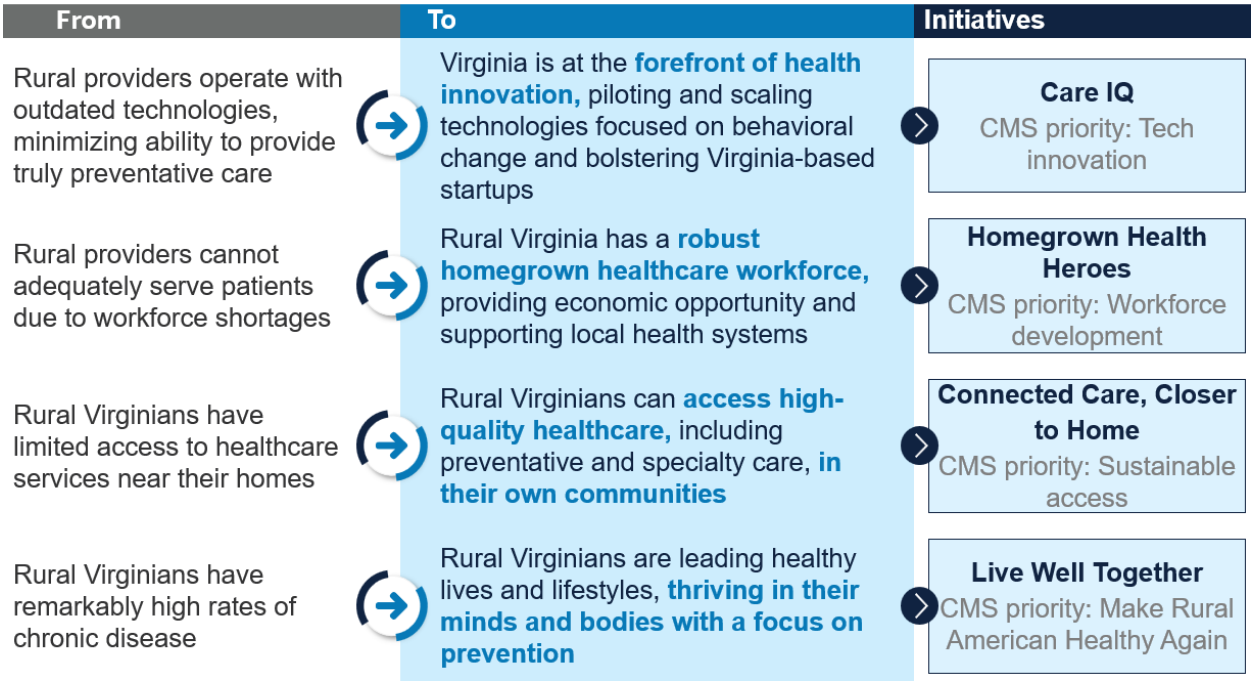
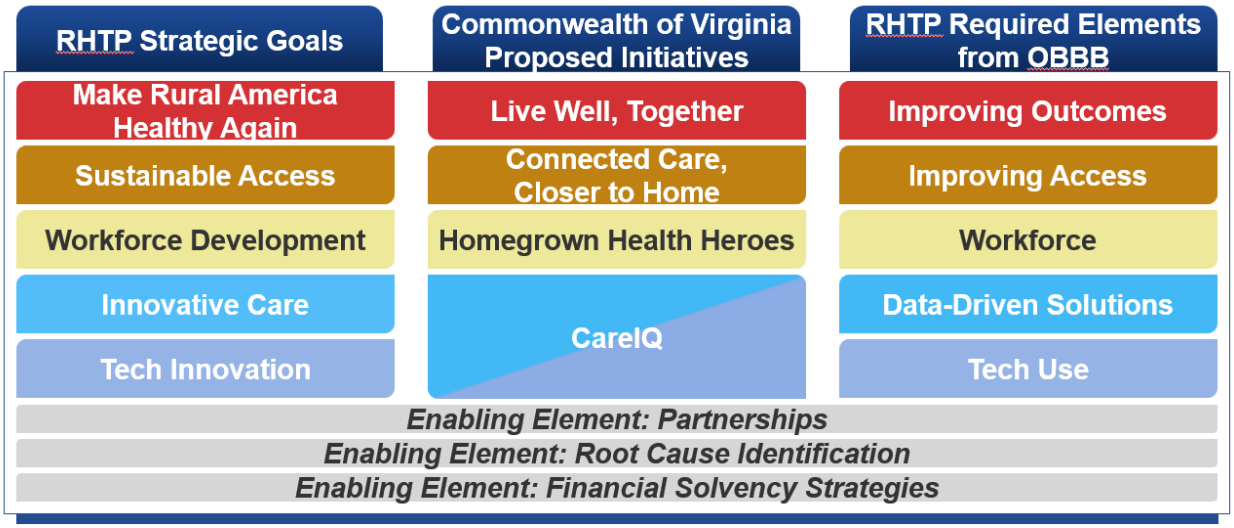


Figure 5. Alignment Mapping of Strategic Goals, Elements, and Initiatives



As required by statute in 42 U.S.C. 1397ee(h)(2)(A)(i), Virginia's approach to transforming rural health responds to the eight required elements that transformation plans must

address. Virginia's proposed initiatives are mapped above in Figure 5 to both the Strategic Goals issued in the Notice of Funding Opportunity as well as the elements outlined in H.R.1.

1. Improving access. "Connected Care, Closer to Home" will improve access to preventative and primary care, diagnostics, dental and oral care, and maternal healthcare by ensuring rural Virginians can access care in their own homes or convenient locations nearby. Stakeholder discussions consistently reinforced that lack of access to care is a dire issue in rural communities, with residents often needing to drive hours across county lines for critical services. This initiative will overhaul the current model, bringing care to people where they are– the grocery store, church, and school. The "Mobile and Hybrid Care" sub-initiative will utilize mobile vans and conveniently located kiosks that enable remote and secure connection with providers. "Community Paramedicine" projects will enable EMS to provide in-home preventative visits to high utilizers and conduct 'treat-in-place' to provide better care and avoid long and costly patient trips to Emergency Departments. "Innovative Maternal Care" will continue to drive down Virginia's maternal and infant mortality rates by enabling prenatal screenings, tele-presence of specialists for high-risk births, as well as post-partum remote patient monitoring. "Homegrown Health Heroes" will positively impact access to care by increasing the number of local providers.

2**. Improving outcomes.** All initiatives included in this proposal will contribute to the overarching goal of improving outcomes, whether by expanding access to prevention, enabling healthy lifestyle changes, improving access to care or leveraging innovative technology. In particular, the "Live Well, Together" initiative equips rural residents with resources, tools, and information to lead healthier lifestyles. This will help to reduce the burden of chronic disease – both by helping those with chronic diseases better manage them, and even more importantly, enabling rural residents to avoid chronic disease in the first place. The "Food as Medicine" sub-

initiative will provide the start-up funds and technical assistance for health systems and others stand up medically tailored meal programs and nutritional education, leading to reduced hospital readmissions and longer-term health. The "Consumer Tech for Education and Lifestyle Change" sub-initiative similarly focuses on adults with or at risk of chronic conditions to provide innovative technology, data, and incentives – including 'gamification' of health literacy and lifestyle changes – that can improve patient self-management and long-term health outcomes.

3. Technology use and 4. Data-driven solutions. Innovative use of technology and data is the focus of the "CareIQ" initiative and underpins all other initiatives. Virginia will make innovative use of data & technology to allow rural areas to 'leapfrog' legacy health infrastructure and enable more targeted and connected care. "CareIQ," including four sub-initiatives, seeks to both "nail the basics" in supporting free clinics, FQHCs, RHCs and other providers to improve their EHR systems and interoperability, while also "raising the bar" by investing in clinic-level adoption of cutting-edge, AI-enabled decision support and workflow management tools. The "Tech Innovation Fund" sub-initiative, administered the Virginia Innovation Partnership Corporation (VIPC), will foster development of Virginia-based consumer health technologies for prevention and management of disease. The "Remote Patient Monitoring" sub-initiative will deploy technology for AI-driven monitoring, improving outcomes and lowering readmissions.

5. Partnerships. Listening sessions reinforced the importance of partnerships in rural communities – and many communities, such as Eastern Shore, demonstrated a strong ecosystem of existing partnerships between providers, local officials, and community-based organizations (CBOs). Virginia has structured initiatives to drive partnerships between different provider types and stakeholders, catalyzing the impact of each initiative. For example:

Table 8. Sample initiative partnership models

Sample Sub-Initiative	Partnership model
Remote Patient Monitoring	Virginia Hospital Research and Education Foundation (VHREF) to facilitate partnerships between hospitals and FQHCs, RHCs and free clinics
Food as Medicine	Health systems and rural providers to partner with community-based organizations (CBOs) (e.g., food banks, AAAs) to deliver services
Hybrid and Mobile Care	Health systems to partner with small rural providers for virtual consults

6. Workforce. Building the health workforce in rural Virginia is critical to expanding access to high quality care. Focusing on a "homegrown" workforce is key, since training rural residents for healthcare careers in their own communities has proven more effective and sustainable than recruiting professionals from elsewhere, who are often less likely to stay long-term. Healthcare workers with rural roots are also more likely to understand how to reach people and build trusted provider-patient relationships. That is why the Commonwealth is proposing $132M for the "Homegrown Health Heroes" initiative over 5 years. This is a top priority for the first year of implementation, as the other initiatives will be bolstered by a stronger workforce. This initiative will increase rural track residency slots, expand in-demand community college health degrees via innovative learning models, provide grants for paid apprenticeships for desirable and attainable health career paths, and support high school training programs to create job-ready pathways for roles like EMTs. Training local talent will also enable economic opportunities for rural residents to thrive by serving their communities in the health professions.

7. Cause Identification and 8. Financial Solvency Strategies. Quantitative and qualitative analyses suggest several causes that make it difficult for rural providers to sustain traditional models of care. The initiatives in this proposal leverage several different financial solvency strategies to address these root causes.

Table 9. Drivers of Provider Financial Solvency Challenges

Cause	Financial Solvency Strategy	Applicable Initiative
Payer mix drives lower revenues and margins	Invest in innovative technology improvements that increase provider efficiency and prevent burnout.	CareIQ
Workforce shortages can make it difficult to find providers	Workforce development programs across all educational levels and levels of care. Targeted to rural populations and with post-completion residency requirements.	Homegrown Health Heroes
Rural providers have insufficient volume and revenue as residents often seek care at large urban centers that are better resourced with more specialties	Mobile and hybrid options bring care closer to where residents live, and partnerships with larger health systems will provide connections to specialists and other resources. Additionally, hub and spoke models will allow for consolidation of resources to sustain existing infrastructures.	Connected Care, Closer to Home
High rates of acute conditions lead to high costs to the health system	Provide supports "outside the four walls" to improve overall population health and lowers rates of acute conditions, thereby lowering overall costs.	Live Well Together

Healthcare workforce development efforts that raise employment and economic prosperity in rural areas can help to increase rates of commercial insurance which is favorable to payor mix and decreases state and federal Medicaid costs. Residents who participate in the training programs will also qualify as having met the community engagement requirement mandated in H.R.1, enabling them to maintain coverage while working toward better long-term employment.

Program Key Performance Objectives

The objectives of VA Rural Vitality have been developed to address the unique challenges rural communities face in the Commonwealth. Each initiative has been intentionally designed to drive lasting improvements in the access and outcomes metrics outlined below.

Table 10. Program Key Performance Objectives

Objective	Data Source[30]	Metric	Baseline	Target (5Y)	Supporting Initiatives
Decrease rates of chronic disease in rural adults and children	CDC PLACES, survey and claims data (e.g., DMAS for Medicaid,	% of rural adults diagnosed with diabetes[31]	15.7%	13.8% (US rural avg)	Live Well Together; Connected Care, Closer to Home; CareIQ
		% of rural adults diagnosed with hypertension[32]	41.7%	38.8% (US rural avg)	
		% of rural adults diagnosed with obesity	39.9%	38.8% (US rural avg)	

Objective	Data Source[30]	Metric	Baseline	Target (5Y)	Supporting Initiatives
	All Payers Database for Commercial, Medicare)	% of children diagnosed as overweight or obese[33]	26.2%	23.4% (~10% reduction)	
Increase access to primary care for rural residents including number of preventative visits and screenings	Claims data (e.g., DMAS for Medicaid, All Payers Database for Commercial, Medicare)	% of rural patients with an annual primary care visit[34]	-	-	Connected Care, Closer to Home; Homegrown Health Heroes; Live Well Together
		% of avoidable emergency department (ED) visits among rural patients	-	-	Connected Care, Closer to Home; CareIQ; Homegrown Health Heroes; Live Well Together
Decrease rates of substance use disorders	VDH data	Overdose deaths per 100K residents	16.3	14.7 (~10% reduction)	Connected Care, Closer to Home
Increase number of prenatal and postpartum visits conducted for rural mothers	Claims data (e.g., DMAS for Medicaid, All Payers Database for Commercial, Medicare)	% women with prenatal care	-	-	Connected Care, Closer to Home
		% women with post-partum follow-up care	-	-	
Improve maternal and infant health outcomes by reducing maternal and infant mortality, as well as neonatal abstinence syndrome in rural communities	VDH Dashboards	Rate of maternal mortality per 1,000 births	34.5	31.1 (~10% decrease)	Connected Care, Closer to Home
		Rate of infant mortality per 1,000 live births in rural counties	6.7	6.4 (~5% decrease)	
		Babies with neonatal abstinence syndrome per 1,000 births in rural counties	8.2	7.4 (~10% decrease)	
Build a lasting pipeline of rural residents into healthcare careers	Virginia Healthcare Workforce Dashboard	Ratio of Primary Care physicians per 100k rural residents	73.5	76.2 (~4% increase)	Homegrown Health Heroes
		Rural counties with no OBGYN	63%	53% (~10 p.p.)	
		Ratio of dental hygienists per 100k rural residents	30.9	38.9 (~25% increase)	
		Ratio of registered nurses per 100k rural residents	903.0	923 (~2% increase)	
		Ratio of radiologic technologists per rural residents	49.1	62.4 (~25% increase)	

Objective	Data Source[30]	Metric	Baseline	Target (5Y)	Supporting Initiatives
Modernize provider operations and increase adoption of technology in rural communities	DMAS and VHCF reporting; provider self-assessments	% of providers using EHRs or digital workflow tools aligned with CMS Health Technology Ecosystem criteria and ASTP/ONC criteria	-	-	CareIQ
	DMAS / VIPC reporting	Private sector capital catalyzed by innovation fund	-	-	CareIQ
		Number of new start-ups with products deployed in rural Virginia	-	-	

For initiative-specific performance measures, please see Tables 15, 20, 25, and 31 in the "Proposed Initiatives and Uses of Funds" section, and Table 36 in "Metrics and Evaluation."

State Policies and Legislative and Regulatory Action

The Commonwealth of Virginia is committed to a series of policy actions, including legislative and regulatory, consistent with the areas laid out in the Notice of Funding Opportunity. The table below demonstrates current policy, planned legislative and regulatory actions, timeline of actions, and how those actions will impact access, quality, and / or cost of care.

