Center for Rural Health Sustainability & Innovation (CRHSI)

RFP# 27-630-1000-0003

June 1, 2026

Q&A

	Submitted Question	Answer
1	Would HCA be able to provide the organizational reference questions or evaluation criteria that references will be asked to complete through the portal? Additionally, are organizational references evaluated primarily on overall performance quality, similarity to the CRHSI scope, rural/frontier healthcare experience, technical assistance experience, project scale/complexity, or federal healthcare program experience?	The Organizational Reference Questionnaire is included in Appendix D of the RFP and will be provided to identified references through Submittable. References must submit responses directly through Submittable by the deadline stated in the RFP. Organizational references will be evaluated in accordance with Section V.B.2, Organizational References. References are evaluated based on responses to the Organizational Reference Questionnaire, including evidence of positive service history, successful execution of services, and customer/client satisfaction. The purpose of the references is to document the Offeror's experience relevant to the Detailed Scope of Work, including the Offeror's ability to provide the required services, performance under similar contracts, and ability to provide knowledgeable and experienced staffing. Organizational references may reflect multiple relevant factors, including performance quality, similarity to the CRHSI scope, rural/frontier health care experience, technical assistance experience, project scale and complexity, and federal or health care program experience, to the extent those factors are addressed in the questionnaire responses and are relevant to the RFP requirements.
2	Can the State confirm that all team member experience and qualifications (including subcontractors) will be evaluated in the scoring of Technical Proposal. (IV.A)	Yes. Offerors should include the experience and qualifications of all proposed key personnel and subcontractors who will support performance of the contract. The RFP requires Offerors to describe the experience of all proposed subcontractors and provide detailed biographies for all key personnel proposed for performance of the resulting contract, including education, work experience, relevant certifications or licenses, and other qualifications demonstrating the individual's capacity to perform the required work. Subcontractor and team member experience will be evaluated to the extent it is included in the Offeror's proposal and is relevant to the applicable evaluation factors, including Qualifications and Experience, Specifications, Staffing and Organizational Structure, and the Offeror's ability to deliver the Scope of Work. The prime

		Contractor remains responsible for all services and deliverables, including work performed by subcontractors.
3	Can the state confirm that proposals including participation from subcontractors with NM residents' certifications will receive New Mexico/Native American Resident Preferences credit? (RFP Section IV.B.8)	No. New Mexico/Native American Resident Preference points will not be applied to this RFP because the expenditure includes federal funds for a specific purchase. Section 13-1-21(J) NMSA 1978 provides: "This section shall not apply when the expenditure includes federal funds for a specific purchase." This RFP is funded through the federal Rural Health Transformation Program, which is administered by CMS, and the RFP states that CRHSI implementation supports New Mexico's federally funded Bridge to Resilience initiative. Accordingly, neither an Offeror's New Mexico/Native American Resident Preference certification nor a proposed subcontractor's New Mexico/Native American Resident Preference certification will result in preference points under this RFP.
4	Section III.C.VII – Reference Letters. Would the State consider pushing back the reference letter submission date (May 27, 2026) to align with the proposal submission date (June 4, 2026)?	Yes. HCA has extended the organizational reference submission deadline as reflected in the amended Sequence of Events. Organizational references must still be submitted directly by the business reference through Submittable.
5	Section III. C.X – Completed Cost Proposal and Section III.XI – Workplan. For purposes of preparing comparable cost proposals and workplans, should prospective vendors submit a one-year pricing estimate and workplan for RHT Program Year 1 approved funding or a five-year pricing estimate and workplan through the full RHT Program period (FFY 2026 – FFY 2030)?	Offerors should submit a pricing estimate and workplan for the first two federal fiscal years of CRHSI work. For purposes of this RFP, Federal Fiscal Year (FFY) means October 1 through September 30, and State Fiscal Year (SFY) means July 1 through June 30. Offerors should structure the Cost Proposal and Workplan for the initial implementation period and break costs out by State Fiscal Year, as applicable. Offerors should separately identify: 1. FFY26 allocation: The portion of the FFY26 CRHSI allocation proposed to be used during the anticipated initial contract period, beginning August 1, 2026, through September 30, 2027. FFY26 funds are authorized to be used through FFY27. 2. Additional anticipated FFY27 need: Any additional amount the Offeror anticipates needing in FFY27 beyond the FFY26 allocation. This amount must be listed separately from the FFY26 allocation and is for informational purposes only. It will not be included in the initial contract unless and until FFY27 federal funding is secured and HCA authorizes the additional funding. Offerors should not include funding estimates for FFY28 through FFY30 in the Cost Proposal or Workplan. Future-year funding and contract extensions will be dependent on federal funding availability, State RHT Program performance, Contractor performance, operational need, and HCA approval.

6	Section III. C.X – Completed Cost Proposal. The State referenced a $26M Year 1 and $128M total (five year) budget for the CRHSI during the webinar on May 13. To support comparable pricing, of the $26M budgeted for CRHSI in Year 1 and $128M for the five-year program period, what proportion of funding is allocated for the specific services and scope outlined in this RFP?	The referenced $26 million Year 1 and $128 million five-year amounts reflect the broader Bridge to Resilience / CRHSI initiative budget and should not be interpreted as a guaranteed contract value or as the amount available solely for CRHSI Contractor operating costs. For purposes of this RFP, Offerors should submit a CRHSI budget consistent with the Cost Proposal guidance provided in response to Question 5 and any related amendment. The budget should include the full estimated cost of CRHSI for the initial contract period, including: CRHSI Contractor operating/service delivery costs, such as staffing, subcontractors, technical assistance, implementation support to HCA, provider engagement, learning collaboratives, data-informed support, travel, administrative costs, and other costs necessary to perform the Scope of Work; and Estimated provider-directed payments, including provider incentive payments, direct provider payments, or other provider-directed funding anticipated under CRHSI. New Mexico's RHT Budget Narrative includes an FFY26 provider payment estimate of $5 million for Bridge to Resilience / CRHSI. Offerors should use this amount as a reference point when preparing the overall CRHSI budget. The detailed provider incentive structure, eligibility criteria, metrics, and distribution process will be developed during implementation and approved by HCA. Offerors must clearly identify provider-directed payment estimates separately from CRHSI Contractor operating/service delivery costs. Provider-directed payment estimates are included for overall CRHSI budget planning and comparability, but they will not be included in the cost figure used to calculate Cost Proposal points unless otherwise directed by HCA. All proposed costs must comply with applicable federal requirements, including 2 CFR Part 200, CMS cooperative agreement terms and conditions, and the approved RHT Program budget structure. Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Equipment costs must be separately identified and will be reviewed for allowability, allocability, reasonableness, alignment with the Scope of Work, and compliance with applicable CMS or federal cost limitations. HCA is not assigning a fixed percentage of the Year 1 or five-year CRHSI initiative budget to the Contractor operating scope through this FAQ. The final contract amount and funding structure will depend on the selected Offeror's proposed cost, HCA's determination of cost reasonableness and feasibility, available

		federal funding, approved scope, federal allowability, and HCA direction.
7	Section III. C.X – Completed Cost Proposal. Could the State please define "Cost Category" included in the sample Cost Proposal table?	For purposes of the Cost Proposal table, Cost Category refers to the general budget classification or type of cost being proposed. Offerors should use cost categories that clearly describe the nature of the expense and allow HCA to evaluate cost reasonableness, allowability, and alignment with the CRHSI Scope of Work. Examples of cost categories may include, but are not limited to: • Personnel / staffing • Fringe benefits • Subcontractor costs • Travel • Supplies • Equipment, if applicable and allowable • Technology, systems, software, or platform costs • Training, facilitation, or convening costs • Administrative costs • Indirect costs • Other direct costs Offerors may add or modify cost categories as needed, provided the Cost Proposal includes the minimum information required in the RFP, clearly identifies all assumptions used to calculate costs, and includes sufficient detail to support evaluation of cost reasonableness and feasibility. The RFP states that the Cost Proposal must include all staffing, operational, administrative, technology, and subcontractor costs and be presented in sufficient detail to support evaluation. Administrative costs must be clearly identified in the proposed budget and may not exceed applicable federal limits.
8	Section III.C.XI – Workplan. The RFP instructs Offerors to complete "the template" for the workplan, but the RFP does not appear to include a template. Will the State be providing a template or should Offerors use their own format for the workplan?	Offerors should use their own format for the Workplan. HCA will not provide a separate Workplan template for this RFP. The Workplan must be comprehensive and describe how the Offeror will establish, implement, and operate the CRHSI throughout the applicable contract period. At minimum, the Workplan should demonstrate the Offeror's ability to launch and operationalize CRHSI in alignment with the Scope of Work, deliver required services in a structured and timely manner, coordinate staffing and resources across functional areas, maintain continuity of services, and monitor progress toward deliverables and performance expectations. Offerors may include narrative, tables, timelines, milestones, staffing assumptions, dependencies, and other supporting information needed to clearly explain the proposed implementation approach. The Workplan should also align with the Cost Proposal

		and any amended guidance regarding the initial CRHSI implementation period and budget structure.
9	Section V.B.8.F – New Mexico / Native American Resident Preferences. In the spirit of supporting New Mexico / Native American Resident businesses, would the State consider awarding preference points to prospective vendors engaging a New Mexico / Native American Resident business as a subcontractor?	No. Please see the response to Question 3. New Mexico/Native American Resident Preference points will not be applied to this RFP because the expenditure includes federal funds for a specific purchase. Accordingly, neither an Offeror's New Mexico/Native American Resident Preference certification nor a proposed subcontractor's certification will result in preference points under this RFP. HCA still encourages Offerors to build teams that reflect the experience, relationships, and capacity needed to serve rural, frontier, and tribal communities in New Mexico.
10	Appendix B: Standard Contract Terms and Conditions. For purposes of preparing comparable pricing and delivery assumptions, would HCA consider clarifying in the contract that the Contractor's responsibility and liability are limited to the services, deliverables, and actions within the Contractor's control, and do not extend to provider supplied data quality, provider participation delays, third-party system availability, State-directed decisions, or other external dependencies outside the Contractor's control? Further, would HCA consider a reasonable cap on the Contractor's liability under the contractual agreement?	HCA is not modifying the Standard Contract Terms and Conditions through this FAQ. If an Offeror seeks alternate contract language related to the Standard Contract Terms and Conditions, the Offeror must propose specific alternative language with its proposal, including a brief discussion of the purpose and impact of the proposed change. HCA may or may not accept proposed alternative language. Final contract terms will be determined through the procurement and contract negotiation process. General references to an Offeror's standard terms and conditions or attempts to substitute the draft contract are not acceptable and may result in disqualification.
11	Appendix B: Standard Contract Terms and Conditions. Would HCA consider incorporating terms into the Standard Terms and Conditions clarifying that the Contractor retains ownership of its pre-existing intellectual property used to deliver the services, provided that HCA be granted a license to use such pre-existing intellectual property in subjection with the services?	HCA is not modifying the Standard Contract Terms and Conditions through this FAQ. If an Offeror seeks alternate contract language related to the Standard Contract Terms and Conditions, the Offeror must propose specific alternative language with its proposal, including a brief discussion of the purpose and impact of the proposed change. HCA may or may not accept proposed alternative language. Final contract terms will be determined through the procurement and contract negotiation process. General references to an Offeror's standard terms and conditions or attempts to substitute the draft contract are not acceptable and may result in disqualification.
12	Appendix B: Standard terms and Conditions. Would HCA consider limiting the Contractor's indemnification obligations under the Standard Terms and	HCA is not modifying the Standard Contract Terms and Conditions through this FAQ. If an Offeror seeks alternate contract language related to the Standard Contract Terms and Conditions, the Offeror must propose specific alternative language with its proposal, including a brief discussion of the purpose and impact of the proposed change.

	Conditions to direct third-party claims?	HCA may or may not accept proposed alternative language. Final contract terms will be determined through the procurement and contract negotiation process. General references to an Offeror's standard terms and conditions or attempts to substitute the draft contract are not acceptable and may result in disqualification.
13	If an Offeror has submitted an application for NM/Native American preference certification but approval is pending at proposal submission, can that status be acknowledged or considered? (Section V Evaluation Factors)	No. Please see the response to Question 3. New Mexico/Native American Resident Preference points will not be applied to this RFP because the expenditure includes federal funds for a specific purchase. Accordingly, pending or approved New Mexico/Native American Resident Preference certification status will not be considered for purposes of evaluation or scoring under this RFP.
14	For Questionnaire Specifications Sections 2 ("Sustainability & Financial Viability Analysis") and 3 ("Agreement Initiation and Execution Support"), can HCA clarify whether the intended response limit is 1,200 words or 1,200 characters? The RFP document references 1,200 words, while the Submittable form currently displays a 1,200-character limit. (Questionnaire Specifications Sections 2 & 3)	The intended response limit is 1,200 words for each response. The 1,200-character limit displayed in Submittable is an error. HCA will update the Submittable form to align with the RFP and allow responses of up to 1,200 words for Questionnaire Specifications Section 2, "Sustainability & Financial Viability Analysis," and Section 3, "Agreement Initiation and Execution Support."
15	The RFP references a Workplan "template" in multiple sections; however, we were unable to locate a Workplan template within the RFP attachments or Submittable platform. Can HCA please confirm whether a Workplan template will be provided, or whether Offerors should develop and submit their own format? (Section X Workplan)	Please see the response to Question 8. Offerors should use their own format for the Workplan. HCA will not provide a separate Workplan template for this RFP. The Workplan should include sufficient detail to describe the Offeror's proposed approach to establishing, implementing, and operating CRHSI, including proposed activities, milestones, staffing and resource assumptions, timelines, dependencies, and alignment with the Cost Proposal.
16	Sections 2.3, 2.5, 8, and 9 of the RFP reference stakeholder engagement, coalition-building, convenings, and stakeholder coordination activities. During the recent RHTP stakeholder meeting presentation, HCA also described a "Stakeholder Advisory Committee" that would be "coordinated by PMO and CRHSI." Can HCA clarify whether participation on the Stakeholder Advisory Committee by providers,	Participation on the anticipated RHT Program Stakeholder Advisory Committee, once established, will not automatically create a conflict of interest or make an organization ineligible to receive CRHSI technical assistance, CRHSI-related support, or participate in other RHT Program activities. The Stakeholder Advisory Committee has not yet been established. HCA anticipates establishing the Committee as an advisory body to support structured stakeholder engagement, transparency, and community input during RHT Program implementation. The Committee will not hold decision-making or approval authority over program scope, funding, procurement, awards, provider eligibility, or CMS reporting. Final decisions regarding program scope, funding,

	partners, associations, or other stakeholders would create any actual or perceived conflict of interest related to eligibility for CRHSI funding, technical assistance, or participation in other RHT Program activities?	procurement, awards, eligibility, and compliance will remain with HCA in accordance with applicable federal and state requirements. All participants will be expected to comply with applicable conflict of interest, confidentiality, procurement, and program integrity requirements. HCA may require disclosure of actual, potential, or perceived conflicts and may take appropriate steps to manage conflicts, including recusal from specific discussions, limiting access to non-public information, or other safeguards as determined necessary by HCA. Participation on the Stakeholder Advisory Committee will not provide preferential treatment, priority access, or guaranteed eligibility for CRHSI services, funding, technical assistance, or participation in any other RHT Program activity. Eligibility and participation decisions will be made based on applicable program criteria, available funding, HCA direction, and federal and state requirements.
17	What is the anticipated maximum award amount for the initial contract term, and is there a total "not to exceed" amount for the full five-year RHT Program Period? (Section III.C.10/ Section V.B.6)	HCA is not establishing a guaranteed maximum award amount or a five-year "not-to-exceed" amount through this FAQ. The referenced CRHSI amounts are planning estimates for the broader Bridge to Resilience / CRHSI initiative budget and should not be interpreted as a guaranteed contract value. For purposes of this RFP, Offerors should follow the Cost Proposal guidance provided in response to Question 5 and any related amendment. Offerors should submit a pricing estimate and workplan for the first two federal fiscal years of CRHSI work, separately identifying: The portion of the FFY26 CRHSI allocation proposed to be used from the anticipated contract start date through September 30, 2027; and Any additional anticipated FFY27 need beyond the FFY26 allocation, listed separately for informational purposes only. The overall CRHSI budget should include estimated provider incentive payments, direct provider payments, or other provider-directed funding anticipated under CRHSI. New Mexico's RHT Budget Narrative includes an FFY26 provider payment estimate of $5 million for Bridge to Resilience / CRHSI. Provider-directed payment estimates must be clearly identified separately from CRHSI Contractor operating/service delivery costs. Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Equipment costs must be separately identified and will be reviewed for allowability, allocability, reasonableness, alignment with the Scope of Work, and compliance with applicable CMS or federal cost limitations.

