Rural Health Transformation Program Year 1 Notice of Grant Opportunities for Rural Hospitals, FQHCs, CCBHC/CMHC, and Tribal Nations Questions and Answers

MAY 22, 2026

Important updates

- Application deadline extended to May 26 at 4:30 p.m.
- Expenses may be eligible even if not named in the Notice of Grant Opportunity, if they align with RHTP goals and activity priorities, result in transformative change for organizations and communities, are sustainable, and meet all other RHTP funding requirements
- After you submit your application, MDH will continue working with you to finalize your plans

General RHTP

Q1. Our organization has a project that is set to launch soon. We have contracted for the expenses and made purchases. Can RHTP reimburse for any of these expenses?

A1. Given that the activity is already underway, this would not be an eligible activity for RHTP. Costs incurred prior to the execution of your grant agreement are not eligible for reimbursement. RHTP funds may not be used for any project or initiative that is currently funded (or planned to be funded) by other sources. All grant-funded activities must be either entirely new or expansions of existing activities. When expanding a project, grantees may only apply RHTP funds to costs associated with the new population and/or new activities. The costs of the original project must continue to be funded by their current funding sources. If there are additional components that the applicant would like to add to their project beyond what has already been planned and budgeted for using other funding sources, the applicant may propose that in their application.

Q2. We understand that 1:1 consultation is available to assist with our RHTP plan, is the TA request form the way to make this request?

A2. ORHPC is available to provide technical assistance to eligible applicants listed in the Notices of Grant Opportunity. The TA Request Form is the way to request this assistance.

To ensure that we're able to provide clear and consistent guidance, we ask that organizations submit specific questions regarding their potential work plan and budget. Due to the volume of needed technical assistance for all entities, general consultation session requests without specific questions will be sent back with a request for specific questions. Please be sure to submit all specific questions and requests through the RHTP Application Technical Assistance Request form.

Thank you for taking the time to submit questions; we look forward to assisting you in your application development.

Q3. Under Section 2.1 Priorities we see workforce initiatives are listed, but don't see any workforce options in our Notice of Grant Opportunity. We also see other initiatives listed more than once. Could you please explain?

A3. The priorities listed in section 2.1 are the overall Rural Health Transformation Program priorities, which include workforce initiatives. Initiative 2 Recruiting and Retaining Talent in Rural Communities is not part of the Notices of Grant Opportunity for the entities eligible for a direct allocation of RHTP funding (the rural hospitals, FQHCs, CCBHCs/CMHCs, and Tribal Nations listed in Attachment A of each Notice of Grant Opportunity).

Several competitive grant opportunities related to Initiative 2 workforce activities will become available later this spring. Please watch the RHTP Funding website for competitive applications your organization may be eligible for. Entities receiving a direct allocation are in many cases also eligible for competitive funding opportunities.

Regarding Initiative 3, please note that in each Notice of Grant Opportunity for direct allocation entities, there are multiple activities that fall under the initiatives, which is why you see Initiative 3 twice. Organizations must select at least two different initiatives to work in, but do not need to select all activities under each initiative.

Q4. Must all projects for eligible hospitals align with the activities listed in the NOGO, and the "Eligible Projects and Expenses" listed for each activity? Or can proposed projects be closely related?

A4. Eligible hospitals must select activities from the list of eligible activities in the hospital direct allocation Notice of Grant Opportunity. Proposed projects must align with these activities. There may be work related to a particular activity that is not explicitly described in the Notice of Grant Opportunity but is eligible as part of a grantee's work on that activity. Applicants are encouraged to carefully review the priorities, activities, eligible projects and expenses, and required data reporting in the Notice of Grant Opportunity. If you have specific questions about your project's alignment with eligible activities, please send questions via the TA Request Form and we are happy to meet to discuss your project.

Q5. Could you confirm whether MDH will be approving applications on a rolling basis given that you're accepting applications on a rolling basis?

A5. MDH is accepting and reviewing applications on a rolling basis and will be executing grant agreements on a rolling basis. The final deadline for applications in response to the direct allocation Notices of Grant Opportunity is May 26, 2026 at 4:30 p.m., but we encourage applicants to submit early in the application period so that your grant agreement may be executed sooner.

Q6. Do we know any more about potential claw back if a facility isn't able to reach the targets?

A6. CMS, MDH, and subrecipients share the goal of a successful Rural Health Transformation Program. Funds would only be recouped (clawed back) from a subrecipient if it was discovered that the funds were spent in ways that did not comply with RHTP requirements. This would be unlikely, as funds are paid to subrecipients on a reimbursement basis, and MDH reviews documentation of all expenses incurred and paid by subrecipients prior to reimbursing those costs.

Funding in future budget periods will be impacted by subrecipients' progress toward initiative goals and activity outcomes, as CMS will assess Minnesota's progress in determining whether to make awards in future budget periods and the size of any award. With proactive, open communication between MDH and grantees, we hope to be able to mitigate any challenges impacting grantees' progress in their activities. It is important that grantees report their progress and any concerns in their bimonthly progress reports, so MDH can support the continued success of each grantee and RHTP as a whole.

Q7. Is a new staff person an allowable expense if some services are billable?

A7. Salaries are allowable only if directly related to RHTP, and only the portion dedicated to RHTP work may be paid with RHTP funds. Salaries are allowable only if they are not covered by another funding source; RHTP funds may not be used to supplant an existing funding source for salaries. Payment for direct health care services is unallowable; this includes replacing payment for clinical services that could be reimbursed by insurance or another form of health coverage. This also includes payment for clinical services if they duplicate billable services and/or attempt to change the payment amounts of existing fee schedules. Salaries are subject to the annual salary cap; see Attachment C in the Notice of Grant Opportunity for details. All salaries and hourly rates must be reasonable and justifiable.

Q8. We are in the process of becoming a CCBHC. Does that make our organization eligible to apply for funding?

A8. For the first budget period, only the entities named in Attachment A of each Notice of Grant Opportunity are eligible to apply for these direct allocation funds. Your organization may be eligible for upcoming competitive funding opportunities and may be eligible for a direct allocation in future budget periods.

Q9. We are a mental and behavioral health center that is not listed as an eligible entity. What are the criteria we need to meet to be listed?

A9. The CCBHCs and CMHCs eligible for direct allocations in the first budget period were determined based on the following information from the Centers for Medicare and Medicaid Services (CMS):

Report the most current list of Certified Community Behavioral Health Clinic (CCBHC) entities within your State as of September 1, 2025, every active site of care associated with each CCBHC entity, and the address of every active site of care. In the absence of this information on your application, CMS will estimate the number of CCBHCs in your State using the most recent list of Certified Community Behavioral Health Clinics (CCBHCs) as maintained by SAMHSA, CCBHCs supported through the Section 223 CCBHC Medicaid Demonstration and through SAMHSA administered CCBHC Expansion (CCBHC-E) Grants, and State-certified CCBHCs listed on State government websites for States that use other Medicaid authority to designate CCBHCs (such as Medicaid State Plan rehabilitation authority). The addresses of the sites of these CCBHCs, as available, are compared to rural area designations using the current HRSA definition of rurality to determine whether a CCBHC is in a rural area.

MDH applied this guidance to Community Mental Health Centers as well. In Minnesota's application, a list of all active CCBHCs and CMHCs as of September 1, 2025 that met the Health Resources & Services Administration (HRSA) definition of rurality was submitted.

Q10. If we don't apply under this NOGO for Year 1 Direct Allocation grants, can we apply next year or in subsequent years?

A10. If an eligible organization does not apply for a year 1 direct allocation grant, they may apply in future years. We strongly encourage eligible applicants to apply in year 1.

Q11. Please say more about the Single Audit requirement. Does that pertain to a certain initiative, and if so, which one?

A11. A Single Audit is required for non-federal entities (such as nonprofits, governments, and Tribal Nations) that expend $1 million or more in federal awards during their fiscal year. This includes federal awards that are passed through, or subgranted, to the organization by the state. This requirement does not pertain to a certain initiative, but rather the entire federal award that an organization expends during their fiscal year. For some entity types eligible for a RHTP direct allocation, the estimated award exceeds $1 million. An organization that spends an RHTP award of $1 million or more during their fiscal year would need to complete a Single Audit. A Single Audit involves a financial statement audit and compliance review, with reports filed with the Federal Audit Clearinghouse within 30 days of receipt or nine months after fiscal year-end.

Q12. If we do not select to pursue a certain initiative, do we still need to provide the baseline data as part of the application for that initiative?

A12. You do not need to provide baseline data for activities your organization does not participate in. Baseline data is only required for the activities you select to implement. As you select activities within the online application, questions will appear pertaining to those activities.

Q13. Will there be ways to be reimbursed for purchases and such faster than every two months when reporting?

A13. Organizations may request to submit financial reports (reimbursement requests) and progress reports monthly or more frequently, and MDH will strive to accommodate those requests. Please note that an updated progress report must accompany every financial report (reimbursement request).

Q14. Our organization only has one project idea. I see that the grant stipulates that you must have projects that meet the needs of two initiatives. If we are not asking for the full $1.4 million estimated award for a rural hospital, and instead are focusing on the one project that is meaningful to our area and that we have capacity for, is it ok to submit for just one of the initiatives?

A14. All organizations must select activities in at least two initiatives to implement when accepting these funds. We appreciate your organization's focus on projects that are meaningful to your community and feasible for you to complete. You might consider a second activity that is smaller in scope or an expansion of an activity that has been successful for your organization. You might not need or request the full award amount even for two activities from two different initiatives. We would be happy to meet with you to discuss your ideas and other activities you might consider.

Q15. I noted in the NOGO that MDH is requesting a budget and work plan. I am not seeing a spot for submission of those documents in the grant portal. Are these submitted in the grant portal?

A15. Yes, work plans and budgets are submitted as part of the application via the grants portal. Once organizations select their activities in the online application, a section for each activity will open up where applicants will complete an activity-specific work plan and budget. When planning their budgets, applicants should consider how to spread their award amount across their selected activities.

Q16. Can we modify our proposed timeline tailored to the original plan and make modifications based on emerging needs?

A16. Organizations should be in regular communication with their grant manager to discuss potential modifications to timelines and other aspects of activity implementation and the reasons for the changes. MDH appreciates grantees' responsiveness to the emerging needs of their patients and communities, while also encouraging grantees to stay focused on timely and successful completion of their work plan. Each year, organizations will submit a new work plan and budget for their ongoing activities and any new activities. MDH may approve modifications during the budget period on a case-by-case basis.

Q17. We are looking at expanding services in a small area and will have trouble meeting the metrics for Minnesota's RHTP.

A17. Some of the performance goals and target numbers are for Minnesota's RHTP as a whole, not for each individual organization. Organizations should set feasible goals and focus on improving from their baseline.

Q18. When a hospital has a separate state grant — such as the Rural Hospital Capital Improvement Grant — funding related but distinct work in the same building, what level of documentation does MDH require to demonstrate separation between RHTP expenditures and the other grant? Is it sufficient to maintain separate contractor scopes of work, separate invoicing, and separate draw schedules, or are additional controls expected?

A18. Documentation including separate contractor scopes of work, separate invoicing, and separate draw schedules will be helpful to demonstrate separation of RHTP and non-RHTP grant work. Grantees should implement fund accounting, in which income and expenses related to grant projects are maintained as separate lines in their general ledger. All grantees will also submit supporting documentation with each invoice to show expenses incurred and paid. Expenditure documentation should include invoice numbers and dates.

Q19. Is the $1.4M cap fixed for all hospitals or does it vary by hospital size or other criteria?

A19. Each rural hospital named in Attachment A of the Notice of Grant Opportunity is eligible to receive $1.4 million in budget period 1 with an approved application.

Q20. Is there a support group for all participants to share questions during application development?

A20. MDH is working to put together various opportunities for organizations to share ideas. Please watch for communication regarding these opportunities.

Q21. On Page 58 of the Notice of Grant Opportunity, it states that "Payment for direct health care services is unallowable." Can this be clarified - does this mean that services to be provided under this grant cannot be billable?

A21. Correct: any costs that are billable cannot be funded by RHTP. Replacing payment for clinical services that could be reimbursed by insurance or another form of health coverage is unallowable. So are payments for clinical services that duplicate billable services and/or attempt to change the payment amounts of existing fee schedules.

Q22. Where is the slide deck from the informational webinars located?