Table 11. State Policy Action Summary

State Policy Area	Current Policies and Commitments to Action	Timeline
B.2. Health and Lifestyle	**Current Policy:** Governor Youngkin issued Executive Order 55, "Reestablishing the Presidential Fitness Test in the Commonwealth's Public Schools." The Governor directed the Virginia Department of Education to adopt and implement the Presidential Fitness Test by the start of the 2026-27 school year, and the Superintendent and Department shall work with local school divisions to ensure that the Presidential Fitness Test is fully implemented by July 1, 2027, unless earlier directed by federal guidance. **Impact of legislative / regulatory action:** Reinstating the President's Physical Fitness Test via Governor Youngkin's Executive Order 55 is intended to reinvigorate physical education in Virginia schools, helping to motivate and focus kids of all on the physical and mental health benefits of an active lifestyle which complements the Active Kids initiative.	EO issued November 4th, 2025
B.3. SNAP waivers	**Current Policy:** On November 4th, Virginia submitted a waiver to USDA that would prohibit the use of SNAP benefits for sweetened beverages, including those artificially sweetened.	Virginia submitted waiver on

State Policy Area	Current Policies and Commitments to Action	Timeline
	Impact of legislative / regulatory action: The SNAP waiver is intended to set targeted boundaries on purchases made by recipients via their SNAP benefits. This helps create an environment where rural Virginians have the education, incentives, information, and structures to support healthy diets and lifestyles.	November 4th, 2025
B.4. Nutrition Continuing Medical Education	**Current policy:** On October 30, 2025, the Board of Medicine adopted 1 hour of continuing education in the subject of nutrition for the 2028-2029 renewal cycle for all licenses. This requirement was pursuant to Virginia Code § 54.1-2928.3, created by HB1426 which Governor Youngkin signed into law on March 23, 2023, which states that the Board can require continuing education on specific topics. **Impact of legislative / regulatory action:** Taken together, these policy changes will positively impact health care access and outcomes for rural Virginians and complement the proposed initiatives in this application.	Nutrition will be a component of CME as of 1/1/28
C.3. Certificate of Needs	**Current Policy:** Cicero index listed in the data source definition and source column is accurate	NA
D.2. Licensure Compacts	**Current Policy:** VA is part of NLC, EMS, PSYPACT and PA Compact. VA is not part of IMLC (physicians). We believe Virginia's current model more effectively supports RHTP's goal of expanding access to health professionals in rural areas by allowing clinicians to serve patients across state borders. Virginia has not joined the IMLC due to the cost to applicants and length of time for licensure under the IMLC. Virginia offers much faster and less costly alternatives for licensure as a physician that are in support of RHTP goals to increase access to health professionals in rural areas by providing clinicians with the opportunity to serve patients across states. Physicians may be licensed through endorsement (having a license in another jurisdiction), reciprocity (agreements with Maryland and DC), or by military pathway for servicemembers or spouses. All three options offer significantly faster timelines to the IMLC, do not require criminal background checks as the IMLC requires, and cost less than a privilege to practice under the IMLC.	NA
D.3. Scope of Practice	**Current Policy:** Virginia is semi-restrictive according to national indices referenced for PAs, pharmacists and dental hygienists. While Virginia is currently categorized as "restrictive" for NPs by the AANP, we believe this misrepresents the Commonwealth's policies. Virginia should at least be classified as a "Reduced Practice" state under the AANP designation. AANP lists Virginia as only allowing practice by "NPs" (advanced practice registered nurses in Virginia, or APRNs) under "career-long" supervision or collaboration. This is not true. Virginia APRNs can practice without oversight of or collaboration with another healthcare practitioner following various amounts of practice or in certain practice scenarios. These are detailed in Virginia Code § 54.1-2957(H), (I), and (J).	NA
E.2. Dual Eligibles	**Current Policy:** VA identifies DMAS to manage coordination of dual eligibles. VA offers FIDE-SNPs plans: Beginning January 1, 2025, Virginia mandated that dual eligibles must be enrolled in a D-SNP with a corresponding Medicaid plan through the same health plan provider VA is 94.7 percentile of duals enrolled in D-SNPs.	NA
E.3. Short-term, limited-duration insurance	**Current Policy:** VA limits STLDIs to 3-month initial terms and up to 6 months total duration in a 12-month period.	NA

State Policy Area	Current Policies and Commitments to Action	Timeline
F.1. Remote Care Services	**Current Policy:** VA reimburses live video, Store and Forward and RPM, and has in-state licensing requirement exceptions. VA currently has no Telehealth License / Registration process.	NA

Other required information is included below:

Scoring factor	Requested information
A2. CCBHCs	Virginia has four Community Services Boards (CSBs) that are CCBHCs. Virginia has invested significantly in CCBHC-like models through its Right Help, Right Now initiative, including through CSBs and the completion of a CCBHC state planning grant through SAMHSA in 2018. Building on this foundation, Virginia launched the System Transformation Excellence and Performance (STEP-VA) initiative, which is modeled on the national CCBHC framework and aims to ensure that all 40 CSBs deliver a consistent, high-quality set of core behavioral health services statewide. The full list is included in on page 15 of **Other Supporting Materials (OSM).**
A7. Medicaid DSH payments	For the most recent state plan rate year, 85 in-state hospitals and out-of-state hospitals received DSH payments. A full list of these hospitals is included on page 16 in OSM.

Proposed Initiatives and Use of Funds

The four proposed initiatives in "VA Rural Vitality" form an innovative, transformational strategy to dramatically improve healthcare and health outcomes. Technology is our foundation – the CareIQ initiative *[CMS priority: Tech innovation]* will introduce cutting edge innovation to Virginia's rural providers, while also investing in core building blocks like interoperability. Our "Homegrown Health Heroes" initiative *[CMS priority: Workforce development]* will catalyze the growth of rural physicians and allied health professionals. Investment is front-loaded to kick-start the workforce growth that will be foundational for the broader strategy. "Connected Care, Closer to Home" will enable sustainable access *[CMS priority: Sustainable access]* – turning the traditional model of care on its head by bringing care to residents in their homes and neighborhoods, instead of asking them to seek services far from home and with limited availability. "Live Well, Together" *[CMS priority: Make rural America healthy again]* empowers rural residents to live healthy lives and take control of their own health through effective and innovative consumer facing apps, wearables, and care navigation tools, better

nutrition, and opportunities for physical activity. Virginia is addressing CMS's *Innovative care* priority by connecting care innovation and payment reform in real time. Through the "Connected Care, Closer to Home" and "Live Well, Together" initiatives, we are co-designing and testing mobile, home-based, tech-driven care models with providers, payers, and community partners. These initiatives will generate the evidence and operational insights needed to craft payment models that are effective, data-driven, and truly sustainable in rural settings. Through the "Connected Care, Closer to Home" and "Live Well, Together" initiatives, we are co-designing and testing mobile, home-based, tech-driven care models with providers, payers, and community partners. These initiatives will generate the evidence and operational insights needed to craft payment models that are effective, data-driven, and truly sustainable in rural settings.

Table 12. Overview of VA Rural Vitality initiatives

Initiative	Funding Allocated	Sub-Initiatives in Scope	
CareIQ	$282.6M	• Tech Innovation Fund • Provider Productivity	• Provider Interoperability • Remote Patient Monitoring
Homegrown Health Heroes	$132.0M	• Attract and Retain Physicians • Allied Health Degrees	• Earn to Learn programs • Build career pipelines
Connected Care, Closer to Home	$412.0M	• Mobile and Hybrid Care • Community Paramedicine	• Innovative Maternal Care
Live Well, Together	$124.2M	• Food as Medicine • Consumer Tech for Education and Lifestyle Changes	• Active Kids • Integrated Care for Duals

CareIQ

Description: CareIQ supports the RHTP goal to advance innovative technologies that promote efficient care delivery, improved provider satisfaction and enhanced patient outcomes. The initiative will enable rural providers to 'leapfrog' the current models and delivery data-informed, effective care. CareIQ includes four sub-initiatives that range from supporting rural

safety net providers in "nailing the basics" of EHRs and cybersecurity to advancing Virginia-based health technology innovation that can bring cutting-edge care to underserved regions. **The Tech Innovation Fund** aims to grow Virginia's health technology ecosystem and deploy homegrown innovations that strengthen care delivery in rural communities. The **Provider Productivity** sub-initiative is intended to support adoption of decision-support, documentation, and workflow tools, including AI advances to reduce administrative burden, ease provider burnout and allow rural clinicians to focus more of their valuable time on patient care. The **Provider Interoperability** sub-initiative will support independent rural providers, FQHCs, RHCs, free clinics and eligible health systems in modernizing their digital infrastructure—closing the technology gap that often prevents rural providers from keeping pace with EHR and cybersecurity advancements. The **Remote Patient Monitoring** sub-initiative will provide health systems and rural providers with funding to implement remote patient monitoring (RPM) and continuous care technologies that extend clinical insight beyond the hospital walls, enabling proactive, coordinated care and better long-term outcomes for patients.

Where possible, Virginia will establish regional purchasing collaborations with providers and associations in neighboring states (including West Virginia) to leverage shared demand, reduce duplication, and acquire technologies at a lower cost. These collaborations can enhance purchasing power and promote standardization across health systems, allowing rural providers to access high-quality health technologies and equipment that might otherwise be cost-prohibitive.

The **Tech Innovation Fund** will be led by the Virginia Innovation Partnership Corporation (VIPC), the operating nonprofit of the Virginia Innovation Partnership Authority (VIPA). Established by the Commonwealth legislature, VIPC strengthens Virginia's startup ecosystem by

accelerating technology commercialization and attracting early-stage investment capital. VIPC was selected for its proven track record in managing large-scale state and federal innovation programs and its success in helping more than 300 Virginia startups secure over $2.5 billion in follow-on private investment. Its experience supporting early-stage technology commercialization and rural entrepreneurship makes VIPC uniquely positioned to extend these capabilities to healthcare innovation and consumer-facing health technology. VIPC would provide non-dilutive grant funds, and potential recipients must present and commit to a compelling long-term strategic plan, sustainable funding strategy and measurable outcomes that will be reported back to the Commonwealth. Through these investments, the Commonwealth aims to accelerate Virginia-based innovations that improve rural health, create jobs and reinvest economic growth within the state. For further information on oversight and award details for the fund, please see pages 19-20 in OSM.

The **Provider Productivity** fund will support independent rural providers, clinics, and health systems in adopting or upgrading digital tools that improve efficiency and reduce administrative burden on provider practices. Funded technologies must align with at least one of three focus areas—clinical decision support, documentation assistance, or workflow automation—to enhance interoperability, streamline provider operations, and strengthen coordination across the care continuum. Providers will receive technical assistance to select appropriate tools and vendors. In addition to improving speed and quality of care delivery, these tools will help alleviate workforce shortage issues by making nurses, doctors and other support staff more efficient and reducing burnout. Funding will be distributed through a partnership between DMAS and the Virginia Health Care Foundation (VHCF), a public–private organization with strong existing relationships across Virginia's rural primary care and behavioral health provider networks. VHCF

will run a competitive process to award grants to rural providers and health systems. The Fund is expected to reduce provider burnout, increase patient visit volume and availability and bolster provider financial solvency—ensuring rural practices remain sustainable over time.

The **Provider Interoperability** fund focuses on supporting those providers who are at the earlier stages of incorporating technology into their practices. It will provide targeted funding to help independent rural providers (incl. federally recognized Tribes), FQHCs, RHCs, free clinics and eligible health systems to modernize their EHR systems and strengthen cybersecurity infrastructure. The program will support upgrades to legacy systems, enhance internal data exchange and reporting, and protect patient information from increasing cybersecurity threats. These investments are intended to decrease administrative burden, reduce risk of costly data breaches and privacy issues, and improve care coordination across rural clinics, laying the groundwork for long-term digital resilience. Funding will be distributed through a partnership between DMAS and the Virginia Health Care Foundation (VHCF), with VHCF managing the competitive process to award grants to providers.

The **Remote Patient Monitoring (RPM)** fund aims to improve the experience, outcomes, and long-term recovery of patients who are managing chronic or high-risk conditions. RPM provides a lifeline for rural Virginians who often live far from hospitals or specialists, helping them stay connected to their care teams without long travel times or costly readmissions. This fund will support health systems, hospitals, and rural providers in implementing RPM and continuous care technologies that enable providers to track patient outcomes both in-facility and at home.

Technologies funded under this initiative may include wearables, remote monitoring devices and clinical dashboards integrated with EHR systems to support continuous patient oversight and early intervention. Technology innovators such as BioIntelliSense, Andor Health,

and Philips submitted proposals through the stakeholder engagement process, offering potential solutions for consideration. RPM from such technology companies has been proven to improve patient safety, engagement, and quality of life while giving providers critical data to better manage chronic conditions and reduce costly hospitalizations.

Funding will prioritize scalable solutions that demonstrate strong clinical integration, patient engagement and measurable improvements in care quality. Funding will be distributed through a partnership between DMAS and the Virginia Hospital Research and Education Foundation (VHREF), the 501(c)(3) non-profit affiliate of the Virginia Hospital and Healthcare Association. VHREF will manage a competitive process to grant awards to providers, beginning with pilots at hospitals and expanding through partnerships with primary care providers, FQHCs, RHCs, free clinics and others. DMAS and VHREF will validate technologies identifies by providers selected technologies to ensure alignment with program goals and national best practices. This model is designed to promote strong provider participation by offering technical assistance, implementation support, and coordinated infrastructure to ensure new technologies are smoothly integrated into clinical workflows. This will enable providers to focus on patient care rather than bureaucracy, building sustained buy-in across rural practices.