		Offerors should not include costs for administering provider payments, payment processing, fiscal intermediary functions, or related payment administration, as those functions will be supported by the Administrative Services Organization (ASO), HCA, or another HCA-authorized mechanism. The final contract amount and funding structure will depend on the selected Offeror's proposed cost, HCA's determination of cost reasonableness and feasibility, available federal funding, approved scope, federal allowability, and HCA direction. Future-year funding and contract extensions are not guaranteed and will depend on federal funding availability, State RHT Program performance, Contractor performance, operational need, and HCA approval.
18	Will the contract be structured as Cost Reimbursement, Fixed Price per Deliverable, or a hybrid? (Appendix B: Section 2)	HCA anticipates that the resulting contract may use a hybrid compensation structure, which may include approved budget-based costs, hourly rates, deliverables, milestones, or other payment structures as finalized through contract negotiation. Offerors should submit a Cost Proposal that clearly identifies all proposed cost categories, assumptions, staffing and resource levels, unit or hourly costs, quantities/FTE, annual costs, and any deliverable or milestone-based pricing assumptions, as applicable. The overall CRHSI budget should include estimated provider incentive payments, direct provider payments, or other provider-directed funding anticipated under CRHSI. These provider-directed payment estimates must be clearly identified separately from CRHSI Contractor operating/service delivery costs and will not be included in the cost figure used to calculate Cost Proposal points unless otherwise directed by HCA. Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Equipment costs must be separately identified and will be reviewed for allowability, allocability, reasonableness, alignment with the Scope of Work, and compliance with applicable CMS or federal cost limitations. Offerors should not include costs for administering provider payments, payment processing, fiscal intermediary functions, or related payment administration, as those functions will be supported by the Administrative Services Organization (ASO), HCA, or another HCA-authorized mechanism. The final payment structure will be determined by HCA during contract finalization and will be subject to available funding, federal allowability, approved scope, and HCA direction.
19	Does the state anticipate a standard four-year contract with	HCA anticipates an initial contract period aligned with the initial CRHSI implementation period described in the response to

	annual renewals, or an initial pilot year followed by a multi-year extension to align with the 2030 federal deadline? (Section I.C/ Appendix B: Section 3)	Question 5, with any future extensions dependent on funding availability, State RHT Program performance, Contractor performance, operational need, and HCA approval. HCA does not anticipate structuring the contract as a "pilot year" with an automatic multi-year extension. The RHT Program is federally funded through CMS budget periods, and future funding is not guaranteed. HCA anticipates considering contract extensions on an annual basis, as appropriate, to align with federal funding availability and the RHT Program period ending in 2030. Offerors should submit a Cost Proposal and Workplan for the first two federal fiscal years of CRHSI work, as described in the response to Question 5. However, funding beyond the initial authorized period will not be included unless and until federal funding is secured and HCA authorizes the additional funding. Final contract term, renewal structure, and extension options will be determined through contract finalization and will remain subject to the RFP, available funding, federal requirements, and HCA direction.
20	Is there an allowable ramp up period for staffing and infrastructure development before full technical assistance services must be operational? (Section III.XI Workplan)	Yes. HCA recognizes that an initial ramp-up period will be necessary to support staffing, infrastructure development, provider engagement, workplan refinement, coordination with HCA and the ASO, and operational readiness before all CRHSI technical assistance services are fully operational. Offerors should describe their proposed ramp-up approach in the Workplan, including key start-up activities, timelines, staffing milestones, dependencies, and the point at which core technical assistance services will become operational. The Workplan should also identify any services or activities the Offeror can begin during ramp-up, such as planning, onboarding, stakeholder coordination, provider outreach, development of tools and workflows, early technical assistance activities, and coordination related to provider incentive design and programmatic oversight. HCA may implement CRHSI services in phases based on funding, program readiness, operational considerations, interagency coordination, and other State priorities. Full implementation expectations, ramp-up milestones, and performance timelines will be finalized during contract negotiation and implementation planning.
21	How is the CRHSI vendor expected to integrate with the Rural Health Data Hub (Initiative #5)? Will the CRHSI vendor be responsible for building any data infrastructure? (Appendix E: Section 2.4)	The CRHSI Contractor will be expected to coordinate with and use outputs from the Rural Health Data Hub, but the CRHSI Contractor is not expected to build the Rural Health Data Hub or serve as the primary data infrastructure contractor under this RFP. The CRHSI Contractor's role is expected to include helping providers access and interpret available data tools, incorporating data insights into technical assistance, using risk stratification or

		provider profiles to inform outreach and support, and coordinating with HCA, the Rural Health Data Hub contractor, and the Administrative Services Organization (ASO), as applicable. The Rural Health Data Hub is a separate RHT Program initiative focused on developing statewide health analytics infrastructure, data integration, dashboards, reporting tools, and related data capabilities. CRHSI may provide provider-facing support, education, coordination, feedback, and adoption assistance related to Data Hub outputs, but Offerors should not assume responsibility for building core data infrastructure unless specifically directed by HCA through written contract terms or future contract modification. The ASO is also expected to serve in a supportive role for performance monitoring and program administration. Accordingly, CRHSI should anticipate coordination with the ASO and HCA on performance tracking, reporting workflows, documentation, and use of data to support implementation oversight. Offerors should describe in their proposal how they would coordinate with HCA, the Rural Health Data Hub, and the ASO; use available data to support CRHSI technical assistance; and help translate data into actionable operational, financial, and sustainability strategies for rural providers.
22	The CRHSI vendor is expected to develop the risk stratification and outreach methodology, but does/will HCA have insights or input related to at-risk or priority providers to engage with? (Appendix E: Section 2.1)	Yes. HCA expects to provide direction, input, and available information related to at-risk or priority providers. The CRHSI Contractor should not assume it will independently determine provider priorities without HCA review and approval. Offerors should propose a risk stratification and outreach methodology that uses available data, provider input, community context, and HCA-identified priorities to identify rural providers that may benefit from CRHSI support. HCA anticipates working with the selected Contractor to refine the methodology during implementation, including review of proposed criteria, outreach sequencing, and provider prioritization. HCA may provide input based on available information such as provider type, geography, rural/frontier/tribal community needs, financial or operational risk indicators, access-to-care concerns, service availability, payer mix, prior program participation, stakeholder feedback, and other relevant State priorities. Final risk stratification criteria, outreach priorities, and provider engagement strategies will be subject to HCA review and approval.
23	While the RFP states the Contractor will not function as a fiscal intermediary, will the contractor be responsible for the calculation and submission of payment requests to the State on	The CRHSI Contractor will not function as a fiscal intermediary, process provider payments, adjudicate claims, or directly submit payment requests to the State on behalf of providers unless specifically authorized by HCA through written direction or future contract modification.

	behalf of providers? (Appendix E: Section 2.7)	However, the CRHSI Contractor is expected to oversee and support the programmatic components of provider incentives and outcome metrics. This may include developing or recommending provider incentive structures, documenting provider participation, tracking milestone achievement, validating programmatic completion of required activities, supporting data collection, and preparing reports or recommendations for HCA review. Fiscal administration and payment processing will be managed through HCA, the Administrative Services Organization (ASO), or another HCA-authorized mechanism, as determined by HCA. The CRHSI Contractor should coordinate with HCA and the ASO to support administration of payments consistent with HCA direction. Offerors should include estimates of provider incentive payments or other provider-directed funding in the overall CRHSI budget, clearly identified separately from CRHSI Contractor operating costs. Offerors should not include costs for administering provider payments, payment processing, fiscal intermediary functions, or related payment administration unless specifically directed by HCA.
24	Appendix E notes that CRHSI will "coordinate the day-to-day program management efforts of the other four initiatives". Does the HCA expect the CRHSI contractor to act as the Project Management Office (PMO) for all RHT initiatives, or is the coordination limited to technical assistance alignment? (Appendix E: Section 1)	No. HCA does not expect the CRHSI Contractor to act as the Project Management Office for all RHT Program initiatives. HCA will retain responsibility for overall RHT Program governance, strategic oversight, funding decisions, federal compliance, CMS reporting, procurement, and final approval of program scope and deliverables. The CRHSI Contractor's role is to support coordination, alignment, and implementation activities within the scope of the Bridge to Resilience initiative and related cross-initiative needs. CRHSI coordination with the other RHT Program initiatives may include technical assistance alignment, provider engagement, stakeholder coordination, learning collaboratives, data use, performance monitoring support, implementation feedback, and implementation support to HCA. CRHSI may help identify cross-initiative dependencies, coordinate provider-facing supports, support HCA with implementation planning and follow-through, and elevate operational issues to HCA, but it will not replace HCA's PMO or independently manage the full RHT Program. Final decision-making authority for all RHT Program initiatives remains with HCA.
25	For purposes of the CRHSI Cost Proposal, should Offerors include provider incentive payments, direct provider payments, or other pass-through funding to participating providers within the proposed budget, or does HCA intend for CRHSI funding to support only contractor-operated	Offerors should include estimates of total provider incentive payments, direct provider payments, or other provider-directed funding anticipated under CRHSI in the overall CRHSI budget. These amounts must be clearly identified separately from the CRHSI Contractor's proposed operating/service delivery costs. New Mexico's RHT Budget Narrative includes an FFY26 provider payment estimate of $5 million for Bridge to Resilience / CRHSI. Offerors should use this amount as a reference point when

	technical assistance, implementation support, and administrative activities? If provider-directed funding is anticipated under CRHSI, should such amounts be reflected within the Offeror's proposed budget?	preparing the overall CRHSI budget. The detailed provider incentive structure, eligibility criteria, metrics, and distribution process will be developed during implementation and approved by HCA. The CRHSI Cost Proposal should include the costs necessary for the Offeror to operate and deliver CRHSI services, including technical assistance, implementation support to HCA, provider engagement, learning collaboratives, data-informed support, programmatic oversight of provider incentives and outcome metrics, staffing, subcontractors, travel, administrative costs, and other costs necessary to perform the Scope of Work. Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Equipment costs must be separately identified and will be reviewed for allowability, allocability, reasonableness, alignment with the Scope of Work, and compliance with applicable CMS or federal cost limitations. The CRHSI Contractor may support the programmatic components of provider incentives, including developing or recommending provider incentive structures, documenting provider participation, tracking milestone achievement, validating completion of required activities, supporting data collection, and preparing recommendations or reports for HCA review. The administration of provider payments should not be included as a CRHSI Contractor cost, as that function will be supported by the Administrative Services Organization (ASO), HCA, or another HCA-authorized mechanism. Offerors should not include costs for payment processing, fiscal intermediary functions, or administration of provider payments in the CRHSI Cost Proposal unless specifically directed by HCA.
26	The RHT Program application materials reference approximately $25 million allocated for CRHSI activities during FFY26. Should Offerors assume the CRHSI contract budget is intended to support only the remaining portion of FFY26, or should Offerors assume the proposed budget should support an extended implementation period spanning FFY26 and FFY27 consistent with CMS expenditure timelines?	Please see the response to Question 5. Offerors should submit a pricing estimate and workplan for the first two federal fiscal years of CRHSI work. For purposes of this RFP, Federal Fiscal Year (FFY) means October 1 through September 30, and State Fiscal Year (SFY) means July 1 through June 30. Offerors should separately identify: 1. FFY26 allocation: The portion of the FFY26 CRHSI allocation proposed to be used from the anticipated contract start date of August 1, 2026, through September 30, 2027. FFY26 funds are authorized to be used through FFY27. 2. Additional anticipated FFY27 need: Any additional amount the Offeror anticipates needing in FFY27 beyond the FFY26 allocation. This amount must be listed separately from the FFY26 allocation and is for informational purposes only. It will not be included in the initial contract unless and until

		FFY27 federal funding is secured and HCA authorizes the additional funding. Offerors should not include funding estimates for FFY28 through FFY30 in the Cost Proposal or Workplan. Future-year funding and contract extensions will be dependent on federal funding availability, State RHT Program performance, Contractor performance, operational need, and HCA approval.
27	We would like to clarify the indirect cost policy for organizations with federally negotiated indirect cost rates. If an offeror has a current federally negotiated indirect cost rate agreement (NICRA), may that negotiated rate be applied in lieu of the de minimis 15% indirect cost rate referenced in the procurement materials?	Yes. If an Offeror has a current federally negotiated indirect cost rate agreement, or NICRA, the Offeror may propose use of that rate in lieu of the de minimis indirect cost rate referenced in the procurement materials. Offerors proposing to use a NICRA must include documentation of the current approved rate and clearly identify how the rate is applied in the Cost Proposal. Indirect costs must be clearly identified and distinguished from direct program-related costs, provider-directed payment estimates, equipment costs, and other cost categories. All proposed indirect costs remain subject to applicable federal requirements, including 2 CFR Part 200, CMS cooperative agreement terms and conditions, and any RHT Program cost limitations. Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Use of a NICRA does not waive or supersede that cap. HCA may review proposed indirect costs for allowability, reasonableness, allocability, and consistency with the approved budget and final contract terms.
28	What is the identified budget for this project, or is there a not-to-exceed amount for the CRHSI Operator contract? (*Appendix E, Scope of Work (general); Section III.C.X (Cost Proposal))*	Please see the response to Question 17. HCA is not establishing a guaranteed maximum award amount or a five-year "not-to-exceed" amount through this FAQ. The referenced CRHSI amounts are planning estimates for the broader Bridge to Resilience / CRHSI initiative budget and should not be interpreted as a guaranteed contract value or as the amount available solely for CRHSI Contractor operating/service delivery costs. For purposes of this RFP, Offerors should follow the Cost Proposal guidance provided in response to Question 5 and any related amendment. Offerors should submit a pricing estimate and workplan for the first two federal fiscal years of CRHSI work, separately identifying the portion of the FFY26 CRHSI allocation proposed to be used through September 30, 2027, and any additional anticipated FFY27 need, which should be listed separately for informational purposes only. The overall CRHSI budget should include estimated provider incentive payments, direct provider payments, or other provider-directed funding anticipated under CRHSI. New Mexico's RHT Budget Narrative includes an FFY26 provider payment estimate of $5 million for Bridge to Resilience / CRHSI. Provider-directed

		payment estimates must be clearly identified separately from CRHSI Contractor operating/service delivery costs and will not be included in the cost figure used to calculate Cost Proposal points unless otherwise directed by HCA. Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Equipment costs must be separately identified and will be reviewed for allowability, allocability, reasonableness, alignment with the Scope of Work, and compliance with applicable CMS or federal cost limitations. The final contract amount and funding structure will depend on the selected Offeror's proposed cost, HCA's determination of cost reasonableness and feasibility, available federal funding, approved scope, federal allowability, and HCA direction. Future-year funding and contract extensions are not guaranteed.
29	The RFP requires that costs comply with the CMS RHT Cooperative Agreement Terms and Conditions. Can HCA confirm whether provider incentive payments (Section 2.7) will flow through the CRHSI Operator's contract budget, or will those be administered separately by HCA? (*Appendix E, SOW Section 2.7 (Provider Incentives and Outcome Metrics); Section I.C (Scope of Procurement))*	Please see the response to Question 25. Provider incentive payments, direct provider payments, or other provider-directed funding should be included in the overall CRHSI budget estimate, but must be clearly identified separately from the CRHSI Operator's proposed operating/service delivery costs. These provider-directed payment estimates will not be included in the cost figure used to calculate Cost Proposal points unless otherwise directed by HCA. The administration of provider payments should not be included as a CRHSI Operator cost, as that function will be supported by HCA, the Administrative Services Organization (ASO), or another HCA-authorized mechanism. The CRHSI Operator may support the programmatic components of provider incentives and outcome metrics, consistent with the Scope of Work and HCA direction.
30	To what extent is in-person engagement expected from the CRHSI Operator team? The SOW references both on-site and virtual support delivery — can HCA clarify expectations for the frequency and nature of in-person presence required, and whether there are requirements for a New Mexico-based office or staff? (*Appendix E, SOW Section 2.2.4 (Contractor Services); Section III.C.IX.B (Staffing Table, work location))*	HCA expects the CRHSI Operator to use a combination of in-person and virtual engagement to effectively support rural, frontier, and tribal providers across New Mexico. The frequency and nature of in-person engagement will depend on provider needs, geography, service type, implementation phase, and HCA direction. Offerors should propose an engagement model that explains when services will be delivered virtually, when on-site support is recommended, and how the Offeror will ensure meaningful access to CRHSI services across the state. Examples of in-person engagement may include provider site visits, regional convenings, stakeholder meetings, technical assistance sessions, implementation planning meetings, training, or other activities where in-person support is necessary or beneficial. Virtual engagement may be appropriate for routine technical assistance, follow-up meetings, learning collaboratives, document review, data

		discussions, and other support activities that can be effectively delivered remotely. HCA does not require the CRHSI Operator to maintain a New Mexico-based office unless otherwise determined during contract finalization. However, Offerors should describe any proposed New Mexico-based staff, regional presence, travel approach, or local partnership strategy that will support timely and effective service delivery in rural, frontier, and tribal communities.
31	Will out-of-state vendors be considered, or is preference given to New Mexico-based organizations beyond the formal NM Resident Preference points? (*Section II.C.33 (New Mexico/Native American Resident Preferences); Section V.B.8 (Resident Preference scoring)*	Yes. Out-of-state vendors may submit proposals and will be considered in accordance with the RFP evaluation criteria. Please also see the responses to Questions 3, 9, and 13. New Mexico/Native American Resident Preference points will not be applied to this RFP because the expenditure includes federal funds for a specific purchase. HCA will not apply an additional preference for New Mexico-based organizations beyond the evaluation criteria stated in the RFP, as amended. However, an Offeror's demonstrated experience, partnerships, staffing approach, previous work in New Mexico, understanding of New Mexico's rural, frontier, and tribal communities, and ability to effectively serve providers across the state may be considered to the extent those elements are relevant to the applicable scored sections of the proposal. Relevant experience and understanding of New Mexico may be reflected in several evaluation categories, including B.1 Qualifications and Experience, B.2 Organizational References, B.3 Specifications, including staffing, stakeholder engagement, provider support, implementation, risk stratification, performance monitoring, and technical assistance responses, and C. Workplan. The RFP states that Organizational Experience is scored based on the relevancy and extent of the Offeror's experience, expertise, and knowledge, and the RFP also requires the Staffing Table to identify work location and relevant qualifications or experience for proposed personnel.
32	The SOW references coordination with the Rural Health Data Hub (Initiative #5). Can HCA clarify the current status of the Data Hub — is it operational, in development, or expected to be stood up concurrently with CRHSI? What data assets will be available to the CRHSI Operator at contract start? (*Appendix E, SOW Section 2.4 (Data Analytics Platform Access and Support); Section I.B (Background Information, Initiative #5)*	The Rural Health Data Hub is a separate RHT Program initiative and is expected to be stood up concurrently with CRHSI. HCA does not anticipate that the full Rural Health Data Hub will be operational at CRHSI contract start. At contract start, available data assets may be limited to existing HCA-held or publicly available data sources, HCA-identified provider information, program planning data, rural health needs information, and other data or reports available to HCA at that time. Additional data assets, dashboards, rural community profiles, analytics tools, and decision-support resources are expected to become available in phases as the Rural Health Data Hub is developed and implemented.