A22. The slides for the informational webinars are available on MDH's RHTP Funding website (https://www.health.state.mn.us/facilities/ruralhealth/ruraltrans/grants.html)

Q23. Where can I find the RUCA score for locations?

A23. Find the RUCAs and their associated zip codes posted to the ORHPC Funding webpage (https://www.health.state.mn.us/facilities/ruralhealth/funding/grants/docs/mnruca.xlsx)

Q24. The RFP states that "award amounts may vary from the estimated amounts depending on the number of eligible entities that apply and the amounts requested by eligible applicants." Would leftover funds be reallocated among Minnesota applicants, or would they be automatically returned to CMS? How does that impact Minnesota's overall award? If facilities cannot meet the $1.4M maximum award amount, how does that impact award allocations in Y2-5?

A24. If funding remains after all eligible applicants that submitted by the deadline have received their grants, additional funds may be offered to those grantees, or a new Notice of Grant Opportunity may be published. If funding remains after all eligible entities have had an opportunity to request funds, funding may be redirected toward other, competitive RHTP grant programs. Funds that are not spent by the end of the spending period (September 30, 2027) will be returned to CMS and redistributed across states. CMS will assess Minnesota's

overall progress toward initiative-based checkpoints in determining awards for budget periods 2-5. Direct allocations for eligible entities in budget periods 2-5 will not be based on past spending by those entities. If an entity has struggled to spend down their funding, MDH will work with that entity to address spending challenges and propose feasible plans for future spending.

Q25. We currently contract with a third party for our ER/Hospitalist Provider coverage. Would the development of our own employed ER/Hospitalist department staff quality for funding under the MN RHTP?

A25. We will need more information in order to determine the eligibility of this expense. It is important to demonstrate which activity this project falls under and its connection to the purpose and priorities of that activity as well as overarching RHTP goals.

Q26. Will we be able to apply for competitive grants for our emergency medical services (EMS) funding? It has a separate cost center from the hospitals.

A26. The Minnesota Office of EMS will administer Treatment in Place grants later this year. Watch for those funding opportunities.

Q27. Is participation in and/or development of a structured Emergency Department bootcamp for Advanced Practice Providers (APPs) practicing in a rural hospital setting an eligible project? The bootcamp will focus on acute care decision making, high risk presentations, and rural emergency medicine. The training is intended for APPs who staff or will staff the Emergency Department.

A27. In order to make a full determination, MDH will need additional information. Competitive grant opportunities under RHTP for APP rural training will be available later this spring and may be better suited to this project.

Q28. Our system has eight eligible hospitals. Will it be permissible to apply as a system and include the eight RHTP sites under one application? As a system with multiple eligible hospitals for this program, we are concerned about where expenses originate as it pertains to eligibility for costs. There are some costs that are at the system level such as IS/IT programs. Can

program costs originate at the system level and then be formulaically allocated to RHTP sites?

A28. A separate application must be submitted for each named entity. If the parent company or system is applying on behalf of the named entity or needs to be the primary signer, indicate that in the Authorized Organization Representative field in the application. A portion of each location's budget may go toward activities conducted across eligible locations, if relevant. If a local site has expenses that originate at the system level, the local site will need to provide documentation as to how that cost is assigned to them. This could include, for example, a policy document or itemized invoices from the system to the local site. If a system has similar activities proposed for each of its eligible hospitals and would need to copy and paste a lot of data between applications, systems may request that MDH duplicate applications on the back end. To do this, please contact hospitals.ruraltransformation.mdh@state.mn.us.

Q29. Our system operates different hospitals with unique entity identifiers (UEI) under the parent entity. Since the system is responsible for infrastructure support for all entities including financial grant management and facilitation of an annual Single Audit, could the system apply on behalf of multiple hospitals for a combined award to be equally distributed for specific programs at each site?

A29. A separate application must be submitted for each named entity. If the parent company or system is applying on behalf of the named entity or needs to be the primary signer, indicate that in the Authorized Organization Representative field in the application. A portion of each location's budget may go toward activities conducted across eligible locations, if relevant. If a local site has expenses that originate at the system level, the local site will need to provide documentation as to how that cost is assigned to them. This could include, for example, a policy document or itemized invoices from the system to the local site. If a system has similar activities proposed for each of its eligible hospitals and would need to copy and paste a lot of data between applications, systems may request that MDH duplicate applications on the back end. To do this, please contact hospitals.ruraltransformation.mdh@state.mn.us.

Q30. As a part of a system, our hospitals are focusing on a couple areas under Initiative 5 and 1: RPM and fall prevention. Will have focus on workforce development and training. They are operating in multiple states and want to allocate these expenses appropriately by state. Are there existing frameworks for allocating the expenses?

A30. If a local site has expenses that originate at the system level, the local site will need to provide documentation as to how that cost is assigned to them. This could include, for example, a policy document or itemized invoices from the system to the local site.

Q31. Initiative 2 — Workforce. Education Coordinator, rural family medicine residency (U of M), simulation lab, paid HS internship program. Not available Year 1? Are paid HS internships eligible or flagged as HR costs?

A31. These may be eligible under RHTP. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q32. Could you please expand on the % of funds allocated over the 5-year grant (ex: 70% in year 1, but 45% in future years)? Do these %'s apply to the total funds allocated by CMS to MN each year? How does this change in % of funds allocated affect the max amount that could be awarded to each rural hospital, assuming the amount allocated to MN does not change?

A32. Hospitals will receive 70% of MN's award from CMS in year one and 45% of MN's award in years 2-5. In year 1, hospitals will each receive a maximum of $1.4 million. If MN's award remains the same in years 2-5, hospitals would each receive approximately $924,300 each year for years 2-5.

Q33. Where does the remaining 30% of funding go in Yr 1, as well as the remaining 55% in years 2-5?

A33. 97.69% of MDH's award is going out in outgoing funds. This includes 5% to Rural FQHCs, 2% to Rural CCBHCs/CMHCs, 2% to Rural Tribal Nations, competitive opportunities, and direct grants for expansions of existing work. MDH's administration of the entire program is 3%.

Q34. On the criteria of supplantation, what other funding sources apply? If we have projects that are "in the pipeline", and the plan was to assess whether or not we could afford to fund out of operations, would those projects (assuming eligibility otherwise) be ineligible because we conceptually were planning to fund those projects from cash flow from operations?

A34. Organizations need to demonstrate that the program being considered is not fundable in any other way. If it has been considered and other funding sources are available, these may not be eligible expenses.

Organizations should submit specific questions around projects and other funding source availability in their 1:1 TA requests.

Q35. Will the base year be fully obligated and funded to the eligible facility for the base year or is incremental funding subject to monthly or periodic flow down funding obligations from CMS?

A35. Base year funds will be fully encumbered and allocated to each organization upon contracting. Organizations will not receive the funding until they submit reimbursement requests demonstrating the expenses have been incurred and paid.

Q36. For Initiative 4, you didn't mention the OB ROSE and ECHO programs. Is this an activity that is available to hospitals under initiative 4 during Year 1?

A36. The MN ROSE program is currently being expanded with RHTP funds. A separate competitive Request for Proposal for the ECHO program was issued on May 4, 2026. Once these programs are in place, rural hospitals will be eligible to receive the benefit and services from these providers at no cost to the hospitals and other organizations that would like to participate.

Q37. How much should we be describing and budgeting year 2-5 activities in our application, given that the total award and disbursement adjustments are unknown (besides the stated 45%)?

A37. Applicants only need to budget and provide workplans for budget period 1. In your project proposal, you may discuss broadly how this project will continue in future years, but you do not need to provide specifics at this time. Each year, grantees will submit additional workplans and budgets for the continuation of their activities.

Q38. How much detail should we provide in our budget?

A38. Budgets and budget narratives should be as detailed as possible. Please describe each expense and how it relates to your organization's selected activities. Include, for example, the unit cost of individual items multiplied by number of units for supplies, or hourly rate times number of hours for salary.

Q39. What would happen if not all awarded funds would not be spent by October 2026/September 2027?

A39. CMS will reclaim funds not spent by the end of the budget period.

Q40. Are there specific requirements for the record keeping of the grant funds or is the organization responsible for tracking and reporting?

A40. Grantees must maintain all records related to the grant programming per the MDH grant contract template: "The relevant books, records, documents, and accounting procedures and practices of Grantee and any entity with which Grantee has engaged in carrying out the purpose of this Grant Agreement are subject to examination under Minn. Stat. § 16B.98, subd. 8. Examinations may be conducted by MDH, the Minnesota Commissioner of Administration, the Minnesota State Auditor, Attorney General, or and the Minnesota Legislative Auditor, as appropriate, for a minimum of six years from the end of this Grant Agreement, receipt and approval of all final reports, or the required period of time to satisfy all state and program retention requirements, whichever is later."

Q41. We are seeking clarification on how MDH defines "expansion" in the RHTP context. Does it include: Reorganization or redeployment of existing staff into population health roles, Scaling existing programs (e.g., community-based initiatives) to increase reach, capacity, and impact, and Understanding expectations for demonstrating net-new versus enhanced services versus what is existing.

A41. Expansion will be considered on a case by case basis. It hinges on being able to increase capacity which could not have otherwise been done without RHTP funding. Increasing reach, capacity and services does fall under the expansion definition.

Q42. Are we able to submit 2025 baseline data only using dates of service between 4/1/2025 and 12/31/2025 due to changing EHRs in calendar year 2025?

A42. Organizations should make every effort to provide baseline data for the entire calendar year in 2025, however if this data is inaccessible, an organization can submit the data available to them but should note the time period from which data originates.

Q43. What justification is needed to ensure we are able to get the budget extension?

A43. Grantees should communicate regularly with their grant manager about their expenditures and timelines, including whether they will be able to spend down all funds during the budget period (budget period 1 ends 10/30/26) or need to continue spending in the extended spending period, which ends 9/30/27. Regular progress reporting helps MDH understand the unique needs of each grantee. Note that all budget period 1 funds must be spent by 9/30/27. CMS does not allow carryover of funds beyond that date.

Q44. What if portions of the project have purchase orders that have already been signed?

A44. No work on grant activities can begin until a fully executed grant agreement is in place and the State's Authorized Representative has notified the grantee that work may start. This includes signing purchase orders.

Q45. Are we able to qualify for any funding if we do not have selected programs under two of the criteria areas?

A45. No. Direct allocation grantees must select at least two initiatives to participate in.

Q46. Do our projects still qualify if a formal RFP has not been completed?

A46. For all RHTP programs, a detailed application and budget must be written and submitted to MDH. MDH cannot contract with an organization who has not submitted a response to the Notice of Grant Opportunity. Note, this is not a Request for Proposal as these are not competitive funds.

Q47. Is program evaluation an allowable expense? While "research" is excluded, can staff time be used for evaluation and measurement of activities?

A47. Staff time can be utilized for program evaluation and reporting but will count towards your 6% administrative cost limits. Note that program evaluation activities that are integral to implementing and continually improving your program, including collecting and using data to implement your activities, will generally be considered programmatic costs, not administrative costs. But costs associated with reporting data to MDH are administrative.

Q48. Can RHTP be used to strengthen specialty recruitment to meet growing community needs, with a focus on additional General Surgery capacity, clinic-based Neurology, clinic-based Cardiology, and other high demand specialties identified through ongoing service area analysis?

A48. Specialty recruitment is not an allowable expense under RHTP.

Timeline

Q1. Are grantees allowed to spend awarded funds through Sep 30 of the following fiscal year?

A1. Grantees are strongly encouraged to spend their funds fully in each budget period. If a compelling need arises, grantees are allowed to continue spending for up to 11 months beyond the budget period (through September 30, the end of the following federal fiscal year). However, CMS will evaluate Minnesota's spending and progress toward our goals and metrics at the end of each budget period. Our results during the budget period will determine whether Minnesota receives an RHTP award for the next budget period and the amount of that award.

Q2. Are grantees allowed to spend through Sep 30, 2031? Why does our grant agreement only go through Oct 30, 2030?

A2. CMS may allow states to continue spending funds through September 30, 2031, in which case MDH will execute a new grant agreement for work taking place between October 30, 2030 and September 30, 2031. The current Notice of Award from CMS to states goes through Oct 30, 2030.

Q3. Please confirm when the funds need to be spent by for Budget Period 1.

