A) Rural health needs and target population

West Virginia is an amazing gem: home to unmatched energy resources; gorgeous landscapes that make our state one of the most attractive tourism destinations in the United States; and a hard-working and indomitable spirit among our people who have great pride in our state. Today, West Virginia has a new discipline to improving the fundamentals of our economy that the state has never seen before.

West Virginia is forging its comeback story. However, to truly transform our state and standard of living to much higher levels, the Mountain State must dramatically reverse the poor healthcare outcomes that serve as a major barrier to high workforce participation and economic strength. The West Virginia Rural Health Transformation (WV RHT) Program represents a one-of-a-kind opportunity to drive major healthcare improvement in West Virginia and become a catalyst for revitalization and growth.

West Virginia faces some of the nation's most challenging health outcomes, ranking 49th in overall health status.[1] As one of the nation's most impoverished and hard-to-traverse states,[2] the State has struggled to establish stable employment opportunities and private healthcare coverage. High rural healthcare costs and poor outcomes constrain the state's growth and its workforce participation rate—which is the lowest in the U.S.[3] **West Virginia cannot afford to let poor rural health remain a drag on its economy.**

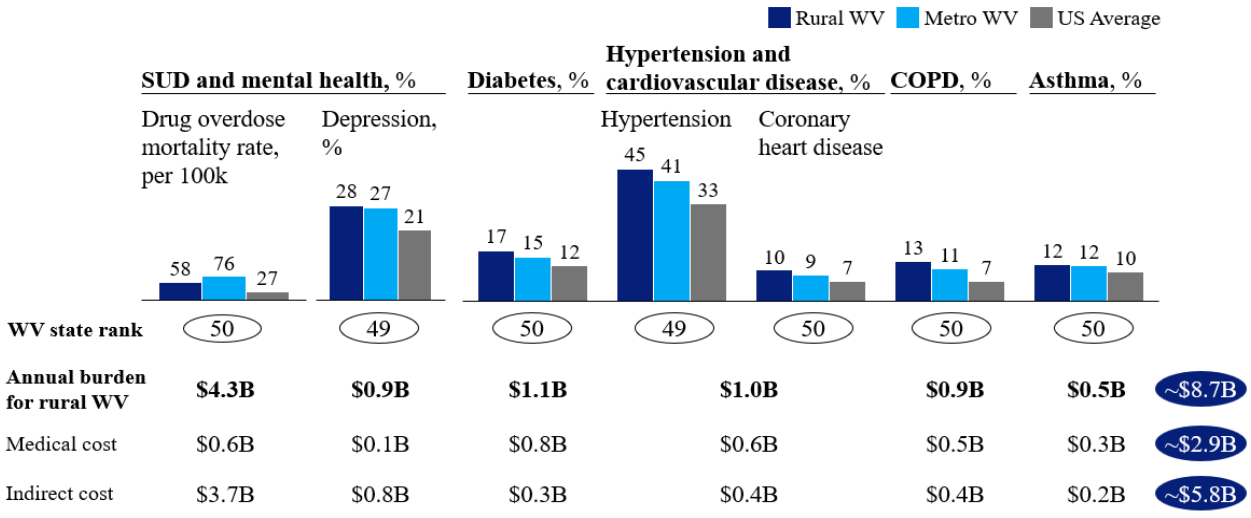
The WV RHT program will revitalize rural communities by activating an integrated set of robust rural initiatives – a "flywheel" – that generates health and economic prosperity, connecting prevention, recovery, technology, and workforce innovation. WV leads in advancing several Make America Healthy Again (MAHA) priorities, as one of the first states in the nation to secure a Supplemental Nutrition Assistance Program (SNAP) waiver for

soda, banning several food dyes, prioritizing work for SNAP and Medicaid recipients, and launching the Mountaineer Mile program to encourage active lifestyles. This transformative investment is critical to expanding these state-initiated efforts to create the structural changes needed to improve health outcomes for the long term, which will help citizens get back to work, get healthier, and reduce reliance on public coverage. Investing in innovations that prevent poor health is essential to reducing public costs. An ounce of prevention is worth a pound of cure.

Health Outcomes and Rural Disparities

Rural West Virginians experience significantly worse health outcomes compared to metropolitan areas and national averages. **Life expectancy in rural WV is six months lower than in-state metro areas and approximately 2.5 years below the national average—with McDowell County's life expectancy being *11 years* lower than the national average.**[4] West Virginia has the nation's highest adult obesity rate (41% vs. 37% nationally) and the highest smoking rate (20% vs. 12% nationally).[5] Chronic disease rates are among the highest in the nation—and significantly worse in rural areas—and the state has the deadliest overdose crisis in the country, with rural overdose rates twice the national average.[6]

Prevalence of chronic disease/health conditions by rural and metro regions (2022)[7]

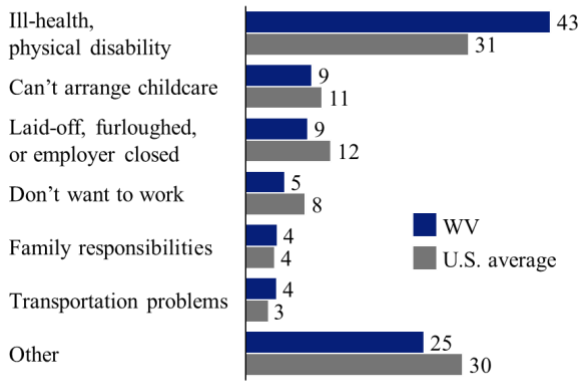


The MAHA framework helps address these challenges through coordinated prevention (Food-is-Medicine, movement, and prevention programs), connected-care technology (remote patient monitoring (RPM), telehealth follow-up), and recovery-to-work initiatives. Aligned with MAHA's ambition, Governor Patrick Morrisey launched his "Healthy West Virginia" initiative this year with four pillars—Clean Up the Food; Find Purpose, Find Health; Move Your Body, Change Your Life; and Reward Healthy Choices—to improve nutrition, promote daily physical activity, and realign incentives toward healthier living statewide. This RHT effort will build on this work to catalyze investment to drive transformative change in rural communities.

The Inseparable Link between Poor Health and Economic Well-Being in West Virginia

Poor health is a barrier to economic growth, especially in rural areas. Poor health and disability is the **#1 reason that West Virginians cite for not working**.[8] The state's workforce participation rate is **54.3% versus 62.4% nationally**. Only 5% of those not working indicate they do not want to work (below the national average of 8%). While unemployment is relatively low,[9] workforce participation remains constrained by health challenges that sideline working-age adults. With an aging population and high rates of health challenges and disability, we must create conditions that help residents recover, stay healthy, and rejoin the workforce.

Adults 18+ Not Working and Not Retired, by Self-Reported Reason,[8] %



The most common health-related reasons keeping working-age adults out of the labor force include arthritis, depression, asthma, chronic obstructive pulmonary disease (COPD), diabetes (with obesity as a driver)—along with substance use disorder (SUD), which Request for

Information (RFI) submissions and stakeholder interviews consistently identified as a major barrier to employability and family stability. Over 20% of West Virginians suffer from three or more of these types of chronic conditions, highlighting the need for improved management and prevention.[10] Each of these conditions could be better managed or prevented, helping to engage more in the workforce for a better quality of life.

This interplay between work and health creates a negatively reinforcing cycle: poor health restricts employment which contributes to higher rural poverty rates (**18% of rural West Virginians live below the poverty line**[11] and rural households have a median income of only $53.4k, 16% lower than the $62.2k in metro counties).[12]

Key Health System Challenges in Rural West Virginia

Insights from over 50 state agency and community group discussions and 250 RFI responses—over 3,000 pages—underscore the depth and breadth of the rural healthcare crisis:

High prevalence of mental illness and SUD: Addiction is the leading driver of preventable mortality and community strain. West Virginia's overdose death rate is nearly twice the U.S. average,[13] with limited recovery supports and high rates of readmission and overdose recurrence. Stakeholders emphasized that SUD touches every part of life in West Virginia and that the path to community stability includes coordinated recovery-to-work programs, peer-coaching, and employer partnerships that help maintain sobriety and regain employment.

High chronic disease burdens: With rates of COPD, cardiovascular disease, and diabetes 20-45% above the national average, rural communities face higher costs and needs. Many RFI respondents highlighted struggles with missed visits and adherence that amplify risks—not because of lack of care about health, but because of access issues. Diabetes management was

highlighted as a top priority, calling for expanded prevention, glucose-monitoring, remote monitoring, and nutrition access through clinics, grocers, and pharmacies.

Maternal & child health gaps: Nearly half (49.1%) of counties are maternity care "deserts," exceeding the national average (32.6%).[14] Child mortality rates are significantly higher in rural areas (72 deaths per 100,000 children vs. 55 deaths in metro areas).[15] Several RFI respondents cited instances of families traveling 1-2 hours for obstetric or pediatric care, contributing to poor outcomes. Community partners urged expansion of mobile obstetric teams, postpartum wellness programs, and maternal nutrition supports through hospitals, schools, and county health depts.

Geographic isolation & transportation barriers: Many communities face significant transportation barriers to access care. One provider highlighted this reality, noting that many *"live in communities of fewer than 2,500 people connected by winding mountain roads with no public transportation between isolated towns."* Stakeholders proposed county-based networks and integration of non-emergency medical transportation (NEMT) with local emergency medical services (EMS) and volunteer drivers to reduce missed appointments.

Food insecurity: West Virginia's food insecurity rate is around 14%,[16] which exacerbates chronic disease risk factors (e.g., diabetes, COPD, hypertension). Stakeholders noted food insecurity as a challenge, highlighting for many families "the nearest grocery store is miles away, leaving them reliant on convenience stores with limited nutritional options," calling for coordinated food-access programs, produce-prescription models, and nutrition-incentive pilots.

Broadband/digital divide: West Virginia ranks 50th nationally in internet availability.[17] Many RFI responses emphasized that access is essential for modernizing healthcare. Telehealth sites placed in locations such as libraries, schools, pharmacies, and community centers can help improve digital access—along with basic digital-skills training.

Health workforce shortages: All rural West Virginia counties are Health Professional Shortage Areas as of June 2025.[18] Healthcare capacity is very low, with ~20% of counties having a population to healthcare worker ratio greater than 40:1 (> 2 times as the national average).[19] In rural counties, 22% of healthcare practitioners and technical workers are aged 55 or older, including ~5% (1k individuals) aged 65 and above who could retire at any time.[20] These age distributions indicate that a substantial portion of the state's experienced healthcare workforce is nearing or already at retirement age. Without targeted recruitment, training, and retention strategies, West Virginia will continue to face workforce shortages in critical healthcare occupations over the next decade, including in the home care and long-term care sectors. Stakeholders urged faster credentialing, financial support tied to rural service, and structured "return-to-home" incentives for West Virginians trained in health professions elsewhere.

Limited access to specialty services: Access to specialty services is limited, with network adequacy rates <90% in rural counties for Medicaid managed care organizations (MCOs). Key shortages include OBGYN specialists (85% adequacy), cardiologists (70% adequacy), pulmonologists (45% adequacy), and oncologists (40% adequacy).[21] RFI respondents recommended expanding tele-specialty coverage through academic-medical partnerships and creating regional rotation schedules so specialists can serve multiple counties efficiently.

Provider sustainability amidst a declining population: Rural providers (including EMS providers) and hospitals face significant financial challenges as rural populations decline (-8.9% since 2010).[22] Stakeholders urge programs to modernize billing, streamline administrative requirements, and test new payment approaches that reward outcomes.

System fragmentation: Many rural providers operate on Electronic Health Record (EHR) systems that are not fully integrated with the WV Health Information Network (WVHIN), EMS,

behavioral health, and hospital systems. As an RFI respondent noted, *"bidirectional data sharing is currently limited…resulting in delays in care, information gaps, and suboptimal care."* Providers and payers stressed that better data infrastructure (e.g., shared data spine to integrate multiple systems) is needed for care coordination and tracking population outcomes.

Target Populations & Geographic areas

The WV RHT Program will serve residents, providers, and communities across all rural counties, prioritizing early implementation efforts on regions where working adults with poor health, elevated chronic diseases, healthcare workforce shortages, and access challenges are most acute. Specific target populations include:

- **Working-age adults experiencing health-related barriers to employment**, including chronic illness, recovery needs, and transportation constraints.
- **High-cost, high-need patients**, including the top 1% of utilizers, represent the cases that most significantly benefit from integrated care management and prevention supports.
- **Adults and at-risk children with priority chronic conditions** (e.g., behavioral health, SUD, diabetes, obesity, hypertension, cardiovascular disease, COPD, asthma).
- **Rural mothers, children, and older adults lacking access to care** that need support through diverse access options, prevention, nutrition, and efforts.
- **Rural healthcare providers and systems** (e.g., Federally Qualified Health Centers (FQHCs), Community Health Centers (CHCs), EMS, clinics, home healthcare) that would benefit from modernization, data, and payment-reform pilots.
- **Students, trainees, and practicing clinicians** recruited, trained, and placed in key shortage areas to strengthen the state's rural workforce pipeline and retention.

Multi-State Collaboration

The state will collaborate with neighbors on holistic solutions for rural populations, as ~40% of the WV rural population lives in a county that borders a neighboring state, and a large portion of care is provided out-of-state for these residents.[23] During the application process, Governor Morrisey held calls with the Virginia Governor, Ohio Governor, and New Hampshire Governor to discuss joint efforts to serve their people regardless of state boundaries. A number of the states have agreed to explore the potential for a multi-state consortium to facilitate shared purchasing power, volume discounts, and coordinated access to innovative healthcare technologies and rural solutions. This type of collaboration will promote the exchange of best practices, joint evaluation of outcomes, and align efforts to strengthen rural health infrastructure and capacity across states. In addition, Governors DeWine and Morrisey have committed to exploring collaborative models to provide workforce development opportunities, extend reciprocity for healthcare licensure, and leverage innovative technology and remote care for rural residents. WV will continue discussions during the pre-award and implementation phases and coordinate activities with border states and many others to deliver care in a way that reflects need and not artificial borders.

Case for Transformation

The resilience, work ethic, and determination of West Virginians have carried our state through every hardship. Today, that same strength will power a new era of health and prosperity. The state's success depends on turning illness into employability, and dependency into self-sufficiency. Without significant intervention, West Virginia's rural communities will continue to see declining health outcomes, worsening economic stagnation, and further destabilization of the healthcare delivery system. Our plan seeks to improve outcomes and make

healthcare more affordable for our residents that struggle with high costs. Hospitals, payers, and community groups warned that "we are at the breaking point" without coordinated investment.

The WV RHT Program is the intervention needed to change these dynamics. By targeting high-need populations that could benefit from targeted interventions and investing in the community systems that support them, West Virginia will not only improve health outcomes but reignite economic participation, strengthen families, address affordability, and build resilient rural health infrastructure. Stakeholder feedback reinforces the central mission: a locally driven, data-informed system that rewards results and restores dignity through work and wellness.

B) Rural health transformation plan: Goals and strategies

Program Vision

West Virginia's vision is to dramatically improve our healthcare outcomes to facilitate the creation of a larger, more productive, and healthier workforce. Enabled by strategic investments in technology and unprecedented collaboration within our rural communities, improved healthcare outcomes will underpin West Virginia's new economic strength and comeback effort. West Virginia will build upon the indomitable spirit of its people and ignite transformational opportunities to grow our workforce, strengthen rural health, and improve our standard of living—overcoming decades of barriers to productivity. With weak health inextricably linked to poor economic outcomes in rural West Virginia, this program represents a once-in-a-generation opportunity to break this cycle. **The state will leverage technology, private-sector partnerships, and local leadership to improve health outcomes and drive economic participation.** By helping more West Virginians return to work, reduce dependency on public insurance, and extend life expectancy, this approach delivers measurable and sustainable results.

Strategic Priorities and Flagship Initiatives

To deliver health and prosperity for rural residents, we propose three connected strategies:

1. Address health-related barriers to workforce participation. Poor health and disabilities are the largest drivers of West Virginia's lowest-in-the-country labor force participation (50th).[24] The state will attack these health-related barriers that hold back workforce participation by targeting interventions at working-age adults with chronic conditions – especially obesity, diabetes, cardiovascular disease, and addiction recovery – using prevention, treatment, and return-to-work programs. Expanding recovery and chronic care solutions (e.g., innovative SUD treatment, remote monitoring technologies), preventative personal health and onsite employee wellness programs, and flexible care access options will keep more West Virginians in the workforce longer for sustained access to employer-sponsored coverage that improves long-term health outcomes. This approach restores self-sufficiency and reduces reliance on government assistance while strengthening families and local economies.

2. Establish WV as a center for rural health technology innovation and partnership. WV will commit its resources to focusing on innovation to improve rural health, becoming a leader in healthcare system transformation. The state will partner with universities, entrepreneurs, and investors to test and scale technologies that make care accessible and affordable in rural settings. Successful models attract sustained private co-investment and position WV as a national model for transformation. Care will focus on where individuals are, including schools and faith communities.

3. Improve access to care and sustainability of the healthcare system. Access will expand through better transportation, telehealth, and targeted workforce incentives – while

payment reforms promote quality, value, affordability, and sustainability. These efforts ensure rural facilities remain viable anchors for care and employment, strengthening the WV ecosystem.