		The CRHSI Contractor will not be responsible for building the Rural Health Data Hub or serving as the primary data infrastructure contractor under this RFP. The CRHSI Contractor will be expected to coordinate with HCA, the Rural Health Data Hub contractor, and the ASO, as applicable, to use available data to inform risk stratification, provider outreach, technical assistance, performance monitoring support, and provider-facing education. Offerors should describe how they would operate in a phased data environment, including how they would use available data at start-up, incorporate new Data Hub outputs as they become available, and help translate data into actionable operational, financial, and sustainability strategies for rural providers.
33	Has CMS provided any specific requirements or constraints on deliverable formats, reporting structures, or performance metric frameworks that the CRHSI Operator will be required to follow? (*Section I.A (Purpose); Appendix E, SOW Sections 3.1 (Contractor Deliverables) and 3.2 (Performance Monitoring and Reporting); Section II.C.14 (Governing Law — CMS cooperative agreement)*	CMS has provided reporting templates and requirements for the overall RHT Program. Those templates are completed at the PMO/HCA level, and HCA anticipates having a separate entity responsible for supporting those overall RHT Program reporting deliverables. CMS has not provided a CRHSI-specific deliverable template or standalone reporting framework for the CRHSI Operator to use at this time. However, CRHSI activities, outputs, and performance information will be reported through an HCA-established process and must align with CMS RHT Cooperative Agreement Terms and Conditions, the CMS-approved RHT Program application, applicable federal requirements, and HCA direction. The CRHSI Operator should anticipate supporting HCA's reporting process by providing timely, accurate, and complete information related to CRHSI implementation, utilization, provider engagement, technical assistance activities, provider incentive metrics, outcomes, and other performance information requested by HCA. HCA may modify or refine CRHSI reporting formats, deliverable requirements, data elements, performance measures, or reporting timelines as CMS guidance evolves. Offerors should propose a flexible performance monitoring and reporting approach that can align with HCA-approved templates, CMS reporting expectations, provider-level and program-level metrics, and future changes in federal reporting requirements.
34	The SOW references engagement with Tribes, Nations, and Pueblos throughout. Does HCA have existing government-to-government consultation protocols in place that the CRHSI Operator will be expected to operate within, or will the Operator be responsible for establishing tribal engagement frameworks independently? (*Appendix E, SOW Sections 2.6*	HCA will retain responsibility for government-to-government consultation and formal Tribal engagement protocols. The CRHSI Operator will not be responsible for independently establishing government-to-government consultation frameworks or representing HCA in formal consultation unless specifically directed by HCA. The CRHSI Operator may be expected to support Tribal engagement activities within the scope of CRHSI, including outreach, provider engagement, technical assistance coordination, meeting support, documentation, follow-up, and implementation support, as

	(Guardrails and Equity Requirements) and 2.2.2 (Provider Engagement and Service Delivery Model); Section I.B (Background Information)	directed by HCA. Any engagement with Tribes, Nations, and Pueblos must be conducted in alignment with HCA direction, applicable State protocols, federal requirements, and respect for Tribal sovereignty. Offerors should describe their experience working with Tribal health systems, Tribal communities, and culturally responsive engagement approaches, including how they would support HCA-led engagement and ensure that CRHSI services are accessible and appropriate for Tribal providers and communities. Final Tribal engagement processes, roles, and communication protocols will be established by HCA.
35	The RFP states that ASO functions (payment processing, fiscal disbursement, provider reimbursement administration) are explicitly out of scope for the CRHSI Operator. Can HCA clarify whether Medicaid re-enrollment support (listed under Operational TA, Section 2.2.3) requires any direct interface with HCA's Medicaid Management Information System (MMIS) or other fiscal/claims infrastructure? (*Section I.C (Scope of Procurement — ASO exclusions); Appendix E, SOW Section 2.2.3 (Areas of expertise, Medicaid re-enrollment support)*	No. Medicaid re-enrollment support under CRHSI Operational Technical Assistance is not intended to require the CRHSI Operator to directly access HCA's Medicaid Management Information System, fiscal systems, claims infrastructure, or payment systems. For purposes of this RFP, Medicaid re-enrollment support is intended to mean provider-facing technical assistance and operational support, such as helping providers understand re-enrollment requirements, prepare documentation, identify workflow needs, address operational barriers, and coordinate with appropriate HCA or Medicaid contacts as directed by HCA. The CRHSI Operator should not assume responsibility for eligibility determinations, claims processing, provider reimbursement administration, payment processing, or direct system transactions within HCA's Medicaid or fiscal infrastructure unless specifically authorized by HCA through written direction or future contract modification. Offerors should describe how they would provide Medicaid-related operational technical assistance while maintaining appropriate role boundaries, data security, confidentiality, and coordination with HCA, the ASO, and other relevant partners.
36	The SOW references coordination of the CRHSI with the four other RHT Program initiatives (Healthy Horizons, Rooted in New Mexico, Rural Health Innovation Fund, Rural Health Data Hub). Can HCA describe the current state of those initiatives — are contractors already in place for any of them — and what coordination infrastructure, if any, will exist at contract start? (*Section I.B (Background Information — five RHT initiatives); Appendix E, SOW Sections 1 (Background and Purpose) and 3.1 (Contractor*	The other RHT Program initiatives are in varying stages of planning, procurement, and implementation. HCA does not anticipate that all contractors, subrecipients, or implementation partners for Healthy Horizons, Rooted in New Mexico, the Rural Health Innovation Fund, and the Rural Health Data Hub will be fully in place at CRHSI contract start. HCA will retain responsibility for overall RHT Program governance, procurement, funding decisions, federal compliance, CMS reporting, and final approval of initiative scope and deliverables. The CRHSI Operator should expect to coordinate with HCA, the ASO, and other contractors or subrecipients as they are selected and onboarded. At contract start, coordination infrastructure may include HCA's RHT Program governance structure, HCA-led implementation

	Deliverables — cross-initiative coordination framework	planning, PMO direction, ASO administrative and performance monitoring support, and available initiative planning materials. Additional coordination processes, including cross-initiative meeting structures, reporting workflows, stakeholder engagement processes, and data-sharing or performance monitoring workflows, will be established or refined by HCA during implementation. Offerors should describe how they would operate in a phased implementation environment, including how they would coordinate with HCA and other entities as they come online, identify cross-initiative dependencies, support implementation planning and follow-through, and maintain flexibility as RHT Program infrastructure matures.
37	The RFP anticipates a contract start as early as August 1, 2026, with contract award June 30, 2026. Given the scope of designing and implementing a statewide technical assistance center from inception, does HCA have a phased implementation expectation (e.g., a planning/design phase before full provider-facing operations begin)? (*Sections I.A (Purpose — phased implementation), I.C (Scope of Procurement — phasing), and II.A (Sequence of Events — contract award June 30, 2026)*	Yes. HCA anticipates a phased implementation approach for CRHSI. HCA recognizes that an initial planning, design, and ramp-up period will be necessary before all provider-facing technical assistance services are fully operational. The selected CRHSI Operator should expect to work with HCA during the initial implementation period to refine the workplan, confirm priorities, establish operating processes, develop provider engagement and risk stratification approaches, coordinate with the ASO and other RHT Program implementation partners, and prepare for phased launch of CRHSI services. Offerors should describe their proposed phased implementation approach in the Workplan, including start-up activities, staffing and onboarding timelines, infrastructure development, early provider engagement, proposed milestones, and the point at which core provider-facing services would become operational. HCA may implement CRHSI services in phases based on funding availability, program readiness, interagency coordination, operational considerations, federal requirements, and other State priorities. Full implementation expectations, ramp-up milestones, and performance timelines will be finalized during contract negotiation and implementation planning.
38	Please confirm that organizational references should be submitted ahead of the full proposal by May 27, 2026? (*Section III.C.VII (Reference Letters — references due May 27, 2026 at 3PM MST)*	HCA has extended the organizational reference submission deadline as reflected in the amended Sequence of Events. Organizational references must still be submitted directly by the business reference through Submittable and must be received by the updated deadline identified in the amendment. The proposal submission deadline and any related procurement dates will also be updated through amendment, as applicable.
39	To what extent will HCA facilitate the CRHSI Operator's access to existing rural provider data, Medicaid claims data, or financial data held by HCA or CMS for	HCA anticipates facilitating access to available data, as appropriate and allowable, to support CRHSI baseline assessment, risk stratification, performance monitoring, and technical assistance activities. Available data may include HCA-held provider information, Medicaid-related data, existing program data, publicly

	purposes of baseline assessment and performance monitoring? (*Appendix E, SOW Section 2.2.4 (Contractor Services); Section III.C.IX.B (Staffing Table, work location)*	available rural health data, and other information HCA determines is necessary and appropriate for CRHSI implementation. Access to Medicaid claims data, provider financial data, CMS-held data, or other sensitive information will be subject to applicable federal and state privacy, security, confidentiality, data governance, and data use requirements. HCA will determine what data may be shared, the format and timing of any data sharing, and any required data use agreements, confidentiality agreements, security controls, or other approvals. Offerors should not assume unrestricted or direct access to HCA systems, Medicaid claims systems, CMS systems, provider financial systems, or protected data sources at contract start. Offerors should describe how they would conduct baseline assessment and performance monitoring using available data, public data sources, provider-submitted information, HCA-approved data extracts, and phased access to additional data as authorized by HCA. The CRHSI Operator should also anticipate coordination with HCA, the Rural Health Data Hub, the ASO, and participating providers to support data collection, reporting, performance monitoring, and translation of data into actionable technical assistance.
40	Expected Value (Reference link included): According to p.17 of the detailed budget posted on NM's website (https://www.hca.nm.gov/wp-content/uploads/Approved_New-Mexico-RHT-Budget-Narrative-Revised-03.26.pdf), our understanding is the work to establish the CRHSI is budgeted for $25,100,772.81. Can you please clarify if this is the expected value for this RFP?	No. The amount referenced in the approved RHT Budget Narrative reflects a planning estimate for the broader Bridge to Resilience / CRHSI initiative and should not be interpreted as the expected contract value, guaranteed award amount, or not-to-exceed amount for this RFP. Please also see the responses to Questions 6, 17, and 28. HCA is not establishing a guaranteed maximum award amount or five-year not-to-exceed amount through this FAQ. For purposes of this RFP, Offerors should follow the Cost Proposal guidance provided in response to Question 5 and any related amendment. Offerors should submit a budget for the first two federal fiscal years of CRHSI work, separately identifying the FFY26 allocation proposed for use through September 30, 2027, and any additional anticipated FFY27 need. The overall CRHSI budget should include estimated provider-directed payments, where applicable, including the FFY26 provider payment estimate of $5 million identified in New Mexico's RHT Budget Narrative for Bridge to Resilience / CRHSI. Provider-directed payment estimates must be clearly identified separately from CRHSI Contractor operating/service delivery costs and will not be included in the cost figure used to calculate Cost Proposal points unless otherwise directed by HCA.

		Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Equipment costs must be separately identified and will be reviewed for allowability, allocability, reasonableness, alignment with the Scope of Work, and compliance with applicable CMS or federal cost limitations. The final contract amount and funding structure will depend on the selected Offeror's proposed cost, HCA's determination of cost reasonableness and feasibility, available federal funding, approved scope, federal allowability, and HCA direction.
41	Will the prime contractor who is awarded this work be precluded from bidding on the 4 other upcoming opportunities (i.e., Rural Health Data Hub, Healthy Horizons, Rooted in New Mexico, Rural Health Innovation Fund)?	No. Award of the CRHSI Operator contract does not automatically preclude the prime Contractor from submitting proposals or applications for other RHT Program opportunities, including the Rural Health Data Hub, Healthy Horizons, Rooted in New Mexico, or Rural Health Innovation Fund. However, participation in multiple RHT Program opportunities may require conflict of interest review and appropriate safeguards. HCA may evaluate actual, potential, or perceived conflicts of interest, including access to non-public information, involvement in developing requirements or evaluation materials, ability to obtain an unfair competitive advantage, or roles that could impair independent judgment or objectivity. If an Offeror proposes to participate in multiple RHT Program opportunities, the Offeror should disclose any actual, potential, or perceived conflicts and describe proposed mitigation strategies. HCA reserves the right to determine whether a conflict exists and what mitigation, limitation, recusal, firewall, or other safeguard is necessary. Participation as the CRHSI Operator will not provide preferential treatment, priority access, or guaranteed eligibility for any other RHT Program funding, procurement, application, or award.
42	Will any subcontractor on the awarded contract for this work be precluded from bidding on the 4 other upcoming opportunities (i.e., Rural Health Data Hub, Healthy Horizons, Rooted in New Mexico, Rural Health Innovation Fund)?	No. Serving as a subcontractor on the awarded CRHSI Operator contract does not automatically preclude that subcontractor from submitting proposals or applications for other RHT Program opportunities, including the Rural Health Data Hub, Healthy Horizons, Rooted in New Mexico, or Rural Health Innovation Fund. However, participation in multiple RHT Program opportunities may require conflict of interest review and appropriate safeguards. HCA may evaluate actual, potential, or perceived conflicts of interest, including access to non-public information, involvement in developing requirements or evaluation materials, ability to obtain an unfair competitive advantage, or roles that could impair independent judgment or objectivity. If an Offeror or subcontractor proposes to participate in multiple RHT Program opportunities, the Offeror or subcontractor should

		disclose any actual, potential, or perceived conflicts and describe proposed mitigation strategies. HCA reserves the right to determine whether a conflict exists and what mitigation, limitation, recusal, firewall, or other safeguard is necessary. Participation as a CRHSI subcontractor will not provide preferential treatment, priority access, or guaranteed eligibility for any other RHT Program funding, procurement, application, or award.
43	Section 3.2.1 of the Scope of Work names quarterly and annual performance reporting. Will HCA confirm the federal reporting cycle for the contract starting August 1, 2026? • Will the first quarterly performance report be due covering Q4 Federal Fiscal Year 2026 (October to December 2026), with submission expected approximately January 2027 (Month 6 of the contract)? • Or does HCA expect a different first-quarterly cycle, such as Q1 calendar 2027 covering January to March 2027 with submission in April 2027 (Month 9)?	HCA expects CRHSI reporting to align with the CMS RHT Program reporting cycle and HCA-established internal reporting processes. The CMS RHT quarterly reporting periods are not structured as standard calendar-year quarters. For the RHT Program, CMS has identified the following quarterly reporting periods: August 1–October 30, October 31–January 30, and January 31–April 30. CMS does not require a separate quarterly progress report for May 1–July 31, because the annual progress report is submitted in its place. The first CMS quarterly progress report covering August 1, 2026 through October 30, 2026 is due to CMS on November 29, 2026. Accordingly, if the CRHSI contract begins on August 1, 2026, the first CRHSI performance report would be expected to support the August 1, 2026–October 30, 2026 reporting period. If the contract begins after August 1, 2026, the first report would cover the period from the contract effective date through October 30, 2026, unless otherwise directed by HCA. The CRHSI Contractor should anticipate submitting information to HCA on a timeline that allows HCA, the PMO, the ASO, and any other reporting support entities to review, validate, and incorporate CRHSI information into the State's CMS reporting process. HCA will establish specific CRHSI reporting formats, due dates, and internal submission timelines during contract implementation.
44	Will HCA confirm whether incentive eligibility criteria, payment thresholds, and outcome metric definitions will be: • Pre-specified by HCA before contract start • Co-designed with the CRHSI within an HCA-approved framework, on a defined timeline post-award • CRHSI-proposed for HCA approval	HCA has not finalized all incentive eligibility criteria, payment thresholds, or outcome metric definitions at this time. HCA anticipates that these elements will be developed within an HCA-approved framework during implementation, with support from the CRHSI Contractor and coordination with other HCA-contracted support organizations, as applicable. The CRHSI Contractor may propose or help refine incentive eligibility criteria, payment thresholds, outcome metric definitions, validation processes, and reporting approaches for HCA review and approval. Final approval of provider incentive methodology, eligibility criteria, payment thresholds, outcome metrics, and disbursement processes will remain with HCA. Offerors should describe their proposed approach to developing, validating, and operationalizing provider incentive metrics and payment recommendations, including how they would coordinate

		with HCA, the ASO, the Rural Health Data Hub, PMO/reporting support, and other implementation partners.
45	Section 2.7.1 of the Scope of Work and the Bridge to Resilience Federal Fiscal Year 2026 budget (Table A-4) from the 3.26 revised budget narrative document include $5 million in provider incentive payments. Section I.C states that the CRHSI Operator is not a fiscal pass-through. Will HCA confirm: • The interface specification between the CRHSI Operator's incentive recommendations and the disbursing entity (HCA Finance or an Administrative Services Organization) • The frequency and format of incentive payment recommendation submissions (monthly, quarterly, on-demand) • The reconciliation expectations between the CRHSI's recommendations and actual payments issued	HCA has not finalized the detailed interface specifications, submission frequency, format, or reconciliation process for CRHSI provider incentive recommendations at this time. These processes will be established during implementation and will be subject to HCA direction, fiscal controls, federal requirements, and coordination with the disbursing entity. The CRHSI Operator will not function as the fiscal pass-through or payment processor. However, the CRHSI Operator is expected to support the programmatic components of provider incentives and outcome metrics. This may include developing or recommending incentive structures, documenting provider participation, tracking milestone achievement, validating programmatic completion of required activities, supporting data collection, and preparing payment-related recommendations or reports for HCA review. HCA anticipates that provider incentive payment administration will be supported by HCA, the Administrative Services Organization (ASO), or another HCA-authorized mechanism. The CRHSI Operator should expect to coordinate with HCA and the applicable disbursing entity to support payment administration, including providing documentation or recommendations in an HCA-approved format and timeline. The frequency and format of incentive payment recommendation submissions may be monthly, quarterly, milestone-based, or otherwise determined by HCA based on the final incentive design, reporting needs, fiscal controls, and operational requirements. Reconciliation expectations will also be established by HCA and may include comparing CRHSI programmatic recommendations, HCA approvals, ASO or disbursing entity payment records, and provider milestone documentation. Offerors should propose an approach for how they would document provider incentive eligibility, validate milestone completion, submit programmatic recommendations, and support reconciliation with HCA and the ASO, while recognizing that final processes will be determined by HCA during contract implementation.
46	Section 2.2.2 of the Scope of Work requires the Operator to submit the standardized assessment methodology to HCA for review and approval prior to implementation. Will HCA confirm: • The expected timeline for methodology submission and approval relative to contract start (Month 0 to Month 3 range)	HCA expects the standardized assessment methodology to be developed early in the CRHSI implementation period. Offerors should propose a timeline for methodology development, submission, review, revision, and approval in the Workplan. HCA anticipates that the methodology would generally be submitted during the initial planning and ramp-up period, likely within the first Month 0 to Month 3 of the contract, but the final timeline will be established during contract negotiation and implementation planning.

