

**Q&A for NOFO/NOA #03410-240-26 (Activity 18):  
Primary Care-Focused Data and Analytics Infrastructure**

1. Are DAs (Designated Agencies) eligible [for this grant opportunity]?

**Answer:** No, DAs are not eligible for this grant. As reflected in Section 2.1 of the NOFO, eligible healthcare organizations and administrative entities with CHTs must provide consistent primary care services that are recognized by the Vermont Blueprint for Health program can apply for this grant.

2. If DAs are eligible, is the grant applicable for a single provider organization to improve their own capabilities within their client populations? In other words, is the work for our organization only and then reporting to be established as needed through state systems?

**Answer:** DAs are not eligible.

3. Can you please provide guidance on the reporting timeline as the ability to begin projects and be reporting by 10/30/2026. The tight timelines would preclude the ability to start many new initiatives. Would the state support proposals with a longer runway needed to develop the foundation improvements and investments?

**Answer:** We will consider this if included in the proposal with detailed justifications as to why this would be required. The first progress report for the State is 9/30/2026. It is worth noting that RHT grants must adhere to performance expectations and timelines set forth by AHS and CMS, which expects some results in Year 1. Additional years of funding and continued agreements are not yet guaranteed as this determination depends on milestone achievements with evidence of significant progress in Year 1, actual spend, results of performance measurements taken throughout the year, and the like.

4. If we don't spend all the grant money awarded to us, what happens with the difference between what we were awarded and the amount we invoiced for?

**Answer:** RHT grants are strictly reimbursement-based. If a grantee does not utilize the full budgeted amount for the year, that funding is forfeited. Doing so may have implications on future funding for this opportunity, however. Budgets should be as accurate as possible, as we do not have the opportunity to increase nor change the budget once it is approved by AHS and CMS and the grant agreement is active.

5. With the AI grant, we had to prove that at least 20% of our patient population was in specific zip codes. Does the same apply to this grant?

**Answer:** [Blueprint practices and Administrative Entities are eligible under a separate category.](#)

6. Regarding the CMS2, depression screening, and follow-up: We aren't supposed to include any award requests for items that we receive payment for. We bill depression screening to insurance, and some reimburse us for that charge. However, we do not bill for a f/u plan after a positive screen. Can we include initial workflow and reporting development as well as reporting time as opposed to the time taken to review the depression assessment and develop the depression f/u plan?

**Answer:** [This award is for implementation and the capture and reporting of data. Billing is allowable for non-CHT providers. All budgets and allowable items will be approved by DVHA, AHS, and CMS, so costs outside of the scope provided are not guaranteed.](#)

7. Can EHR-generated reports capturing the numerators and denominators for each eCQM be uploaded to a VHIE or do the numbers need to be captured automatically by a VHIE?

**Answer:** [The data may be manually uploaded to the VHIE.](#)

8. Can EHR reports capturing numerators and denominators for the various measures can be uploaded to a VHIE manually if the EHR isn't capable of sending electronic results through a VHIE connection?

**Answer:** [See the answer to Question 7 above. EHR's should all be connected to VITL for Blueprint practices.](#)

9. For CMS50: according to calculation tool that is linked in the RHT grant document, the measurement period is 1/1-10/31. Can you confirm that referrals made on 11/1/26 and after are meant to be included?

**Answer:** [Yes.](#)

10. CHT encounter tracking: Are we required to attach a CPT code to the CHT service even when not seeing a medical provider? (The description for the service type is "...typically a medical service type code").

**Answer:** [The description says 'typically'; other types of service codes are acceptable.](#)

11. Is there a minimum or maximum grant amount that an individual primary care practice or Blueprint Administrative Entity may request?

**Answer:** The dollar amount was not posted in order to allow proposals to come in competitively and to allow bidders to calculate the amount necessary to complete the deliverables required in this NOA/NOFO in a manner that is satisfactory to the State. Please ensure to follow budget guidance and provide sufficient justification in the budget document (provided excel document, “Appendix C”).

12. Are grant funds allowable for EHR vendor costs necessary to implement the proposed project, including software modules, reporting tools, interfaces, custom programming, implementation services, training, and ongoing maintenance fees related to eCQM calculation and/or CHT encounter tracking?

**Answer:** Yes. Please provide details of such in the justification sections of the budget document. Grant funding will only cover the costs during the timespan the grant agreement is active, given those costs are necessary for the project.

