Virginia Rural Health Transformation Program

CareIQ Tech Innovation Fund Request for Applications (RFA)

RFA #C-27-002

Frequently Asked Questions (FAQs)

Revised October 21, 2026

Applicants are reminded that this FAQ is provided solely as guidance for preparing their applications, and the information contained in the RFA takes precedence over all other materials and communications. For Applicants who may not be ready to submit this cycle and plan to submit in a future cycle, consider applying for VIPC's Launch Grant Cohort 7, which is currently open and closes on October 30, 2026. VIPC programs Lab-to-Launch (rolling application) or Proof of Concept (opens in December).

October 21 Update: As noted in the FAQ posted on October 15, VIPC was waiting on additional guidance on a few specific questions. Those have now been addressed, and any additions made to this document have been highlighted.

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APPLICANT ELIGIBILITY AND ORGANIZATIONAL REQUIREMENTS

1. **Question:** We are a small LLC and do not have audited financial statements or a prior federal single audit. Are unaudited financial statements acceptable for the risk assessment? I have a SAMS Number and am registered as a federal contractor.

Answer: Applicants are encouraged to review the audit compliance requirements of 2 CFR Part 200 and 300. Typically, a prior federal Single Audit is not required if your organization has never been subject to one per Federal regulations. The RFA requires applicants to complete a federal risk assessment and demonstrate capacity to manage federal funds; it identifies audited financials or a Single Audit *"if applicable."*

Applicants should provide the most complete financial documentation available and clearly indicate that audited statements and a Single Audit are not applicable to the organization and why. The broader RHTP guidance emphasizes assessment of financial-management capacity, including the ability to separately track federal funds.

An active SAM.gov registration with a valid UEI, at time of application, satisfies that portion of the eligibility requirement, provided there are no active exclusions, debarments, or suspensions.

2. **Question:** In response to the Tech Innovation Fund opportunity, [Company Name] is considering developing a tailored solution that enables rural patients to [description of proposed intervention]. We are based in Virginia and were founded in 2014. Could we qualify to develop and pilot this new solution, or does the ten-year company-age limit exclude us regardless of the proposed technologies development stage?

   Answer: Under the current RFA, the company-age requirement applies to the applicant's organization, not to the age of the proposed product. Companies must be less than 10 years since founding and have raised less than $50 million in prior funding.

   Because [Company Name] was founded in 2014, it would not meet the current company-age criterion, even if the proposed solution itself is new and at an eligible development stage. We encourage you to visit the Virginia Rural Health Transformation website to explore other funding opportunities.

3. **Question:** We wanted to clarify whether the requirement that "companies must be fewer than 10 years old" applies only to companies, or if it also applies to nonprofit organizations. Throughout the eligibility section, the criteria appear to address organizations broadly, then specify companies, startups, universities, nonprofits, governmental entities, and Tribal entities. The reference to being fewer than 10 years from founding seems to be specifically tied to companies, but we wanted to confirm our interpretation. [Organization] is a Virginia-based 501(c)(3) nonprofit organization founded in 1989. Based on the eligibility requirements, would [Organization] still be eligible to apply as a nonprofit?

   Answer: The requirement that entities be fewer than 10 years since founding, with less than $50 million in prior funding raised, applies to all applicants regardless of organizational type.

4. **Question:** Does the applicant need an active UEI at submission on Oct 29, or only at award?

   Answer: Applicants have until October 29 to submit their proposals. This timeframe should provide sufficient opportunity to obtain a UEI, so applicants are expected to have an active UEI at the time of submission. Entities are encouraged to begin the UEI process as early as possible and work on it in parallel with preparing their proposals. See also Answer to Question 13.

5. **Question:** Are private companies, LLCs eligible?

   Answer: Yes. Private companies, including LLCs, are eligible to apply, provided they meet the RFA's other organizational and product eligibility requirements.

6. **Question:** Can a Clinic be the lead applicant and contract with a technology company as a partner and implementer?

   Answer: In that scenario, the technology company should serve as the applicant because it owns and will deploy the technology. The clinic should participate as a project partner and deployment site.

7. **Question:** Can a university serve as the sole applicant, or the university needs to partner with a company for the application?

   Answer: In order to meet the less than 10 years old and under $50 million raised threshold, universities are best off partnering with a technology firm that meets this requirement as the lead applicant and the university as a partner.

8. **Question:** Company age / “since founding.” The eligibility criteria state that companies must be fewer than 10 years since founding. Our predecessor entity, [Organization] was legally formed in 2010 but did not begin operating activities at that time. In 2016, the founders executed the operating agreement, the company received its first outside investment ($500,000), product development began, and the first beta implementation was launched. The business subsequently converted from an LLC to a C corporation effective January 1, 2026. For purposes of the “fewer than 10 years since founding” requirement, which date or event would VIPC use?

   Answer: See Answer to Question 10.

9. **Question:** May a U.S.-based health technology company that is not currently delivering services in rural Virginia apply if the proposed project will directly serve rural Virginia residents and providers during the grant period?

   Answer: Yes

10. **Question:** [Organization] requests clarification of the applicant-age criterion in RFA C-27-002, Section 1.4 ("founded less than 10 years ago"). Relevant facts: [Organization] is a Delaware corporation. It was created on September 4, 2024, by statutory conversion, under Section 265 of the Delaware General Corporation Law, of [Original organization] LLC, a Delaware limited liability company first formed November of 2014.

    For purposes of the Section 1.4 eligibility criterion, does VIPC treat [Company Name] founding date as September 4, 2024 (date of incorporation by conversion) or August 27, 2014 (date of the predecessor LLC's formation)? If eligibility depends on additional facts or documentation, please indicate what VIPC would require.

    Answer: Without having further information available to better answer this question, changes to your EIN number may indicate to the IRS that you are a new company as of 2024; however, other documents you may want to consult to confirm the date your company was formed may be your Articles of Incorporation, as well as whether your SAM.gov UEI number has also changed (and shows you as a company founded in 2024). If both have been updated for 2024, then based on the information available, your entity *could* be considered formed in 2024 unless additional documentation shows otherwise. It is suggested that applications apply their due diligence for confirming assurance of the date they were founded before applying.

    October 21 Update: As reflected in the published RFA FAQ, applicants are responsible for conducting their own due diligence and determining whether they meet this eligibility requirement based on their specific organizational circumstances. Accordingly, VIPC cannot confirm whether December 5, 2018, or any other date, would be accepted as your organization's founding date for purposes of this requirement prior to submission and review of an application. If your organization believes it satisfies the eligibility requirements, you may submit an application and include any documentation and explanation you believe supports your position. In evaluating eligibility, applicants should rely on the organizational, formation, registration, incorporation, conversion, and other legal records they believe are relevant to their particular facts and circumstances.

11. **Question:** You mention future RFA rounds. Could you share the expected timing of the next round and whether the eligibility criteria are expected to stay the same?

    Answer: Future Tech Innovation Fund rounds are anticipated as part of Virginia's five-year RHTP implementation, but the date is not confirmed for the next RFA round. Future funding is subject to program progress, availability of federal funding, and continued CMS/DMAS approval.

    Eligibility criteria for future rounds are subject to change and will be dependent upon federal requirements, program requirements, funding priorities, rural eligibility definitions, or other criteria in subsequent rounds. VIPC will communicate the timing and requirements for any future round once they are finalized.

12. **Question:** For the "Tech Innovation Fund," which is due on October 29, 2026, would [university] be eligible to apply, specifically if the application is submitted by an [university] faculty member through [university]? Also, during yesterday's webinar, it was mentioned that preference is given to companies. Does this mean that a joint application between [university] and a private company would be viewed more favorably during the review process?

    Answer: According to the eligibility criteria in Section 1.4 of the RFA, only entities that are founded less than 10 years ago and with less than $50M prior funding raised since the organization's inception. VIPC recognizes that some small spin-off companies formed by institutions of higher education (IHEs) may meet these criteria. Applicant entities may partner or subcontract with other organizations, including IHEs, when appropriate. However, applicants should note that creating a spin-off or small company solely to avoid applying through an IHE, or for the purpose of routing funds through an IHE, is not permitted.

13. **Question:** For an applicant using the alternative Section H past performance documentation pathway, must Virginia registration be completed by the application deadline, or may registration be pending at submission?

    Answer: Because VIPC is moving quickly through the application, review, and award process, applicants are expected to be registered and prepared to answer affirmatively this eligibility question within their application. Applicants should also note that, per Section 5.1 of the RFA, eligibility criteria are scored, and those who are registered will receive a higher score than those who are not. If Applicants are not eligible for this first year of funding, they have the opportunity to work towards eligibility for year two.

14. **Question:** For a non-Virginia-based applicant using the alternative past-performance route, must Virginia business registration be completed by application submission or by award execution? What evidence of Virginia administrative and strategic operations establishes the Virginia-based preference? The webinar mentioned three additional points, while the posted RFA lists two; which applies?

    Answer: First Applicants should be made aware that the RFA rules and takes precedence. As for the answer to your other question, please see the Answers to Questions 15 through 18 below.

15. **Question:** State Corporation Commission (SCC) Registration Timing - Regarding the Section 4.0 Application Cover Page (requesting a Virginia SCC#) and Section 4.2 Section H Option 2 (requiring proof of registration to do business in Virginia), is an applicant required to have a fully issued Certificate of Authority and SCC ID number from the Virginia SCC at the time of submission on October 29, 2026, or is evidence of a pending foreign entity registration filing acceptable prior to final subaward agreement execution?

    Answer: Applicants have until October 29 to submit their proposals. This timeframe should provide sufficient opportunity to obtain a SCC registration, so applicants are expected to have an active SCC#

at the time of submission. Entities are encouraged to begin the registration process as early as possible and work on it in parallel with preparing their proposals. See also answer to Question 13.

16. **Question:** Criteria for 'Expanding into Virginia' Extra Credit - Under Part V (Review Criteria and Scoring, p. 15), up to 2 extra credit points are available for *"Virginia-based companies or companies expanding into Virginia"*. Does an out-of-state company that registers as a foreign entity with the Virginia SCC and deploys its platform directly to patients and providers in Appendix A rural communities qualify for the "expanding into Virginia" extra credit, or does this require maintaining physical commercial real estate within the Commonwealth?

    Answer: Applicants should review the definition of Virginia-based per Section 1.4 of the RFA and determine their eligibility per this definition.

17. **Question:** How is “preference” defined? It doesn’t state in NOFO.

    Answer: See Answer to Question 16.

18. **Question:** What is the amount of preference for VA entities? Out of the 100 points?

    Answer: There are two (2) “extra credit” points that can be earned for Virginia-based companies.

19. **Question:** If a non-VA based company who is currently doing an initial MVP (TRL6-7) application [project] with a VA based entity better to partner with the VA based entity or have a VA based entity as a sub?

    Answer: Based on the RFA, the non-Virginia technology company may serve as the applicant if it independently meets the applicant eligibility requirements, including providing direct services to rural Virginia communities and satisfying the applicable federal requirements. Virginia-based organizations receive preference, but Virginia-based status is not stated as an absolute eligibility requirement.

    The existing Virginia entity may be included as a deployment or implementation partner. If that entity will perform a defined portion of the grant-funded work and receive award funds, it may instead be structured as a sub-award, subject to the RFA’s budget, scope, rationale, and selection-methodology requirements.

    Importantly, partnering with or subcontracting to a Virginia entity does not make the applicant itself Virginia-based under the RFA’s definition. If the technology company owns and is responsible for deploying the technology, the RFA supports the company serving as the applicant and the Virginia organization serving in the appropriate implementation role.

20. **Question:** [Company Name] is headquartered in [state name], but we have an employee, [employee name], who resides in Virginia and serves as [Company Name] for [product]. [Employee] has many years of [product] leadership experience in Virginia, including helping develop the [product] program in Virginia Beach, and is actively involved in [Company Name] strategy, partner development, and implementation activities within the Commonwealth. [Company] also has existing [product] deployments and relationships in Virginia. If [Company] is legally registered to conduct business in Virginia, would this level of in-state strategic and operational activity satisfy VIPC’s definition of an organization with “administrative and strategic operations performed within Virginia” for purposes of the Virginia-based preference? If not, could you clarify what level of in-state operations would be required?

    Answer: See Answers to Questions 15 through 19.

21. **Question:** Is a non-VA company (MD) really able to compete?

Answer: Yes; however, applicants from other states should also consider the RHT program in their state.

22. **Question:** Can a Canadian-incorporated company apply if it has a named rural Virginia provider and a defined direct-service project?

    Answer: Per Section 1.4 of the RFA, to be eligible for an award under this RFA, applicants are required to be a U.S.-based and U.S.-owned entity with all RHTP-supported work performed in the U.S. by U.S. employees and contractors.

TECHNOLOGY AND PRODUCT ELIGIBILITY

23. Question: Would a self-administered, video- and online-learning-based intervention qualify as a "novel healthcare technology" under the RFA, given that novelty can come from the care delivery model? Does it fall within the digital therapeutics category?

Answer: Yes, potentially. The RFA expressly provides that novelty may arise from a new care delivery model, including solutions that change how or where care is delivered to address rural barriers such as travel distance or limited specialist access. A self-administered intervention delivered through video and online learning could therefore qualify as a “novel healthcare technology” if it represents a meaningful new approach to care delivery - not simply digitized educational content - and meets the other requirements, including chronic disease prevention or management, consumer-facing technology, rural relevance, evidence/ feasibility, and the required product-development stage. Applicants should refer to Section 2.2 in making their determination.

