



**State of Vermont Agency of Human Services**  
280 State Drive, - Center Building  
Waterbury, VT, 05676

**Rural Health Transformation Program  
Subrecipient Grants to Healthcare Providers to Adopt Remote Patient  
Monitoring (RPM)**

**Subrecipient activity #11**

**RHT\_AHSCO\_0002\_FY26**

**Questions and Answers**

1. I am inquiring as to whether you would be open to working with a community pharmacy chain on a remote patient monitoring program?

Applications that meet all applicable eligibility criteria will be reviewed. Please refer to Section 2.1, Eligibility.

2. For purposes of this RFQ, will the State of Vermont accept organizations that provide commercially available RPM technologies and associated services (e.g., system integration, cybersecurity infrastructure, training, and operational support) to participate as contractors (via subcontract agreements) rather than as subrecipients? Specifically, please confirm whether entities delivering discrete, fee-for-service products and services within their normal course of business may submit proposals via this RFQ to the State of Vermont as subcontractors, which is consistent with 2 CFR §§200.320 and 200.331(b).

The State is not seeking to contract with vendors to provide this service. Subrecipients submit proposals which may include contracting with vendors to meet the service need.

3. If there is/are incumbent(s) for this opportunity, please disclose.

No.

4. Will the state confirm that licensing RPM software technologies also falls within the scope of this RFP?

Yes.

5. What is the definition of "provider consortiums"?

Provider consortiums represent or pursue the interests of their healthcare provider members.

6. Should we decide to proceed forward with your tender would it be possible to have a slight extension to respond as we came across the opportunity only recently.

No.

7. An organization is preparing its application for the RPM grant. Is it required that the RPM program – which will be new for us – be fully up and running for the entirety of the 14-month grant period, or is there an allowance for some period of several months within the first 14-month period to stand up the program?

Organizations should submit proposals that outline their plans for how to best implement the services as described in this NOFO.

8. May an eligible provider submit concurrent applications for this Subrecipient Activity #11 (RPM) and one or more other Rural Health Transformation subrecipient activities and if so, must budget items be cleanly siloed across applications such that no cost — including shared staff time, shared infrastructure, or shared technology — appears in more than one application? Clarification is requested on (a) whether concurrent applications are permitted, (b) whether the Agency will coordinate review across activities to identify duplicative budget items, and (c) whether shared indirect cost allocations across multiple awards are permissible if properly documented.

Providers may submit individual applications for each RHT related NOFO. Consolidated applications to cover multiple NOFOs are not permitted, and the Agency will not coordinate review across subrecipient activities to identify duplicative budget items. Applicants are responsible for ensuring their proposals meet all State and Federal requirements.

9. Section 2.1.1 defines a multi-practice-site provider as eligible only for those sites meeting the 20% rural-patient threshold (for urban-located sites). For an applicant operating multiple practice sites where some urban sites meet the threshold and others do not, may the applicant include the qualifying sites in a single application and exclude non-qualifying sites, or must a separate application be submitted per qualifying site?

Qualifying sites may be included in a single application, excluding non-qualifying sites.

10. Section 2.1 includes “provider consortiums that are offering shared RPM purchasing, leasing, and/or service opportunities” as eligible applicants. Will the Agency clarify (a) what formal documentation is required to establish a provider consortium for purposes of this application (e.g., MOUs, letters of commitment, formal entity status), and (b) whether the lead applicant in a consortium must itself be a healthcare provider, or whether a non-provider entity may serve as the administrative lead on behalf of provider members?

Please refer to Section 2.1 for eligibility requirements.

11. Section 1.2 references “purchase or lease” of RPM equipment and platform. For lease or subscription-based RPM platform arrangements that extend beyond the September 30, 2027 Year 1 spend deadline, may an applicant prepay the full multi-year subscription cost within the Year 1 period, or must lease/subscription costs be limited to the services consumed within the grant period?

Please refer to Section 1.3, Award Period. Grants are for services performed within the Award Period only.

12. Section 1.2 contemplates RPM data transmission “through an intermediary device such as a tablet or smartphone application (including ‘bring your own device’).” May grant funds be used to purchase patient-facing tablets or cellular-connected hubs for patients who do not have a personal smartphone or sufficient connectivity, and if so, what documentation is expected to demonstrate that such devices are not duplicative of the broadband restriction in Section 1.9, item 5?

