Rural Health Transformation Program

Subrecipient Grant for Adoption of a Shared Electronic Medical Record Platform

Subrecipient activity #9

RHT_AHSCO_0004_FY26

Questions and Answers

1. What is the definition of “provider consortium”?

   A provider consortium represents or pursues the interest of their healthcare provider members.

2. Understanding the federal requirement that “no more than 5% of total funding CMS awards to the State in a given budget period can support funding the replace of an EHR/EMR system if a previous HITECH certified EHR/EMR system is already in place as of September 1, 2025. Vermont Federal Fiscal Year (FFY) 2026 award is $195,053,740.44.” is there guidance on what meets the definition of “support funding the replacement of a certified EHR/EMR? For example, would the costs of replacement or addition of non-HITECH certified 3rd party applications, required to fully leverage an EMR count towards the 5% cap? Are preparatory activities or investments needed to prepare a certified EMR for expansion to meet this requirement? If a site requires investment in IT infrastructure and/or cybersecurity infrastructure to meet the standards required for the implementation of a shared EMR, would those costs be subject to the 5% rule?

   See section 1.9. Funding Restrictions and Section 2.3. Compliance Requirements.

3. Under 1.9 Funding Restrictions does #4 “Construction or building expansion, purchasing or significant retrofitting of buildings, cosmetic upgrades, or any other cost that materially increase the value of capital or useful life as a direct cost” preclude a subrecipient from using grant funding to purchase capital IT equipment to provide infrastructure support to deliver a shared EMR? For example, if a capital investment was required in IT network infrastructure at a site to bring that site up to standards required for a certified EMR and that required modifications to building or network closets within those buildings would such capital expenditure meet this definition?

If the proposed capital investment met the definition of what is described under section 1.9 Funding Restrictions, then the cost would not be allowable.

4. How will duplicative be defined if functionality in a shared EMR has overlap with other RHT funding opportunities? For example, A shared EMR if used by a high number of Vermont hospitals could fulfill the goals of a statewide bed placement system. A shared EMR could facilitate multispecialty eConsult workflows and advanced referral processes as well as some telehealth related functions.

   See section 1.9. Funding Restrictions and Section 2.3. Compliance Requirements.

5. Is the State intending this NOFO to fund individual rural hospitals or provider organizations implementing or converting to a shared EMR/EHR platform?

   Applicants should submit proposals that best deliver the service and meet all funding and compliance restrictions.

6. Is the State intending this NOFO to fund a consortium or collaborative entity coordinating implementation across multiple providers?

   Applicants should submit proposals that best deliver the service and meet all funding and compliance restrictions.

7. Is the State intending this NOFO to fund an EMR/EHR vendor acting as implementation lead?

   Applicants should submit proposals that best deliver the service and meet all funding and compliance restrictions.

8. Would a single hospital or health system be considered an eligible applicant if it is implementing a shared EMR platform that supports interoperability with other Vermont providers, or is participation in a formal consortium required?

   Applicants should submit proposals that best deliver the service and meet all funding and compliance restrictions.

9. In the case of a hospital transitioning to Epic, would eligible costs potentially include implementation, integration, onboarding, training, interoperability, cybersecurity, and related operational readiness activities associated with the conversion?

   See section 1.2 Statement of Purpose.

10. May an EMR/EHR software vendor serve as the direct applicant/subrecipient?

See section 2.1 Eligibility.

11. If the applicant is expected to function as a program manager or implementation lead for multiple participating organizations, does the State have minimum expectations regarding:
    a. number of participating providers,
    b. governance structure,
    c. executed participation agreements,
    d. or geographic/rural coverage at the time of application?

    Applicants should submit proposals that best deliver the service and meet all funding and compliance restrictions. See section 2.2.1.

12. Are Service and Solution providers able to respond to the RFP, or are you only looking for existing provider organizations working in the state to respond in partnership with their solution and service providers?

    See section 2.1 Eligibility.

13. Is VT's objective, via this RFP, to have all providers using the same EMR vendor? Or is the objective to have a shared platform where all providers have access to one longitudinal patient record? If the later, are they also interested in cross-facility workflow features?

    See section 2.2. Services.

14. What technology does the HIE utilize that the subrecipient must strengthen?

    See section 1.2. Statement of Purpose.

15. Does the subrecipient need to be a provider organization, or can a technology vendor apply?

    See section 2.1 Eligibility.

16. In the question below, where you reference "improved patient access", are you referencing access to care or patient access to data?
    a. How will the shared EMR/EHR system be used in conjunction with other RHT program initiatives (e.g., telehealth, remote patient monitoring, e-consult, expanded Blueprint community health teams) and with multiple healthcare provider types (e.g., patient-centered medical homes, other primary care, specialty care, mobile integrated health, emergency medical services, skilled nursing facilities, and Support And Services at Home) to improve patient access, care management, and outcomes?

Patient access to care, however, if an applicant has a proposal to share related to patient access to data, they may do so.

17. What does the 5% total funding award to replace an existing HITECH certified EHR/EMR include? Is this cap solely related to the replacement of the system in terms of the purchase or lease from the EMR/EHR organization that we eventually choose? What about training and implementation costs in 2.2.3? Would it include our planned IT Infrastructure feasibility study related to 2.2.2? How about consulting support related to a due diligence request for information, evaluation, pricing and selection toward a group system selection? We plan to utilize external sources for grant accounting, compliance and reporting to support 2.2.5, would this be included in the 5%? Would any associated VITL/VHIE costs be inclusive in the 5% cap?

    Allowable costs are outlined in section 2.2. Services, subject to section 1.9 Funding Restrictions.