This vision and these strategies will be operationalized through seven flagship initiatives:

Initiative	Description
Connected Care Grid	Build the infrastructure to bring virtual and in-person care access to people on-demand
Rural Health Link	Transport vulnerable rural West Virginians to care when they need it
Mountain State Care Force	Recruit, train, and retain the healthcare workforce of the future
Smart Care Catalyst	Support transformative tech-enabled innovation, streamlined operations, and paying for healthcare value & quality
Health to Prosperity Pipeline	Help West Virginians rebuild health, rejoin the workforce, and thrive in their communities
Personal Health Accelerator	Empower healthy living through food-is-medicine programs, education and rewards for exercise and wellness activities
HealthTech Appalachia	Incubate leap-frog innovations that unlock healthcare outcomes and economic growth

Each initiative reinforces the others: technology facilitates access; infrastructure ensures reach; workforce builds capacity; payment reforms sustain progress; and prevention keeps people healthy enough to participate in prosperity. These initiatives advance CMS's strategic goals and the statutory requirements:

Mapping to CMS Strategic Goals by Initiative

✔ Primary Impact ✔ Secondary Impact

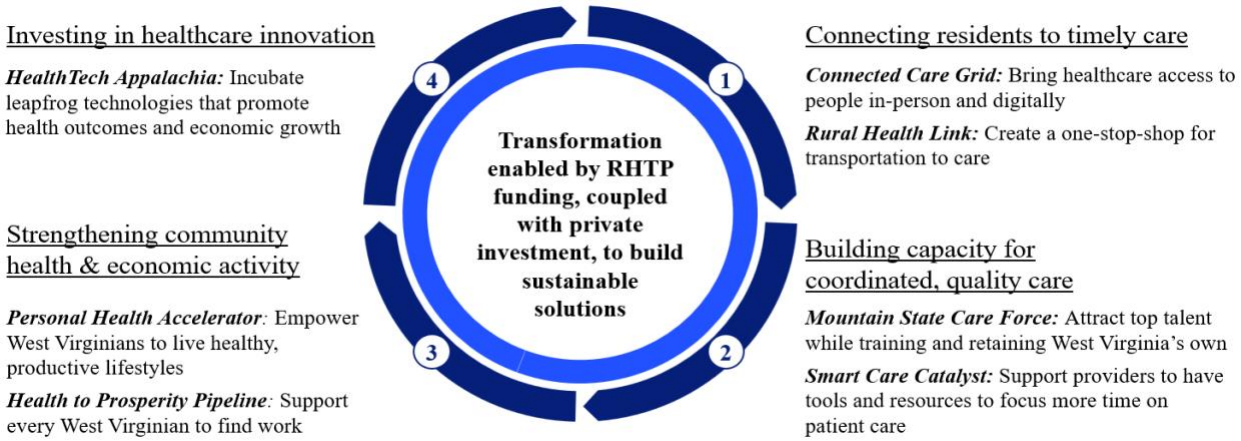
CMS Strategic Goal	Connected Care Grid	Rural HealthLink	Mountain State Care Force	Smart Care Catalyst	Health to Prosperity Pipeline	Personal Health Accelerator	HealthTech Appalachia
Make Rural America Healthy Again	✔	✔	✔	✔	✔	✔	✔
Sustainable Access	✔	✔	✔	✔	✔	✔	✔
Workforce Development		✔	✔	✔		✔	
Innovative Care Model	✔	✔	✔	✔	✔	✔	✔
Tech Innovation	✔	✔		✔	✔	✔	✔

Statutory Requirement	Key Initiatives
Improving Access & Improving Outcomes	• *Connected Care Grid* expands access points and chronic disease mgmt. • *Rural Health Link* supports transports to create access and reduce no-shows • *Mountain State Care Force* builds local capacity for care delivery • *Smart Care Catalyst* ties payment models to quality outcomes • *Personal Health Accelerator* promotes nutrition and exercise to improve obesity, diabetes, hypertension, cardiovascular disease, COPD, and asthma • *Health to Prosperity Pipeline* helps residents return to work • *HealthTech Appalachia* seeds innovations for sustainable health outcomes
Partnerships	• *Smart Care Catalyst* creates provider partnerships to improve efficiency • *Mountain State Care Force* fosters rotational staffing and training programs
Workforce	• *Mountain State Care Force* develops homegrown pipelines; rotational and shared-practice models augment capacity and reduce burnout • *Connected Care Grid* incentivizes virtual care delivery (e.g., for specialists)
Technology Use & Data-Driven Solutions	• *Connected Care Grid* enhances telehealth/RPM capabilities while building a data spine for interoperability, predictive analytics, and performance tracking • *Personal Health Accelerator* supports referral pathways to nutrition and aging-at-home programs • *HealthTech Appalachia* represents a cornerstone in WV technology strategy to incubate and deploy solutions that improve access, quality, and costs
Financial Solvency Strategies & Cause Identification	• *Smart Care Catalyst* will support technology and collaboratives to improve productivity and efficiency, addressing pressures of population decline, out-of-state referrals, and high rates of chronic disease • *Smart Care Catalyst* will also transition providers to payment models that focus on improving health to lower utilization and reduce costs • *Rural Health Link* and *Health to Prosperity Pipeline* mitigate access and payer-mix challenges that lower patient volume or reimbursement

Building a Sustainable Flywheel

These initiatives create a self-sustaining rural health–economy "flywheel": *Community Care Grids* and *Rural Health Link* bring care to people; *Mountain State Care Force* and *Smart Care Catalyst* stabilize and upskill providers; *Health to Prosperity Pipeline* helps adults return to employment while *Personal Health Accelerator* expands prevention and nutrition; and *HealthTech Appalachia* catalyzes private co-investment and leapfrog tools.

West Virginia RHT flywheel of impact



As access expands and outcomes improve, rural residents regain health, labor force participation rises and more adults move to employer-sponsored coverage, and stable care networks attract further private and employer investment – creating a reinforcing loop of health and prosperity. This drives an enduring case for change to sustainably improve health outcomes for rural West Virginians. **Short-term investments catalyze long-term independence, making rural West Virginia a national example of sustainable, locally led transformation.**

Policy Commitments and Initiative Priorities Against Technical Score Factors

West Virginia already has a strong rural health policy foundation, anchored by broad participation in national licensure compacts, modern telehealth laws, and healthy lifestyle reforms (e.g., SNAP waivers, activity programs). Building on its national leadership in advancing MAHA priorities, WV will adopt policies in 2026 to advance health outcomes:

Technical Factor	WV Policy Foundations and Key Initiatives *(not exhaustive)*
B.1 Population Health Clinical Infrastructure	*Personal Health Accelerator* builds wellness infrastructure and empowers residents to take actions today to reduce need for future healthcare services. *Connected Care Grid* advances health by expanding access points. *Smart Care Catalyst* supports provider collaboration.

B.2 Health & Lifestyle	**Policy:** WV will require the Presidential Fitness Test with the target of having this policy passed in 2026 and no later than Dec 31, 2028. *Personal Health Accelerator* will advance nutrition, movement, and prevention programs to improve lifestyle solutions.
B.3 SNAP Waivers	**Policy:** WV has secured a SNAP waiver to exclude soda from eligible SNAP purchases (effective Jan 1, 2026).[25] WV also has a SNAP stretch program to support fruit and vegetable consumption.[26]
B.4 Nutrition Continuing Medical Education	**Policy:** WV will pass legislation that mandates continuing medical education (CME) for nutrition for physicians no later than Dec 31, 2028. WV will also aim to include nutrition for other providers (e.g. NPs, PAs). Two of West Virginia's medical schools (WVU School of Medicine, WV School of Osteopathic Medicine) already lead with nutrition integrated into core curricula.[27]
C.1 Rural Provider Strategic Partnerships	*Smart Care Catalyst* will enable rural provider collaboration to create administrative efficiencies through shared purchasing and support functions. *Connected Care Grid* will build provider partnerships and capabilities for telehealth and RPM.
C.2 EMS	SB 533 (2024) enabled EMS to remotely triage – up to and including treat-in-place – and route to appropriate care sites or alternative destinations.[28] *Connected Care Grid* integrates EMS into telehealth services and builds infrastructure for treatment-in-place and aging-at-home solutions. *Rural Health Link* integrates EMS with platforms to improve transit coordination and reduce avoidable, emergency department (ED) visits, and preventable admissions. *Smart Care Catalyst* can promote EMS treat-in-place through value-based care collaboration.
C.3 Certificate of Need	**Policy:** West Virginia has made recent progress in CON reform, including SB 613 (2023), which raised the capital-expenditure minimum from $5 million to $100 million for projects triggering CON and added and clarified exemptions including birthing centers and physician MRI/diagnostic imaging.[29]
D.1 Talent Recruitment	*Mountain State Care Force* expands rural capacity by funding residencies and return-to-home programs to attract clinicians. *Personal Health Accelerator* and *Health to Prosperity Pipeline* create new community health, behavioral health, and peer-recovery roles.
D.2 Licensure Compacts	**Policy:** WV has full licensure compacts through SB 458 (2025), which establishes the "Universal Professional and Occupational Licensing Act."[30] As a complementary policy action, the State has passed legislation to allow qualified military medics to receive recognition for paramedic licensure in West Virginia, expanding the EMS workforce.[31]
D.3 Scope of Practice	**Policy:** Earlier this year, WV expanded pharmacist scope of practice to include test and treat for numerous conditions. Nurse practitioners and physician assistants/associates have received the ability to prescribe Schedule II narcotics. Nurse practitioners have enjoyed the ability to practice

	independently, with collaborative practice environment requirements reduced to 3 years. Dental hygienists were approved to use certain lasers in periodontal therapy. In light of WV's severe and ongoing SUD impacts, the state will maintain adherence to its laws limiting opioid prescribing (i.e., physician-only prescription).
E.1 Medicaid Provider Payment Incentives	*Smart Care Catalyst* creates value-based care payment models that reward quality and lower cost. *Health to Prosperity Pipeline* offers outcome-based incentives to providers and MCOs for helping residents return to work.
E.2 Dual eligibles	*Connected Care Grid* improves outcomes for dual-eligibles by increasing telehealth access points (e.g., at senior centers), RPM (e.g., discharges, avoiding readmission), and data analytics for continuous improvement. *Smart Care Catalyst* supports shared analytics and payment alignment for these populations (e.g., PACE, VBC in Medicaid). The state will strengthen its D-SNP contract to enhance care coordination with CO-only plans. *Personal Health Accelerator* will provide a resource hub for duals to help them connect to resources.
E.3 STLDI	**Policy:** WV does not have restrictions that limit STLDI plans beyond federal guidance with a maximum allowable initial contract term for STLDI of 3 months and total coverage period of 4 months, aligned with federal practice.
F.1 Telehealth / Remote Care Policies	**Policy:** WV permits interstate telehealth registration, Medicaid reimbursement at parity, and recognition of licensure compacts in telehealth.[32] WV will continue to strengthen its telehealth reimbursement policies to increase use of RPM and provider-to-provider e-consult with implementation no later than 2028 and with a target of 2026. *Connected Care Grid* operationalizes these capabilities, linking providers statewide through the WVHIN data spine.
F.2 Data Infrastructure	*Connected Care Grid* modernizes statewide health data systems through an integrated data spine, creating interoperability, and launching an integrated claims database. *Personal Health Accelerator* will integrate nutrition and wellness data through closed loop tracking. *Smart Care Catalyst* enables rural providers to upgrade analytics and IT infrastructure to enable efficiency, innovation, and VBC model adoption.
F.3 Consumer-facing Tech	*Connected Care Grid* deploys RPM tools to empower residents and providers in managing chronic disease. *HealthTech Appalachia* will promote innovation in consumer health through investments in AI-enabled diagnostics, digital therapeutics, and mobile wellness applications. *Rural Health Link* will create a digital health-mobility platform to enable better access to patient care.

Overall Goals & Key Performance Objectives

West Virginia's strategic priorities and flagship initiatives are designed to transform the rural healthcare ecosystem in durable, measurable ways. **By 2031, West Virginia will expand access to prevention and wellness programs, raise labor-force participation, and build financially stable rural healthcare systems that attract innovation and private investment.**

Overall performance objectives reflect this ambition and will be used to assess progress towards healthy communities and thriving economies, directly advancing CMS' strategic goals.

Overall WV RHT Program Performance Objectives

CMS Strategic Goal	Objectives	5-Year Target Metrics	Connected Care Grid	Rural Health Link	Mountain State Care Force	Smart Care Catalyst	Health to Prosperity Pipeline	Personal Health Accelerator	HealthTech Appalachia
Make Rural America Healthy Again	Improve control of chronic disease	Improve control of chronic disease (incl., SUD, diabetes, hypertension, CVD, COPD, asthma) by 5-10%	✓	✓	✓	✓	✓	✓	✓
		Reduce prevalence of adult obesity by 4%	✓	✓	✓	✓	✓	✓	✓
	Help citizens overcome health barriers to workforce participation	5% reduction in percent of individuals citing health as barrier to employment					✓	✓	✓
		Increase workforce participation rate by 2 percentage points		✓	✓		✓	✓	
	Deploy targeted strategies to mitigate Neonatal Abstinence Syndrome (NAS) birth rates	Reduce instance of NAS births by 5-10%						✓	
Sustainable Access	Improve access to reduce avoidable ED/inpatient use	Reduce avoidable ED visits by 15–20%	✓		✓	✓			
	Provide satisfactory wait times and patience experience	Improve patient satisfaction with access by 5% as measured by CAHPS scores	✓	✓	✓	✓			
Workforce Development	Increase provider capacity and productivity to see patients	Reduced average outpatient appointment wait times by 20% for key provider types	✓		✓	✓			
	Improve rural clinician retention	Achieve workforce retention rate of 2/3 (5 yrs. in supported role)	✓		✓				
Innovative Care Model	Improve rural healthcare's financial sustainability and value	Reduce total cost of care growth rate by 1/3				✓		✓	✓
Tech Innovation	Increase adoption of evidence-based solutions that improve outcomes	Over 50% of HealthTech investments are demonstrating clinical and cost outcomes						✓	✓

The state will also leverage its existing provider initiatives aimed at improving healthcare outcomes, setting performance targets against quality metrics for select conditions. Collectively, these efforts deliver on West Virginia's goal to achieve improved health status for its rural communities, driving a better quality of life and enhanced economic opportunity.

The initiatives compound in their impact to achieve these objectives. Improving provider access to reduce avoidable ED visits and inpatient stays depends on getting people access to urgent care virtually or proactively identifying risks with RPM (*Connected Care Grid*), developing revolutionary technologies (*HealthTech Appalachia*), training more clinicians and providers who can expand provider access (*Mountain State Care Force*), and incentivizing high-value provider activities (*Smart Care Catalyst*). Developing the healthcare workforce by improving provider retention depends not only on incentives (*Mountain State Care Force*) but also on making jobs in rural areas more satisfactory, ensuring providers have the technology and tools they need to automate workflows and spend more time with patients (*Smart Care Catalyst*).

These approaches move the needle for West Virginians. The table below describes how the WV RHT will support individuals across our state who are impacted by conditions that drive poor health outcomes and limit economic prosperity.

WV RHT Initiatives: Impact on Priority Conditions

Initiatives referenced: Connected Care Grid (CCG), Rural Health Link (RHL), Mountain State Care Force (MSCF), Smart Care Catalyst (SCC), Health to Prosperity Pipeline (H2P), Personal Health Accelerator (PHA), HealthTech Appalachia (HTA).

Priority Condition	How the seven initiatives address needs (non-exhaustive)
Substance Use Disorder	**CCG** enables tele-SUD care and remote monitoring, including support for medications for opioid use disorder. **SCC** funds BH/SUD value-based models. **MSCF** grows the BH workforce, while **RHL** improves access to visits. **H2P** integrates recovery-to-work and wraparound supports that reduce relapse and readmissions. **HTA** co-invests in breakthrough SUD treatment technologies, and **PHA** provides peer and community supports.

Mental health	**CCG** expands access to therapy and medication mgmt. via tele-behavioral health and mobile units. **SCC** incentivizes measurement-based care and integration in primary care and schools. **MSCF** expands behavioral health workforce. **PHA** provides peer-led wellness and self-management supports. **RHL** reduces transportation barriers. **HTA** invests in evidence-based digital mental health tools. **H2P** connects individuals to employment and social supports that improve recovery.
Diabetes and obesity	**PHA** scales food-is-medicine, nutrition, and activity programs that prevent obesity and diabetes. For diabetics, **CCG** enables RPM and telehealth so teams can track glucose and adjust therapy between visits. **SCC** aligns value-based payment so clinics are rewarded for better HbA1c control and reducing BMI as a risk factor, while **RHL** reduces missed visits with transportation support. **HTA** pilots effective digital tools that promote weight loss and diabetes and obesity prevention.
Hypertension	**CCG** supports home blood pressure monitoring with care team titration and e-consults. **PHA** promotes nutrition, physical activity, and tobacco cessation—key evidence-based levers for BP control. **SCC** ties payment to hypertension outcomes and team-based care; **RHL** reduces missed chronic-care visits. **HTA** brings in proven digital tools, **MSCF** adds clinicians in shortage areas, and **H2P** addresses social drivers (e.g., food, stress) that influence control.
Cardiovascular disease	**CCG** enables tele-cardiology, cardiac rehab follow-up, and RPM to prevent readmissions. **RHL** provides transportation to rehab and specialty visits. **MSCF** fills cardiology and nursing gaps in underserved areas. **PHA** scales prevention (nutrition, movement) and secondary prevention adherence, while **SCC** funds models that reward risk-factor control and fewer readmissions.
COPD	**PHA** funds smoking-cessation and pulmonary rehab adherence supports, while **CCG** delivers tele-pulmonology and RPM to catch exacerbations early. **RHL** helps patients reach rehab and follow-ups, reducing preventable ED use. **SCC** rewards fewer exacerbations and admissions.
Asthma	**CCG** enables remote tracking and action-plan management. **SCC** pays for outcomes like fewer exacerbations. **RHL** reduces missed care visits. **MSCF** expands clinical capacity in schools and clinics.

C) Proposed initiatives and use of funds

Initiative 1: Connected Care Grid

The *Connected Care Grid* initiative expands access to healthcare by strengthening virtual and local care delivery – bringing care closer to where residents live. As highlighted above, most of WV's rural residents lack ready access to primary or specialty care, with 49% of counties defined as maternity care deserts and with gaps in key specialties in rural counties, forcing families to travel one to two hours for basic services. EHR use and interoperability among independent rural providers and small clinics lags significantly behind national

benchmarks – creating barriers to effective implementation of VBC, remote monitoring, care coordination, and population health analytics. Through *Connected Care Grid,* rural citizens gain access to primary, preventive, urgent, and specialist care – bridging gaps between those who live in the state's urban and rural communities. With West Virginia ranking 50th in broadband availability, it is critical to implement a blended in-person and virtual access strategy so patients can receive virtual care from home or community access points. Funds will support access point expansion, bring more providers into virtual networks, and integrate user-friendly scheduling platforms to support access across care types. This focused use of funds will strengthen provider capacity and data infrastructure for services that can be sustained through existing reimbursement mechanisms.