It may also fall within the digital therapeutics category, but that classification would depend on the intervention itself. If the video/online intervention is an evidence-based, technology-delivered therapeutic intervention designed to produce measurable health outcomes in preventing or managing a disease, it could reasonably be presented as a digital therapeutic. If it is primarily educational or informational, without a therapeutic intervention and measurable clinical effect, it would be better characterized as a consumer-facing digital health or self-management technology rather than a digital therapeutic.

24. Question: Product stage. For a content-based digital intervention, what evidence would reviewers accept as a functional prototype and demonstrated feasibility at TRL 4? Would a live product with early users and usage and outcome data being collected meet that bar, or are you expecting something more developed?

Answer: For a content-based digital intervention, reviewers would likely look for evidence that the product is functional, usable, and technically feasible, rather than requiring a fully validated or commercially mature solution. The RFA defines the eligible stage as proof-of-concept through minimum viable product, requiring a functional prototype, evidence or demonstration of feasibility, and readiness at approximately TRL 4 to 7. It expressly excludes concepts with no validated science and products that are already fully commercialized and focused primarily on marketing and sales.

A live product with early users, documented usage, and outcome data actively being collected would generally appear to meet - and potentially exceed - the TRL 4 threshold, assuming the product is still in an early validation/development stage. For a digital intervention, appropriate evidence could include a working platform, completed intervention content and workflows, successful user completion, engagement or adherence data, preliminary outcome signals, usability findings, and evidence that the intervention can be deployed as intended. Applicants are encouraged to review GAO Best Practices Technology Readiness Assessment Guide.

Applicants should clearly demonstrate both technical functionality and early real-world feasibility, while explaining what additional validation, refinement, or rural deployment the proposed funding will enable.

25. **Question:** The RFA indicates that eligible technologies should fall within TRL 4–7, between proof-of-concept and minimum viable product, and that technologies that are fully commercialized and primarily focused on marketing and sales would be considered too mature. Given where [Company name] is today and the work we would propose under the CareIQ Tech Innovation Fund, I wanted to confirm that you would consider us to fall within the eligible TRL 4–7 range described in the RFA.

    Answer: See answers to Questions 23 and 24. Applicants are encouraged to review GAO Best Practices Technology Readiness Assessment Guide.

26. **Question:** For a product deployed in a limited real-world pilot but not commercially scaled or focused on sales, does VIPC generally consider an adequately documented TRL-7 MVP to fall within the eligible product-stage range?

    Answer: Yes. The RFA identifies the eligible product stage as proof-of-concept through minimum viable product, approximately TRL 4–7. It states that a product is too mature when it is fully commercialized with a focus on marketing and sales.
    Accordingly, an adequately documented TRL-7 MVP in a limited real-world pilot may fall within the eligible range, provided it has not progressed to full commercialization and otherwise meets the RFA's eligibility requirements. Applicants are encouraged to review GAO Best Practices Technology Readiness Assessment Guide.

27. **Question**: Would a caregiver- and parent- facing platform that supports health education, navigation, follow-up, and engagement between primary-care visits be considered aligned with the Fund's objectives around rural chronic disease and primary care?

    Answer: Yes, potentially. The RFA seeks consumer-facing, technology-driven solutions that support chronic disease prevention and management in rural populations, with preference for solutions that directly deliver or enable care.

    A caregiver- or parent-facing platform could align if its education, navigation, follow-up, and engagement functions are tied to a defined chronic-disease or primary-care use case and are designed to improve access, care delivery, or health outcomes for rural users. A general education or navigation platform without that connection would be less clearly aligned with the Fund's stated scope.

28. **Question:** [Company name's] platform is already deployed with health and community partners. Would a proposed rural Virginia use case or new implementation/application of the technology be eligible under the Fund's product-stage/TRL requirements, or would the existing deployment make the technology too mature for this opportunity?

    Answer: Existing deployment does not, by itself, make the platform ineligible. The RFA identifies the eligible product stage as proof-of-concept through minimum viable product, approximately TRL 4–7, and states that a product is too mature when it is fully commercialized with a focus on marketing and sales.

    A new rural Virginia use case or application may be eligible if it still involves meaningful development, adaptation, testing, or validation and otherwise meets the RFA's novelty and deployment requirements. If the proposal is primarily to expand an already mature commercial product into a new market, it would be less clearly aligned with the Fund's product-stage requirements.

29. **Question:** Could a patient-facing continuity platform with patient-approved longitudinal information and clinician-governed follow-up qualify where the proposed benefits include improved access, timely follow-up and care delivery, with clinical outcome measures defined alongside an implementation partner?

    Answer: Yes, potentially. The RFA seeks consumer-facing, technology-driven solutions that support chronic disease prevention and management in rural populations, with preference for solutions that directly deliver or enable care and demonstrate measurable improvements in health outcomes, access, affordability, or care delivery.

    A patient-facing continuity platform could align if the proposed use case is tied to chronic disease prevention or management and the application clearly defines the rural population served, implementation approach, and measurable outcomes. Clinical outcome measures may be developed with an implementation partner, but the application should identify the intended outcomes and explain how they will be measured.

30. **Question:** For this type of platform, what evidence establishes TRL 4–7 and demonstrated feasibility? Can functional prototypes, synthetic workflow testing and usability validation support eligibility, or is prior real-patient deployment evidence required?

    Answer: The RFA does not require prior real-patient deployment to establish eligibility at TRL 4–7. It requires a product to be between proof-of-concept and minimum viable product, with a functional prototype, evidence or demonstration of feasibility, and readiness at approximately TRL 4 - 7.

    Accordingly, functional prototypes, controlled or synthetic workflow testing, and usability validation may support a feasibility showing if they demonstrate that the technology works as intended. Prior real-world patient use may strengthen the evidence, but the RFA does not state that it is required for eligibility.

31. **Question:** Would [Organization] meet this requirement by supplying [product] to rural clinical partners, training and supporting their staff, and supporting deployment and usage reporting, while the clinical partners perform patient assessments and provide any clinical follow-up? Or must the applicant itself deliver services directly to patients? Must rural services already be in place at submission, or can they begin during the funded project?

    Answer: The RFA does not require the applicant to provide clinical care directly to patients. It expressly contemplates solutions that “directly deliver or enable care” and recognizes systems-focused technologies for which people served may include staff trained to implement the technology and indirect users.

    Accordingly, the model described—where the applicant deploys and supports the technology in rural Virginia, trains clinical partners, and manages deployment and reporting, while the clinical partner performs patient assessments and clinical follow-up—could be consistent with the RFA. The applicant would remain responsible for meeting the applicable deployment, evaluation, reporting, and rural-service requirements.

    Rural services do not need to be operational at the time of application. The RFA requires awardees to develop the rural deployment strategy after award and begin deployment within three months of the funding award. No specific implementation partnership is required at application.

    The RFA does not further define “provide direct services,” so eligibility should ultimately be evaluated based on the applicant’s proposed role and whether the funded activities directly serve eligible rural Virginia communities.

32. **Question:** Can the grant fund the cost or providing devices such as blood pressure monitors or blood glucose meters or tablets or video platform?

    Answer: Potential applicants should refer to Sections 1.4 for an overview of the Eligible Products, Section 2.2, the Novel Tech Innovation.

33. **Question:** Does the innovation need to be in direct care? My innovation improves the business of rural hospital and profitability.

    Answer: The potential technology solution should be involved in direct care. Applicants are encouraged to review other Virginia Rural Health Transformation Initiatives.

34. **Question:** You noted that eligible products must directly deliver or enable care. For a consumer-facing technology that provides preventive support and then connects appropriate rural users into existing clinical care, would that satisfy the 'enable care' requirement even if the technology itself is not diagnosing or treating patients?

    Answer: This will likely need to be evaluated on a case-by-case basis. The central consideration is whether the proposed solution meaningfully improves access to care, care delivery, or quality of care for rural users.

35. **Question:** May an established healthcare technology company propose a new clinical module or integrated product that is itself at TRL 4–7, even though portions of the underlying technology platform are already commercially deployed?

    Answer: Potentially, yes. The RFA evaluates product stage at the level of the proposed healthcare technology. A new clinical module or integrated product could fall within the eligible TRL 4–7 / proof-of-concept-to-MVP range even if parts of the underlying platform are already commercially deployed, provided the proposed product itself still requires meaningful development, testing, or validation and is not already fully commercialized and focused on sales.

    However, the applicant's organization must separately meet the RFA's organizational eligibility requirements, including being founded less than 10 years ago and having raised less than $50 million since inception. An eligible-stage new product would not override those applicant-level requirements.

36. **Question:** Beyond the Section 4.2C narrative summarizing TRL using the GAO Technology Readiness Assessment Guide, what specific documentation does VIPC expect as proof that a product meets the proof-of-concept criteria (functional prototype, evidence or demonstration of feasibility, demonstrated readiness)?

    Answer: The RFA does not prescribe a specific set of supporting documents to prove TRL 4–7 eligibility. It requires the product to have a functional prototype, evidence or demonstration of feasibility, and demonstrated readiness.

    Section 4.2C requires applicants to describe the current state of the technology, provide demonstrated proof points, summarize the TRL using the GAO guide, describe any current deployment and outcomes, and provide pilot or beta-user feedback to the extent it exists.

    Accordingly, the RFA leaves the form of the supporting evidence to the applicant. It does not require a particular certification, third-party validation report, clinical study, or prior real-world deployment as a condition of demonstrating proof of concept.

37. **Question:** What specific evidence is required to demonstrate TRL 4?

Answer: Per section 1.4, Proof-of-concept (TRL 4) criteria must have a functional prototype, have evidence/demonstration of feasibility, and demonstrate readiness.

PARTNERSHIPS, RURAL DEVELOPMENT AND IMPLEMENTATION

38. **Question:** Multiple technology partners. May one eligible technology company serve as the applicant while another technology company participates as a subcontractor or technology partner in developing and implementing the proposed integrated solution?

    Answer: Yes. The RFA permits an eligible technology company to serve as the applicant while another technology company participates as a sub-award or technology partner in developing or implementing the proposed solution.

    The application should clearly describe the partner's role and, for any planned subrecipient, include the scope of work, estimated cost, rationale, and selection methodology**.** The arrangement must also comply with the RFA's applicable procurement and the Federal regulations of 2 CFR Part 200 and 300.

    The RFA does not state that a technology partner or subrecipient must independently meet the applicant's organizational eligibility criteria unless that entity is itself applying as the lead applicant.

39. **Question:** Users outside eligible localities. Our product is also used by people outside Virginia. Do only users in the designated rural localities count toward the required metrics, and is it acceptable to serve other users with the same product?

    Answer: Yes, it is acceptable for the same product to serve users outside the designated rural Virginia localities. CMS guidance expressly states that applicants do not need to serve rural communities exclusively.

    Funding for this award must only be used towards budgeted activities in Virginia. Applicants should be prepared to separately identify and report on the users and outcomes associated with the funded rural Virginia deployment. Users outside of a rural locality in Virginia will not count towards the program's metrics.

    Accordingly, non-rural and out-of-state users may continue using the product, but they should not be relied upon to demonstrate achievement of the program's rural Virginia deployment and impact requirements.

40. **Question:** Partner and deployment evidence: What rural partner, recruitment or locality commitments are expected at application versus day 45? Can a rural provider support implementation without becoming the lead applicant? May an explicitly defined phased rollout satisfy day-90 deployment, and what minimum operational evidence is required?

    Answer: At application, the RFA requires a credible deployment strategy and stakeholder engagement plan. Applicants should describe existing rural partnerships, if any, and how they will reach the target population. No specific implementation partner is required at application; if none is in place, the applicant must explain why one is not needed and/or how patients will be reached. A rural provider may therefore participate as an implementation partner without serving as the lead applicant.

    By the 45-day milestone, the awardee must have completed identified rural-readiness modifications and begun identifying implementation localities. The RFA lists a written report and letter(s) of support from identified localities or potential implementation partners as example evidence.

For Day 90, the technology must be deployed in the market(s) identified in the approved application. The RFA permits applicants to propose a phased work plan, but it does not expressly state that a partial rollout automatically satisfies the Day-90 milestone. At minimum, there must be actual deployment supported by receipts, email confirmations, or other third-party confirmation. The RFA does not prescribe a minimum number of operational sites or users.

41. **Question:** Please also let us know what documentation would be needed to demonstrate these partnerships and whether any restrictions would apply to an institute of higher education (IHE) funded role.

    Answer: The RFA does not require a particular partnership document at application, such as a signed MOU. It requires applicants to identify partnerships or collaborative efforts and describe the purpose and significance of the partnership and the partner's role in the project. Letters of support may also be used as evidence of implementation partnerships only for compliance with Section 4.2, H.2. If the IHE receives grant funds, the application and budget should clearly identify its role within the application. For any planned subaward or subcontract, the RFA requires a narrative rationale, estimated cost, scope of work, and selection methodology.

    A funded IHE role is permitted, but the applicable requirements depend on whether the relationship is structured as a subaward or a procurement contract. Contractors are subject to the federal procurement standards incorporated into the RFA, and work that is subcontracted or sub-awarded after award but was not identified in the approved application requires prior approval. The RFA does not impose the under-10-year or under-$50M to IHE as a sub-award partner to the applicant; however, applicants should ensure they are not partnering with IHE's to only flow substantial funds to the IHE as a method to circumvent the 10-year, $50M eligibility threshold.