Table 13. Initiative Summary: CareIQ

Sub-Initiative Design	Uses of Funds	5Y Budget
Tech Innovation Fund VIPC will oversee a grant process to provide awards of up to $500k to promising early stage health technology start-ups based in Virginia.	Grants provided through innovation fund office to Virginia-based entities. Subawards will follow guardrails outlined on pages 19-20 of OSM (e.g., all grants will be non-dilutive).	$31.6M
Provider Productivity VHCF will administer a fund to support rural providers in adopting new, pre-selected tools to	• Procurement of digital productivity and documentation tools, including licenses or subscriptions covered for up to two years to support infrastructure development and program start-up for participating providers and health system	$79.3M

improve productivity through better decision support, documentation automation, and workflow efficiency.	• One-time hardware or software integration with existing EHR systems and clinic workflows
	• Training, technical assistance, and implementation support:
	  ○ Understanding digital offerings and selecting health tech vendors
	  ○ Implementing and optimizing system functionality, including workflow redesign and interoperability with existing data systems
	  ○ Training providers and staff to effectively use new technologies for documentation, clinical decision support and workflow automation
	  ○ Incorporating tech expenses into ongoing operating costs after 5-year funding from RHTP is complete	

Provider Interoperability
VHCF will administer a fund to support rural providers (incl. FQHCs, RHCs, and free clinics) in adopting upgraded EHR, cybersecurity and data analytics platforms.
	• Assessments of current IT, EHR and cybersecurity tech to identify gaps
	• One-time hardware and software integration to support adoption or enhancement of EHR and cybersecurity systems
	• Time-limited (up to two years) support for ongoing EHR and cybersecurity licenses and subscriptions during implementation/startup
	• Training, technical assistance, and implementation support:
	  ○ Understanding digital offerings and selecting health tech vendors
	  ○ Optimizing system functionality, interoperability, workflow alignment
	  ○ Training staff on EHR and cybersecurity best practices and tech use
	• Incorporating tech expenses into ongoing operating costs after 5-year funding from RHTP is complete
		$92.5M

Remote Patient Monitoring
A fund that is operated under a partnership agreement with VHREF. Potential to identify 2-3 hospitals to support first year deployment, with additional providers participants coming on board in later years as model is tested and ready to scale.
	• Purchase and deployment of wearable/RPM devices, patient-facing applications and clinical dashboards
	• Integration of device data with EHR/data systems to support patient management and outcomes tracking
	• Training, technical assistance, and implementation support for:
	  ○ Optimizing system functionality, interoperability, workflow alignment
	  ○ Training staff on EHR and cybersecurity best practices and tech use
	  ○ Incorporate and maintain consumer health tech expenses into ongoing operating costs after 5-year funding from RHTP is complete
	  ○ Explore alternative payment models and reimbursement avenues for adopted solutions
	• Stand-up staffing support (e.g., data analysts) to manage data intake and work with clinical staff on patient coordination for first two years
	• Continuous evaluation of technology performance and readiness for scale, including assessment of patient engagement, usability and outcomes
	• Contracting with an actuary or data analytics partner to analyze pilot data and estimate expected savings and financial impact to explore alternative payment models and reimbursement pathways
	• Partner enablement support to build necessary data, claims tracking and reporting capabilities if alternative payment models / reimbursement pathways established
		$79.2M

For the above sub-initiatives, which have trusted subrecipient partners designated to administer funding, DMAS will work with these designated entities to ensure funding is allocated via appropriate award processes, including competitive selection processes. Further detail on initiative-specific subaward criteria is included in the Budget Narrative.

Main Strategic Goal: Tech Innovation

Uses of Funds: D, F

Technical Score Factors: B.1, F.1, F.2, F.3,

Key Stakeholders:

Across all sub-initiatives, participating community members, advocacy organizations, federally recognized Tribes, and provider organizations are important stakeholders to provide ongoing input in support of the success of this work. Further detail on ongoing stakeholder engagement efforts is included in the Section "Stakeholder Engagement."

Table 14. Initiative-Specific Stakeholders: CareIQ

Program	Key Specific Stakeholders
Tech Innovation Fund	Health tech start-ups, health systems and providers deploying new technology; VIPC
Provider Productivity	Full range of providers, including independent rural providers, free clinics, FQHCs, RHCs, federally recognized Tribes, and health systems; Virginia Healthcare Foundation
Provider Interoperability	Safety net providers including free clinics, FQHC and RHCs, independent rural providers and federally recognized Tribes; Virginia Healthcare Foundation
Remote Patient Monitoring	Health systems with additional participation from free clinics, FQHCs, RHCs and independent rural providers and federally recognized Tribes; VHREF

Table 15. Initiative-Specific Metrics: CareIQ

Sub-Initiative	Metric	Data Source
Tech Innovation Fund	Number of innovation fund awardees	Subrecipient reporting
Tech Innovation Fund	Number of active users of innovation fund awardee products	Subrecipient reporting
Provider Productivity	Incremental number of rural providers **by county** using tech-enabled provider productivity tools by provider type	Subrecipient reporting
	Average estimated provider time savings achieved through productivity tools	Subrecipient reporting
	Average increase in estimated provider revenue or billable services achieved through productivity tools	Subrecipient reporting
Provider Interoperability	Incremental number of rural providers/hospitals on EHR platforms	Subrecipient reporting
Remote Patient Monitoring	Incremental number of rural hospitals and health care settings actively using ≥1 RPM technology	Subrecipient reporting

Table 16. Impact of Initiative on Program Key Performance Objectives

Overall Program Key Performance Objective	Impact of this initiative on Key Performance Objectives
Decrease rates of chronic disease in rural adults and children	Start-ups funded by the Tech Innovation fund will have a focus on reducing chronic disease and increase health literacy. The initiative metrics ensure accountability toward deployment of that funding and end user adoption
Modernize provider operations and increase adoption of technology in rural communities	The Provider Productivity, Interoperability, and RPM sub-initiatives directly contribute to modernization of provider operations and adoption of technology. The initiative metrics also directly feed into the overall program performance objective metrics.

Impacted Counties: All rural Virginia counties

FIPS Codes											
51001	51005	51007	51011	51017	51021	51025	51027	51029	51033	51035	51036
51037	51043	51045	51047	51049	51051	51057	51061	51063	51065	51067	51071
51077	51079	51081	51083	51089	51091	51097	51099	51101	51103	51105	51109
51111	51113	51115	51117	51119	51125	51127	51131	51133	51135	51137	51139
51141	51143	51147	51155	51157	51159	51163	51167	51171	51173	51175	51181
51183	51185	51187	51193	51195	51197	51530	51580	51590	51595	51620	51640
51678	51690	51720	51750								

Estimated Required Funding:

Table 17. Sub-initiative 5-year Budgets: CareIQ

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Innovation Fund	$10.5M	$5.3M	$5.3M	$5.3M	$5.3M	$31.6M
Provider Productivity	$10.5M	$10.6M	$15.9M	$21.2M	$21.2M	$79.3M
Provider Interoperability	$17.0M	$18.9M	$18.9M	$18.9M	$18.8M	$92.5M
Remote Patient Monitoring	$15.7M	$7.5M	$7.5M	$23.2M	$25.3M	$79.2M
Total	**$53.7M**	**$42.3M**	**$47.6M**	**$68.5M**	**$70.6M**	**$282.6M**

Homegrown Health Heroes

Description: Homegrown Health Heroes is focused on growing rural provider workforce while providing career pipelines and economic opportunities for rural Virginians. The Commonwealth believes that building a homegrown workforce will have a multiplier impact on rural communities. It will help address acute provider shortages in the near term, as well as in the

long term, given the deep roots that these providers will have in their communities. It also creates positive employment opportunities to improve local economies and help prevent population loss.

This initiative is comprised of four sub-initiatives covering different provider types and levels of education: **Attract and retain physicians** via residency slots in high priority specialties with wraparound support and retention models, expand **Allied health degrees** to enable community college students to enroll in health degree programs that are currently in critical shortage in rural Virginia due to cost-prohibitive one-time infrastructure needs to stand up programs, **Earn to Learn apprenticeship programs** developed in partnership with educational institutions and committed health care employers and **Building career pipelines** to stand up high school training academies, creating opportunities in allied health professions in rural areas. Virginia will require a 5-year rural commitment for all workforce programs consistent with CMS guidance. “Attract and retain physicians” and “Earn to learn apprenticeship” sub-initiatives will have minimum 5-year service requirements for the residencies and apprenticeships created. “Allied health degrees” and “Build career pipelines” sub-initiatives create funding for overall infrastructure investment and program expansion instead of specific individuals. Virginia will engage with CMS on these 'allied' and 'build career' to clarify if a 5-year residency is required.

The **Attract and Retain Physicians** sub-initiative will establish a fund via the VHREF to expand slots for primary care, OBGYN, psychiatry, and nurse midwife residencies in rural areas. This sub-initiative will also provide wraparound supports, centralize outcomes tracking, and establish five-year commitments to rural areas to drive rural retention and long-term sustainability. This approach and $50M funding level could support approximately 80-100 incremental residency slots across multiple specialties with dire need for new providers, targeted by county-specific provider type shortages. A 2024 analysis by The Cicero Institute concluded that 32.4 percent of

Virginia physicians are currently within retirement age. The goal of this approach is to begin to reverse that trend and build a strong provider base in rural Virginia.

Allied Health Degrees is a sub-initiative to expand access to high-demand allied-health training programs, including nurses, dental hygienists, diagnostic medical sonographers, radiologic technologists, physical therapy assistants, and others using a community college hub and spoke model for virtual and in-person instruction across rural communities. It will leverage dual-appointed hospital-college instructors to solve faculty gaps and invest in mobile simulation and training labs to deliver hands-on instruction. This initiative will be executed via a fund and coordinated effort at the Virginia Foundation for Community College Education Foundation (VCCS Foundation). Funding will be used to increase enrollment capacity of 2-year health programs, adding about 1,200 health graduates by 2031 and creating lasting capacity for expanded enrollment via upfront investment in equipment and partnerships. Additional details on projected incremental enrollment by degree program are included on page 27 of OSM.

The **Earn to Learn Programs** sub-initiative will fund provider-education partnerships to build apprenticeships for allied health specialties with the goal of bringing new talent to the healthcare field and upskilling existing workers requiring a combination of education and experience to advance. This will result in increased job placement into advanced allied health roles in participating rural facilities. DMAS will partner with Virginia Works, Virginia's workforce development agency, to administer employer-directed incentives to establish new healthcare Registered Apprenticeship programs with multiyear commitments to serve rural areas. Funding will also provide wraparound supports for participants, and early pipeline development through youth and pre-apprenticeship opportunities. Additional funding will be directed to rural intermediaries, including industry/sector regional partnership entities, to build regional ecosystems

that coordinate employer engagement, recruitment, and supportive services. This initiative will create 1,500 new Registered Apprentice slots in rural areas over 5 years, a 400% increase in Virginia's rural health apprenticeships today,

The **Build Career Pipelines** sub-initiative will fund the expansion of healthcare credential offerings at Career and Technical Education (CTE) centers for high-school students in rural areas across the Commonwealth. Currently, 25% of high school students enrolled in Health and Medical Sciences CTE are from rural counties.[35] There is a significant opportunity to expand the number of seats across rural CTE sites to provide critical healthcare credentials, with a focus on nurse aides (37% rural CTE enrollment), emergency medical technicians and responders (13% rural), pharmacy technicians (19%), radiologic technicians (0%), and pre-dental students (9%). VDOE will administer funding to rural CTE centers and school districts for upfront investments, such as technical assistance, equipment, and other upfront costs, to expand credentials and program capacity. Note that no funding will be used for construction of new CTE centers.

Table 18. Initiative Summary: Homegrown Health Heroes

Sub-Initiative Design	Uses of Funds	5Y Budget
Attract and Retain Physicians Fund ~80-100 residency slots across rural health systems in priority specialties, via VHREF. Activate rural clinical rotations, incl. FQHC, and retention requirements.	• Resident salary and benefits (including wraparound supports) for residency slots • Administrative costs required by health systems to implement residency slots	$52.8M
Allied Health Degrees Provide funding to VCCS Foundation to stand up 5+ mobile labs, upgrade colleges tech, and scale dual appointed faculty across community college system	• Hub and spoke tech upgrades at community colleges • Curriculum development and accreditation support • Time-limited personnel to facilitate program rollout • One-time purchases of equipment for mobile training labs • Rural marketing and recruitment • Technical assistance for program standup	$31.7M
Earn to Learn Programs Provide funding to Virginia Works to select employer led and college led ETL programs	• Incentives to providers to hire, train, and retain healthcare apprentices in partnership with educational institutions • Grants for wraparound supports such as childcare, transportation, and other participant needs • Funding to rural partners and community organizations for recruitment, outreach, and engagement of rural residents • Support for youth and pre-apprenticeship programs	$21.1M

Sub-Initiative Design	Uses of Funds	5Y Budget
	• Technical assistance for employers and education partners to design, launch, and sustain apprenticeship programs • Planning grants to develop platforms and processes for connecting job seekers with employers	
Build Career Pipelines Partner with VDOE to provide funding to rural regional CTE centers to expand capacity for existing healthcare credentials and add new credentials	• Equipment and supplies for lab and simulation build-outs, safety upgrades, etc. • Technical assistance for clinical placement coordination and development of curriculum • Startup costs to build curriculum, onboard faculty (until sustainability)	$26.4M

For the above sub-initiatives, which have trusted subrecipient partners designated to administer funding, DMAS will work with these designated entities to ensure funding is allocated via appropriate award processes, including competitive selection processes. Further detail on initiative-specific subaward criteria is included in the Budget Narrative.

Main Strategic Goal: Workforce Development

Uses of Funds: D, E, F, K

Technical Score Factors: C.1. D.1

Key Stakeholders:

Table 19. Initiative Specific Stakeholders: Homegrown Health Heroes

Sub-Initiative	Key Specific Stakeholders
Attract and retain physicians	Medical School Graduates, Health systems, VHREF
Allied Health degrees	VCCS Foundation, Community Colleges
Earn to Learn programs	Virginia Works, Health systems and community providers, education institutions
Build career pipelines	Virginia Dept. of Education, CTE centers, high schools

Table 20. Initiative Specific Metrics: Homegrown Health Heroes

Sub-Initiative	Metric	Data Source
Attract and retain physicians	Number of new residency slots filled per year	Subrecipient reporting
Attract and retain physicians	Physician to patient ratio in rural counties in fields targeted by sub-initiative	Virginia Healthcare Workforce Data Center
Allied Health degrees	Number of incremental accredited 2-year allied health graduates per year	Subrecipient reporting
Allied Health degrees	Allied health professional to patient ratio (measured **by county**)	Virginia Healthcare Workforce Data Center

Earn to Learn programs	Incremental number of apprenticeships placements in allied health fields	Subrecipient reporting
Build career pipelines	Incremental number of high school students earning industry-read healthcare credentials	Subrecipient reporting

Table 21. Impact of Initiative on Program Key Performance Objectives

Overall Program Key Performance Objective	Impact of this initiative on Key Performance Objectives
Increase access to primary care for rural residents including number of preventative visits and screenings	Expanding the healthcare workforce through the Attract and Retain Physicians, Allied Health Degrees, Earn to Learn, and Build Career Pipelines sub-initiatives will directly improve access to care at the program-level by, for example, increasing the availability of primary care providers for preventive visits and paramedics to reduce emergency utilization.
Build a lasting pipeline of rural residents into healthcare careers	Building a lasting pipeline of rural residents into healthcare careers is the core focus of the Homegrown Health Heroes initiative. Training rural residents increases the likelihood they will stay and practice locally, while the Rural Residency and Earn to Learn programs include five-year service commitments to strengthen this workforce. Residencies and allied health degrees will focus on high-need professions identified in the program key performance objectives, including primary care, OBGYNs, dental hygienists, nurses, and radiologic technicians.

Impacted Counties: All rural counties; Please see page 27 for applicable FIPS codes

Estimated Required Funding:

Table 22. Sub-initiative 5-year Budgets: Homegrown Health Heroes

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Attract and Retain Physicians	$10.5M	$14.2M	$17.7M	$7.1M	$3.5M	$52.8M
Allied health degrees	$6.3M	$7.4M	$7.9M	$5.3M	$4.8M	$31.7M
Earn to learn programs	$5.2M	$5.3M	$4.2M	$3.2M	$3.2M	$21.1M
Build career pipelines	$10.5M	$5.3M	$5.3M	$3.2M	$2.1M	$26.4M
Total	**$32.5M**	**$32.2M**	**$35.1M**	**$18.7M**	**$13.5M**	**$132.0M**

Connected Care, Closer to Home

Description: Access to care was one of the most frequently cited challenges in the listening sessions, qualitative research and quantitative data analysis. The goal of "Connected Care, Closer to Home" is to rewire how rural healthcare is delivered by bringing primary, urgent, specialty, SUD, dental, vision, and maternity care directly into rural communities. **Mobile and Hybrid Care** will expand access through mobile units for primary and preventative care and diagnostics, electronic interprofessional consults, telehealth kiosks, and "clinics in a box." **Community**

Paramedicine will fund pilots and startup costs to enable EMS to provide treat-in-place care, preventative visits for at-risk patients, and telehealth consults. **Innovative Maternal Care** tackles Virginia's maternal health deserts by expanding rural prenatal and postpartum services through community hubs, mobile units, and telehealth. It prioritizes mothers with substance use disorders, enhances remote monitoring, and supports rural hospitals to prevent L&D unit closures.