	• HCA's review criteria for methodology approval • Whether HCA will require methodology revision cycles, and the expected timeline for them	HCA's review of the methodology may consider factors such as alignment with the CRHSI Scope of Work, consistency with RHT Program goals and CMS requirements, appropriateness for rural, frontier, and tribal providers, use of available data, feasibility of implementation, equity and geographic access considerations, clarity of provider engagement processes, risk stratification approach, data security and confidentiality considerations, and ability to support performance monitoring and outcome tracking. HCA may require one or more methodology revision cycles before approval. The number and timing of revision cycles will depend on the completeness and quality of the initial submission, HCA feedback, program needs, and any applicable federal or operational requirements. Offerors should build reasonable time for HCA review and revision into their proposed Workplan and should not implement the standardized assessment methodology until it has been reviewed and approved by HCA.
47	Section 2.4 directs the CRHSI to coordinate with the State's Rural Health Data Hub procured under Initiative 5. Will HCA confirm: • The procurement timing for the Rural Health Data Hub (current expectation is late spring or early summer 2026) • Whether the CHRSI Operator should design integration to a Data Hub contractor selected before CRHSI contract start, or maintain vendor-agnostic integration architecture pending Initiative 5 award • HCA's expectation for the operational state of the Data Hub at CRHSI's August 1, 2026 contract start.	HCA anticipates that the Rural Health Data Hub procurement will proceed separately from the CRHSI procurement. The current anticipated timing for the Rural Health Data Hub procurement is late spring or early summer 2026, subject to change based on procurement readiness, HCA priorities, and operational considerations. The CRHSI Operator should maintain a vendor-agnostic coordination and integration approach unless and until HCA provides more specific direction. Offerors should not assume that a Rural Health Data Hub contractor will be selected, fully onboarded, or operational before the CRHSI contract start date. Offerors should describe how they would coordinate with HCA and any future Data Hub contractor, incorporate available Data Hub outputs over time, and adapt CRHSI workflows as the Data Hub is developed. HCA does not anticipate that the full Rural Health Data Hub will be operational at the anticipated CRHSI contract start. The Data Hub is expected to be implemented in phases. At CRHSI start-up, the Operator should expect to use available data sources, HCA-provided information, publicly available rural health data, provider-submitted information, and other HCA-approved data or reports while the Data Hub is being developed. The CRHSI Operator will not be responsible for building the Rural Health Data Hub or serving as the primary data infrastructure contractor under this RFP. CRHSI's role is to coordinate with HCA and the Data Hub initiative, use available data to inform provider outreach and technical assistance, and support provider-facing adoption, interpretation, and use of Data Hub outputs as they become available.
48	When do you anticipate the Data Hub being operational	HCA does not have a specific anticipated operational date for the Rural Health Data Hub at this time. The Data Hub is currently in the

		planning phase and will be implemented separately from the CRHSI procurement. Offerors should not assume that the Data Hub will be fully operational at CRHSI contract start. The CRHSI Operator should propose an approach that can function in a phased data environment, using available HCA-provided information, public data sources, provider-submitted information, and other approved data or reports while the Data Hub is being developed. As the Data Hub becomes available, the CRHSI Operator will be expected to coordinate with HCA and the Data Hub contractor or implementation team to incorporate Data Hub outputs into provider outreach, technical assistance, performance monitoring support, and provider-facing education.
49	How many providers will be eligible for CRHSI services at launch, Year 1, and over the full contract term (by type/geography)	HCA has not finalized the number of providers that will be eligible for CRHSI services at launch, in Year 1, or over the full contract term by provider type or geography. CRHSI is intended to support eligible rural, frontier, and tribal providers across New Mexico, including rural hospitals, clinics, FQHCs, long-term care providers, in-home providers, home- and community-based services agencies, Tribal health providers, and other organizations delivering health care services, as determined by HCA. The number and type of providers served will depend on available funding, provider need, readiness, risk stratification, geographic priorities, service demand, HCA direction, and the final CRHSI implementation approach. HCA anticipates working with the selected CRHSI Operator to refine eligibility criteria, provider prioritization, outreach sequencing, and service capacity during implementation. Offerors should propose a scalable service delivery model that can support phased implementation and adjust to different provider types, geographies, and levels of technical assistance need over time. HCA may provide additional direction on priority providers or regions based on available data, stakeholder input, access-to-care concerns, and RHT Program priorities.
50	Please identify the required submission format and location in Submittable for the pass/fail financial-stability materials, including what period of financial statements HCA expects.	HCA will update Submittable to include required fields for pass/fail financial stability materials under Questionnaire Specifications Section 4: Financial Monitoring, Incentive Tracking, and Program Accountability. Offerors will be required to provide the following information in Submittable: D. Litigation, Bankruptcy, and Investigation Disclosure Offerors must list any pending lawsuit or bankruptcy petition, any lawsuit or bankruptcy that has been concluded within the last five years, or any current investigation of the Offeror, its parent,

		affiliates, or subsidiaries that may be relevant to operation of this program. Offerors must include a brief description of each item listed. This response will have a 500-word limit. E. Financial Statements Upload Offerors must upload copies of the most recent year's independently audited financial statements and the most current 10-K, if applicable, as well as financial statements for the preceding three years, if they exist. The submission must include the audit opinion, balance sheet, statements of income, retained earnings, cash flows, and notes to the financial statements. If independently audited financial statements do not exist, the Offeror must state the reason and submit sufficient alternative information demonstrating financial stability, such as a D&B report or other comparable documentation. Financial stability materials will be reviewed on a pass/fail basis. HCA may request clarification or additional information as permitted under the RFP and applicable procurement requirements.
51	The RFP defines "Hourly Rate" as a fully loaded rate that includes travel and per diem (Section I.F.19). However, the Cost Proposal format allows Offerors to present multiple cost categories including travel. To support transparency and consistent evaluation, please confirm travel should be shown as a separate line item in the Cost Proposal Table.	Yes. For transparency and consistent evaluation, Offerors should show travel as a separate line item in the Cost Proposal Table. Although the RFP defines "Hourly Rate" as a fully loaded rate that may include travel and per diem, Offerors should separately identify any travel-related costs or assumptions in the Cost Proposal to allow HCA to evaluate cost reasonableness, service delivery assumptions, and alignment with the proposed Workplan. Offerors should clearly state whether travel costs are included within proposed hourly rates, proposed as a separate cost category, or both. Travel costs should not be double-counted. Travel should also be categorized consistently with the purpose of the expense, such as CRHSI Contractor operating/service delivery, administrative, or other direct cost, so HCA can evaluate allowability and cost treatment. Any travel costs must be reasonable, necessary, allocable to the Scope of Work, and compliant with applicable federal and state requirements.
52	Please confirm the compensation for the resultant contract will be based on hourly rates rather than price per deliverable/milestone.	No. HCA is not confirming that compensation under the resulting contract will be based solely on hourly rates. As described in the response to Question 18, HCA anticipates that the resulting contract may use a hybrid compensation structure, which may include approved budget-based costs, hourly rates, deliverables, milestones, or other payment structures as finalized through contract negotiation.

		Offerors should submit a Cost Proposal that clearly identifies proposed hourly rates, staffing assumptions, cost categories, deliverable or milestone-based pricing assumptions, and any other proposed compensation structure, as applicable. The Contractor's compensation structure will apply to CRHSI Contractor operating/service delivery costs. Provider-directed payment estimates should be included in the overall CRHSI budget for planning purposes, but provider payment administration will be supported by HCA, the ASO, or another HCA-authorized mechanism, and provider-directed payment estimates will not be included in the cost figure used to calculate Cost Proposal points unless otherwise directed by HCA. The final payment structure will be determined by HCA during contract finalization and will be subject to available funding, federal allowability, approved scope, and HCA direction.
53	Please confirm the period of performance is August 1, 2026-September 30, 2027.	Yes. HCA anticipates that the initial contract period will be August 1, 2026, through September 30, 2027, subject to final contract execution. Offerors should follow the Cost Proposal and Workplan guidance provided in response to Question 5 and any related amendment. Offerors should submit pricing and workplan information for the first two federal fiscal years of CRHSI work, including the portion of the FFY26 allocation proposed to be used from August 1, 2026, through September 30, 2027, and any additional anticipated FFY27 need listed separately for informational purposes only. HCA anticipates extending the contract for additional years through contract amendment, dependent on federal funding availability, State RHT Program performance, Contractor performance, operational need, and HCA approval. Future-year funding and contract extensions are not guaranteed.
54	Please confirm that offerors can redact portions of the cost proposal and only the total price would be released to the public.	No. Offerors should not assume that portions of the Cost Proposal may be redacted or that only the total price will be released to the public. The RFP states that an Offeror's submitted Cost response may not be labeled as confidential. The RFP also states that the price of products offered or the cost of services proposed shall not be designated as proprietary or confidential information. HCA will follow all applicable Inspection of Public Records Act (IPRA) laws and requirements, as well as applicable procurement and confidentiality requirements. Offerors may submit a redacted version of their proposal consistent with the RFP's confidentiality provisions; however, HCA will make final determinations regarding what information may be withheld from public disclosure in accordance with applicable law.

		Offerors should not include confidential, proprietary, or trade secret information in the Cost Proposal unless necessary. Any information claimed as confidential must be clearly identified and supported as required by the RFP, but cost information is not automatically protected from disclosure.
55	Per New Mexico's RHTP Budget Narrative, the estimated contractual cost for Bridge to Resilience is $22,590,695. Can you confirm this is the estimated Year 1 value for the resulting contract from this RFP?	No. The $22,590,695 estimated contractual cost for Bridge to Resilience reflects a planning estimate within New Mexico's RHTP Budget Narrative and should not be interpreted as the confirmed Year 1 value, guaranteed award amount, or not-to-exceed amount for the resulting CRHSI Operator contract. Please also see the responses to Questions 6, 17, 28, and 40. The Bridge to Resilience / CRHSI budget includes multiple cost components, which may include CRHSI Contractor operating/service delivery costs, provider-directed payment estimates, administrative costs, equipment costs, and other program-related costs. For purposes of this RFP, Offerors should follow the Cost Proposal guidance provided in response to Question 5 and any related amendment. Offerors should submit a budget for the first two federal fiscal years of CRHSI work, separately identifying the FFY26 allocation proposed for use through September 30, 2027, and any additional anticipated FFY27 need. The overall CRHSI budget should include estimated provider-directed payments, including the FFY26 provider payment estimate of $5 million identified in New Mexico's RHT Budget Narrative for Bridge to Resilience / CRHSI. Provider-directed payment estimates must be clearly identified separately from CRHSI Contractor operating/service delivery costs and will not be included in the cost figure used to calculate Cost Proposal points unless otherwise directed by HCA. Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Equipment costs must be separately identified and will be reviewed for allowability, allocability, reasonableness, alignment with the Scope of Work, and compliance with applicable CMS or federal cost limitations. The final contract amount and funding structure will depend on the selected Offeror's proposed cost, HCA's determination of cost reasonableness and feasibility, available federal funding, approved scope, federal allowability, and HCA direction.
56	The evaluation points total 1100 rather than 1000. Should we assume 1000 is the appropriate denominator?	Yes. The scored evaluation criteria are intended to total 1,000 points. As described in the response to Question 3, New Mexico/Native American Resident Preference points will not be applied to this RFP because the expenditure includes federal funds for a specific

		purchase. Any references to New Mexico/Native American Resident Preference points will be removed through amendment and will not be included in the evaluation denominator. If oral presentations are conducted, the oral presentation points will be included in the evaluation process as stated in the RFP. HCA will clarify the evaluation point total and remove any inconsistent scoring references through amendment.
57	What primary data sources will CRHSI have access to (e.g., Medicaid claims, MCO encounter data, hospital discharge data, EHR feeds, public health datasets)?	Please see the response to Question 39. HCA anticipates facilitating access to available data, as appropriate and allowable, to support CRHSI baseline assessment, risk stratification, performance monitoring, and technical assistance activities. Available data may include HCA-held provider information, Medicaid-related data, existing program data, publicly available rural health data, provider-submitted information, and other HCA-approved data or reports. HCA has not finalized the full list of primary data sources that will be available to the CRHSI Operator at contract start. Access to Medicaid claims, MCO encounter data, hospital discharge data, EHR feeds, public health datasets, provider financial data, CMS-held data, or other sensitive data will be subject to applicable federal and state privacy, security, confidentiality, data governance, and data use requirements. Offerors should not assume unrestricted or direct access to HCA systems, Medicaid claims systems, MCO systems, EHR systems, CMS systems, provider financial systems, or protected data sources at contract start. Offerors should describe how they would use available data, public data sources, provider-submitted information, HCA-approved data extracts, and phased access to additional data as authorized by HCA. The CRHSI Operator should also anticipate coordination with HCA, the Rural Health Data Hub, the ASO, and participating providers as data assets and reporting processes are developed.
58	Will HCA provide the data, or is the vendor expected to establish data-sharing agreements with providers?	HCA anticipates providing or facilitating access to available data, as appropriate and allowable, to support CRHSI implementation. However, the CRHSI Operator may also be expected to support collection of provider-submitted information and coordinate with providers to obtain information needed for technical assistance, baseline assessment, performance monitoring, and provider incentive metrics. The CRHSI Operator should not assume unrestricted access to HCA systems, Medicaid claims systems, MCO systems, EHR systems, provider financial systems, or other protected data sources at contract start. Access to HCA-held data or other sensitive data will be subject to applicable federal and state privacy, security, confidentiality, data governance, and data use requirements.

		HCA will determine whether data-sharing agreements, business associate agreements, confidentiality agreements, provider authorizations, or other data governance mechanisms are required. The CRHSI Operator may be asked to support development, coordination, documentation, or execution of those processes, but should not assume independent authority to establish data-sharing agreements on behalf of HCA unless specifically directed by HCA. Offerors should describe how they would use HCA-provided data, public data sources, provider-submitted information, and HCA-approved data-sharing processes to support CRHSI activities.
59	What are the expected data refresh frequencies (e.g., monthly claims, daily clinical feeds)?	HCA has not finalized expected data refresh frequencies for all CRHSI-related data sources at this time. Data refresh frequency will vary by data source, data owner, data availability, reporting requirement, and applicable privacy, security, and data governance requirements. For example, Medicaid claims, provider-submitted information, public datasets, Data Hub outputs, and performance monitoring data may each be refreshed on different timelines. Offerors should not assume that all data will be available in real time or on a daily, weekly, or monthly basis at contract start. Offerors should propose a flexible data and reporting approach that can operate with phased data availability, including use of available HCA-provided data, public data sources, provider-submitted information, and periodic data extracts or reports approved by HCA. HCA will establish data refresh expectations, reporting timelines, and data submission processes during implementation, in coordination with the CRHSI Contractor, the Rural Health Data Hub, the ASO, and other relevant partners.
60	Are there existing data governance policies or committees the vendor must align with?	Yes. The CRHSI Operator will be expected to align with applicable HCA, State, federal, and RHT Program data governance, privacy, security, and confidentiality requirements. HCA has not finalized all CRHSI-specific data governance processes at this time. However, the CRHSI Operator should anticipate working within HCA-established data governance policies, security requirements, data use processes, and any applicable governance structures related to Medicaid data, provider data, the Rural Health Data Hub, performance monitoring, and RHT Program reporting. The CRHSI Operator may also be required to coordinate with HCA, the ASO, the Rural Health Data Hub, and other relevant partners or governance bodies established during implementation. HCA will identify applicable data governance requirements, review processes, approvals, and documentation requirements during contract implementation.

