These questions and answers are for the Louisiana Telehealth Infrastructure for Rural Access Program, Year 1 Notice of Funding Opportunity (NOFO). Submitted questions were combined and modified in the interest of brevity. This document is intended to be a resource for all prospective applicants.

Application Details

1. **Does the 5-year maintenance period for funded telehealth infrastructure run from the date of purchase, the date of project completion, or the award date?**
   The 5-year maintenance period should begin when the funded telehealth infrastructure/equipment is operational.

2. **This NOFO is classified under the "Expand Physical Activity and Nutrition Interventions Through Community-Based Partnerships", does that mean that the tele-health has to be directly related to nutrition and physical activity initiatives?**
   No, proposed telehealth projects are not restricted to nutrition and physical activity. The NOFO states that the initiative is designed to accelerate implementation of projects that directly:

   A. Improve insufficient telehealth infrastructure to expand access to primary, specialty, and behavioral healthcare services in rural and underserved parishes, including services related to:
      - Maternal and prenatal health
      - Behavioral health and psychiatric care
      - Chronic disease management, including diabetes, hypertension, COPD, and cardiovascular conditions
      - Substance use disorder treatment and recovery services
      - Emergency specialty consultation and care coordination
      - Cancer treatment
      - Remote patient monitoring (RPM) and care management services

3. **Can a rural provider applicant include both senior/chronic disease cardiovascular screening and maternal/postpartum cardiac risk monitoring under one proposed telehealth infrastructure project if both populations are served by the same rural access, remote monitoring, and care-coordination infrastructure?**
   Yes, applications may cover multiple purposes under an eligible organization.

4. **For larger integrated initiative what is the preferred approach to referencing the overall program goals, target population, outcomes framework and sustainability**

while ensuring each NOFO response remains focused on the specific eligible activities of that initiative? Is there any guidance on sequencing or layering funding while still allowing each response to stand alone and demonstrate clear linkage to the required outcomes and sustainability?
When preparing Statements of Work, applicants should describe the larger initiative/project in Section I. Applicant Information.

Provide information that will describe how the larger project will affect the organization and the individuals served by the organization, including the organization's intent to apply for funds through other RHTP initiatives/strategies. This may include references to other planned RHTP applications for funding.

Section II. Program Description should focus on the capital improvement portion of the project specifically. The project description and project plan should outline the project's scope, objectives, tasks, milestones and resources related to the capital improvement portion of the larger project.

Applicants should clearly distinguish the activities, costs, milestones, and outcomes supported by this funding from those supported through other funding sources. Leveraging multiple funding sources is encouraged; however, applicants must demonstrate how funds will complement one another and avoid duplication of payment for the same activities, equipment, services, or deliverables.

Note: All strategic NOFOs will all be released by mid July. Applications will be scored and awardees will be notified of selection by mid/late August.

5. **Should the Sustainability Plan be written based on the actual project period (e.g. sustainability beyond 3 years for a 3-year project), or based on the assumption that future funding will be available from RHTP though 2030?**
The sustainability plan should explain how the program funded through this funding opportunity will be continued once the proposed project period is over.

Per the NOFO, Applicants must describe the anticipated post-grant operating model for the proposed telehealth infrastructure investment, including expected utilization, staffing support model, reimbursement strategy, payer alignment, anticipated telehealth-related revenue generation, and long-term maintenance or technology support plans.

Sustainability plans should clearly explain how the proposed investment will remain operational, financially viable, and integrated into routine care delivery workflows following the conclusion of grant funding.

6. **May a single organization receive awards under both the Rural Health Facilities Capital Improvement Program and the Telehealth Infrastructure for Rural Access Program in Budget Year 1? If so, are there restrictions on funding related or complementary scopes across the two awards?**
   Yes, organizations can receive funds under both programs. Funding should be detailed in each budget proposal to assure that duplication of payment is not being sought or funded.

7. **RPM devices are listed as eligible. How does the required 5-year maintenance obligation apply to remote patient monitoring devices that are issued to or held by patients, as opposed to equipment retained at the facility?**
   Yes, the requirement must be met by maintaining the capability or service line for five years**.**

Eligible Use of Funds

1. **What will the funding cover for telehealth?**
   Funding supports one-time telehealth infrastructure investments that directly improve care delivery.

2. **Are costs associated with software configuration, workflow implementation, data integration, secure reporting, and care-coordination dashboards allowable if they are directly tied to telehealth, remote patient monitoring, chronic disease management, or specialty-care access for rural patients?**
   Applicants should provide a detailed budget and budget narrative explaining the need for all requested expenses for LDH review and approval.

