Mobile & Hybrid Care #1 FAQs

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Mobile & Hybrid Care Frequently Asked Questions #1

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Frequently Asked Questions

Application/RFA Process

1. Which RFA should my organization apply to if the proposed program crosses the geographic footprint of multiple PDC regional models?

Your organization should apply to the RFA where the majority of the proposed services are being delivered. If it is unclear and proposed services will cross RFA service territories, your organization should apply to the RFA where the central organization or project teams are located. For additional guidance on which RFA to apply to, please reach out to Joel Reagan (joel.reagan@dmas.virginia.gov) and Isabelle Drayer (isabelle.drayer@dmas.virginia.gov).

2. Can I include eligible localities that my proposed program will reach, even if they are not listed in the RFA as part of the RFA service territory?

You do not have to limit the proposed program to the eligible localities listed in the RFA you are applying to.

3. Would a model combining secure electronic consultations and referrals with in-person specialty treatment at existing rural clinical facilities qualify as an eligible hub-and-spoke or hybrid-care initiative?

Yes. A model combining secure electronic consultations, specialty referrals, and in-person treatment at existing rural clinical facilities may qualify under the Mobile and Hybrid Care RFA. The RFA identifies electronic consultations, provider-to-provider specialty referrals, and technology-enabled hub-and-spoke models as eligible approaches. Applicants should demonstrate how the proposed model will connect rural healthcare providers with specialty services, address identified healthcare needs, and improve access to care for eligible rural populations.

4. Would you recommend submitting one integrated application addressing glaucoma and AMD, or may an organization submit separate applications for distinct clinical initiatives under this RFA?

Applicants may propose an integrated approach addressing multiple clinical needs within a single application. If the glaucoma and AMD initiatives share the same provider network, technology infrastructure, and implementation approach, submitting one integrated application may help demonstrate a coordinated specialty-care model while minimizing duplicative costs. However, if the initiatives differ substantially, applicants may choose to submit separate applications; there is no limit on the number of applications an applicant may submit, but applicants should prioritize the approach that best aligns with their proposed activities and presents the strongest, most competitive proposal or proposals. Applicants should clearly describe the proposed activities, associated budgets, and anticipated outcomes for each component.

5. Would letters of commitment or memoranda of understanding from participating rural primary care providers be sufficient to document the proposed hub-and-spoke partnerships? Must those partnerships be finalized before submission?

Letters of commitment, memoranda of understanding, existing agreements, or similar documentation may be acceptable methods of demonstrating participating healthcare partnerships.

We would strongly encourage obtaining documentation from participating rural healthcare providers before submission. The application should identify each partner's anticipated responsibilities and demonstrate that the necessary clinical relationships are sufficiently established to implement the proposed initiative within the required timeframe.

6. May a for-profit entity incorporated and headquartered outside Virginia apply directly if its project serves eligible residents within the specified counties? If so, is Virginia foreign-entity registration required at application, award execution, or commencement of services?

Any entity that meets the application eligibility requirements in Section 1.4 of the RFA is eligible to apply, including for-profit organizations or those based outside of Virginia. However, the funded program must only deliver services within Virginia. Any required registrations must be obtained by the time the award is executed.

7. Could a for-profit technology organization serve as the sole applicant without a formal clinical provider partner, provided that it does not deliver licensed clinical services?

A for-profit technology organization may apply as the sole applicant, provided it meets the eligibility requirements outlined in the RFA. While a formal clinical provider partnership may not be required for models that do not directly deliver licensed clinical services, competitive applications should demonstrate established partnerships with healthcare providers or community organizations that support the specific healthcare needs of the eligible rural population. Applicants should clearly describe how these partnerships will facilitate access to care and support successful project implementation.

In addition, for-profit entities are prohibited from generating profit in connection with the award. This prohibition on profit means that funded program activities (including any supplies, personnel, equipment, or other cost types) are provided at cost and on a reimbursement basis. Any income generated by a subrecipient in connection with the funded activities, such as fees for services, is treated as program income subject to the requirements of 2 CFR 200.307 and 2 CFR 300.218.

For grant programs from the Department of Health and Human Services, for-profit organizations may only use program income to deduct from the total Federal award amount. To provide an example, a for-profit entity with a federal award of $500,000 that generates $100,000 in program income will only be reimbursable up to $400,000 from the awarding entity. The

funded organization may not generate and retain income in excess of actual costs for funded program activities over the lifetime of the award.