		Offerors should describe how they would comply with applicable data governance requirements, protect sensitive information, maintain appropriate access controls, and support secure data sharing, reporting, and performance monitoring in alignment with HCA direction.
61	Is there an existing "Rural Health Data Hub" architecture that CRHSI must integrate with, or is the vendor expected to help design/build it?	The Rural Health Data Hub is currently in the planning phase. HCA does not have a finalized Data Hub architecture that the CRHSI Operator must integrate with at this time. The CRHSI Operator is not expected to design or build the Rural Health Data Hub under this RFP. The Rural Health Data Hub is a separate RHT Program initiative and will be implemented separately from the CRHSI procurement. The CRHSI Operator should maintain a vendor-agnostic and flexible coordination approach that can incorporate Data Hub outputs as they become available. During start-up, the CRHSI Operator should expect to use available HCA-provided information, public data sources, provider-submitted information, and other HCA-approved data or reports while the Data Hub is being developed. As the Data Hub architecture, contractor, tools, dashboards, reports, or other outputs become available, the CRHSI Operator will be expected to coordinate with HCA and the Data Hub implementation team to support provider-facing adoption, interpretation, and use of those outputs for technical assistance, risk stratification, performance monitoring support, and provider engagement.
62	What systems must CRHSI integrate with (e.g., MMIS, HIE, provider systems, other RHT vendors)?	HCA has not finalized a required list of system integrations for CRHSI at this time. The CRHSI Operator should not assume that direct technical integration with HCA's MMIS, HIE, provider EHR systems, claims systems, fiscal systems, or other protected systems will be required or authorized at contract start. Any system access or integration will be subject to HCA direction, applicable privacy and security requirements, data governance approvals, and final implementation planning. CRHSI is expected to coordinate with HCA, the ASO, the Rural Health Data Hub, participating providers, and other RHT contractors or subrecipients, as applicable. Coordination may include use of HCA-approved data extracts, reports, dashboards, provider-submitted information, Data Hub outputs, shared reporting processes, or other approved mechanisms. Offerors should propose a flexible, vendor-agnostic approach that can support coordination with other RHT vendors and data sources as they become available, while maintaining appropriate role boundaries, data security, and confidentiality. Direct system

		integration should not be assumed unless specifically directed by HCA through written contract terms, implementation guidance, or future contract modification.
63	Are there established interoperability standards or APIs (e.g., HL7/FHIR, flat file extracts)?	HCA has not finalized CRHSI-specific interoperability standards, APIs, or data exchange specifications at this time. The CRHSI Operator should not assume that direct API-based integration, HL7/FHIR connectivity, flat file exchanges, or other system-to-system interfaces will be required or available at contract start. Any interoperability standards, file formats, APIs, data exchange methods, or reporting specifications will be established by HCA during implementation, in coordination with the Rural Health Data Hub, the ASO, and other relevant partners. Offerors should propose a flexible and secure approach that can support multiple data exchange methods, which may include HCA-approved reports, data extracts, flat files, dashboards, provider-submitted information, or future interoperability standards as they are established. Any data exchange must comply with applicable privacy, security, confidentiality, data governance, and federal and state requirements.
64	What are the priority analytic use cases in Year 1 (e.g., quality performance tracking, access analysis, financial sustainability modeling, workforce analytics)?	HCA has not finalized the full set of Year 1 analytic use cases for CRHSI at this time. HCA anticipates that Year 1 analytic priorities may include use cases related to provider risk stratification, baseline assessment, access-to-care analysis, financial and operational sustainability, provider engagement and utilization tracking, technical assistance prioritization, performance monitoring, and provider incentive or outcome metric tracking. Offerors should propose a flexible analytic approach that can support these types of use cases while adapting to available data, HCA-identified priorities, provider-submitted information, Rural Health Data Hub outputs, and other implementation needs as they evolve. Final Year 1 analytic priorities, data sources, reporting formats, and performance metrics will be established by HCA during implementation in coordination with the CRHSI Contractor, the Rural Health Data Hub, the ASO, and other relevant partners.
65	Have the priority populations or conditions (e.g., maternal health, behavioral health, chronic disease) been pre-defined in terms of denominators, or are you looking for vendors to take on that piece?	HCA has identified priority populations and focus areas through the RHT Program application, including rural, frontier, and tribal communities; pregnant women; children; older adults; individuals with behavioral health conditions or disabilities; individuals with chronic conditions; Tribal populations; justice-involved individuals; and rural provider organizations. HCA has also identified program focus areas such as maternal health, behavioral health, chronic disease management, access to care, workforce, and financial sustainability.

		HCA has not finalized all denominator definitions, attribution methodologies, or analytic specifications for these populations or conditions at this time. The CRHSI Operator may be expected to support HCA in refining analytic definitions, identifying feasible denominators, and operationalizing measures based on available data and HCA direction. Offerors should propose an approach for developing and applying population and condition definitions that is transparent, data-informed, feasible with available data, and adaptable as the Rural Health Data Hub, provider-submitted data, and other data sources become available. Final priority populations, measure definitions, denominator specifications, attribution methods, and reporting requirements will be established by HCA during implementation and must align with CMS requirements, HCA direction, and applicable data governance requirements.
66	How much emphasis is placed on provider-facing vs. statewide analytics/reporting?	CRHSI is expected to support both provider-facing analytics and statewide reporting needs; however, the primary role of the CRHSI Operator is to use data and analytics to support provider-facing technical assistance, risk stratification, performance improvement, and sustainability activities. Provider-facing analytics may include support for baseline assessment, technical assistance prioritization, operational and financial improvement planning, provider incentive and outcome metric tracking, and helping providers interpret and act on available data. Statewide analytics and reporting will be coordinated through HCA-established processes and may also involve the Rural Health Data Hub, ASO, PMO, and other HCA-authorized entities. The CRHSI Operator should expect to contribute CRHSI-related data, performance information, provider engagement information, and implementation updates to support statewide monitoring and CMS reporting, but should not assume responsibility for the State's overall RHT Program reporting unless specifically directed by HCA. Offerors should propose an approach that balances provider-facing analytics with CRHSI reporting obligations and can adapt as HCA's data, reporting, and performance monitoring infrastructure matures.
67	Are there pre-defined RHT quality measures/KPIs, or are you expecting the vendor to help scope and refine these?	HCA has identified high-level RHT Program performance objectives and initiative-level goals through the CMS-approved RHT Program application. For CRHSI, these include goals related to stabilizing rural health care providers, strengthening financial and operational sustainability, improving access, supporting provider engagement, and reducing financial distress among rural providers.

		HCA has not finalized all CRHSI-specific quality measures, KPIs, technical specifications, benchmarks, or provider-level reporting requirements at this time. The CRHSI Operator may be expected to support HCA in scoping, refining, and operationalizing CRHSI performance measures and provider-facing metrics based on available data, provider readiness, CMS requirements, HCA priorities, and the final implementation approach. Offerors should propose a flexible performance measurement approach that can support both HCA-defined measures and refinement of CRHSI-specific KPIs during implementation. Final measures, definitions, reporting formats, baselines, targets, and timelines will be established by HCA and may evolve as CMS guidance, Data Hub capabilities, provider data, and program priorities are refined.
68	Does HCA have preferred approaches to: • Dashboard hosting (state systems vs. vendor-hosted) • Data visualization standards or branding?	HCA has not finalized CRHSI-specific dashboard hosting requirements, data visualization standards, or branding requirements at this time. Offerors should not assume that dashboards must be hosted in vendor systems or State systems unless specifically directed by HCA during implementation. Any dashboard hosting, data visualization, or reporting tool used for CRHSI must comply with applicable HCA, State, federal, privacy, security, confidentiality, accessibility, and data governance requirements. Offerors should propose a flexible approach to dashboarding and data visualization that can support HCA review, provider-facing use, performance monitoring, and coordination with the Rural Health Data Hub, ASO, and other RHT Program reporting processes. Proposed dashboards or reports should be able to align with HCA-approved branding, accessibility standards, reporting templates, and data visualization expectations once established. Final dashboard hosting, visualization standards, branding requirements, access controls, and publication or distribution processes will be determined by HCA during implementation.
69	Is there a requirement that all systems must: • Reside within state-hosted infrastructure • Be cloud-based • Meet specific hosting constraints?	HCA has not finalized CRHSI-specific hosting requirements or system infrastructure constraints at this time. Offerors should not assume that all CRHSI systems must reside within State-hosted infrastructure, be cloud-based, or meet a specific hosting model unless directed by HCA during implementation or contract finalization. Any proposed system, platform, dashboard, data repository, or technical tool used to support CRHSI must comply with applicable HCA, State, federal, privacy, security, confidentiality, accessibility, and data governance requirements. This may include requirements related to data protection, user access controls, auditability,

		business continuity, disaster recovery, and restrictions on storage, transmission, or use of protected data. Offerors should describe their proposed hosting approach, security controls, compliance posture, and ability to adapt to HCA's final infrastructure and data governance requirements. Final hosting, infrastructure, and security requirements will be determined by HCA during contract finalization and implementation planning.
70	Is there an established data governance framework for the RHT Program? What roles will CRHSI play in: Data standardization, Metadata management, Data stewardship?	HCA has not finalized a CRHSI-specific data governance framework for the RHT Program at this time. The CRHSI Operator will be expected to align with applicable HCA, State, federal, privacy, security, confidentiality, and data governance requirements, as well as any RHT Program data governance processes established during implementation. The CRHSI Operator is not expected to independently establish statewide data governance authority or serve as the primary data governance body for the RHT Program. Data governance for the RHT Program will be directed by HCA and may involve the PMO, Rural Health Data Hub, ASO, and other HCA-authorized entities. CRHSI may support data governance activities within its scope, including helping identify provider-facing data needs, supporting standardized data collection processes for CRHSI activities, documenting provider-submitted information, supporting performance monitoring workflows, and coordinating with HCA, the ASO, and the Rural Health Data Hub on data definitions, reporting needs, and data quality issues. HCA will establish final roles and responsibilities related to data standardization, metadata management, and data stewardship during implementation. Offerors should describe how they would support those activities in coordination with HCA and other RHT Program partners, while maintaining appropriate role boundaries, privacy safeguards, and data security controls.
71	Is there a date by which the HCA requires the CRHSI to be fully established and operational, or specific milestones (e.g., provider intake operational, first cohort onboarded) that must be achieved within the first 90 or 180 days of the contract? This will help Offerors structure the Workplan and ramp-up staffing assumptions.	HCA has not established a single fixed date by which CRHSI must be fully established and operational. HCA anticipates a phased implementation approach, including an initial planning, design, staffing, and ramp-up period before all CRHSI services are fully operational. Offerors should propose a Workplan that identifies key start-up milestones for the first 90 and 180 days of the contract. These may include activities such as staffing and onboarding, workplan refinement, development of the standardized assessment methodology, provider intake design, risk stratification and outreach planning, coordination with HCA and the ASO, development of tools and workflows, early provider engagement, and phased launch of technical assistance services.

		HCA expects the selected Contractor to work with HCA during implementation to finalize operational milestones, timelines, and performance expectations. Final launch milestones and due dates will be established during contract negotiation and implementation planning and may be adjusted based on funding, program readiness, HCA priorities, and operational considerations.
72	Section II.A., Sequence of Events, indicates Best and Final Offers may be submitted on June 23, 2026, only one day after potential Oral Presentations. Would the HCA please confirm: (a) the expected turnaround time for a BAFO; (b) whether BAFO requests will be issued in writing with specific scope/cost areas identified; and (c) whether Offerors may decline to revise without forfeiting their original offer?	The dates listed in Section II.A., Sequence of Events after the proposal submission deadline are anticipated dates and may be adjusted at HCA's discretion in accordance with the RFP and applicable procurement requirements. If HCA elects to conduct oral presentations and request Best and Final Offers (BAFOs), HCA will assess the time necessary for the BAFO process at that stage. Any BAFO request will be issued in writing and will identify the due date, submission instructions, and any specific proposal areas HCA is requesting the Offeror to address, which may include scope, cost, staffing, assumptions, contract terms, or other proposal components. An Offeror may decline to revise its proposal in response to a BAFO request; however, HCA may evaluate the Offeror's proposal based on the most recent proposal or BAFO response submitted, consistent with the RFP and applicable procurement requirements. Failure to respond to a BAFO request by the stated deadline may affect HCA's ability to consider any revisions or clarifications from that Offeror.
73	Section III.C., Proposal Content Detail (starting on page 27), indicates a Word Limit associated with the questions for each task. Would the HCA please confirm that the "words per question" refers to the level A, B, C, etc., inclusive of the subordinate bulleted/numbered content, and is not intended to establish a limit for every subordinate bullet or number?	Yes. The stated word limit applies to each primary questionnaire response, such as the level A, B, C, or other main question prompt, inclusive of any subordinate bullets or numbered items listed under that prompt. The word limit is not intended to apply separately to each subordinate bullet or numbered item unless the RFP or Submittable form expressly identifies a separate response field and word limit for that item. Offerors should ensure that each full response addresses the main prompt and any subordinate elements within the applicable word limit.
74	Section III.C., Questionnaire Specifications, Question 9 (Staffing and Organizational Structure), permits up to ten document uploads. For the remaining narrative questions (Sections 1–8, 10, 11), would the HCA please confirm: (a) whether attachments, exhibits, graphics, or appendices are permitted in addition to the stated word limits; (b) whether tables, charts, and	Offerors must provide required narrative responses within the applicable response fields and word limits. Supporting documentation may be submitted in the additional upload locations made available in Submittable, including attachments, exhibits, graphics, appendices, resumes, expanded biographies, tables, charts, or other supplemental materials relevant to the proposal. Supporting documentation may provide additional context, detail, or supporting information, but it should not replace the required narrative responses. Offerors should ensure that each required

	embedded graphics count toward the word limit; and (c) whether headers, footers, citations, and footnotes count toward the word limit?	narrative response is complete and responsive within the applicable response field and word limit. Tables and charts included within a narrative response field count toward the applicable word limit to the extent they contain words or substantive response content. Supporting documentation uploaded separately in an allowable Submittable upload field is not counted toward the narrative word limit unless otherwise stated in the RFP, as amended, or in Submittable. Headers, footers, citations, and footnotes should not be used to circumvent word limits. To the extent they contain substantive response content within a narrative response field, they may be considered part of the applicable word limit. HCA is not required to consider materials submitted outside the format or location required by the RFP, as amended, or Submittable.
75	Section III.C.X., Completed Cost Proposal, provides a Cost Proposal table as "an example of the minimum a budget submission must include" and allows additional supporting documentation. Would the HCA please confirm: (a) whether Offerors may modify the table structure (e.g., add columns for FY breakdown, indirect rate, fringe) so long as all required elements are present; (b) whether a separate narrative budget justification is expected or optional; and (c) whether the HCA prefers a specific file format (Excel, PDF, both) for cost supporting documentation?	Yes. Offerors may modify the Cost Proposal table structure, including adding columns for items such as fiscal year breakdowns, indirect rate, fringe, provider-directed payment estimates, administrative costs, equipment costs, program-related costs, or other budget detail, provided that all required elements from the RFP are included and the proposal remains clear, complete, and comparable. A budget narrative or budget justification is expected to the extent necessary to explain the proposed costs, assumptions, cost categories, staffing levels, provider-directed payment estimates, administrative costs, equipment costs, indirect costs, travel, and alignment with the Workplan. The budget justification should provide enough detail for HCA to evaluate cost reasonableness, allowability, feasibility, and compliance with applicable federal and state requirements. Offerors must clearly distinguish CRHSI Contractor operating/service delivery costs from provider-directed payment estimates. Provider-directed payment estimates should be included in the overall CRHSI budget for planning purposes but will not be included in the cost figure used to calculate Cost Proposal points unless otherwise directed by HCA. Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Equipment costs must be separately identified and will be reviewed for allowability, allocability, reasonableness, alignment with the Scope of Work, and compliance with applicable CMS or federal cost limitations. Offerors should submit cost supporting documentation in a format that is clear, accessible, and reviewable. HCA prefers that detailed cost tables be submitted in Excel where possible to support review, with a PDF version also provided if needed for formatting or official

		proposal consistency. Any required uploads must be submitted through the appropriate location in Submittable.
76	Section II.C.9., Disclosure of Proposal Contents, requires a redacted version of the proposal for public inspection. Would the HCA please confirm: (a) the file format expected for redactions (blacked-out PDF, separate document, both); (b) whether the redacted version must be uploaded at the time of proposal submission or only upon FOIA request; and (c) whether redactions of personnel home addresses and phone numbers are accepted as confidential despite Section I.F.7?	Offerors should follow the instructions in Submittable for submitting redacted copies of their proposal. Redacted copies should be submitted as directed in Submittable and should clearly show the proposed redactions. Any redactions submitted by an Offeror will be treated as recommendations only. HCA will follow all applicable Inspection of Public Records Act (IPRA) laws and requirements, as well as applicable procurement and confidentiality requirements, when determining what information may be withheld from public disclosure. If IPRA or other applicable law requires disclosure, HCA will disclose the information regardless of whether the Offeror marked or redacted the information in its submitted redacted copy. The RFP provides that personal information such as personal telephone numbers and home addresses may be excluded from Staff/Personnel Resumes/Bios. Accordingly, redaction of personnel home addresses and personal phone numbers is acceptable. However, HCA will make the final determination regarding disclosure in accordance with IPRA and applicable law.
77	Section V.A., Evaluation Point Summary, indicates that there are a total of 1,000 points available for factors B, C, D and E. However, the individual point allocations appear to sum to 1,100 (Technical Specifications: 650 + Workplan: 100 + Cost: 300 + Oral Presentations: 50 = 1,100). Would the HCA please confirm the corrected points available for each factor and the resulting total?	Please see the response to Question 56. The scored evaluation criteria are intended to total 1,000 points. The corrected point allocation is: **Evaluation Factor** — **Points** Organizational Experience — 50 Organizational References — 50 Questionnaire Specifications — 450 Workplan — 100 Cost Proposal — 300 Oral Presentation, if conducted — 50 **Total** — **1,000** The reference to 650 points for Technical Specifications should be read as 550 points for the combined technical components: Organizational Experience, Organizational References, and Questionnaire Specifications. As described in the response to Question 3, New Mexico/Native American Resident Preference points will not be applied to this RFP because the expenditure includes federal funds for a specific purchase. HCA will clarify the evaluation point total and remove any inconsistent scoring references through amendment.
78	Section V.B.6., Cost Proposal, applies a strict lowest-cost formula. Would the HCA please confirm: (a) how cost realism and	HCA will clarify the Cost Proposal requirements and cost evaluation methodology through amendment.

