The Virginia Health Care Foundation

REQUEST FOR APPLICATIONS

Virginia Rural Health Transformation Program (RHTP)
Provider Productivity: Technology that Makes Time for Care

Issuing Organization:	The Virginia Health Care Foundation (VHCF)
Program Name:	Provider Productivity: Technology that Makes Time for Care
CFDA / Assistance Listing:	93.798 - Rural Health Transformation Program
Federal Award Identification Number	RHTCMS332088
Federal Award Date:	December 29, 2025
Awarding Agency:	U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), Office of Acquisitions and Grants Management
Statutory Authority:	Section 71401 of Public Law 119-21
Primary Recipient:	Virginia Department of Medical Assistance Services (DMAS); 600 E Broad St, Suite 1300, Richmond, VA 23219-1856
Federal Funds Expiration Date:	October 30, 2030
RFA Reference Number:	RFA-RHTP-2026-02
Initiative:	CareIQ
Sub-initiative:	Provider Productivity
RFA Issue Date:	August 14, 2026
Pre-application Webinar	August 20, 2026. Please register via this **Webinar Registration Page**.
Application Questions	Please submit written questions using this **FAQ Submission Form.** Answers will be published each Friday at **https://www.vhcf.org/rural-health/**.
Application Deadline:	September 14, 2026, 5:00 PM Eastern
Review Period	September 15 – October 14, 2026
Notice of Awards	October 15, 2026
Submission Method:	Please submit proposals via this **Application Submission Form**. Please read the submission portal instructions carefully to ensure your entire proposal is submitted.
Period of Performance:	October 15, 2026 – September 30, 2027
Estimated Award Range:	VHCF anticipates awarding between $7 million and $9 million over the performance period. Individual award amounts will reflect the scope and scale of each applicant's proposed project.
Funding Availability	Awards made under this RFA are contingent upon the continued availability of federal funding. VHCF may reduce or terminate any award in the event of the termination, reduction, restriction, or unavailability of the prime award or the upper-tier subaward through which it is funded.
Geographic Scope:	Eligible applicants must be physically located in, or provide direct services to, rural Virginia communities as defined under Virginia's RHTP. The Program's baseline definition of rurality is based on the federally required Federal Office of Rural Health Policy (FORHP) definition. Over the course of the Program, Virginia may build upon the FORHP baseline definition to better reflect the Commonwealth's unique rural landscape and the needs of rural communities. Applicants should refer to the RHTP website for the most up-to-date rural definition and eligibility requirements. The current list of FORHP-designated localities is available in **Appendix A**.

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PART I: BACKGROUND

1.1 Rural Health Transformation Program

Virginia is home to more than 1.5 million rural residents spanning the Northern Piedmont, Shenandoah Valley, Roanoke/Alleghany, Southwest, Southside, and the Eastern Shore and Northern Neck. Rural communities face persistent access barriers, high chronic disease burden, healthcare workforce shortages, behavioral health gaps, maternal health disparities, and financially fragile rural hospitals and clinics.

Virginia's Rural Health Transformation Program (RHTP) application was developed through statewide engagement with rural providers, community organizations, health systems, federally recognized Tribes, and state agencies. The RHTP was established under Section 71401 of Public Law 119-21 and is administered by the Centers for Medicare & Medicaid Services (CMS). The RHTP provides funding over five budget periods (Federal Fiscal Years 2026–2030) to States for investments that structurally transform health care delivery in rural communities.

CMS awarded the Commonwealth of Virginia a Cooperative Agreement designating the Virginia Department of Medical Assistance Services (”DMAS”) as the primary recipient. DMAS administers RHTP funds and issues subrecipient awards to qualified organizations to implement approved program sub-initiatives. The Virginia Health Care Foundation (VHCF) is a subrecipient of DMAS and will carry out the Provider Productivity sub-initiative, one of four sub-initiatives under the CareIQ key initiative.

Future funding opportunities will be contingent upon continued federal appropriations and the Commonwealth’s participation in the Rural Health Transformation Program. **Applicants are strongly encouraged to submit proposals that can be successfully implemented during the current performance period while establishing a foundation for future enhancements or expansions.**

1.2 Provider Productivity Sub-initiative

Rural health care providers spend hours each day on administrative tasks, competing with patient care for providers’ time and attention. Providers routinely finish these tasks after hours, a pattern that drives burnout and staff turnover. In rural communities, where a single clinician’s departure can close a service line, it is also an access problem.

The purpose of the Provider Productivity sub-initiative is to support adoption of digital productivity tools, including AI-enabled decision-support, documentation, and workflow automation, to reduce administrative burden, ease provider burnout, and allow rural clinicians to focus more of their valuable time on patient care.

To better understand rural Virginia’s digital productivity landscape, VHCF interviewed 84 stakeholders representing 44 organizations and surveyed 50 rural Virginia health care safety net providers. The assessment found rapid but uneven adoption of digital (often AI) productivity tools. Providers also reported meaningful time savings but noted these gains do not necessarily translate into reduced burden or burnout.

Informed by these findings and Virginia's CMS-approved **Rural Health Transformation Program application**, VHCF seeks proposed projects that support rural providers in adopting or upgrading digital productivity tools in one or more of three areas: decision support, documentation, and workflow automation (see **Section 1.3**). Proposals must identify the specific source of administrative burden the tool will address, explain how the tool will be integrated into clinical or operational workflows, and

describe how the organization will measure the resulting change in provider time savings and burden, along with any associated change in billable services or revenue.

As a part of this program, VHCF will facilitate technical assistance for subrecipients scaled to each provider's existing technical capacity and the scope of their project.

1.3 Objectives

The Provider Productivity sub-initiative objectives are aligned with CMS's "Technology Innovation" Rural Health Transformation strategic goals (see Table 1). These objectives also serve as funding areas that define the scope of eligible activities under this RFA. Applicants' proposals must align with at least one of the following objectives; activities that fall outside these areas are not eligible for funding under this RFA.

Table 1: Provider Productivity Objectives/Funding Areas

Objective/Funding Area	Description	CMS Goal Alignment
Decision Support	Rural providers have patient-specific clinical guidance available to support timely, informed decisions.	Technology Innovation
Documentation	Rural providers spend less time producing and maintaining clinical documentation, returning that time to patient care.	Technology Innovation
Workflow Automation	Rural providers have automated the administrative and operational processes surrounding the visit, reducing manual work for clinical and non-clinical staff.	Technology Innovation

These funding areas are independent of each other. Applicants are not required to address more than one, and no funding area is a prerequisite for another. Where applicable, proposed projects should align with **ONC/ASTP certification standards** and **CMS Health Technology Ecosystem criteria**.

1.4 Eligibility

To be eligible for an award under this RFA, applicants must meet all the following requirements.

Table 2: Minimum Eligibility Requirements

Eligibility Category	Requirement
General	• Be a legally organized entity in good standing (nonprofit, governmental, Tribal entity, hospital/health system, independent practice, free/hybrid or charitable clinic, federally qualified health center, rural health clinic, educational institution, or other entity) capable of receiving federal subaward funding. • Hold an active SAM.gov registration with a current Unique Entity Identifier (UEI) and no active exclusions, debarments, or suspensions.
Geographic	• Eligible applicants must be physically located in, or provide direct services to, rural Virginia communities as defined under Virginia's RHTP. The Program's baseline definition of rurality is based on the federally required Federal Office of Rural Health Policy (FORHP) definition. Over the course of the Program, Virginia may build upon the FORHP baseline definition to better reflect the

Eligibility Category	Requirement
	Commonwealth's unique rural landscape and the needs of rural communities. Applicants should refer to the RHT Program website for the most up-to-date rural definition and eligibility requirements. The current list of FORHP-designated localities is available in **Appendix A**.