8. Would specialized forensic medical examinations, including sexual assault, domestic violence, strangulation, trafficking, and child abuse examinations, qualify as specialty or diagnostic healthcare services under this initiative? These examinations include medical assessment, injury evaluation, appropriate treatment, and forensic documentation.

Yes, specialized forensic medical examinations may qualify as specialty or diagnostic healthcare services under this initiative, provided they align with the objectives and requirements of the Mobile and Hybrid Care RFA. Applicants should note that RHTP funds may not be used to supplant existing funding or reimburse services that are otherwise billable to other payers.

Project Selection & Awards

9. What subaward execution date should applicants plan around, so the work plan meets the FFY 2027 Q3 deployment deadline?

Award notices are anticipated to be issued on January 8, 2027. Following award notification, the PDC will work with selected applicants to execute subaward agreements as soon as practicable.

10. If one clinical technology or project component were determined ineligible, could the remaining eligible components be considered for funding independently?

Potentially. Eligible components of a proposed project may be considered independently if another component is determined to be ineligible. Applicants should clearly distinguish each project component, including the associated activities, budget, anticipated outcomes, and connection to the applicable RFA requirements. This will allow the regional planning district collaborative to evaluate the eligibility and merits of each component separately.

Contracting, Agreements, and Procurement

11. May a technology vendor be named as a contractor in more than one application within the same region, provided each application has a different lead applicant, serves a distinct eligible rural population and has entirely separate, non-duplicative costs?

Yes, provided all applicable RHTP and procurement requirements are met. Neither the applicable RHTP guidance reviewed, nor 2 CFR Part 200 establishes a general prohibition on the same technology vendor being identified in multiple applications. However, each application must have a distinct, allowable scope that supports the eligible rural population and must not duplicate costs or services funded through another RHTP award or other funding source.

12. If an application identifies a specific technology vendor in its budget and narrative, and the application is awarded, may the subrecipient contract with that vendor as proposed? Or will the subrecipient need to run a separate competitive procurement under 2 CFR 200.317–327 after award?

Applicants may identify a preferred technology vendor in their application narrative and budget; however, identifying a vendor in an approved application does not automatically authorize the subrecipient to contract with that vendor. Subrecipients must comply with applicable procurement requirements under 2 CFR 200.317–327 and follow their own documented procurement policies and procedures.

A separate competitive procurement may be required depending on the purchase amount, applicable procurement thresholds, and procurement method. Noncompetitive procurement is permitted only when the conditions outlined in 2 CFR 200.320 are met. If a vendor was previously selected through a compliant procurement process, a new competition may not be necessary, provided the procurement and resulting contract meet applicable requirements.

Applicants should account for any necessary procurement activities in their proposed implementation timelines to ensure timely project deployment.

13. Are contracted patient rides, mileage reimbursement, gas cards, or transportation vouchers allowable? Are there restrictions on payment methods or dollar limits?

Contracted patient rides, mileage reimbursement, gas cards, and transportation vouchers may be allowable when they directly support an approved RHTP activity and are necessary and reasonable to achieve the initiative's objectives, such as addressing transportation barriers to rural health care access. For Mobile and Hybrid Care, applicants should also consider the initiative's emphasis on implementation and start-up costs and demonstrate how recurring transportation costs would be sustained beyond RHTP funding. Please note, the program's proposed budget must not duplicate costs or services funded through otherwise reimbursable services, including non-emergency medical transportation and other services currently covered.

14. How will the federal license described in Section 6.7 apply when a project uses pre-existing commercial software? What documentation should distinguish pre-existing intellectual property from grant-funded modifications or deliverables, and which requirements apply to technology contractors?

The Federal government only has rights to intellectual property that was acquired or developed with Federal funds, including any copyrighted material developed or acquired, or data generated, under the Federal award. For modifications to existing technologies, the license and rights apply only to those copyrighted materials and data produced in connection with the award.

Federal guidance does not prescribe a specific form for documenting pre-existing intellectual property. Applicants intending to produce copyrighted modifications to pre-existing commercial software or other intellectual property should clearly distinguish the existing technology from the specific work, modifications, deliverables, or data that will be supported by RHTP funds. *Please refer to 2 CFR 200.315 for full details of the Federal license.*

Contractors are subject to different requirements than awardees in general because they fulfill a different role than subrecipients. However, the license is applicable regardless of whether the material was generated under contract or through another method. For Federally required contract provisions, please refer to 2 CFR 200 Appendix II. In addition, some other requirements are imposed by Virginia, such as Drug-Free Workplace and anti-trafficking provisions.