3. **Are first-period subscription or licensing fees for telehealth/RPM platforms and interoperability interfaces treated as allowable one-time infrastructure within the project period, or as routine operational costs that may only be counted as match?**
   Funding requests for ongoing subscription costs should be limited to 3 years, at reduced proportion towards demonstrated sustainability. Applicants must provide justification for the expenditure.

4. **What are the non-allowable use of Capital Improvement funds?**
   a. AI-assisted clinical documentation or ambient-scribe tools
   b. Scholarship program to help pay for patient co-pays for those unable to pay co-pays
   c. Vendor implementation, configuration, and EHR-interface build services (may be eligible under future EHR initiative/strategy)

d. Repair due to water/storm damage that is covered (in whole or in part) by property insurance
e. Patient outreach, onboarding, scheduling, device setup support, adherence support, and training costs

5. **Are construction costs considered an allowable cost for this project?**
   Limited renovation of infrastructure to support telehealth implementation can be requested or used as match. The applicant should describe the relationship between construction and the telehealth project.

6. **Are remote patient monitoring devices, wearable cardiac monitoring coordination tools, patient setup materials, and related deployment infrastructure allowable when used to support rural cardiovascular screening, chronic disease management, maternal/postpartum risk monitoring, or specialty referral workflows?**
   Some may be allowable upon LDH review. Documented need for these types of investments should be clearly defined in all project proposals.

7. **CP/MIH organizations lack an established reimbursement mechanism for our services. We are concerned the EMS industry may decline to participate, focusing on core business, which has a structured reimbursement mechanism. Is it possible funding can apply to non-billable CP/MIH services? Alternatively, can funding be used to guarantee capacity or coverage in these rural areas rather than reimbursing for services?**
   LDH will review and consider such funding requests. Documented need for these types of investments should be clearly defined in all project proposals.

8. **Can funds be used to equip ambulances, non-transport vehicles, or CP units with telehealth capabilities? Are telehealth-enabled community paramedicine kits (e.g., tablets, peripherals, diagnostic tools, remote monitoring devices) considered allowable infrastructure? Does Initiative 4 support telehealth models where community paramedics: conduct in-home assessments with a remote clinician, divert low-acuity patients from ED transport, or support chronic disease management via telehealth?**
   Telehealth Infrastructure supporting EMS or community paramedicine programs may be eligible when they expand access to healthcare services for rural populations and are integrated with a broader healthcare delivery model. The lead applicant should be a licensed rural healthcare provider, and the application should demonstrate measurable improvements in healthcare access, care coordination, chronic disease management, emergency care, or other health outcomes.

9. **Are costs related to training rural provider staff on telehealth/RPM workflows, patient activation, escalation protocols, and structured reporting allowable under the program?**
   Provider staff salaries and wages cannot be requested. Costs related to contracted training of staff may be allowed if need is clearly detailed in the proposal.

10. **May a provider applicant include costs for interfaces or data exchange between the applicant's EHR, care management systems, remote monitoring vendors, and a contracted technology partner, if those costs are necessary to support reporting, care coordination, and outcomes measurement?**
    Costs related to such items may be allowed after LDH review and approval. Applications should include clearly link the need for these efforts and their link to telehealth programs.
11. **Can grant-funded infrastructure be used across multiple rural care settings, such as clinic, home, mobile/community site, and maternal health access points, if the applicant can document governance, patient eligibility, data security, and reporting controls?**
    Yes.

Eligible Organizations

1. **Can an eligible rural provider applicant include a contracted health technology partner to support implementation of remote cardiac screening workflows, patient activation, remote monitoring coordination, structured reporting, care coordination, and outcomes dashboards, if the applicant remains the grant recipient and the technology partner is paid under fair-market-value implementation terms? . If an eligible rural provider applies with a contracted technology partner, what documentation should be included at application submission: letter of support, memorandum of understanding, draft statement of work, vendor quote, budget narrative, or executed agreement.**
   Yes. Costs related to a contracted health technology partner should be itemized and justified in the budget narrative. Proposals including supporting documentation such as those listed above may be viewed more favorably.