Key pillars and activities for this initiative include the following:

Pillar	Key activities
Build New Pathways to Care	Equip hub-and-spoke modelled grid to support telehealth, telemedicine, mobile care units, RPM, and paramedicine to serve people closer to home: • Use funds to outfit provider "hubs" (e.g., hospitals, FQHCs/CHCs, mobile care units) & patient access "spokes" (e.g., employer campuses, schools, libraries, community centers, kiosks[33]) with the capabilities and technology needed to enable provision of care[a] • Prioritize schools as key community access points by funding telehealth enablement, billing capacity, and start-up grants for expanded school-based clinics and insurance billing • Approvals based on competitive applications and demonstrated need • Design funds to prioritize performance and private sector matching[b] • Equip grid to expand specialty and tele-specialty care, connecting rural residents to services such as tele-maternal health, behavioral health (BH), and chronic disease management • Funds can support providers to equip new office locations to expand access to care in rural areas

[a] Applicants can include healthcare facilities (e.g., FQHCs/CHCs, dental offices, public health, pharmacies), community locations (e.g., employer campuses, schools, libraries, senior centers), mobile units, EMS, associations (e.g., WV Primary Care Association)
[b] The State may design funding awards to best incentivize performance and outcomes (e.g., grants, forgivable loans)

	Fund EMS community paramedicine and treatment-in-place programs to deliver in-home urgent care, reduce avoidable transport, and expand access Catalyze development and uptake of interoperable provider directory and scheduling platform(s) to enable patients to receive real-time, accurate provider availability (e.g., in-person and telehealth schedule) and book appointments across options (i.e., in-person, virtual at access hubs, fully virtual, in-home): • Partner with external vendor to develop directory mgmt. and scheduling integration (e.g., ZocDoc, Kyruus) • Fund integration with existing provider EHRs and payer scheduling applications to enable "no wrong door" options • Launch a consumer-facing interface option with AI-empowered navigation of directory and scheduling to help people find the best care option near them
RPM Enablement for Mgmt. of Chronic Disease	Fund and scale RPM programs by subsidizing both connected devices and service enablement infrastructure – coordinating with care hubs, health systems, and provider networks for inpatient and outpatient monitoring • Prioritize RPM with FDA-cleared devices for conditions with strongest evidence of clinical and cost impact (e.g., hypertension, heart failure, COPD, and diabetes), supporting VBC and provider productivity[34] • Support RPM service enablement and interoperability by investing in data integration and workflow tools that allow patient-generated data to flow securely into provider systems • Fund RPM for additional conditions according to accumulated evidence (e.g., SUD care management and intervention) • Integrate comprehensive RPM services by supporting Chronic Care Management and Remote Therapeutic Monitoring models that extend provider oversight, improve patient engagement, and enhance care coordination across chronic and post-acute conditions
Bring More Local WV Providers Online	Provide matching grants to fund telemedicine equipment and technology for in-state providers, based on competitive application and demonstrated need • Funding for EHR capabilities to monitor RPM data in real time (e.g., for WVHIN interoperability), cyber-security upgrades, e-consult capabilities and interfaces, and training and technical assistance for virtual care Fund provider incentives, focusing on priority specialties, to go-live with payers in providing virtual services • Explore tiered or time-limited incentive models to go live with payers (e.g., per-visit or per-virtual-day reimbursement, one-time participation bonuses, or limited-term e-consult payments[35]), with flexibility for the State to adjust based on provider uptake and demonstrated impact

Create an Enabling Data Spine	Invest in interoperable digital spine connecting providers and payers, with cloud-based platforms for secure and real-time data exchange
	• Expand WVHIN capabilities to develop shared analytics for tracking access, outcomes, and costs
	  • Include AI-enabled reporting and advanced analytics (e.g., for predictive analytics on early risk factors, alerts and dashboards to care teams, tracking outcomes across rural populations)
	  • RPM and telehealth integration to provide Video-Supported Treatment capabilities for rural clinical networks to facilitate medication assisted treatment (MAT)/medications for opioid use disorder (MOUD) (includes enhancing data exchange between clinic EHRs and WVHIN for monitoring and care management)
	  • Address PHI and HIPAA data-sharing roadblocks by establishing secure data-exchange infrastructure to enable coordination across providers, payers, and community partners
	• Provide interoperability incentives to equip rural providers with seamless data exchange capabilities with WVHIN to eliminate data silos and support lightweight, certified electronic health records (EHRs) where needed
	• Fund integrated claims database to support data infrastructure & analytic capabilities (e.g., tracking telehealth, RPM, care hub usage, pharmacy)

Across these pillars, *Connected Care Grid* establishes the **state's integrated "any-door" access network** linking clinics, homes, and hospitals through modern technology, data, and locally staffed care hubs. The initiative will build on existing assets—including the WVHIN, early telehealth programs, EMS paramedicine programs, and WV Primary Care Association and FQHC/CHC telehealth investments—by organizing providers into regional hubs that coordinate specialty access, data exchange, and RPM support. The data spine infrastructure also provides the critical spine to integrating wellness (part of *Personal Health Accelerator)* and health-to-work data integration (part of *Health to Prosperity Pipeline*).

Connected Care Grid will explicitly help address dual-eligible beneficiaries by aligning RPM, data exchange, and Long-Term Services and Supports (LTSS) coordination to improve continuity of care across Medicare and Medicaid. Through this initiative and *Smart Care Catalyst*, West Virginia will explore strategies (e.g., PACE) and shared data infrastructure to

improve care for dual-eligible populations. This initiative also strengthens coordination for foster care populations by linking health records and telehealth services to ensure seamless, continuous care during placement transitions.

This work will be supported by other state policy actions, including broadband expansion. WV will prioritize alignment with the Broadband Investment Plan for the use of a potential $1B for broadband funding, particularly to support telehealth and last-mile access to critical healthcare infrastructure. The state's existing interstate telehealth registration and Medicaid parity policies support seamless virtual care across county and state lines.

Mapping to strategic goals, use of funds, and technical score factors	
Main CMS Strategic Goal	Sustainable Access
Use of Funds	B, C, D, F, G, H
Technical Score Factors	B.1 (Pop health clinical infrastructure), C.1 (Rural provider strategic partnerships), C.2 (EMS), E.2 (Dual eligibles), F.1 (Remote care services), F.2 (Data infrastructure), F.3 (Consumer-facing technology)

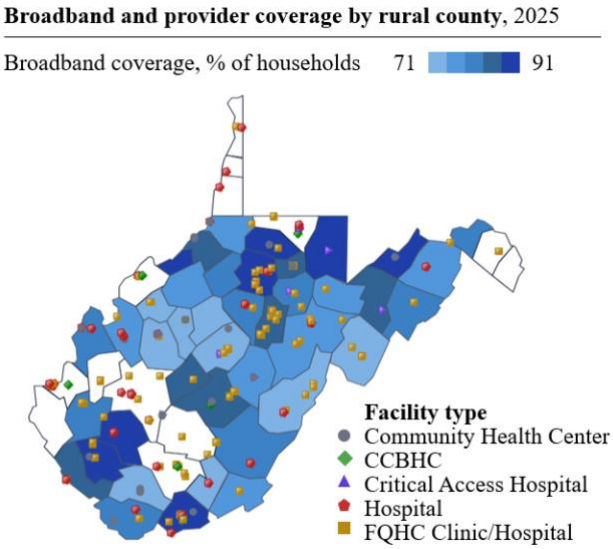
Outcomes for Connected Care Grid
Outcome 1: Expanded access to real-time care by increasing appointment availability
Metric: Reduce average outpatient wait time for visits or consults among target populations, clinics, provider types (e.g., primary care, specialist, behavioral health), and counties **Data notes:** Medicaid and payer claims databases and reporting; secret shopping (Medicaid); data from central scheduling platform in later years; at county level **Preliminary baseline & target:** *Baseline to be validated during Stage 0*; preliminary target to reduce wait time by 20% in 5 years
Outcome 2: Expanded access to primary and urgent care
Metric: Reduce avoidable ED visit rate in target service areas receiving investment **Data notes**: Medicaid and payer claims, WVHIN encounter data; county level **Preliminary baseline & target:** *Baseline to be collected in Stage 0;* preliminary target to reduce avoidable ED visits by 15-20% in target service areas in 5 years[36]
Metric: Decrease average virtual first response time for immediate provider consult **Data notes**: Medicaid and payer claims, WVHIN encounter data, payer reporting, interoperable provider directory and scheduling platform (once available) **Preliminary baseline & target:** *Baseline to be collected in Stage 0;* Preliminary target to increase % of responses <30 min from initiation (call/chat/app) to live clinical triage
Outcome 3: Improved connectivity to virtual care

Metric: Increase number of telehealth access points in target areas with low broadband access **Data notes**: CMS provider data on certified telehealth providers; county level **Preliminary baseline & target:** *Baseline to be collected in Stage 0;* Preliminary target to increase access points by 50%
Metric: Increase rate of utilization of virtual care with participating programs in target service areas for eligible visits **Data notes:** Medicaid and payer claims data, WVHIN reporting **Preliminary baseline & target:** *Baseline to be collected in Stage 0; (*current national utilization at 8-10% of visits done virtually[37]); Preliminary target to sustain 10-20% utilization of eligible visits by virtual care versus in-person[38]
Metric: Increase the number of providers offering virtual care in target service areas **Data source:** State and payer directories and claims databases **Preliminary baseline & target:** *Baseline to be collected in Stage 0;* Preliminary target of 50% of providers offering virtual care for patients in rural areas[39]
Metric: Increase rate of individuals receiving RPM within target populations & service areas **Data notes:** WVHIN reporting, Medicaid & payer claims data; county level **Preliminary baseline & target:** *Baseline to be collected in Stage 0;* Preliminary target of 10% of eligible rural population[40]
Outcome 4: Strengthened chronic disease & preventive care management
Metric: Reduce rate of preventable hospitalizations among recipients of RHT funded RPM **Data notes:** WVHIN and participating provider reporting, Medicaid and payer claims **Preliminary baseline & target:** *Baseline to be collected in Stage 0;* preliminary target to reduce preventable hospitalizations by 10-20% amongst population receiving RPM[41]
Outcome 5: Expanded access to behavioral health for children in the state
Metric: Increase rate of K-12 students with access to BH services for target service areas **Data notes:** WV Dept. of Education BH reporting, Medicaid/MCO claims data; at county level **Preliminary baseline & target:** *Baseline to be collected in Stage 0;* preliminary target to increase availability rate of services to 90% of students [42]

Key stakeholders: The Dept. of Health will lead coordination across pillars, with WVHIN as operational lead for the data spine pillar. Other vendor partners (e.g., device providers, virtual service enablers) will manage RPM scaling and provider onboarding. Partnerships with healthcare directory and scheduling connectors will be developed for easy patient scheduling through the care hubs. Hospitals, health systems, universities, providers (e.g., community hospitals, pharmacies, FQHCs/CHCs, MCOs), and community centers (e.g., schools, libraries)

will recommend priority areas for access points and be implementing partners on-the-ground (e.g., leverage Marshall University research on school behavioral health needs).

Impacted counties: For initial implementation, the state will consider the mix of interventions likely to benefit each county, based on facility access and broadband coverage (see chart at right). For instance, counties with weaker broadband and a limited number of facilities may benefit from community-based virtual care locations and mobile telehealth units.

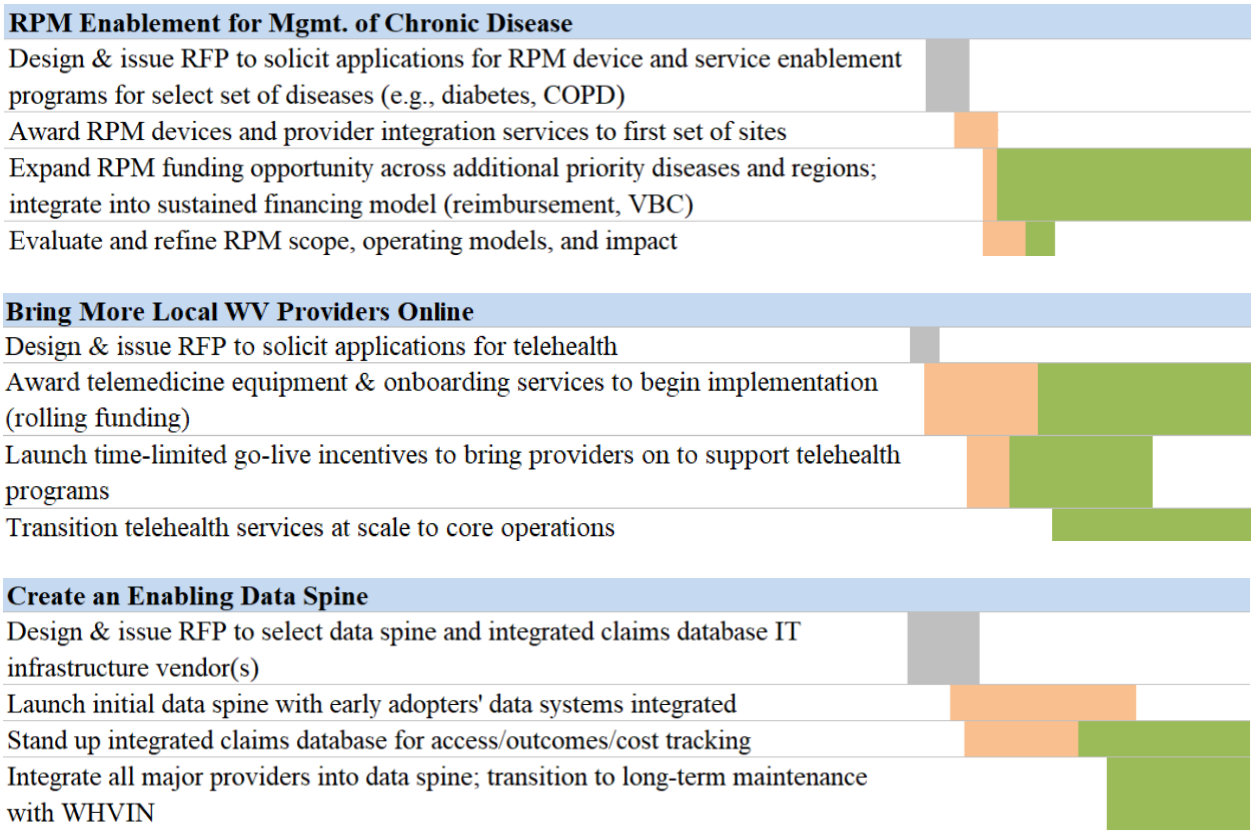


Estimated funding: $174M over five years ($35M per yr)

Implementation plan: Dept. of Health will oversee implementation, selecting additional technology vendors (e.g., appointment scheduling platforms, telehealth equipment providers), partnering with local providers to prioritize locations for access points, and coordinating with WVHIN to build enabling data infrastructure. Within the first 18 months, the first set of telehealth, mobile, and physical access points will be rolled out with data infrastructure development underway.

Legend **Stage 0-1: Planning** **Stage 2-3: Underway** **Stage 4-5: Full Implementation**

Pillar & Key Activities	*'26*	*'27*	*'28*	*'29*	*'30*	*'31*
Build New Pathways to Care						
Design & issue RFP for applications for implementing multi-modal care hub access points						
Award initial set of hub-and-spoke locations (virtual, mobile, physical)						
Design & issue RFP to select integrated scheduling vendor; integrate with first care access points						
Design & issue RFP for EMS community paramedicine & treat-in-place						
Award EMS community paramedicine & treat-in-place programs (rolling funding)						
Issue awards to scale hub-and-spoke access points with integrated scheduling platform statewide; support with transition to reimbursement payment models						



Sustainability plan:

Pillar(s)	Description
Build New Pathways to Care *and* Bring More Local WV Providers Online	**Transition access point costs to providers:** Providers that utilize sites will take over costs of ongoing funding and maintenance, sharing costs based on share of utilization. Some providers can build these access point costs into their cost reports
	Transition interoperable scheduling: Transition directory and scheduling infrastructure to payers, providers, and other entities with share of costs based on utilization of the platform, which provides value by reducing the overhead for current network management and directory admin costs.
	Leverage VBC: VBC models implemented will further incentivize these services and outcomes to reinforce sustainability over time.
RPM Enablement for Mgmt. of Chronic Disease	**Embed services into reimbursement and payment models:** Beyond current coverage for RPM (incl. Medicare), value-based care will enable support for evidence-based RPM services that support quality and cost-reduction. The state will also consider making RPM a reimbursable service for Medicaid, ensuring savings are achieved so that aggregate Medicaid costs are not increased.
Create an Enabling Data Spine	**Sustain enabling technology through subscription model:** WVHIN services and ongoing operating costs will be incorporated into WVHIN

	subscription fees. Ongoing costs for directory and scheduling platform maintenance will also follow subscription model.

Initiative 2: Rural Health Link

Rural Health Link addresses transportation barriers, one of the most common and preventable causes of lack of care in rural WV, as discussed above.[c] This initiative will enable citizens to access a **unified health-mobility platform to connect to transport options**, whether public buses, rideshare, volunteers, or local community organizations. It will also bring more public and private transit capacity online, creating options for NEMT, on-demand micro-transit, and multi-county public transit. A key outcome will be reduction in missed appointments due to transit barriers. Supporting demand navigation and supply in parallel will help build a self-sustaining marketplace that can leverage existing NEMT, public transit, and consumer funding to sustain system capacity after the start-up period. Optimizing and increasing transit utilization will also improve the effectiveness and efficiency (and generate cost savings) of EMS and NEMT system to sustainably improve performance.