13. If EHR vendor costs are allowable, are there any restrictions on funding ongoing licensing, subscription, or maintenance fees beyond initial implementation?

**Answer:** Costs for the first year only – and only during the active grant period (eg. 8/1/26 – 7/30/27) are allowable costs for this grant. This may require some calculations and/or explanations in the justification sections of your budget document.

14. Does the Community Health Team (CHT) encounter tracking system need to be fully integrated within the practice’s existing EHR, or can an external platform/interface be used if it supports the required reporting to the State?

**Answer:** Either is acceptable, however, it must be utilized by the practice/CHT and must submit information to the VHIE.

15. Can grant funds be used for staff time associated with implementation, workflow redesign, training, data validation, report development, and quality improvement activities, provided the funds are not replacing existing operational expenses?

**Answer:** Yes. Please ensure an explanation of such is included in your justification section of your budget document.

16. Can grant funds be used to contract with EHR vendors, consultants, or other technology partners for implementation, customization, data reporting, and

maintenance activities?

**Answer:** Yes. Please ensure justification narratives are included in your budget document.

17. Several of the listed eCQMs (such as diabetes and hypertension measures) may have limited applicability to pediatric populations. How will applications from pediatric practices be evaluated, and is there flexibility in the expected eCQM measures based on the population served?

**Answer:** Applications will be considered based on the appropriateness of the project to population served.

18. For small independent practices, what level of detail is expected regarding the required sustainability plan and demonstration of ongoing support beyond the grant period?

**Answer:** It is necessary to prove that the ability to report the information will not end after the grant's funding ends. In alignment with strategic RHT goals at the federal level, providers must be willing and able to integrate this initiative into their standard operations.

19. What happens if we are awarded the money and can't meet the requirements?

**Answer:** We are requesting applicants demonstrate their ability to fulfill the requirements in their proposal and invite those who can meet the deliverable requirements apply to this funding opportunity. If you are uncertain about the ability to deliver on the requirements for this project, this may not be a good fit. In addition, we do not award advanced payments for RHT grants. The State uses a reimbursement method in which we require documentation to support the reconciliation and request (costs on invoices). If deliverables have not been met in a satisfactory manner, the State has the right to withhold some or all funding and the State has the right to terminate the agreement.

20. What happens if we are awarded the money and are only able to meet some of the requirements?

**Answer:** Refer to the answer in Question 19. The State invites eligible providers and organizations to apply only if they are able to meet the requirements.

21. Are we required to report data for CHT encounters, diabetes, BP, depression, tobacco, referral loop closure, through a centralized system such as VITL?

**Answer:** Ideally, yes, this information should go to VITL. All Blueprint practices are

required to be connected to VITL. CHT encounter information must go to VITL. ECQM measures may be uploaded manually.

22. Can reports generated from our EHR be submitted if we aren't using a VHIE such as VITL?

**Answer:** See answer to 21.

23. Are the CHT encounters to be reported electronically? If not, what reporting is needed, in which format, and to whom?

**Answer:** Yes. CHT encounters are expected to be reported through the EHR.

24. For the depression f/u order, do they need just need to capture the data specifying confirmation that a follow-up plan was made?

**Answer:** The specifications of CMS 2 must be followed.

25. Referral loop closure: do we need to report the specialist note, or do we just need to capture the data specifying confirmation that the note has been received?

**Answer:** The specifications of CMS 50 must be followed.

26. Our Athena Electronic Medical Record used by our primary care practices (~20 providers) can do eCQM reporting. However, we would like to apply for RHT Funds to templatize our CHT documentation in the Athena record which would allow better analytics of their work and to train our CHT how to properly use the templatized documentation. Would this fit the grant?

**Answer:** Yes. The grant description says 'or'.

27. Under Eligibility and Applicant Structure, Section 2.1 requires applicants to be "Blueprint Providers and/or Administrative Entities with a Community Health Team (CHT)" and assigns funding priority first to applicants committing to CHT encounter tracking and second to applicants committing to all five eCQMs, while Appendix E directs the Grant Subrecipient to implement "at least one" of the tools. Can a Blueprint Provider that does not host its own CHT apply for eCQM-only work? May a Blueprint Provider participate in CHT encounter tracking through a hosted arrangement with its Administrative Entity, and if so, who is the appropriate applicant of record?