15. If awarded, could a group retain ownership of the mobile medical unit, subject to applicable federal property management, use, and disposition requirements?

Yes. If purchased with RHTP funds, the mobile medical unit will be owned by the purchasing entity. However, the unit remains subject to applicable federal property management, use, and disposition requirements under 2 CFR 200.310–200.316, including any applicable restrictions on the use or disposal of equipment acquired with federal funds.

16. How does the prohibition on recipient profit apply to commercial pricing charged by an independent technology contractor, and what supporting documentation is required?

The RFA's prohibition on recipient profit applies to organizations receiving RHTP subawards and does not apply to the commercial pricing of an independent contractor.

Subrecipients may contract with technology vendors at commercially reasonable rates, provided the procurement complies with applicable requirements under 2 CFR 200.317–327. Subrecipients must maintain appropriate documentation supporting the procurement method, vendor selection, price reasonableness, and contract terms.

RHTP funds may not be used to duplicate or supplant funding for services otherwise reimbursable through other sources. All expenditures must comply with the RFA's allowable-cost requirements.

Funding & Budget

17. Is the approximately $11.8M specific to this collaborative's service area, or shared with other regions?

The approximately $11.8 million is the anticipated funding allocation specifically for this collaborative’s service area. There are five regional planning district collaboratives each with an anticipated allocation of approximately $11.8 million. Note that the Commonwealth may adjust funding across regions based on the quality and scope of applications received, proposed

budgets, anticipated community impact, and the geographic distribution of competitive applications.

18. Are there any required applicant match or cost-sharing contribution for this funding opportunity?

No. Under RHTP, there is no required applicant match or cost-sharing contribution for this funding opportunity.

Allowable Uses of Funds

19. May the project transport residents of eligible counties to a clinic outside the RFA's designated service area?

Yes. Residents of the eligible counties identified in the RFA may be transported to a clinic located outside the RFA service area when doing so is part of the proposed mobile or hybrid care model and directly addresses an identified healthcare access need of those eligible rural residents. The physical location of a healthcare facility or project partner does not, by itself, determine eligibility under the RFA. Transportation and related costs must be included within the approved project scope and budget and otherwise meet applicable RHTP and federal cost requirements.

20. Our company is preparing an application under the *Mobile and Hybrid Care RFA* to place clinically validated blood pressure stations across the eligible counties and cities. The stations serve as telehealth access points. Patients connect directly with their provider through the station's text and email feature and through EHR integration, consistent with the "telehealth access points and kiosks" and "screening and diagnostic services" approaches in Section 2.2B. Our company is a mobile health technology organization and will apply directly as a for-profit entity. We would appreciate clarification of Section 6.5, item 41, which lists as unallowable: "Profit to any recipient, including a for-profit organization. Profit is any amount in excess of allowable direct and indirect costs." Could you clarify how this applies to an applicant that manufactures the equipment it proposes to deploy?

The prohibition on profit means that funded program activities (including any supplies, personnel, equipment, or other cost types) are provided at cost and on a reimbursement basis. Any income generated by a subrecipient in connection with the funded activities, such as fees for services, is treated as program income subject to the requirements of 2 CFR 200.307 and 2 CFR 300.218.

For grant programs from the Department of Health and Human Services, for-profit organizations may only use program income to deduct from the total Federal award amount. To provide an example, a for-profit entity with a federal award of $500,000 that generates $100,000 in program income will only be reimbursable up to $400,000 from the awarding entity. The funded organization may not generate and retain income in excess of actual costs for funded program activities over the lifetime of the award.

21. Are expenses associated with secure electronic consultation platforms, referral coordination, staff training, patient navigation, and outcomes reporting eligible for funding?

Yes. Expenses associated with secure electronic consultation platforms, referral coordination, staff training, patient navigation, and outcomes reporting may be eligible under the Mobile and Hybrid Care RFA. These costs must directly support the proposed project, be

necessary and reasonable, and comply with applicable RFA and RHTP requirements. Applicants should clearly describe how the proposed investments will support implementation, expand access to healthcare services, and contribute to long-term sustainability.