Key pillars and activities for this initiative include the following:

Pillar	Key activities
Simplify How Rural Residents Get to Care	Invest in one unified health-mobility platform to dispatch rides across transportation options (e.g., NEMT, public transit, rideshare, volunteer). • Partner with external vendor to lead development of platform (e.g., Modivcare, Roundtrip) • Transition in later years to an independent, self-sustaining entity or entities to continue statewide scheduling/dispatch

[c]Survey data from the Center for Rural Health Development and Mountain Line Transit show 40–50% of missed appointments are due to transportation barriers. HealthNet and Mountain Line report 60–90 minute travel times for specialty care, and hospitals estimate transport issues cause 25–30% of missed chronic care visits.

	Integrate triage capabilities with 911 to ensure non-emergency patients receive NEMT, not EMS, enabling alternative destination transport (building on WV's enabling legislation for alternative destination for EMS)[d]
Expand Local Mobility Options	Create targeted investments to address key gaps in supply: • Establish multi-county public transport collaborative to pool local transit resources and coordinate multi-county rides • Equip EMS agencies to expand capacity regionally and statewide for scheduled, non-emergency transport and triage services, supported by flexible reimbursement models • Support EMS agencies to sign alternative destination transport agreements • Issue funds to support vehicle acquisition, insurance, driver recruitment, and expanded service hours in partnership with transit authorities, providers, community organizations (including startup funds for community faith-based and nonprofit partners)

Together, these two pillars transform transportation from a barrier into a core part of West Virginia's healthcare infrastructure—linking patients, providers, and payers through a modern, data-driven mobility network that reduces no-shows, lowers costs, and improves outcomes statewide. National evidence demonstrates that integrated mobility systems can reduce no-shows by more than 40% in some cases and can lower per-ride costs by more than 50%.[43] *Rural Health Link* will build on existing Medicaid NEMT, regional transit, and community ride programs.

Mapping to strategic goals, use of funds, and technical score factors	
Main CMS Strategic Goal	Sustainable Access
Use of Funds	F, H
Technical Score Factors	C.2 (EMS), F.3 (Consumer facing technology)

Outcomes for Rural Health Link

Outcome 1: Access to reliable, timely transportation is expanded in rural WV counties
Metric: Increase utilization rate of NEMT rides for eligible participants in target service areas[44] **Data Notes:** NEMT vendor reporting; at county level

[d] Potential characteristics include layered clinical triage and tele-navigation so that low-acuity 911 transports can be routed to clinic/urgent care with NEMT instead of EMS, or treat-in-place, using standard processes (e.g., DC Right Care Right Now; Ethan-Houston; DeKalb County, GA; Miami-Dade Procedure 53). Local EMS could also work with a nurse-navigation vendor and a physician to implement treatment-in-place/transport-to-alternate destination protocols (e.g., MedStar-Fort Worth, McLennan County, TX).

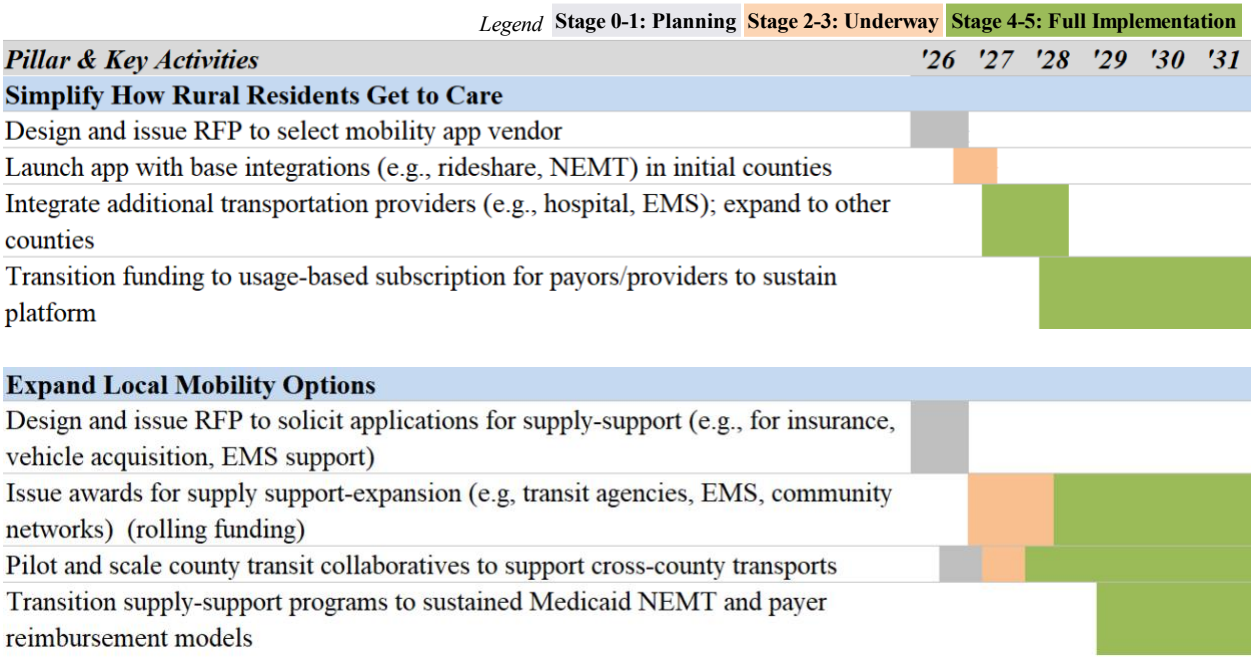
Preliminary baseline & target: Preliminary baseline in Medicaid is approx. 3,800 rides per 1,000 eligible people per year with target to double rides per 1,000 eligible people per year[45]; *baseline and target for other lines of business to be set during Stage 0*
Outcome 2: More rural residents successfully reach scheduled appointments on time
Metric: Increase rate of requested and on-time health trips (arrival within a 15-min window of scheduled appointment)[46] **Data Notes:** NEMT vendor reporting; transit automatic vehicle location dispatch data; at county level **Preliminary baseline & target:** Preliminary baseline is 83.6% completion statewide*; Target to be set during Stage 0*[47]
Outcome 3: Transportation is less of a barrier to accessing healthcare
Metric: Decrease appointment no-show rate among target populations in target service areas **Data Notes:** EHR reporting in targeted rural counties among funded entities (incl. disposition code for appoint no-show tracking); at county level **Preliminary baseline & target:** To be set during Stage 0; Baseline to be collected during application process for funding[48]
Outcome 4: More rural residents avoiding unnecessary ED visits
Metric: Reduce avoidable ED visit rate for priority cohorts in target service areas[49] **Data Notes:** Medicaid Claims and hospital encounters; at county level **Preliminary baseline & target:** *To be set during Stage 0*

Key stakeholders: The Depts. of Health and Transportation will provide leadership for administration of *Rural Health Link*, competitively selecting vendors to implement key efforts. Regional transit authorities, local NEMT/EMS providers, community driver networks, and mobility tech companies will be engaged to co-design the program attuned to local contexts and integrate services into the *Health Link* platforms, as further discussed below.

Impacted counties: All rural counties with phased implementation determined via stakeholder engagement during planning process

Estimated funding: $46M over five years ($9M per year)

Implementation plan: Depts of Health and Transportation, through selected vendors, will begin rolling out early versions of the mobility platform in late 2026 with initial versions available in initial areas by end of 2027.



Sustainability plan:

Pillar	Sustainability Plan
Simplifying How Rural Residents Get to Care	**Transition platform to subscription model:** Maintain platform operations through integrated payer/provider subscription model (e.g., MCOs, WV Public Employees Insurance Agency (PEIA), hospitals/health systems), supported through flexible, VBC arrangements that benefit from reduced no-shows.
Expanding Local Mobility Options	**Use a braided funding mix to continue supporting services:** Funding could include Medicaid, hospital ROI reinvestment, FTA 5311 transit, philanthropic, and modest local contributions.

Initiative 3: Mountain State Care Force

Mountain State Care Force **addresses WV's persistent health workforce shortages by developing home-grown talent, attracting providers to the state, and strengthening retention and staffing models to secure WV's healthcare future**. With all rural WV counties designated as healthcare shortage areas and 22% of current rural practitioners nearing retirement age, [50] this initiative will tackle these challenges to transform capacity before further shortages occur. **The State will augment RHT funds with state funds for workforce development**, such

as running targeted marketing and recruitment campaigns to attract healthcare professionals to live and work in rural WV and provide incentives for relocation. The State's three medical schools, the community and technical college system, and the K-12 educational system will be essential partners in this effort. Outcomes focus on closing shortages across critical disciplines – medicine, behavioral health, EMS, allied health professions, pharmacy, community health workers (CHWs), and oral health – while expanding the next generation of local providers.

Key pillars and activities for this initiative include the following:

Pillar	Key activities
Grow Local Talent Pipelines	Fund outreach programs to expose high school students to healthcare careers Co-fund faculty positions with private-sector at regional local colleges and technical programs to fill critical faculty shortages
Recruit and Retain Rural Workforce[e]	Fund new rural residency (e.g., medicine, pharmacy) and rural fellowship slots with co-funding between providers, hospitals, universities[51] Provide targeted incentives tied to a 5-year rural service commitment to attract and retain healthcare workers in shortage areas: • Offer multi-year cash incentive grants (e.g., annual income supplements), similar to South Carolina's Rural Provider Incentive Program[52] • Pair financial incentives with professional support (e.g., rural provider networking, mentorship, and telehealth training) to strengthen retention • Coordinate relocation and lifestyle support through concierge services aligned with WV's Ascend and other evidence-based programs, including housing assistance, spouse employment support, and relocation bonuses • Potential supplemental incentives such as "return-to-home" rebates, deferred compensation, income tax credits for qualifying practitioners • Establish annual compliance processes to verify continued rural service before disbursements, with repayment provisions for early departure • Offer direct incentives for providers moving into the state to set up practice, potentially leveraging income tax relief or rebate (e.g., analogous to GA income tax relief)[53]

[e] Proper controls and data tracking will be put in place to ensure that recruit and retain efforts meet 5-year rural service requirements. For all co-funded initiatives, providers must demonstrate a match through new or increased recruitment / workforce investments. Matching funds must supplement, not replace, existing activities – requiring verified maintenance of effort to ensure non-supplanting of existing healthcare workforce recruitment spending.

	• Fund statewide recruitment campaigns to promote WV as a destination for healthcare professionals (incl., physicians, allied health, nurses, pharmacists, dentists, dental assistants/hygienists, EMS), highlighting incentive programs, lifestyle advantages, community impact, and success stories to attract providers and their families, modeled after Ascend[54] and other programs Co-fund paid, entry-level healthcare apprenticeship roles (e.g., tech, EMT I positions) in rural areas, leveraging WV's Learn & Earn model Support career-ladder advancement programs with provider cost-sharing to help workers move into higher-skill roles (e.g., janitor to CNA, CNA to LPN/RN, paramedic to nurse practitioner)
Improve Workforce Staffing & Practice Models	Use start-up grants to create regional rotational staffing pools, fund technical assistance and other start-up support Co-invest in additional training (e.g., Project ECHO, WV Academic Mentoring Partnership) to enable rural clinicians to receive virtual education from academic medical centers[55]

Mountain State Care Force strategies build upon existing state workforce programs, including Area Health Education Centers (AHEC), WV Higher Education initiatives, FQHC/CHC career ladder and pipeline development efforts, and goes beyond existing Graduate Medical Education (GME) and loan repayment efforts, to accelerate recruitment and training in rural communities. Implementation will be led by the WV Higher Education Policy Commission and the Dept. of Health with a combination of direct management and competitive sub-awards to academic, health system, and regional training partners. Sub-awards will prioritize partnerships demonstrating local match funding, data sharing, and measurable rural placement outcomes.

Mapping to strategic goals, use of funds, and technical score factors	
Main CMS Strategic Goal	Workforce Development
Use of Funds	D, E, F
Technical Score Factors	D.1 (Talent recruitment)

Outcomes for Mountain State Care Force
Outcome 1: Build the education infrastructure for a homegrown workforce pipeline
Metric: Increase number of WV students enrolled in rural health training tracks from participating counties

Data notes: Initiative data tracking; at county level **Preliminary baseline & target:** *Baseline to be collected during Stage 0*; preliminary target of 10,000 high-school age students per year[56]
Metric: Increase number of in-state training slots available by healthcare role **Data notes:** WV Higher Education Policy Commission (HEPC) – Health Sciences Division, Medical school partner self-reporting **Preliminary baseline & target:** *Preliminary baseline of 15 total rural residency slots per year[57] – remaining baseline to be collected during Stage 0;* preliminary target to double annual residency slots available – remaining targets to be set during Stage 0
Metric: Increase in-state and rural placement rate for WV-trained healthcare workers **Data notes:** WV HEPC, WV medical, and nursing programs **Preliminary baseline & target:** *Baseline to be collected during Stage 0*; preliminary target of 77% placement rate[58]
Outcome 2: Increase number of physicians & healthcare workers in rural WV
Metric: Increase number of licensed clinicians per 10,000 rural residents **Data notes:** WV Dept. of Health – Office of Rural Health (ORH) **Preliminary baseline & target:** *Baseline to be collected during Stage 0*; preliminary minimum target of 2.9 primary care physicians per 10,000[59]
Metric: Increase number of rural residents and fellows **Data notes:** WV HEPC – Health Sciences / GME Data Reports **Preliminary baseline & target:** *To be set during Stage 0*
Metric: Count of out-of-state healthcare workers placed in rural areas via funded placement **Data notes:** Initiative data tracking **Preliminary baseline & target:** *To be set during Stage 0*
Outcome 3: Improve stability of rural systems by reducing workforce churn
Metric: Percent of RHT funded clinicians and healthcare workforce retained by year **Data notes:** WV Health Care Workforce Report / HEPC Health Sciences Division, Licensure renewal data, initiative data tracking **Preliminary baseline & target:** Baseline to be validated during Stage 0; preliminary target of 2/3 retention over 5 years[60]
Outcome 4: Leverage private funds to improve pipeline ownership and sustainability
Metric: Total private-sector match for RHT funded programs over and above current and planned maintenance of ongoing efforts (to be defined for each program and partner) **Data notes:** Initiative data tracking **Preliminary baseline & target:** Preliminary target of 1:0.5-1 match

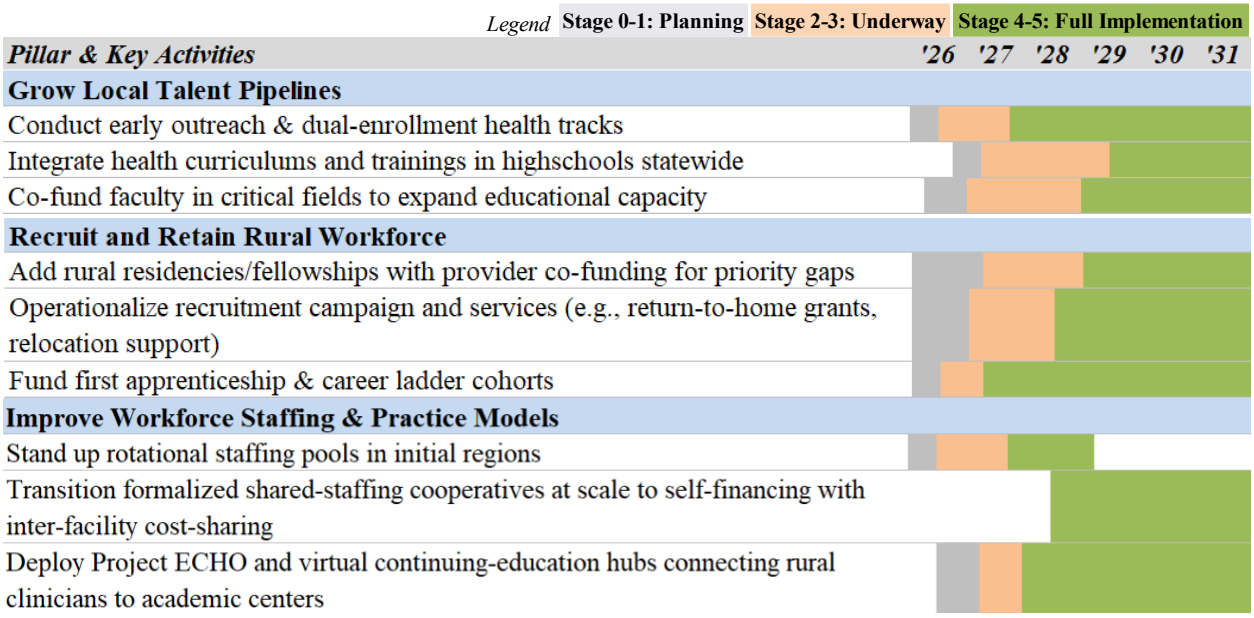
Key stakeholders: The WV Higher Education Policy Commission will be a key program leader in partnership with a range of stakeholders, including the Dept. of Health for workforce planning and prioritization; Dept. of Commerce; WV Ascend Program and other program experts for alignment with best-practice initiatives (e.g., to add spousal relocation support); universities and

community colleges; FQHCs/CHCs; state provider associations; medical schools (e.g., WVU, Marshall, WV School of Osteopathic Medicine); hospital systems and community providers for placement and rotational staffing model development; and local education institutions (e.g., high schools, vocational colleges) for early outreach and engagement.

Impacted counties: Potential initial counties will include those with healthcare workforce shortages[f] and then build throughout the state.

Estimated funding: $167M over five years ($33M per year)

Implementation Plan: The WV Higher Education Policy Commission in collaboration with the Dept. of Health—and other key stakeholders—will start early outreach, expand rural residencies, and launch a statewide recruitment campaign within 12 months to kickstart pipeline expansion.



[f] Counties with low primary care density, for instance, include Mercer (54055), Preston (54077), Logan (54045), Jackson (54035), Randolph (54083), Mason (54053), Upshur (54097), Boone (54005), Wyoming (54109), Taylor (54091), Barbour (54001), Wetzel (54103), Roane (54087), Monroe (54063), Braxton (54007), Summers (54089), Tyler (54095), Tucker (54093), Calhoun (54013).