Grant funds may be used to provide the services specified in Section 2.2 of the NOFO, subject to the restrictions of Sections 1.9 and 2.2.2. Grant-funded devices and services may not be used to provide broadband internet services to households. If internet connectivity is to be purchased for the functioning of the healthcare provider’s device in patient homes for grant-eligible services, the applicant should explain how that connectivity will be restricted to exclude broadband internet services for the household.

13. Section 1.9, item 3 prohibits supplanting existing State, local, tribal, or private funding of infrastructure or services, such as staff salaries. For an applicant that currently operates a limited RPM program funded through existing operational budgets, may grant funds be used to (a) expand the patient census of an existing program, (b) replace end-of-life RPM equipment that is currently in service, or (c) add new chronic-condition cohorts (e.g., adding diabetes monitoring to an existing CHF program)? Clarification is requested on where the boundary lies between permissible expansion and prohibited supplantation.

The three examples potentially could be applicable for this grant opportunity, pending details in an application that meet all NOFO requirements.

14. Section 2.2.5 (Operational Readiness and Service Activation) and Section 2.2.3 (Provider Technical Assistance and Training) reference integrating RPM into routine operations and staff readiness. Are staff costs allowable for clinical and non-clinical personnel time spent on program implementation, training, and workflow integration during the grant period, given the prohibition in Section 1.9, item 3 against supplanting staff salaries and item 7 against clinician salaries at facilities with noncompete clauses? If allowable, what level of detail is required in the budget to distinguish implementation effort from ongoing operational salary support?



See section 1.2, Statement of Purpose, additionally, subrecipients are responsible for ensuring they stay within the grant's funding requirements.

15. Section 1.9, item 6 permits funding of clinical services only where the applicant justifies that they are not already reimbursable, fill a gap in care coverage, or transform the current care delivery model. For RPM monitoring services that are partially reimbursable under existing CPT codes (e.g., 99453, 99454, 99457, 99458) but for which reimbursement does not cover the full cost of program operation, may grant funds be used to cover the unreimbursed portion of monitoring costs, and what documentation will be required to demonstrate the gap? Would it be possible and permissible to establish a fund to compensate those who are uninsured or unable to afford RPM?

Grant-funded services must comply with Section 1.9 "Funding Restrictions" and be within the scope of Section 2.2, "Services".

16. Section 3, Criterion 2 (Comprehensiveness of Proposal and Implementation Plan, 35 points) includes a bullet that begins "Only for provider consortiums servicing providers." Will single-site or multi-site applicants (above 15 sites) who are not consortiums be evaluated on the remaining three bullets within this criterion using the full 35 points, or will the scoring scale be adjusted for non-consortium applicants? Clarification is requested on whether non-consortium applicants with multiple sites are competitively disadvantaged on this criterion.

The criteria that states it only applies to provider consortiums.

17. Section 3, Criterion 3 (Sustainability Plan, 5 points) asks how providers might "in the future obtain adequate insurance reimbursement...for services provided using this technology." Given that CMS, Vermont Medicaid, and major commercial payers already reimburse for RPM under established CPT codes, will applicants be evaluated favorably for sustainability plans that rely on existing reimbursement pathways combined with operational efficiencies, or is the Agency seeking evidence of advocacy for expanded coverage of services not currently reimbursable?

It is up to the applicant to complete the sustainability plan requirement to the best of their ability.

18. Section 3, Criterion 6 (Rurality, 15 points) awards full 15 points to applicants whose practice sites are all located in rural ZIP codes, regardless of the proportion of patients served from rural ZIP codes. For an all-rural-located applicant whose patient panel includes a meaningful percentage of patients from urban ZIP codes (e.g., regional referral populations), is any documentation required regarding the rural-patient proportion, or does rural site location alone secure the full 15 points?



Practices who are only in rural ZIP codes do not need to provide additional documentation as part of their application related to the rurality of their patient population.

19. Section 2.4 establishes two quarterly reporting metrics (unique providers using RPM and unique patients using RPM through the grant). For applicants who already operate an RPM program and use grant funds to expand or modernize, will metrics be reported as (a) only new providers and patients added through grant-funded equipment, or (b) total program census, including patients on legacy equipment? Clarification on baseline measurement is requested.