Mobile and Hybrid Care. Currently, rural Virginians often need to drive great distances to get care, especially preventative care, taking time off from jobs or missing school. This sub-initiative brings needed care directly into rural communities by funding the startup costs of mobile care units, telehealth kiosks and "clinics in a box," development of rural care centers to operate as "hubs" in hub-and-spoke models (e.g., urgent cares), and technology enablers for hub-and-spoke models, like provider-to-provider e-consults for specialty care. Funding will be disbursed for upfront physical infrastructure needs (e.g., vans, tele-imaging equipment, telehealth kiosks), required data infrastructure, technical assistance and training, and other start-up expenses. Innovative payment models, which may include capitation or shared risk models, will ensure sustainability of the programs moving forward.

Mobile clinics present a proven model to accelerate implementation and make a significant access difference to rural communities in a short timeframe, especially as broadband challenges limit access to telehealth. This initiative will include primary care, behavioral health/SUD, dental, vision, and others. In addition, there will be focused investment on specialty equipment required for mobile screenings. For example, mobile vans for primary care and diagnostics can bring care to patients through a rotating schedule in community spaces where individuals already spend time, such as grocery stores and schools. During a listening session in Danville, VA, community members highlighted a mobile clinic for sports physicals which enabled substantial enrollment in

middle and high school sports – so much so that four more middle and high school coaches were hired. This proves the potential of the mobile care model.

Additionally, remote care delivery sites, like telehealth kiosks and "clinics in a box," can be placed in community spaces, including in community pharmacies, enabling patient access to the requisite secure space and technology connect with their providers, particularly remote specialists. Innovative startups, like OnMed Care Stations, provide "clinic in a box" solutions which include equipment for scans, vitals, and other checks that would typically be conducted in a live visit, increasing the range and quality of care provided remotely.

The Commonwealth has already heard from several providers including Valley Health, Lifepoint, the University of Virginia (in conjunction with the Tri-Area Community Health FQHC), Ballad Health, and Chesapeake Regional that they are willing and ready to deploy mobile care units for primary and specialty diagnostic care. In addition, there is significant opportunity to expand dental care availability via mobile care (e.g., expansion of the Rockbridge Area Health Center's mobile dental clinics). Aetna has expressed interest in expanding proven provider-to-provider eConsult models across Virginia, and the Upper Mattaponi Tribe has a potential plan to integrate behavioral health and substance use treatment services into primary care settings.

Virginia plans to run a competitive process in the first year of this grant to select strong projects to provide coverage across a range of rural geographies and specialties. Further detail is provided in the implementation and sustainability plans. The Commonwealth will partner with local healthcare providers and an actuarial firm in the final 2 years of the grant to enable ongoing value-based payment models via technical assistance and data/tech infrastructure funding.

Community Paramedicine. This sub-initiative focuses on expanding the role of EMS to preventative services and 'treat-in-place' visits to mitigate avoidable ED visits and provide rural

patients with more timely preventative treatment. Currently, EMS providers in Virginia are only paid if a patient is transported to a hospital – there is no incentive (or ability) to treat-in-place for preventive or low-acuity health needs. Through this sub-initiative, Virginia will explore options to implement a payment model that builds on ET3 (Emergency Triage, Treat, and Transport) models that have been successful in other states to enable EMS as billing providers for non-transport services. EMS professionals will be able to practice to the full scope of their licenses and will be supported by tele-presence consultations with specialists facilitating remote care, reducing overall costs to the system by reducing unnecessary ED visits. Funded subawards will cover the tech infrastructure and equipment for screenings, telehealth, and tele-presence communication, as well as related training for EMTs and paramedics. This sub-initiative will only fund those costs that are not currently reimbursable via other sources, such as Medicare and Medicaid.

As part of this sub-initiative, Virginia plans to award fully funded pilots via three EMS Councils for two years in close partnership with VDH's Office of EMS, followed by state-wide expansion and development of self-sustaining payment models in years 3-5.

Innovative Maternal Care. The Innovative Maternal Care sub-initiative directly addresses maternal health care deserts in the Commonwealth, including the 60+% of rural counties without an OBGYN. While available to all rural pregnant women, this program will have a special focus on supporting expectant mothers who have struggled with substance use, to reduce the very high rates of neonatal abstinence syndrome currently found in rural Virginia. This sub-initiative will connect pregnant and postpartum women with community maternal health hubs and mobile units for pre- and postnatal care (building on existing successful programs), as well as education, support, and resource navigation. Funding will be allocated for technology for remote patient monitoring, as well as tele-presence for high-risks births, so that women can safely give birth at a

rural hospital with an L&D unit while enabling tele-consults with off-site specialists. Lastly, funds will be deployed for technical assistance to work with maternal health providers on innovative solutions, including new payment models, to solve the crisis of rural L&D unit closures.

Example solutions include fostering new partnerships between Maternal-Fetal Medicine specialists and local providers, establishing birthing centers in maternity deserts, and introducing innovative technologies to triage high vs. low-risk pregnancies to the best suited providers. Many Virginia organizations are well-positioned to provide innovative maternal care, including VCU Health and Urban Baby Beginnings (UBB). The Virginia Health Care Foundation (VHCF) has also proposed expansion of substance treatment services for expectant mothers. Each interested organization will be evaluated as part of the competitive initiative implementation process.

Table 23. Initiative Summary: Connected Care, Closer to Home

Sub-Initiative Design	Uses of Funds	5Y Budget
Mobile and Hybrid Care Grants to rural healthcare providers to fund purchase and build out of mobile care units, telehealth kiosks, "clinics in a box", e-consults, and development of "hubs". Providers would leverage a "hub and spoke" model to provide community-based care while enabling connection to larger facilities and specialists.	• Equipment (e.g., vans for mobile units, screening equipment, basic diagnostic equipment) • Initial time-limited personnel costs • Data infrastructure needed for mobile units, telehealth kiosks, etc. • Minor renovations to existing buildings • Technical assistance for development of care models and value-based payment models • Training for physicians and clinical staff	$264.0M
Community Paramedicine Grants to EMS Councils to support local EMS in training, staffing, and equipping to expand scope of services to include those not currently reimbursable via other means, such as in-home preventative care to high-risk community members and treat-in-place services to prevent unnecessary ED visits and provide high quality on-site care.	• Reimbursement of services provided not currently reimbursable (treat in place) • Training for EMTs and paramedics in preventative screenings, telehealth, and tele-presence • Tech infrastructure and equipment for screenings, telehealth & tele-presence communication • Technical assistance for new services • Technical assistance for payment model implementation	$84.7M
Innovative Maternal Care Grants to collaboratives of maternal and family medicine practices, community-based organizations, and health systems to support an array of pre-natal, L&D, and postpartum care in rural communities.	• Equipment, technology, and IT infrastructure for maternal health providers • Technical assistance for providers to utilize remote patient monitoring and tele-presence • Technical assistance in sustainability to fund go-forward costs into operating budgets and expenses	$63.4M

Sub-Initiative Design	Uses of Funds	5Y Budget
	• Technical assistance for development of creative L&D closure solutions (as allowable by CMS)	

DMAS plans to run competitive selection processes for all subawards within this initiative.

Further detail on initiative-specific subaward criteria is included in the Budget Narrative.

Main Strategic Goal: Sustainable Access

Uses of Funds: A, B, C, D, F, G, H, I, J, K

Technical Score Factors: B.1., C.1, C.2, E.1, F.1

Key Stakeholders:

Table 24. Initiative Specific Stakeholders: Connected Care Closer to Home

Sub-Initiative	Key Specific Stakeholders
Mobile and Hybrid Care	Health care providers, community areas that will serve as homes to mobile units, kiosks, "clinics in a box", etc., mobile health technology companies
Community Paramedicine	EMS councils & agencies, health systems, mobile health technology companies
Innovative Maternal Care	Health systems, maternal and family medicine providers, L&D units in rural hospitals, maternal health technology companies

Table 25. Initiative Specific Metrics: Connected Care, Closer to Home

Sub-Initiative	Metric	Data Source
Mobile and Hybrid Care	Number of rural Virginians on Medicaid w/ an annual wellness visit per 1k population	All Payers Database
Mobile and Hybrid Care	Number of incremental patients served by mobile and hybrid care programs **per county**	Subrecipient reporting
Community Paramedicine	Number of rural Virginians receiving regular preventative visits from community paramedicine	Subrecipient reporting
Community Paramedicine	Rate of avoidable ED admissions by rural Virginians on Medicaid	DMAS clinical efficiencies data, All Payers Database
Innovative Maternal Care	HEDIS measure PPC: Timeliness of prenatal care and completion of postpartum care	HEDIS; NCQA as data steward
Innovative Maternal Care	Rate of postpartum hospital readmissions in rural Virginians on Medicaid	All Payers Database

Table 26. Impact of Initiative on Program Key Performance Objectives

Overall Program Key Performance Objective	Impact of this initiative on Key Performance Objectives
Increase access to primary care for rural residents including	The Mobile and Hybrid Care and Community Paramedicine initiatives focus on increasing preventive and wellness visits for rural Virginians while

Overall Program Key Performance Objective	Impact of this initiative on Key Performance Objectives
number of preventative visits and screenings	reducing emergency department use, with initiative-level metrics ensuring accountable use of funding to achieve these program-level objectives.
Decrease rates of substance use disorders	The Mobile and Hybrid Care and Community Paramedicine initiatives will also expand preventive visits to support behavioral health and monitor individuals at risk for substance use. In addition, Innovative Maternal Care will focus on treating SUD to reduce neonatal abstinence syndrome.
Improve maternal and infant health outcomes by reducing maternal and infant mortality, as well as neonatal abstinence syndrome in rural communities	Innovative Maternal Care metrics directly align with program-level goals to increase the percentage of women receiving timely prenatal and postpartum care and to reduce hospital readmissions. Initiative-level metrics focus on the quality and effectiveness of programs deployed to improve maternal health outcomes statewide.

Impacted Counties: All rural counties; Please see page 27 for applicable FIPS codes

Estimated Required Funding:

Table 27. Sub-initiative 5-year Budgets: Connected Care Closer to Home

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Mobile and Hybrid Care	$67.7M	$53.6M	$46.6M	$44.5M	$51.6M	$264.0M
Community Paramedicine	$5.2M	$26.5M	$26.5M	$15.9M	$10.6M	$84.7M
Innovative Maternal Care	$13.0M	$14.5M	$13.2M	$10.7M	$11.9M	$63.4M
Total	**$85.9M**	**$94.6M**	**$86.3M**	**$71.1M**	**$74.1M**	**$412.0M**

Live Well, Together Initiative

Description: The "Live Well, Together" initiative focuses on preventing chronic disease through community-based whole-health sub-initiatives. **Food as Medicine** funds the infrastructure and start-up costs for food pharmacy programs. **Consumer Tech** funds pilots to test and scale digital health solutions to empower individuals to make sustainable lifestyle and behavioral changes. **Active Kids** funds minor renovations and repurposing of existing community spaces to include multi-use spaces for structured physical activity programs. **Integrated Care for Duals** promotes community-based engagement and education for dual-eligible seniors to learn about, compare, and connect with integrated care plan options.

Food as Medicine addresses root causes of poor health by improving access to nutritious food and education. It offers medically tailored meals and "produce prescriptions" for food-

insecure patients with or at risk of chronic disease. Health systems and rural providers will lead projects in partnership with CBOs, ensuring sustainability through clinically integrated food provision, nutrition education, and disease self-management support. This will strengthen health literacy, support behavior change, and help break the generational cycle of poor health in rural communities. Funding will cover infrastructure, distribution networks, and technology for patient tracking, with options to partner with digital health firms like RxDiet for remote support.

Virginia will launch pilot projects through a competitive RFP to test and scale effective models. Strong interest has emerged from Carilion Clinic, Valley Health, Riverside Health, Bon Secours Mercy Health, the Federation of Virginia Food Banks, and Area Agencies on Aging. Existing pilots from Anthem and UnitedHealthcare show success connecting high-risk patients with dietitians and tailored meal programs—laying groundwork for scale via MCO "in lieu of services" mechanisms.

To sustain programs, the Commonwealth will enhance data connectivity across hospitals, health systems, and rural providers for coordinated care and future reimbursement under alternative payment models. While food procurement won't be funded directly, it will be supported through hospital, CBO, and private partnerships. Food as Medicine will also integrate into broader payment reform under RHTP, potentially within capitated or shared-risk primary care models. DMAS will work with partners and actuaries to develop effective reimbursement approaches informed by pilot results.

Consumer Tech for Education and Lifestyle Change is a complementary sub-initiative that will focus on deploying consumer-facing digital health tools that empower individuals to make sustainable lifestyle and behavioral changes. Technologies in scope include mobile and web-based applications, wearable devices, and digital engagement platforms that promote healthy behaviors

such as increased physical activity, improved nutrition, stress management, and medication adherence. DMAS will run a competitive RFP to collect program model designs from health systems, providers (including FQHCs, RHCs, free clinics and federally recognized Tribes), and digital health and consumer technology companies. DMAS will select a technical assistance partner to help support evaluation of technologies proposed and guiding strong programs to best-in-class technologies. Use cases for consumer tech projects may include:

Table 28. Potential use cases for consumer tech projects

Use case	Description
Chronic disease self-management	Tools that enable patients with conditions such as diabetes to remotely follow care plans using wearable monitors and integrated digital coaching apps.
Care navigation	Platforms (e.g., Thrive Health) that connect patients to community resources, social supports, and health education to strengthen care coordination and self-management.
Nutrition and weight loss management	Apps that promote healthy behavior change by tracking diet, weight, and activity levels, with personalized goal setting and visual progress dashboards.
Digital health literacy and coaching	Gamified tools and digital nudges (e.g., *EdLogics*, a Virginia-based program) that motivate users through rewards, challenges and interactive education to build health knowledge and engagement.

Projects will also test the impact of behavioral incentives (e.g., rewards, reminders, or virtual coaching) on sustained engagement and long-term health outcomes. Additionally, similar to the Food as Medicine sub-initiative, the Commonwealth will work with local healthcare providers, vendors, and an actuarial firm to leverage pilot data and success to build consumer technology programs into innovative payment models that enable ongoing rural access.

Active Kids will fund rural communities, local governments, and CBOs to expand access to safe, engaging spaces and programs that promote physical activity for children and youth. Research shows people with nearby parks or recreation facilities exercise 38% more than those without easy access.[36]. Funding will support minor renovations or repurposing of spaces, such as school gyms, recreation centers, and libraries, into multi-use areas for sports, fitness classes, and

wellness education. These projects will revitalize underused spaces, foster lifelong fitness habits, and encourage kids and families to engage in active play and disconnect from screens.