Note on Eligibility for Applicants to Provider Interoperability & Provider Productivity RFAs
Organizations that intend to apply or have applied for an award under the Provider Interoperability RFA (RFA-RHTP-2026-01) are eligible to apply under this RFA. If applying for both opportunities, applicants must ensure that no cost is charged to both awards and that the budget narrative clearly distinguishes the activities, personnel effort, and purchases supported by each.

PART II: REQUIRED SCOPE OF WORK

2.1 Scope of Work and Use of Funds

Provider Productivity subrecipients will implement projects that put proven digital tools into daily clinical and administrative use. Examples include, but are not limited to, deploying an ambient documentation tool across a clinical team, integrating decision support into an existing EHR, or automating referral, prior authorization, or inbox triage processes.

Collectively, these investments should return clinician time to direct patient care and reduce the administrative burden that drives burnout and turnover in rural practices.

Successful applicants will demonstrate effective plans to implement or expand one or more of the following eligible uses of funds:

- **Reduce time spent on clinical documentation, inbox management, prior authorization, and other administrative tasks;**
- **Improve the timeliness, consistency, or quality of clinical decision-making at the point of care;**
- **Automate manual administrative and back-office processes;**
- **Reduce clinician and staff burnout and support workforce retention; and**
- **Expand patient access by returning clinical time to direct care.**

2.2 Required Milestones, Activities, and Deliverables

If funded, subrecipients must complete the following required activities and submit the associated deliverables outlined below.

Milestone 1: Project Kickoff (October 2026 – December 2026)
Prior to applying, applicants must have completed sufficient planning to begin work immediately upon award. This includes identifying the technology needs, defining the proposed solution, securing organizational commitment, and confirming key personnel are in place.

During the project kickoff phase, subrecipients will complete any remaining pre-implementation steps, including selecting and executing vendor contracts, finalizing implementation timelines, and completing any internal approvals necessary to begin project execution no later than January 1, 2027. Subrecipients must also collect and submit baseline metric data before the funded tool is placed into active use.

Required deliverables include:

- Finalized implementation timeline.
- Executed vendor contract(s), if applicable.
- Baseline metric data submission.

Milestone 2: Project Implementation (January 2027 – June 2027)
Subrecipients will implement their approved projects. Activities may include tool procurement and licensing, EHR or system integration, configuration and testing, workflow redesign, staff training, and phased rollout, as applicable.

Required deliverables include:

- Attestation that the funded tool has been deployed and is in active use, including documentation of the number of providers and staff using it and the clinical or administrative workflows it supports, as determined by VHCF.

- Attestation that staff training and workflow integration activities have been completed, supported by documentation to be determined by VHCF.

Milestone 3: Project Closeout (July 2027 – September 2027)
Subrecipients will participate in program evaluation and reporting activities, confirm sustainability of project benefits beyond the grant period, and complete all required close-out activities.

Required deliverables include:

- Final project report summarizing implementation activities, outcomes, lessons learned, and sustainability plans.

- Completed program evaluation data submission to VHCF for subsequent delivery to the Virginia Center for Health Innovation (VCHI), the designated evaluator for Virginia's Rural Health Transformation Program.

2.3 Required Coordination and Partnerships

Section A: Coordination
Applicants must identify the key programmatic staff members who will implement the project and explain how they will carry out the work, including a defined level of effort (e.g. hours per week dedicated to the project).

Applicants must also commit to coordinating with VHCF, including participation in any required kickoff, technical assistance, and check-in activities. Applicants must also commit to tracking and reporting data as needed with VCHI and DMAS by providing data and information needed for program evaluation and federal reporting under the RHTP. Specific data and reporting requirements are described in Part III.

Section B: Partnerships
Applicants are not required to partner with other organizations to be eligible for an award under this RFA; a single provider organization may apply solely on its own behalf. However, where the success of a proposed project depends on the participation of another organization, the applicant must demonstrate that organization's committed support. In each such case, the applicant must document the partner's commitment through a letter of support or memorandum of understanding that identifies the partner's role and responsibilities in the proposed work.

An association or convening entity applying on behalf of two or more provider organizations must demonstrate a formal relationship with each participating organization. The applicant must submit a letter of support or memorandum of understanding, signed by an authorized representative/organizational leader, that confirms each organization's agreement to participate, identifies the key programmatic staff members who will implement the project, and explains how they will carry out the work, including a defined level of effort (e.g. hours per week dedicated to the project).

PART III: REQUIRED PERFORMANCE METRICS, MILESTONES, AND REPORTING

3.1 Required Metrics

Applicants must track and report the required metrics below. These metrics apply to all subrecipients regardless of the objective/funding area or areas addressed by the proposed project.

Table 3: Provider Productivity Metrics[1]

Metric	Target / Milestone	Collection Methodology
Digital Productivity Tool Use	By the end of the performance period, subrecipients will have adopted or expanded use of a digital productivity tool.	Subrecipients will report a count of active tool users by provider type at the beginning and end of the performance period.
Time Savings	By the end of the performance period, subrecipients will have reported time savings achieved attributable to the digital productivity tool.	Subrecipients will report EHR audit-log data if applicable; otherwise, a structured provider time estimate collected using a VHCF-provided instrument at the beginning and end of the performance period.
Revenue & Billable Services	By the end of the performance period, subrecipients will have reported a positive impact on revenue or billable services achieved attributable to the digital productivity tool.	Subrecipients will report encounter and billable service counts from the practice management or billing system at the beginning and end of the performance period.
Clinician Burnout	By the end of the performance period, subrecipients will have reported reduced clinical burnout among clinical staff.	A single-item validated burnout measure administered to all clinical staff at the beginning and end of the performance period.

Subrecipients will also be expected to report unique patients served and total patient visits (overall and disaggregated by FORHP-designated rural locality) at the beginning and end of the performance period.

Baseline data must be collected before the funded tool is placed into active use and submitted as a Milestone 1 deliverable.

3.2 Required Milestones

These milestones apply to all subrecipients under this RFA. All milestones will be incorporated into the executed subrecipient agreement.

- Milestone 1: Project Kickoff (October 2026 – December 2026)
- Milestone 2: Project Implementation (January 2027 – June 2027)
- Milestone 3: Project Closeout (July 2027 – September 2027)

3.3 Reporting Requirements

Subrecipients must submit complete, accurate, and timely programmatic and financial reports in the form and cadence required by VHCF. Subrecipients must maintain documentation sufficient to support

[1] Subrecipients will receive additional specifications on these metrics and recommended data collection methods.

reported activities, expenditures, outputs, milestones, and performance results. Subrecipients must cooperate with monitoring, audit, and oversight activities and must provide access to records personnel, systems, and facilities upon request by VHCF, DMAS, CMS, HHS, auditors, or other authorized officials.