Reporting should be specific to the RHTP-funded work.

20. Section 2.2.1 requires RPM technology to be “interoperable with federally Certified Electronic Health Record Technology (CEHRT)” and to comply with HIPAA Security Rule and 45 CFR170.215 API standards. For RPM platforms whose EHR integration is achieved via flat-file export or HL7 v2 messaging rather than FHIR/USCDI APIs, will such platforms satisfy the interoperability requirement, or is FHIR-based API integration with CEHRT a hard requirement?

It may. Information should be included in the application to explain this in detail including any limitations related to the proposed RPM platform and/or provider EHR.

21. The NOFO does not appear to require matching funds, cost-share, or in-kind contribution from the applicant. Will the Agency confirm (a) that no match or cost-share is required for eligibility, and (b) whether voluntary committed cost-share or leveraged investment (e.g., applicant capital contribution, in-kind staff time, or third-party philanthropic funds) will be scored favorably under Criterion 3 (Sustainability Plan) or any other criterion? If voluntary cost-share is treated favorably, clarification is requested on the documentation required to substantiate it.

No match or cost share is required for eligibility. If a voluntary cost share is including within a proposal, sufficient details for it to be evaluated may help ensure clarity, including within the sustainability plan.

22. Section 1.1 establishes August 1, 2026 as the grant commencement date and September 30, 2027 as the deadline by which Year 1 funds must be expended. May costs incurred between the application submission date (June 10, 2026) and the August 1, 2026 commencement date be reimbursed as preaward costs if the application is funded — for example, vendor selection activities, contract negotiation, or initial procurement deposits — or must all reimbursable activity occur on or after August 1, 2026? If pre-award costs are allowable, clarification is requested on the maximum lookback period and whether pre-award costs require prior written approval from the Agency.



Please refer to Section 1.3, Award Period. Grants are for services performed within the Award period only.

23. Would a pharmacy-led model partnering with primary care providers be considered a “provider consortium”?

Provider consortiums represent or pursue the interests of their healthcare provider members. See section 2.1 “Eligibility”.

24. Can grant funds support non-clinician staff (RPM support staff) associated with implementation and monitoring?

See section 1.2 Statement of Purpose: “Funds may be used to provide technical assistance and training to grantees on technology selection, implementation, cybersecurity, and compliance.” Additional information is in section 2.2.3. Technical Assistance and Training.

25. How does the prohibition on “supplanting existing staff salaries” apply to new roles created specifically for RPM program launch?

See section 1.2 Statement of Purpose: “Funds may be used to provide technical assistance and training to grantees on technology selection, implementation, cybersecurity, and compliance.” Additional information is in section 2.2.3. Technical Assistance and Training.

26. What specific reimbursement pathways (Medicare RPM codes, Medicaid, ACO models, etc.) does the State expect applicants to rely on post-grant?

The state is not requiring specific reimbursement pathways.

27. Does the State have preferred or anticipated payment models to support long-term sustainability?

No.

28. Can grant funds support care management activities associated with RPM (e.g., outreach, data review, escalation), if those services are not independently reimbursed?

See section 1.2 Statement of Purpose: “The purpose of this subrecipient grant opportunity is to provide funds to provider organizations for the purchase or lease of Remote Patient Monitoring (RPM) equipment and/or platform.” Funds may also be



used to provide technical assistance and training to grantees on technology selection, implementation, cybersecurity, and compliance. Additional information is in section 2.2.3. Technical Assistance and Training.

29. Is full bidirectional integration with CEHRT required at the time of implementation, or is phased integration acceptable?

A phased integration could be acceptable with clear milestones.

30. Are there preferred interoperability standards, vendors, or health information exchanges expected (for example, VITAL)?

See section 2.2.1. Telehealth Technology Implementation for details.

31. If no grant funds are allowed to support non-clinician staff (RPM support staff) associated with implementation and monitoring, then how can the applicant recoup this large item of expense?

See section 2.2. Services, including subsection 2.2.3. Technical Assistance and Training for details.

32. Is the state considering legislative changes to allow pharmacists to be providers of RPM?

Not at this time, see section 2.2.1. Remote Patient Monitoring (RPM) Technology.

33. Is the expectation for pharmacists to partner with providers through a CPA?

The State cannot answer this question due to a lack of context.