The sub-initiative complements the President's Physical Fitness Test by building local infrastructure that supports a culture of movement and athletic excellence. It also advances Governor Youngkin's Reclaiming Childhood Initiative, focused on reducing screen time, improving mental health, and promoting healthy lifestyles. Together, these efforts will strengthen community health, prevent chronic disease, reduce childhood obesity, and make physical activity more accessible and affordable for rural families. New construction will not be funded via this initiative, and all minor renovation will be compliant with CMS allowable uses of funds.

Integrated Care for Duals focuses on seniors in rural areas who are eligible for both Medicare and Medicaid. Virginia is already a leader in enrolling individuals who are dually eligible into integrated plans – the Commonwealth is one of thirteen states with dual eligibles enrolled in Fully-Integrated D-SNPs[37]. However, there is an opportunity to drive further progress, especially given the complexity of policy and plans for dually eligible enrollees. Integrated plans are intended to provide high-quality, coordinated care, while reducing duplication, fragmentation, and administrative burden on the low-income seniors that comprise many dually eligible individuals.

This sub-initiative will develop a platform with user-friendly, multilingual educational modules explaining Medicaid and Medicare coverage, eligibility, and enrollment processes, and have tools to compare plan options. Individuals will be able to indicate their plan of interest and securely submit contact information, enabling selected plans to conduct direct outreach to complete enrollment. Local Area Agencies on Aging (AAAs) and other organizations focused on the aging population will deploy existing staffing resources into homes and community spaces

(e.g., places of worship, grocery stores, rec centers) equipped with a tablet with the platform on it.

These resources will help the senior population utilize the platform and understand their options.

Table 29. Initiative Summary: Live Well Together

Sub-Initiative	Uses of Funds	5Y Budget
Food as Medicine Food pharmacy pilots offering produce, nutrition counseling, and medically tailored meals for food insecure patients with or at risk of chronic disease or recently discharged from the hospital.	• Infrastructure and start-up costs to establish food pharmacies • Coordination with CBOs and providers including training, technical assistance, and technology • Nutritional counseling and education services (currently non-reimbursable costs only) • Technical assistance for operationalizing sustainability • Technical assistance and planning grants for alt. payment models • EHR and data system integration • Digital health technology partnerships • Contracting with an actuary or data analytics partner to analyze pilot data and estimate expected savings and financial impact to explore alternative payment models and reimbursement pathways • Partner enablement support to build necessary data, claims tracking and reporting capabilities if alternative payment models / reimbursement pathways established	$26.4M

Consumer Tech for Education and Lifestyle Changes
Pilot integrated chronic disease management programs to scale approaches to monitor and support high needs patients with chronic disease mgmt.
Include and evaluation behavioral incentives, such as rewards and gamification structures, to sustain engagement and drive lifestyle change
	• Procurement of consumer-facing health apps, wearables, and digital engagement platforms, including licenses or subscriptions covered for up to two years to support program stand-up
	• Integration of technology with existing provider systems (e.g., referral networks, care management systems) to support data sharing and program tracking
	• Technical assistance for rural providers and community partners to:
	  ○ Understand digital offerings, select consumer health tech vendors
	  ○ Support patient onboarding and digital health literacy
	  ○ Incorporate and maintain consumer health tech expenses into ongoing operating costs after 5-year RHTP funding is complete
	  ○ Explore alternative payment models and reimbursement avenues for adopted solutions
	• Program coordination and partnership development among providers, CBOs and technology vendors
		$74.0M

Active Kids Fund minor renovation and repurposing of community spaces into recreational spaces for structured physical activity programs, sports, and wellness education.	• Minor renovation or upgrades to existing recreation centers or community spaces or repurposing of underutilized spaces (e.g., schools, community halls) into areas suitable for physical activity • Purchase of sports, exercise, and recreation equipment to support youth and family fitness programs • Development and delivery of structured youth programs (e.g., after-school sports, dance, martial arts or movement-based classes) • Health and fitness education focused on helping children and families understand the importance of activity and healthy routines • Staffing for instructors, coaches, and recreation coordinators in first two years to support stand-up • Partnerships and community outreach activities to sustain youth participation and family involvement	$13.2M

Sub-Initiative	Uses of Funds	5Y Budget
	• Technical assistance to support local governments, parks and recreation departments, schools and CBOs to integrate ongoing program costs into operating budgets	
Integrated Care for Duals Provide community-based education and engagement to support dual-eligible seniors in navigation of health care coverage and enrollment in integrated care plans.	• Development and deployment of supporting technology • Training for Area Agencies on Aging (AAA) and community staff • Technical assistance for AAAs and other community navigators to understand integrated care plan options and enrollment processes	$10.6M

DMAS plans to run competitive selection processes for all subawards within this initiative.

Further detail on initiative-specific subaward criteria is included in the Budget Narrative.

Main Strategic Goal: Make Rural America Healthy Again

Uses of Funds: A, B, C, D, F, G, I,

Technical Score Factors: B.1, B.2, C.1, E.1, E.2, F.1, F.3

Key Stakeholders:

Table 30. Initiative Specific Stakeholders: Live Well Together

Sub-Initiative	Key Specific Stakeholders
Food as Medicine	Health systems and other rural providers, such as FQHCs, RHCs and free clinics, in partnership with CBOs (e.g., Federation of Virginia Food Banks)
Consumer Tech	Partnerships including digital and technology companies, health systems, CBOs, FQHCs, RHCs, free clinics, other rural primary care / specialty providers
Active Kids	Local governments, schools, parks and recreation departments, and community-based organizations, innovative sports / rec programming partners
Integrated Care for Duals	Area Agencies on Aging (AAAs), managed care plans, DMAS, community-based organizations, and mobile care providers

Across all sub-initiatives, participating community members, advocacy organizations, Tribes, and provider organizations are important stakeholders to provide ongoing input in support of the success of this work. Further detail on ongoing stakeholder engagement efforts is included in the Section “Stakeholder Engagement.”

Table 31. Initiative Specific Metrics: Live Well Together

Sub-Initiative	Metric	Data Source [if available]
Food as Medicine	Number of incremental patients **by county** enrolled in food prescription or medically tailored meal services	Subrecipient reporting
Food as Medicine	Change in average HbA1c level (for participants with diabetes) or change in blood pressure (for participants with hypertension) after "Food as medicine" participation	Subrecipient reporting (via EHR analysis)
Consumer Tech	Number of participants **by county** onboarded to consumer digital health platforms and receiving engagement support (e.g., coaching, reminders, or gamified prompts)	Subrecipient reporting
Consumer Tech	% of participants actively engaging with digital health tools after 6 months of enrollment	Participant survey or tool reporting
Consumer Tech	% of participants reporting improved digital literacy and confidence in managing their health or symptoms	Participant survey or tool reporting
Active Kids	% of youth participants in target areas engaged in regular physical activity or organized sports programs	Subrecipient reporting
Integrated Care for Duals	% of dual-eligible population enrolled in integrated care plans	DMAS enrollment data
Integrated Care for Duals	Number of Area Agencies on Aging (or similar) utilizing education / navigation platform	Subrecipient reporting

Table 32. Impact of Initiative on Program Key Performance Objectives

Overall Program Key Performance Objective	Impact of this initiative on Key Performance Objectives
Decrease rates of chronic disease in rural adults and children	Food as Medicine, Consumer Tech for Education and Lifestyle Change, and Active Kids directly support chronic disease prevention and management by improving nutrition, promoting healthy lifestyle behaviors, and increasing health literacy. Initiative metrics ensure accountability for deploying funds effectively to support projects achieving these outcomes.
Increase access to primary care for rural residents including number of preventative visits and screenings	Consumer Tech for Education and Lifestyle Change and Integrated Care for Duals improve care navigation and help rural residents connect to needed services. Metrics assess whether rural patients are receiving these services and how confident and empowered they feel in accessing available care.

Impacted Counties: All rural counties; Please see page 27 for applicable FIPS codes

Estimated Required Funding:

Table 33. Sub-initiative 5-Year Budgets: Live Well Together

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Food as Medicine	$2.6M	$6.0M	$6.0M	$6.0M	$6.0M	$26.4M
Consumer Tech	$10.5M	$10.6M	$10.6M	$21.2M	$21.2M	$74.0M
Active Kids	$1.3M	$3.0M	$3.0M	$3.0M	$3.0M	$13.2M

Integrated Care for Duals	$2.1M	$2.1M	$2.1M	$2.1M	$2.1M	$10.6M
Total	**$16.5M**	**$21.7M**	**$21.6M**	**$32.2M**	**$32.2M**	**$124.2M**

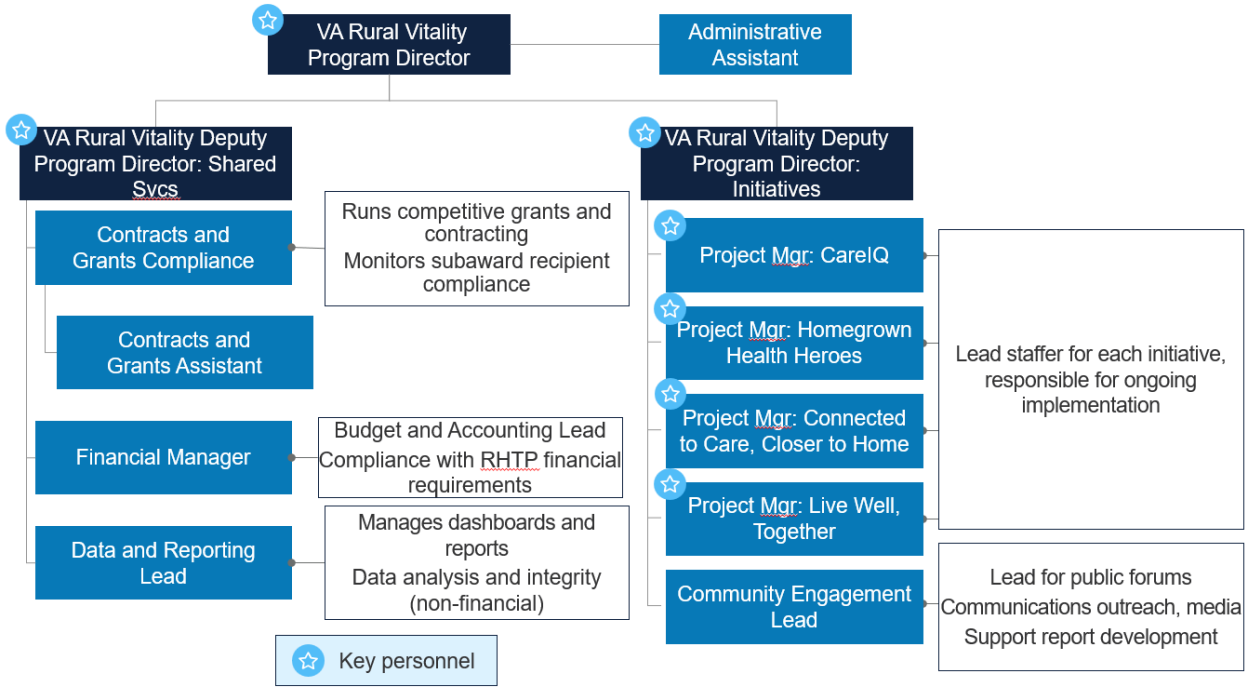
The year-over-year funding distribution model reflects up front planning costs, initial implementation, pilot expansions, and movement toward long-term sustainability. Further detail on the required funding, cost breakdown, and justification is available in the Budget Narrative section of this application.

Implementation Plan and Timeline

Governance and Program Management

To effectively implement these transformational rural health efforts, the Commonwealth proposes a governance and management structure that includes a Core Team at DMAS and an Interagency Steering Committee. Virginia will track progress, share lessons learned, and support stakeholder engagement through Initiative Learning Consortiums and Regional Advisory Committees. The governance and program management structure will apply to all initiatives.

Figure 6. VA Rural Vitality Core Team Structure



The VA Rural Vitality Core Team will be an Office in DMAS with thirteen new full-time employees (FTEs). Senior roles will be hired as soon as possible following award. Remaining positions are anticipated to be hired by March, 2026. The Core team will have contract support to ensure rigorous implementation, evaluation, and program integrity.

The Core Team is overseen by a Program Director and two Deputy Directors, who are key personnel. The Program Director is the overarching point of accountability. Virginia anticipates four project managers, one for each initiative, who will be the key personnel to oversee the subawards and have responsibility for the programmatic implementation, as well as a community engagement lead, given the importance of collaborating with rural communities. Virginia also envisions 4 FTE with a shared services focus, who will oversee contracts and grants compliance, financial management, data, and reporting. DMAS aims to hire all core team FTE in the first quarter of 2026. In addition, Virginia anticipates three supporting contracts: implementation support, program integrity, and evaluation. Implementation support contractor(s) will provide critical support in the early period of the grant award, ensuring that RFPs are developed and programs can be launched as close to Jan 1, 2026 as possible, even as the full DMAS team is being onboarded. In the later years, contractor(s) will ramp down to a level where it will complement the work of the Core team as required, in areas which may include strategic advisory services and project management support. The program integrity contractor will focus on compliance, early risk identification and mitigation, and audit support. The evaluation contractor, detailed on Page 58, will support gathering and analysis of performance metrics, assessing lessons learned, and overall program impact.

An **VA Rural Vitality Steering Committee** will lead interagency governance. The proposed members of the Steering Committee are the Secretary of HHR (Governor's

representative), DMAS Director, VDH Commissioner, VDH Office of Rural Health Director, Department of Health Professions (DHP) Director, and the RHTP Program Director. This group will meet no less frequently than quarterly and provide strategic direction, review and approve major decisions, and monitor program progress and ensure accountability for milestones.