42. **Question:** Section H (Option 2) Letter of Support Signatories - Under Section 4.2 Section H (Option 2), applicants may upload up to two letters of support from *"customers or prospective customers, partners, and/or industry experts"*. Can one of these letters be provided by a national non-profit research foundation or co-development partner (e.g., attesting to clinical data rigor, market necessity, and commercial licensing viability), or must both letters originate from regional clinical healthcare delivery providers located in Virginia?

    Answer: It is to the Applicant's discretion as to which organizations they should request Letters of Support to best support their application and to meet the requirement of Section 4.2., H.2.

43. **Question:** Milestone 3 Deployment Verification for Direct-to-Consumer / SaaS Solutions For digital health software platforms that operate via direct-to-consumer or patient-facing models (as referenced in Section 3.1.1), what specific third-party evidence is required to substantiate Milestone 3 deployment within 90 days? Are verified user account registrations, consent logs, and geolocated access analytics demonstrating active users residing within Appendix A rural localities sufficient, or is physical clinic-level integration required within those counties?

    Answer: For Milestone 3, the RFA requires deployment within 90 days in the market(s) identified in the approved application, supported by "receipts, email confirmations, or other third-party documentation confirming deployment."

    For a direct-to-consumer or patient-facing platform, the RFA does not require physical clinic-level integration unless that integration is part of the approved deployment model. Section 3.1.1 contemplates direct-to-consumer technologies and measures such as unique users/registrations and rural locality of use.

    However, the RFA does not state that internally generated registration records, consent logs, or geolocation analytics alone satisfy the third-party documentation requirement. Those records may

substantiate use and rural reach, but applicants should also plan to provide independent documentation confirming that deployment occurred as approved.

44. **Question:** What constitutes acceptable day-90 deployment for a clinical software pilot? Must all proposed sites and users be operational, or can an agreed phased rollout satisfy the milestone?

    Answer: The RFA requires the technology to be deployed within 90 days in the market(s) identified in the approved application, with third-party documentation confirming deployment. It does not state that every proposed site or user must be operational by Day 90, nor does it expressly define whether a phased rollout satisfies the milestone.

    Accordingly, the applicable deployment expectation should be established through the approved application and project work plan. If phased deployment is proposed, the application should clearly define what will be operational by Day 90 and what will follow thereafter.

45. **Question:** Given it takes 18 months on average for technology deployment into a hospital, are you anticipating launches Q1?

    Answer: As designated in the milestone section of the RFA, we expect funded projects to begin deployment within the first 90 days. We recognize that this is an accelerated timeline, but it is necessary given that the Year One performance period ends August 31, 2027.

46. **Question:** How does VIPC evaluate the technical-lead requirement for healthcare startups? Does the technical lead need to be a full-time W-2 software engineer at the time of application, or can the company maintain internal technical/product accountability while using specialized U.S.-based engineering contractors for implementation?

    Answer: The RFA does not require a technical lead to be a full-time W-2 software engineer. It requires the applicant to demonstrate that the team has the necessary “in-house technical, clinical, and operational expertise to build and deploy the solution” and to provide resumes for named key personnel who will lead and carry out the work.

    The RFA also permits RHTP-supported work to be performed by U.S.-based employees and contractors and allows properly documented subcontracts.

    Accordingly, a company may use specialized U.S.-based engineering contractors for implementation. However, the RFA does not state that contractors alone satisfy the in-house expertise requirement. The application should clearly demonstrate that the applicant retains internal technical and product leadership, accountability, and the capability to oversee development and deployment.

47. **Question:** My group has a prototype of [product], but I have no idea how to connect to rural health organizations. Could you comment on any mechanism or resources for making this connection?

    Answer: VIPC does not anticipate serving as the primary connector between applicants and potential partners or stakeholders. Applicants are expected to have a clear strategy for identifying, engaging, and maintaining the stakeholder relationships necessary to successfully deploy their proposed solution.

48. **Question:** Is VIPC offering assistance to individual companies to help navigate the application process and coordination of potential partners in the Rural community settings? If so, to whom can we work with to help us figure things out?

    Answer: VIPC can aid in the application process. However, does not anticipate serving as the primary connector between applicants and potential partners or stakeholders. Applicants are expected to have a clear strategy for identifying, engaging, and maintaining the stakeholder relationships necessary to successfully deploy their proposed solution.

49. **Question:** In the required deployment plan to be included in the application, do we need to identify specific healthcare facilities or organizations that we will be deploying into? Or do we propose a plan and VIPC helps us identify the deployment location post-award?

    Answer: The RFA does not require applicants to identify a specific healthcare facility or organization as a deployment partner. It states that no specific partnerships are required. However, applicants must provide a credible deployment strategy, identify the rural locality or localities for implementation, and describe any existing partnerships and stakeholder engagement. If an applicant does not have an implementation partner, the application must explain why one is not needed and/or how the applicant will reach the targeted patient population.

    The RFA does not state that VIPC will identify deployment locations or partners after award. Applicants should therefore submit a deployment plan that is sufficiently developed to demonstrate how deployment in rural Virginia will occur, including beginning deployment within three months of award.

50. **Question:** At the end of the period of performance, may devices remain with the participating patients or clinics? What title and disposition requirements apply under Section 6.16?

    Answer: Section 6.16 does not authorize devices to remain automatically with participating patients or clinics at the end of the project**.** Disposition depends on how the property is classified under the applicable federal rules.

    For federally owned property, the subrecipient must obtain and follow VIPC's disposition instructions before any transfer, disposal, or other disposition. For equipment purchased with award funds**—**defined in the RFA as nonexpendable personal property with an acquisition cost of $10,000 or more—the subrecipient must follow 2 CFR 200.313 and complete the required SF-428 closeout reporting. Residual unused supplies are subject to 2 CFR 200.314.

    Accordingly, applicants should not assume that grant-funded devices may simply be left with patients or clinics. The RFA does not provide a blanket rule on that point; disposition must follow the applicable property classification and closeout requirements.

51. **Question:** Would a combined solution in which a consumer-facing RPM platform is integrated with a provider-facing clinical workflow platform qualify where the combined technology directly enables chronic disease care for rural patients?

    Answer: Yes, potentially. The RFA seeks consumer-facing, technology-driven solutions for chronic disease prevention and management and gives preference to technologies that directly deliver or enable care.

    A combined solution could qualify if the consumer-facing RPM component is a meaningful part of the proposed product, and the integrated platform directly supports care for rural patients. The provider-facing workflow component would not, by itself, make the solution ineligible, but the application should clearly show how the combined technology benefits the patient, supports chronic-disease care, and meets the Fund's rural deployment and outcome requirements.

52. **Question:** May a healthcare technology applicant satisfy the requirement to provide direct services to rural Virginia communities by deploying the proposed technology through committed rural Virginia EMS/MIH, primary care/FQHC, and/or hospital pilot partners that deliver the clinical services to patients?

    Answer: Please refer to the RFA for specific information required per Part IV.

53. **Question:** Is a formal partnership with a rural Virginia FQHC, Rural Health Clinic, hospital/health system, independent practice, or other rural provider required at application? If not required, would such a deployment partner strengthen the application?

    Answer: A formal partnership with a rural Virginia provider is not required at the time of application. The RFA states that no specific partnerships are required; however, applicants must describe any existing partnerships, stakeholder engagement, and how they will reach the intended rural population. If no implementation partner is identified, the application should explain why one is not needed and/or how deployment will occur.

    A rural provider partner may strengthen an application where the partnership makes the deployment plan, patient access strategy, clinical integration, or outcome measurement more credible. The RFA does not guarantee additional scoring simply for having a partner; the value depends on the partner's defined role and contribution to successful rural deployment.

54. **Question:** What level of committed rural Virginia deployment is expected at application—for example, a named provider, letter of support, MOU/LOI, identified patient population, or executed agreement

    Answer: Please refer to the RFA for specific information required per Part IV.

55. **Question:** The RFA contemplates rapid deployment. Does the three-month expectation mean the technology must be live with rural Virginia users within three months of award, or may that period include contracting, integration, onboarding, training, and implementation?

    Answer: The RFA contemplates that implementation activities may occur during the first 90 days, but Milestone 3 requires the technology to be deployed within 90 days in the market(s) identified in the approved application.

    Accordingly, contracting, integration, onboarding, training, and implementation may occur during that period, but they do not substitute for deployment. By Day 90, the applicant should be able to demonstrate that the technology is operational in the approved rural Virginia market(s), supported by the required deployment documentation. The RFA does not specify a minimum number of live users or sites.

56. **Question:** Is there a vendor partnership program in place in VIPC? Let me illustrate. We are a tech enabled company with an innovative platform, which can bring transformation in population healthcare.

    Since there is a clause that applicants have to be Virginia based, my company is not eligible because we have no presence. In that case, can we partner with a Virginia-based hospital/clinic/company/FQHCS/ to apply for the RFA?

    If yes, where can I find consolidated information on this? I checked VIPC innovation funding sites.

    Answer: VIPC encourages organizations to collaborate with other entities to strengthen their applications and products. Currently, however, VIPC does not maintain a list of individuals or organizations, like yourself, that are seeking Virginia partners. Please check with your state's RHT program, as there may be some opportunities for you there within your state.

57. **Question:** I saw CareIQ's tech fund is open through October 29 and is focused on technology that directly delivers or enables care for chronic disease in rural Virginia. We're interested in whether [Organization] [proposed intervention] fits that scope. I'm reaching out on the state side because we'd also want the right rural clinical partner involved. Are you the right person to help with that connection?

Answer: VIPC does not anticipate serving as the primary connector between applicants and potential partners or stakeholders. Applicants are expected to have a clear strategy for identifying, engaging, and maintaining the stakeholder relationships necessary to successfully deploy their proposed solution.

58. **Question:** Multiple partners. May more than one clinical deployment partner participate under a single award?

    Answer: Yes. The RFA does not limit an applicant to a single clinical deployment partner**.** More than one provider or clinical organization may participate under a single award if the application clearly defines each partner's role, the rural localities and populations served, and how the partners support deployment and outcome measurement.

    If any partner will receive grant funds, the application follow the requirements of the RFA to identify the applicable subaward or subcontract scope, cost, rationale, and selection methodology.

59. **Question:** Must the project already have an established Virginia partner at the time of application?

    Answer: See Answers to Questions 40 and 53.

APPLICATION REQUIREMENTS, REVIEW, AND SCORING

60. **Question:** The RFA identifies C-27-002, but the applicant Appendix B Debarment Certification identifies C-27-001. Which reference number/form should applicants use?

    Answer: All documentation and information associated with the RFA should reference VIPC #C-27-002.

61. **Question:** Are there particular factors that distinguish the strongest Tech Innovation Fund applications—such as a committed rural provider partner, number of rural patients/providers served, speed to deployment, evidence of prior use, sustainability after grant funding, or ability to scale across multiple rural Virginia communities?

    Answer: Yes. The RFA identifies the factors reviewers will score, and the strongest applications will be those that perform well across those stated criteria rather than simply maximizing the number of sites or users.

    A committed rural provider partner can strengthen the stakeholder engagement and deployment case but is not required. Evidence of prior use or early results can strengthen the technology product solution criterion. A credible post-grant sustainability plan is expressly scored. Patient/provider reach, deployment timing, and geographic scale should be supported by clear, measurable targets, but the RFA does not award separate points simply for serving more users, deploying faster than required, or covering more rural localities. Geographic distribution and broader program priorities may also be considered in VIPC's final best-value funding decisions.

62. **Question:** Will you share the recorded video of your ppt with us?

    Answer: Yes. It will be available at https://vipc.org/initiatives/rural-health-transformation-program/

63. **Question:** Do you think focusing on a specific population, such as pregnant and postpartum women, would make the application too narrow or hurt our chances?

    Answer: No. The RFA does not indicate that focusing on a defined population would disadvantage an application. A focused population may be appropriate if the proposal clearly demonstrates the rural

need, the chronic-disease prevention or management use case, the deployment strategy, and measurable outcomes.

A focus on pregnant and postpartum women could be consistent with the Fund if the proposed technology addresses an eligible chronic-disease or related care-management need in rural Virginia. The application should explain why that population was selected, the size and characteristics of the population to be served, and how the proposed solution addresses an unmet rural need.

The RFA does not award additional points simply for serving a broader population, so the key issue is the strength and relevance of the proposed use case rather than breadth alone.

64. **Question:** Are letters of support required with the application, or only at the 45-day deployment-strategy milestone? For applicants using the Section 4.3 alternative documentation pathway (fewer than three comparable projects), do the two letters of support referenced there serve the same purpose, and is a template available?

    Answer: Letters of support are not generally required with the application. They are required, at application, only for applicants using the alternative Section H: Past Performance and References pathway because they do not have the required number of comparable projects. That pathway calls for no more than two letters of support from customers or prospective customers, partners, and/or industry experts, along with the other specified alternative documentation.

    Those letters serve a different purpose from the letter(s) of support identified for the 45-day Rural Deployment Strategy milestone. The application-stage letters are intended to validate the market problem, need, competitiveness, and commercialization potential. The 45-day letters are example evidence from identified rural localities or potential implementation partners supporting deployment.