2. **Does equipping school-based clinics with telehealth carts/kiosks, remote patient monitoring (RPM) devices (particularly for pediatric chronic conditions such as asthma, obesity, or behavioral health), interoperability interfaces, scheduling/workflow tools, and cybersecurity upgrades align with the priority areas for expanding access to specialty, behavioral health, prenatal, and chronic care services for high-need rural children?**
   Telehealth infrastructure investments supporting school-based or school-linked health clinics may be eligible when the project expands access to healthcare services for rural populations, including primary care, behavioral health, preventive services, telehealth, or care coordination. The lead applicant should be a licensed rural healthcare provider, and the application should demonstrate how the proposed investments support healthcare delivery and measurable rural

health outcomes. Applicants should clearly identify the specific healthcare services, target population, and expected access or health outcome improvements associated with the proposed investment.

3. **Can a hospital network or collaborative organization, representing multiple independent rural hospitals, apply as the primary applicant if it is not itself located in a rural-designated area but primarily serves rural hospitals?**
   Each individual rural provider must apply for telehealth infrastructure support at its own facility.

4. **Clarify the types of organizations/legal entities that are eligible to apply for this funding. Is it only for non-profits or is it also open to for profit entities?**
   Both for profit and not for profit licensed healthcare providers are eligible for telehealth infrastructure funds.

5. **For projects involving shared infrastructure and services across multiple eligible hospitals, how should applicants define project scope, allocate project costs, and document matching contributions amongst multiple providers/hospitals?**
   A licensed healthcare provider is the preferred lead applicant when projects involve shared infrastructure. Lead applicants must qualify as "rural" under the Louisiana Rural Health Transformation Program definition and methodology. To confirm your organization is rural, visit RHTP Funding Opportunities

   The project scope should define the relationship between all parties. Budgets should delineate both requested and matching funding with written support documentation included with the application.

Budget and Invoicing Questions

1. **In the NOFO, it says "routine operational costs cannot be request but can be documented as match/cost share (e.g. salaries, supplies, equipment leases). On the budget worksheet spreadsheet, staff expense is considered an indirect cost with a max of 1.5%. Does that mean you can request up to 1.5% of the staff salaries? Also, if they can't be requested, then how can they be matched?**
   Salaries and wages are not equivalent to indirect costs. Indirect costs are calculated as 1.5% of all "requested" total direct costs.

2. **Both Initiative 4 and Initiative 5 require a mandatory minimum 10% cost share/match and a detailed sustainability/post-grant operating model. What types of in-kind contributions (e.g., existing technology platforms, data integration capabilities, school**

partnership agreements, or development of Alternative Payment Model/VBC infrastructure) qualify toward the match? What level of detail is expected in the sustainability plan when the post-grant model relies on a combination of existing and future VBC/APM contracts with Louisiana MCOs? What are not acceptable matching pathways?

Applications should include for LDH review and approval:

1. A description/itemization of each contribution that will make up the minimum 10% cost share, including the relationship of the contribution to the project goals.
2. A proposed method of documentation for each contribution.
3. All contributions must be expended during the contracted project period.
4. Contributions may be in-kind or in-cash.

3. **How should the costs related to RHT required audits and reporting be presented in our requests for funding?**

   Costs related to required Federal audits are not allowed.

4. **Does LDH prefer that contracted technology partner costs be included as vendor/contractual expenses, professional services, software/technology expenses, or another budget category in the application budget?**

   Technology partner costs should be requested under the CMS approved budget category, contractual.

Performance Metrics

1. **For a project involving remote cardiac screening and monitoring, should the applicant define success primarily through access metrics, such as patients reached and monitoring completion, or through clinical workflow metrics, such as detection yield, physician-review turnaround, follow-up routing, and avoided referral burden?**

   Examples of performance measures may include, but are not limited to:

   - Increase in completed telehealth visits or unique patients served
   - Reduction in specialist wait times or delays in access to care
   - Reduction in missed appointments or no-show rates
   - Improvement in behavioral health follow-up completion
   - Increase in access to maternal, specialty, or chronic disease services
   - Improvement in remote patient monitoring (RPM) participation and engagement
   - Reduction in avoidable emergency department utilization or hospital transfers
   - Improvement in care coordination, referral completion, or patient retention
   - Technology deployment and implementation milestones
   - Workforce adoption and provider utilization metrics

Rural Determination

1. **For an organization (e.g., an FQHC) operating sites in both a rural parish and a metropolitan parish, is "rural" eligibility determined at the organization level, the individual service-site level, or by rural patient population served? May such an organization apply based on its rural sites and rural patient population while continuing to operate non-rural sites?**
   Rural eligibility can be established at the service-site level through eligibility pathways 1 or 2 or by rural population served, pathway 3. For more information visit, visit RHTP Funding Opportunities.