Table 34. RHTP engagement plan for Viginia agencies

Entity type	Virginia-specific entity	RHTP engagement plan
State health agency or department of health	VDH	• Integrated into VA Rural Vitality Steering Committee
State Medicaid agency	DMAS	• Leading RHTP grant program
State office of rural health	VDH Office of Health Equity, Rural Health Office	• Integrated into VA Rural Vitality Steering Committee
State tribal affairs office or tribal liaison, as applicable	Tribal Ombudsman	• Actively engaged in Regional Update and Listening Sessions
Indian health care providers, as applicable		• Actively engaged in Regional Update and Listening Sessions (see Page 56 below)

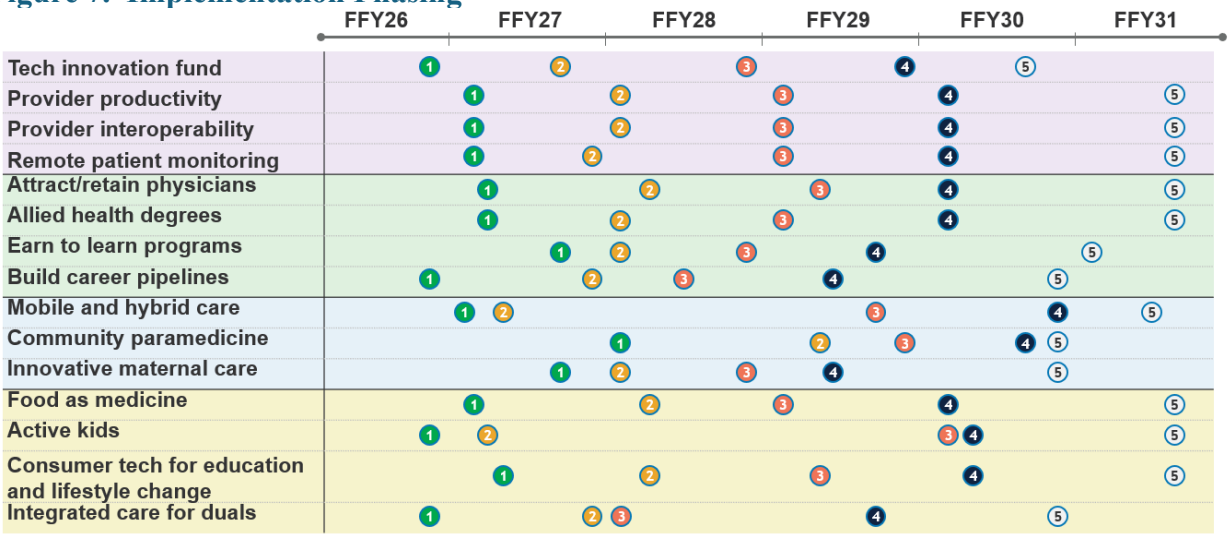
Implementation Approach

The Commonwealth recognizes the need to balance thoughtful planning and timely program implementation. Virginia developed its implementation approach with three principles for initiative phasing, outlined below in Table 35 and Figure 7. These principles are also reflected in the timelines below, which are designed to adhere to the funding award schedule outlined in the NOFO. In addition to the implementation plans detailed below, DMAS will also be hiring the VA Rural Vitality Core Team Project Managers for each initiative by March 2026 to oversee this work. As it relates to the Policy factors, Virginia does not have any additional legislative or regulatory actions planned.

Table 35. Implementation approach principles

Prioritize readiness	Fund and launch programs in Year One that are well-defined, ready to implementation and foundational to future initiatives
Plan for design	Build in time for programs that need additional development or coordination before launch
Start early, show results	Initiate all initiatives early enough to demonstrate measurable progress within five years

Figure 7. Implementation Phasing



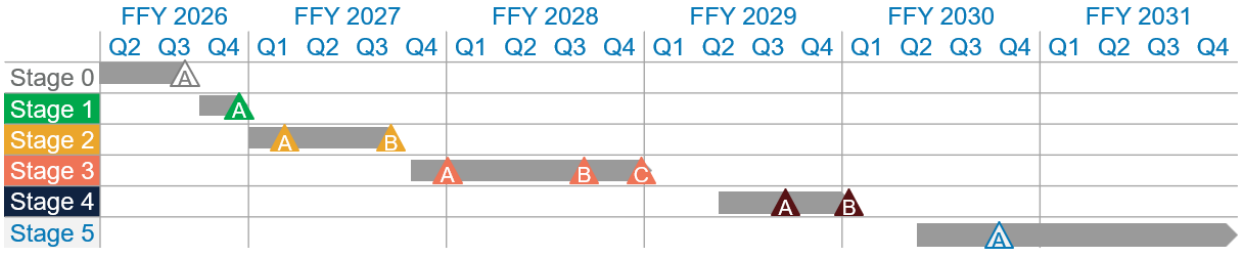
Note: Program evaluation and support of existing sub-award organizations may continue to take place after stage 5 milestones until end of 2031

Key Milestones and Target Dates

Virginia has developed implementation plans for each initiative, aligned to project stages referenced in the NOFO. The GANTT charts below show the key milestones of when planning will be conducted, when subrecipient selection will be determined and funding deployed, and when programs shift to sustainability for each sub-initiative. Virginia has developed thoughtful operating frameworks, along with feasible implementation milestones for each component of the grant – more detail for each can be found in OSM.

CareIQ – Key Milestones and Target Dates

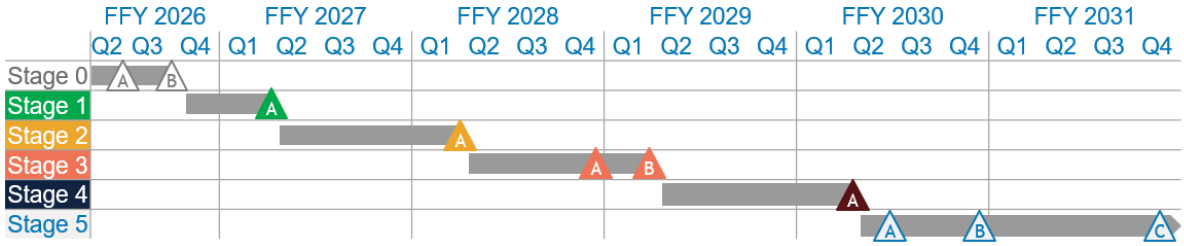
Figure 8. Tech Innovation Fund Implementation



Milestones

- A Finalize program design and formalize VIPC partnership
- A Launch first funding round
- A Award first round of innovation grants; execute agreements
- B Launch second funding round
- A Award second round of grants; evaluate initial progress
- B Launch third funding round
- C Award third round of grants; initiate impact evaluation
- A Launch fourth funding round
- B Award fourth round of grants; mid-program analysis
- A Launch fifth funding round; develop long-term strategy

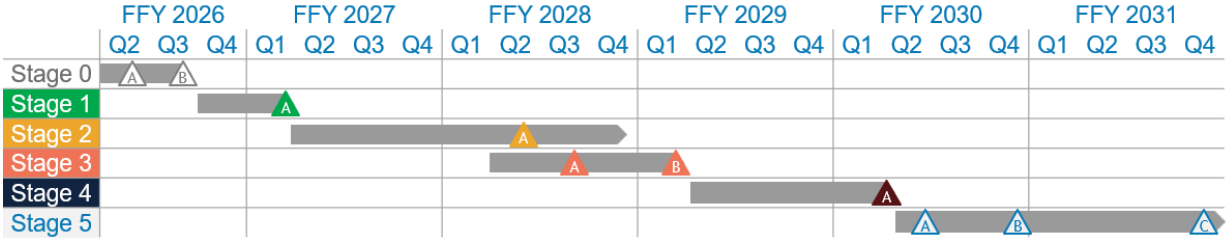
Figure 9. Provider Productivity Implementation



Milestones

- A Develop detailed program design
- B VCHF to run competitive RFP process to select sites
- A Provide tech assistance to chosen sites
- A Launch productivity tools and continue tech assistance
- A Run RFP / launch productivity tools in second round of sites
- B Mid-program report on KPIs
- A Run RFP / launch productivity tools in third round of sites
- A Run RFP / launch productivity tools in fourth round of sites
- B Absorb maintenance costs into operating budgets
- C Final report on key outcomes and sustainability

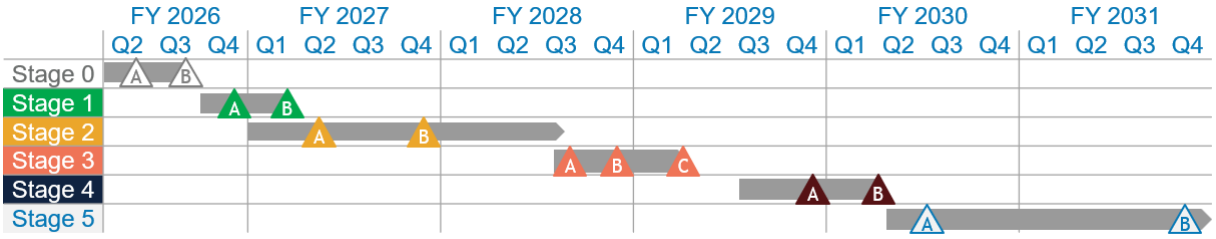
Figure 10. Provider Interoperability Implementation



Milestones

- A Develop detailed program design
- B VCHF to run competitive RFP process to select sites
- A Provide tech assistance to chosen sites
- A Launch EHR and cybersec. updates in initial sites
- A Run RFP / launch updates in second round of sites
- B Mid-program report on KPIs
- A Run RFP / launch updates in third round of sites
- A Run RFP / launch updates in fourth round of sites
- B Absorb maintenance costs into operating budgets
- C Final report on key outcomes and sustainability

Figure 11. Remote Patient Monitoring Implementation

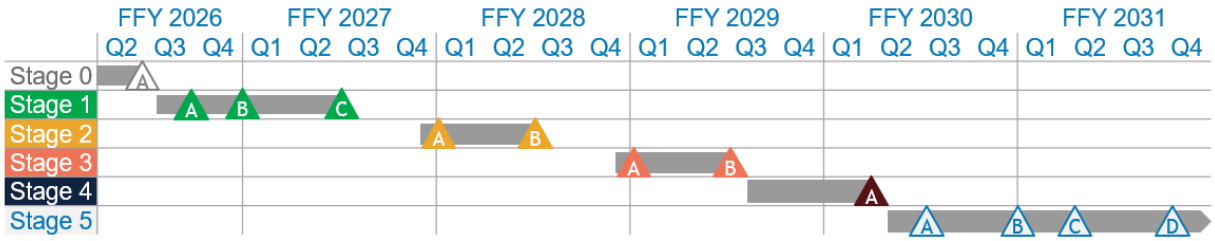


Milestones

- A Develop detailed program design
- B Run competitive RFP process to select sites
- A Finalize operating/funding model at pilot sites
- B Support pilot sites with tech assistance, vendor selection
- A Launch initial pilot sites and begin patient onboarding
- B Conduct early performance monitoring and collect data
- A Launch additional pilot programs
- B Evaluate pilot performance and ID best products/strategies
- C Adjust operating model based on results
- A Scale pilots and launch additional programs
- B Finalize sustainability plan, explore alt. payment models
- A Continue scaling and supporting mature programs
- B Final report on key outcomes and sustainability approach

Homegrown Health Heroes – Key Milestones and Target Dates

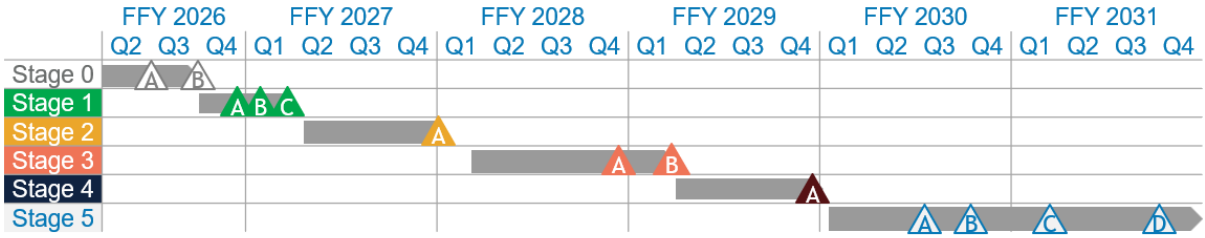
Figure 12. Attract and Retain Physicians Implementation



Milestones

- A Finalize program design and formalize VHHA partnership
- A Develop funding framework and launch application
- B Award first round residency slot funding (50 incremental residences)
- C Provide tech assistance and oversight
- A Award second round residency slot funding (17 incremental residences, 50 existing)
- B Provide tech assistance and oversight
- A Award third round residency slot funding (16 incremental residencies, 67 existing)
- B Provide tech assistance and oversight
- A Evaluate residency program outcomes and ID adjustments
- A Develop innovative payment/incentive models
- B Pilot/refine sustainability strategies across health systems
- C Finalize sustainability and policy recommendations
- D Transition oversight and funding to sustainable sources

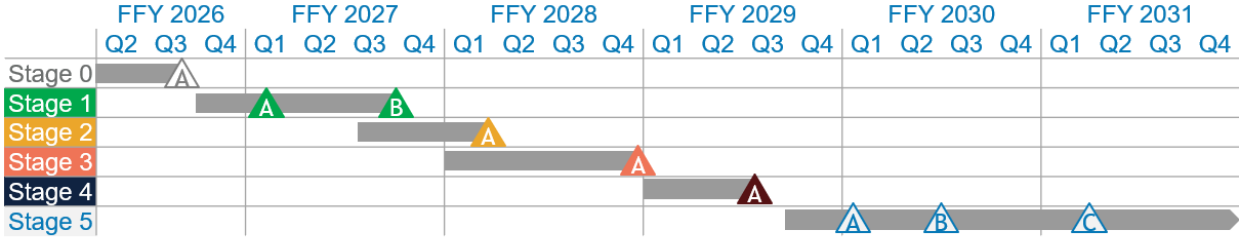
Figure 13. Allied Health Degrees Implementation



Milestones

- A — Finalize program design and formalize VCCS partnership
- B — Develop application and select initial comm. coll. sites
- A — Deploy funding to selected colleges
- B — Begin hiring and program rollout in priority regions
- C — Enrollment of 60 incremental allied health professionals
- A — Enrollment of 60 incremental allied health professionals
- A — Enrollment of 120 incremental allied health professionals
- B — Evaluate progress, refine rural recruitment strategies
- A — Enrollment of 120 incremental allied health professionals
- A — Enrollment of 120 incremental allied health professionals
- B — Begin development of sustainability framework
- C — Pilot long-term sustainability and funding approaches
- C — Finalize sustainability framework

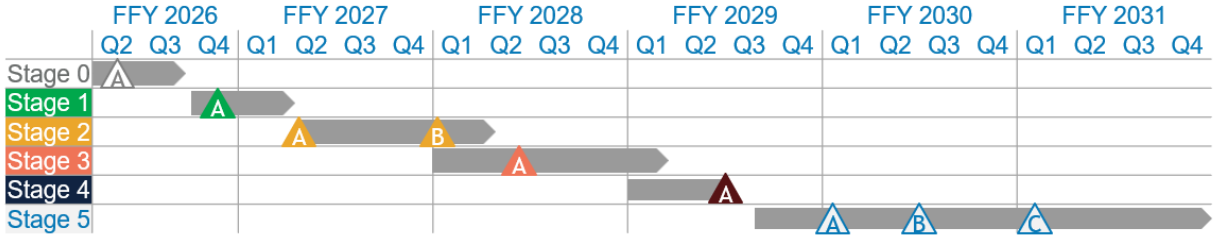
Figure 14. Earn to Learn Program Implementation



Milestones

- A — Finalize program design and formalize VA Works partnership
- A — Develop competitive RFP for apprenticeship programs
- B — Award grants to selected partners; initiate project planning
- A — Launch initial apprenticeship programs
- A — Expand to add'l allied health specialties/regions
- A — Evaluate progress on outcomes and success
- A — Begin development of sustainability framework
- B — Pilot enhanced connection platforms; refine pathways
- C — Finalize sustainability framework