**Answer:** Yes. Either party may be the applicant of record provided there are no duplication of applications.

28. Also under Section 2.1, Are Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospital–affiliated primary care practices that are recognized by the Vermont Blueprint for Health program eligible to apply directly? Must hospital-affiliated primary care practices apply through their Hospital Service Area Administrative Entity, or may they apply independently?

**Answer:** They can apply independently provided no duplication of applications.

29. Sections 2.3.4 and 2.3.6 — Section 2.3.4 references services “offered in the pharmacy through the test-to-treat protocol,” and Section 2.3.6 references “how the pharmacy will address inclusion, diversity, equity, and accessibility.” These appear to be inadvertent references carried from a prior pharmacy-focused NOA. Please confirm whether Sections 2.3.4 and 2.3.6 apply to this NOA, and if a CLAS plan and IDEA plan are required, in what form they should be presented for primary care applicants.

**Answer:** Applicants should ignore Sections 2.3.4 and 2.3.6 and formatting (numbering) errors. This was a template that was adopted from a Test-to-Treat DVHA RHT grant and the final version must have accidentally included information irrelevant to this grant opportunity. To confirm CLAS and IDEA plans are not for proposals under Activity 18.

30. The NOA section numbering jumps from 2.1 to 2.3 (no Section 2.2), and within Section 2.3 the numbering skips 2.3.2. The reporting metrics narrative references 2.7.1 through 2.7.5 without a Section 2.7 parent header (and with 2.7.4 absent). The budget workbook is referenced as both “Appendix C” and “Appendix D” in different locations. Please confirm the intended section structure, appendix labels, and the full required appendix set, or issue a corrected NOA.

**Answer:** As a reused template, the formatting did not get updated when irrelevant sections for this NOFO/NOA were removed. There are two required attached documents aside from the proposal itself: the pre-award risk assessment and the budget (including justification narratives for each spend line/category). The budget is Appendix C. The pre-award risk assessment is Appendix D.

31. Section 2.3.7 — Subcontracting is permitted to deliver required programmatic services. Are teaming arrangements where a Blueprint Provider or Administrative Entity acts as prime applicant with a technology vendor, EHR partner, or program management firm identified as a named subawardee permitted? What documentation of the teaming relationship (letters of commitment, scope-allocation summaries, draft subaward terms) should be included with the

application?

**Answer:** Subcontractors and subrecipients must be included in the proposal and in the budget (tab for contracting). The examples given, such as letters of commitment and scope allocation summaries, are sufficient. Please note that any subrecipients and/or subcontractors must be able to agree and adhere to the State's standard terms of the grant agreement as well.

32. Sections 1.1 and 2.6 — The NOA does not specify a maximum amount available per award, a minimum award size, an expected number of awards, or a total funding pool reserved under this NOA. Section 2.6 references the statewide RHT Year 1 allocation of \$195,053,740.44, which is the pool across multiple NOAs. Please specify:

- (a) the total funding available under this NOA;
- (b) the maximum amount a single applicant may request;
- (c) the anticipated number of awards; and
- (d) whether smaller Blueprint Provider applicants and Administrative Entity applicants compete in the same pool or separate pools.

**Answers:**

**(a and b):** This is not publicly available in order to allow proposals to come in competitively and to allow bidders to reflect the amount they believe they need to complete the deliverables required in this NOA/NOFO in a manner that is satisfactory to the State. Please ensure to follow budget guidance and provide sufficient justification in the Budget document (separate excel document, "Appendix C").

**(c):** This may depend on the number of quality proposals received.

**(d):** All applicants to this NOA/NOFO are in the same competitive pool, adhering to State and Federal granting and contracting rules.

33. Section 2.1 — Are applicants who commit to both CHT encounter tracking and all five eCQMs eligible for a proportionally larger award than applicants committing to a single tool or measure? Is there a per-element funding ceiling, or are budgets evaluated based on demonstrated cost per implementation element?

**Answer:** Proposals are competitive bids that should reflect the amount the applicant believes is necessary to complete the deliverables they apply for.

34. Sections 1.2 and 2.6 — Year 1 funds must be fully spent by September 30, 2027. How should multi-year EHR module licenses, eCQM calculation engine subscriptions, or CHT tracking platform hosting commitments that extend beyond

September 30, 2027, be reflected in the Year 1 Budget Workbook? Are prepaid multi-year licenses allowable as Year 1 expenses?