Sustainability plan:

Pillar	Sustainability plan
Grow Local Talent Pipelines	**Institutionalize training pipelines:** Convert training initiatives into permanent components of K-12 education and accredited medical, pharmacy, nursing, and allied health programs.
Recruit and Retain Rural Workforce	**Focus on provider match:** Co-funding in partnership with providers builds sustainable funding stream to continue workforce development. **Prioritize retention:** Rigorously track and promote retention to ensure that funded workforce initiatives place individuals in rural service areas far beyond 5 year time horizon.
Improve Workforce Staffing & Practice Models	**Transition shared staffing pools into self-sustaining networks:** After start-up, regional rotational staffing pools will operate as provider-funded cooperative networks.

Initiative 4: Smart Care Catalyst

***Smart Care Catalyst* helps rural providers reduce administrative burden, modernize operations, cut waste and abuse, and focus time on patient care.** Rural healthcare providers shoulder higher administrative and clinical fixed costs than metro healthcare providers to support local access to care for smaller and declining populations. WV hospital services already represent the second-highest per capita cost in the nation.[61] As rural health improves through WV RHT initiatives, reductions in hospital admissions will challenge the financial sustainability of hospitals operating under fee-for-service payment models, as reduced utilization erodes revenue while only modestly reducing resource requirements. To address this, *Smart Care Catalyst* supports rural providers in evolving clinical service lines, administrative processes, and payment models to improve financial sustainability and promote value.

The first pillar of ***Smart Care Catalyst* will focus on helping providers reduce clinical and administrative operating expenses.** The State will establish a productivity support fund to provide direct support to rural providers to modernize operations, invest in technology, restructure service-lines to align to local needs, and stand-up shared-service collaboratives to

reduce administrative burden. These investments will lower fixed costs, improve efficiency, and build shared capacity needed to sustain rural care delivery.

The second pillar of ***Smart Care Catalyst*** **supports rural payers and providers to transition from fee-for-service payment models to outcomes-driven, VBC payment models to improve both quality and affordability of healthcare.** These models will ensure that providers share in the financial benefit of reduced acute-care utilization as health improves and preventable hospitalizations decline. The State will partner with Medicaid MCOs and commercial payers to develop and operationalize standardized multi-payer VBC payment models – supported by shared analytics, Care Transformation Organization (CTO)/Management Service Organization (MSO) structures, and targeted startup and incentive funding. The State will consider models supported by CMS for Medicare populations to establish models that providers may adopt across the majority of their patients and revenue sources. The Catalyst will build on WV's existing Medicaid VBC efforts and payer partnerships to coordinate statewide adoption.

Within 5 years, *Smart Care Catalyst* aims to support rural hospitals and providers in transitioning to financial risk. In the coming months, the State will facilitate a dialogue among leading payers and rural providers to determine: (1) the end-state model(s) that are best aligned with targeted improvements in care and financial sustainability of rural providers; and (2) a transitional path to that end-state, which may involve pay-for-performance or shared savings models to reward improvements and create a sustainable foundation for VBC across WV.

Key pillars and activities for this initiative include the following:

Pillars	Key activities
Reduce Provider Operating Expenses	Establish a productivity support fund for direct provider investments in technology and efficiency improvements: • Design funds for tools for productivity and efficiency (e.g., revenue cycle management, billing, virtual staff augmentation, automation, ambient listening, AI-enablement)[62, g] • Support technical assistance for service line planning and cost restructuring (e.g., OB, BH, SUD) to align supply with local demand • Support shared-service collaboratives for purchasing infrastructure and services (e.g., data analytics, care management, IT infrastructure, administrative services, enrollment, credentialing), which may be enabled through MSOs/CTOs

Advance VBC Models	Design and administer statewide, multi-payer payment models to improve population health and cost of care on priority conditions (incl. behavioral health and chronic disease management for diabetes, hypertension, cardiovascular disease, COPD, asthma):
	• Define standard, multi-payer VBC payment models that support providers transitioning to total cost mgmt. and reward quality, including:
	  • A shared savings model for primary care (e.g., rural clinics, independent PCPs, primary care at rural hospitals)
	  • A shared risk model for TCOC with larger providers or collaboratives (e.g., health systems, ACOs)
	  • Additional model(s) as needed to improve care outcomes and cost, such as for duals and BH/SUD (e.g., CMMI Innovation in BH, pay-for-performance for SUD or tied to foster care population outcomes, school-based VBC model to support behavioral health / reduce absences, collaboration with EMS for treat-in-place)
	• Develop model design, performance metrics, and data-sharing infrastructure (with appropriate protections) to support VBC uptake
	• Coordinate with MCOs, payers, and providers to define model parameters and participation agreements
	• Fund centralized analytics, reporting and other activities to oversee model operations and evaluate impact (supported by WVHIN)
	
	Provide implementation support to strengthen VBC participation:
	• Coordinate with centralized or regional resources (e.g., via CTO/ MSOs) to support providers in VBC participation – particularly smaller independent practices – by delivering shared analytics, contracting, care management, and technical assistance functions

[g] The State may design funding awards to best incentivize performance and outcomes (e.g., grants, forgivable loans)

	• Offer assistance on data management, quality improvements, and care model redesign • Support providers in joining or forming ASOs or CINs (building upon existing infrastructure where possible) to enhance coordination, achieve scale, and participate effectively in VBC payment models • Support tool implementation (e.g., AI analytics) to achieve VBC goals Provide startup funds and structured incentives to expand provider participation, according to narrow set of approved uses and eligibility criteria: • Limited fund uses include time-limited care-management or coordination payments as approved by application; analytics or data support incentive; match on shared savings achieved • Prioritize participation by rural and primary-care providers with defined funding limits and clear accountability metrics Expand PACE program implementation through SPA, providing startup funds to create new centers (private or state-run), where HRSA's Rural PACE Planning/Development funding is not available

Critically, these efforts help provide an updated policy/payment spine to sustain other WV RHT initiatives benefiting from VBC approaches. VBC models are critically important to supporting the financial sustainability of preventative solutions in *Personal Health Accelerator,* recovery programs in *Health to Prosperity Pipeline,* and low-cost mobility solutions in *Rural Health Link.* By linking payment reform with programs that expand telehealth and RPM, address broadband and transportation barriers, and promote healthy lifestyles, these models ensure improved access translates into measurable outcomes. An MSO/CTO infrastructure can integrate data from *Connected Care Grid* to guide proactive, community-based care management, and *Mountain State Care Force* workforce alignment will enable local teams to deliver timely, coordinated, and cost-effective care. In this way, the *Smart Care Catalyst* becomes the financial engine and the operational glue that sustains population health improvement across the state.

Mapping to strategic goals, use of funds, and technical score factors	
Main CMS Strategic Goal	Innovative Care
Use of Funds	B, D, F, G, I

Technical Score Factors	B.1 (Pop health clinical infrastructure), C.1 (Rural provider strategic partnerships), C.2 (EMS), E.1 (Medicaid provider payment incentives), E.2 (Duals), F.2 (Data infrastructure)

Outcomes for Smart Care Catalyst

Outcome 1: Improved provider productivity and admin efficiency
Metric: Percent of providers scoring at median or better in quality and RVU productivity across participating provider entities **Data notes:** WV health system billing/EHR data, CMS Physician Fee Schedule (RVU File) **Preliminary baseline & target:** *To be set during Stage 0*
Metric: Administrative cost reduction rate across participating provider entities **Data notes:** Initiative data tracking, provider financial reporting **Preliminary baseline & target:** Achieve 2% admin cost reduction across >50% of facilities by Year 5
Outcome 2: Expanded participation in VBC payment models
Metric: Standard payment model definition and state support **Data notes:** Initiative data tracking **Preliminary baseline & target:** *Baseline N/A,* 1 model defined and aligned by end of Year 1
Metric: % of rural lives covered by payers implementing new standard VBC payment models **Data notes:** Payer reporting, CMS and WV BMS enrollment data; at county level **Preliminary baseline:** Current state contract with MCOs has minimum of 12% of enrollees must be within APM arrangements **Preliminary target:** >50% of lives covered by participating payers by Year 5
Metric: % of eligible providers in new standard VBC payment models with at least one payer **Data notes:** Provider & initiative reporting; at county level **Preliminary baseline & target:** *Baseline N/A,* >50% eligible providers participating by Year 5
Metric: Percent of total rural lives attached to new standard VBC payment models **Data notes:** Data to be reported by participating Medicaid MCOs, State Health Benefits TPA, and other participating payers; at county level **Preliminary baseline & target:** *Baseline N/A,* 30% of rural lives attached to VBC payment models by Year 5
Outcome 3: Achieve net savings, utilization improvement, and quality improvement
Metric: Number and percentage of attributed members in VBC payment models achieving shared savings or total cost of care improvement relative to benchmark **Data notes:** Analysis of claims data for Medicaid MCOs, State Health Benefits program, and other participating payers **Preliminary baseline & target:** *To be set during Stage 0*
Metric: Decrease ED visit / inpatient admissions rate for members in new VBC payment models **Data notes:** Analysis of claims data for Medicaid MCOs, State Health Benefits program, and other participating payers

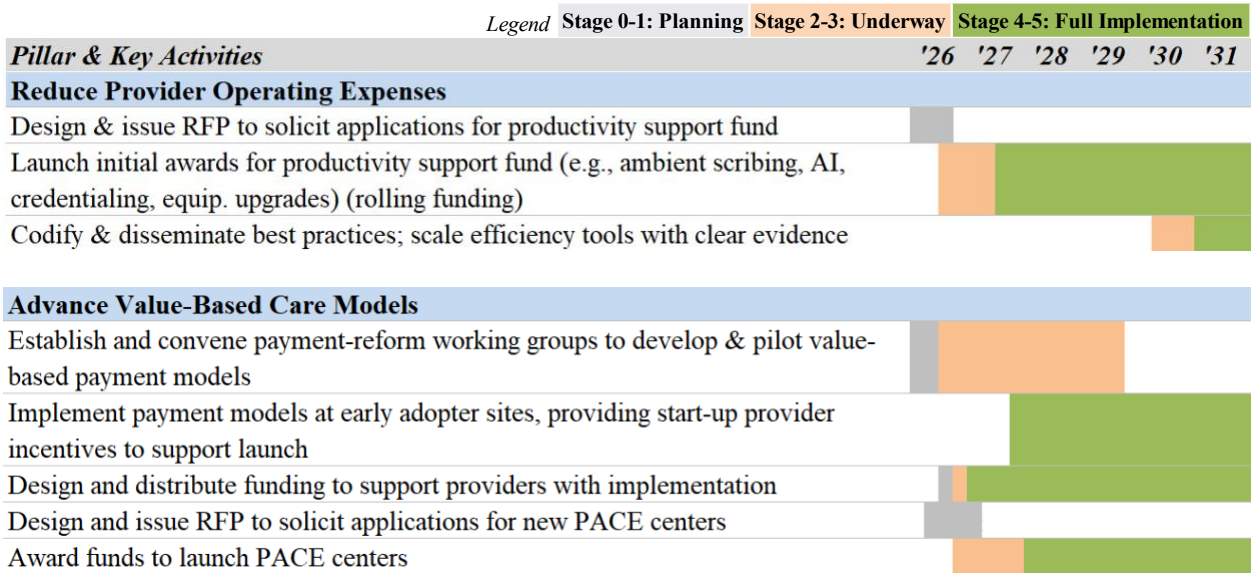
Preliminary baseline & target: *Baseline N/A,* Reduce preventable inpatient admissions by 5-10%, preventable ED visits by >10%, and preventable readmissions by >10% by Year 5
Metric: Percent of participating providers achieving improvements in core quality indicators as part of new standard VBC payment models **Data notes:** Reporting by participating payers **Preliminary baseline:** N/A **Preliminary target:** >50% of participating providers show measurable improvement in quality metrics for majority of core metrics by Year 5
Outcome 4: Expand community-based resources and improve transitions of care
Metric: Percent of discharges in which patients receive a follow-up (in-person or virtual) with a qualified provider within 30 days of discharge among participants in VBC payment models **Data notes:** Provider data, payer reporting, WVHIN tracking **Preliminary baseline & target:** *To be set during Stage 0*
Metric: All-cause readmission rate among providers participating in VBC payment models **Data notes:** Provider data, payer reporting, WVHIN tracking **Preliminary baseline & target:** *To be set during Stage 0*
Metric: Percent of individuals at institutional level of care in community-based settings **Data notes:** WV Dept. of Human Services, BMS Medicaid LTSS data **Preliminary baseline & target:** *To be set during Stage 0*

Key stakeholders: The Dept. of Health will spearhead this initiative in partnership with the Dept. of Human Services, WV Center for Rural Health Development, and vendor partners to support aspects of VBC development and implementation. This initiative will engage payers, provider networks, and associations to co-create and scale VBC approaches that work for WV's rural healthcare ecosystem and communities. The WV PEIA will also be a partner and is expected to be an early adopter of VBC models.

Impacted counties: All rural counties

Estimated funding: $245M over five years ($49M per year)

Implementation plan: The Dept. of Health will lead implementation, working with selected partners to establish the productivity framework and hold convenings to develop and pilot VBC payment models.



Sustainability plan:

Pillar(s)	Sustainability Plan
Reduce Provider Operating Expenses	**Phase in multi-payer alternative payment models:** Integrate Smart Care Catalyst payment models into Medicaid MCO, PEIA, and then commercial contracts, creating permanent reimbursement and incentive structures that reward efficiency and quality
and **Advance VBC Models**	**Sustain shared-service collaborative(s) or MSO/CTO operations through membership and shared-service fees**: After initial startup support, regional collaboratives or MSO/CTOs will be financed via annual provider membership and/or service contracts

Initiative 5: Health to Prosperity Pipeline

The *Health to Prosperity Pipeline* will tackle health issues that pose barriers to employment, helping drive economic productivity and move rural adults from Medicaid or no insurance to employer-sponsored coverage. **The State will support West Virginia's workforce participation by connecting adults facing chronic disease, pain, or behavioral-health challenges to coordinated care and job placement.** It will also help employees stay healthy and productive, embedding wellness and preventive services directly in the workplace. Partnerships between Medicaid MCOs, providers, employers, and higher education can promote

these return-to-work and stay-at-work outcomes. A greater focus on prevention and VBC (through *Personal Health Accelerator* and *Smart Care Catalyst),* expansion of innovative chronic, SUD, and disability solutions (incubated through *HealthTech Appalachia),* and ongoing employer partnerships and implementation of work requirements will help to embed these pathways and practices in perpetuity. Medicaid MCOs will have incentives to continue return-to-work efforts through performance incentives, including auto-assignment criteria or quality bonuses. The state will also augment RHT funds with targeted state investments of other state funds to build workforce participation.

Key pillars and activities for this initiative include the following:

Pillar	Key Activities
Help West Virginians Get Back to Work	Establish integrated health-to-work programs for at-risk adults including identification, care support coordination, career coaching, job resources, and wrap-around supports • Expand health-to-work field-based liaison programs to focus on chronic illness management and recovery-to-work with liaisons placed within *Connected Care Grid* hubs or other existing entities • Grow SUD recovery-to-work programs (e.g. ACCORN[h]) to provide full continuum of care[63] • Enhance technical assistance in existing rehabilitation services (e.g., Dept. of Commerce Rehabilitation Services) and build a clinical rehab track focused on SUD treatment in target counties • Include transition-to-employment supports for aging-out foster care youth, helping them access training and entry-level healthcare positions through *Mountain State Care Force* partnerships • Standardize ready-for-work and return-to-work protocols with employers (e.g., job-specific pre-placement/fit-for-duty testing, early injury triage, and liaison-led benefits counseling) • Invest in funding mechanisms tied to verified employment milestones, such as to cover non-clinical essentials (e.g., RPM devices transitional supports)

[h] Appalachian Continuum of Care for Overdose Reduction Network (ACCORN); See additional materials for further detail

	Provide MCOs performance incentives such as quality withhold and preferential auto-assignment tied to employment and ESI-transition outcomes[64]
Keep People Healthy and Employed	Develop worksite programs to help keep at-risk adults in current employers: • Fund embedded occupational health and worksite wellness (on-site or mobile) at high-risk employers[65] to deliver prevention (e.g., hearing loss), rapid injury care, and ready-to-work planning (e.g., Active Southern WV)[66] • Coordinate disability and ready-to-work supports by improving cross-program benefit tracking to prevent combined cash benefits from multiple programs exceeding pre-disability earnings and ensure a speedy, safe return to work. • Provide cost-sharing or insurance subsidies to employers hiring participants from health-to-work programs to offset initial healthcare needs

This *Health to Prosperity* initiative will expand on existing successful WV programs (e.g., ACCORN, Division of Rehabilitation Services), using the WVHIN and *Connected Care Grid* for closed-loop referrals to improve outcomes. The initiative complements, not replaces, current workforce and treatment services by funding the "connective tissue" —liaisons, data integration, and outcome-based supports—and expansion capital needed for going beyond existing programs.