Table 4: Subrecipient Reporting Schedule

Report Type	Frequency	Description	Due Date
Monthly Financial Report	Monthly	See **Section 6.3** for required monthly financial reporting requirements	7 days after the end of each month
Quarterly Progress Reports	Quarterly	Milestone progress, project risks, technical assistance needs, emerging compliance issues	15 days after the end of each quarter
Final Progress & Financial Report	One-Time	Cumulative qualitative and quantitative progress; all metric data; expenditures by activity. Actual expenditures by budget category, unliquidated obligations, unobligated balance	15 days after the end of the performance period

Subrecipient reports will inform Virginia's quarterly reports to CMS. Subrecipients are not expected to report on their progress ahead of the first CMS quarterly report, due November 27, 2026. Subrecipient reports will inform future CMS quarterly reports, due March 1, 2027, May 30, 2027, and November 2027, as well as an annual report due August 30, 2027.

VHCF will conduct ongoing monitoring of all subrecipients. Monitoring activities will include:

- Desk reviews of financial reports, progress reports, invoices, and supporting documentation;
- Risk assessments at onboarding and annually to calibrate monitoring intensity;
- Site visits (announced and/or unannounced) to assess program operations, records, and internal controls;
- Follow-up on audit findings, corrective action plans, and identified compliance deficiencies.

Subrecipients must cooperate fully with all reporting and monitoring activities and provide requested documentation within timeframes specified by VHCF. Failure to cooperate constitutes non-compliance and may result in corrective action or termination of the award.

PART IV: APPLICATION REQUIREMENTS AND INSTRUCTIONS

This Request for Applications deadline is September 14, 2026, 5:00 PM Eastern.

Please submit applications via the **Application Submission Form**.

Applicants must include all required submission components and follow the Project Narrative formatting instructions described below. These instructions are also available on the application submission form.

The Project Narrative must:

- Address each section in order and not omit or combine sections.
- Use an 11-point Arial typeface for all text, tables, and figures.
- 1-inch margins on all sides.
- Double spacing.
- Follow all page limits.

Required Submission Components

*Complete the Application Cover Page directly in the online **Application Submission Form**. Attach all other components as directed by the form. All applications must include:*

- Application cover page
- Project narrative
- Budget & budget narrative (use provided template)
- Key programmatic staff resumes and letters of support / memorandums of understanding.
- AI Governance Policy (if applicable)
- Most recent audited financial statements (or most recent Federal Single Audit, if applicable).
- Active SAM.gov registration confirmation and debarment certification (screenshot is sufficient).

Applications that do not meet these requirements will not be reviewed.

Pre-Application Webinar

VHCF will host a pre-application webinar on August 20 at 11:00 AM Eastern to answer questions about the Provider Productivity sub-initiative and the application process. Please register for the webinar using this **Webinar Registration Page**.

Questions & Answers

Please submit written questions using this **FAQ Submission Form**.
Responses will be published each Friday at **https://www.vhcf.org/rural-health/**.

4.1 Application Cover Page

This page is available for reference only. Please complete the cover page online via the Application Submission Form

APPLICANT ORGANIZATION AND PROJECT INFORMATION

Project Title	
Total Funding Requested (USD)	
Legal Name of Organization	
DBA / Trade Name (if applicable)	
Organization Type	☐ Federally Qualified Health Center ☐ Free/Hybrid or Charitable Clinic ☐ Hospital / Health System ☐ Independent Practice ☐ Rural Health Clinic ☐ Tribal Entity ☐ Health Care Association ☐ Other (specify): Click or tap here to enter text.
Year Established	
Number of Full-Time Employees (FTEs)	
Organization Website	
EIN (Federal Tax ID, 9 digits)	
Unique Entity Identifier (UEI)	
SAM.gov Registration Active (Y/N)	
Mailing Address (Street)	
City, State, ZIP	

AUTHORIZED ORGANIZATIONAL REPRESENTATIVE (AOR) CERTIFICATION

By signing below, the Authorized Organizational Representative certifies that all information in this application is true, accurate, and complete; that the organization accepts all conditions of a Virginia RHTP subrecipient award; and that the organization will comply with 2 CFR Part 200, CMS RHTP Program Terms and Conditions, and all applicable federal and state requirements (See Part VI, "**Award Terms, Reporting, and Compliance Requirements**").

Full Name	
Title	
Email	
Direct Phone	
Date	

AOR Signature:	

4.2 Project Narrative

Section A: Organizational Overview (2 Pages)

- State the organization's mission.

- Describe patient count and visit data from the organization's most recently completed fiscal year using the following table. If unable to break down this data by locality, please list the rural localities from which the organization has served at least one patient in the most recently completed fiscal year.

Metric	# Patients/Visits	Notes
Unique patients served		
Total patient visits		
Unique patients served who live in a FORHP-designated rural locality.		
Total visits among patients who live in a FORHP-designated rural locality.		

- Describe the organization's payer mix from the most recently completed fiscal year using the following table:

Payer Type	# (%) Patients	Notes
Medicaid		
Medicare		
Commercial		
Self-Pay/Uninsured		
Other		

- Describe the organization's current use and familiarity with decision support, documentation, and workflow automation digital productivity tools.
    - What is the organization's familiarity with digital productivity tools? For instance, not at all familiar, somewhat familiar, very familiar, etc.
    - What tools are already in use? Applicants may list specific tools or, for larger organizations, provide a summary with examples.
    - If using digital productivity tools, are they integrated with the organization's electronic health record platform, third-party applications, or both?

Section B: Project Design and Need (3 Pages)

- Describe the proposed project.
    - Identify the applicable objective/funding area (Section 1.3).
    - Explain how the project aligns with the allowable use of funds (Section 2.1).
    - Describe in detail the administrative burden(s) that the project will address.
    - Explain how the project will reduce administrative burden and achieve time savings for clinicians.

- Describe how the proposed project will directly benefit patients living in one or more of the FORHP-designated rural localities, available in Appendix A.

- Provide an estimate of the number of patients who will benefit from the proposed project using the following table. Estimates should be reasonable, supported by available data, and reflect the scope and reach of the initiative.

Metric	# Patients	Notes
Patients who will benefit		
Patients who live in a FORHP-designated rural locality who will benefit		

- Describe whether the proposed tool will be interoperable with systems used by other organizations. If so, identify the systems or organizations involved and the data standards the tool will use. If the tool will not exchange data externally, indicate so.[2]

Section C: Project Readiness (3 Pages)

- Describe the planning activities already completed and explain why the project is ready for implementation.

- Describe vendor evaluation, procurement, or solution-selection activities completed to date, and identify what remains outstanding.
    - What procurement methodology did or will the organization use?
    - What is the scope of work, and why is this partnership needed?
    - What is the expected cost?

- Describe the technical assistance needed to complete the project and if the technical assistance capacity is available internally or if the organization will utilize VHCF-facilitated TA.

Section D: Digital Technology Safeguards (3 Pages)

- Describe what policies or standards the organization has in place, if any, that govern the use of AI tools in clinical or administrative settings. If the organization has a written policy, please attach it to the Application Submission Form.

- Describe how the organization will protect patient information in connection with the proposed tool.

- If the proposed tool drafts clinical documentation or generates clinical recommendations, describe how clinical staff will review and approve output, and who is responsible for these decisions.

- If the proposed tool records or transcribes patient encounters, describe how patients will be informed and how the organization will respond to patients who decline.

- Describe whether the organization anticipates charging patients any additional fee associated with the use of the funded tool (e.g., a separate charge for an AI-assisted diagnostic read). If so, explain why and describe how the charge would be determined and communicated to patients.