A3. Budget period 1 goes from your Grant Agreement execution date through October 30, 2026. Because budget period 1 is so short, all grantees will be able to spend funds through September 30, 2027; work plans and budgets may reflect that time period. In budget periods 2-5, grantees are strongly encouraged to spend their funds fully within each budget period. In those future budget periods, if a compelling need arises, grantees are allowed to continue spending for up to 11 months beyond the budget period (through September 30, the end of the following federal fiscal year). CMS will evaluate Minnesota's spending and progress toward our goals and metrics at the end of each budget period. Our results during the budget period will determine whether Minnesota receives an RHTP award for the next budget period and the amount of that award.

Q4. Due to the short timeframe, September 2027 is the deadline for year one, correct?

A4. Yes, September 30, 2027 is the end of the spending period for budget period 1.

Q5. Our project involves procurement, renovation, equipment installation, and Epic integration — all within BP1 funds that can be spent through September 30, 2027. For hospitals with technology and minor renovation

projects under Initiative 5.2, is it acceptable for the work plan to show procurement and renovation occurring in the first half of the extended spending period and technology installation and go-live occurring in the second half, with spending extending through September 30, 2027? Or does MDH expect measurable technology deployment outcomes by October 30, 2026?

A5. Grantees should make every effort to conduct activities within the budget period. CMS allows for continued spending for the first budget period through September 30, 2027. Grantees should outline their work plan with estimated timeline accordingly, including spending beyond October 30, 2026 when necessary.

Q6. If we follow the estimated timeline, what costs would be allowable during budget period 1 considering it's a majority of planning? Would staff/committee time be eligible?

A6. Staff and committee time for planning in budget period 1 are allowable as are implementation related expenses, though MDH recognizes implementation related expenses may not be a large portion of budget period 1.

Selecting initiatives and activities

Q1. Can these investment areas change from year to year, or does it have to be the same area for 5 years?

A1. The initiatives in year 1 are not the only initiatives organizations can participate in during years 2-5. Each year when MDH requests a new work plan and budget, organizations will have the opportunity to add new activities. Please note that it takes time to demonstrate transformative impact, so organizations are encouraged to continue activities over multiple years. If an organization does not elect to add more money to an activity in future years, they will still be required to report on the previous activities implemented in order to demonstrate change over the 5 years of the RHTP.

Q2. If we select certain activities in year 1, but then our evaluation of the program shows we should move to a different approved activity, can we renegotiate our work plan?

A2. The activities in year 1 are not the only activities organizations can participate in during years 2-5. Each year when MDH requests a new work plan and budget, organizations will have the opportunity to add new activities. Please note that it takes time to demonstrate transformative impact, so organizations are encouraged to

continue activities over multiple years. If an organization does not elect to add more money to an activity in future years, they will still be required to report on the previous activities implemented in order to demonstrate change over the 5 years of the RHTP. Organizations should be in regular communication with their grant manager to discuss potential changes to the way an activity is implemented or reasons why they may not continue an activity.

Q3. If we are funded in Year 1, are we committed to conducting activities in subsequent years?

A3. Organizations that receive a grant in year 1 are not committed to accepting additional funds in subsequent years. However, they are committed to continuing to report on the implementation of the year 1 activity, in order to demonstrate change over the 5 years of the RHTP. Please note that it takes time to demonstrate transformative impact, so organizations are encouraged to continue activities over multiple years.

Q4. Is a single campus project with costs allocated between Initiative 4 and Initiative 5 using a consistent methodology acceptable, or would MDH prefer separate project narratives per initiative?

A4. Organizations will submit one application that encompasses all of their initiatives and activities. Within that application, applicants will provide narratives, work plans, and budgets for each activity separately.

Q5. Do hospitals have to keep deploying the same two activities every year or can they shift how they use the $1.4M annually?

A5. The activities in year 1 are not the only activities organizations can participate in during years 2-5. (Note: the allocation for hospitals decreases in years 2-5 as outlined in the Notice of Grant Opportunity on page 5). Each year when MDH requests a new work plan and budget, organizations will have the opportunity to add new activities. Please note that it takes time to demonstrate transformative impact, so organizations are encouraged to continue activities over multiple years. If an organization does not elect to add more money to an activity in future years, they will still be required to report on the previous activities implemented in order to demonstrate change over the 5 years of the RHTP. Organizations should be in regular communication with their grant manager to discuss potential changes to the way an activity is implemented or reasons why they may not continue an activity.

Q6. The NOGO states, "Each year MDH will amend the grant agreement to add funds based on that year's CMS award to Minnesota and the allocation formulas outlined above." Would this allow our hospitals in other

initiatives to be added in future years if not included in year 1? Or, are we restricted to the initiatives that we select for year 1?

A6. The initiatives in year 1 are not the only initiatives organizations can participate in during years 2-5. Each year when MDH requests a new work plan and budget, organizations will have the opportunity to add new activities. Please note that it takes time to demonstrate transformative impact, so organizations are encouraged to continue activities over multiple years. If an organization does not elect to add more money to an activity in future years, they will still be required to report on the previous activities implemented in order to demonstrate change over the 5 years of the RHTP.

Q7. Which activities should we focus on for Year One and which should we focus on in Year 2? We are looking at activities in Initiative 1 to advance RHTP goals but are still considering our options.

A7. In year 1, organizations are encouraged to focus on activities that lay the foundation for longer-term, sustainable success, such as investments in planning, infrastructure, and tools. Year 1 projects must be feasible, as the timeline for spending funds and making progress is short. Initiative 1 activities can certainly meet these criteria. In year 2, organizations will build on the foundation they have created in year 1 and may also branch out into additional activities that work together to advance RHTP goals. Please consider that MN's award from CMS in years 2-5 is unknown. Hospitals specifically should consider that their direct allocation amount in years 2-5 (pending MN's award from CMS) will be 45% of MN's RHTP award divided among all 94 eligible hospitals, rather than 70% of MN's RHTP award divided among all 94 eligible hospitals as it is in year 1. There will be more competitive funding opportunities offered in year 2 for which direct allocation recipients may also be eligible.

Q8. Is the RHTP grant limited to the Activities specifically stated for each initiative?

A8. Rural Hospitals, Rural FQHCs, Rural CCBHCs/CMHCs and Tribal Nations are limited to the activities outlined in their respective Notice of Grant Opportunity. The activities available to each entity may change each year. In addition to a direct allocation award, these entities may also be eligible for competitive opportunities to fund other activities. Please watch MN's RHTP funding site for competitive opportunities.

Consulting, contracting, and subcontracting

Q1. Questions from contractors - Are members or customers allowed to use our services for their RHTP programming, for example to hire out services such as evaluation and measurement?

A1. It is up to each eligible applicant entity to determine what their activities are and how their funds are spent. Activities must be eligible and approved by MDH and CMS. If an eligible applicant entity has specific questions,

they can reach out to MDH to request answers and technical assistance through the RHTP Application TA Request Form (MS Form) (https://forms.microsoft.com/pages/responsepage.aspx?id=RrAU68QkGUWPJricIVmCjGG4ndZDcqNMhwhz9CfuprdUMkY1VlkxMFo4UjJSRDgwSUlaUkFMSVpFSC4u&route=shorturl).

Q2. Our hospital is listed as an eligible entity to apply for RHTP funding, we were hoping that some of our activity could be operated out of another service line of our organization like our long-term care or rural clinic. Are we allowed to use funds for these activities?

A2. The hospital is the entity receiving the award, but affiliated services operated by the hospital, such as clinics and long-term care, may be involved in the delivery of activities as appropriate. Eligible rural hospitals and other eligible entities may also choose to subcontract with other organizations that are not directly affiliated with the eligible entity. The application submitted to MDH by the eligible entity should detail which parts of the applicant organization and/or other organizations are involved with each component of the work plan and budget.

Q3. Would you please confirm that consulting services are eligible costs under all initiatives, or advise if not allowable. If we plan to work with a contractor that we onboarded through a compliant competitive bidding process, will an amendment to that contract suffice or will we be required to re-initiate the contracting process?

A3. Consulting services may be eligible costs. Please note that consulting services may be considered administrative costs if they are not directly related to implementing/delivering activities. For example, consulting services related to accounting, audits, or reporting to MDH would be considered administrative costs and count toward the 6% cap. If a consultant designs a training for community participants as part of an activity, for example, those costs would not be administrative. If you already have a contract with a consultant through a compliant competitive bidding process, you may amend that contract to add RHTP work, but there must be a separate work plan and budget for the RHTP work. It must be very clear that the RHTP work is new and different from the work the contractor was previously doing or planned to do. RHTP funds may not be used to continue existing work or for work that is funded by, or planned to be funded by, other sources. When submitting your application to MDH, provide as many details about any subcontracts as possible, even if vendors have not yet been selected.

Q4. Do applicants need to have solid quotes from vendors before the application deadline of May 26? Or can our application include our best estimates of costs?

A4. You do not need to have solid quotes from vendors when applying to MDH. Include your best estimates of costs, based on your research and information-gathering, in your budget. All applicants are asked to indicate which parts of their project will require contracts, to describe their organization's procurement process, and to name any identified contractors or indicate a timeline for completing the procurement process in compliance with MDH contracting and bidding requirements for grantees. MDH will allow budget revisions on a case-by-case basis if your budget changes after you complete your procurement processes.

Q5. As a vendor that provides an evidence-based physical activity intervention that directly impacts cardiometabolic health, how do we effectively connect with MN rural hospitals? Is there a way to create visibility that we can help a rural hospital reach rural populations?

A5. Organizations are encouraged to research vendors that best meet their needs. MDH does not have a mechanism for vendors to connect with eligible grantees.

Q6. If a clinic is affiliated with an eligible hospital under the same EIN, can its activities be included under the hospital's application?

A6. The hospital is the entity receiving the award, but affiliated services operated by the hospital, such as clinics and long-term care, may be involved in the delivery of activities as appropriate. Eligible rural hospitals and other eligible entities may also choose to subcontract with other organizations that are not directly affiliated with the eligible entity. The application submitted to MDH by the eligible entity should detail which parts of the applicant organization and/or other organizations are involved with each component of the work plan and budget.

Q7. Are subcontracts allowable (like partnering with and subcontracting some funding to a community-based organization as part of the project)? Given that much of the work is about collaboration with community-based organizations, we would like to support their capacity to participate.

A7. Eligible entities may choose to subcontract with other organizations. The application submitted to MDH by the eligible entity should detail how the subcontracted organization is involved in the project, and their role should be clear in the work plan and budget. Note that all funding requirements in place for grantees also flow down to any subcontractors. MDH and CMS will review all work plans and budgets and will need to approve subcontracts as part of that review.

Q8. If we expand work with existing vendors/contractors, do we need to go through the formal state required procurement and bidding processes?

A8. In your application, you will outline your procurement process. The Notice of Grant Opportunity state: Which parts of your project will require contracts for services, equipment, or supplies? Describe your organization's procurement process. If you have already identified contractors/suppliers, please name them here. If you have not yet completed the procurement process, please indicate your timeline for doing so. (Note that costs incurred prior to your grant agreement execution date will not be reimbursed. Please review the Contracting and Bidding Requirements in the sample grant agreement on the MDH Grant Resources webpage and ensure that your organization's procurement process aligns with those requirements.)

Q9. Do you provide a list of vetted vendors to applicants? Have you thought about a "speed dating" opportunity or any activity for applicants to learn about vendors like other states have done?

A9. State of Minnesota Procurement Policies prevent MDH from offering a list of vetted vendors. Organizations are encouraged to research vendors that will best suit their needs.

Minor renovations and alterations

Q1. What do you consider minor renovations or alterations?

A1. Examples of minor renovations or alterations include, but are not limited to, installing or relocating interior walls and partitions; upgrading lighting to more energy-efficient systems; replacing vents and thermostats for better climate control; installing automatic door openers to enhance accessibility; converting private offices to a more open office layout; moving electrical outlets; adding wiring necessary for equipment for an activity; or adding soundproofing to a room. Please request an individual TA meeting with MDH to discuss your selected activities and related minor renovation/alteration needs.

Q2. Would room reconfiguration qualify as minor renovation if we demonstrate that it directly relates to Initiatives 4 and 5, given that the renovation enables technology deployment and the MOUD clinical model?

A2. Room reconfiguration may qualify as a minor renovation and may be eligible if it is clearly aligned with the priorities of the activity.

Q3. Can RHTP funds be used to purchase a new clinical space or just to remodel the space for future use?