	price reasonableness will be assessed independent of this formula (e.g., to evaluate whether the lowest-priced proposal can actually deliver the Scope of Work); and (b) How the HCA will evaluate vendors that only respond to a part of the technical requirements outlined in the proposal?; and (c) How will the HCA evaluate appropriate resourcing of the proposed work effort?	Offerors are expected to respond to the full Scope of Work and all applicable technical requirements. A proposal that only responds to part of the required Scope of Work may be determined non-responsive or may receive reduced scoring under the applicable evaluation factors. For Cost Proposal scoring, HCA will use the Offeror's proposed CRHSI Contractor operating/service delivery cost, excluding separately identified provider-directed payment estimates. Provider-directed payment estimates must still be included in the overall CRHSI budget for planning purposes, but they will not be included in the cost figure used to calculate Cost Proposal points. New Mexico's RHT Budget Narrative includes an FFY26 provider payment estimate of $5 million for Bridge to Resilience / CRHSI. Offerors should include provider-directed payment estimates in the overall CRHSI budget, using the Budget Narrative as a reference point, but must clearly separate those estimates from CRHSI Contractor operating/service delivery costs. The detailed provider incentive structure, eligibility criteria, metrics, and distribution process will be developed during implementation and approved by HCA. Before applying the cost formula, HCA will review whether the Cost Proposal complies with required budget category separation and applicable federal cost limitations, including the 10 percent cap on administrative costs. Any proposal that exceeds the applicable 10 percent administrative cost cap will receive zero points for the Cost Proposal category and will not be used as the lowest responsive cost for calculating other Offerors' Cost Proposal scores. Offerors must separately identify equipment costs. Equipment costs will be reviewed for allowability, allocability, reasonableness, alignment with the Scope of Work, and compliance with any applicable CMS or federal cost limitations. HCA may review Cost Proposals for completeness, allowability, reasonableness, feasibility, and alignment with the Offeror's technical approach and Workplan, including whether the proposed staffing, level of effort, assumptions, and budget are sufficient to perform the required services. HCA is not required to select the lowest-cost proposal. Award will be made to the responsible Offeror whose proposal is most advantageous to the State, taking into consideration the evaluation factors set forth in the RFP, including technical approach, staffing, Workplan, cost, feasibility, and ability to perform the full Scope of Work. A proposal may receive reduced scoring or be deemed non-responsive if the proposed cost, staffing, level of effort, or Workplan is not sufficient to perform the full Scope of Work, even if the proposal receives a high score under the cost formula.

79	Section II.B.9., Best and Final Offers, indicates that finalists may be asked to submit revisions. Would the HCA please confirm: (a) whether BAFOs are expected to address Cost only, Technical only, or both; (b) whether BAFO scoring replaces or supplements initial scoring; and (c) the anticipated turnaround time for BAFO responses?	If HCA elects to request Best and Final Offers (BAFOs), HCA will issue the BAFO request in writing and identify the specific proposal areas to be addressed. A BAFO may request revisions to cost, technical approach, staffing, assumptions, contract terms, or other proposal components, depending on the issues identified during evaluation, oral presentations, or negotiations. BAFO scoring will be conducted in accordance with the RFP and applicable procurement requirements. If a BAFO is requested, HCA may evaluate the revised BAFO response as the Offeror's final offer for the areas addressed and may use the revised response in the final evaluation and award determination. The anticipated turnaround time for BAFO responses will be determined by HCA at the time BAFOs are requested. HCA will assess the time needed based on the nature and complexity of the requested revisions and will provide the due date and submission instructions in the written BAFO request. Dates after the proposal submission deadline may be adjusted at HCA's discretion in accordance with the RFP and applicable procurement requirements.
80	Given the uncertainty noted by the HCA that "Funding for program implementation is contingent upon compliance with federal and state requirements, performance expectations...," would the HCA please provide additional guidance on how bidders should provide pricing to allow for an "apples-to-apples" comparison of prices in line with the stated evaluation approach (lowest-cost responsive Offeror divided by each Offeror's cost)?	HCA will clarify the Cost Proposal requirements and cost evaluation methodology through amendment to support consistent, apples-to-apples cost comparison. Offerors should submit an overall CRHSI budget for the required initial pricing period identified in the RFP and amendment. The budget must separately identify, at minimum, CRHSI Contractor operating/service delivery costs, provider-directed payment estimates, administrative costs, equipment costs, program-related costs, indirect costs, travel costs, subcontractor costs, and any other direct costs necessary to perform the Scope of Work. For purposes of Cost Proposal scoring, HCA will use the Offeror's proposed CRHSI Contractor operating/service delivery cost, excluding separately identified provider-directed payment estimates. Provider-directed payment estimates must still be included in the overall CRHSI budget for planning purposes, but they will not be included in the cost figure used to calculate Cost Proposal points unless otherwise directed by HCA. Administrative costs, including direct and indirect administrative costs, are subject to the applicable federally required 10 percent cap. Any proposal that exceeds the applicable 10 percent administrative cost cap will receive zero points for the Cost Proposal category and will not be used as the lowest responsive cost for calculating other Offerors' Cost Proposal scores. HCA may review Cost Proposals for completeness, allowability, reasonableness, feasibility, and alignment with the Offeror's technical approach and Workplan. HCA is not required to select the

		lowest-price offer. Award will be made to the responsible Offeror whose proposal is most advantageous to the State, taking into consideration the evaluation factors set forth in the RFP. Future-year funding and contract extensions are not guaranteed and will depend on federal funding availability, State RHT Program performance, Contractor performance, operational need, and HCA approval.
81	Section I.B., Background Information, notes the RHT Program is a $211.5M cooperative agreement, while Initiative #4 (Bridge to Resilience) represents one of five initiatives. Would the HCA please share: (a) the allocated funding ceiling for Bridge to Resilience over the five-year period; (b) the expected annual funding profile; and (c) whether funding is tranche-based, performance-based, or annually appropriated?	The RHT Program is funded through a federal CMS cooperative agreement, and funding for each initiative is subject to federal funding availability, CMS requirements, State RHT Program performance, approved budgets, federal allowability, and HCA direction. Amounts identified in New Mexico's RHT Budget Narrative for Bridge to Resilience / CRHSI are planning estimates and should not be interpreted as a guaranteed contract value, funding ceiling, maximum award amount, or not-to-exceed price for this RFP. For purposes of this RFP, Offerors should follow the Cost Proposal guidance provided in response to Question 5 and any related amendment. Offerors should submit pricing for the first two federal fiscal years of CRHSI work, separately identifying the FFY26 allocation proposed to be used through September 30, 2027, and any additional anticipated FFY27 need beyond the FFY26 allocation for informational purposes only. Future-year funding and contract extensions are not guaranteed and will depend on federal funding availability, State RHT Program performance, Contractor performance, operational need, federal allowability, and HCA approval.
82	Will the HCA please clarify: (a) whether the Contractor's pricing should be inclusive of New Mexico Gross Receipts Tax (NMGRT) or whether GRT will be reimbursed in addition to the contract amount per Appendix B Section 2; (b) the applicable GRT rate the Contractor should assume; and (c) whether out-of-state Offerors are subject to different tax treatment?	Offerors are responsible for determining their own tax obligations and should consult their tax advisor regarding applicability of New Mexico Gross Receipts Tax (NMGRT), including any differences based on business location, nexus, sourcing, or other tax requirements. For purposes of proposal comparison, Offerors should clearly state whether NMGRT is included in the proposed pricing or listed as a separate line item. Any NMGRT assumptions should be clearly identified in the Cost Proposal and budget narrative. NMGRT should not be double-counted. HCA is not providing a single GRT rate for Offerors to assume because applicable rates may vary based on location, sourcing, taxability, and other factors. The New Mexico Taxation and Revenue Department provides official GRT rate and location code resources, including a Gross Receipts Location Code and Tax Rate Map. Out-of-state Offerors are responsible for determining whether and how New Mexico GRT applies to their proposed services. New

		Mexico's Taxation and Revenue Department explains that GRT is imposed on businesses and that it is common for a business to pass the GRT on to the purchaser. Final tax treatment will depend on applicable law and the Offeror's specific circumstances.
83	Section I.C., Scope of Procurement, states that Administrative Services Organization (ASO) functions "are not within this scope of services for the CRHSI, unless specifically authorized by HCA." However, Appendix E, Section 2.7 (Provider Incentives and Outcome Metrics), requires the Contractor to "track and validate provider progress" and "report on performance data" for incentive payments. Would the HCA please clarify the operational boundary between CRHSI's performance validation role and the entity responsible for payment processing/disbursement of provider incentives? Additionally, would the HCA please clarify how the administrative support for the CRHSI will be determined?	The CRHSI Contractor's role is programmatic, not fiscal. The CRHSI Contractor may support the provider incentive process by developing or recommending incentive structures, tracking and validating provider progress, documenting milestone achievement, supporting data collection, and preparing performance reports or recommendations for HCA review. The CRHSI Contractor will not be responsible for payment processing, fiscal disbursement, provider reimbursement administration, claims processing, or acting as a fiscal intermediary unless specifically authorized by HCA through written direction or contract modification. Provider incentive payment administration will be supported by HCA, the Administrative Services Organization (ASO), or another HCA-authorized mechanism, as determined by HCA. The operational boundary is that CRHSI may validate and report on the programmatic basis for incentive payments, while HCA, the ASO, or another HCA-authorized entity will manage the fiscal administration of approved payments. Final approval of provider incentive methodology, payment criteria, payment recommendations, and disbursement processes will remain with HCA. Administrative support for CRHSI will be determined by HCA during implementation. HCA anticipates that CRHSI will coordinate with the ASO for applicable administrative functions, which may include payment administration support, documentation, financial tracking, reporting support, and related program administration activities as directed by HCA.
84	Appendix E, Section 2.4 (Data Analytics Platform Access), requires CRHSI to coordinate with the Rural Health Data Hub (Initiative #5). Would the HCA please share: (a) the current status, timeline, and Operator (if selected) of the Rural Health Data Hub; (b) whether data integration points, APIs, or shared platforms have been defined; and (c) how data governance and data-sharing agreements between CRHSI and the Data Hub will be established?	Please see the responses to Questions 32, 46, 47, 61, and 70. The Rural Health Data Hub is currently in the planning phase and will be implemented separately from the CRHSI procurement. HCA has not selected a Rural Health Data Hub Operator at this time and does not have a specific date by which the Data Hub will be fully operational. HCA has not finalized Data Hub integration points, APIs, shared platforms, or CRHSI-specific data exchange specifications at this time. The CRHSI Operator should not assume that the Data Hub will be fully operational at CRHSI contract start or that direct system-to-system integration will be required or available at that time. The CRHSI Operator should propose a flexible, vendor-agnostic approach that can operate with available HCA-approved data, public data sources, provider-submitted information, and other

		approved reports or data extracts while the Data Hub is being developed. As the Data Hub becomes available, CRHSI will be expected to coordinate with HCA and the Data Hub implementation team or contractor to incorporate Data Hub outputs into provider outreach, technical assistance, performance monitoring support, and provider-facing education. Data governance and data-sharing processes between CRHSI and the Data Hub will be established by HCA during implementation. Any data access, data-sharing agreements, confidentiality agreements, business associate agreements, system access, or data exchange processes will be subject to HCA direction and applicable federal and state privacy, security, confidentiality, and data governance requirements.
85	Appendix E, Section 3.1.1 (Contractor Deliverables), references performance against penalty thresholds in "the chart in Section 8.4.2 below," and Section 4.6 of the Scope of Work appears to be referenced but the heading is blank in the RFP document. Would the HCA please provide the complete penalties chart (Section 4.6) and confirm the correct Section reference?	HCA will correct the section reference through amendment. The reference to “the chart in Section 8.4.2 below” is incorrect. HCA will provide the correct section reference and complete performance/penalty chart, if applicable, through an amendment to the RFP. Until amended, Offerors should not rely on the incorrect Section 8.4.2 reference or the blank Section 4.6 heading as establishing additional penalty requirements beyond those clearly stated in the RFP and contract terms. Final performance expectations, service levels, reporting requirements, and any applicable remedies or penalty thresholds will be governed by the RFP as amended and the final executed contract.
86	Does the HCA intend for the selected Contractor to inherit any existing State infrastructure, data assets, prior technical-assistance materials, staff, or vendor contracts to support CRHSI implementation? If yes, will the HCA please provide an inventory or describe the transition approach?	HCA does not anticipate that the selected CRHSI Contractor will inherit existing State staff, vendor contracts, or a fully established CRHSI infrastructure at contract start. HCA may provide available program materials, planning documents, data sources, templates, stakeholder information, prior technical assistance materials, or other resources that HCA determines are appropriate and allowable to support CRHSI implementation. However, Offerors should not assume that existing infrastructure, staff, data assets, tools, or vendor contracts will be transferred to or made available to the Contractor unless specifically identified by HCA. The selected Contractor will be expected to establish and operate CRHSI in coordination with HCA, the ASO, the Rural Health Data Hub as it develops, and other RHT Program partners. Any transition approach, available materials, data access, system access, or coordination with existing vendors will be determined by HCA during implementation and will be subject to applicable privacy, security, procurement, contractual, and data governance requirements. Offerors should propose an implementation approach that can stand up CRHSI from inception while also remaining flexible enough

		to incorporate HCA-provided resources or existing materials if made available.
87	Section I.A., Purpose of this RFP, notes the Contractor will serve as "the State's centralized technical assistance and sustainability entity." Would the HCA please clarify: (a) whether the Contractor is expected to deliver TA exclusively, or also operate as a single-point-of-entry for federal/state rural health funding navigation; (b) the relationship between CRHSI and the Rural Health Care Delivery Fund (administered by HCA); and (c) whether CRHSI is expected to coordinate with HRSA Federal Office of Rural Health Policy programming?	The CRHSI Contractor is expected to serve as a centralized technical assistance and sustainability support entity for rural providers under the RHT Program. This includes delivering technical assistance, supporting provider engagement, helping providers navigate sustainability challenges, coordinating learning and implementation supports, and connecting providers to relevant resources as directed by HCA. CRHSI is not intended to replace HCA's role in administering federal or state rural health funding programs or to make funding decisions on behalf of HCA. CRHSI may support providers in understanding available rural health resources, preparing for participation in RHT-related activities, identifying operational or financial sustainability needs, and coordinating with HCA or other partners, but final decisions regarding eligibility, awards, funding, and program administration remain with HCA or the applicable funding entity. The Rural Health Care Delivery Fund is a separate HCA-administered program and is not being transferred to the CRHSI Contractor through this RFP. HCA may direct CRHSI to coordinate with RHCDF-related providers, lessons learned, sustainability needs, or technical assistance opportunities where appropriate, but CRHSI will not administer the RHCDF unless specifically authorized by HCA. HCA may also direct CRHSI to coordinate with relevant federal, state, and partner programs, including HRSA Federal Office of Rural Health Policy programming, where alignment supports RHT Program goals and rural provider sustainability. Any such coordination will be conducted under HCA direction and within the final approved Scope of Work.
88	Appendix E, Section 2.1 (Strategic Technical Assistance), references partnership development including "collective contracting" and "group purchasing." Would the HCA please clarify: (a) whether the Contractor is expected to facilitate Group Purchasing Organization (GPO) arrangements as an intermediary, or only support providers in joining existing GPOs; and (b) any antitrust safe-harbor guidance the State has issued for collective negotiation with commercial payers?	The CRHSI Contractor is not expected to act as a Group Purchasing Organization, payer contracting intermediary, or legal representative for providers unless specifically authorized by HCA through written direction or contract modification. For purposes of this RFP, partnership development activities may include helping providers identify opportunities for shared services, collaboration, group purchasing participation, collective learning, operational alignment, and sustainability strategies. CRHSI may support providers in understanding available options, assessing feasibility, convening partners, and connecting providers to existing resources or organizations, including existing GPOs where appropriate. HCA has not issued antitrust safe-harbor guidance for collective negotiation with commercial payers through this RFP. Offerors should not assume that CRHSI will facilitate collective negotiation