Section E: Work Plan and Key Programmatic Staff (3 Pages, Excluding Resumes)

- Provide a detailed project work plan and implementation timeline aligned with the milestones in **Section 2.2.**

[2] *This question is for information purposes only and answers will not be scored. Interoperability with external partners is not a requirement under this RFA.*

- Describe any major project risks and mitigation strategies.

- Identify the key programmatic staff members who will implement the project, and explain how they will carry out the work, including a defined level of effort (e.g. hours per week dedicated to the project).

    - An association or convening entity applying on behalf of two or more provider organizations must demonstrate a formal relationship with each participating organization. The applicant must submit a letter of support or memorandum of understanding, signed by an authorized representative/organizational leader, that confirms each organization's agreement to participate, identifies the key programmatic staff members who will implement the project, and explains how they will carry out the work, including a defined level of effort (e.g. hours per week dedicated to the project). Association or convening entities **are not** required to submit resumes for key programmatic staff at each participating organization.

Section F: Stakeholder Engagement & Partnerships (3 Pages, Excluding Letters of Support)

- Describe how organizational leadership engaged clinical and non-clinical staff in identifying the challenges and proposed solution.

- Describe how clinical and non-clinical workflows will change during and after implementation.
    - How will leadership communicate these changes to clinical and non-clinical staff?
    - What actions will be taken to minimize disruptions and administrative burden during implementation?
    - How will clinical and non-clinical staff be trained to use these new tool(s)? Who will be responsible?

- If applicable, identify community partners or other stakeholders that are engaged in or supportive of the project and describe the role. Attach documentation demonstrating stakeholders' support (e.g. letters of support) to the Application Submission Form.

- Describe plans for gathering and addressing stakeholders' feedback and concerns during project implementation.

Section G: Performance Metrics and Evaluation Plan (1 Page)

- Describe how the organization will collect and report the required metrics, including the data sources, systems, and staff responsible.

Section H: Sustainability (1 Page)

- Identify specific future funding sources and plans for covering ongoing costs, including subscription and license renewals, vendor support, and staff time required to sustain the tool.

- Describe how the proposed project may have a positive impact on revenue or billable services.

- Describe how new workflows and operational improvements will be maintained and incorporated into ongoing organizational operations.

Section I: Previous Grant Experience (1 Page)

- If applicable, submit information on federal, state, local, or private grant-funded projects within the past five years using the template below. Please provide no more than three projects. Organizations without grant-funded experience are not precluded from applying or being awarded.

Table 5: Past Projects Template

#	Project / Funder	Period & Funding	Role	Outcomes & Reference Contact
1	*[INSERT: project name; funder/grantor]*	*[INSERT: period of performance; total funding amount; funding source]*	*[INSERT: prime / subrecipient / subcontractor]*	*[INSERT: 2–3 measurable outcomes; reference name, title, organization, email, phone]*
2	*[INSERT]*	*[INSERT]*	*[INSERT]*	*[INSERT]*
3	*[INSERT]*	*[INSERT]*	*[INSERT]*	*[INSERT]*

VHCF may contact references directly without further notice to the applicant. Reference responses will inform scoring of the Past Performance review criterion and may inform any specific conditions imposed under 2 CFR 200.208.

4.3 Budget & Budget Narrative

- **Applicants must submit a budget and budget narrative using the template available at https://www.vhcf.org/rural-health/.** Budgets submitted in any other format will not be reviewed. See the template for additional guidance and instructions.

- Rural Health Transformation funds may only support new projects or meaningful expansions of existing projects, including extending services to rural populations not currently served.

- See **Section 6.5** for a complete list of prohibited use of funds.

PART V: REVIEW CRITERIA AND SCORING

5.1 Review Process

Complete applications will be scored against the following criteria. VHCF will issue notice of awards by October 15, 2026. **Please refer to the application formatting and submission instructions in Part IV before applying.**

Table 6: Evaluation Criteria

Review Criterion	Description	Maximum Points
Project Design & Need	Demonstrated need for the proposed project; alignment with the selected funding area and Provider Productivity objectives; strength of the proposed solution and its fit with existing clinical and administrative workflows; anticipated impact on provider time, administrative burden, and burnout.	10 points
Project Readiness	Evidence that the project is implementation-ready and that applicants have identified their technology needs, defined a proposed solution, secured organizational commitment, and have key programmatic staff in place.	10 points
Digital Technology Safeguards	Adequacy of plans to protect patient information in connection with the funded tool; ensure clinical review and approval of AI-generated documentation or recommendations before use; inform patients when encounters are recorded or transcribed; and address any patient-facing fees associated with the tool.	10 points
Work Plan & Key Programmatic Staff	Reasonableness of work plan and implementation timeline; sufficient staff time allocated to the project to achieve milestones; thoughtful risk-planning. Key programmatic staff are in place and qualified to implement the project.	10 points
Stakeholder Engagement & Partnerships	Strength of partnerships and stakeholder engagement; involvement of rural providers, community partners, and other stakeholders; plans for communication, change management, and ongoing engagement throughout implementation.	10 points
Performance Metrics & Evaluation Plan	Quality of the proposed performance measurement approach; feasibility of data collection and reporting; alignment with required program metrics and reporting requirements.	5 points
Sustainability	Credibility and specificity of plans to maintain the funded tool, associated workflows, and project benefits after grant funding ends; identification of future funding sources, such as additional revenue or billable services, for ongoing licensing and support.	5 points
Grant Experience	Organizational experience implementing similar projects; demonstrated ability to manage grant funds and achieve project objectives.	5 points
Budget & Budget Narrative	Reasonableness of the proposed budget; alignment of costs with project activities and anticipated outcomes; overall value of the proposed investment.	5 points
TOTAL		
70 Points Maximum		**70 points**

PART VI: AWARD TERMS, REPORTING, AND COMPLIANCE REQUIREMENTS

The applicant's Authorized Organizational Representative must certify that the applicant accepts the following conditions of a Virginia Rural Health Transformation Program subrecipient award (**Section 4.1, "Application Cover Page**").

6.1 Federal Regulatory Framework

All awards under this RFA are federal subawards. Subrecipients shall comply with:

- 2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance);
- Applicable provisions of 2 CFR Part 300
- HHS Grants Policy Statement
- CMS Rural Health Transformation Terms and Conditions
- Notice of Award
- CMS guidance and clarifications
- Public Law 119-21
- Upper-tier subaward between DMAS and VHCF
- Exhibit A – Special RHTP Terms and Conditions
- Any additional requirements imposed by DMAS or VHCF to meet federal award obligations, the Code of Virginia and applicable VHCF procurement policies;
- Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.);
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794);
- Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.);
- Section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116);
- Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.) where applicable;
- Anti-Lobbying Act and Byrd Amendment (31 U.S.C. 1352) for awards over $100,000;
- Drug-Free Workplace Act;
- SAM.gov registration and UEI requirements (2 CFR Part 25, Appendix A).

For Programs that could implicate Title IX (i.e., awards to or for school, colleges, universities, 4-H programs, non-governmental organization (NGO) programs, sports programs, and education-related awards to prisons or other detention facilitates):

- Subrecipient is compliant with Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. §§ 1681 et seq., including the requirements set forth in Presidential Executive Order 14168 titled Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, and Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d et seq., and subrecipient will remain compliant for the duration of the period of performance.