Mapping to strategic goals, use of funds, and technical score factors	
Main CMS Strategic Goal	Make Rural America Healthy Again
Use of Funds	A, D, H
Technical Score Factors	E.1 (Medicaid provider payment incentives)

Outcomes for Health to Prosperity Pipeline
Outcome 1: Reduced health barriers to entering employment
Metric: Number of individuals supported back into the workforce via participating programs **Data source:** Program data for compliance monitoring and reimbursements; at county level **Preliminary baseline & target:** *To be set during Stage 0*
Outcome 2: Participants stay employed and reduce Medicaid dependence
Metric: 6-month job retention rate among program recipients[67] **Data source:** Program data collected for compliance monitoring and reimbursements **Preliminary baseline & target:** *To be set during Stage 0*[68]
Metric: Increased labor force participation rate in WV **Data source:** Program data collected for compliance and reimbursements; at county level **Preliminary baseline & target:** Baseline state rate of 54.3%; Target to increase by 2 percentage points

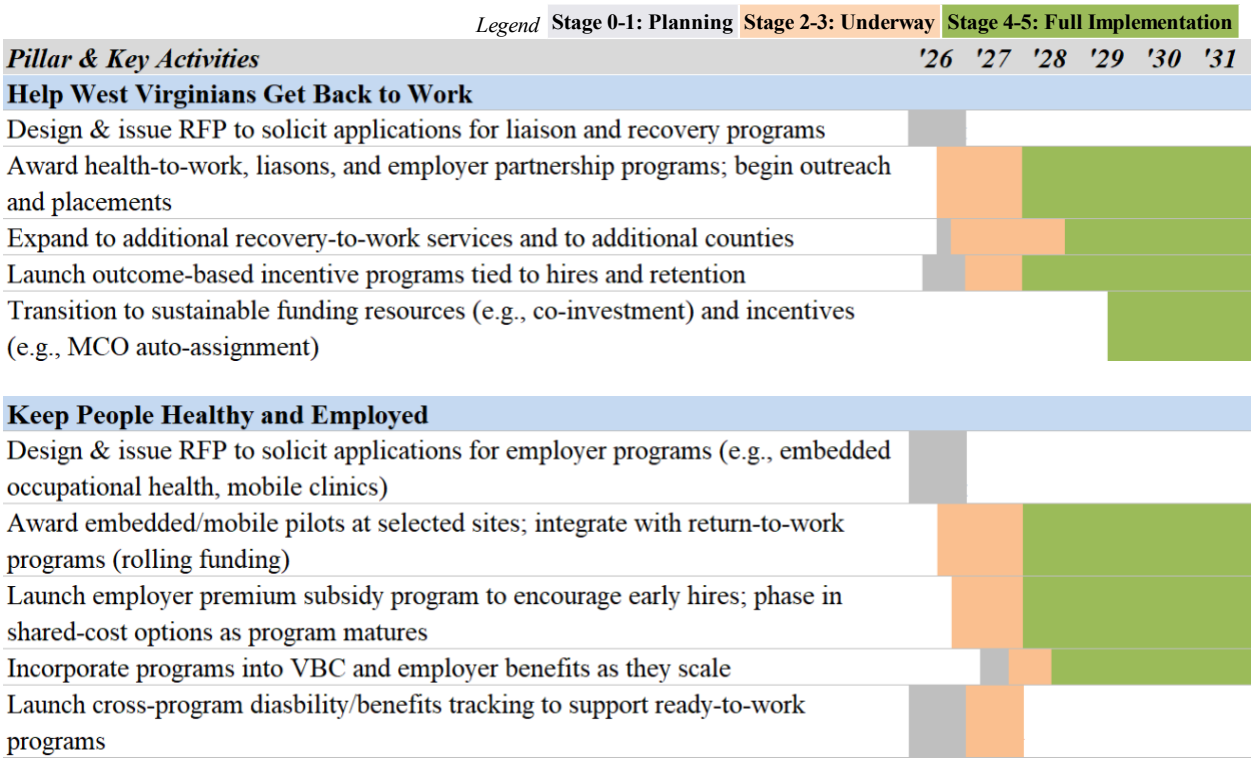
Outcome 3: Employers adopt wellness/onsite care that improves preventive care uptake
Metric: Number of employers offering additional on-site care that promotes chronic condition management, occupational wellness **Data source:** Program data collected for compliance monitoring and reimbursements **Preliminary baseline & target:** *To be set during Stage 0*
Metric: Increase rate of employee preventative screening and primary care visits among participating employers **Data source:** Program data collected for compliance monitoring and reimbursements **Preliminary baseline & target:** *To be set during Stage 0*
Outcome 4: Reduced health barriers to maintaining employment
Metric: Decrease rate of employees who leave due to health conditions **Data source:** Program data collected for compliance monitoring and reimbursements **Preliminary baseline & target:** *To be set during Stage 0*

Key stakeholders: The Dept. of Human Services will lead administration of these programs, in close collaboration with the Dept. of Commerce that will drive the employer partnership programs. As discussed below, both Departments will design and implement programs in close coordination with stakeholders leading existing job placement efforts (e.g., WIOA, Workforce WV regional boards) and care programs (e.g., ACCORN's SUD-to-work program, RNI addiction treatment, Active Southern WV, behavioral health providers, chronic disease mgmt. solutions). The State Office of Rural Health will support recruitment and placement through its 3RNet rural provider network. Rural employers and associations (e.g., WV Behavioral Healthcare Providers Assoc., Toyota, WV Manufacturing Assoc.) will be key collaborators, hiring residents that improve their health and promoting onsite wellness to existing employees. Marshall Health Network has offered to partner through its Occupational Medicine and CORE programs to expand rural rehabilitation and recovery-to-work efforts. Additional coordination with WorkForce WV and Division of Labor will support data inputs for programming.

Impacted counties: All rural counties will benefit.[69] The initial phase could target counties that have a relatively lower labor force participation alongside lower unemployment rates, indicating untapped participation potential that can be unlocked by reducing health barriers.

Estimated funding: $65M over five years ($13M per year)

Implementation plan: The Dept. of Health will lead implementation, working closely with Dept. of Commerce to initiate employer-partnerships and with local partners (e.g., ACCORN) to quickly design and stand-up liaison-based health-to-work programs.



Sustainability plan:

Pillar	Sustainability Plan
Help West Virginians Get Back to Work	**MCO performance incentives:** Incentivize MCOs to continue return-to-work programs through performance incentives, which may include auto-assignment incentives (e.g., provide a greater share of auto-assigned lives for demonstrated success on return-to-work programs) and/or quality programs (e.g., include metrics in quality withhold).
Keep People Healthy and Employed	**Employer-provider partnerships sustain employer-based wellness:** Wellness programs and clinics sustained through provider partnerships and ongoing insurance reimbursement.

Initiative 6: Personal Health Accelerator

The *Personal Health Accelerator* will build statewide wellness infrastructure targeting the state's most prevalent chronic conditions and empower rural residents with education and financial incentives. Lifestyle factors (e.g., nutrition, inactivity, smoking) are some of the strongest predictors of preventable disease and lower life expectancy in rural WV counties.[70] **The *Personal Health Accelerator* will empower West Virginians to take ownership of their health through nutritious food, exercise, and local care connections**. Funds will kickstart efforts to support nutrition and lifestyle improvement, incentivize planning for aging-in-place and future home care needs, and integrate wellness promotion tracking into medical data systems—enabling rigorous tracking of outcomes. Coupling these efforts with RPM will support monitoring, creating synergies with *Connected Care Grid*. A co-investment model will engage local, private sector and provider partners to build local ownership in programs and sustainable funding streams. In addition, data-driven demonstrations of healthcare value to payers will help justify ongoing operational funding (e.g., Medicaid 1115, employer benefit integration, VBC programs).

Key pillars and activities for this initiative include the following:

Pillar	Key activities

Local Health Challenge	Create statewide challenge competition among counties/communities for achieving health and lifestyle outcomes, with winners receiving awards:
	• Seed local groups (e.g., local health departments, local health alliances) to coordinate local efforts toward goals defined by WV RHT Leadership, potentially including
	  • Student achievement on the Presidential Fitness Challenge
	  • Measurable progress on childhood obesity
	  • Other nutrition, exercise, lifestyle (e.g., smoking) outcomes that improve population health
	• Local leadership will lead efforts that achieve goals (e.g., nutrition, exercise, healthy outdoors initiatives)

	• Targets will be set in collaboration with the Dept. of Health • Winning locales will receive a Governor's proclamation of being a healthy community, along with financial incentives (e.g., playgrounds and park improvement, bike paths and trail renovation, greenhouses/gardens), funded through a combination of RHT and additional state funds • WV will challenge neighboring states to participate in a state-to-state competition with similar goals

Improve Health Outcomes Through Nutrition and Lifestyle	Improve prevention of obesity, diabetes, hypertension, and cardiovascular diseases by creating access to nutrition, lifestyle, and care interventions:[71]
	• Launch direct incentive-based weight management program in state employee benefit plan:[72]
	  • Include pilot to incentivize state employees who choose high-deductible plans and health savings accounts (HSAs)
	  • Provide small HSA contributions for engagement (e.g., activity milestones) and large contributions for outcomes (e.g., weight loss)
	  • Incorporate RPM and direct incentive programs by tying financial rewards to RPM-tracked outcomes and targets[73]
	• Fund demonstrations of innovative care models in partnership with FQHCs/CHCs, hospitals, payers, and other local partners (e.g., via local health alliances, home health, pharmacy):
	  • Launch a Type 2 Diabetes reversal demonstration (e.g., enroll Medicaid patients in a ketogenic, remote-care model)[74]
	  • Launch a Healthy Food Benefit Marketplace to support healthy nutrition (e.g., using an AI/smart SNAP model to deliver digital healthy-food credits through grocers and local farmers)
	• Enhance food and wellness programs (e.g., locally grown produce prescription, healthy food access, healthy hospital menus)[75]
	
	Reduce hospitalizations and improve quality of life for individuals with COPD and asthma through early detection, monitoring, and management:
	• Use evidence-based smoking cessation incentive models, such as programs offering bundled financial rewards for verified abstinence[76]
	• Tie to RPM programs that equip patients with connected devices and follow-ups to detect symptom flare-ups and prevent hospitalizations[77]
	
	Target behavioral health and SUD recovery by embedding wellness, prevention, and wraparound supports into treatment and community care:
	• Support integrated recovery-nutrition programs with peer-led wellness and movement as relapse-prevention (in collaboration with *Health to Prosperity*)
	• Provide direct incentives and support for mothers to reduce substance use and smoking to improve maternal health and infant outcomes

	• Deploy targeted strategies to mitigate neonatal abstinence syndrome (NAS) birth rates statewide Expand resources to support seniors and aging-at-home: • Create a long-term care resource hub with AI navigation linking seniors, families, and providers to aging, home, and community-based services (e.g., CaringWire) • Fund home- and community-based supports for families at risk of nursing home placement or Medicaid spenddown, including home modifications and caregiver assistance • Incentivize participation in education and evidence-based programs that help older adults manage chronic conditions and remain home safely
Integrate Wellness into Core Medical Data Systems	Develop shared referral and tracking systems by funding data integration between EHRs, WVHIN, and community resource databases—aligning all implementation with HIPAA requirements • Support development of shared referral and tracking infrastructure integrated with the WVHIN • Integrate a closed-loop referral system between healthcare and community service, enhancing existing investments (e.g., FindHelp capabilities) • Enable data sharing for food prescriptions, exercise programs, caregiver supports, and transportation to make prevention and wellness measurable and coordinated across care settings

This focus on personal wellness is supported by other policies and state programs, including WV's SNAP soda-exclusion waiver, planned nutrition CME requirements, healthier options for women, infants, and children (WIC) state programs, aggressive efforts to clean up the food, and a statewide Mountaineer Mile fitness challenge launched in 2025 encouraging West Virginians to walk at least one mile a day.[i] The WV Food-is-Medicine Association and FARMacy WV already have active programs, which provide a strong foundation to rapidly expand on to reach rural communities.

Mapping to strategic goals, use of funds, and technical score factors	
Main CMS Strategic Goal	Make Rural America Healthy Again
Use of Funds	A, D, H

[i] Statewide initiative in West Virginia encouraging residents to walk at least one mile per day via designated "Mountaineer Mile" trails (West Virginia Office of the Governor)

Technical Score Factors	B.1 (Population health clinical infrastructure), B.2 (Health and lifestyle), E.1 (Medicaid provider payments), E.2 (Duals)

Outcomes for Personal Health Accelerator

Outcome 1: Empower local health challenges
Metric: Increase number of rural counties participating in a local health challenge **Data notes:** Initiative data tracking; county level **Preliminary baseline & target:** *Baseline to be collected during Stage 0*; preliminary target of 100% of rural counties participating by Year 5
Metric: Ratio of matching dollars to RHT funded dollars in expenses of local health challenges **Data notes:** Initiative data tracking **Preliminary baseline & target:** *Year 5 goal to attract enough matching funding to be self-sustaining (~1:1 match on non-start-up funds)*
Outcome 2: Increased participation in prevention and healthy living programs
Metric: Increase percent of patients receiving nutrition or lifestyle counseling from a provider or dietician in target service areas **Data notes:** Medicaid claims and managed care encounter data, CMS Medicare data, Commercial payer reporting, WVHIN reporting; at county level **Preliminary baseline & target:** *Baseline to be collected during Stage 0*; preliminary target of 50% patients receiving counseling during routine care from participating providers[78]
Metric: Increase number of patients receiving food-as-medicine and activity prescriptions within participating programs **Data notes:** Program self-reporting, WV Dept of Health, WV Dept. of Agriculture **Preliminary baseline & target:** *To be set during Stage 0*
Metric: Increase access and adherence rate for nutrition and exercise prescriptions **Data notes:** Clinical EHR systems, WV BPH, Community partner program logs; WVHIN closed-loop referrals, WV Dept. of Agriculture **Preliminary baseline & target:** *Baseline to be collected during Stage 0*; preliminary target of 50% adherence rate[79]
Metric: Increase percent of eligible patients enrolled in at least one validated prevention, wellness, or digital self-management program through their insurance company (e.g., diabetes prevention, hypertension control, remote lifestyle coaching) in target service areas **Data notes:** Medicaid claims and payer reporting; at county level **Preliminary baseline & target:** *Baseline to be collected during Stage 0*; preliminary target of 20-25% of eligible patients enrolled in insurance covered program[80]
Outcome 3: Reduced chronic disease burden and exacerbations in rural counties
Metric: Decrease in adult obesity prevalence in rural WV **Data notes:** CDC PLACES data **Preliminary baseline & target:** Baseline: current 41% prevalence of obesity; Preliminary target to decrease prevalence by 4 percentage points to <37% in 5 years
Outcome 4: Improved maternal and child wellness

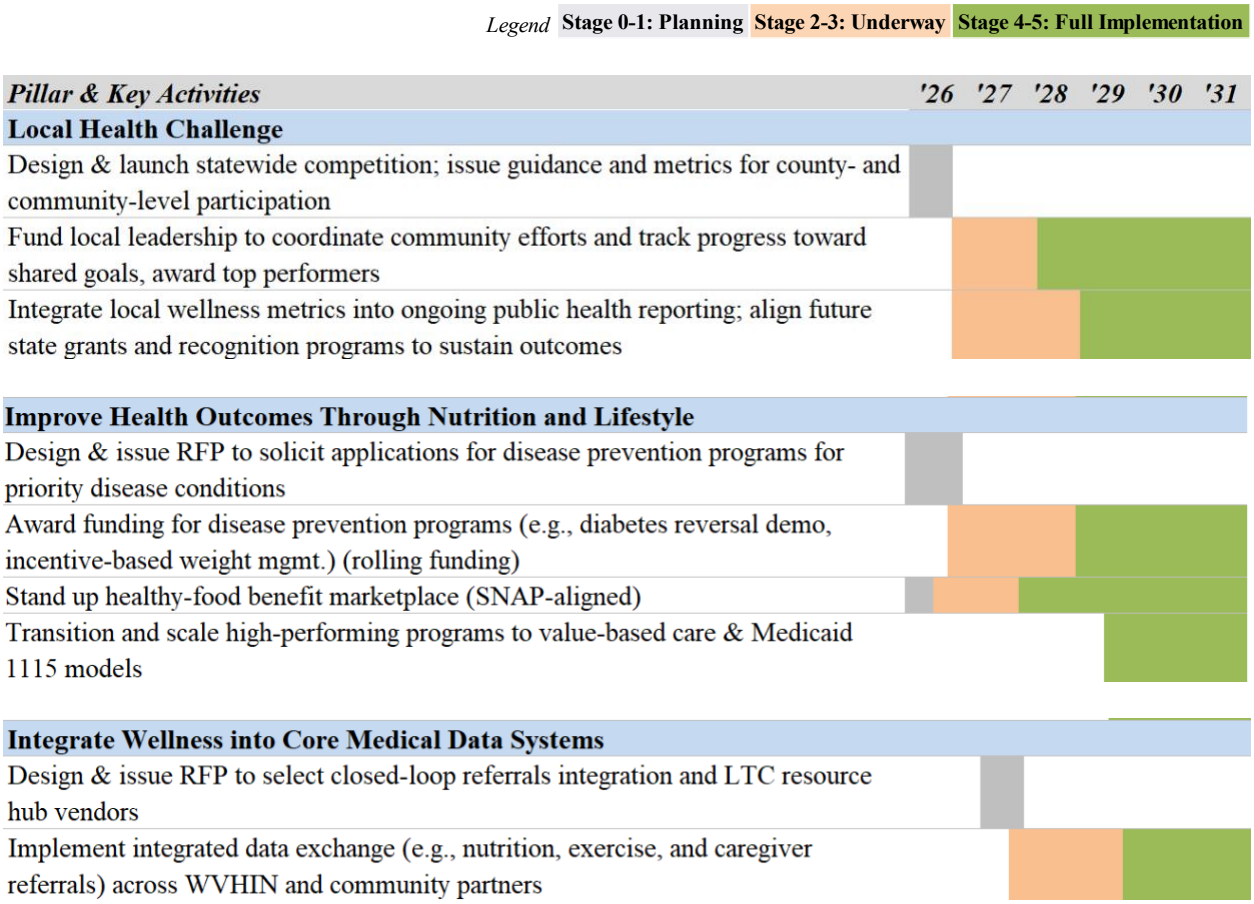
Metric: Decrease severe maternal morbidity and infant mortality rate among populations receiving interventions **Data notes:** WV Dept. of Health; WV Dept. of Human Services **Preliminary baseline & target:** Baseline infant mortality rate: 52 per 10,000, [81] *Additional baseline and targets to be set during Stage 0*
Metric: Decrease Neonatal Abstinence Syndrome (NAS) birth rates **Data notes:** WV Dept. of Health **Preliminary baseline & target:** Preliminary target to decrease by 5-10% in 5 years; *Additional baseline and targets to be set during Stage 0*

Key stakeholders: The Dept. of Health will lead implementation coordination, in partnership with WVHIN (for integrating wellness into data systems), PEIA (for embedding wellness into public employee insurance programs), WV Dept. of Agriculture (for partnership on locally grown food-based programs), medical schools (for partnership on research and innovative program design), and others. Local community sites (e.g., school-based health centers, employers, churches, food banks, local nonprofits) and healthcare access points (e.g., hospitals, FQHCs/CHCs) will be key partners to integrate and deliver wellness programming to rural communities. Philanthropic partners (e.g., Benedum Foundation), MCOs, and payers (including local employers) will be engaged to help financially sustain programs and recognize the value—an effort supported by the *Smart Care Catalyst* VBC work.