22. Could the acquisition of treatment systems such as for Direct Selective Laser Trabeculoplasty qualify as allowable capital expenditures when these technologies support the proposed rural specialty-care network?

The acquisition of such treatment systems may qualify as allowable expenditures, provided the system is necessary, reasonable, appropriately procured, and directly supports the proposed rural specialty-care model. Applicants should demonstrate how these investments will expand access to specialty care, increase treatment capacity at participating rural facilities, and reduce travel burdens for eligible rural patients. Final funding determinations will be subject to applicable RFA and RHTP requirements and review of the proposed expenditures.

23. Does the eligible vehicle category include purchasing a brand-new, purpose-built mobile medical clinic that arrives fully equipped for patient examinations, rather than purchasing and converting an existing vehicle? Would the integrated clinical buildout, medical equipment, and necessary technology be allowable expenses?

Yes, a new, purpose-built mobile medical clinic may be an allowable expense under this initiative; however, vehicle purchase requests are subject to case-by-case review and approval is not guaranteed. The proposed vehicle and associated costs should directly support the approved mobile healthcare services and comply with applicable RFA and RHTP requirements.

Applicants should separately identify and appropriately categorize the vehicle, clinical equipment, technology, and other components in their proposed budget, as applicable. Equipment and other capital expenditures remain subject to applicable federal requirements, including 2 CFR Part 200. Certain capital expenditures require prior written approval, and applicable procurement, equipment/property management, and disposition requirements continue to apply.

Accordingly, applicants should clearly describe the components and costs of the proposed mobile clinic, explain how each component is necessary to deliver the proposed rural healthcare services, and demonstrate compliance with the RFA, RHTP requirements, and applicable federal requirements.

24. May approved project costs include software subscriptions or licensing, usage-based technology charges, configuration, integration, training, and time-limited implementation personnel?

Yes. Software subscriptions, licensing, usage-based technology charges, configuration, integration, training, and time-limited implementation personnel may be allowable expenses, provided they directly support the proposed project and comply with applicable RFA and RHTP requirements. Applicants should demonstrate how these costs support implementation and long-term sustainability.

Payment & Reimbursement

25. We understand that the grant operates on a reimbursement basis without advance payments. For a mobile medical clinic requiring a substantial capital investment, can reimbursement be requested for documented manufacturer deposits or contractual progress payments, or must the completed vehicle be delivered and paid for in full before reimbursement is available? Are installment financing or other approved purchasing arrangements permitted, and what is the anticipated reimbursement frequency and processing timeline?

When a payment is made, reimbursement can be submitted, including deposits for large purchases. Reimbursement frequency details will be established in an eventual sub awardee agreement. For large upfront capital expenses, additional arrangements are available and can be explored after awards and contracts are completed.

26. What reimbursement submission frequency and typical processing interval should applicants use for cash-flow planning? Does payment to a subrecipient depend on the PDC first receiving the corresponding funds from DMAS, and are there deadlines governing each stage?

Reimbursement frequency, submission procedures, and processing timelines will be established in the subaward agreement between the selected applicant and the regional PDC. Applicants should plan for reimbursement-based funding and maintain sufficient documentation of eligible expenditures. Federal cash management requirements under 2 CFR 200.305 govern the timing and disbursement of federal funds, including requirements to minimize the time between the transfer and expenditure of funds.

Reporting Requirements

27. Will DMAS share baseline annual wellness visit rates by locality, so awardees can align their targets with the program-level metric?

Yes, DMAS will work with PDCs to provide additional information and guidance regarding baseline annual wellness visit data and targets for relevant geographic areas to awardees.

28. For projects combining nonclinical access support with clinical services, when may an eligible resident be counted as served? Must a healthcare encounter be completed, or may documented navigation or access assistance qualify? How should applicants establish the baseline and demonstrate that residents served are incremental?

For projects combining nonclinical access support with clinical services, the Number of People Served is not necessarily limited to individuals who complete a healthcare encounter. Documented navigation or access assistance may qualify when it represents a substantive benefit delivered through the RHT-funded activity. States should use the population measure that most reasonably reflects the individuals who benefited from the initiative during the reporting period.

Applicants do not need to establish a separate baseline or demonstrate that individuals counted as People Served are incremental. The People Served measure should reflect the individuals who benefited from RHT Program funds during the applicable reporting period.