A3. RHTP funds cannot be used to acquire a new space. Construction costs are not allowable. Requests to fund minor renovations/alterations may be eligible if the project is clearly linked to program goals.

Q4. We are considering operating rooms expansion and remodeling. Is this an allowable project under RHTP?

A4. Construction costs, such as operating room expansion and remodeling, are not eligible under RHTP. Minor renovations/alterations may be eligible, such as minor alterations needed to accommodate the installation of new tools.

Q5. Can RHTP be used for redesigning outreach and clinical spaces, including updating outreach sites and hospital space to support increased specialty outreach in surrounding areas; creating dedicated clinical space on the hospital campus for on-call specialties; reconfiguring the main clinic to improve patient flow and accommodate additional specialty recruitment; and recruiting specialties that are needed?

A5. Only minor alterations/renovations are allowed; construction is not allowed under RHTP.

Q6. ER Safe Room - $500,000 to renovate the ER space to allow for safety for patients, workers, HIPAA, separate ER waiting securely providing barrier to rest of hospital, and build a safe room for mental health patients.

A6. Construction for this project is not allowed under RHTP.

Q7. Endoscopy Suite - Renovate the prior pharmacy into a Endoscopy suite. This would facilitate different OR space for clean and dirty procedures resulting in better infection prevention practices. Currently, only one OR room is available today for both endoscopy procedures and all other operating room procedures.

A7. The description of room changes as described is construction, which is not allowable under RHTP.

Q8. For minor renovations that require MDH and CMS prior approval, what is the approval process and timeline? Specifically, is prior approval addressed during the application review and contracting phase, or must it be obtained separately before or after the grant agreement is executed? Our concern is aligning renovation timelines with technology procurement so that rooms are ready when equipment arrives.

A8. All proposals, including minor renovations, will be reviewed and approved or denied during the contracting process.

Initiative 1

Q1. We'd like to understand the potential allowable relationship of activities between chronic disease prevention and management and pharmacists' role in comprehensive medication management. Could you explain if this is an allowable project for RHTP?

A1. Multi-disciplinary teams and pharmacist-led interventions to support chronic disease management specifically around cardiovascular disease, hypertension, high cholesterol, diabetes, and chronic kidney disease are acceptable approaches. This includes medication management, patient counseling, leading of evidence-based programs, and support for clinical interventions such as continuous blood glucose monitoring and self-measured blood pressure. We view this role as appropriate to help patients manage risk factors prior to a clinical event or hospitalization as well as part of the suite of care services offered post-discharge after a hospital event.

Q2. Under Initiative 1, the activity related to physical activity, nutrition, and upstream drivers of health referrals: Are we limited to state programs such as ProduceRx or Walk with Ease, or can we do our own in-house programs in partnership with community-based programs?

A2. Programs in Initiative 1 for physical activity and nutrition upstream health supports can include evidence-based or promising practice programming, including in-house programming. In your application, provide a clear, thorough description of the program and explain how it is evidence-based or a promising practice. If you have more questions about your particular program, we would welcome an individual meeting to discuss the specifics.

Q3. We are looking at strategies for chronic care management. What devices and/or brands are eligible? Would our organization own these devices and check them out to patients who are participating in a program that we create?

A3. MDH does not recommend certain brands, but does recommend that devices purchased are validated for accuracy by a third party. For example, for blood pressure cuffs, we recommend two directories of validated devices (US Validate BP: https://www.validatebp.org/ or Stride BP: https://www.stridebp.org/bp-monitors/). The primary function and use of the supplies/equipment should be clearly described in the work plan, and should help the grantee accomplish the chronic condition management goals and performance measures in Initiative 1. A device such as an Apple Watch does not fit this purpose as its primary function is not health-related. Many devices may be available through some patient insurance plans. For sustainability purposes, we don't recommend that organizations rely primarily on RHTP funds to purchase patient supplies; a potential work plan initiative could be to address billing practices for durable medical equipment through various insurance providers. MDH recommends that the grantee own the devices and provide them to patients on a loaner or as-needed basis.

Q4. We are looking at partnering with a local gym for upstream/prevention programming. Could we purchase new fitness equipment for this gym to be used as part of the program?

A4. A partnership with a local fitness center is allowable and encouraged. However, purchasing new fitness equipment to be owned by the gym is not allowed. The primary function and use of the supplies/equipment should be clearly described in the work plan, and should help the grantee accomplish the chronic condition management goals and performance measures in Initiative 1.

Q5. For Initiative 1 baseline data: Cardiometabolic Screenings in 2025 - What is the list of screenings that quality as eligible cardiometabolic screenings? Do all cardiometabolic screenings count, or just within a defined population? If so, what is the defined population?

A5. Cardiometabolic conditions that elevate risk of cardiovascular events and other poor health outcomes, including hypertension, dyslipidemia, diabetes, pre-diabetes, and chronic kidney disease.

The population is any adult who is screened.

Q6. For Initiative 1 baseline data: Cardiometabolic Screening Eligibility in 2025 -What is the definition of a patient who is eligible for a

cardiometabolic screening (e.g., age range, diagnosis, number/types of office visits in the calendar year, any other clinical criteria, etc.)?

A6. Eligibility: any adult without a diagnosed cardiometabolic condition for whom additional screening activities are conducted following evidence-based guidelines.

Q7. For Initiative 1 baseline data: Cancer Screening in 2025 -What is the list of specific cancer screenings needed? Does this include preventive and diagnostics screenings or only preventive?

A7. This is primary detection screenings, notably breast, cervical, colorectal, lung, and prostate cancers.

Q8. For Initiative 1 baseline data: How many patients with a diagnosed cardiometabolic condition received services to address upstream drivers of health in calendar year 2025? What is the value set for cardiometabolic conditions? What is the lookback period for the ICD-10 code and how many instances need to be coded for a patient to be considered to have a cardiometabolic condition? What services are considered upstream drivers of health? How should completion of services be tracked for referrals sent outside of our health system?

A8. Cardiometabolic conditions: a cluster of cardiometabolic conditions that elevate risk of cardiovascular events and other poor health outcomes, including hypertension, dyslipidemia, diabetes, pre-diabetes, and chronic kidney disease. Notably for hypertension, dyslipidemia (high cholesterol), diabetes, and pre-diabetes, there are evidence-based screening and treatment guidelines, yet many patients are either inadequately screened or not at clinical goal. Screening guidelines for chronic kidney disease are not as consistently established in primary care, leading to underdiagnosis of chronic kidney disease. Improved management of these conditions and getting patients to a clinical goal has a direct impact on reduced cardiovascular event rates and deaths.

Similarly named, cardiometabolic disease is most often defined as having 3 or more of the following diagnoses by using standard screenings:

- Abdominal obesity
- Pre-diabetes or Diabetes
- High triglycerides
- Low HDL
- Hypertension

ICD-10 code for Metabolic Syndrome is E88.81. However, many patients may have 3 or more separate diagnoses from the above list but may not have the official diagnosis of Cardiometabolic Syndrome. For the purposes of this intervention, we are focused on addressing multiple chronic conditions in this cluster described in the first paragraph of this answer, not this narrow definition that relies on E88.81.

The measure sets we recommend to identify these patients are those that inform the clinical goal performance measures:

- • Optimal Diabetes Care (MNCM)
- • Controlling High Blood Pressure (HEDIS and NQF-18)
- • Statin Measure

There is no current performance measure for chronic kidney disease screening and management, but we would welcome the opportunity to pilot such a measure as part of improved CKD screening and treatment protocols.

Upstream Drivers of Health: Non-medical factors that can affect the ability of a patient to follow provider recommendations, engage in behavior changes, access and adhere to medication or treatment regimens, attend clinic visits, and ultimately prevent or manage a chronic condition. These may be related to where a person lives, access to health care, access to nutritious foods, income, housing stability, education level, employment status, disability status, caregiver status, and whether they have health insurance, for example.

Types of services to address upstream drivers of health: Social services and supports that may be acceptable for referral include food and nutrition support, income support, housing support, education, employment services, disability services, health insurance services, child or elder care services, transportation services, and services designed to help people stay in their homes, for example.

Completion of services should be tracked through bidirectional referral processes/systems between the health care system and the services outside of the system.

Q9. For Initiative 1 baseline data: What percentage of your patients with a diagnosed cardiometabolic condition reached their clinical goal in calendar year 2025? What is the definition of a clinical goal? Do they need to be meeting their clinical goal at the last office visit of the measurement period or just at any time during the measurement period?

A9. D5 for Diabetes or Optimal Diabetes Care: The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes and whose diabetes was optimally managed during the measurement period as defined by achieving ALL of the following:

- HbA1c less than 8.0 mg/Dl
- Blood pressure less than 140/90 mmHg
- On a statin medication, unless allowed contraindications or exceptions are present
- Non-tobacco user

- Patient with ischemic vascular disease is on daily aspirin or antiplatelets, unless allowed contraindications or exceptions are present

V4 for Vascular Health or Optimal Vascular Care Measurement: The percentage of patients 18-75 years of age who had a diagnosis of ischemic vascular disease and whose ischemic vascular disease was optimally managed during the measurement period as defined by achieving ALL of the following:

- Blood pressure less than 140/90 mmHg
- On a statin medication, unless allowed contraindications or exceptions are present
- Non-tobacco user
- Patient is on daily aspirin or antiplatelets, unless allowed contraindications or exceptions are present

Controlling High Blood Pressure: The percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

A Chronic Kidney Disease measure is not currently defined, but could be under development.

The patient needs to meet their clinical goal at any time during the measurement period.

Q10. For Initiative 1 baseline data: How many patients had a cardiometabolic diagnosis in calendar year 2025? What is the value set for cardiometabolic diagnoses.

A10. Cardiometabolic conditions that elevate risk of cardiovascular events and other poor health outcomes, including hypertension, dyslipidemia, diabetes, pre-diabetes, and chronic kidney disease.

Q11. For Initiative 1 reporting, could you define “screened for cardiometabolic conditions”?

A11. Eligible conditions include cardiometabolic conditions those that elevate risk of cardiovascular events and other poor health outcomes, including hypertension, dyslipidemia, diabetes, pre-diabetes, and chronic kidney disease.

Screening: The systematic practice of assessing patient characteristics as part of their clinical care. This includes screening both for health conditions and for upstream drivers of health following evidence-based best practice guidelines. Screening can occur in community or clinical settings.

- Community settings are screening events or programs designed specifically to identify cases through community outreach, offering education and screening tests (blood pressure measurements, blood tests, etc.) to identify new cases. Participants are often outside of the health care system, presenting an opportunity to bring them into care.

- Clinical settings refer to the application of best practice guidelines as part of routine clinical care, and the use of the technology to identify potential cases via the Electronic Health Record or other patient-level registry system, and formally following up with a more detailed assessment of patient health. These patients are already within the health care system, either as regular or periodic consumers.

Q12. For Initiative 1 reporting, could you define "screened for cancer"? Does this include colon, breast, and cervical or additional cancers (e.g., lung) as well?

A12. Screening: The systematic practice of assessing patient characteristics as part of their clinical care. This is primary detection screenings, notably breast, cervical, colorectal, lung, and prostate cancers.

Q13. For Initiative 1 reporting, could you define "chronic self-management program"?

A13. People with cardiometabolic diseases should be referred to evidence-based lifestyle programs that can increase blood pressure control, lower cholesterol levels, lower HbA1c, and improve overall health and well-being. These programs should promote the following elements: managing healthy weight, adopting DASH (Dietary Approaches to Stop Hypertension) eating plan principles including lower sodium intake, engaging in regular physical activity, and adhering to medication regimens. Some examples include:

- Diabetes Prevention Program
- Diabetes Self-Management Education and Support
- Health Coaches for Hypertension Control
- Walk With Ease
- Living Well with Chronic Conditions

Q14. For Initiative 1 reporting, could you define "upstream drivers of health"?

A14. Non-medical factors that can affect the ability of a patient to follow provider recommendations, engage in behavior changes, access and adhere to medication or treatment regimens, attend clinic visits, and ultimately prevent or manage a chronic condition. These may be related to where a person lives, access to health care, access to nutritious foods, income, housing stability, education level, employment status, disability status, caregiver status, and whether they have health insurance, for example.

Types of Services: Social services and supports that may be acceptable for referral include food and nutrition support, income support, housing support, education, employment services, disability services, health insurance services, child or elder care services, transportation services, and services designed to help people stay in their homes, for example.