**Answer:** First, we must note that we have received recent updated guidance from CMS regarding all RHT funding opportunities for Year 1. All Year 1 agreements must end no later than 7/30/27. Error-free invoices and reports for Year 1 must be received by the State no later than 8/13/2027. However, Year 2 funding will be available Summer 2027, meaning grantees will not experience a lapse in funding from Y1 to Y2 if the agreement and funding is to continue (which will depend on actual spend, sustainability plans, performance metrics, progress, and overall milestone/deliverable achievements in Year 1).

Second, applicants are welcome to include costs that would be incurred to complete the deliverables in this NOFO/NOA in your Budget document (Excel file, Appendix C). Please note that you can only bill for the time in which it was utilized during Year 1 so long as the funding doesn't act as a replacement for other funding sources and does not act as supplanting. For items like prepaid licenses, please include the (Year 1) costs in your budget. Budgets and specific line items will be reviewed and approved by DVHA, AHS, and CMS. Please ensure all budget line items have sufficient explanations and justifications.

35. Section 2.6 — If a Blueprint Provider applies funds toward clinician, nurse, or quality improvement staff time for eCQM workflow design, denominator validation, or measure-result review, what documentation demonstrates that the funded time is not “clinical services that could be reimbursed by insurance” and is not supplanting existing salary support? Is QI staff time for workflow redesign treated differently from clinician time spent on measure review?

**Answer:** In the budget document (excel file), you will notice gray boxes on each page to provide justification and supportive explanations. Please provide details on the activities with a budget appropriate for such activities, noting the guidance on the personnel tab.

36. Section 2.6 — Is the 10 percent de minimis indirect cost rate under 2 CFR 200.414(f) acceptable in the absence of a federally Negotiated Indirect Cost Rate Agreement? On what cost base (e.g., Modified Total Direct Costs as defined at 2 CFR 200.1) should it be calculated, and where in the Budget Workbook should indirect costs appear?)

**Answer:** The indirect rate cannot be more than 15% of the total MTDC or the organization can submit a copy of their NICRA/VICRA in their application.

37. Section 2.5 / Appendix E — Several CHT data elements in the Appendix E table are listed with “TBD” descriptions (Referral Source, Referral Reason, Risk Score / Complexity Level, SDOH Screening, MH Screening, SUD Screening). Are field definitions for these elements forthcoming, and if so, when? Should applicants use current Vermont Blueprint program or VHCURES specifications, or propose definitions in the project narrative subject to State approval?

**Answer:** Either is acceptable. Definitions of these fields are open at this time.

38. Section 2.5 / Appendix E — Reports “may be submitted through the VHIE (VITL) or through a secure EHR feed to State systems.” Is VITL connectivity required for all awardees, or is a direct EHR-to-State feed acceptable? Are expected technical specifications, file formats, or transport standards (HL7 FHIR, CCD, flat-file) available, and is integration with the “common shared EHR platform being implemented under the RHTP” anticipated to be in scope or out of scope for Year 1?

**Answer:** The current State system is VITL. HL7FHIR data is preferred where possible. The scope for Year 1 is as described in this NOFO/NOA.

39. Sections 2.5 and 2.7 — The reporting metrics narrative references 2.7.1 (CHT encounter system utilization), 2.7.2 (eCQM measures), 2.7.3 (Lessons learned), and 2.7.5 (Outcomes), with no 2.7 parent header and 2.7.4 absent. Please confirm the complete intended reporting metric set and clarify whether quarterly programmatic reports must include numeric performance data (eCQM measure rates, encounter counts by service type) or whether narrative reporting is sufficient for early quarters.

**Answer:** Quarterly reports are required to include numeric performance data and narrative briefs. Specific performance measurements will be provided in the grant agreement.

40. Section 3 — Sustainability Plan is scored at 20 percent. For Year 2 and beyond, will follow-on RHT funding be available through future NOAs to support continued eCQM and CHT tool operations, or must sustainability plans assume full transition to non-RHT funding sources (commercial payer programs, Medicaid value-based payment, practice operating budgets) by October 1, 2027?

**Answer:** The sustainability plan must demonstrate the ability and willingness to continue operations with non-RHT funded support. While we aim to continue support year-over-year (for 5 years), future funding is not guaranteed. The continuation of the State-grantee partnership and RHT funds for Year 2 will be based upon the progress, milestone/deliverable achievements, sustainability plans, and actual spend in Year 1.