    The RFA does not provide a template for either type of letter. It describes the content expected for the alternative past-performance letters, but applicants should consult the formatting guidelines per the RFA.

FUNDING, BUDGET, PAYMENTS AND ALLOWABLE COSTS

65. **Question:** Section 1.5 prohibits program management salaries. How does VIPC distinguish direct project work by a named Project Director, such as clinic partner deployment and training, from prohibited administrative effort?

    Answer: Section 1.5 prohibits administrative costs, including program management salaries, and permits only direct costs. The RFA does not distinguish allowable versus prohibited effort based on an individual's title.

    Accordingly, a named Project Director's time may be charged only to the extent it is for direct project activities**,** such as deployment, implementation, stakeholder training, or other work specifically required by the approved scope. General project administration, grant management, scheduling, budgeting, reporting administration, or similar program-management effort would not be allowable.

    The RFA does not provide a more detailed allocation methodology, so the budget narrative should clearly identify the specific direct project activities associated with any personnel costs. Additionally, applicants should consult the definition of direct and indirect costs per the Federal regulations 2 CFR Part 200 and 300.

66. **Question:** Section 1.5 limits awards to direct costs. May an applicant include connected health devices, such as scales, that are provided to enrolled patients as an itemized supply cost at the applicant's acquisition cost with no markup? Section 6.5 prohibits costs for "subjects and patients under study" unless specifically approved. We would list the devices in the budget and narrative to request that approval.

    Answer: Potentially, but the RFA does not expressly state that patient-facing devices are automatically allowable as supplies. Section 1.5 permits only direct project costs and prohibits profit or fee, so budgeting devices at the applicant's acquisition cost with no markup is consistent with those limitations. Section 4.4 also requires each cost to be itemized, justified, tied to project activities, and included in both the budget and budget narrative.

    Section 6.5, however, includes costs associated with "subjects and patients under study" among prohibited uses while also referencing circumstances that are "specifically approved as part of the project or program activity." The RFA does not clearly state whether approval of an itemized device cost in the application budget, by itself, satisfies that exception.

    Accordingly, the devices should be specifically identified and justified in the proposed budget and narrative, but applicants should not assume the cost is allowable unless VIPC approves it as part of the funded project. If any device has a unit cost of $10,000 or more, the RFA's equipment and prior-approval requirements would also apply.

67. **Question:** Section 1.4 requires all supported work to be performed in the U.S. If a device is manufactured outside the U.S. and purchased as a supply, does that meet the requirement? Does final assembly, quality checks, and kitting in Virginia change the answer? Do any domestic purchasing preferences apply?

    Answer: The RFA requires the applicant to be U.S.-based and U.S.-owned and requires RHTP-supported work to be performed in the U.S. by U.S. employees and contractors. It does not state that every supply or device purchased with award funds must be manufactured in the United States. Accordingly, the RFA does not, by itself, make a foreign-manufactured device ineligible solely because of its country of manufacture; however, in the case of telecommunications and surveillance equipment, applicants should consult the restrictions of Federal regulation 2 CFR Part 200.216.

    Final assembly, quality checks, or kitting in Virginia may be relevant to where project work is performed, but the RFA does not state that those activities change the device's status for domestic-preference purposes.

    The RFA does in corporate domestic preferences for procurements among the federal procurement requirements applicable to contracts. Applicants should therefore evaluate any device procurement under those requirements. The RFA does not provide a separate domestic-content test or state that Virginia assembly alone satisfies that preference.

68. **Question:** Please clarify whether milestone payments are reimbursements limited to allowable incurred costs through the milestone date, and whether the initial 20% milestone may be invoiced immediately upon execution of the approved subaward/workplan.

    Answer: Applicants are required to provide a detailed cost breakdown and budget justification by milestone. Awarded subrecipients may invoice VIPC per the first milestone for 20% of their costs at time of execution and approval of workplan.

Subrecipients should keep in mind that they will be required to certify that the milestones have been completed, and all expenditures are for allowable purposes. Upon receipt and acceptance of the required milestone deliverable and invoice, VIPC will invoice for reimbursement to DMAS, and the awardee will be paid upon VIPC's receipt of payment from DMAS.

Milestone-based payments do not eliminate record-retention or audit-access requirements; subrecipients must maintain supporting records, and upon request, make records available for review.

69. **Question:** Can approved project-specific costs include engineering migration, rural software adaptations, security/privacy preparation and validation, integrations, hosting, user onboarding, and implementation/evaluation personnel? How should applicants distinguish direct delivery work from prohibited administrative or program-management costs?

    Answer: Applicants should consult the Federal requirements of 2 CFR Part 200 and 300, which defines direct and indirect/administrative costs. It should be reminded that only direct costs will be supported, and indirect/administrative costs are not allowable.

70. **Question:** Closeout and award cap: How should applicants reconcile the final report due within seven days after the performance period with all milestone payments being completed by August 31, 2027? Please also confirm whether the maximum request is $999,000 or $999,999.

    Answer: VIPC understands that the final report will evolve throughout the period of performance and should be completed, or nearly completed, by the end of the project. Applicants may include any anticipated costs associated with preparing the final reporting for their budgets.

    For the second question, we have corrected the amount within the RFA, and the revised version has been included on VIPC's RHTP webpage. The amount should be $999,999.

71. **Question:** Is the initial 20% an advance following execution or reimbursement for incurred approved expenses? What documentation and typical payment timing apply?

    Answer: The initial 20% is not an advance payment. Under Section 3.2, the Initial Award milestone is 20% of the total award, with completion evidenced by a fully executed subgrant agreement incorporating the approved project work plan. Section 6.3 provides that subrecipients invoice VIPC for completed milestones and that VIPC reimburses approved expenses. VIPC may request additional supporting documentation, including itemized costs by budget category.

    For payment timing, VIPC submits reimbursement requests to DMAS on the 7th of each month. DMAS is expected to reimburse VIPC for approved expenses within 30 days, and VIPC will reimburse the subrecipient within three business days after receiving those funds.

72. **Question:** What percentage of your funding do you hope to deploy into VA's 76 rural counties?

    Answer: The Tech Innovation Fund has slightly more than $9 million available in Year One to support eligible projects deployed in rural Virginia.

73. **Question:** Is it anticipated that funding could be continued year over year?

    Answer: At this time, we cannot confirm whether current awardees will be eligible for follow-on funding. The Tech Innovation Fund is being implemented for one budget period at a time, and future funding will depend on program performance, available federal funding, and applicable CMS and state requirements. Applicants should plan on the assumption that any funding opportunities in Years 2 through 5 would require a new competitive application rather than an automatic continuation of a Year One award.

For planning purposes, applicants should structure Year One projects to deliver meaningful results within the current performance period and should not rely on future Tech Innovation Fund awards to complete the proposed work.

74. **Question:** We have an active VIPC Launch grant, and its agreement says VIPC-funded performance periods cannot overlap. Can we receive this award for separate work, or would we need an amendment or to finish the existing grant first?

    Answer: Because this is federal funding, it would not be considered a direct overlap, as the funding comes from a federal source, as opposed to being from a Commonwealth source.

75. **Question:** How many awards will be granted?

    Answer: VIPC has approximately $9 million in grant funds available in Year One of the Tech Innovation Fund. Per Section 1.5 of the RFA, we anticipate awarding between 10-25 awards. The number of awards made will ultimately be determined by the number of applications recommended for award and the associated funding requested.

76. **Question:** Are milestone payments fixed percentages of the total award (for example, 20% per milestone as illustrated in Section 3.2), or are they limited to documented costs incurred as of each milestone?

    Answer: See Answers to Question 80 through 84.

77. **Question:** Section 1.5 prohibits indirect and administrative costs for the applicant. If an applicant includes a lower-tier subaward to a university or research institution for evaluation services, may that institution's negotiated facilities-and-administrative (F&A) rate be included within the contractual line, or does the prohibition extend to all tiers?

    Answer: At this time, applicants should treat the activity described as prohibited. We are capturing these questions for the program FAQ and will validate this interpretation with the appropriate state and federal partners where needed. If that review results in different guidance, we will update the published FAQ accordingly.

    October 21 Update: In this case the university/research institution appears to be operating as a contractor rather than a subrecipient because they are only providing evaluation services rather than bearing responsibility for program execution. Therefore, they would not need to bill on a line-item basis.

78. **Question:** Section 2.2B requires modifications for rural deployment, and Section 6.5 prohibits independent research and development. Where does VIPC draw the line for connectivity or setup adaptations made for rural homes?

    Answer: The RFA does not establish a precise boundary between allowable rural-deployment modifications and prohibited independent research and development.

    Section 2.2B expressly requires applicants to identify and execute modifications needed for successful rural deployment**.** Accordingly, connectivity configuration, device setup, workflow adaptation, or similar changes needed to make the approved technology operational in rural homes may be appropriate project activities if they are directly tied and allocable to the approved deployment.

    Section 6.5 separately prohibits independent research and development of goods or services not allocable to the approved project. General product development, creation of unrelated new capabilities, or R&D beyond what is necessary for the approved rural deployment should therefore not be charged to the award.

Where an adaptation could reasonably fall into either category, it should be specifically described and justified in the application and budget for VIPC review.

79. **Question:** Can grant funds support software licensing, implementation/configuration, onboarding/training, interoperability or integration work, cybersecurity/compliance work directly required for deployment, and measurement/evaluation activities?

    Answer: See Answers to Questions 88, 131, 170-176, and 220.

80. **Question:** May an applicant budget reasonable implementation-related payments to participating rural providers or other project partners, where those costs are necessary to deploy and evaluate the technology?

    Answer: Yes, potentially. The RFA permits applicants to use subawards and subcontracts for project activities, provided the costs are necessary, reasonable, allocable to the approved scope, and properly documented in the budget. For planned partner costs, the application should identify the partner's role, scope of work, estimated cost, rationale, and selection methodology.

    Implementation-related payments to rural providers or other partners may therefore be allowable when they directly support deployment, training, evaluation, or other approved project activities. They may not be used for prohibited administrative costs, profit or fee, or other unallowable expenses under Section 6.5.

81. **Question:** Please confirm whether indirect/administrative costs, profit/fee, and pre-award costs are prohibited, and whether there are any additional cost categories applicants should specifically exclude.

    Answer: Correct – profit, fee, and administrative costs are prohibited. Applicants should refer to the RFA, especially the budget section, for preparing their budgets; the budget template will guide the Applicant through the preparation of the line-item budget, and costs should be reasonable, allocable, and allowable per the guidance in the RFA, as well as 2 CFR Part 200 and 300.

82. **Question:** While preparing our budget for RFA C-27-002, we found formula errors on the Budget Summary tab of the itemized budget template. The detail tabs calculated correctly. We checked each reference against the total rows on those tabs. May applicants submit the corrected workbook, or will VIPC post an updated template? Is there anything else we should change before submitting?

    Answer: An updated template posted to VIPC's RHTP webpage on Wednesday, October 7, 2026.

83. **Question:** Our product will be at proof-of-concept stage (TRL 4) at submission and will mature toward minimum viable product (TRL 5-7) during the period of performance through the modifications described in Section 2.2B. Are development activities tied to the approved deployment work plan allowable direct costs, given the prohibition on independent research and development

    Answer: Yes, potentially. The RFA expressly contemplates products entering at proof-of-concept through MVP (TRL 4–7) and requires awardees to make modifications necessary for successful rural deployment under Section 2.2B. Development work that is necessary to execute the approved deployment plan—such as adapting, configuring, integrating, testing, or refining the product for the identified rural use case—may therefore be treated as a direct project cost if it is specifically included in the approved scope and budget.

    The prohibition on independent research and development applies to R&D that is separate from, or not allocable to, the approved project. The RFA does not provide a more detailed line-item test, so

applicants should clearly tie each development activity to the approved rural deployment work plan and explain why it is necessary to move the product from TRL 4 toward MVP readiness.

84. **Question:** Clinical partner costs. May the rural Virginia clinical partner's personnel costs (clinical review of prioritized cases, data extraction, patient engagement, follow-up, evaluation support) be budgeted as direct project costs or through a subaward or subcontract under Section 4.4? What structure does VIPC expect?

    Answer: Yes, potentially. Section 4.4 permits planned subawards and subcontracts, and clinical-partner personnel costs may be included where the work is a necessary, reasonable, and direct part of the approved project—for example, clinical review, patient engagement, implementation support, data extraction, follow-up, or evaluation. Administrative and indirect costs remain unallowable.

    The RFA does not prescribe whether a clinical partner must be structured as a subaward or subcontract. Whichever structure is used, the application must provide the partner's scope of work, estimated cost, rationale, and selection methodology, and link those costs to project activities and milestones.

    Accordingly, applicants should choose the structure appropriate to the partner's role and clearly document it in the budget and budget narrative.

85. **Question:** Is FHIR and EHR integration engineering required for rural deployment an allowable direct cost under the Section 2.2B modifications?

    Answer: Yes, potentially. Section 2.2B allows modifications necessary for successful rural deployment, and FHIR or EHR integration engineering may qualify where it is required to make the proposed technology operational within the approved rural use case.

    The cost should be specifically tied to the approved deployment scope, justified in the budget, and treated as a direct project cost. General interoperability development, platform-wide engineering, or work not allocable to the funded rural deployment would be less clearly allowable and could fall within the prohibition on independent research and development.

86. **Question:** Please confirm that payments to clinical sites for data extraction, clinical-review time, patient engagement, and evaluation are allowable direct costs, and clarify the boundary with the prohibition on administrative costs.