Q15. For Initiative 1 baseline data: Cancer Screening Eligibility in 2025 - Based on the answer above, should already established Healthcare Effectiveness Data and Information Set (HEDIS) or Minnesota Community Measurement (MNCM) criteria be used to determine eligibility?

A15. Yes, HEDIS and MNCM measures can be used to determine eligibility as they are the same for breast, cervical, and colorectal cancers, and are consistent with the US Preventive Services Taskforce (USPSTF) recommendations. If you are also thinking about an additional focus on lung cancer, we recommend a screening performance measure consistent with the USPSTF guideline. The eligible screening population for lung cancer is adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.

Q16. Would postage necessary to notify patients overdue for screening be an eligible expense under Initiative 1?

A16. Postage may included in an organization's indirect calculation but cannot be expensed directly to the grant.

Q17. Wound Care - is a billable service. Would we be able to obtain any training, equipment, certification costs?

A17. The equipment & training may be procured with RHTP funding. If individuals earn a certification with RHTP funds, the 5-year rural MN service commitment is triggered. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q18. Infusion Therapy - This is a billable service. Would we be able to obtain any training, equipment, certification costs?

A18. The equipment & training may be procured with RHTP funding. If individuals earn a certification with RHTP funds, the 5-year rural MN service commitment is triggered. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q19. Any concerns with weight management as part of Initiative 1?

A19. In order to make a full determination, MDH will need more information including what activities are a part of the program, how it is innovative, and why it would only be available to patients with RHTP funding. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q20. Related to Initiative 1. We have several sites that are interested in purchasing cancer screening equipment to be able screen patients locally for cancer rather than having to refer them to a site that requires travel. Would this be eligible under activity 1.1.1.? This would be a strategic initiative for some sites to offer screening capabilities they do not currently have and would be financially sustainable through billables services generated by adding the screening capabilities.

A20. In order to make a full determination, MDH needs to know which cancer screening equipment you are planning to purchase. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q21. New wound care service line with hyperbaric chamber. Closest centers: 126-138 mi away. Regional model serving surrounding communities. Can RHTP cover hyperbaric chamber cost - $100-$150k? If there are ongoing costs for wound care best practices, i.e., external vendor, is this covered? Are facility modifications "minor renovations" (eligible) or "construction" (ineligible)?

A21. The equipment & training may be procured with RHTP funding. If individuals earn a certification with RHTP funds, the 5-year rural MN service commitment is triggered. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q22. We are wondering if barometric chamber for wound care - which is not currently available in our community - would be an allowable expenditure.

A22. This may be an allowable investment in RHTP. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q23. Is park enhancement with workout equipment for community, connected to initiatives/goals allowable?

A23. This activity may be allowable under RHTP, but there are many restrictions in place including construction not being allowable. Please provide more information to MDH in order for us to assist in planning this initiative.

Q24. In planning for our Community-based preventative care and chronic disease management we are wondering if the following staff roles are eligible to pay for with RHTP funds: Chief Medical Officer help establish the programming and practices moving forward; Clinical Informatics Analyst to help staff collect, analyze, and report data available in the EHR and other sources to improve care; Athletic Trainer to develop and lead programming for the community and geriatric exercise programming; Speech Therapist to assist individuals who have suffered strokes (only requesting recruitment costs, since this is a billable service).

A24. All of these positions are allowable to conduct the planning and implementation of the program. Please note, per the Notice of Grant Opportunity: "Payment for direct health care services is unallowable. This includes, but is not limited to, replacing payment for clinical services that could be reimbursed by insurance or another form of health coverage. This also includes payments for clinical services if they duplicate billable services." "Clinician salaries or wage supports may be allowable expenses only if directly related to RHTP. RHTP funds may not pay clinicians, clinicians in training, or other employees for work they are already doing. As with all salaries, only the portion dedicated to RHTP work may be paid with RHTP funds."

Q25. Can we request funding for food costs under Initiative 1 for a "Food is Medicine" chronic disease management program? This could include medically tailored meals, produce prescriptions or healthy food boxes.

A25. Food costs, including medically tailored meals, prescription food, or healthy food boxes, are unallowable costs under RHTP. Planning the structure to implement these programs, however, is allowable under Initiative 1.

Q26. Questions on the reporting metric requirements for Initiative 1 including do you have to show an increase in all of those areas included in the table or is it just the one you pick? (Example, if you focus on HgbA1c- will we just be reporting baseline data and then progress reports showing movement of just that one metric)? The sample timeline states you can use

year 1 to establish the baseline metrics but then it says the application will require baseline metrics to be included in it?

A26. Organizations are required to provide baseline data in the application. In Initiative 1, if you do not select a sub-activity, you do not have to report on that data (example if your project focuses on heart disease, you do not need to report on cancer screenings). Organizations will have their 2025 baseline data established in the application and be gathering more data from 2026 during budget period 1.

Q27. Can RHTP be used to add a clinical pharmacist to the ambulatory care team to support chronic disease management and medication optimization?

A27. Multi-disciplinary teams and pharmacist-led interventions to support chronic disease management specifically around cardiovascular disease, hypertension, high cholesterol, diabetes, and chronic kidney disease are acceptable approaches. This includes medication management, patient counseling, leading of evidence-based programs, and support for clinical interventions such as continuous blood glucose monitoring and self-measured blood pressure. We view this role as appropriate to help patients manage risk factors prior to a clinical event or hospitalization as well as part of the suite of care services offered post-discharge after a hospital event. Please outline your program planning, implementation, and sustainability structures. Please note, per the Notice of Grant Opportunity: "Payment for direct health care services is unallowable.

Initiative 3 mobile units

Q1. Please clarify if RHTP funds can be used for the technology and facilitation of the technology implementation, but not the actual care provider delivering the technology. For example, if a mobile clinic is implemented under the program, can the program include cost for travel and program development but not care delivery.

A1. RHTP funds may be used for technology planning and implementation, and for other aspects of infrastructure planning and implementation, but RHTP funds may not pay for direct patient care. The care delivered should be billed to payers through normal mechanisms.

Q2. Is there a cost limitation on mobile vans?

A2. There is not a specified cost limitation on mobile vans, but overall funding for van purchases is limited, and approval is not guaranteed. Requests to purchase a van will be reviewed on a case-by-case basis by MDH and CMS. Applicants should submit a detailed budget for each activity, corresponding to their work plan.

Q3. When considering mobile vans, our organization is concerned about sustainability, especially regarding delivering care in Minnesota winters.

A3. Sustainability is a key requirement for RHTP funding. Organizations should incorporate sustainability planning and considerations into their application and continue sustainability planning and groundwork during the grant period.

Q4. For Initiative 3 (mobile care delivery), can you confirm what qualifies as allowable equipment versus unallowable costs?

A4. Supplies and equipment related to providing mobile primary care or oral health care are eligible. This could include, for example, supplies and equipment related to primary physical and oral health needs, screening, preventive care, lab work, basic restorative dental care, and technology needed to support these efforts.

Q5. Are mobile clinics an eligible activity for CCBHCs and CMHCs? We see that mobile clinics are listed in the MOUD activity.

A5. The creation of mobile units or mobile clinics is not an eligible activity for CCBHCs and CMHCs in budget period 1. This activity may be added to the CCBHC/CMHC direct allocation menu in future years. For the "Expand Rural Access to Medications for Opioid Use Disorder (MOUD)" activity, the Strengthening Rural Pathways to MOUD program and services may be implemented in existing mobile clinics.

Q6. We currently have an MRI truck that comes once a week. If we got a permanent MRI truck that was available more often to our patients, would that fall under the mobile care area?

A6. An MRI truck may be an allowable expense. Your application should outline the cost savings of owning the MRI truck vs. having it rotate through the community once per week. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q7. We are looking at a mobile van/clinic project. What are you looking for to determine who qualifies for this?

A7. Funding for van purchases is limited; applications will be reviewed on a case-by-case basis. Organizations are required to conduct a feasibility assessment of lease vs. purchase of the vehicle. Further considerations when reviewing van purchase requests include, for example, the organization's capacity to maintain the vehicle, the sustainability plan for the vehicle after RHTP funding ends, and other vehicle options available to the organization.

Q8. Does MDH have a goal of how many Mobile Health Care units they'd like to get in the state through this grant?

A8. MDH has not set a goal for the number of mobile units in year 1. Organizations are encouraged to determine what type of mobile care delivery will best serve their communities in sustainable ways to ensure care is accessible close to home for rural Minnesotans.

Q9. What is required of the mobile units and can they be used for transporting patients?

A9. Mobile units should be providing primary physical and oral health care. Your program narrative should include a detailed justification of purpose and goals, service area, and population served. RHTP funds cannot be used to pay for patient transportation.

Q10. Could school based virtual access points fit into the mobile units initiative?

A10. No. School-based telehealth access points are not a part of the direct allocation activities for year 1. Competitive opportunities for telehealth connectivity will be released later this spring/summer.

Q11. The development of a ALS transfer service under the hospital. I feel this meets a number of items related to the goals of the RHTF as getting patients in need of a higher level of care or a specialty provider in our remote area is a true challenge. We have had patients in need of transfer be 'stuck' in our ER for days because of the inability to coordinate the ALS transfer with outlying services who are greatly spread thin. This ALS service could also provide some of the home well checks as it would be required to be staffed with trained employee such as Paramedics who would be under the medical direction of the department medical director. This service development would greatly enhance the overall health and continuity in getting members of our community/service area the specialty and advanced care required in a timely manner.

A11. This may not fit well under RHTP. There are a lot of licensing and staffing that would need to be worked out with OEMS to identify clear next steps. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q12. Our project is centered on transitioning EMS from BLS to a part-time ALS model, with additional components that may include workforce development, diagnostic access (mobile radiology), patient access improvements (transportation), and technology that supports care delivery. Is this allowable?

A12. This may not fit well under RHTP. There are a lot of licensing and staffing that would need to be worked out with OEMS to identify clear next steps. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q13. Our organization proposes to establish an in-house American Heart Association (AHA) HeartSaver, BLS, and ACLS certification and recertification program to strengthen our rural healthcare workforce. This initiative will reduce barriers to required clinical certifications, improve staff retention, and build long-term workforce sustainability by developing internal training capacity. The program will be designed to meet AHA standards and will be supported by new training infrastructure, instructor development, and simulation-based learning tools by developing internal training capacity. I am wondering if this would fall in line with Initiative 3: sustain access to services to keep care closer to home?

A13. The programming as you've described is currently funded through MN's Small Hospital Improvement Program (training tools) and the Comprehensive Advanced Life Support Program (CALS). Please reach out to the MN SHIP and Flex Programs for more information on how to move forward with these existing funding streams for this work.

Initiative 3 frontline staffing

Q1. For the Initiative 3 activity "Implement or Expand Models that Integrate Frontline Staffing into Care Settings," we are interested in Community Paramedic staffing models. Our hospital does not own an ambulance service; however, we contract with a provider for these services. Our understanding of the state requirements is that community

paramedics must be employed by an ambulance service rather than a hospital. Could you please confirm if this is correct? Additionally, I would like to know if our hospital is eligible to apply for funding to contract a community paramedic through the provider specifically for our critical access hospital's needs.

A1. MN Statutes 144E.28 Subd 6 (B) reads, "A community paramedic must practice in accordance with protocols and supervisory standards established by an ambulance service medical director in accordance with section 144E.265."

Because of the required alignment with an ambulance service medical director, there is no other way to practice as a community paramedic in the state outside the oversight and involvement of an ambulance service medical director.

The hospital could see if an ambulance service provider would be willing to contract for medical director oversight and supervision of a hospital-employed community paramedic. RHTP funds could be used for this.

Q2. What costs are eligible for short-term housing for workers?

A2. Housing may be provided for up to six months for rural clinical rotations or short-term training programs. This means that RHTP funds may only be used to support housing costs incurred during a rotation or training program that is no longer than six months. Note that if housing support is provided to individuals as part of a training program leading to a health care career, it may obligate the individuals to fulfill the five-year rural service commitment.

Q3. Could other disciplines (outside of CHW, doulas, paramedics, etc.) fall into Initiative 1.b. or 2.b. and be paid out of the grant? They are planning on providing family practice services including mental health, pain management, osteoporosis screening, dermatology (and others). They would also want to use telehealth services at this site as well.