		with commercial payers or establish provider contracting arrangements that would require legal or antitrust review. Any activities involving collective contracting, group purchasing, shared services, or payer-related strategy must be conducted in compliance with applicable federal and state laws and under HCA direction. Offerors should describe how they would support provider collaboration while maintaining appropriate legal, ethical, and compliance safeguards.
89	Appendix E, Section 3.1.1, lists deliverables including an "Annual CRHSI Strategic Plan" and "Annual CRHSI Implementation Plan." Would the HCA please confirm: (a) the relationship/sequencing between these two plans; (b) the expected approval cycle (HCA review window, revision rounds); and (c) whether the first-year plans are due within the initial 90 days?	HCA anticipates that the Annual CRHSI Strategic Plan and Annual CRHSI Implementation Plan will be related but distinct deliverables. The Annual CRHSI Strategic Plan should describe the broader direction, priorities, goals, provider engagement strategy, technical assistance priorities, sustainability focus areas, and alignment with RHT Program objectives for the year. The Annual CRHSI Implementation Plan should operationalize the Strategic Plan by identifying the specific activities, timelines, milestones, staffing/resource approach, deliverables, dependencies, reporting processes, and implementation steps the Contractor will use to carry out the strategy. HCA anticipates that the first-year plans will be developed during the initial planning and ramp-up period. Offerors should propose a timeline for development, HCA review, revision, and approval of both plans in the Workplan, including whether the first-year plans can be submitted within the initial 90 days of the contract. The final due dates, approval cycle, HCA review window, and any revision rounds will be established during contract negotiation and implementation planning. HCA may require one or more revision cycles before approval. The Contractor should not treat either plan as final until approved by HCA.
90	Appendix E, Section 1, indicates CRHSI will "coordinate the day-to-day program management efforts of the other four initiatives." Would the HCA please clarify: (a) the staffing and authority CRHSI has over the other four initiatives' contractors; (b) whether escalation/conflict-resolution authority sits with CRHSI or HCA; and (c) the cross-initiative governance structure?	Please see the response to Question 24. HCA does not expect the CRHSI Contractor to act as the Project Management Office for all RHT Program initiatives or to have independent authority over contractors, subrecipients, or implementation partners for the other four initiatives. CRHSI may support cross-initiative coordination, technical assistance alignment, provider engagement, stakeholder coordination, learning collaboratives, data use, performance monitoring support, implementation feedback, and implementation support to HCA. CRHSI may also help identify cross-initiative dependencies, coordinate provider-facing supports, and elevate operational issues to HCA. The CRHSI Contractor will not have supervisory, contractual, funding, or decision-making authority over other RHT initiative

		contractors or subrecipients unless specifically authorized by HCA in writing. Escalation and conflict-resolution authority will remain with HCA. The cross-initiative governance structure will be established and directed by HCA. HCA will retain responsibility for overall RHT Program governance, strategic oversight, funding decisions, federal compliance, CMS reporting, procurement, and final approval of program scope and deliverables. CRHSI will operate within that HCA-directed governance structure and will support coordination as assigned by HCA.
91	Will the HCA please clarify the expected role of CRHSI in supporting providers preparing for or transitioning to Rural Emergency Hospital (REH) designation, given that the only current REH (Guadalupe County Hospital) and several at-risk CAHs may consider conversion during the contract term?	CRHSI may support providers that are preparing for, evaluating, or transitioning to Rural Emergency Hospital designation as part of its broader technical assistance and sustainability role, as directed by HCA. Support may include helping providers assess operational, financial, workforce, access-to-care, and community impact considerations related to REH designation; identifying technical assistance needs; supporting sustainability planning; connecting providers to relevant federal or state resources; and coordinating with HCA and other partners as appropriate. CRHSI will not make REH designation decisions, regulatory determinations, certification decisions, or funding decisions on behalf of HCA, CMS, or any other regulatory entity. Any REH-related technical assistance must be consistent with applicable federal and state requirements and HCA direction. Offerors should describe their experience supporting rural hospitals, Critical Access Hospitals, financially at-risk providers, service-line transitions, and sustainability planning, including how they would support providers exploring REH conversion or other operational models while maintaining access to essential services in rural communities.
92	Section II.C.16., Contract Terms and Conditions, states that the CMS Cooperative Agreement Terms and Conditions "shall control" in the event of conflict with the Scope of Work. Would the HCA please confirm: (a) whether the Standard Contract Terms and Conditions (Appendix B) are subordinate to the CMS Cooperative Agreement; and (b) whether Offerors should propose specific alternate language in Appendix B to address conflicts already identified (e.g., 2 CFR Part	Yes. To the extent there is a conflict between the RFP, Scope of Work, Appendix B Standard Contract Terms and Conditions, and the CMS Cooperative Agreement Terms and Conditions, the CMS Cooperative Agreement Terms and Conditions and applicable federal requirements will control. Offerors should assume that the resulting contract must comply with all applicable federal requirements, including the CMS Cooperative Agreement Terms and Conditions, 2 CFR Part 200, and any required federal flow-down provisions. HCA may incorporate additional federal terms, conditions, or flow-down requirements into the final contract as needed to ensure compliance with the CMS award. If an Offeror identifies a potential conflict or seeks alternate contract language related to Appendix B, including intellectual

	200 flow-down requirements, intellectual property treatment)?	property, federal flow-down provisions, data rights, confidentiality, indemnification, or other contract terms, the Offeror should propose specific alternate language with its proposal, including a brief discussion of the purpose and impact of the proposed change. HCA may or may not accept proposed alternate language. Final contract terms will be determined through the procurement and contract negotiation process and must remain consistent with applicable federal and state requirements.
93	Section II.C.5., Subcontractors/Consent, requires the prime contractor to receive written HCA approval before any subcontractor is used. Would the HCA please clarify: (a) the anticipated approval timeline (e.g., 10 business days, 30 days); (b) whether subcontractors disclosed in the proposal are deemed pre-approved upon contract award; and (c) the criteria the HCA will use to evaluate subcontractor approval requests during performance?	Subcontractors identified in an Offeror's proposal are not automatically deemed approved upon contract award unless expressly approved by HCA in the final executed contract or through separate written approval. The selected Contractor must obtain written HCA approval before using any subcontractor, consistent with the RFP and final contract terms. HCA anticipates reviewing subcontractor approval requests as expeditiously as practicable; however, the approval timeline will depend on the completeness of the request, the nature of the proposed subcontracted work, any required compliance review, and operational needs. HCA is not establishing a fixed approval timeline through this FAQ. In reviewing subcontractor approval requests, HCA may consider factors such as the subcontractor's proposed role, qualifications, experience, capacity, financial and operational stability, compliance with applicable federal and state requirements, conflict of interest considerations, data security or confidentiality requirements, and alignment with the approved Scope of Work, Workplan, and budget. The prime Contractor remains responsible for all services, deliverables, performance, compliance, reporting, and subcontractor oversight under the final contract, including work performed by any HCA-approved subcontractor.
94	Appendix B, Section 11 (Product of Service — Copyright), states that all materials developed under the Agreement "shall become the property of the State of New Mexico" with no Contractor copyright claim. Would the HCA please confirm whether this provision applies to: (a) pre-existing Contractor intellectual property, methodologies, and tools used in performance; (b) generally applicable templates and frameworks the Contractor may continue to use across other clients; and (c) any third-party	HCA is not modifying the Standard Contract Terms and Conditions through this FAQ. If an Offeror seeks alternate contract language related to pre-existing intellectual property, methodologies, tools, templates, frameworks, third-party licensed materials, or related license rights, the Offeror must propose specific alternative language with its proposal, including a brief discussion of the purpose and impact of the proposed change. HCA may or may not accept proposed alternative language. Final contract terms will be determined through the procurement and contract negotiation process. General references to an Offeror's standard terms and conditions or attempts to substitute the draft contract are not acceptable and may result in disqualification.

	licensed materials embedded in deliverables?	Offerors should clearly identify any assumptions related to pre-existing intellectual property, reusable tools or frameworks, and third-party licensed materials that would be used to perform the work or incorporated into deliverables.
95	Appendix E, Section 6.2 (Data Security and Confidentiality), states that the Contractor may reuse "general knowledge, skills, methodologies, and non-proprietary tools developed or improved during the course of this engagement." Would the HCA please reconcile this with Appendix B, Section 11 (which assigns all rights to the State), and clarify the intended scope of the Contractor's reuse rights post-contract?	HCA is not modifying the Standard Contract Terms and Conditions through this FAQ. If an Offeror seeks alternate contract language related to pre-existing intellectual property, methodologies, tools, templates, frameworks, third-party licensed materials, or related license rights, the Offeror must propose specific alternative language with its proposal, including a brief discussion of the purpose and impact of the proposed change. HCA may or may not accept proposed alternative language. Final contract terms will be determined through the procurement and contract negotiation process. General references to an Offeror's standard terms and conditions or attempts to substitute the draft contract are not acceptable and may result in disqualification. Offerors should clearly identify any assumptions related to pre-existing intellectual property, reusable tools or frameworks, and third-party licensed materials that would be used to perform the work or incorporated into deliverables.
96	Appendix B, Section 20 (Indemnification), requires the Contractor to defend, indemnify, and hold harmless the Agency from all claims "caused by the negligent act or failure to act" of the Contractor or its subcontractors. Would the HCA please confirm: (a) whether mutual indemnification is available; (b) whether the indemnification is subject to a liability cap (e.g., aggregate cap at contract value or insurance limits); and (c) whether consequential and punitive damages are excluded?	HCA is not modifying the Standard Contract Terms and Conditions through this FAQ. If an Offeror seeks alternate contract language related to indemnification, mutual indemnification, liability caps, insurance limits, consequential damages, punitive damages, or other liability-related terms, the Offeror must propose specific alternative language with its proposal, including a brief discussion of the purpose and impact of the proposed change. HCA may or may not accept proposed alternative language. Final contract terms will be determined through the procurement and contract negotiation process. General references to an Offeror's standard terms and conditions or attempts to substitute the draft contract are not acceptable and may result in disqualification.
97	Section II.C.17., Offeror's Terms and Conditions, allows Offerors to submit additional terms with their proposal. Would the HCA please clarify: (a) whether failure to propose alternate terms now (e.g., on items not yet identified) waives the ability to negotiate them during contract execution; and (b) how the HCA evaluates proposals that include proposed contractual	Offerors should identify any proposed alternate terms and conditions with their proposal, as provided in the RFP. Proposed alternate terms should include specific language and a brief discussion of the purpose and impact of the requested change. HCA is not confirming through this FAQ that failure to propose alternate terms at the time of proposal submission waives all ability to discuss contract terms during contract finalization. However, Offerors should not assume that new or additional alternate terms may be raised after proposal submission or accepted during

	modifications relative to those that accept Appendix B as-is?	contract execution. HCA may decline to consider proposed changes that were not submitted in accordance with the RFP. Proposals that include proposed contractual modifications will be evaluated in accordance with the RFP and applicable procurement requirements. HCA may consider whether proposed modifications are acceptable, material, consistent with federal and state requirements, and compatible with the Scope of Work, CMS Cooperative Agreement Terms and Conditions, and HCA's contracting requirements. HCA may or may not accept proposed alternate language. Final contract terms will be determined through the procurement and contract negotiation process. General references to an Offeror's standard terms and conditions or attempts to substitute the draft contract are not acceptable and may result in disqualification.
98	Appendix E, Section 6 (Data Security and Confidentiality), requires compliance with "all applicable state and federal data security, confidentiality, and privacy requirements." Would the HCA please specify: (a) whether HIPAA Business Associate Agreement (BAA) status applies, and if so, the scope of PHI access expected; (b) any required hosting/data-residency requirements (e.g., U.S.-only, in-state); and (c) applicable cybersecurity frameworks (NIST 800-53, HITRUST, FedRAMP, CMS MARS-E)?	HCA has not finalized CRHSI-specific data access, hosting, data residency, or cybersecurity requirements at this time. Final requirements will depend on the data sources, systems, tools, and functions approved by HCA during implementation. If the CRHSI Contractor will access, create, receive, maintain, or transmit protected health information or other protected data, HCA may require a Business Associate Agreement, data use agreement, confidentiality agreement, or other applicable agreement. The scope of any PHI or sensitive data access will be determined by HCA based on the approved Scope of Work, data needs, privacy requirements, and minimum necessary standards. Offerors should not assume unrestricted access to PHI, Medicaid claims systems, provider systems, HCA systems, CMS systems, or other protected data environments at contract start. Offerors should also not assume a specific hosting or data residency model unless directed by HCA. Any proposed system, platform, dashboard, data repository, or technical tool must comply with applicable federal and state privacy, security, confidentiality, accessibility, and data governance requirements. HCA may require compliance with applicable cybersecurity frameworks or standards based on the final technical architecture and data access model. Offerors should describe their cybersecurity posture, hosting approach, access controls, data protection practices, incident response processes, and ability to comply with applicable frameworks and requirements, which may include NIST, HIPAA, CMS, State of New Mexico, or other relevant standards as determined by HCA.
99	Would the HCA please confirm: (a) whether the Contractor may use commercial cloud infrastructure (AWS, Azure, Google Cloud) for storing CRHSI data and	HCA has not finalized CRHSI-specific cloud hosting, FedRAMP authorization, or State data classification requirements at this time. Final requirements will depend on the data sources, systems, tools, hosting model, and data access approved by HCA during implementation.

	deliverables; (b) whether FedRAMP Moderate or High authorization is required for cloud hosting; and (c) any State data classification framework (e.g., NM ITC standards) that applies?	The Contractor should not assume that use of commercial cloud infrastructure, including AWS, Azure, or Google Cloud, is automatically approved or prohibited. Any proposed cloud infrastructure must comply with applicable HCA, State of New Mexico, federal, privacy, security, confidentiality, accessibility, and data governance requirements. HCA has not determined through this FAQ whether FedRAMP Moderate, FedRAMP High, or another specific cloud security authorization will be required for CRHSI. Any FedRAMP, NIST, CMS, HIPAA, State of New Mexico, or other cybersecurity requirements will be determined based on the final technical architecture, data classification, and type of information stored, processed, or transmitted. Offerors should describe their proposed hosting approach, security controls, data protection practices, data residency assumptions, access controls, incident response processes, and ability to comply with applicable federal and State requirements. Final hosting, cloud security, FedRAMP, and data classification requirements will be established by HCA during contract finalization and implementation planning.
100	Will the HCA please confirm the breach notification requirements applicable to the Contractor, including: (a) the notification window upon discovery of a suspected or confirmed incident; (b) the State office and CMS office to be notified; (c) the form of notification (written, verbal, automated); and (d) whether notification obligations flow down to subcontractors?	HCA has not finalized CRHSI-specific breach notification procedures, notification windows, points of contact, or reporting forms at this time. Final breach notification requirements will depend on the data accessed, systems used, applicable agreements, and final contract terms. The Contractor will be required to comply with all applicable federal and State privacy, security, confidentiality, incident response, and breach notification requirements, including any requirements established by HCA, CMS, HIPAA, applicable data use agreements, business associate agreements, or other governing agreements. If the Contractor discovers a suspected or confirmed privacy or security incident, the Contractor must notify HCA in accordance with the final contract terms and any applicable data security, privacy, or confidentiality agreements. HCA will identify the required notification contacts, timing, format, and escalation process during contract finalization or implementation planning. Any breach notification obligations will flow down to subcontractors as applicable. The prime Contractor remains responsible for ensuring that subcontractors comply with all applicable privacy, security, confidentiality, incident reporting, and breach notification requirements.
101	Section III.C., Questionnaire Specifications, Question 9 (Staffing and Organizational Structure), asks Offerors to identify	HCA does not require the CRHSI Contractor to maintain a New Mexico-based office, locate a minimum percentage of FTEs in New Mexico, or provide routine on-site presence at HCA offices unless

	physical location of staff including "in-state/out-of-state; remote/on-site, and any proposed on-site presence." Would the HCA please clarify whether there is a preference, requirement, or scored advantage for: (a) New Mexico-based staff; (b) on-site presence at HCA offices; and (c) a minimum percentage of FTEs based in New Mexico?	otherwise determined during contract finalization or implementation. There is no separate preference point category or automatic scored advantage for New Mexico-based staff, on-site HCA office presence, or a specific percentage of New Mexico-based FTEs. As stated in responses to Questions 3, 9, 13, and 31, New Mexico/Native American Resident Preference points will not be applied to this RFP. However, HCA may consider the extent to which an Offeror's staffing model supports effective service delivery in New Mexico. This may include consideration of New Mexico-based staff, proposed in-person or on-site presence, travel approach, local partnerships, responsiveness, familiarity with New Mexico's rural, frontier, and tribal communities, and ability to provide timely support to providers across the state. These factors may be considered within the applicable scored evaluation categories, including Staffing and Organizational Structure, Qualifications and Experience, Specifications, and Workplan, to the extent they demonstrate the Offeror's capacity to successfully perform the Scope of Work. Offerors should identify staff work locations as requested in the RFP and clearly explain how the proposed staffing model will meet the needs of the Scope of Work.
102	Will the HCA please confirm whether questions submitted by Offerors will be published anonymously alongside the HCA's responses, or whether the identity of the submitting Offeror will be disclosed?	Questions submitted by Offerors will be published anonymously with HCA's responses. HCA does not intend to identify the Offeror that submitted each question in the published FAQ. HCA may consolidate, rephrase, or group similar questions for clarity, consistency, or administrative efficiency. All published responses will apply equally to all Offerors.
103	Does HCA have specific expectations regarding security frameworks (e.g., NIST 800-53, NIST 800-171, HITRUST, SOC 2 Type II) for the CRHSI platform beyond what is stated in SOW §6.1?	HCA has not finalized CRHSI-specific security framework requirements beyond those stated in the RFP and Scope of Work at this time. Final security requirements will depend on the data sources, systems, hosting model, platform functionality, and type of information the Contractor is approved to access, store, process, or transmit. Offerors should describe their existing security posture and any applicable certifications, attestations, or controls, such as NIST 800-53, NIST 800-171, HITRUST, SOC 2 Type II, HIPAA security controls, or other relevant standards. HCA may consider these as part of evaluating the Offeror's ability to protect sensitive information and comply with applicable privacy, security, confidentiality, and data governance requirements.