    Answer: Yes, potentially. The RFA permits reasonable, necessary, and allocable direct project costs, including costs incurred through approved subawards or subcontracts. Accordingly, payments to clinical sites for activities such as data extraction, clinical-review time, patient engagement, follow-up, and evaluation support may be allowable when those activities are specifically required to implement or evaluate the approved project and are clearly documented in the budget and scope of work.

    The distinction is whether the cost is directly attributable to the funded project. General administration, grant management, routine organizational overhead, or program-management effort is not allowable merely because it supports the project broadly. Site payments should therefore be itemized by specific project activity, personnel effort, and purpose rather than characterized as general administrative support.

MILESTONES, PERFORMANCE METRICS, AND AWARD ADMINISTRATION

87. **Question:** Are award announcements still expected December 21, and when do you expect agreements to be fully executed? Does the 45/90-day clock start at full execution rather than notice or receipt of funds?

Answer: December 21, 2026, is the anticipated Notice of Awards date. The stated period of performance begins on the date the subaward agreement is fully executed and runs through August 31, 2027.

For the 45- and 90-day milestones, Section 3.2 uses the phrase “within 45 days of award” and “within 90 days of award.” Both of these dates should be built on full execution.

88. **Question:** For the 180-day outcome milestone, is a demonstrated improvement in access or care delivery sufficient, or is VIPC expecting every project to demonstrate a clinical or physiologic health outcome within six months?

Answer: The RFA does not state that every project must demonstrate a clinical or physiologic outcome within six months. The Challenge Statement expressly contemplates measurable improvements in health outcomes, access, affordability, or care delivery.

However, the six-month milestone specifically requires reporting on the Section 3.1 metrics and demonstrating improvement toward predetermined health outcome(s).

Accordingly, applicants should define their intended outcomes in advance and show measurable progress toward them. The RFA does not expressly state that an access- or care-delivery measure, standing alone, automatically satisfies the six-month health-outcome requirement.

89. **Question:** Will VIPC provide standardized definitions for ‘active user’ and ‘people served, or should applicants propose defensible definitions based on their technology?

Answer: Applicants should refer to Sections 3.1 and 3.1.1 of the RFA for definitions of active users and people served.

90. **Question:** Are unpaid community volunteers, such as volunteer fire and rescue members, who are trained to help install and check devices allowable as a training activity? May they be counted under "persons trained and successfully implementing" in Section 3.1.1?

Answer: Yes, potentially. The RFA includes stakeholder training among the required project activities, and it does not limit that training to paid employees or clinical staff. Training unpaid community volunteers to assist with device installation, setup, or checks could therefore be consistent with the RFA if those activities are part of the approved rural deployment plan.

For Section 3.1.1, the RFA allows systems-focused technologies to count people trained and successfully implementing the technology. The RFA does not distinguish between paid and unpaid personnel. Accordingly, volunteers may be counted if they are actually trained and are performing an implementation role—not merely attending training.

The application should define the volunteers’ role, training, and how successful implementation will be documented.

91. **Question:** May a university research partner be a subrecipient if its costs are direct only, with no indirect costs? May People Served include participants in a university study if the study is funded by other sources and uses the applicant's platform?

Answer: Yes, potentially. The RFA permits subawards**,** so a university research partner may participate as a subrecipient where its role is appropriate to the approved project. Its budget must be limited to allowable, reasonable, and allocable direct project costs**;** the RFA does not authorize indirect-cost recovery under the Tech Innovation Fund.

For People Served, the RFA requires reporting on people served through the funded project, including unique users/registrations for consumer-facing technologies. It does not specifically address participants whose study participation is funded from another source.

Accordingly, applicants should not assume that participants in a separately funded university study may be counted solely because they use the applicant's platform. They would need to be part of, or demonstrably served through, the RHTP-supported deployment and otherwise meet the applicable reporting definition.

92. **Question:** For solutions involving patient or caregiver information, are there CareIQ-specific cybersecurity, HIPAA, interoperability, data-hosting, data-sharing, or Virginia-specific requirements beyond applicable federal/state law and the requirements stated in the RFA?

Answer: Yes. The RFA includes several requirements that go beyond a general statement to comply with applicable law.

For solutions handling PII, PHI, or ePHI, Section 6.12 requires safeguards and written policies at least as protective as those applicable to HIPAA covered entities and business associates, even if the subrecipient is not itself a covered entity or business associate. It also requires immediate notice to VIPC of actual or suspected breaches or unauthorized access, use, or disclosure.

Section 6.13 requires funded HIT, APIs, patient-facing applications, and related digital tools to comply with applicable federal interoperability requirements, including information-blocking rules where applicable. It also allows VIPC to communicate additional HIT or interoperability requirements in writing during the performance period.

Section 6.14 requires a written cybersecurity plan only where the subrecipient or lower-tier contractor both has ongoing access to HHS systems and handles HHS PII or PHI.

The RFA does not specify a separate CareIQ data-hosting location requirement, a distinct data-sharing architecture, or additional Virginia-specific technical standards beyond applicable state law and the requirements stated in the RFA.

93. **Question:** Beyond deployment and active-user measures, are there preferred outcomes applicants should prioritize—for example, chronic-disease engagement, provider time savings, care-plan adherence, follow-up completion, patient/caregiver engagement, utilization, or other measures?

Answer: The RFA does not prescribe a preferred set of project-specific outcomes beyond the required program metrics. It does, however, expect applicants to define measurable outcomes appropriate to the proposed technology and to demonstrate progress toward predetermined health outcomes. The broader program standard is improvement in health outcomes, access, affordability, or care delivery, with a focus on chronic disease prevention and management in rural populations.

Measures such as care-plan adherence, follow-up completion, patient or caregiver engagement, utilization, or provider time savings may be appropriate where they are directly tied to the proposed solution and its intended rural impact. The RFA does not identify any of those measures as preferred over the others. Applicants should select measures that are feasible within the performance period and clearly connected to the outcomes the project is designed to achieve.

94. **Question:** The total performance period in year 1 is 8 months; correct?

Answer: Yes – the approximate period of performance is eight months.

10/14: APPLICANT ELIGIBILITY AND ORGANIZATIONAL REQUIREMENTS

95. Question: May a single applicant submit more than one application, or receive more than one award, within this solicitation?

Answer: There is no limitation stated in the RFA about the number of applications submitted or awards received.

96. Question: Is a newly incorporated company eligible if its founder owns or is affiliated with another company established more than 10 years ago?

Answer: See Answer to Question 10.

97. Question: Does 100% ownership by a U.S. lawful permanent resident satisfy the U.S. ownership requirement?

Answer: We are seeking additional guidance from CMS.

October 21 Update: The key distinction from CMS requirements is that the organization is organized under U.S. law rather than the residency or citizenship status of the owner.

CMS requirements are based on the following guidance:

- U.S.-based and U.S.-owned non-profits, businesses (a corporation, partnership or sole proprietorship organized under U.S. law), or government entities.
- U.S.-based and U.S.-owned non-profits, businesses (a corporation, partnership or sole proprietorship organized under U.S. law), or government entities. Perform the RHT Program-supported work in the U.S. with U.S. employees and, if applicable, contractors. International applicants are ineligible.

98. Question: Can a newly established company demonstrate qualifications using its founders' and technical team's prior project experience?

Answer: If the founder and technical team are part of the project implementation, they can be referenced in Section 4.2.A to demonstrate that the team possesses necessary expertise.

99. Question: Are the 10-year age and $50 million funding thresholds assessed solely at the applicant entity level, or are parent companies, affiliates, and common ownership also considered?

Answer: See Answer to Question 10.

100. Question: If an applicant's SAM.gov registration is submitted but not yet Active by the deadline, can the application still be accepted?

Answer: See Answer to Question 4.

101. Question: Can a company based outside Virginia apply as the lead applicant if all pilot sites and patients are in rural Virginia?

Answer: Yes. See Answer to Question 19.

102. **Question:** What documentation demonstrates financial capacity for an LLC applicant?

Answer: See Answer to Question 1.

103. **Question:** Can the same project apply to other state or federal grants if each grant funds different work?

Answer: This RFA does not explicitly limit applicants from applying to other state or federal grants. Applicants are encouraged to refer to all regulations.

104. **Question:** For an existing out-of-state applicant registered with the Virginia SCC, what minimum activities and documentation establish "administrative and strategic operations performed within Virginia"? Would a Virginia-based employee or contracted operational lead performing documented company administration, deployment planning, and strategic work qualify? Must those operations already be active by October 29, or can a binding commitment to establish them before award execution qualify for the "expanding into Virginia" extra credit?

Answer: Out of state applicants will be accepted. VIPC anticipates using Section 1.4 to evaluate whether applicants are Virginia-based at the time of application.

105. **Question:** For commercial cloud, AI, and telephony services, does the requirement that supported work be performed in the U.S. apply only to applicant and project-contractor personnel, or also to vendor processing locations and support personnel? Is U.S.-region hosting sufficient, and what vendor documentation is expected?

Answer: All RHTP supported work must be performed in the U.S. with U.S. employees, and if applicable, contractors.

106. **Question:** UEI vs. full SAM.gov registration. 2 CFR 25.300 says subrecipients are not required to complete full SAM.gov registration to obtain a UEI. Will a UEI without full registration meet the eligibility requirement, or must the registration show "Active" with an expiration date, as the cover page asks? If our registration is submitted before October 29 but is still processing at the deadline, may we still apply?

Answer: Yes. UEI without full registration meets the eligibility requirement.

107. **Question:** If a Virginia-based small business was incorporated more than 10 years ago but has recently launched a new healthcare technology initiative, is eligibility determined strictly by the original legal entity's formation date, or can the establishment date of the new technology venture be considered?

Answer: See Answer to Question 10.

108. **Question:** Would a newly established, separately incorporated company developing its own healthcare technology qualify if it shares founders or ownership with an existing company that is more than 10 years old?

Answer: See Answer to Question 10.

109. **Question:** Does CMS provide specific guidance on how affiliated companies, common ownership, or predecessor organizations are evaluated when determining eligibility under the 10-year requirement?

Answer: See Answer to Question 10.

110. **Question:** If we have been around for more than 10 years but the tech division is under 10 are we eligible?

Answer: See Answer to Question 10.

111. **Question:** Would [Organization's] formation date govern the "founded less than 10 years ago" criterion, or would VIPC look to the parent's founding date?

Answer: See Answer to Question 10.

112. **Question:** Can a Virginia-based startup that licenses or commercializes technology developed at a Virginia university apply for the fund, provided that the startup meets all eligibility requirements?

Answer: See Answer to Question 12.

113. **Question:** What financial documentation is required if a company lacks three years of audited statements or a federal single audit?

Answer: See Answer to Question 1.

114. **Question:** Is it possible for me to take part in two proposals? Possibly one as CoPI and one as PI?

Answer: The RFA does not include a limit to the number of applications that an individual can participate in. Potential applicants should ensure that their organization meets all eligibility requirements in Section 1.4 of the RFA.

115. **Question:** How does VIPC view applications led by a university, given the stated preference for companies and startups?

Answer: See Answers to Questions 7 and 12.

10/14: TECHNOLOGY AND PRODUCT ELIGIBILITY

116. **Question:** Are AI-powered chronic disease management, risk prediction, care coordination, and patient engagement solutions eligible for funding?

Answer: Yes, potentially. Applicants should refer to Answers to Questions 22, 26, 28, and 33.

117. **Question:** Is a functional prototype using synthetic data sufficient at the application stage, provided a credible rural deployment plan is included?

Answer: See Answer to Question 29.

118. **Question:** Can a new healthcare delivery application of an established commercial technology qualify under TRL 4–7 if the proposed application requires additional development, testing, or validation?

Answer: See Answer to Question 29.

119. **Question:** Are innovative healthcare logistics and delivery solutions eligible when they directly enable patient care, medication access, or continuity of care?

Answer: Yes, potentially. Applicants should refer to Answers to Questions 22, 26, 28, and 33.

120. **Question:** Chronic disease scope. Building on Q60, does VIPC consider [list of health conditions] to be within the Fund's chronic disease prevention and management scope?

Answer: Yes, potentially. Applicants should refer to the RFA (sections including but not limited to 1.2, 1.4, 2.1, and 2.2) regarding scope. Applicants can also refer to Virginia's RHTP Application for additional information into Virginia's priorities.

121. **Question:** Is there a minimum number of patients or homes required for the pilot?

Answer: The RFA does not have a minimum number required as long as all application requirements are met.

122. **Question:** Would a [health focused] complex-care platform focused on identifying previously undiagnosed genetic conditions, facilitating specialty access, and coordinating ongoing care qualify under CareIQ's requirement that funded innovations address chronic disease prevention and management?

Answer: Yes, potentially. Applicants should refer to Answers to Questions 22, 26, 28, and 33.

123. **Question:** [Company] is considering an application to the Tech Innovation Fund. We are developing [solution]. Would this use case qualify under the Fund's chronic disease prevention and management focus if the proposed project serves families in designated rural Virginia communities? Are there particular scope limitations we should consider?

Answer: Yes, potentially. Applicants should refer to Answers to Questions 22, 26, 28, and 33. Applicants can also refer to Virginia's RHTP Application for additional information into Virginia's priorities.