A3. The addition of other frontline workforce may be allowable under Initiative 3. MDH will need more information including the types of staff, roles, and sustainability of the position. Direct patient services are not allowable. Additionally, MDH must confirm with CMS that other positions are allowable.

Q4. We are wondering if the grant could pay for an RN Case Coordinator for Mental Health.

A4. The addition of other frontline workforce may be allowable under Initiative 3. MDH will need more information including the types of staff, roles, and sustainability of the position. Direct patient services are not allowable. Additionally, MDH must confirm with CMS that other positions are allowable.

Q5. Our region with the shifts in Medicaid has been struggling with obtaining insurance. This makes it hard for the CAHs to get reimbursed and hard for patients to receive care. Could funding be used to train and/or hire community educators who could help patients navigate insurance?

A5. This is allowable. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q6. Are organizations able to pay for hours for frontline workers like CHWs, or is it only for the certification costs and supervision costs?

A6. Any time direct patient care is being provided and it is a billable service, this cannot not be funded with RHTP dollars. Training time for the CHW to learn about the job though, may be considered eligible. If your organization does not have billing structures in place for frontline workers, MDH will be able to connect you to a TA provider during the implementation of your activity who will be able to assist with setting up policies and procedures to ensure sustainability of your frontline workers.

Q7. Is "frontline staffing" limited to community health workers (CHWs), community health representatives (CHRs), community paramedics, doulas, and peer support specialists? Could we include RN population health coaches or nurse navigators under the activity: Implement or Expand Models that Integrate Frontline Staffing into Care Settings?

A7. Additional frontline staffing roles may be allowable. Applications should outline the roles envisioned and sustainability of the role beyond RHTP funds.

Q8. Can you clarify if salary costs associated with "front-line" workers are allowable? Since CHWs, doulas, and community paramedics are all technically billable, but it can take time to build a program, and

reimbursement is low. Is the expectation that RHTP funding could support program development until billing is in place?

A8. RHTP funds can support implementation of a program for frontline workers. Eligible expenses are outlined on pages 39-40 of the hospital Notice of Grant Opportunity, pages 38-39 of the FQHC Notice of Grant Opportunity, pages 39-40 of the Tribal Nation Notice of Grant Opportunity. MDH will have a TA vendor in place for organizations choosing to implement this activity who can assist with setting up the billing structures.

Note: Payment for direct health care services is unallowable. This includes, but is not limited to, replacing payment for clinical services that could be reimbursed by insurance or another form of health coverage. This also includes payments for clinical services if they duplicate billable services and/or attempt to change the payment amounts of existing fee schedules

Initiative 3 community-based mental health postvention programs

Q1. For the initiative 3 activity, "Support Community-based Mental Health Postvention Programs," do postvention trainers need to be licensed clinicians? Do organizations need to provide all 4 postvention programs (NAMI Connect Postvention Model, Mental Health First Aid, MDH Postvention 101, and MDH Changing the Narrative on Mental Health and Suicide Prevention)?

A1. The intention of the activity is to involve both licensed and natural helpers from communities. This programming is aimed at supporting communities with the resources they need, including having people trained in postvention and having the clinical support needed beyond that initial support. Organizations should evaluate who is available in their community to provide support to the communities being served through this activity. Organizations do not need to provide all four trainings/programs, but must implement a sequenced, tiered approach that includes foundational readiness as a first step and core postvention education as a second step, followed by role-specific skill development (as needed) and systems and infrastructure development.

Q2. Does our organization need to provide all 4 trainings (NAMI Connect, Mental Health First Aid, MDH Changing the Narrative, and MDH Postvention 101)?

A2. Organizations do not need to provide all four trainings/programs, but must implement a sequenced, tiered approach that includes foundational readiness as a first step and core postvention education as a second step, followed by role-specific skill development (as needed) and systems and infrastructure development.

Q3. We would like help forming a community postvention response plan.

A3. The organizations that offer the various trainings are available to assist you in your planning and finding the right resources for your community's needs. Please reach out to the MDH Suicide Prevention Team with Injury Prevention and Mental Health at health.suicideprev.mdh@state.mn.us, NAMI MN at namihelps@namimn.org, and/or the National Council for Mental Wellbeing - Mental Health First Aid at hello@mentalhealthfirstaid.org.

Initiative 4 medications for opioid use disorder (MOUD)

Q1. For Initiative 4, does the project have to be focused on medications for opioid use disorder (MOUD)? Can we do something else that improves whole person health that fits better for our community?

A1. Some direct allocation entities are eligible for two activities under Initiative 4, one for developing new mental health urgent care centers, and one for expanding rural access to MOUD. The MOUD activity must indeed focus on expanding rural access to MOUD. You might consider whether your organization's ideas could fit under Initiative 1. We would be happy to meet with you to talk through your ideas and whether they are a fit for this direct allocation funding.

Q2. For the MOUD activity, can we purchase long-acting injectables (like Sublocade and Vivitrol) with RHTP funding, to get patients started on the medication while waiting for the prior authorization to go through?

A2. Purchase of temporary bridge medication is not allowable under RHTP. Eligible expenses include planning and operational support to incorporate long-acting injectable buprenorphine into care, including clinical protocols, staff training, pharmacy coordination, storage and administration workflows, and patient education.

Q3. In the Notice of Grant Opportunity under MOUD, it states that "Activities to strengthen partnerships to improve rapid access to MOUD, including coordinated workflows, starter medications until pharmacy access can be established, and collaboration to reduce delays in treatment initiation" are eligible expenses. Does this mean we are able to pay for the medications?

A3. No. RHTP funds cannot pay for the medications themselves, but can support the staffing structures, policies, and procedures required to coordinate the provision of starter medications.

Q4. Under Initiative 4.7, our proposed low-barrier MOUD model requires that a patient can receive a telehealth consultation with an addiction medicine specialist during MOUD induction while a nurse simultaneously provides bedside monitoring and care. Our current mobile cart cannot support that workflow — the cart occupies the space the nurse needs, has no Epic integration for real-time documentation, and must be shared across the entire campus. When we describe in our application that the fixed telehealth stations are necessary to implement Initiative 4.7 MOUD clinical workflows, is it sufficient to document the specific clinical workflow limitations of the existing mobile cart, or does MDH require a formal side-by-side comparison or other specific format to establish that the existing capability cannot meet the initiative requirements?

A4. Applicants should demonstrate the need for their projects and expenses and how they relate to overall RHTP goals and the purpose and priorities of your selected activities. This may include documentation of current equipment and workflows and their limitations. Please discuss the improvements being made with the funding and how they will result in demonstrable, transformative change for your community, keeping in mind the required metrics for each activity.

Q5. In the case of MOUD, would funds be able to cover cost of care for uninsured/underinsured clients, or does that fall into the ineligible expense of "payment for direct health care services"?

A5. Covering the costs of care for uninsured/underinsured clients is not an eligible expense. You are correct that this falls under the category of "payment for direct health care services," which are ineligible.

Q6. When preparing to report on baseline information for MOUD, is MN looking at providers delivering MOUD in all settings: clinic, ED, hospital for each eligible location?

A6. When reporting baseline data, the data should align with the scope of the applicant's proposed project. If the application is focused on a single setting (emergency department), applicants should report on providers delivering MOUD within that setting. If the application includes multiple settings (emergency department, inpatient, and outpatient/clinic), applicants should report on providers delivering MOUD across all included settings.

Q7. When preparing to report on baseline information for MOUD on unique patients and encounters receiving MOUD is MN looking for administered/dispensed from the specific eligible location or home location of patients? Zip/code county level data?

A7. Applicants should report patients and encounters based on where MOUD services are delivered (the clinical site or program providing care) while providing zip code level data.

Q8. Can you please describe in further detail how the LAI MOUD project can lift off without being able to purchase the LAI's in advance? We've been trying to get Sublocade but due to individual's lack of insurance or the lengthy PA process, we are not able to get the Sublocade even with people's insurance. It seems our only real route is to go with buy and bill but this grand does not offer that as an option. Can you explain more why that isn't an option and how the grant meaningfully helps getting Sublocade off the ground when insurance and lack of insurance is such a barrier for our individuals?

A8. RHTP funds can be used to build, implement, and operationalize the systems, workflows, and capacity needed to deliver long-acting injectable (LAI) buprenorphine, while actual medication and administration are billed to payers.

Allowable infrastructure uses include:

- clinical workflow and protocol development
- staff training
- administrative costs related to REMS certification
- EHR and billing infrastructure such as building order sets and PA workflows
- establishing workflows for pharmacy and medication access such as establishing workflows with specialty pharmacies and processes for medication ordering and storage
- purchasing non-billable equipment needed to support administration such as medication storage units, etc.
- non-billable roles such as patient navigators to support appointment reminders, follow-up outreach, warm handoffs to other care
- community outreach and education such as developing materials explaining LAI options
- data systems to track LAI update, retention, and adherence

These are some examples of activities that could help support the startup barriers to implementing a new program.

Initiative 4 mental health urgent care

Q1. Can a Mental Health Urgent Care Site be developed within an existing outpatient site, or does it need to be its own location/site?

A1. Yes, a mental health urgent care center may be developed within an existing outpatient site. Your application should demonstrate clearly how the mental health urgent care center is different from or an expansion of your existing services. Please request an individual TA meeting to discuss specifics.

Q2. Does an urgent care need to be its own facility, or can you create a program within an outpatient office? Can the urgent care facility be mobile?

A2. Mental Health Urgent Care facilities do not need to be their own location and can be within an existing clinic space or new space within the community. The Urgent Care facilities should be consistently located within a space in community, for example one day a week at a community space in one town and another day of the week in another town. It is important that community members know of a consistent space to access the services. The services are not meant to be provided in the field (a patient's home).

Q3. Can we use RHTP funds to conduct a feasibility study for Urgent Care Services?

A3. Sustainability is an important aspect of RHTP. CCBHCs/CMHCs may use their RHTP funds under Initiative 3 to conduct feasibility studies for their proposed urgent care services.

Initiative 5

Q1. As part of activity 5 in the hospital grant it looks like there is a technical resource that would be provided by MDH – would you be able to get us in touch with this vendor for a review for our facility?

A1. There will be technical assistance available to grantees who select Initiative 5 activities. As soon as MDH has secured a contracted vendor for Initiative 5 TA, we will connect interested grantees to the vendor. Please indicate interest in Initiative 5 technical assistance in your application.

Q2. We are in need of a new and expanded Enterprise Resource Planning/Accounting/Financial System that will help with revenue cycle management. Can this be considered for the grant?

A2. This purchase may be eligible under Initiative 5, especially if it is a revenue cycle management platform or other software that improves efficiencies and assists your organization in moving toward alternative payment models. You will need to demonstrate that the purchase of a system like this advances RHTP goals. Additionally, you will need to demonstrate that this purchase does not have another existing or planned funding source.

Q3. For cybersecurity, under Initiative 5, I would assume most facilities have something in place already, so how can we utilize the dollars to meet the requirement of "new or expanded activities" for this? Can RHTP pay for upgrades of what we have, and/or cover the cost of new cybersecurity-related fees? I'm assuming it can be used on new hardware but we are wondering about software or cloud-based services.

A3. As you noted, proposed activities must be new or expanded, and RHTP may not replace existing funding for activities, including for cybersecurity. Organizations may choose to hire consultants to test their existing cybersecurity infrastructure. If the results show that the organization needs to strengthen their cybersecurity, upgrades or additional functionality may be considered eligible under RHTP. Hardware, software, cloud-based services, and new fees could be allowable, but applicants will need to provide a detailed rationale for each requested item.

Q4. If a hospital has a very old EHR, would a new EHR be an eligible item to fund with RHTP funding, under Initiative 5? We have had trouble connecting the existing EHR to the population health platform. The challenges have been on 2 fronts: some due to technology and others due to vendor collaboration.

A4. Replacements of EHRs may be an eligible expense, if the organization does not have another existing or planned funding source for the new EHR and can justify why the EHR replacement advances RHTP goals. The issue you mention of capacity to connect to the population health platform may be relevant to a justification. The overall CMS award to MDH is subject to limits on funding EHR replacements in cases where a previous HITECH-certified EHR system was in place as of September 1, 2025. MDH will keep this limit in mind when evaluating EHR replacement requests. Organizations should also consider sustainability beyond RHTP funding. MDH encourages you to schedule a 1:1 TA meeting to discuss your organization’s circumstances and plans for a replacement EHR.