A knowing false statement regarding the subrecipient's compliance may subject the subrecipient to liability under the False Claims Act (31 U.S.C. 3729 et seq.) and to criminal liability under 18 U.S.C. 287 and 18 U.S.C. 1001.

Subrecipients shall maintain records demonstrating compliance with applicable civil rights requirements and shall permit DMAS, CMS, and other authorized federal or state entities to review and audit such records. Subrecipients shall cooperate with any civil rights compliance reviews or investigations conducted by DMAS, the HHS Office for Civil Rights, or other authorized entities.

Applicable requirements may be amended, supplemented, or replaced by CMS, HHS, OMB, DMAS, or other federal authorities during the Performance Period. Subrecipients must flow down applicable requirements to any further lower-tier subrecipients or contractors, in accordance with 2 CFR 200.101(b), as applicable.

6.2 Stevens Amendment Acknowledgement Requirements

The Stevens Amendment (Section 507 of P.L. 104-208, as continued in subsequent appropriations acts) requires that any document, statement, press release, or other publication describing a project or program funded in whole or in part with RHTP funds clearly state both the dollar amount and the percentage of total program costs financed with federal money. Subrecipients must include appropriate acknowledgement language below verbatim in this RFA and require via subaward that all awardees include the same acknowledgement in any such publications, including websites, reports, press releases, and presentations.

If the subaward is funded entirely with federal funds (no non-federal sources):

"This subaward [is/was] supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $[XX] with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CMS/HHS or the U.S. Government."

If the subaward is partially funded with non-governmental sources:

"This subaward [is/was] supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $[XX] with [XX] percent funded by CMS/HHS and $[XX amount] and [XX] percent funded by non-government source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CMS/HHS or the U.S. Government."

Update both the dollar amount and the percentage figures whenever the funding mix changes during the period of performance.

Subrecipients shall include the substance of this Stevens Amendment section in each lower-tier subaward and shall require each lower-tier subrecipient to include the percentage and dollar amount disclosures required by this section in any statements, press releases, publications, requests for proposals, bid solicitations, toolkits, resource guides, websites, presentations, and other documents describing projects or programs funded in whole or in part with HHS funds.

Any planned external public communications related to activities funded under the sub-initiative shall be submitted for review and approval in accordance with CMS Rural Health Transformation Program and DMAS requirements, including submission to DMAS for CMS approval. Subrecipients shall not release such external public communications until any required review and approval has been completed.

6.3 Invoicing Process & Documentation

Section A. Invoicing Process

VHCF will award funds to subrecipients on a cost-reimbursement basis at a monthly cadence according to the following process:

1. Subrecipients shall invoice VHCF for allowable costs via a monthly financial report due to VHCF no more than seven (7) days after the end of the previous month. All invoices must be supported by appropriate documentation.

2. VHCF will review all invoices and submit a reimbursement request for allowable expenses on behalf of all subrecipients to DMAS within three (3) business days.

3. DMAS will review and make a determination on VHCF's reimbursement request. DMAS will reimburse VHCF for approved expenses within thirty (30) days.

4. VHCF will reimburse subrecipients for their approved expenses within three (3) business days of receiving reimbursement from DMAS.

Where necessary to meet the terms of a subaward agreement or to address reasonable cash flow needs, subrecipients may request advance funding or other payment mechanisms approved by VHCF and DMAS.

Section B. Invoicing Documentation

Subrecipients shall submit invoices via a monthly financial report to VHCF no more than seven (7) days after the end of the previous month. Each invoice must include the following, each generated from or reconcilable to the subrecipient's Financial Management Information System (FMIS) of record:

1. A report of costs by approved budget category, exported from the subrecipient's FMIS, showing for each category the period costs, cumulative Performance Period costs, approved budget, and remaining balance;

2. An FMIS-generated transaction-level expenditure detail report covering all costs included in the invoice, identifying for each transaction the date, vendor or payee, general-ledger or account code, tax ID, budget category, dollar amount, and a description sufficient to establish allocability to the subaward

3. Item-level supporting documentation for each transaction, including but not limited to:

    a. Personnel (Salaries and Wages) payroll detail from the FMIS showing employee, pay period, hours or effort allocated to this sub-initiative, gross pay charged, and fringe, supported by records meeting the standards of 2 CFR 200.430(g) (records that accurately reflect work performed, supported by a system of internal control, incorporated into the subrecipient's official records, and not exceeding 100% of compensated activity); for nonexempt employees, records of total hours worked each day per 29 CFR Part 516;

    b. Fringe Benefits: the calculation applying the subrecipient's fringe benefit rate or pool to each charged employee's salary; identification of the components included (e.g., FICA, retirement, health insurance, paid leave); and either the subrecipient's currently-effective federally-approved fringe benefit rate agreement (if applicable) or the subrecipient's documented allocation methodology, consistent with 2 CFR 200.431;

    c. Travel: traveler, dates, purpose, and itemization conforming to state travel expenditure regulation **Cardinal Topic 20335** and 2 CFR 200.475;

    d. Contractual: payee, dates, purpose of payment, contract or PO reference, and either the underlying invoice or, for recurring payments, a summary tied to the contract;

e. Supplies: itemized list of supplies, vendor invoices or receipts, and identification of the program activity to which each item is allocable; computing devices and other tangible items below the equipment threshold in 2 CFR 200.1 are charged here;

f. Equipment (if any): description of the item, vendor invoice, acquisition cost equal to or exceeding the lesser of the subrecipient's capitalization level for financial statement purposes or $10,000 (the threshold set at 2 CFR 200.1, definition of "Equipment," as adopted for HHS awards effective October 1, 2024 by the HHS Interim Final Rule, 89 FR 80055 (Oct. 2, 2024)), and the property-record entry required by 2 CFR 200.313(d);

g. Other: itemized list of costs charged to the "Other" category (e.g., telephone, mobile, IT services, training, communications, dues and memberships), vendor invoices or receipts, and, where charges are centrally allocated, the cost-allocation methodology and the calculation supporting the amount charged to this sub-initiative;

h. A reconciliation of any advanced funds received, disbursed, and held, including beginning balance, receipts, disbursements, ending balance, and interest earned, consistent with 2 CFR 200.305(b);

i. A report of program income received and expended during the billing period and cumulatively, traceable to the corresponding entries in the subrecipient's FMIS, per 2 CFR 200.307;

j. A certification, signed by an authorized financial officer of the subrecipient, that (A) all costs included in the invoice are allowable, allocable, and reasonable under 2 CFR Part 200, Subpart E, the NoA, NOFO CMS-RHT-26-001, and this sub-initiative; (B) the costs are recorded in the subrecipient's FMIS in accordance with 2 CFR 200.302; (C) no cost has been or will be charged to any other federal, state, local, or private funding source (no duplication of benefits per 2 CFR 200.403); and (D) the supporting documentation required by this Section is maintained and available for inspection on request.

Invoices that omit required documentation may be returned for correction and completion and may delay reimbursement.

6.4 Final Reconciliation & Closeout

Subrecipients shall submit a reconciliation invoice and any overpayment due to VHCF no later than fifteen (15) days following the end of the Performance Period. This invoice may include but is not limited to costs incurred and obligations liquidated for the final month of the performance period, any unobligated balance for that period, the reconciliation of any advanced funds for that period, and a certification of program income earned and expended during the Performance Period.

This closeout does not limit post-closeout adjustments, disallowances, or recovery consistent with 2 CFR 200.345.