Figure 15. Build Career Pipelines

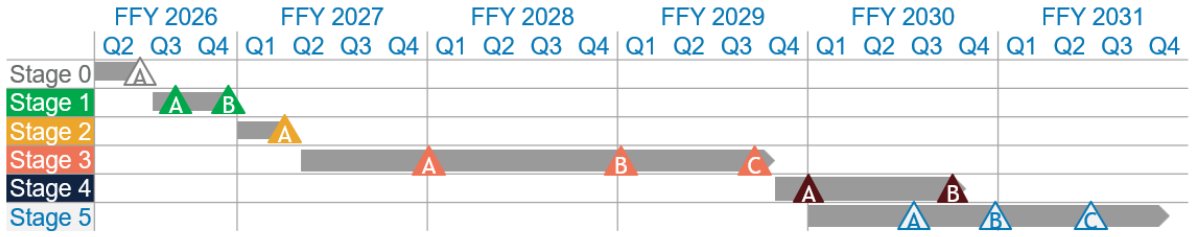


Milestones

- A — Finalize program design and formalize VDOE partnership
- A — Launch competitive funding application for CTE centers
- A — Award grants; initiate project planning
- B — Initiate process of expanding capacity incl. building out labs, procuring equipment, recruiting faculty and staff
- A — Launch first programs; begin student enrollment
- A — Evaluate pilot program efficacy
- A — Begin development of sustainability framework
- B — Expand successful pilots to new regions; refine supports
- C — Finalize sustainability framework

Connected Care, Closer to Home – Key Milestones and Target Dates

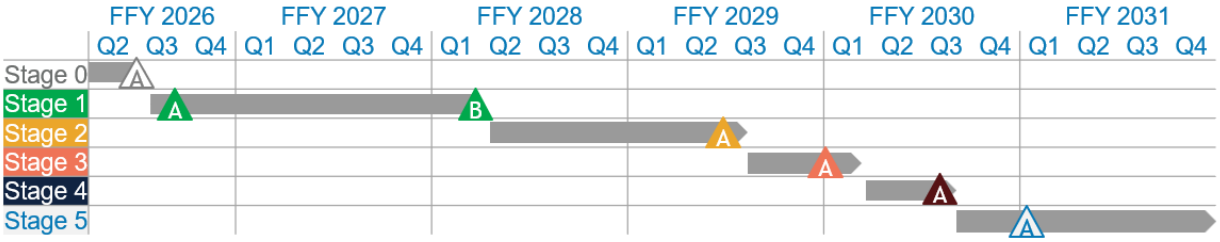
Figure 16. Mobile and Hybrid Care Implementation



Milestones

- A: Establish governance and implementation framework
- A: Release competitive RFP for sub-grantees
- B: Award first round of sub-grants and begin start-up
- A: Deploy initial mobile units and infrastructure
- A: Run additional RFP / deploy second round of mobile units
- B: Run additional RFP / deploy third round of mobile units
- C: Run additional RFP / deploy third round of mobile units
- A: Evaluate operational outcomes and ID sustainability strategy
- B: Run additional RFP / deploy third round of mobile units
- A: Begin design of innovative payment with partners
- B: Launch and refine innovative payment arrangements
- C: Finalize payment model and integration plans

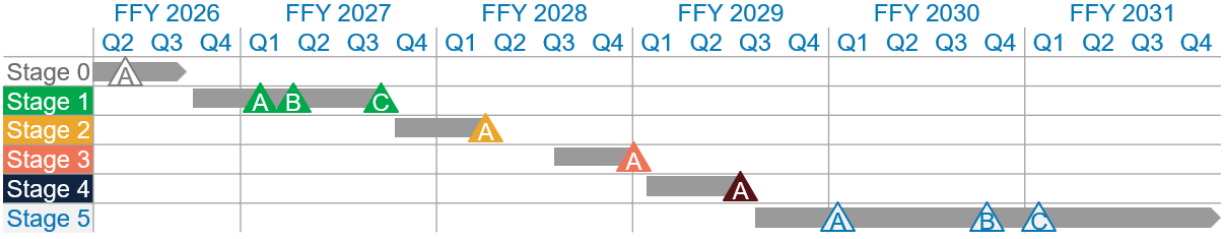
Figure 17. Community Paramedicine Implementation



Milestones

- A: Establish governance and develop RFP framework
- A: Select EMS agencies for participation
- B: Onboard pilot EMS agencies and prepare implementation
- A: Launch and operate pilots in selected agencies
- A: Evaluate pilot outcomes; develop statewide expansion framework
- A: Begin design of innovative funding models
- A: Go live with innovative funding models

Figure 18. Innovative Maternal Care Implementation

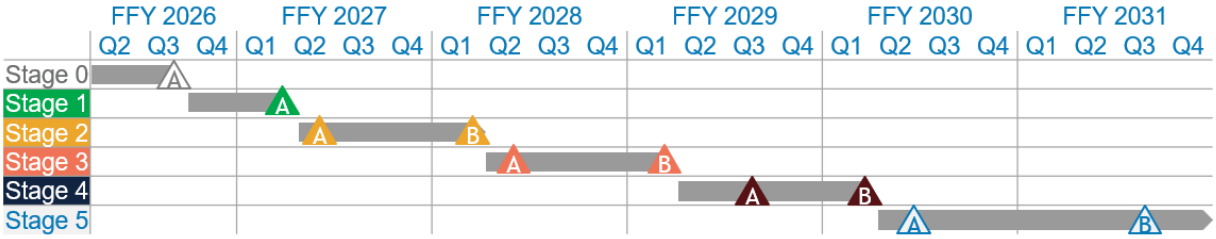


Milestones

- A: Finalize program design, release competitive RFP
- A: Select awardees and execute sub-grant agreements
- B: Convene first L&D closure strategy meeting
- C: Launch maternal health hubs
- A: Implement postpartum RPM; expand tech infrastructure
- A: Summarize L&D strategy meeting findings; deploy funds
- A: Evaluate clinical and operational outcomes, sustainability
- A: Design innovative payment approach
- B: Pilot & refine innovative payments, sustainability models
- C: Finalize sustainability plan for statewide adoption

Live Well, Together – Key Milestones and Target Dates

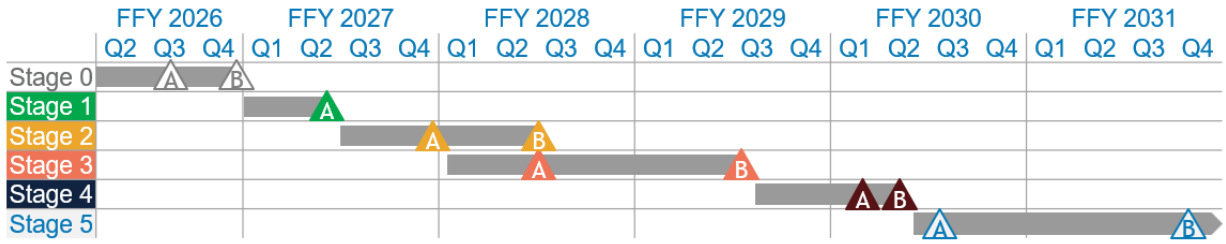
Figure 19. Food as Medicine Implementation



Milestones

- A: Finalize program design, issue planning grants
- A: Run competitive RFP process to select pilots
- A: Launch initial pilot sites
- B: Provide continued tech assistance to pilot sites
- A: Evaluate pilot progress and adjust model as needed
- B: Scale pilots and run RFP to launch additional programs
- A: Scale existing and run RFP to launch additional programs
- B: Finalize sustainability plan and alternative funding models
- A: Continue scaling and supporting mature programs
- B: Final report on key outcomes and sustainability

Figure 20. Consumer Tech for Education and Lifestyle Change



Milestones

- A: Develop detailed program design
- B: Run competitive RFP process to select pilot sites
- A: Finalize operating/funding model with pilot sites
- A: Launch initial consumer tech pilots
- B: Provide continued technical assistance to pilot sites
- A: Run RFP to launch additional pilots, reflecting best practices
- B: Evaluate pilot performance and ID elements to scale
- A: Scale pilots and run RFP to launch new programs based on successes
- B: Finalize sustainability plan
- A: Continue scaling and supporting mature programs
- B: Final report on key outcomes and sustainability

Figure 21. Active Kids Implementation

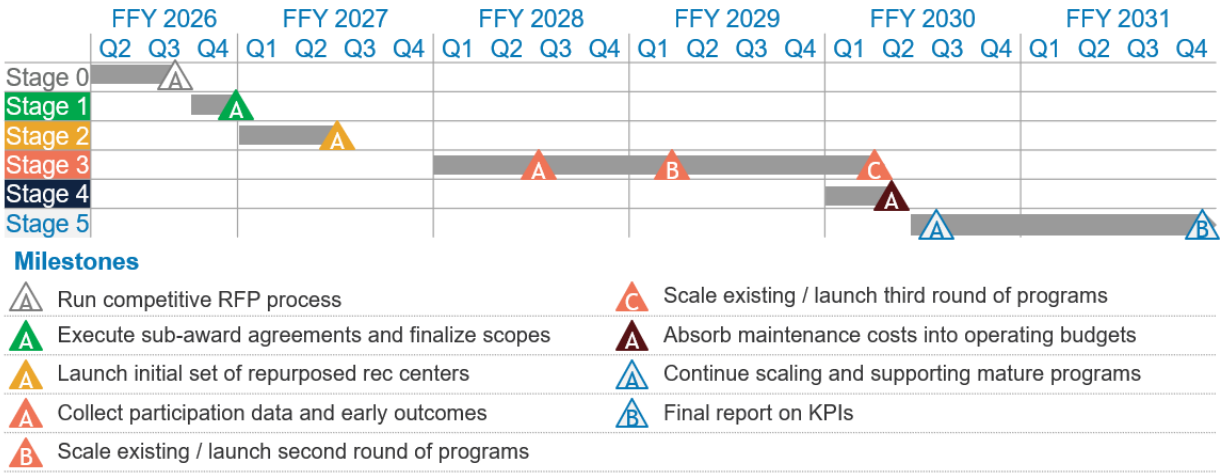
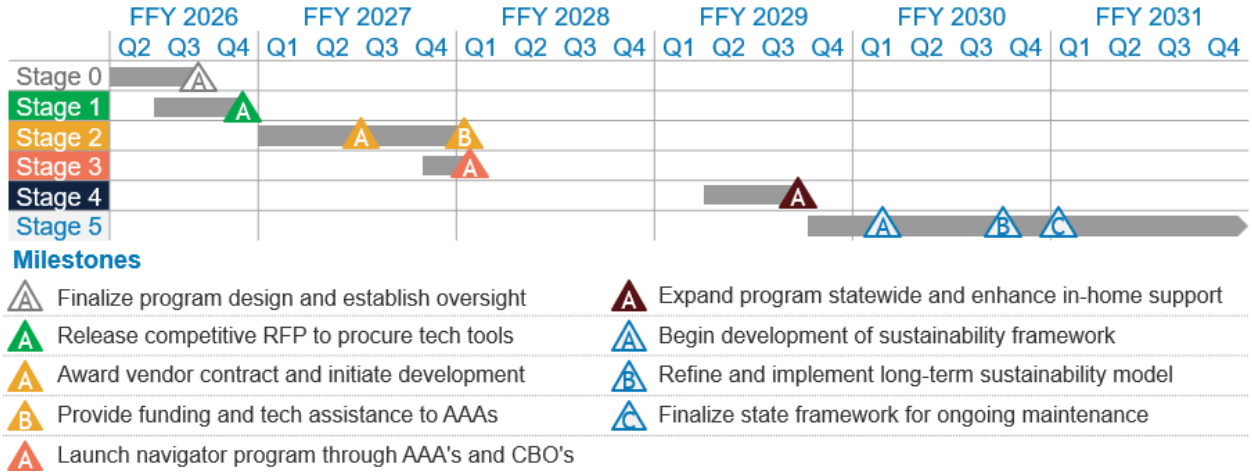


Figure 22. Integrated Care for Duals Implementation



Stakeholder Engagement

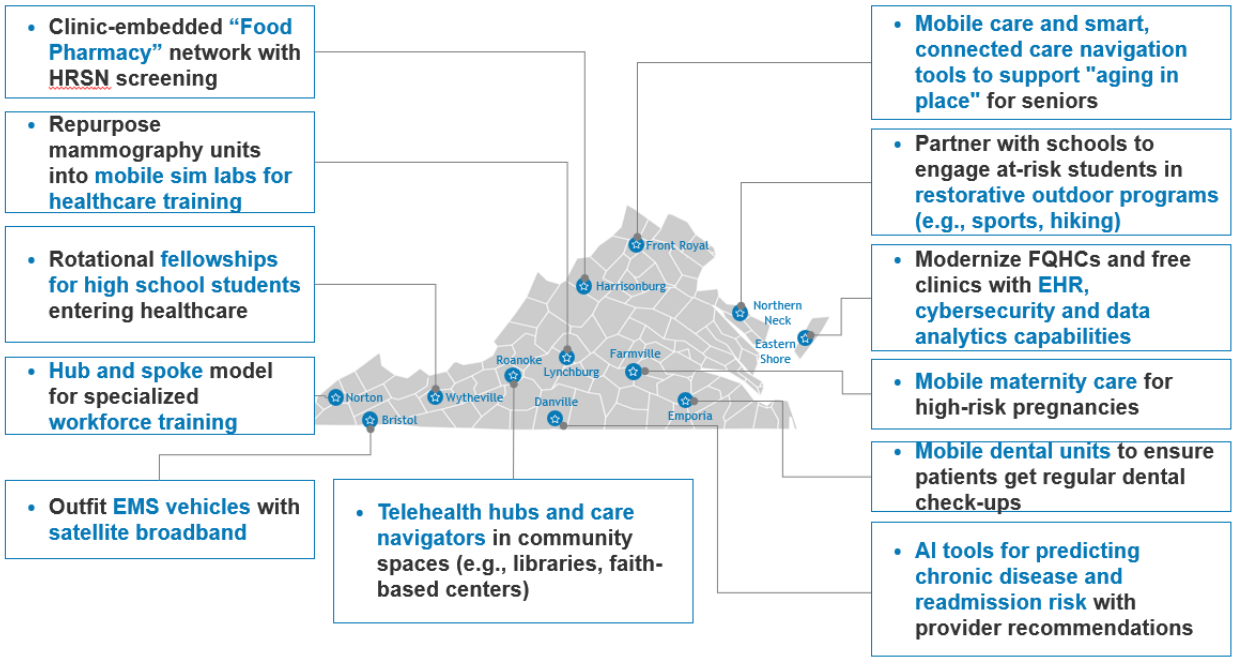
The Commonwealth undertook a robust stakeholder engagement process in the development of this application and remains committed to strong ongoing stakeholder engagement throughout the lifecycle of this cooperative agreement.

Stakeholder Engagement for Application Development

The Office of the Secretary of Health and Human Resources, DMAS, and VDH held twelve listening sessions attended by over 400 focused invitees in total. Key stakeholders who were represented in these listening sessions include rural hospitals, EMS providers, physicians, rural

health clinics, community groups, educational institutions, advocacy groups, local food banks, county representatives, and more. Figure 23 illustrates some of the more unique ideas that came out of the various sessions, several of which are incorporated into the innovative proposals. Letters of support from key entities, including subrecipients named, are included in pages 2-14 of OSM.

Figure 23. Sample of unique ideas in listening sessions



In addition, the Governor's office solicited conceptual ideas through a publicly-advertised inbox, ruraltransformation@governor.virginia.gov. More than 350 ideas and proposals were received and reviewed. These informed the development of Virginia's proposed initiatives. In addition, Virginia also engaged with federally recognized Tribes to solicit both written feedback and offer the opportunity to meet. UMIT Health Services, a Tribal health clinic serving rural community members, submitted written feedback and met with members of the Governor's team to provide input. The Pamunkey Indian Tribe also provided written comments, and their input informed the development of this application.