Impacted counties: All counties will benefit.

Estimated funding: $107M over five years ($21M per year)

Implementation plan: The Dept. of Health will lead implementation, in collaboration with PEIA, WVHIN, WV Dept. of Agriculture, and selected community partners. Rollout of chronic disease management programs start within 12 months.



Sustainability plan:

Pillar(s)	Sustainability Plan
Local Health Challenge	**Sustain through continued local engagement:** The local health challenge will build community engagement partners that can continue to drive coordination. Community incentives can be sustained after 5 years through non-monetary incentives (e.g., proclamations) as well as the transition to state-funded awards for measurable progress.
Improve Health Outcomes Through Nutrition and Lifestyle	**Integrate wellness programs into payer programs:** Embed successful wellness and community-health programs into existing benefit design (e.g., PEIA HSA program), Medicaid program design (e.g., value-added services) or waiver frameworks (e.g., 1115), making them reimbursable and part of payer operations rather than one-time projects.
Integrate Wellness into Core Medical Data Systems	**Sustain LTC/shared data/referral systems via subscription and payer support:** After the grant period, support the statewide referral and data-platform spine through provider subscription fees and payer contributions, leveraging the WVHIN infrastructure, and incorporate ongoing participation into payer/MCO reporting requirements.

Initiative 7: HealthTech Appalachia

HealthTech Appalachia incubates and scales breakthrough technologies that improve rural health and productivity while drawing private investment to expand statewide impact. WV faces 20–45% higher rates of COPD, cardiovascular disease, and diabetes than the national average, along with an overdose death rate nearly twice the national average.[82] These conditions demand new, technology-enabled prevention and treatment tools. *HealthTech Appalachia* will foster tech-enabled innovations to address chronic disease management and SUD recovery, including through AI-enabled prevention and consumer tools to encourage nutrition, movement, and behavioral-health resilience. This public funding kickstarts an innovation ecosystem with long-term private market support.

The State will use a public-private collaborative to make investment decisions, blending public-private funds to accelerate scaling solutions that work in WV rural communities. To govern funding decisions, the State will establish a healthcare advisory investment committee appointed by the Governor. This may include representatives from medical schools (e.g., WVU, Marshall, WVSOM), government agencies (e.g., Dept. of Health), payers, the private sector, and consumers. The committee will rely on the WV Jobs Investment Trust (WV JIT) to administer awards, including diligence and award design. **The State will augment the RHT funds with state dollars, supporting fund administration and technology incubation as needed to drive maximum impact**. The funding process will filter to select solutions that promote healthcare quality and cost, creating value for payers and consumers. This initiative will seed innovations to make them accessible in perpetuity and drive sustainable outcomes.

Key pillars and activities for this initiative include the following:

Pillar	Key activities
Incubate and scale new, innovative solutions	Provide seed grants to incubate new technologies that measurably improve access, outcomes, and total cost[j] - prioritizing the following 3 theses: • **SUD treatment & recovery** (e.g., Rockefeller Neuroscience Institute (RNI) ultrasound neuromodulation to address the root causes of addiction) • **Chronic-disease control** (e.g., Welldoc's BlueStar FDA-cleared digital therapeutic for diabetes with hypertension modules, RAIsonance AI smartphone-based respiratory analysis for early COPD/ asthma detection) • **Consumer engagement in healthy living** (e.g., AI-empowered health coaching, Humetric AI triage/PHR with personalized safety alerts; Microsoft AI consumer navigation; Higi retail/community risk screening; blood pressure cuff machines; Topcon AI retinal screening in pharmacies/clinics, Rhino AI med adherence, or similarly innovative products) Create an Accelerator to drive broad adoption in WV's marketplace and benefits in rural communities. The Accelerator will provide innovation grants or forgivable loans to subsidize innovations. The following areas will be targets: • **SUD treatment & recovery** (e.g., RNI digital health and monitoring for addiction and recovery) • **Chronic-disease control (**e.g., Virta's diabetes reversal at scale, Cadence titration support for cardiometabolic RPM) • **Consumer engagement in healthy living** (e.g., Omada Health's connected lifestyle programs) • **Care model innovations and commercialization** (e.g., home dialysis, home infusion) • **Advanced analytics and AI solutions for providers and payers (**e.g., Moodr care mgmt. analytics, risk and predictive analytics)

Mapping to strategic goals, use of funds, and technical score factors	
Main CMS Strategic Goal	Tech innovation
Use of Funds	A, C, H
Technical Score Factors	F.3 (Consumer-facing technology)

HealthTech Appalachia is inspired by other, proven state innovation fund models while building on existing investment and startup incubation assets within WV.[83] Existing research and

[j] *Grant funding will be contingent on compliance with robust data collection requirements via EHRs/HIE. Note that listed solutions are non-comprehensive of range of eligible recipients.*

translational commercialization assets include WVU's Clinical and Translational Science Institute, WVU's Innovation Corporation, WVU RNI, Marshall Health's Clinical Research Center, and potentially the new WVSOM $35 million Bio Hub expansion.[84] For instance, WVU RNI has developed innovative digital monitoring and ultrasound technology that can address the underlying drivers of cravings and addiction, which could directly support the *Health to Prosperity Pipeline's* focus on helping adults avoid and recover from SUD challenges to reenter the workforce.[85] Incubation pilots could be chosen in collaboration with payers and providers to prioritize models that drive outcomes, as discussed in the Stakeholder Engagement section.

Target Outcomes for HealthTech Appalachia

Outcome 1: Health improvements among target populations for funded solutions
Metric: Increase abstinence rate, reduce relapse/usage rate among SUD patients using solutions **Data notes:** Payer and solution reporting at county level **Baseline and target:** *Baseline set upon funding; investment committee to set targets*
Metric: Weight loss achieved for target populations using funded solutions **Data notes:** Payer and solution reporting at county level **Baseline and target:** *Baseline set upon funding; investment committee to set targets*
Metric: Decrease diabetes patients with A1C >9% **Data notes:** Payer and solution reporting at county level **Baseline and target:** *Baseline set upon funding; investment committee to set targets*
Metric: Decrease 30-day all-cause readmission after an HF hospitalization **Data notes:** Payer and solution reporting at county level **Baseline and target:** *Baseline set upon funding; investment committee to set targets*
Metric: Percentage of people in target population for funded solutions addressing hypertension whose blood pressure (BP) was adequately controlled (<130/80 mm Hg) **Data notes:** Payer and solution reporting at county level **Baseline and target:** *Baseline set upon funding; investment committee to set targets*
Metric: Decrease avoidable ED and inpatient admission rate in target population for funded solutions addressing diabetes, COPD, asthma, and congestive heart failure **Data notes:** Payer and solution reporting at county level **Baseline and target:** *Baseline set upon funding; investment committee to set targets*
Metric: Improve asthma control for populations receiving relevant funded solutions **Data notes:** Payer and solution reporting at county level **Baseline and target:** *Baseline set upon funding; investment committee to set targets*
Metric: Tobacco cessation rate for target populations using funded solutions **Data notes:** Payer and solution reporting at county level

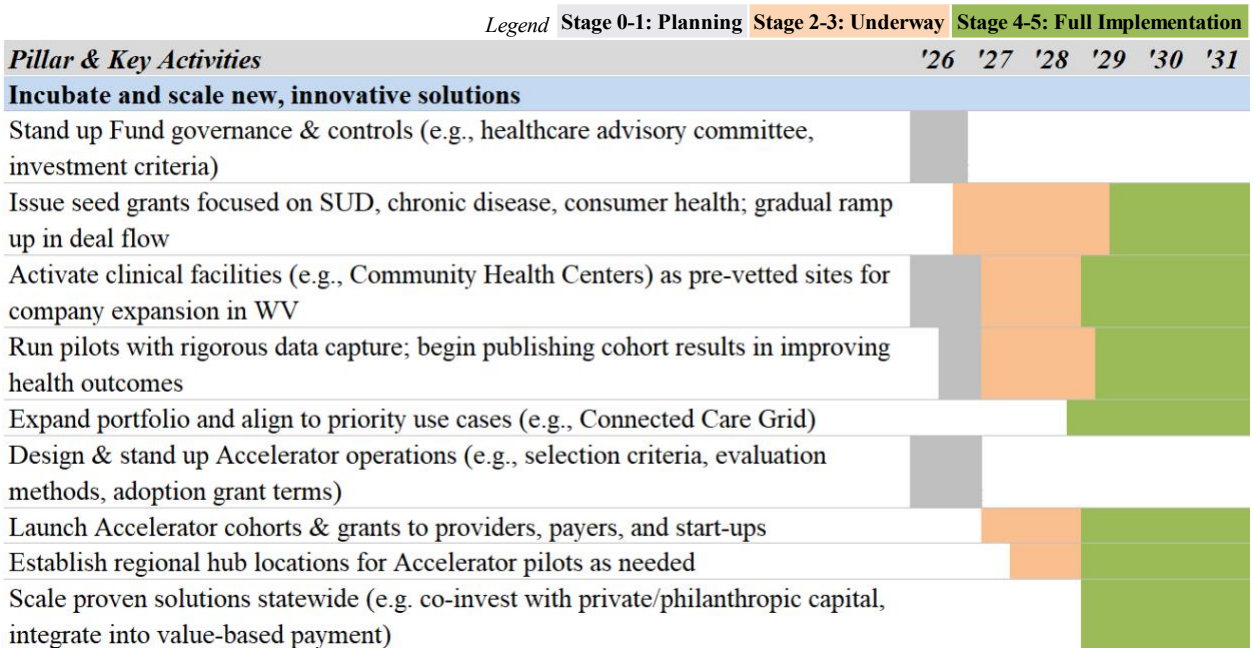
Baseline and target: *Baseline set upon funding; investment committee to set targets*
Outcome 2: Innovative solutions are improving access to care
Metric: Number of individuals benefiting from funded solutions on monthly basis **Data notes:** Payer and solution reporting at county level **Baseline and target:** *Baseline set upon funding; investment committee to set targets*
Outcome 3: Innovative solutions are being funded and adopted in the market
Metric: Number of incubated portfolio companies **Data notes:** Consortium institution reporting **Preliminary baseline & target:** *Target of >15 companies by 2030*[86]
Metric: Number of healthcare start-ups supported by Accelerator adopted via incubation pilots **Data notes:** Accelerator compliance reporting through Dept. of Health **Preliminary baseline & target:** *To be set during Stage 0*
Outcome 4: Initiative expands impact by attracting private capital
Metric: Ratio of private/philanthropic capital to public RHT investment **Data notes:** *Public-private collaborative* institution reporting **Preliminary baseline & target:** *To be set during Stage 0*

Key stakeholders: WV's medical innovation hubs (e.g., WVU,[87] Marshall Health,[88] WVSOM) will provide healthcare expertise while local foundations and private investment partners (e.g., Benedum, Appalachian Regional Commission, private equity & venture investors) will participate as co-investors.

Impacted counties: All counties

Estimated funding: $103M over five years ($21M per year)

Implementation plan: WV is prepared to launch *HealthTech Appalachia* in early 2026. Early milestones include standing up the governance structure, including the healthcare advisory investment committee, and issuing the first seed grants within the first 8-12 months.



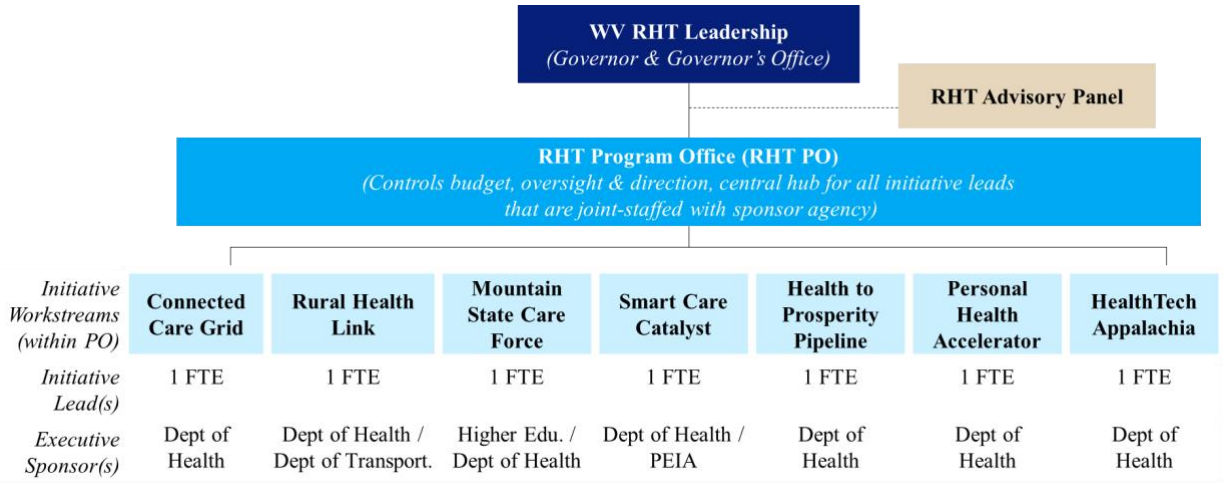
Sustainability plan:

Pillar(s)	Sustainability Plan
Incubate and scale new, innovative solutions	**Use sustainability as a criterion for funding:** the funding governance process will prioritize solutions with a clear path to payer, provider, or consumer adoption, ensuring the innovations remain available in market in perpetuity.

D) Implementation Plan & Timeline

WV's implementation approach is designed to secure early wins that build momentum while staging activities to test, learn, and scale across rural communities. The Governor and Governor's Office will provide overall leadership. The Dept. of Health will be the lead agency of the RHT Program Office (RHT PO). The Program Office (PO) will serve as the central hub for initiative coordination, budget management, and performance oversight.

Overview of West Virginia RHT Program Governance



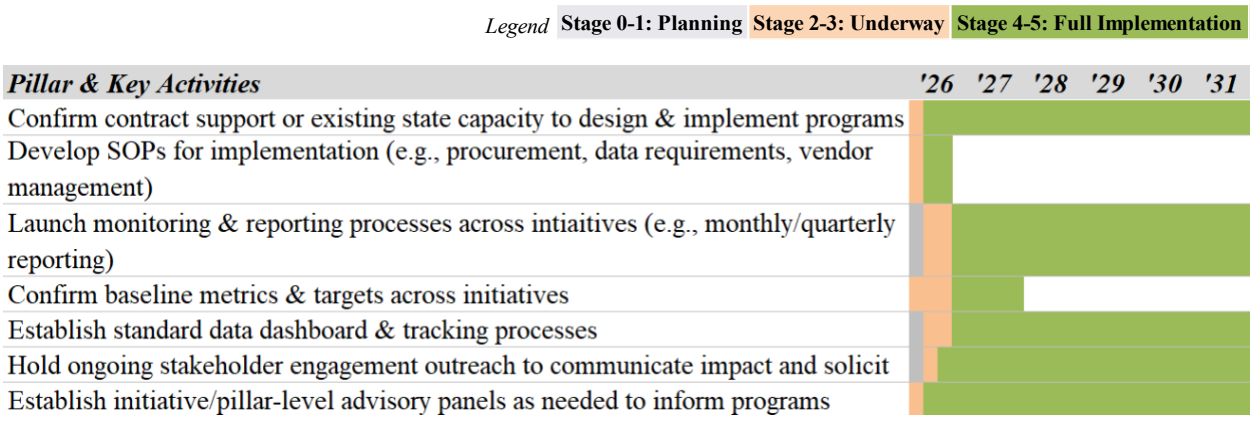
Key roles and responsibilities of these governing bodies include:

Role	Responsibilities
WV RHT Leadership	• Led by the Governor • Provides high-level policy direction, interagency coordination, and barrier removal; monitors statewide progress toward RHT outcomes
RHT Program Office (RHT PO)	• The PO is the central coordinating and decision-making body for the RHT portfolio with primary authority for program oversight, budget, and coordination
Initiative Workstreams	• Each Initiative Workstream will have a state agency as an Executive Sponsor that contributes support and cabinet-level accountability • Each flagship initiative will be led by ~1 jointly-staffed Initiative Lead, co-embedded in the PO and their home agency • Workstreams will manage day-to-day execution, lead deliverable tracking and problem-solving against initiative milestones, coordinate with delivery partners, and escalate issues to the PO as needed
RHT Advisory Panel	• Provides external consultation to RHT Leadership and PO, advising on program design, implementation progress, and opportunities for private-sector collaboration • Key forum for ongoing stakeholder engagement, including representatives from health systems, academia, provider and community organizations, payers, and local governments

External project management and implementation support will augment the PO's capacity as well as operational leads where needed. It is the intention of the state of WV that purchases

under this program shall be exempt from state purchasing laws to facilitate the expeditious implementation of RHT initiatives and to comply with the timing requirements of the grant. External partners can provide specialized technical assistance for data systems integration, payment reform modeling, evaluation and other specialized capabilities or surge capacity, as needed. The first 12-month implementation plan for PO governance can be found in the supporting materials. Early awards will be issued in Jan-Mar of 2026. Authorizing legislation will be passed by the end of Jan 2026. RHT PO will track milestones, budgets, and outcome metrics. Executive Sponsors will be accountable for monthly or quarterly progress and performance reports to the RHT PO. RHT PO data lead with initiative Program Managers will oversee data reporting for transparency and accountability.