Q5. A project that would benefit our hospital greatly is a new Patient Call Light System that would be used throughout our hospital, care center, and assisted living center. Is this eligible as a technology and infrastructure investment?

A5. The patient call light and care board systems are allowable investments through RHTP. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q6. Our current EMR provider has let us know that they are sunsetting CCBHC capabilities. They are no longer adding new features or customizations. They will not be able to meet our needs as a CCBHC. Page 48 of the NOGO mentions strict limitations on funding EMR replacements. What are the limitations?

A6. Replacements of EHRs may be an eligible expense, if the organization does not have another existing or planned funding source for the new EHR and can justify why the EHR replacement advances RHTP goals. The overall CMS award to MDH is subject to limits on funding EHR replacements in cases where a previous HITECH-certified EHR system was in place as of September 1, 2025. MDH will keep this limit in mind when evaluating EHR replacement requests. Organizations should also consider sustainability beyond RHTP funding. MDH encourages you to schedule a 1:1 TA meeting to discuss your organization's circumstances and plans for a replacement EHR.

Q7. If we were to hire a consultant to review our revenue cycle process, would all consultation costs be covered, including their review of our current system, the process of providing feedback and a proposed plan, and the cost to implement the plan proposed?

A7. Organizations are encouraged to seek consultation and technical assistance to evaluate their current systems and processes (including revenue cycle management), assess their technology needs, and recommend tools and other improvements. As part of initiative 5, organizations may use a portion of their RHTP award to procure their own consultation/technical assistance, or they may receive services from the technical assistance vendor(s) arranged by MDH. The types of activities and costs you reference in your question would likely be eligible expenses.

Q8. What is the specific limit on funding EMR replacement?

A8. The overall CMS award to MDH is subject to limits on funding electronic medical record (EMR) system replacements in cases where a previous HITECH-certified EHR system was in place as of September 1, 2025.

Specifically, no more than 5% of Minnesota's award in a given budget period may be used for this purpose. MDH will keep this limit in mind when evaluating EMR replacement requests.

Q9. Can we add additional features to technology that we have already purchased?

A9. Adding features to existing technology may be an eligible expense, if the additional features are integral to achieving RHTP goals and activity outcomes and the organization does not have an existing or planned funding source for those additional features.

Q10. Can you clarify the supplanting criteria? If a hospital wants to upgrade a current process / technology / platform (e.g., RCM) with a more advanced / AI-based tech solution, would this be allowable?

A10. Upgrades to more advanced technology are potentially allowable, as long as they advance RHTP goals and do not have another existing or planned/budgeted funding source. If a new component is added to an existing system, only the new component may be paid for with RHTP funds; the existing system must be paid for with its current funding source.

Q11. Our hospital is managed by a system and they are switching to Epic in May 2026. Could RHTP pay for expenses related to this?

A11. Costs incurred prior to the execution of your grant agreement are ineligible.

Q12. If we were to look at care coordination and getting more e-care services for neurology, behavioral health, etc. would those qualify?

A12. Care coordination technology is an eligible activity under Initiative 5.

Q13. How flexible is the definition of “technology investments” under Initiative 5? Can EPIC-related modules like Compass Rose and Healthy Planet be included if they align with the RHTP priorities and initiatives? For EPIC-related investments, how does MDH view one-time implementation costs in Budget Period 1 versus expectations for sustainability in Years 2–5?

Would adding new EPIC modules be considered an eligible "technology upgrade" vs. ineligible replacement or maintenance?

A13. The purchase of additional EHR modules is potentially allowable under RHTP as long as the purchase aligns with overall RHTP and activity-specific priorities and goals. Applicants must have a plan for the sustainability of the technology and address sustainability in their application narrative and work plan.

Q14. Can cybersecurity investments be included, and what types of activities are considered allowable?

A14. Cybersecurity investments are allowable under initiative 5. Investments could include testing of current cybersecurity infrastructure, assessment of needed improvements, and the purchase of new cybersecurity systems, along with training to implement the systems.

Q15. Are ACS (or similar vendor/platform) fees allowable under this grant?

A15. Accountable Care Systems, primarily for care coordination, are allowable under Initiative 5.

Q16. If we use the technical assistance through MDH outlined in initiative 5, how do we work this into our overall timeline and budget request?

A16. MDH's TA vendor for Initiative 5 will come on board in early summer 2026. Organizations interested in working with the TA vendor should indicate this in their activity narrative and work plan. Services provided by the MDH vendor are free of charge to organizations, but will be subject to limits to ensure that vendor time is equitably distributed across organizations. MDH will connect the TA vendor with organizations.

Q17. Our organization is evaluating a transition to Epic's Willow Ambulatory Pharmacy software system for our outpatient pharmacy. Currently, our hospital and ambulatory electronic medical record platform is Epic, and this transition would allow for more integrated workflows between pharmacy and clinical operations. As part of this transition, a significant cost component involves data conversion and migration from our current pharmacy system into Willow Ambulatory. Could you please clarify whether: 1. Implementation of a pharmacy system that enhances integration with an existing EMR platform would be considered an eligible activity under this funding opportunity? 2. Costs associated with data

conversion and migration as part of such a transition would qualify as allowable expenses?

A17. The hospital is the entity receiving the award, but affiliated services operated by the hospital, such as an outpatient pharmacy, may be involved in the delivery of activities as appropriate. The costs to implement a pharmacy system that enhances integration with an existing EMR platform, and costs associated with data conversion and migration as part of such a transition, may be eligible under Initiative 5 as part of improving care coordination.

Q18. Our current EMR is sunsetting CCBHC reporting updates and modifications. We are in the demo process with new providers. What are the funding limitations?

A18. Replacements of EHRs may be an eligible expense, if the organization does not have another existing or planned funding source for the new EHR and can justify why the EHR replacement advances RHTP goals. The overall CMS award to MDH is subject to limits on funding EHR replacements in cases where a previous HITECH-certified EHR system was in place as of September 1, 2025. MDH will keep this limit in mind when evaluating EHR replacement requests. Organizations should also consider sustainability beyond RHTP funding. MDH encourages you to schedule a 1:1 TA meeting to discuss your organization's circumstances and plans for a replacement EHR.

Q19. Our organization is working to expand and strengthen obstetric (OB) services in our rural community. As part of improving patient safety and supporting OB service delivery, we are considering implementation of an infant security system. Would the purchase and implementation of an infant security system be considered an allowable expense under the grant?

A19. Infant security systems may be allowable under Initiative 5. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q20. Project idea under initiative 5: a software product for surgical instrumentation and asset management. It allows facilities to meet compliance with detailed electronic quality management reporting and validates patient safety by providing proof that all sterilization steps have

been completed. It adds value to productivity by shortening training times, locating instruments and reducing the risk of surgical delays and infections.

A20. This is an allowable project under RHTP Initiative 5. Applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q21. Project idea under initiative 5: a minimally invasive technology that assists surgeons to measure esophageal function and pressures, either by itself or in conjunction with other studies. It provides diagnostic data and information to aid in therapeutic and clinical decisions regarding the need for treatment or surgical intervention. This technology allows our patients to remain in the community without traveling to specialized centers far from home. Our fellowship-trained reflux specialists provide personalized care for GERD and heartburn using this system. (Our current system is over 10 years old and is no longer supported for software upgrades or repairs – we have been notified by the manufacturer that to continue care an upgraded system is required.)

A21. This is not allowable under MN's RHTP funding. Hospitals may consider applying for this request under the Rural Hospital Capital Improvement Grant Program (https://www.health.state.mn.us/facilities/ruralhealth/funding/grants/index.html#rhci).

Q22. Does the following project qualify for funding: Lab Automation System with capital equipment and capital facility investments. Our hospital laboratory is a vital diagnostic hub for a rural population, supporting emergency, inpatient, and a rapidly growing outpatient service line. However, our current operational design no longer aligns with the increasing demand for timely, high-quality laboratory services or the evolving realities of the rural healthcare workforce. Funding will support redesigning the laboratory layout to improve workflow efficiency, patient privacy, and safety; implementing automation to streamline processes and reduce manual workload; adding redundant core instrumentation, ensuring

continuity of testing during equipment downtime; enhancing capacity to support increased outpatient volumes.

A22. A lab automation system, increasing efficiencies and adding automation, is an allowable expense under RHTP Initiative 5. The modifications of the laboratory design will need to be approved on a case-by-case basis, as only minor alterations/renovations are allowable. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q23. Does MDH consider AI-enabled clinical imaging software (licensing + implementation) an allowable cost under Initiative #5 when focused on efficiency, diagnostic quality, and access? This would be a software upgrade only - no new scanner, no construction, no staffing increase. The software is intended to improve speed and resolution of MRI imaging on existing equipment. What outcome measures would MDH expect (e.g., scan time reduction, improved access, diagnostic confidence)?

A23. AI-enabled software to improve care delivery and efficiencies is allowable under RHTP Initiative 5. This includes the software and training to use the new software. Evaluation metrics may evolve throughout the program based on grantee contributions, findings from the ongoing work and evaluation, and CMS requirements. At this time hospitals are required to complete the Rural Health Value: Value Based Care Assessment Tool and report on the type of software or technology purchased and implemented.

Q24. Can RHTP be used to engage a patient access consultant to evaluate current workflows and recommend improvements to the patient experience?

A24. Grantees can use their funds to conduct evaluations of their current workflows and improve clinical efficiencies under Initiative 5. There will be technical assistance available to grantees who select Initiative 5 activities. As soon as MDH has secured a contracted vendor for Initiative 5 TA, we will connect interested grantees to the vendor. Please indicate interest in Initiative 5 technical assistance in your application.

Q25. Can RHTP be used to implement system wide patient self-check in stations to streamline registration and reduce bottlenecks?

A25. This is an allowable investment under Initiative 5. Please be sure to include information in your proposal on its alignment with the initiative's priorities and overall RHTP programmatic goals.

Q26. We are exploring a project to expand local access to surgical care in our rural community, where a portion of patients are currently referred outside our service area due to limited local capability. The project would involve implementing new surgical capacity to perform additional procedures locally, supported by investment in advanced surgical technology, along with workforce training and implementation planning. The goal is to reduce patient outmigration, improve access to timely care, and strengthen the sustainability of local surgical services.
Could you advise whether a project that includes investment in surgical technology as part of expanding local service capacity would be considered aligned with the intent and eligible activities of the Rural Health Transformation Program? Also, are there any considerations or limitations regarding capital equipment within this type of project?

A26. This may be an allowable investment in RHTP. In order to make a full determination, MDH needs to know which surgical lines you plan to incorporate with this work. Be sure to detail all costs in an itemized way (equipment, tech purchases, software fees, minor renovation costs, Epic/EMR integration costs, training, travel). There are caps on MN's overall award for minor renovations and EMR replacement (there are no caps on the addition of EMR modules/functionality). All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q27. We are looking at the addition of a vitals interface to reduce nurse time entering those and increase timeliness of documentation and utilization of staff time to improve patient care. Other billing changes we are reviewing as part of the grant would be a chargemaster review and the possibility of switching to method II billing.

A27. These investments are allowable under initiative 5, but more details are needed. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q28. We are considering requesting support for electronic care boards, telehealth in patient rooms, etc. Is this allowable?

A28. Minnesota will be doing an assessment of telehealth support services as part of first year RHTP funding. Electronic care boards are an eligible investment with RHTP funds. The telehealth support should come from within a hospital's organization, entity, system or neighboring institutions located in Minnesota. It is important to tie the proposed activity to the overall RHTP programmatic goals within the Notice of Grant Opportunity on page 8, as well as demonstrating how the project is transformative.

Q29. Does the following project qualify for funding: Tele-Critical Care Services. Service Overview
Provider: Allina Health
Scope: Tele-Critical Care support for critical patients via telehealth technology.
Billing: Monthly subscription + per-consult fee + one-time implementation cost.

A29. Minnesota will be doing an assessment of telehealth support services as part of first year RHTP funding. Tele-Critical Care Services may be allowable with additional information. The telehealth support should come from within a hospital's organization, entity, system or neighboring institutions located in Minnesota. It is important to tie the proposed activity to the overall RHTP programmatic goals within the Notice of Grant Opportunity on page 8, as well as demonstrating how the project is transformative.

Q30. Can RHTP be used to implement ICU telehealth to provide real time support for our Hospitalist team and enhance critical care capabilities?