124. **Question:** Our product is a [proposed solution]. It is non-medical: it does not diagnose, treat, or track vital signs. Is this within the Fund's scope of chronic disease prevention and management, and would it count as enabling care? If a defined chronic-disease use case is needed, what would reviewers expect to see?

Answer: Yes, potentially. Applicants should refer to Answers to Questions 22, 26, 28, and 33. Applicants can also refer to Virginia's RHTP Application for additional information into Virginia's priorities.

125. **Question:** The RFA allows Virginia-based companies or companies providing direct services to rural Virginia communities. Does remote collection of specimens from rural residents (at home, at work, or at a community site) count as direct services?

Answer: Yes, potentially. Applicants should refer to Answers to Questions 22, 26, 28, and 33. Applicants can also refer to Virginia's RHTP Application for additional information into Virginia's priorities.

126. **Question:** What evidence of technology readiness level 4 is expected for a new product? Would a university validation study or an early pilot count as feasibility evidence?

Answer: See Answers to Question 23, 24, 25, 29, and 35.

127. **Question:** Do FDA or other regulators treat a collection device used in a funded pilot differently?

Answer: This question is being posed to CMS.

128. **Question:** Given the TRL4-7 status, may an applicant deploy a medical device that has not yet received FDA clearance, if it is used under an IRB-approved protocol at clinical sites with clinician oversight?

Answer: This question is being posed to CMS. A medical device that has not received FDA clearance or approval may be eligible for funding consideration if the proposed activities align with the RFA and comply with all applicable FDA requirements. TRL 4–7 status, IRB approval, and clinician oversight do not independently establish authorization for clinical use. Applicants should identify the device's regulatory status and provide documentation of any applicable FDA authorization or exemption, IRB approval, and other required safeguards. Eligibility and allowability will be determined based on the proposed activities and applicable program requirements.

129. **Question:** How will you assess technology readiness (TRL 4–7) and the "direct services" requirement for academic, faculty-developed technologies?

Answer: See Answers to Questions 23, 24, 29, and 35.

130. **Question:** Would a diagnostic service designed to expand access to [target population] in rural Virginia, including the evaluation and management of [disease] align with the program's chronic disease prevention and management objectives, particularly its goals of increasing access to primary care and modernizing rural healthcare delivery?

Answer: Yes, potentially. Applicants should refer to Answers to Questions 22, 26, 28, and 33. Applicants can also refer to Virginia's RHTP Application for additional information into Virginia's priorities.

131. **Question:** Existing intellectual property — Sections 6.7 and 6.15: Where the project uses an independently developed platform and funds a defined rural-deployment adaptation, how will the agreement distinguish pre-existing software, source code, models, workflows and documentation from materials developed or refined with award funds? May the approved scope or agreement include a schedule identifying pre-existing IP and separately identifying funded deliverables?

Answer: Yes. Pursuant to federal regulations - specifically 37 CFR Part 401 - applicants shall disclose pre-existing IP in their proposal under RFA 4.2.C, reference 6.7 and 6.15.

132. **Question:** Can an applicant use or license existing intellectual property developed by an affiliated company?

Answer: Subject to eligibility requirements, then yes, potentially.

133. **Question:** Who owns intellectual property developed with grant funds? Does the Commonwealth retain any rights?

Answer: See RFA Sections 6.7 and 6.15.

October 21 Update: The organization developing the IP retains ownership; however CMS retains a right to the IP. The Commonwealth does not own nor retain a right to IP developed under the award. To comply with federal regulations, the State and all funded subrecipients must protect the federal government's rights regarding any technology or intellectual property developed or acquired using RTCF dollars:

- Copyrighted Works: In accordance with 2 CFR 200.315, CMS retains a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use any copyrighted work developed with RHT Program funds for federal purposes, and to authorize others to do so, including to make such work available through CMS-designated public access repositories. The government retains these rights even if the solution is acquired by another entity.
- Patents and Inventions: The State and any funded entities must comply with all applicable regulations governing patents and inventions, including 37 CFR Part 401, to ensure the government's rights are fully protected.
- Product Ownership: The entity may own the product developed, including associated intellectual property, and may commercialize it, to the extent consistent with these and all other applicable federal requirements. Through the RTCF dollars, neither CMS nor the States have ownership of the product

10/14: PARTNERSHIPS, RURAL DEVELOPMENT AND IMPLEMENTATION

134. **Question:** Out-of-state applicants and rural Virginia service. For an applicant headquartered outside Virginia, what evidence establishes that the organization serves rural Virginia communities under the Federal Office of Rural Health Policy definition? Specifically, does a proposed new service area qualify, or must the applicant demonstrate existing operations, contracts, or patients in rural Virginia at the time of application?

Answer: Out-of-state applicants may apply to the Tech Innovation Fund as long as all eligibility criteria are met. Existing operations in rural Virginia are not required at the time of application.

135. **Question: Partnerships.** May an out-of-state applicant partner with or subcontract to a Virginia-based entity to satisfy the preference or the rural service requirement? If so, must the Virginia entity be the prime applicant, and are there restrictions on how award funds flow between the parties?

Answer: See Answer to Question 19.

136. **Question:** Can an applicant subcontract work to an affiliated company under common ownership or management?

Answer: Yes, as long a there are no conflicts of interest and meet RFA eligibility requirements.

137. **Question:** Can an applicant identify and formalize rural healthcare partnerships after receiving an award, rather than before submitting the application?

Answer: Yes. See Answer to Question 47.

138. **Question:** How does VIPC evaluate the strength of an applicant's operational partnerships with rural healthcare providers, and what level of partner commitment is most valuable during application review?

Answer: See Answers to Questions 38, 47, 51, and 52. Additionally, applicants should refer to Section 4.2.D for how stakeholder engagement should be included in an application, and Section 5.1 for scoring criteria.

139. **Question:** May subrecipients or subcontractors based outside Virginia perform funded work (e.g., evaluation, training, or integration) for a project deployed in rural Virginia, or must funded work be performed by Virginia-based personnel?

Answer: Subrecipients or subcontracts may be based outside of Virginia as long as they meet all other eligibility criteria in the RFA.

140. **Question:** Do letters of support need to come from organizations taking part in the pilot, or can they also come from supporting organizations such as associations?

Answer: Letters of support are only required if applicant does not fulfill 4.2., H.1 for previous performance. Per the RFA, letters can come from customers or prospective customers, partners, and/or industry experts. It is at the discretion of the applicant to determine which organizations will best enhance the strength of the application.

141. **Question:** Can applicants update device specifications or vendors between award and deployment?

Answer: Yes, upon approval from VIPC.

142. **Question:** Are signed partner agreements required at submission, or are letters of support enough until award?

Answer: Applicants are required to identify within the application and also provide a budget for all partnerships. Agreements are not required at time of application, nor are letters; however, if selected for funding award, applicants may be request to submit additional documentation. Also see Answer to Question 47.

143. **Question:** Our university has been contacted to be a potential partner on a new RHTP application. I see that there are no indirect costs allowed in the budget template. Does this restriction apply to universities who may serve as a subrecipient on this application? If so, is there a document that I could submit to our Office of Sponsored Programs to waive this for our internal approval process at our university?

Answer: See Answer to Question 74. The applicant should share the RFA with their Office of Sponsored Programs.

144. **Question:** Section 6.12 refers to both individual and VIPC written consent for disclosure of patient information. May an approved consent and data-sharing protocol authorize routine sharing with the patient's designated clinician or caregiver, or is separate VIPC consent required for each disclosure?

Answer: Under Project Narrative 4.2.F, applicants should describe how PII is collected and protected, including consent and data-sharing protocol for routine sharing with patients designated clinician or caregiver.

145. **Question:** We understand that an implementation partner is not mandatory at application. If an applicant submits a credible deployment plan while provider discussions remain pending, may it finalize a partner after submission or award execution? May a partner's identity be updated without resubmission where the approved geography, population, scope, and budget remain materially unchanged? What approval is required?

Answer: Yes, partners may be finalized after award. An application resubmission is not needed. Confirmed partnership(s) will be a component of meeting the second project milestone within 45 days of the execution of the agreement.

146. **Question:** During the webinar, presenters indicated that the Virginia Rural Health Transformation website contains information about organizations willing to participate as implementation partners. We have been unable to locate that information. Could you provide the direct link to the relevant directory, list, or page and explain how applicants should contact those organizations? If it is not yet published, is there a state program contact or another resource that can help applicants identify and reach interested rural providers or community partners?

Answer: The directory is currently under development, a release date is not known. Due to the short timeframe, neither VIPC nor state programs do not anticipate serving as the primary connector between applicants and partners or stakeholders at this time.

147. **Question:** Would patients discharged from a hospital outside Appendix A but residing in an Appendix A locality (e.g., Nelson, Highland, Bath, Rockbridge counties) count toward program metrics?

Answer: Yes. The Rural Health Transformation Program is focused on people who reside in FORHP communities regardless of where they receive care. In this scenario, it would could towards program metrics.

148. **Question:** May the applicant subcontract field deployment work (e.g., Mobile Integrated Healthcare home visits by paramedics) to its parent or an affiliated company? If so, would VIPC expect a sole-source justification under 2 CFR 200.318–320, and how does the RFA's prohibition on profit and fee apply to costs charged by an affiliated subcontractor?

Answer: Without having additional information, yes, information should be included in the application and upon VIPC approval. Applicants should refer to the RFA and all flow down terms and conditions.

149. **Question:** Appendix A lists FORHP "fully rural" localities. Will patients residing in FORHP-designated rural census tracts within otherwise non-rural counties (e.g., portions of Augusta or Rockingham County) count toward metrics, or only residents of Appendix A localities?

Answer: For the performance period that ends August 31, 2027, only residents within the 76 localities identified in Appendix A will be considered in metrics.

150. **Question:** How are intellectual property rights handled? Does the Commonwealth or the Centers for Medicare & Medicaid Services receive a license to inventions first reduced to practice under the award, and are pending patents affected?

Answer: Applicants should refer to Sections 6.7 and 6.15 of the RFA. The entity may own the product developed, including associated intellectual property, and may commercialize it, to the extent consistent with these and all other applicable federal requirements. Through the Rural Health Transformation, neither CMS nor the Commonwealth has ownership of the product.

151. **Question:** What privacy requirements apply to chain-of-custody records, such as HIPAA, and who holds the data?

Answer: At this time, no flowdown requirements have been provided. It is recommended that applicants refer to NIST SP 800-122 guidelines.

152. **Question:** Can an eligible startup partner with a university for technical development and validation activities under the award? Are there any restrictions on subcontracting or the use of grant funds by the university partner?

Answer: Yes, potentially. An applicant can partner with a university as long as the proposed activities are in scope of the project and allowable. Additional information is available in Question 74. VIPC has reached out to DMAS for additional information, and if/when DMAS responds, the answer to this question may be adjusted.

153. **Question:** Is a partnership or letter of commitment from a rural clinical provider, health system, or community partner required or scored? If optional, does it strengthen an application?

Answer: Letters of support are only accepted to accomplish Section 4.2.H2 or the project narrative.

154. **Question:** Are applicants required to identify and secure commitments from all participating rural Virginia clinical sites at the time of application, or may additional sites be recruited during the award period? Is there a specific rural designation or geographic classification that participating clinics must meet?

Answer: See Answers to Question 38, 47, 51, and 56.

154. **Question:** Will a university–startup partnership would make for a stronger application?

Answer: Not necessarily. Applicants should consider the contents of the RFA and their proposed solution to evaluate the roles and values potential partnerships would add to the strength of proposals.

155. **Question:** Will VIPC publish the list of awardees, or offer any way for Virginia technology companies to connect with funded projects that may need remote monitoring or EHR integration support?

Answer: VIPC anticipates a press release will be published once awarded.

156. **Question:** After awards are made, may an awardee add an established technology company as a subcontractor or subrecipient, with VIPC's prior approval, if that role was not identified in the original application?

Answer: Yes, upon approval from VIPC.

10/14: APPLICATION REQUIREMENTS, REVIEW, AND SCORING

157. Question: What should the sustainability plan include for continuing the service after the grant ends?

Answer: Applicants should refer to 4.2 Section G of the Project Narrative page 13.

158. Question: The leadership criterion calls for in-house technical, clinical, and operational expertise. May clinical expertise be supplied by a named, contracted licensed clinician with defined project responsibilities and a binding commitment, or must that clinician be an employee of the applicant? How should applicants document this distinction?

Answer: Yes. This should be distinguished in the narrative and if the roles are considered key personnel be shared in the proposal and in the budget template.

159. Question: For Section H's alternative pathway, is one substantive letter of support sufficient under "no more than two letters," or are two expected? Can an independent clinician or industry expert provide the letter without committing to serve as a deployment partner? Please also clarify whether the comparable-project lookback is three years, as stated in Option 1, or one year, as referenced in Option 2**.**

Answer: See Answer to Question 40.

160. Question: May applicants provide a demonstration link or supporting prototype-validation evidence outside the 10-page narrative, and will reviewers consider it? If a partner commitment or additional validation result becomes available after October 29, may it be provided during the interview or only upon VIPC's request?

Answer: Only materials incorporated into the 10-page narrative will be considered. Potential additional information will be only at VIPC's request.

161. Question: If we cite partnerships in Section D and attach letters of support as evidence, do those letters count toward the two-letter limit in Section H? May we cite partnerships in Section D without attaching letters?