See above for detailed implementation plans for *Connected Care Grid*, *Rural Health Link*, *Mountain State Care Force*, *Smart Care Catalyst*, *Health to Prosperity Pipeline*, *Personal Health Accelerator*, and *HealthTech Appalachia*. In addition to these initiative-specific plans, the RHT PO (with designated agencies) will lead cross-cutting implementation efforts, including the following:



E) Stakeholder Engagement

This WV RHT Application was built through a deep stakeholder engagement process, including broad public input, interviews, and Governor-led convenings**:**

- A statewide **RFI generated ~3,000 pages of insights from 250+ respondents,** including providers, payers, tech companies, associations, academia, and citizens.
- The RFI was augmented with **50+ stakeholder discussions**, including with rural healthcare providers and payers, medical schools, local governments, and associations.
- **Representatives of the Senate and House reviewed a draft to provide comments**, and the legislature's Oversight Committee on Health was briefed on the RHT application strategy.
- **In mid-October, the Governor convened 3 roundtables with 30+ organizations represented to solicit input,** co-hosting with Depts. of Health and Human Services.
- **The Governor held a tele-townhall with 17.1k citizens** in rural areas to gather input.
- **State agencies** (including the Depts. of Health, Human Services, Education, Agriculture, Commerce, and Transportation) **offered leadership across** the application development.

Stakeholders have signaled broad support, evidenced by letters and statements of support from over 40 organizations, which are included in the supporting materials.

Going forward, a breadth of external stakeholders will be engaged through the RHT Advisory Panel and as initiative implementation partners. State agencies will serve as executive sponsors for initiatives, with representatives from populations and stakeholder groups incorporated as members of the Advisory Panel (e.g., rural patient advocates, local county health leaders, CHW representatives). To ensure continued stakeholder engagement beyond formal governance, WV will implement structured feedback and co-design mechanisms during implementation.

Early engagement strategies by initiative include:

Initiative	Early Engagement Approach
Connected Care Grid	• Engage with WVHIN, broadband partners, EMS, and healthcare data providers to co-design and align data and interoperability standards • Host working sessions and interviews with providers and community representatives to identify and prioritize areas for access points
Rural Health Link	• Form joint planning group with Dept. of Health, DOT, transit agencies, and NEMT vendors to co-design scheduling platform and mobility incentives • Hold community engagement sessions in early pilot counties to shape routes, incentives, and local capacity priorities
Mountain State Care Force	• Convene planning group including Higher Ed, medical schools, and providers to align training slots, grants, residencies, and pipeline programs
Smart Care Catalyst	• Co-develop models with payers, providers, rural hospitals, Dept. of Health, WV PEIA, Dept. of Human Services to shape early payment reform pilots and shared-service collaboratives
Health to Prosperity Pipeline	• Conduct regional design roundtables with employers, MCOs, and workforce programs (e.g., ACCORN) to define pilots/incentives • Engage with state agencies to co-design data-sharing, incentive, and tracking frameworks that link health recovery to employment
Personal Health Accelerator	• Hold design workshops with local health alliances, community representatives, and philanthropic partners to define grant criteria
HealthTech Appalachia	• Co-design workshops with research institutions, health systems, and provider associations to define investment theses and fund structure • Engage rural hospitals, startups, and payers early to identify technology priorities and pilot sites

F) Metrics & Evaluation Plan

West Virginia will evaluate the RHT Program using a unified **performance framework that aligns CMS's core priorities of access, quality, and sustainability to drive overall improvement in outcomes**. The State will use a combination of existing data systems (e.g., Medicaid, PEIA, WVHIN, hospital and FQHC reports, licensing data), augmented data sources (e.g., claims databases), and new program dashboards built through the RHT PO to enable regular monitoring. Across initiatives, baseline and target data will be defined (if needed) in Year

1, with measurable progress targets beginning in Years 2–3. Regular reporting is expected on a monthly, quarterly, or annual basis as needed for each initiative.

The State will conduct continuous performance monitoring through its RHT PO to inform frequent reviews and updates; this will complement long-term analysis of outcomes and economic impact. This will be supported by data partnerships with academic institutions and WVHIN. The State expects to engage external evaluation partners to complete dedicated evaluations for specific, large initiatives and activities (e.g., effectiveness of healthcare workforce retention programs). The RHT Leadership and PO will oversee evaluation processes to ensure programs are rigorous and leverage mixed-method approaches. West Virginia will fully cooperate with all CMS monitoring and third-party evaluations and will produce an annual RHT Performance Report summarizing statewide progress, lessons learned, and impact metrics.

See the detail above for detailed metrics for *Connected Care Grid*, *Rural Health Link*, *Mountain State Care Force,* *Smart Care Catalyst*, *Health to Prosperity Pipeline*, *Personal Health Accelerator,* and *HealthTech Appalachia*.

G) Sustainability Plan

West Virginia is leveraging RHT funding to provide the catalytic startup capital needed to kickstart programs that can be durable long term. As part of this plan, WV is driving increased innovation, competition, and value-based structures that facilitate access while reducing the cost of healthcare services. See the detail above for detailed sustainability plans for *Connected Care Grid*, *Rural Health Link*, *Mountain State Care Force,* *Smart Care Catalyst*, *Health to Prosperity Pipeline*, *Personal Health Accelerator,* and *HealthTech Appalachia*.

Endnotes

[1] United Health Foundation (2024)
[2] USDA (2023)
[3] Department of Labor (2023).
[4] County Health Ranking (2024).
[5] Trust for America's Health, *The State of Obesity* (2025); Centers for Disease Control and Prevention (CDC), *Current Cigarette Smoking Among Adults in the United States* (2024); America's Health Rankings, *Adult Smoking – West Virginia* (2023)., Gallup
[6] National Survey on Drug Use and Health
[7] CDC Places, County Health Ranking; Saving Lives and Saving Money; The Economic Burden of Adults with MDD, National Survey on Drug Use and Health ; American Diabetes Association ; Takehealthtohear.org; CDC Chronic Disease fact; Direct Medical Costs of COPD; National Indicator Report COPD; CDC Asthma cost calculator; Cost of Asthma on Society
[8] U.S. Census Bureau Household Pulse Survey
[9] Bureau of Labor Statistics. *Unemployment Rates by State (2025)*
[10] Marshall University (Rural Health Transformation Initiative, RFI response, 2025)
[11] US Census Data (2019-2023)
[12] Moody's (2024)
[13] County Health Ranking (2024). Note: Overdose mortality rates are ~58 in rural WV for every 100,000 people vs. 28 nationally.
[14] March of Dimes. *2023 Maternity care deserts report for West Virginia.*
[15] CDC (2024)
[16] USDA (2025)
[17] West Virginia University. *Telehealth for West Virginians in Rural Areas* (2024)
[18] Rural Health Innovation Hub (2025)
[19] The national US average ratio is 19:1 (population : healthcare worker). Healthcare workforce was defined as employment of 2-digit soc codes: 29-0000 Healthcare Practitioners and Technical Occupations and 31-0000 Healthcare Practitioners and Technical Occupations. This is calculated as Total population / healthcare employment in a specific county.
[20] Lightcast. This pattern is especially pronounced in key clinical roles. Among RNs, 25% are aged 55 or older and 5% are 65 and above, while among physicians, 31% are aged 55 or older and 11% are 65 and above.
[21] Myers and Stauffer Provider Network Adequacy Review of MCOs (2025)
[22] Moody's (2024)
[23] Moody's (2024)
[24] Federal Reserve Bank of St Louis (2025)
[25] Starting January 1, 2026, SNAP benefits in WV can no longer be used to purchase soda—regular, diet, or zero-calorie (West Virginia Department of Health)
[26] Matching-incentive doubling/tripling SNAP/EBT value for produce at local markets in WV (SNAP Stretch)
[27] At West Virginia University School of Medicine the four-year Culinary & Lifestyle Medicine Track (CLMT) runs alongside the standard MD curriculum, offering enhanced training in nutrition, food science and preparation, lifestyle management, physical activity and sleep (WVUSOM)
[28] SB 533 (2024) authorizes EMS agencies in WV to triage, treat in-place, or transport patients to alternate destinations—telehealth/medical coordination required—and mandates insurance coverage (WV Legislature)
[29] WV SB613 (2023)
[30] SB 458 (2025) establishes the "Universal Professional and Occupational Licensing Act," allowing license-eligible individuals from other states to obtain equivalent West Virginia credentials without examination; West Virginia participates in multiple interstate licensure compacts, including IMLC (physicians), PA (physician assistants), eNLC (nursing), PT Compact, REPLICA (EMS), and PSYPACT (psychology) (West Virginia Legislature) Existing compacts: Physicians: WV has enacted the Interstate Medical Licensure Compact (IMLC) in state law (W. Va. Code § 30-1C-11);PA: WV is an active member in the PA compact (W. Va. Code § 30-3G-1); Nursing: WV participates in the Enhanced Nurse Licensure Compact (eNLC) since 2018 (W. Va. Code § 30-7F-1); Physical Therapy: WV is

active in the PT Compact (W. Va. Code § 30-41-1); EMS: WV is active in the EMS Compact (REPLICA) (W. Va. Code § 16-60-1); Psych: WV is an active member of PSYPACT compact (W. Va. Code § 30-21A-1)

[31] West Virginia Code Chapter 16, Article 60

[32] West Virginia mandates that private insurers and Medicaid cover telehealth services on the same basis as in-person care; The state also allows out-of-state practitioners to provide telehealth services through a special interstate registration process, and participates in multiple licensure compacts Center for Connected Health Policy

[33] Potential "spoke" access point through telehealth kiosk (clinic in a box) that is private, secure, ADA-compliant care station that delivers real-time virtual healthcare. Kiosks could be equipped with integrated diagnostic tools such as stethoscopes, high-resolution cameras, self-cleaning, and other vital sign monitoring to enable clinician-guided exams across primary, urgent, behavioral, and post-acute care.

[34] Across >30 randomized trials, RPM for diabetes, heart failure, and COPD lowered hospitalizations by 25–30%, improved HbA1c by 0.5–1.2 percentage points, and reduced all-cause mortality by up to 20% (BMJ, 2022; JAMA Netw Open, 2023; CMS Innovation Center, 2024).

[35] California example: limited-term per e-consult incentive: Health Net implemented a $70 e-consult incentive payment to encourage provider adoption of virtual specialty consultations. Health Net eConsult Incentive Flyer, 2020; Colorado example: time-bound incentives: Colorado has adopted time-limited e-consult incentive payments to expand provider participation in telehealth and e-consult services. Colorado eConsult Newsletter, July 2024

[36] Benchmarked against Cigna study evidence that virtual care can reduce ER visits by ~20%

[37] SageJournals Study

[38] Rural Health Information Hub suggests 1 in 5 care visits can be performed virtually

[39] Benchmarked against national average AMA

[40] Accounting for top portion of utilizers with chronic conditions contributing disproportionate amount to healthcare expenditure

[41] Benchmarked against results from Michigan Medicine RPM study

[42] Benchmarked against national average KFF

[43] Virtua Health's transport platform in New Jersey resulted in a >50% reduction in average cost per ride and a 20% improvement in inpatient bed availability. The Missouri HealthTran program found that every $1 invested in the mobility resources generated $7.50 in reimbursed health-care services, reinforcing the potential for strong return on investment and long-term sustainability of this mobility investment.

[44] Per-1,000 rates are derived from Modivcare analytics: 12,500 monthly users = 2.3% uptake, implies eligible denominator of 543,000. Baseline 1.8M one-way rides/year converts to 3,312 per 1,000. Target 3.6M converts to 6,624 per 1,000. Method consistent with HHS/Mathematica reporting conventions for NEMT utilization.

[45] Assumes baseline of 2,077,765 rides per year based on Modivcare provided data and ~543,478 eligible people based on Modivcare statistic of 2.3% uptake at 12,500 unique riders per month. Target reflects goal to double uptake by eligible participants by 2031 maturity.

[46] Many state contracts define OTP to the appointment, not just pickup. Example: Michigan's Modivcare contract requires ≥90% arrive no later than appointment time and ≥85% pickups within ±15 minutes.

[47] Based on Modivcare provided data; ADA paratransit guidance and industry benchmarks commonly target ~90-96% on time performance with 15-30 minute windows according to the FTA and industry standards DREDF.

[48] Outpatient no-show rates commonly fall within 15-30% in the literature (Empowered-Home.com and CaringWire); Research by Kentucky University shows no show rates for satellite/rural locations is ~25% compared to 19% at main medical campus location; NIH National Library of Medicine; Fabric Health suggested in RFI response ability to reduce baseline no-show rate by 25-30%

[49] Defined as ED visits for ambulatory-care-sensitive/avoidable causes per 1,000 members (i.e., flag "used transportation assistance vs. not"); Uses AHRQ's ED Prevention Quality Indicators (PQEs) area level ED visit rates for conditions where good ambulator care can prevent ED use.

[50] Lightcast. This pattern is especially pronounced in key clinical roles. Among RNs, 25% are aged 55 or older and 5% are 65 and above, while among physicians, 31% are aged 55 or older and 11% are 65 and above.

[51] Rural residency programs increase physician retention in rural practice by 35–60% compared to traditional residencies (HRSA Rural GME Evaluation, 2023). Graduates of rural tracks are 2.3× more likely to remain in rural communities after training (JAMA, 2022).

[52] South Carolina AHEC Rural Provider Incentive program

[53] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-education/a07-cme-incentive-access-care-underserved.pdf#:~:text=A%20number%20of%20states%20have,years%20of%20the%20taxable%20year

[54] Ascend WV is a local recruitment program that has successfully attracted new workers into the state using a variety of marketing, incentive, and concierge tools.
[55] Project ECHO models have demonstrated 20–40% improvements in guideline adherence for chronic and behavioral-health conditions, a 17% reduction in provider isolation scores, and expanded specialty reach to 92% of previously unserved counties in participating states (NEJM Catalyst, 2022; AHRQ, 2023).
[56] Equivalent to ~1 full class of rural high-school students across all rural counties
[57] 2024 West Virginia Health Sciences and Rural Health Report
[58] Potential target placement rate benchmark: 77% of class of medical graduates who completed primary care residency in West Virginia remained in state at the conclusion of their Training. Source: WVSOM Rural Health Initiative RFI Response
[59] Benchmarked off of HRSA minimum adequate ratio
[60] Benchmarked off of National Health Service Corps results with >80% of participants practicing in service communities after initial commitment
[61] CMS Health Expenditures by State of Residence
[62] AI-assisted clinical tools improve diagnostic accuracy by roughly 10–15% and reduce provider documentation time by 30–45%, allowing clinicians to spend more time in direct care (AHRQ Digital Health Evaluation, 2023; NEJM AI, 2024). Early rural pilots reported modest efficiency gains without compromising quality
[63] Appalachian, Continuum of Care for Overdose Reduction Network (ACCORN) is an ARPA-HEROES program that received $20M in startup funding from the West Virginia First Foundation. Full continuum includes prevention, same-day treatment, telehealth, peer recovery, and pay-for-outcomes contracts tied to employment stability. See additional materials for further detail
[64] WV Quality Withhold is 1% of aggregate capitation; withhold begins 7/1/2025 WVDHS p. 33; Auto-assignment equal-share requirement in WV Code; CMS bonus headroom up to 105% of capitation (≈5%). Provide MCO performance-based incentives with preferential auto-assignment tied to employment and ESI-transition outcomes. Highlight plan's results in helping eligible adult participations with job placement, job retention for 12 months, and healthcare coverage for 12 months
[65] e.g., mining, timber, manufacturing
[66] A 2025 systematic review of 10 U.S. studies in the *Journal of Occupational and Environmental Medicine* found 9/10 worksite health center evaluations reported positive employer ROI, supporting onsite/near-site or mobile primary/BH services.
[67] Implies population denominator for all award recipients with >12 months of observation
[68] Informed by industry standards, HR Executive, The Work Institute
[69] BLS LAUS, Lightcast, Moody's; Low labor force participation rate is defined as lower than national average 62.3%, low unemployment rate is defined as lower than national average 4.3% in Jul. 2025
2. The non-institutional population aged 16 and over includes all civilians not in institutions or military and is eligible to participate in the labor market
[70] CDC Places
[71] Evidence-based prevention programs have demonstrated strong and durable impacts: the NIH *Diabetes Prevention Program* reduced diabetes incidence by 58% initially and 34% at 10 years (*NEJM*, 2002; *Lancet*, 2009); smoking cessation delivers one of the highest health returns, saving $2–$3 for every $1 invested (American Lung Association, 2023); and prenatal nutrition and breastfeeding supports reduce preterm birth, low birthweight, and infant mortality (USDA FNS, 2021; AHRQ, 2020).
[72] Modeled on evidence from JAMA published study
[73] Modeled on UnitedHealthcare and Qualcomm Life program providing RPM devices and financial rewards to employees meeting daily step goals
[74] Funding for continuous glucose monitoring, AI-assisted nutrition coaching, and clinician oversight (with demonstration potentially operating under a Section 1115 waiver) This model has been proven to reduce HbA1c by ⩾1%, achieves ⩾35% medication reduction, and saves a n average of $12,600 per participant annually. This demonstration will operate under a Section 1115 waiver, enabling bundled payments tied to outcomes and integrating with value-based care arrangements through Medicaid MCOs. Demonstrated ROI (3:1–5:1) supports permanent adoption statewide.
[75] The national GusNIP program found produce prescriptions improved healthy food intake and contributed to A1c improvements for diabetics.
[76] Clinical trials have been shown to achieve quit rates more than triple usual care (NEJM Penn/GE study)
[77] Modeled on evidence from UC Davis Health initiative
[78] Benchmarked off Michigan Institute for Healthcare Policy & innovation study

[79] Benchmarked off of Massachusetts Produce Prescription Benefits Redemption study
[80] Benchmarked off of 9.5% enrollment rate among eligible population over 4 years in covered diabetes prevention program plus uplift from HSA incentive program
[81] County Health Ranking
[82] County Health Ranking (2024). Note: Overdose mortality rates are ~58 in rural WV for every 100,000 people vs. 28 nationally.
[83] Massachusetts's The Digital Health Sandbox Program, Vermont's Green Mountain Accelerator Fund
[84] The Real West Virginia.com
[85] West Virginia Rural Health Transformation Request for Information, p. 29
[86] Assumes total range of potential spend is $2-$3M across 15-22 deals over 5-year period
[87] Including the WVU Clinical and Translational Science Institute
[88] Appalachian Continuum of Care for Overdose Reduction Network