A30. Minnesota will be doing an assessment of telehealth support services as part of first year RHTP funding. ICU telehealth may be allowable with additional information. The telehealth support should come from within a hospital's organization, entity, system or neighboring institutions located in Minnesota. It is important to tie the proposed activity to the overall RHTP programmatic goals within the Notice of Grant Opportunity on page 8, as well as demonstrating how the project is transformative.

Q31. Can RHTP be used to deploy iPhone Rover technology for inpatient nursing to replace in room barcode scanners and improve workflow efficiency?

A31. This is an allowable investment under Initiative 5. Please be sure to include information in your proposal on its alignment with the initiative's priorities and overall RHTP programmatic goals.

Q32. Can RHTP be used to complete IT PEN testing, Risk Assessment, and FortiNAC implementation to strengthen cybersecurity and protect patient data.

A32. This is an allowable investment under Initiative 5. Please be sure to include information in your proposal on its alignment with the initiative's priorities and overall RHTP programmatic goals.

Q33. Can RHTP be used to purchase two new mammography machines to enhance diagnostic capacity, improve access to breast cancer screening, and support earlier detection for patients across our service area.

A33. Mammography machines may be allowable under Initiative 5. In order to make a full determination, MDH will need more information. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q34. SafeTrace Blood Bank Implementation. Implementing the SafeTrace Blood Bank Module allows us to: Strengthen blood product traceability and transfusion safety through automated, end-to-end tracking, reduce reliance on manual documentation, decreasing the risk of errors and compliance gaps, improve turnaround time and availability of blood products for emergency, surgical, and inpatient care, and optimize inventory management to reduce waste, backorders, and unnecessary costs. SafeTrace interfaces directly with existing laboratory and clinical systems, allowing blood product status, transfusion documentation, and compliance data to be available to clinical teams in real time. This integration supports earlier clinical intervention, improved care coordination, and enhanced readiness for value-based and population health care models.

A34. This is an allowable program under MN's RHTP. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q35. Clinic Imaging Equipment Enhancement: Benefits of upgrading/enhancing 2002-era and 2007-era DR retrofit x-ray equipment

with fully digital equipment with AI capabilities:

1. Increased efficiency and throughput.

2. Expand orthopedic care imaging to clinic with ability to complete full orthopedic imaging views eliminating patients needing to travel.

3. AI-enabled software: Reduces positioning errors, optimizes exposure automatically, improving image quality and reducing exposure errors.

4. Enhanced cybersecurity

5. Financial Sustainability

A35. This may be an allowable investment. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q36. We are wondering about MDH's thoughts on remote tele-monitoring. Our situation is that we currently have little capability to admit patients that need telemetry monitoring due to staffing challenges. We often find we ship patients out of our facility due to a lack of staff availability for monitoring. This greatly affects keeping the community members local. Does MDH consider remote tele-monitoring for inpatients a part of this grant opportunity? Or is it considered more of a patient that is at home and being monitored. We have reached out to remote tele companies that would monitor our inpatients and allow us to admit those in need.

A36. Minnesota will be doing an assessment of telehealth support services as part of first year RHTP funding. Remote tele-monitoring/tele-services may be allowable with additional information. The telehealth support should come from within a hospital's organization, entity, system or neighboring institutions located in Minnesota. It is important to tie the proposed activity to the overall RHTP programmatic goals within the Notice of Grant Opportunity on page 8, as well as demonstrating how the project is transformative.

Q37. Does the Mindray Ultrasound with AI technology Implementation for Anesthesia qualify for initiative 5? The Mindray TE X-Series offers the newest AI interface that redefines accuracy in point of care imaging. This integration supports earlier clinical intervention, improved care

coordination, and enhanced readiness for value based and population health care models.

A37. This is a potentially allowable project under RHTP under Initiative 5. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q38. Are certain capital equipment purchases considered allowable under the RHTP? One example we are thinking of is the cordless fetal monitor to allow greater mobility for laboring patients while maintaining continuous monitoring. This equipment will enhance the quality of care and support our maternal health services - keeping care closer to home.

A38. This is a potentially allowable project under RHTP. To make a full determination, it is important to connection with the overall RHTP goals in the Notice of Grant Opportunity on page 8, the initiative's priorities while thinking about the transformative impact on your community, and sustainability beyond RHTP funds.

Q39. Are any security measures allowable? For example: infant security system or upgraded security badge access.

A39. The infant security system is allowable under RHTP. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant. The upgraded badging system is not allowable and organizations may consider applying for the Healthcare Workplace Safety grant for this (https://www.health.state.mn.us/facilities/ruralhealth/funding/grants/index.html#hcwps).

Q40. We are evaluating technology and investment for operating room scopes to assist with earlier cancer detection, provider efficiency improvements, evidence-based practices, preparation for values based purchasing, enhanced charge capture and performance optimization to improve population health. Is this allowable?

A40. This is a potentially allowable project under RHTP under Initiative 5. To make a full determination, it is important to connection with the overall RHTP goals in the Notice of Grant Opportunity on page 8, the initiative's priorities, sustainability, and the transformation possible given the investment.

Q41. We have prioritized a da Vinci robot as our top priority that checks every box for its transformative nature, creating lasting changes for our

organization and community, sustainability, and preparing for future change. Can we use the funds for this purpose like other rural hospitals in other states are doing with the RHTP funds as MN's standards are different?

A41. This may be an allowable investment in RHTP. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q42. If a site does not have OB services, would a project that couples simulation training for local staff to ensure they are prepared for high-risk, low-frequency deliveries along with the development of care coordination procedures to connect patients with tertiary care sites be allowable under initiative 5, care coordination?

A42. MDH currently supports the Minnesota Rural Obstetrics Simulation & Education Program (MN ROSE) and is expanding it to allow for more training time to rural MN hospitals and birth centers. Therefore, the purchase of simulation equipment for a rural hospital is not allowable. Rural hospitals who are interested in participating in the MN ROSE program should visit: https://cloquethospital.com/ob-simulator-training-program/

Q43. Is the following allowable: Expanding telemedicine/bedside consultation?

A43. Telehealth services may be allowable with additional information. The telehealth support should come from within a hospital's organization, entity, or entities that support their organization, including neighboring institutions. It is important to tie the proposed activity to the overall RHTP programmatic goals within the Notice of Grant Opportunity on page 8. Additionally, considering the initiative and how the project is transformative is key.

Q44. Does MDH require the VBC readiness assessment by individual site? Or can they submit 1 for the organization?

A44. Health systems are allowed to fill out one VBC tool for their system rather than by hospital if individual hospitals within the system are not going to more towards VBC by themselves.

Q45. Another area that our team is assessing to address the challenge of recruiting a general surgeon to a rural setting and needing the latest equipment that they are now being trained on. Do you know if a Da Vinci

surgical system. We are learning as we look to recruit a surgeon that this is a must to recruit new surgeons to rural and supporting surgical care close to home.

A45. This may be an allowable investment in RHTP. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q46. We are exploring upgrading the EMR at our skilled nursing/assisted living facility to help with care coordination between the SN/AL and the hospital. Is this allowable?

A46. This is allowable. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q47. Can we allocate a portion of RHTP funds towards a daVinci robot?

A47. The da Vinci robot may be an allowable investments in RHTP, however MDH will need more information. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q48. Can we purchase Starlink, a wide-area network, to minimize disruption to care due to network instability?

A48. Starlink may be an allowable investments in RHTP, however MDH will need more information. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q49. Given our recent certification as a Primary Stroke Center, becoming a stroke "hub" for other, more rural, hospitals. This would include IT and telestroke infrastructure needs, MRI capability (staffing) on the weekends, additional echo machines, virtual rehab center for stroke rehab, etc.

A49. Telehealth services, the purchase of additional echo machines and set up of virtual rehab centers may be allowable with additional information. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q50. In addition to the Provation software for endoscopy that we identified previously for RHTP funding, we would need to upgrade our equipment to enhance our ability for early colorectal cancer screening and detection. This equipment and software solution would be partnered with our clinic efforts for increased screening. Do you feel that these items would qualify under RHTP section 1 and section 5?

A50. RHTP cannot pay for the whole cost of the endoscopy system, but can pay for the difference between standard endoscopy equipment and the upgraded version which is compatible with the software you've outlined. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q51. Our question is on revenue cycle management/AI project that would involve hiring a company to implement their software to improve our collections through registration coding and the billing process. We want to be sure that this type of project would qualify for the RHTP.

A51. This is an allowable project under RHTP under Initiative 5.

Q52. We'd like to include a workplan that involves analysis to help identify highest areas of need for software and tech implementation. How specific do we have to be with the quotes for pricing on this? Difficult to understand how we can get quotes for pricing on all of these within the very minimal allotted timeframe for this application. What if we don't have a quote in time, are we able to just allot the remaining expenses to equipment and software upgrades and/or how likely will we be able to shift costs throughout the course of the year? If a software install ends up less expensive than originally thought can they be shifted? Do we have to stick with the vendors and quotes as originally outlined in the application?

A52. Quotes don’t have to be extremely specific but should have an estimate. If costs change from the time of obtaining a quote to starting work, budgets can be modified. Obtain quotes and select vendors according to your organization’s procurement policies. Please maintain regular communication with your grant manger as changes like this occur.

Q53. Technology improvements to improve efficiency and cyber protection. Also wondering about aging IT equipment like servers that would also help these areas?

A53. Technology investments that improve efficiency and cybersecurity are allowable projects under Initiative 5. Physical equipment is allowable under this activity. In your proposal, be sure to include its relation to the transformation goals and outline why RHTP funds are needed to make this purchase instead of acquiring it through typical organizational budgeting for normal operating costs. All expenses under RHTP must be reasonable.

Q54. Are subscription fees/annual service fees for technology that is implemented in year 1 allowable costs in future years since the fee would allow the initiative to be maintained?

A54. Ongoing subscription and service fees are allowable, even if they take multiple years to implement. The only unallowable ongoing fee is outlined in Initiative 5: Ongoing or recurring member fees for clinically integrated networks, Accountable Care Organizations or other collaborations.

Q55. As we continue working through the grant application process, one project we are considering including in our request is the implementation of a Data Loss Prevention (DLP) solution. Implementing a solution of this scope would be a significant effort and would likely span multiple budget periods. If the project were to span Budget Period 1 and Budget Period 2, with costs paid as project milestones are completed, would this be acceptable under the grant guidelines? If so, would we need to apply for funding in multiple years, or would we apply for the full project cost up front?

A55. This is an allowable investment with RHTP funds. Most transformative projects will take more than one year to implement. We expect organizations to outline the first budget period in a detailed way in the budget and workplan and, in the narrative, discuss the high-level details of future years and how this achieves the grant goals outlined on page 8 of the Notice of Grant Opportunity. Organizations will complete one full application in this first year and in each of the following budget periods will submit a new workplan and budget to add additional funds and activities to their workplans. Note that MDH cannot guarantee funding for years 2-5 as CMS's award to Minnesota is variable.

Misc equipment

Q1. We would like to introduce a new service line: Interventional Radiology which is not currently available in our community. Provided our expenses are for equipment and renovation - not construction, would this be allowable?

A1. This may be an allowable investment in RHTP. Be sure to outline the minor renovation project and distinguish it from construction costs (which are not allowable under RHTP). All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q2. We would like to look into getting some new equipment for the general surgeon that does outreach hear that would allow him to expand his offerings of surgical procedures within our facility. This would include a surgical table and some surgical instruments.

A2. In order to make a full determination, MDH will need more information. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q3. We are also looking into a new coagulation analyzer for our lab that would allow expanded coag testing for our patients.

A3. In order to make a full determination, MDH will need more information. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q4. Respiratory / Pulmonary Function Equipment - Equipment costs of $40,000. We already have certified individual and training completed, no costs there.

A4. In order to make a full determination, MDH needs to know which respiratory and pulmonary function equipment you are planning to purchase. All applications must demonstrate how each component of the proposal aligns with RHTP goals and activity priorities, results in transformative change for organizations and communities, and is sustainable beyond the RHTP grant.

Q5. Are capital and programmatic investments directly tied to population health are allowable, such as: Transportation resources to expand access to care and community-based services and Pharmacy-related equipment or infrastructure that improves medication access, adherence, and care coordination?

A5. Transportation program planning is allowed, but the actual expense of transporting patients is not allowable. For pharmacy related equipment and infrastructure, MDH will need more information. Software to increase adherence and coordination may be allowable.

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