Answer: Letters of support will only be required to meet requirements of 4.2.H2 of Past Performance and References. To accomplish section 4.2.D, applicants can reference partnerships without including a letter.

162. Question: Section H option 1 refers to projects "active within the past three years," and option 2 refers to fewer than three projects "within the past year." Which window applies?

Answer: The window in option 1 is correct. If the applicant does not have comparable active projects within the past three years, they should completed Section 4.2.H.2.

163. Question: If an applicant voluntarily funds part of the project, does that contribution help the score? Would reporting it create a binding cost-share commitment? What must the Stevens Amendment statement in Section 6.2 say?

Answer: Matching, in-kind, or other contributions are not required and will therefore not impact scoring. Additional guidance as to the Stevens Amendment will be provided at time of award.

164. **Question:** Does the Section H project table count toward the 10-page narrative limit? May tables use a font smaller than 11 point, and if so, what is the minimum?

Answer: Yes, per instructions in Section 4.2.H1, this must be included in the 10-page narrative limit and should follow applicable instructions.

165. **Question:** May we disclose and apply to other state or federal programs for related work?

Answer: Yes, potentially. This information would be appropriate in sections of the narrative, including 4.2.C, 4.2.D and 4.2.H.

166. **Question:** Past performance: Section H refers to projects active within the previous three years, whereas the alternative documentation requirements reference the previous year. Which lookback period should applicants use?

Answer: See Answer to Question 162.

167. **Question:** Project narrative structure: For the 10-page Project Narrative, does VIPC have a recommended page allocation or preferred level of detail for each section? In particular, should applicants emphasize technical evidence and the proposed solution, or allocate greater space to implementation planning, evaluation metrics, and commercial sustainability? Is every section meant to be treated equally in terms of space in the Project Narrative document?

Answer: VIPC does not have a recommendation. Instead applicants are encouraged to refer to review to the Review Criteria in Section 5.1 for potential points associated with sections of the narrative.

10/14: FUNDING, BUDGET, PAYMENTS AND ALLOWABLE COSTS

168. **Question:** Patient RPM devices — follow-up to FAQ 63: For connected devices used in routine chronic-care delivery and evaluation, rather than a separately funded research study, does written approval of the itemized device costs in the award budget satisfy the required specific approval, or is a separate approval instrument required? What ownership and disposition rules apply to devices placed with patients?

Answer: Without additional clarification on the question, equipment should be itemized in the budget. See RFA Section 6.16 Property Reporting and Disposition.

169. **Question:** Milestone invoicing — follow-up to FAQs 65 and 68: Please clarify what incurred-cost evidence is required to invoice the initial 20% upon execution of the agreement and approval of the work plan, given that pre-award costs are prohibited and the FAQ states this payment is not an advance. Are milestone invoices capped at cumulative allowable incurred costs, or payable at the approved milestone amount with later cost reconciliation?

Answer: See Question 65.

170. **Question:** Project-specific cloud and AI costs: May the applicant budget third-party hosting, communications and AI inference costs directly attributable to enrolled rural Virginia users at actual cost? What allocation and supporting documentation does VIPC expect where the same infrastructure also serves users outside the funded project?

Answer: Refer to cost principles of 2 CFR Part 200 and 300 on allowability, allocability and reasonableness of costs.

171. **Question:** Is any match or cost-share required or preferred? If cost share is considered favorably, are in-kind contributions eligible?

Answer: Per RFA Section 1.5, cost-sharing or matching is not required.

172. **Question:** May grant funds support the time of existing personnel working on the funded project, or are personnel costs limited to new hires and net-new scope?

Answer: Refer to cost principles of 2 CFR Part 200 and 300 on allowability, allocability and reasonableness of cost, specifically eligible direct labor.

173. **Question:** Can an established technology operator serve as a funded implementation subcontractor to an eligible applicant, and can allowable direct costs include operational service delivery expenses?

Answer: Refer to cost principles of 2 CFR Part 200 and 300 on allowability, allocability and reasonableness of costs.

174. **Question:** Are salaries for clinical and expert staff (for example, [healthcare providers]) who directly respond to participant messages and escalate concerns allowable as direct service-delivery costs, distinct from program-management effort?

Answer: Refer to cost principles of 2 CFR Part 200 and 300 on allowability, allocability and reasonableness of costs.

175. **Question**: May a single subrecipient provide shared implementation, interoperability, evaluation, and reporting services as an allowable direct cost, provided those services are tied to the approved rural deployment?

Answer: Refer to cost principles of 2CFR Part 200 and 300 on allowability, allocability and reasonableness of costs.

176. **Question:** Are workforce-readiness and retention activities at participating rural sites, such as staff surveys and analysis, and change-management support allowable direct costs when necessary to adopt the funded technology?

Answer: Refer to cost principles of 2CFR Part 200 and 300 on allowability, allocability and reasonableness of costs.

177. **Question:** May a funded consortium partner lead evaluation and performance measurement, or does VIPC expect an independent evaluator?

Answer: VIPC does not expect an independent evaluator.

178. **Question:** Is there a maximum share of the award that may go to subrecipients or subcontractors? Is cost share or matching required, or considered favorably in scoring?

Answer: See section 1.5, the RFA states no cost share or match requirement, and will not impact scoring.

179. **Question:** When a consortium partner provides an established, commercially available software platform and related services (for example, licensing, configuration, staff surveys, and analytics) that it sells to many customers at standard pricing, may the applicant treat that partner as a contractor under 2 CFR 200.331 and budget its standard pricing as a direct contractual cost? Or must all funded partners be structured as subrecipients reimbursed at actual cost, with no profit or fee? If a contract is permitted, what procurement documentation does VIPC expect at application?

Answer: VIPC cannot make that determination for the Applicant. Applicants should use CFR 200.331 to determine if it is a contractor or a subcontractor. The applicant would include this information in their budget and budget narrative at time of application.

180. **Question:** Are in-home devices and their installation allowable direct costs?

Answer: Refer to cost principles of 2CFR Part 200 and 300 on allowability, allocability and reasonableness of costs.

181. **Question:** Are funds paid upfront, by milestone, or as reimbursement?

Answer: Applicants should refer to Section 3.2 of the RFA and Answers to Questions 65, 68, and 73.

182. **Question:** Can pilot partners bill Medicare or Medicaid for remote monitoring during the pilot, or would that be considered double funding?

Answer: Without having additional information available, this would be considered double funding.

183. **Question:** If the evaluation requires home blood-pressure monitors or other modest-cost measurement supplies, does explicit approval in the scope and itemized budget satisfy the exception for costs associated with patients under study, or is separate written approval required? Please also clarify whether necessary project-specific clinical measurements or laboratory tests can be funded when not otherwise paid for by insurance or another source..

Answer: VIPC cannot make a determination without additional information. Applicants should include information in their application, and VIPC will evaluate.

184. **Question:** May direct costs include itemized telephone usage, speech recognition and synthesis, AI inference, secure hosting, and software services used specifically for the approved deployment? For shared infrastructure, is a documented allocation based on actual project usage acceptable? For an applicant-owned platform, should the budget use attributable underlying costs rather than an internal commercial license charge that could include profit?

Answer: Please refer to cost principles of 2CFR Part 200 and 300 on allowability, allocability and reasonableness of costs. Without additional information these appear to be indirect costs.

185. **Question:** May direct costs include project-specific evaluation analysis, outcome validation, and preparation of the technical validation reports required for milestone acceptance? Please distinguish these activities from prohibited reporting administration or grant management.

Answer: Please refer to cost principles of 2CFR Part 200 and 300 on allowability, allocability and reasonableness of costs.

186. **Question:** The RFA requires all milestone payments to be completed by August 31, 2027, while permitting the final report within seven days after the performance period. Given the DMAS reimbursement cycle, what deadline should applicants use for final deliverable acceptance and invoicing? How will the six-month milestone be handled if agreement execution occurs too late to provide six months before August 31?

Answer: Applicants should designate August 31, 2027 as the final day of their performance period. VIPC has built in additional time to ensure all reporting and invoicing requirements can be completed. Once awards are announced, VIPC will work to move the agreement execution process forward efficiently and expects awardees to do the same.

187. **Question:** Prior founder-funded expenditures: May documented founder contributions and startup expenditures incurred before application or award count toward the required match, including expenses paid personally on behalf of the company?

Answer: See section 1.5, the RFA states no cost share or match requirement.

188. **Question:** In-kind professional services: May documented pro bono contributions from qualified industry professionals, researchers, technical collaborators, or clinical advisors be recognized as in-kind matching contributions?

Answer: See section 1.5, the RFA states no cost share or match requirement.

189. **Question:** Financial management for a new company. We formed in July 2026, so we have no audit history and no prior federal awards. For the risk assessment, would a bank account used only for this award, plus accounting software that tracks the award as a separate project, meet the requirement to track federal funds separately? Is a CPA or outside bookkeeper required?

Answer: See 2 CFR § 200.302 and 200.303, the primary requirement is that your financial management system adequately identify and track the receipt and use of federal funds, determine whether costs are allowable, maintain complete records supported by source documentation, compare expenditures against the approved budget, and provide effective internal controls over the use of award funds.

Since your company was formed in July 2026 and has no prior federal award or audit history, consider documenting the controls you intend to implement and providing that documentation as part of your financial management risk assessment. The adequacy of your proposed approach may depend on the systems, procedures, and documentation in place.

190. **Question:** We are a single-member LLC with no W-2 payroll. May the founder's time on direct project work (deployment, onboarding rural users, training partners, evaluation) be budgeted, and what documentation do you require? Or must the founder be on payroll?

Answer: Applicant must be able to substantiate all proposed costs. Applicant should ensure that the salary does not exceed Executive Level II as outlined in Section 6.5. Subject to a program monitoring event or audit, CMS reserves the right to review milestone funds used in accordance with applicable federal requirements.

191. **Question:** Is $250,000 a firm minimum, or may a smaller, well-justified budget be submitted?

Answer: The RFA refers to an estimated award range. A smaller, well-justified budget may be submitted.

192. **Question:** Are costs to enroll [target demographic] (printed flyers, mailers, sign-up sessions at senior centers) allowable, given the prohibition on advertising designed solely to promote the organization?

Answer: Yes, potentially. Per Section 6.5 of the RFA costs are prohibited if they solely promote the organization, but could be allowed if they promote the solution, technology, product, or service proposed in the application.

193. **Question:** Could a qualified applicant budget [organization] implementation consultant, for direct rural deployment, clinical workflows, staff training and evaluation?

Answer: Yes, potentially.

194. **Question:** Please clarify how contractor compensation is treated under the prohibition on profit, fee and administrative costs, including whether overhead embedded in a commercial rate is prohibited**.**

Answer: Refer to cost principles of 2 CFR Part 200 and 300 on allowability, allocability and reasonableness of costs.

195. **Question:** Once a participating clinic uses grant-funded devices, may the clinic bill Medicare, Medicaid, or private payers for remote patient monitoring with those devices? Would that billing count as duplicate funding under the Section 6.3 certification? If billing is allowed, do any limits apply during the award period compared with after it ends?

Answer: During the award period this would be considered duplicate funding.

196. **Question:** FAQ 65 describes the first milestone as 20% of costs, and FAQ 68 describes it as 20% of the total award. Must the costs in each milestone equal 20% of the total budget, or may costs fall unevenly across milestones, for example with most device purchases in Milestone 2 or 3? If costs are uneven, how does VIPC reconcile them with the flat payments?

Answer: Applicants who have a need to vary milestones should provide a compelling argument in their application. But, upon VIPC's review we may or may not accept the proposal.

October 21 Update: We believe CMS requires the same milestone payment structure for all applicants. CMS states in the guidance that "Every selected Applicant in each program track should be subject to the same milestone timeline, and milestone payment structure." Virginia has one program track defined by its challenge statement.

197. **Question:** The budget template calculates "% of Budget Year Supporting RHTP," and FAQ 91 gives a performance period of about eight months. Should we calculate the percentage over the eight months from execution through August 31, 2027? How should months be split across the five milestones?

Answer: Calculations should be calculated over the eight-month performance period with completion by August 31, 2027.

198. **Question:** What documentation does VIPC want to support salaries charged to the award? Is a salary rate adopted by the company before the award acceptable as the established written policy under 2 CFR 200.430?

Answer: Please review the line-item budget and budget narrative requirements per the RFA. The line-item budget template is user-friendly and assists the applicant by walking them through the required information.

199. Question: Are the five milestone payments fixed or proposed by the applicant? Are they paid after each milestone is met, and is any advance available?

Answer: Applicants should refer to Section 3.2 of the RFA and Answers to Questions 65, 68, and 73. No advance will be available.

200. Question: If part of the kit is made overseas, do domestic-sourcing rules apply to federally funded purchases?

Answer: See Answer to Question 67.

201. Question: The RFA excludes administrative costs and program management salaries. Could you clarify whether personnel directly involved in technical development, clinical validation, laboratory implementation, training, and rural deployment are allowable expenses when their effort is specifically allocated to project deliverables?

Answer: Refer to cost principles of 2 CFR Part 200 and 300 on allowability, allocability and reasonableness of costs.

202. Question: Technology finalization and validation: Would project-specific activities necessary for commercialization, including final AI algorithm development, assay validation, technology transfer, and adaptations required for rural clinical implementation, be allowable expenses? How does VIPC distinguish these activities from the excluded costs of independent research and development?