Ongoing Engagement Framework

Initiative Learning and Accountability Consortiums. The Commonwealth proposes that each initiative has a Learning and Accountability Consortium, overseen by the initiative's Project Manager and including subrecipients, key stakeholders, technical experts, and program participant representatives where appropriate. These groups will share lessons learned, provide mutually beneficial technical assistance, keep initiatives on track via dashboards and other tools, and troubleshoot where needed, all while ensuring stakeholder buy-in and transparency. The consortiums will meet quarterly and may meet more frequently during the early years of the grant.

Regional Update and Listening Sessions. The Commonwealth proposes to hold regular regional Update and Listening Sessions, one for each of the six defined rural regions of the state. These will be led by the Program Director and supported by Community Engagement Lead and Project Managers and will focus on the overall impact of the program initiatives in their region. The VA Rural Vitality Core Team and sub-award recipients will report on progress and next steps, share learnings across stakeholders, and provide opportunities for the community to ask questions and offer feedback and input. They will be held twice a year, for a total of twelve meetings annually (two each across six regions), some virtually on a rotating basis. Potential members could include but are not limited to local public health agencies, local providers, Tribal leaders, patient advocates, and local elected officials.

Metrics and Evaluation Plan

The Commonwealth is committed to a robust performance evaluation and management. The table below summarizes the initiative-specific metrics that VA will track to measure success. As specified in the initiative descriptions, subrecipients will be required to report data to DMAS and its formal evaluation partner.

Table 36. Initiative Specific Metrics

Initiative(s)	Sub-Initiative	Metric
CareIQ	Tech Innovation Fund	Number of innovation fund awardees
	Tech Innovation Fund	Number of active users of innovation fund awardee products
	Provider Productivity	Incremental number of rural providers using tech-enabled provider productivity tools by provider type
	Provider Productivity	Average estimated provider time savings achieved through productivity tools
	Provider Productivity	Average increase in estimated provider revenue or billable services achieved through productivity tools
	Provider Interoperability	% of rural providers on certified electronic health record technology (CEHRT)
	Remote Patient Monitoring	% of rural hospitals and health care settings actively using ≥1 RPM technology
Homegrown Health Heroes	Attract and Retain Physicians	Number of new residency slots filled per year
	Attract and Retain Physicians	Physician to patient ratio in rural counties
	Allied Health Degrees	Number of accredited 2-year allied health graduates per year
	Allied Health Degrees	Allied health professional to patient ratio in rural counties
	Earn to Learn Programs	Number of apprenticeships placements in allied health fields
	Build Career Pipelines	Number of high school students earning industry-ready healthcare credentials
Connected Care, Closer to Home	Mobile and Hybrid Care	Number of rural Virginians on Medicaid receiving an annual wellness visit per 1k population
	Mobile and Hybrid Care	Number of patients served by mobile and hybrid care programs
	Community Paramedicine	Number of rural Virginians receiving regular preventative visits from community paramedicine
	Community Paramedicine	Rate of avoidable ED admissions by rural Virginians on Medicaid
	Innovative Maternal Care	HEDIS measure PPC: Timeliness of prenatal care and completion of postpartum care
	Innovative Maternal Care	Rate of postpartum hospital readmissions in rural Virginians on Medicaid
Live Well, Together	Food as Medicine	Number of patients enrolled in food prescription or medically tailored meals
	Food as Medicine	Change in average HbA1c level (for participants with diabetes) or change in blood pressure (for participants with hypertension) after “Food as medicine” participation
	Consumer Tech	Number of participants onboarded to consumer digital health platforms and receiving engagement support (e.g., coaching, gamified prompts)
	Consumer Tech	% of participants actively engaging with digital health tools after 6 months of enrollment
	Consumer Tech	% of participants reporting improved digital literacy and confidence in managing their health or symptoms

Initiative(s)	Sub-Initiative	Metric
	Active Kids	% of youth participants engaged in regular physical activity or organized sports programs
	Integrated Care for Duals	% of dual-eligible population enrolled in integrated care plans
	Integrated Care for Duals	Number of Area Agencies on Aging (or similar) utilizing platform

Evaluation Plan

DMAS is partnering with the Virginia Center for Healthcare Innovation (VCHI) to conduct an evaluation of the program's impact and lessons learned. Components of the plan are below:

Table 37. VCHI Evaluation Plan Components

Virtual Hub	The virtual hub acts as an intranet and technical assistance platform, offering an accessible space for participants to engage with program materials and submit required data for program reporting. It also serves as a knowledge base providing insight into ongoing work for grantees and key stakeholders.
Virginia Rural Health Scorecard	VCHI will create a scorecard with key indicators for VA Rural Vitality initiatives, combining CMS metrics and Virginia-specific measures using state data and reports from funded projects. The annual Virginia Rural Health Scorecard Report will review results, track progress, and recommend changes to improve rural health outcomes statewide.
Academic Evaluation	For a subset of initiatives, VCHI will work with academic partners to conduct detailed evaluations on effectiveness, outcomes, and impact. These evaluations will generate evidence on what works, guide program improvements, and inform future funding or policy decisions.

Data collected and insights from VCHI's program-wide evaluation will be leveraged in "Initiative Learning and Accountability Consortiums," part of Virginia's ongoing stakeholder engagement plan to engage subrecipients, share insights and drive program improvements. VCHI is a trusted and experienced measurement partner across several current statewide programs – for example, they have centralized data availability for the Virginia Primary Care Innovation Hub. The budget for this program evaluation is reflected in the SF 424-A and accompanying budget narrative.

Sustainability Plan

Long-term sustainability is a critical element to enabling lasting change for rural Virginia patients and communities. As such, we have outlined strategies for each sub-initiative to enable sustainment beyond the RHTP Program funding expiration (FY 2031), as outlined in Table 38.

Sustainability approaches will be further developed to incorporate lessons learned from initiative implementation as well as insights and recommendations from evaluation contractor.

Table 38. Initiative Sustainability Approach

Initiative	Sub-Initiative	Sustainability Approach
CareIQ	Tech Innovation Fund	• Funded companies expected to be self-sustaining post-CMS support by operating as independent, revenue-generating businesses that commercialize and scale their solutions
CareIQ	Provider Productivity	• Health systems and providers will absorb ongoing program costs into operating budgets after year 5, supported by technical assistance on budgeting. • Productivity tools expected to yield time and cost savings, incentivizing subrecipients to maintain tools long-term
CareIQ	Provider Interoperability	• Providers will integrate program costs into budgets after year 5 with technical assistance on budgeting and planning • EHR and cybersecurity tools expected to generate efficiency and cost savings, encouraging sustained use. It may also result in increased revenue through more accurate and timely claims submissions.
CareIQ	RPM	• Providers will integrate costs into operating budgets after year 5 with technical assistance on budgeting and planning • RPM expected to provide a reimbursable ongoing revenue stream for providers, while reducing cost of care, making it sustainable • Planning grants will support assessment of long-term reimbursement options and alternative funding mechanisms, including value-based models; existing MCO initiatives will inform design of new payment mechanisms and an actuary or data analytics partner will analyze pilot data and estimate expected financial impact and savings; RPM benefits may be bundled with additional innovative payment models built through other programs in this effort (e.g., mobile care) • In later years of programming, funding may also go towards partner enablement support to build necessary data, claims tracking and reporting capabilities • RPM technologies have already demonstrated measurable impact on reducing long-term healthcare costs. Findings from successful RHTP pilots could help incentivize payers and providers to reimburse technologies that show proven effectiveness in rural communities and reduce hospital readmissions
Homegrown Health Heroes	Attract/Retain Physicians	• Creating residency spots with 5-year time commitments will bolster Virginia's rural provider workforce who will continue to serve beyond the RHTP funding • Recruiting physicians with personal and family ties ("homegrown" workforce) to rural regions will improve retention and long-term sustainability
Homegrown Health Heroes	Allied Health Degrees	• Program will bolster rural allied health workforce that will continue to serve beyond the RHTP funding • Mobile lab equipment funded through this program will remain in use by community colleges, with maintenance built into operating budgets
Homegrown Health Heroes	Earn to Learn	• Creating "earn to learn" programs with 5-year time commitments will bolster Virginia's rural provider workforce who will continue to serve beyond the RHTP funding
Homegrown Health Heroes	Career Pipelines	• Partners will absorb ongoing program costs for Laboratory schools into operating budgets after year 5, supported by technical assistance on budgeting and financial planning

Initiative	Sub-Initiative	Sustainability Approach
Connected Care, Closer to Home	Mobile and Hybrid Care	• Vendors will absorb ongoing program costs for into operating budgets after year 5 and providers will absorb costs in years 2-5, supported by technical assistance on budgeting and financial planning • The Commonwealth will provide planning grants and technical assistance to support adoption of value-based payment models for primary care (e.g., capitation, bundled payments) • Provider enablement efforts will ensure capacity to manage financial risk and make data-driven care decisions at the point of care
Connected Care, Closer to Home	Community Paramedicine	• The Commonwealth will implement a payment model based on the ET3 (Emergency Triage, Treat, and Transport) framework, allowing EMS to bill for all services, including preventive visits, treat-in-place care, and telehealth coordination with primary care providers • Technical assistance will be provided to EMS agencies and councils to support participation in future payment models, including financial, administrative, and technology support
Connected Care, Closer to Home	Innovative Maternal Care	• Services provided will continue to be billed by providers through typical channels (e.g., insurance) • Any additional ongoing program costs required based on new programs (e.g., clinical staff for mobile units) will be built into go-forward operating expenses by providers. The Commonwealth will provide technical assistance to ensure providers are able to do this successfully.
Live Well Together	Food as Medicine	• Health systems will integrate costs into operating budgets after year 5 with technical assistance on budgeting and planning • Planning grants will support assessment of long-term reimbursement options and alternative funding mechanisms (e.g., MCO arrangements (e.g., ILOS), risk-based payment models and private or philanthropic grants) Existing MCO initiatives will inform design; an actuary/analytics partner may be contracted to analyze pilot data for expected financial impact/ savings; Food as Medicine may be bundled with payment models from other initiatives (e.g., mobile care) • In later years of programming, funding may also go towards partner enablement support to build necessary data, claims tracking and reporting capabilities • Food as Medicine services have already demonstrated measurable impact on reducing long-term healthcare costs. Findings from successful RHTP pilots could help incentivize payers and providers to reimburse services that show proven effectiveness in rural communities and reduce hospital readmissions
Live Well Together	Consumer Tech	• Health systems and providers will incorporate ongoing program costs into their operating budgets after year 5, with technical assistance provided on budgeting • Consumer technology companies (e.g., Noom, Thrive Mobile) have already demonstrated measurable impact on reducing long-term healthcare costs; findings from successful pilots could help incentivize payers and providers to reimburse technologies that show proven effectiveness in rural communities
Live Well Together	Active Kids	• Entities leading programs will incorporate ongoing program costs into their operating budgets after year 5, with technical assistance provided on budgeting
Live Well Together	Integrated Care for Duals	• Program sustainability will be achieved by enrolling dual-eligible individuals into integrated care plans, leveraging Virginia's existing FIDE-SNP infrastructure to support ongoing operations • Virginia will explore options for the health plans to fund the platform long-term, given enrollment benefits they achieve through the system

[1] National Institute on Minority Health and Health Disparities - HD Pulse Data Portal
[2] Healthy Appalachia Institute - 2023-2024 Blueprint for Health Improvement and Health-Enabled Prosperity
[3] Roanoke Valley-Alleghany Comprehensive Economic Development Strategy
[4] Roanoke Valley-Alleghany Comprehensive Economic Development Strategy
[5] Roanoke Valley Community Health Assessment
[6] The Institute for Advanced Learning and Research: A Collaborative, Impactful Approach to Public Health: the REACH Partnership. 2024. https://www.ialr.org/a-collaborative-impactful-approach-to-public-health/
[7] Eastern Shore Health District Community Health Assessment 2023 – 2024
[8] Source: CDC PLACES, County Health Rankings, Virginia Health Information dashboards, HRSA Area Resource Files, CDC Birth Files
[9] Virginia number is for full state (no rural data available)
[10] Virginia number is for full state (no rural data available); Defined as children who show affection, resilience, interest and curiosity in learning;
[11] D'Aiuto F, Siripaiboonpong N, et. Al. The root of the matter: Linking oral health to chronic diseases prevention. *International Journal of Cardiology Congenital Heart Disease.* 2025; https://doi.org/10.1016/j.ijcchd.2025.100574
[12] Kianmehr H, Zhang P, Luo J, et al. Potential Gains in Life Expectancy Associated With Achieving Treatment Goals in US Adults With Type 2 Diabetes. *JAMA Netw Open.* 2022;5(4):e227705. doi:10.1001/jamanetworkopen.2022.7705
[13] Emily D. Parker, Janice Lin, Troy Mahoney, Nwanneamaka Ume, Grace Yang, Robert A. Gabbay, Nuha A. ElSayed, Raveendhara R. Bannuru; Economic Costs of Diabetes in the U.S. in 2022. *Diabetes Care* 2 January 2024; 47 (1): 26–43. https://doi.org/10.2337/dci23-0085
[14] America's Health Rankings 2025
[15] Mental Health America 2025
[16] 2023-4 Medicaid and CHIP Maternal and Child Health Focus Study Report, Commonwealth of Virginia
[17] CDC Birth Files 2020-2022
[18] Virginia Department of Health Neonatal Abstinence Rates 2023; America's Health Rankings 2021
[19] Virginia Health Information 2024 hospital discharge data. Drive time calculated on zip code level, assuming driving from geographic center of zip code and with normal traffic patterns.
[20] Bath (106 min), Northumberland (93 min), Lancaster (85 min), Dickenson (79 min), Richmond (76 min).
[21] Virginia Primary Care Scorecard developed by Virginia Center for Health Innovation
[22] Virginia Department of Health Data Commons
[23] 2025 HRSA Health Professional Shortage Area data
[24] 2022 Virginia Healthcare Workforce Data Center
[25] 2024 Virginia Healthcare Workforce Data Center
[26] Sources: HRSA Area Health Resource files from 2022 and 2023; Virginia Department of Health Professions Healthcare Workforce Data Center 2022; Virginia Center for Health Innovation Primary Care Scorecard Dashboard; Federal Office of Rural Health Policy definition of a rural county. 2024 census data.
[27] Center for Healthcare Quality and Payment Reform. "Rural Hospitals at Rick of Closing" August, 2025. Available at https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
[28] Hospitals only include Critical Access Hospitals and Short-Term Hospitals. Data sourced from 2022 CMS cost reports.
[29] Hospitals only include Critical Access Hospitals and Short-Term Hospitals. Data sourced from 2022 CMS cost reports.
[30] Data sources to be supplemented by evaluation partner sources, where possible
[31] Option to use "Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure, as established by data steward NCQA
[32] Option to use "Controlling High Blood Pressure (CBP)" measure, as established by data steward NCQA
[33] Option to use "Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)" measure, as established by data steward NCQA
[34] Option to use "Adults' Access to Preventive/Ambulatory Health Services (AAP)" measure, as established by data steward NCQA
[35] VDOE Office of Student Pathways and Opportunities – CTE Enrollment 2024-2025
[36] American Heart Association Voices for Healthy Kids
[37] Justice in Aging D-SNP Issue Brief