6.5 Prohibited Uses of Funds

Section A. No Indirect Costs

Subrecipients may only charge costs that are necessary, reasonable, allocable, allowable, and adequately documented, in accordance with 2 CFR 200.403-200.405 and 2 CFR Part 200, Subpart E, the RHTP Notice of Award, CMS guidance, and the approved budget and scope of work. Subrecipients may not charge a negotiated indirect cost rate, de minimis indirect cost rate, facilities and administrative (F&A) costs, or any other indirect cost allocation to this award.

Direct administrative costs must be minimized, separately identified in the budget, and supported by a narrative explaining their direct relationship to implementation of the approved project. No cost sharing or matching contribution is required under this RFA.

To be considered an allowable cost, applicants must:

- Identify the specific project activity, deliverable, milestone, or outcome the cost supports;
- For personnel costs, describe the actual project responsibilities the individual will perform under the award, rather than relying on the job title or organizational role;
- Provide justification for any leadership, management, or administrative position included in the budget, describing its direct responsibilities for project implementation; and
- Demonstrate that the cost would not be charged to the award absent a documented connection to the approved project.

Executive, clinical, and organizational leadership personnel may be budgeted only to the extent that they perform documented project responsibilities directly related to the implementation of the funded project.

Some shared expenses may be charged as programmatic costs provided they serve a documented programmatic purpose and have an approved allocation methodology. Allocable shared expenses will be determined during the pre-award phase.

Section B. Other Prohibited Uses

The following expenditures are expressly prohibited and may not be charged to this award:

- Pre-award costs.
- Meeting matching requirements for any other federal funds or local entities.
- Services, equipment, or supports that are the legal responsibility of another party under federal, state, or tribal law such as vocational rehabilitation or education services. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- Goods or services not allocable to the approved project.
- Supplanting existing state, local, tribal, or private funding of infrastructure or services, such as staff salaries.
- Construction.
- Capital expenditures for improvements to land, buildings, or equipment that materially increase their value or useful life as a direct cost except with the prior written approval.
- The cost of independent research and development.
- Profit to any recipient even if the recipient is a for-profit organization. Profit is any amount in excess of allowable direct costs.
- Funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any state government, state legislature or local legislature or legislative body. See also 45 CFR part 93, 2 CFR 200.450, Lobbying, and applicable Appropriations Law.
- Paying the salary or expenses of any grant recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation,

administrative action, or executive order proposed or pending before the Congress or any state government, state legislature, or local legislature or legislative body.

- Expenditures attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure used to finance the non-federal share of expenditures required under any provision of law.
- The salary of an individual at a rate in excess of Executive Level II. This salary cap applies to direct salaries. Subrecipients may pay salaries at a rate higher than Executive Level II if the amount beyond the HHS salary cap is paid with non-HHS funds.
- Lobbying, but recipients can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying;
- Certain telecommunications and video surveillance equipment. See 2 CFR 200.216;
- Costs of promotional items and memorabilia, including models, gifts, and souvenirs;
- Costs of advertising and public relations designed solely to promote the non-Federal entity;
- Meals, except in limited circumstances such as: (i) subjects and patients under study; (ii) where specifically approved as part of the project or program activity (not subrecipient-specific), e.g., children's services programs; or (iii) as part of a per diem or subsistence allowance provided in conjunction with allowable travel.

6.6 Record Retention and Audit Requirements

Subrecipients shall retain all grant-related records (financial, programmatic, procurement) for a minimum of five (5) years following submission of the final expenditure report, or longer if required by a federal audit or litigation hold. If federal expenditures equal or exceed $1,000,000 in any fiscal year, subrecipients are subject to the Single Audit requirements of 2 CFR Part 200, Subpart F. VHCF must receive copies of all Single Audit reports pertaining to the subaward.

6.7 Data Integrity and Intellectual Property

Subrecipients shall protect the confidentiality of all project-related data that includes personally identifiable information (PII) or protected health information (PHI). Subrecipients must assume full responsibility for the accuracy of all data and reports submitted to VHCF. CMS holds a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or use materials, systems, and items developed or refined under the award for federal government purposes per 2 CFR 200.315(b).

6.8 Prior-Approval Triggers

Subrecipients shall obtain written prior approval from VHCF before taking any of the following actions. Subrecipients should submit prior-approval requests at least 30 business days in advance of the proposed action, with sufficient supporting documentation.

Prior-approval requests are required for:

- Any change in scope, objectives, or key personnel identified in the approved application;
- Disengagement of the Project Director or Principal Investigator from the project for more than three (3) consecutive months, or a 25% or greater reduction in their level of effort;
- Any rebudgeting that cumulatively shifts more than 10% of the total approved budget across direct cost categories within a budget period;
- Carryover of unobligated balances from one budget period to the next;
- Subaward, transfer, or contracting out of any work under the federal award not previously identified in the approved application;
- Pre-award costs (which are otherwise prohibited under this RFA);

- No-cost extensions of the period of performance;
- Acquisition of equipment with a unit cost of $10,000 or more not specifically itemized in the approved budget;
- Changes in the approved cost-sharing or matching arrangement, if any;
- Termination of the subaward by the subrecipient.

The list above reflects the prior-approval requirements set forth in 2 CFR 200.308 and applicable CMS RHTP Program Terms and Conditions, as in effect on the date of this RFA. VHCF may impose additional prior-approval requirements based on the subrecipient's risk assessment.

6.9 Whistleblower Protection:

Congress has enacted the whistleblower protection statute 41 U.S.C. Section 4712 to encourage employees to report fraud, waste, and abuse without repercussions. This statute applies to all employees working for subrecipients, grantees, and subgrantees in accordance with this sub-initiative. All grantees, subgrantees, and subrecipients for federal grants and contracts/agreements are required to:

1. Inform their employees in writing of the whistleblower protection under 41 U.S.C. Section 4712 in the predominant native language of the workforce, to include the specific requirements of the statute, and

2. Include this term and condition in any agreement made with a subrecipient or subgrantee.

6.10 Trafficking in Persons

In accordance with Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104(g)), and the government-wide award term at 2 CFR Part 175 (Appendix A), the Subrecipient, its employees, lower-tier subrecipients, and lower-tier subrecipients' employees shall not, during the period of performance of this sub-initiative or any subaward issued under it:

- Engage in severe forms of trafficking in persons;
- Procure a commercial sex act;
- Use forced labor in the performance of this sub-initiative or any subaward; or
- Engage in acts that directly support or advance trafficking in persons, as enumerated in 2 CFR Part 175, Appendix A, paragraph (a)(1)(iv), including without limitation destroying, concealing, removing, confiscating, or otherwise denying an employee access to that employee's identity or immigration documents.

Subrecipients shall inform VHCF and DMAS immediately of any information it receives from any source alleging a violation of a prohibition in this section. Subrecipients shall, in addition, comply with any reporting obligation owed directly to CMS or HHS OIG under 22 U.S.C. 7104(g) and 22 U.S.C. 7104b.

6.11 Selection of Contractors

Section 1. Applicable Procurement Standards

For all procurement contracts entered into using funds provided under this sub-initiative, subrecipients shall comply with the procurement standards set forth at 2 CFR 200.317 through 200.327.