Answer: The RFA explicitly allows for expenses necessary to enable deployment in rural communities. These should be incorporated into Section 4.2.C Proposed Solution and justified under Section 4.4 Budget and Budget Narrative.

203. Question: Clinical study and specimen costs: Are costs associated with IRB-approved clinical specimen collection, patient recruitment, reference diagnostic testing, specimen transportation, and clinical data analysis allowable when these activities directly support validation and commercialization of the proposed technology? Would samples acquired for development and validation come from clinic in rural Virginia or can they come from other rural or medically underserved communities of the country, given they would benefit Virginia once the product is validated?

Answer: Potentially, if necessary for the proposed project to achieve its stated outcomes in adherence to RFA Parts II and III, and properly documented.

204. Question: Our proposed commercialization model involves specimen collection at rural and medically underserved community clinics, with testing performed at a prospective central laboratory in Massachusetts. Would expenses associated with technology transfer, validation, and clinical testing at an out-of-state laboratory be allowable if the resulting diagnostic service directly benefits rural Virginia communities?

Answer: Where laboratory services are not paid by insurers or other programs, provided the costs support the program's strategic goals, demonstrate how each proposed cost supports the initiative and complies with applicable cost principles and RFA requirements, including 2 CFR Part 200 and 300 and Section 6.5 of the RFA. Justify how each cost is necessary, reasonable, allocable, and

adequately documented to achieve the proposed project outcomes and milestones in accordance with Parts II and III of the RFA. See also Answer to Question 41.

205. **Question:** Subcontractors and external service providers: May applicants allocate a portion of the award to external laboratories, clinical research organizations, software developers, or other subcontractors performing project-specific technical activities? Are there restrictions on the percentage of the award that may be subcontracted or spent outside Virginia?

Answer: The RFA does not restrict a percentage of the award contracted or spent outside of Virginia. However, all RHTP supported work must be performed in the U.S. with U.S. employees, and if applicable, contractors. The proposed project should present a compelling argument that the costs are necessary to achieve its stated outcomes in adherence to RFA Parts II and III, and properly documented.

206. **Question:** Equipment, consumables, and software: Are instrument installation, laboratory equipment, assay reagents, collection kits, quality-control materials, and software implementation costs allowable when required for commercial deployment?

Answer: Demonstrate how each proposed cost complies with applicable cost principles and RFA requirements, including 2 CFR Part 200 and 300 and Section 6.5 of the RFA. Justify how each cost is necessary, reasonable, allocable, and adequately documented to achieve the proposed project outcomes and milestones in accordance with Parts II and III of the RFA.

207. **Question:** Credentialing may take 3–6 months, during which these encounters may not be reimbursable. We would propose limiting grant support to documented, medically appropriate encounters directly necessary for the approved rural technology pilot, with no duplicate payment or billing, and discontinuing grant-funded encounters once insurance reimbursement becomes available. Would these costs qualify as allowable direct implementation or evaluation expenses, or does the RFA prohibit funding clinical encounters regardless of whether they are currently reimbursable?

Answer: Where clinical services are not paid by insurers or other programs, provided the costs support the program's strategic goals, demonstrate how each proposed cost supports the initiative and complies with applicable cost principles and RFA requirements, including 2 CFR Part 200 and 300 and Section 6.5 of the RFA. Justify how each cost is necessary, reasonable, allocable, and adequately documented to achieve the proposed project outcomes and milestones in accordance with Parts II and III of the RFA.

208. **Question:** Are temporary clinical and RD services allowable direct costs during insurance credentialing?

Answer: Where clinical services are not paid by insurers or other programs, provided the costs support the program's strategic goals, demonstrate how each proposed cost supports the initiative and complies with applicable cost principles and RFA requirements, including 2 CFR Part 200 and 300 and Section 6.5 of the RFA. Justify how each cost is necessary, reasonable, allocable, and adequately documented to achieve the proposed project outcomes and milestones in accordance with Parts II and III of the RFA.

209. **Question:** For a technology-enabled rural chronic-disease intervention, may CareIQ funds cover direct patient-care encounters provided by appropriately licensed Virginia clinicians and registered

dietitians during an initial implementation and evaluation period when providers are not yet credentialed with commercial insurers or Medicaid managed-care plans?

Answer: Where clinical services are not paid by insurers or other programs, provided the costs support the program's strategic goals, demonstrate how each proposed cost supports the initiative and complies with applicable cost principles and RFA requirements, including 2 CFR Part 200 and 300 and Section 6.5 of the RFA. Justify how each cost is necessary, reasonable, allocable, and adequately documented to achieve the proposed project outcomes and milestones in accordance with Parts II and III of the RFA.

210. Question: Are modest participant incentives, such as gift cards for completing onboarding and follow-up check-ins, an allowable cost?

Answer: Demonstrate how each proposed cost supports the initiative and complies with applicable cost principles and RFA requirements, including 2 CFR Part 200 and 300 and Section 6.5 of the RFA. Justify how each cost is necessary, reasonable, allocable, and adequately documented to achieve the proposed project outcomes and milestones in accordance with Parts II and III of the RFA.

October 21 Update: Applicants may propose participant incentives, including gift cards, when the incentives serve a clearly defined programmatic purpose and directly support the objectives of the proposed Tech Innovation Fund project. All proposed incentives are subject to case-by-case review and prior written approval by DMAS. Applicants seeking to include participant incentives must identify the proposed incentives in their project budget and budget narrative. The application should clearly explain why the incentives are necessary within the specific rural context, how they support participation in the proposed project, and how the associated costs are reasonable, allowable, and directly related to program activities. Proposed incentives should benefit rural communities, align with the initiative's objectives, and be incorporated into a broader strategy that can be sustained beyond the funding period. Incentives may only be provided as a benefit for participation in the grant-funded program. They may not be distributed as general giveaways, offered before participation, or used as promotional items bearing the branding of the applicant organization or its affiliates. Incentives must not influence a Medicare or Medicaid beneficiary's choice of healthcare provider, practitioner, or supplier. Inclusion of incentives in an application or proposed budget does not constitute approval. Applicants must receive prior written approval from DMAS before purchasing or distributing incentives. Any approved incentives will be subject to applicable award conditions, documentation requirements, and financial oversight.

211. **Question:** Would regulatory costs related to FDA testing and IRB prep count as allowable costs?

Answer: Consult the cost principles of 2 CFR Part 200 and 300 on allowability, allocability, and reasonableness of costs.

212. **Question:** Is there a guideline for how much of an award may go to an established technology partner or subrecipient before VIPC would view the arrangement as circumventing the 10-year / $50M threshold? For example, would a defined role such as remote monitoring, device logistics and EHR integration for the rural deployment be appropriate if the eligible applicant owns and leads the proposed product?

Answer: The RFA does not include an explicit guideline beyond 2 CRF 200.331.

213. **Question:** Milestone payments. Are milestone payments fixed at 20% of the award each, or limited to documented costs actually incurred at each milestone? FAQ #73 refers to #83, which covers clinical-site payments, so we weren't sure.

Answer: Current guidance anticipates awards to adhere to the same milestone timeline and payment structure. However, RFA Sections 6.6 and 6.18 instruct subrecipients to retain all grant-related records for subrecipient monitoring and audit. CMS reserves the right to review milestone funds used in accordance with applicable federal requirements.

214. **Question:** FAQ Questions 65 and 68 indicate that the initial 20% may be invoiced upon agreement execution and work-plan approval, but that it is not an advance and reimburses approved expenses. Since pre-award costs are prohibited, must the applicant first incur eligible post-execution costs equal to that 20% before receiving payment? Please clarify the earliest permissible invoice, required documentation, and treatment when incurred costs are below the milestone percentage.

Answer: See Answer to Question 68.

215. **Question:** Are the five 20% installments fixed payment amounts, or maximum amounts limited by eligible costs incurred? May the approved payment schedule reflect unequal costs across milestones? If a milestone is completed but cumulative eligible expenditures are below its scheduled payment, is the unpaid balance carried forward?

Answer: See Answer to Question 65.

10/14: MILESTONES, PERFORMANCE METRICS, AND AWARD ADMINISTRATION

216. **Question:** Six-month outcome milestone — follow-up to FAQ 85: For a chronic-care continuity deployment, would a preapproved combination of follow-up completion, adherence to a clinician-defined care plan, and condition-specific measures such as blood-pressure control satisfy the outcome milestone? Will the acceptable measures, baseline, targets and evidence be agreed in writing in the approved work plan before execution?

Answer: Subject to the proposed purpose, estimated cost, supporting rationale, and connection to the approved initiative. Applicants should be prepared to report on metrics listed in Section 3.1 and 3.1.1, as well as propose and report on metrics identified in Section 4.2.F.

217. **Question:** What pathways exist for successful projects to transition from grant-funded demonstrations to ongoing service contracts or other sustainable funding arrangements?

Answer: Applicants are expected to present a credible post-grant sustainability strategy per Section 4.2.G.

218. **Question:** 180-day outcome milestone. For a [target population] prevention use case, would intermediate measures such as postpartum blood pressure check completion, postpartum and well-child visit completion, and screening completion count as progress toward predetermined health outcomes? Is participant self-reported data acceptable where partner EHR data is not available?

Answer: Yes, potentially. Applicants shall report on metrics listed in Section 3.1, in addition to metrics identified in Section 4.2.F.

219. **Question:** For a non-diagnostic, non-treatment platform, would verified improvement in completion of clinician-directed chronic-disease follow-up—such as indicated primary-care visits, laboratory tests, or screenings—satisfy the six-month requirement for improvement toward predetermined health outcomes? If these measures are insufficient alone, must the project demonstrate a physiologic improvement, or would collecting a disease-specific clinical measure alongside improved care completion satisfy the milestone? Is a minimum effect size or statistical-significance threshold required?

Answer: Applicants shall report on metrics listed in Section 3.1, in addition to metrics identified in Section 4.2.F.

220. **Question:** How should applicants identify pre-existing software, models, workflows, and other background IP so it is distinguished from grant-funded developments? Do the government rights described in Section 6.15 attach only to funded works and applicable subject inventions, or can they extend to pre-existing components incorporated into the deployed product? Can applicants review the proposed subaward IP provisions before accepting an award?

Answer: Applicants should disclose pre-existing IP in their technical proposal. Typically, government rights attach to funded work. Applicants shall review IP provisions prior to accepting an award.

221. **Question:** Health outcomes. The six-month milestone asks for measurable progress toward a predetermined health outcome. For a non-clinical safety and social-connection tool, would outcomes such as change on a validated loneliness or social-isolation scale, faster response after a missed check-in, or connections made to primary care count?

Answer: Applicants shall report on metrics listed in Section 3.1, in addition to metrics identified in Section 4.2.F.

222. **Question:** Section 3.1 asks for "private capital catalyzed." Does customer revenue count, or only equity, loans, and non-public grants? Does capital raised for the company as a whole count, or only capital tied to the Virginia project?

Answer: Subrecipient shall track and report on federal, venture capital, and other funds, including dilutive and non-dilutive sources that are directed toward the innovation funded by the Tech Innovation Fund. Private sector capital catalyzed by the Tech Innovation Fund.

223. **Question:** Project completion and closeout: The RFA requires completion of project milestones by August 31, 2027, while certain final reports are due after the performance period. Could you confirm whether these reporting activities may occur after August 31 without affecting project eligibility or completion requirements?

Answer: All activities related to the award must be completed by August 31, 2027. The seven-day post-performance period is intended to provide time for report writing, invoicing, and other close-out activities. See also Answers to Question 186.

224. **Question:** Clinical performance versus operational outcomes: For a diagnostic technology, would metrics such as participating rural clinics, specimens processed, turnaround time, successful specimen transport, and provider adoption satisfy the required program outcomes, or must applicants also demonstrate measurable changes in patient health outcomes during the award period?

Answer: Applicants are required to adhere to required initiative-specific metrics identified in 3.1 and 3.1.1. Additional applicant-proposed metrics will be accepted in alignment with Section 4.2.F

225. **Question:** Does the requirement to initiate deployment within 90 days of award execution require the technology to be available for routine clinical diagnostic testing, or would activities such as rural clinic onboarding, specimen collection workflow implementation, provider training, and operational feasibility testing qualify as initial deployment while final laboratory validation is completed?

Answer: The RFA does not state what activities would meet the deployment milestone. Applicants should consider the program metrics, program objectives, and the program's purpose when evaluating and creating their project plan. Also see Answers to Questions 87 through 94.

226. **Question:** The RFA refers to a milestone six months after agreement execution, while the example documentation references a six-month post-deployment report. Could you clarify which date governs the milestone?

Answer: The milestone will be accomplished at six months after the agreement execution.

227. **Question:** Commercialization milestones and revenue generation: Must the proposed technology generate commercial revenue or demonstrate paid customer adoption during the award period, or can commercialization success be demonstrated through completed validation, operational deployment, provider adoption, and documented readiness for commercial launch?

Answer: The RFA does not explicitly state that the technology must generate commercial revenue or demonstrate paid customer adoption during the award period. However, applications will be evaluated on a credible post-grant sustainability strategy and ability to accomplish the metrics proposed in Section 4.2.F and 3.1.

Reminder: Under 2.2 Required Activities, Section 2.2A instructs applicants to provide compelling evidence that the proposed novel solution provides a **new capability**, a **new delivery model**, is **market-defying**, or a bridge to commercial viability with a clear and realistic path to becoming a self-sustaining product.