Section 2. Documented Procurement Procedures

In accordance with 2 CFR 200.318(a), subrecipients shall maintain and use documented procurement procedures that are consistent with applicable state, local, and tribal laws and regulations and with the

standards set forth in 2 CFR 200.317 through 200.327. Subrecipients shall make these procedures available to VHCF and DMAS upon request.

Section 3. Contractor Integrity and Responsibility

In accordance with 2 CFR 200.318(h), award shall be made only to responsible contractors possessing the ability to perform successfully under the terms and conditions of the proposed procurement. Consideration shall be given to integrity, compliance with public policy, record of past performance, and financial and technical resources. The subrecipient's obligation to verify SAM.gov exclusion status before entering into any procurement contract above the applicable threshold will be set forth in the subrecipient agreement.

Section 4. Contract Provisions

In accordance with 2 CFR 200.327, all contracts made by under this sub-initiative shall include the applicable provisions described in Appendix II to 2 CFR Part 200, including without limitation: remedies for breach of contract; termination for cause and convenience; equal employment opportunity; Davis-Bacon Act compliance (where applicable); Contract Work Hours and Safety Standards Act compliance (where applicable); rights to inventions made under a contract or agreement; Clean Air Act and Federal Water Pollution Control Act compliance (for contracts in excess of $150,000); debarment and suspension; Byrd Anti-Lobbying Amendment; procurement of recovered materials; and domestic preferences for procurements.

Section 5. Procurement Records

In accordance with 2 CFR 200.318(i), subrecipients shall maintain records sufficient to detail the history of each procurement transaction, including the rationale for the procurement method, the contract type selection, the contractor selection or rejection, and the basis for the contract price. Records shall be retained and made available in accordance with the record retention and access provisions of 2 CFR 200.334 and 200.337.

6.12 Confidentiality

Section 1. Data Privacy

During the Performance Period, subrecipients are required at all times to comply with all applicable federal and state laws and regulations, including those pertaining to information security and privacy.

Section 2. Confidentiality of Personally Identifiable Information and Health Records

Subrecipients shall assure that any information and data obtained as to personal facts and circumstances related to patients or clients will be held confidential during and following the Performance Period. Unless disclosure is required pursuant to court order or other statutory or regulatory authority, disclosure will not be made without the individual’s and the VHCF’s written consent, and only in accordance with applicable federal and state laws and regulations, including but not limited to the HIPAA Security and Privacy rules.

If the subrecipient utilizes, accesses, or stores personally identifiable information (PII), protected health information (PHI), or electronic protected health information (ePHI), in performance of this sub-initiative, the subrecipient is required to safeguard such information in accordance with the HIPAA Privacy, Security, and Breach Notification regulations and other applicable state and federal laws and regulations.

Before beginning any activity under this sub-initiative that involves the use, disclosure, or maintenance of PHI (as defined in 42 U.S.C. § 1320d(6)), the subrecipient shall implement appropriate administrative, technical, and physical safeguards and maintain written policies and procedures that are at least as stringent (i.e., as protective of privacy and security) as those governing the use and disclosure of protected health information by HIPAA covered entities and their business associates

under 45 C.F.R. Part 160 and 45 C.F.R. Part 164. This standard applies regardless of whether the subrecipient is a covered entity or business associate as defined in 45 C.F.R. 160.103.

The subrecipient shall immediately notify VHCF of any actual or suspected breach, unauthorized use, unauthorized access, or unauthorized disclosure of PII, PHI, or ePHI in connection with this sub-initiative, and shall cooperate with VHCF in the investigation and resolution of the incident, including VHCF's exercise of control over external notifications. The subrecipient and its employees working on this project may be required to sign a confidentiality statement. The subrecipient shall document and provide to the Department any information relating to disclosures of health records in connection with performance under this sub-initiative.

6.13 Health Information Technology and Interoperability

Where the subrecipient's approved Scope of Work includes the development, deployment, procurement, or operation of health information technology (HIT) systems, electronic health records, health information exchange capabilities, application programming interfaces (APIs), patient-facing applications, or related digital tools funded in whole or in part under this sub-initiative, the subrecipient shall comply with all federal HIT and interoperability requirements applicable to such activities by operation of law, including without limitation:

- The information-blocking provisions of Section 4004 of the 21st Century Cures Act (42 U.S.C. 300jj-52) and the implementing regulations at 45 CFR Part 171, to the extent the subrecipient is an actor (health care provider, health information network, health information exchange, or developer of certified health IT) within the meaning of those regulations; and

- Any other federal HIT, interoperability, certification, or patient-access requirement applicable to the subrecipient's funded activity by operation of statute or regulation.

The subrecipient shall additionally comply with any HIT or interoperability requirements communicated to the subrecipient by VHCF in writing during the period of performance. The subrecipient shall furnish VHCF with documentation, on request, demonstrating conformance with the operative requirements for any HIT investment funded under this sub-initiative, and shall remediate any non-conformance identified by VHCF within the time frame specified in the notice of non-conformance.

6.14 Cybersecurity Plan

Where the subrecipient (or any lower-tier subrecipient or contractor) (i) has ongoing access to HHS information or technology systems, AND (ii) handles personally identifiable information or protected health information from HHS, the subrecipient shall develop, maintain, and implement a written cybersecurity plan consistent with the HHS Administrative and National Policy Requirements applicable to the federal award. The subrecipient shall furnish the plan to DMAS upon request and shall update the plan to reflect material changes in systems, threats, or controls. The subrecipient shall include the substance of this section in each lower-tier subaward and procurement contract that triggers conditions (i) and (ii) above, and shall ensure that each such lower-tier subrecipient or contractor maintains a written cybersecurity plan that meets equivalent requirements.

6.15 Intangible Property, Patents, Inventions, and Copyright

Subrecipients shall comply with the requirements of the HHS Grants Policy Statement applicable to subrecipients regarding intangible property, patents and inventions, and copyrights, including the requirements at 2 CFR 200.315 and 37 CFR Part 401. The subrecipient shall promptly disclose to DMAS in writing any subject invention conceived or first actually reduced to practice in the performance of this sub-initiative, and shall provide DMAS with the information and certifications DMAS requires to satisfy its own reporting obligations under the NoA (including, where applicable, information needed for the Final Invention Statement and Certification, Form HHS 568).

6.16 Property Reporting and Disposition

Section 1. Annual Property Reporting

In accordance with 2 CFR 200.312, the subrecipient shall, if it holds federally owned property in connection with this sub-initiative, submit annually to DMAS an inventory listing of all such federally owned property in its custody. The inventory shall be furnished in the form and on the schedule designated by DMAS so as to permit the Department to satisfy its own annual property reporting obligation under 2 CFR 200.312.

Section 2. Disposition of Equipment, Supplies, and Federally Owned Property at Closeout

Upon completion or earlier termination of the Performance Period, the subrecipient shall take all appropriate disposition actions for federally owned property, equipment acquired under this sub-initiative (defined as nonexpendable personal property with an acquisition cost of $10,000 or more, consistent with 2 CFR 200.1 as revised effective October 1, 2024), and residual unused supplies, in accordance with 2 CFR 200.313 and 2 CFR 200.314. As part of closeout, the subrecipient shall:

- Complete and submit to DMAS the SF-428 (Tangible Personal Property Report – Cover Sheet) and SF-428-B (Final Report);
- Submit the SF-428-S (Supplemental Sheet) listing all federally owned and acquired equipment with an acquisition cost of $10,000 or more held by the subrecipient under this sub-initiative; and
- Request and follow specific disposition instructions from DMAS (which DMAS will obtain from CMS where required) for any federally owned property, before any disposal, transfer, or other disposition.

Where there is no tangible personal property to report, the subrecipient shall so indicate by selecting the appropriate option on the SF-428-B and submitting the form. The subrecipient shall maintain property records that meet the requirements of 2 CFR 200.313(d).

6.17 Mandatory Disclosures Involving Violations

In accordance with 2 CFR 200.113, the subrecipient shall promptly disclose, in writing and in a timely manner, to DMAS, CMS, and to the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations that potentially affect this subaward or the prime federal award.

Disclosures to DMAS shall be submitted to:

Virginia MFCU (Office of the Attorney General):
Phone: 1-800-371-0824 or 804-371-0779.
Email: MFCU_mail@oag.state.va.us
Hours: Monday-Friday, 8:30 a.m. - 5:00 p.m.

DMAS Fraud and Abuse (Recipient/Provider Fraud):
Phone: 1-866-486-1971.
Email: recipientfraud@dmas.virginia.gov.

State Fraud, Waste, and Abuse Hotline (OSIG):
Phone: 1-800-723-1615.
Online: Submit via the online form.

Disclosures to CMS shall be submitted to:

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Attn: Director, Division of Grants Management, Mandatory Grant Disclosures
7500 Security Blvd, Mail Stop B3-30-03
Baltimore, MD 21244-1850

Disclosures to HHS OIG shall be submitted to:
U.S. Department of Health & Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201
Fax: (202) 205-0604 (Include “Mandatory Grant Disclosures” in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

The subrecipient's disclosure obligations under this section include violations or potential violations committed by the subrecipient itself, its employees, officers, agents, lower-tier subrecipients, and contractors in connection with the performance of this sub-initiative or the use of subaward funds. The obligation to disclose arises upon the subrecipient becoming aware of information giving rise to a reasonable belief that a violation has occurred.

Failure to make required disclosures may result in remedies including suspension, debarment, or other legal action. Nothing in this section limits the subrecipient's obligations to report fraud, waste, or abuse through other applicable channels, including the Virginia Fraud, Waste, and Abuse Hotline.

6.18 Remedies for Noncompliance & Termination

If a subrecipient materially fails to comply with the federal statutes, regulations, or terms and conditions of the federal award, including the performance and reporting milestones set forth in this RFA and the executed subrecipient agreement, VHCF, after providing written notice and a reasonable opportunity to cure where appropriate, may impose one or more of the following remedies in accordance with 2 CFR 200.339 and 2 CFR 200.340:

<u>Remedies for noncompliance with federal rules and program requirements:</u>

- Temporarily withholding cash payments pending correction of the deficiency;
- Disallowing all or part of the cost of the activity or action not in compliance;
- Wholly or partly suspending or terminating the subaward;
- Initiating suspension or debarment proceedings under 2 CFR Part 180;
- Withholding further awards for the project or program;
- Requiring repayment of funds expended in violation of the terms and conditions;
- Other legally available remedies.

<u>Remedies for noncompliance with performance and reporting timelines:</u>

- Requiring submission of a corrective action plan within 30 days of written notice;
- Imposing heightened monitoring, including increased reporting frequency and required site visits;
- Designating the subrecipient as "high risk" under 2 CFR 200.208, with associated specific conditions;
- Reducing future budget periods or declining to renew the subaward;

- Termination of the subaward for cause, based on material noncompliance, unsatisfactory, performance, misuse of funds, fraud, waste, abuse, criminal activity, or failure to remedy compliance.

6.19 Adverse Action Disclosures

A subrecipient may contest any adverse action through the dispute process set forth in the executed subrecipient agreement and applicable Code of Virginia provisions.

Applicants shall disclose, within the past five (5) years, any of the following:

- Terminations for default, convenience following non-performance, or non-renewal due to performance concerns on any federal- or state-funded award;
- Active or resolved suspensions or debarments under 2 CFR Part 180 or any other federal or state regulation;
- Material findings, questioned costs, or unresolved Single Audit findings under 2 CFR Part 200, Subpart F;
- Adverse audit findings.

Failure to disclose any of the above will be grounds for rejection of the application or termination of any resulting subaward. Disclosure is not an automatic bar to award; it informs VHCF's risk evaluation under 2 CFR 200.206 and the imposition, if any, of specific award conditions under 2 CFR 200.208.

APPENDIX A: FORHP-Designated Rural Localities

The following Virginia localities are designated “fully rural” as defined by the Federal Office of Rural Health Policy (FORHP).

Table 1: FORHP-Designated Fully Rural Localities

Accomack County	Greensville County	Rappahannock County
Alleghany County	Halifax County	Richmond County
Amelia County	Henry County	Rockbridge County
Appomattox County	Highland County	Russell County
Bath County	King and Queen County	Shenandoah County
Bland County	King George County	Smyth County
Brunswick County	King William County	Southampton County
Buchanan County	Lancaster County	Surry County
Buckingham County	Lee County	Sussex County
Caroline County	Louisa County	Tazewell County
Carroll County	Lunenburg County	Warren County
Charles City County	Madison County	Westmoreland County
Charlotte County	Mathews County	Wise County
Clarke County	Mecklenburg County	Wythe County
Craig County	Middlesex County	Buena Vista City
Culpeper County	Nelson County	Covington City
Cumberland County	New Kent County	Danville City
Dickenson County	Northampton County	Emporia City
Essex County	Northumberland County	Franklin City
Fauquier County	Nottoway County	Galax City
Floyd County	Orange County	Lexington City
Fluvanna County	Page County	Martinsville City
Franklin County	Patrick County	Norton City
Giles County	Pittsylvania County	Radford City
Grayson County	Prince Edward County	
Greene County	Pulaski County	
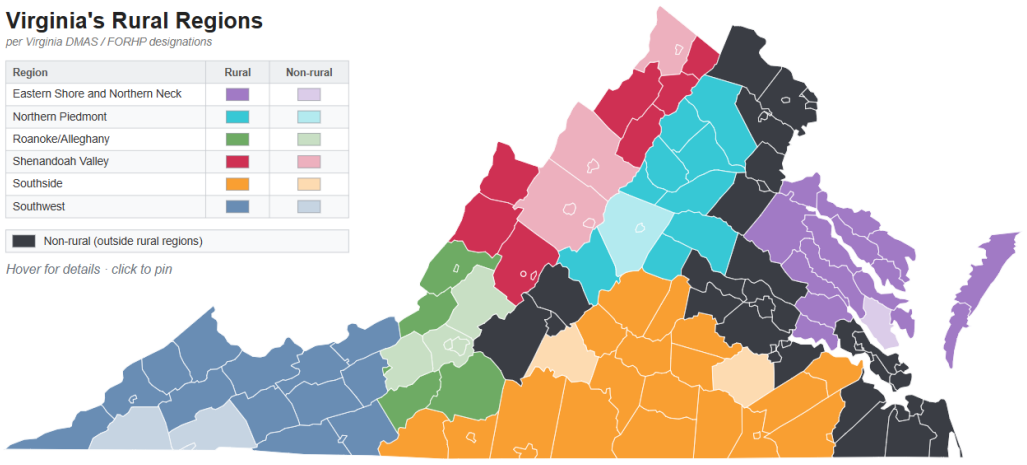
Chart 1: Virginia’s Rural Health Transformation Rural Regions