		Any CRHSI platform, system, dashboard, repository, or tool must comply with applicable HCA, State of New Mexico, federal, CMS, HIPAA, privacy, security, confidentiality, accessibility, and data governance requirements. HCA may establish additional security framework, documentation, or compliance requirements during contract finalization and implementation planning based on the approved technical architecture and data access model.
104	For our planning purposes, does HCA have any planning assumptions for year 1 in terms of: number of providers engaged and participating, anticipated mix (rural hospitals, clinics, tribal entities, etc.) and intensity level(s) of TA expected.	HCA has not finalized Year 1 provider participation targets, provider mix, or technical assistance intensity levels at this time. CRHSI is expected to support eligible rural, frontier, and tribal providers across New Mexico, which may include rural hospitals, clinics, FQHCs, Tribal health providers, long-term care providers, home- and community-based service providers, and other rural health care organizations, as determined by HCA. The number of providers engaged in Year 1 and the intensity of technical assistance will depend on available funding, provider need, risk stratification, provider readiness, geographic priorities, HCA direction, and the final CRHSI implementation approach. HCA anticipates working with the selected Contractor during implementation to refine provider eligibility, prioritization, outreach sequencing, service tiers, and technical assistance intensity levels. Offerors should propose a scalable Year 1 approach that can support phased implementation, including initial provider outreach, baseline assessment, prioritization of higher-need providers, and differentiated levels of technical assistance based on provider type, risk, readiness, and sustainability needs.
105	Does the state use geographical regions/districts routinely that would make sense for the vendor to use in organizing the TA?	Yes. HCA and other State partners use geographic regions for various programs and planning purposes, and HCA may provide regional frameworks or priority geographies for CRHSI during implementation. However, HCA is not requiring Offerors to use one specific regional or district structure for organizing CRHSI technical assistance unless otherwise directed by HCA. Offerors should propose a geographic service delivery approach that supports effective access across rural, frontier, and tribal communities statewide. Offerors may consider existing State, Medicaid, public health, rural health, or regional planning structures, as well as the regional approach being developed through other RHT Program initiatives such as Healthy Horizons. The proposed approach should be flexible enough to align with HCA direction, provider distribution, regional needs, travel considerations, and cross-initiative coordination. Final regional organization, priority geographies, and technical assistance deployment approach will be determined by HCA during implementation in coordination with the selected Contractor and other RHT Program partners.

106	Please identify whether there are priority provider types, geographies, or communities that HCA expects to be addressed first during roll-out of the Centers activities.	HCA has not finalized a specific roll-out order for CRHSI activities by provider type, geography, or community at this time. HCA expects CRHSI to support rural, frontier, and tribal providers across New Mexico, with prioritization informed by provider need, risk stratification, access-to-care concerns, financial and operational sustainability indicators, rural/frontier status, tribal community needs, provider readiness, available funding, and HCA direction. HCA may identify priority provider types, regions, or communities during implementation based on available data, stakeholder input, RHT Program priorities, and emerging needs. Priority providers may include, but are not limited to, rural hospitals, Critical Access Hospitals, rural clinics, FQHCs, Tribal health providers, long-term care providers, home- and community-based service providers, behavioral health providers, and other rural health care organizations. Offerors should propose a phased roll-out approach that can support statewide access while allowing HCA and the selected Contractor to prioritize higher-need providers, geographies, or communities during initial implementation. Final roll-out priorities and sequencing will be determined by HCA during implementation.
107	Will HCA provide standardized definitions, baseline data sources, and validation methodologies for required outcome metrics (e.g., operating margin, days cash on hand, workforce retention), or is the contractor expected to develop these from the ground up for HCA approval?	HCA has not finalized all standardized definitions, baseline data sources, or validation methodologies for CRHSI outcome metrics at this time. The Contractor will be expected to support HCA in refining and operationalizing outcome metrics, which may include measures related to financial sustainability, operating margin, days cash on hand, workforce retention, access, provider participation, technical assistance utilization, provider incentives, and other CRHSI performance indicators. HCA may provide available baseline data sources, existing definitions, program priorities, CMS reporting requirements, and other guidance during implementation. The Contractor should not assume it will develop the methodology independently or implement metrics without HCA review and approval. The CRHSI Contractor will also be expected to coordinate with other HCA-contracted support organizations, such as the ASO, Rural Health Data Hub, PMO/reporting support, or other implementation partners, as applicable, to support metric development, data alignment, validation processes, performance monitoring, and reporting. Offerors should describe their proposed approach for developing measure definitions, identifying feasible data sources, establishing baselines, validating provider-submitted information, coordinating

		with other contracted support organizations, and supporting performance monitoring. Final metric definitions, baseline data sources, validation methods, reporting formats, and approval processes will be established by HCA during implementation.
108	If a group is providing services (as a sub) under the Prime for the ASO work, can they also be eligible to serve as Prime for the CRHSI work?	Serving as a subcontractor under the ASO contract does not automatically preclude an organization from serving as the prime Contractor for the CRHSI work. However, participation in multiple RHT Program roles may require conflict of interest review and appropriate safeguards. HCA may evaluate actual, potential, or perceived conflicts of interest, including access to non-public information, involvement in developing requirements or evaluation materials, ability to obtain an unfair competitive advantage, or roles that could impair independent judgment, objectivity, or program oversight. If an Offeror or subcontractor is participating in, or anticipates participating in, multiple RHT Program contracts or subcontracts, the Offeror should disclose any actual, potential, or perceived conflicts and describe proposed mitigation strategies. HCA reserves the right to determine whether a conflict exists and what mitigation, limitation, recusal, firewall, or other safeguard is necessary. Participation in the ASO contract, whether as a prime Contractor or subcontractor, will not provide preferential treatment, priority access, or guaranteed eligibility for the CRHSI award. Final eligibility and conflict determinations will be made by HCA in accordance with the RFP, applicable procurement requirements, and final contract terms.
109	Section I. Introduction, A. Purpose of This Request for Proposals, page 5, paragraph 3: "*HCA intends to award a contract to a single entity that will serve as the primary contractor and single point of responsibility for all services provided under the resulting contract. Contractor may utilize subcontractors to perform portions of the work; however, Contractor shall remain fully responsible for the performance, compliance, and deliverables of all subcontractors. HCA reserves the right to approve all subcontractors.*" In terms of using local partners as sub-contractors within the proposal of work, do these need to	Proposed subcontractors do not need to be approved by HCA prior to proposal submission. Offerors should include proposed local partners or subcontractors in their proposal as part of the proposed staffing, organizational structure, workplan, and service delivery approach. Subcontractors identified in an Offeror's proposal are not automatically approved unless expressly approved by HCA in the final executed contract or through separate written approval. The selected Contractor must receive written HCA approval before using any subcontractor to perform work under the contract. HCA may review proposed subcontractors as part of proposal evaluation and/or contract finalization. In reviewing proposed subcontractors, HCA may consider factors such as the subcontractor's proposed role, qualifications, experience, capacity, conflict of interest considerations, compliance with applicable federal and state requirements, and alignment with the approved Scope of Work, Workplan, and budget.

	be approved prior to proposal submission or are we to assume we move forward with our proposal and the approval of those included within our proposal will be forthcoming after award?	The prime Contractor remains fully responsible for all services, deliverables, performance, compliance, reporting, and subcontractor oversight, including work performed by any HCA-approved subcontractor.
110	Can HCA clarify the division of responsibilities between the CRHSI operator and other RHT Program components (e.g., Rural Health Data Hub, rural health hubs, other initiatives), including which entity owns provider-facing coordination, stakeholder engagement, and cross-initiative integration?	Please see the responses to Questions 24, 36, 83, and 84. HCA will retain responsibility for overall RHT Program governance, strategic oversight, funding decisions, federal compliance, CMS reporting, procurement, and final approval of program scope and deliverables. CRHSI will not replace HCA's PMO or independently manage the full RHT Program. The CRHSI Operator is expected to support provider-facing coordination, stakeholder engagement, technical assistance alignment, implementation support, and cross-initiative coordination within the scope of Bridge to Resilience / CRHSI and as directed by HCA. This may include coordinating provider-facing supports, identifying cross-initiative dependencies, supporting learning collaboratives, using available data to inform technical assistance, and elevating operational issues to HCA. Other RHT Program components will have distinct roles. For example, the Rural Health Data Hub is expected to support data infrastructure, analytics, dashboards, and related data capabilities; the ASO is expected to support administrative functions, performance monitoring, and payment administration as directed by HCA; and rural health hubs or other initiative partners may support regional coordination, local implementation, or initiative-specific activities as established by HCA. Final roles, coordination processes, escalation pathways, and cross-initiative governance structures will be established by HCA during implementation. The CRHSI Operator should propose a flexible coordination approach that supports collaboration with HCA, the ASO, the Rural Health Data Hub, Healthy Horizons / rural health hubs, Rooted in New Mexico, the Rural Health Innovation Fund, and other RHT Program partners as they are implemented.
111	To what extent will the CRHSI contractor be expected to collaborate and coordinate with the Administrative Services Organization RHTP contractor?	The CRHSI Contractor should expect to collaborate and coordinate closely with the RHTP Administrative Services Organization (ASO), as directed by HCA. The ASO is expected to support RHT Program administration, which may include functions related to performance monitoring support, reporting workflows, documentation, financial tracking, payment administration, and other administrative activities assigned by HCA. CRHSI is expected to support the programmatic and provider-facing components of Bridge to Resilience, including technical assistance, provider engagement, implementation support, performance

		improvement activities, and programmatic oversight of provider incentives and outcome metrics. CRHSI and the ASO may need to coordinate on items such as provider participation documentation, milestone tracking, provider incentive support, reporting timelines, data collection workflows, payment-related documentation, performance monitoring, and other implementation activities. The CRHSI Contractor will not replace the ASO or perform ASO fiscal intermediary functions unless specifically authorized by HCA. Final coordination processes, roles, communication cadence, documentation standards, and escalation pathways between CRHSI and the ASO will be established by HCA during implementation.
112	Can HCA clarify expected review/approval turnaround times for key deliverables (service delivery model, metrics framework, quarterly reports) so we can build a realistic cadence?	HCA has not finalized fixed review or approval turnaround times for all CRHSI deliverables at this time. Offerors should propose a realistic deliverable cadence in the Workplan, including anticipated timelines for submission, HCA review, revision, and final approval of key deliverables such as the service delivery model, metrics framework, standardized assessment methodology, implementation plans, quarterly reports, and other required deliverables. HCA anticipates establishing deliverable review timelines during contract negotiation and implementation planning. Review timelines may vary based on the complexity of the deliverable, completeness of the submission, need for coordination with the ASO, Rural Health Data Hub, PMO/reporting support, CMS requirements, or other HCA-contracted support organizations, and whether revisions are needed. The selected Contractor should plan for iterative review and revision cycles, particularly for foundational deliverables developed during start-up. HCA will work with the selected Contractor to establish a review cadence that supports timely implementation while maintaining appropriate oversight, federal compliance, and alignment with RHT Program goals.
113	Please clarify whether the cost proposal should assume full statewide work at contract start or a phased rollout based on HCA direction and provider onboarding.	Offerors should assume a phased rollout based on HCA direction, provider onboarding, program readiness, available funding, and implementation priorities. The Cost Proposal and Workplan should include the capacity and resources necessary to support statewide CRHSI implementation over the initial contract period, but HCA does not expect all providers or all CRHSI services to be fully operational statewide on the first day of the contract. Offerors should propose a scalable staffing, service delivery, and budget approach that supports start-up activities, provider

		outreach, baseline assessment, risk stratification, initial technical assistance, and phased expansion across rural, frontier, and tribal communities. The proposal should clearly describe any assumptions about timing, staffing ramp-up, provider onboarding, service tiers, travel, regional coverage, and the point at which the Offeror expects to reach full operational capacity. Final rollout sequencing, provider prioritization, service intensity, and statewide implementation expectations will be established by HCA during contract negotiation and implementation planning.
114	Please provide your estimated budget limit or budget range for this project and estimate of level of effort in terms of full-time equivalent staff.	Please see the responses to Questions 6, 17, 28, 40, 55, 78, and 80. HCA is not establishing a guaranteed budget limit, budget range, maximum award amount, or required level of effort through this FAQ. The referenced Bridge to Resilience / CRHSI amounts in New Mexico's RHT Budget Narrative are planning estimates and should not be interpreted as a guaranteed contract value or required staffing level. Offerors should submit a Cost Proposal and Workplan that reflect the staffing, subcontractor support, resources, and level of effort the Offeror determines are necessary to perform the full Scope of Work during the initial contract period. The proposal should clearly identify proposed FTEs, roles, staffing assumptions, subcontractor roles, ramp-up assumptions, and any changes in staffing level over time. For purposes of cost evaluation, Offerors must separately identify CRHSI Contractor operating/service delivery costs, provider-directed payment estimates, administrative costs, equipment costs, program-related costs, indirect costs, travel costs, subcontractor costs, and any other direct costs necessary to perform the Scope of Work. HCA may review proposed staffing and level of effort for reasonableness, feasibility, and alignment with the Offeror's technical approach, Workplan, and budget. HCA is not required to select the lowest-price offer. Award will be made to the responsible Offeror whose proposal is most advantageous to the State, taking into consideration the evaluation factors set forth in the RFP.
115	Will HCA provide initial eligibility criteria, risk indicators thresholds, and any "must-serve" geographies or provider categories (tribal/frontier/remote) beyond the general rural definition?	HCA has not finalized all initial eligibility criteria, risk indicator thresholds, or "must-serve" geographies/provider categories for CRHSI at this time. CRHSI is expected to support rural, frontier, and tribal providers across New Mexico, with prioritization informed by provider need, risk stratification, access-to-care concerns, financial and operational sustainability indicators, rural/frontier status, tribal community needs, provider readiness, available funding, and HCA direction.

		HCA may provide initial priorities, available data, risk indicators, provider lists, or geographic focus areas during implementation. The CRHSI Contractor will be expected to work with HCA and other contracted support organizations, such as the ASO, Rural Health Data Hub, PMO/reporting support, or other implementation partners, to refine eligibility criteria, risk indicators, thresholds, outreach sequencing, and service tiers. Offerors should propose a flexible approach that can support statewide access while allowing HCA to prioritize higher-need providers, geographies, and communities as data and program infrastructure are refined. Final eligibility criteria, risk thresholds, must-serve categories, and rollout priorities will be established by HCA during implementation.
116	Section XII, Questionnaire Specifications, 1.A. Intake and Evaluation Support, page 31: This section requests for the offeror to "the Offeror's experience within the last five (5) years providing intake and initial review support for programs similar to the services required under the CRHSI Scope of Work." Then, it requests "as applicable, include the Offeror's approach to" and lists six sub-questions. Can you clarify if the answers to the six sub-questions are to be with respect to the experience requested in the first part of the question or if we are to describe our approaches to these topics with respect to this statement of work?	Offerors should address both the requested experience and the proposed approach to the CRHSI Scope of Work. The first part of the question asks Offerors to describe relevant experience within the last five years providing intake and initial review support for similar programs. The six sub-questions are intended to allow Offerors to describe, as applicable, how that experience informs the Offeror's proposed approach to performing intake and evaluation support under CRHSI. Offerors should provide examples from prior experience where relevant, but should also describe how they would apply their approach to the CRHSI Scope of Work, including proposed processes, tools, staffing, coordination with HCA, and methods for supporting intake, review, documentation, prioritization, and follow-up. Responses should remain within the applicable word limit for the question.
117	Section XII, Questionnaire Specifications, page 31: There are several sections that seem to have sub-questions, and we request clarification of the word limit for these sections/subsections. These sections include: • 1.A.1-6, page 27 • 1.C.1-6, page 28 • 5.A.1-5, page 29 Are the numbered subsections considered individual questions, and each have a 600-word limit? Or are they not individual questions and all must be	Please see the response to Question 73. The numbered subsections are not intended to each have a separate 600-word limit unless the RFP or Submittable form provides a separate response field and word limit for that subsection. For sections such as 1.A.1–6, 1.C.1–6, and 5.A.1–5, the 600-word limit applies to the full response for the primary question, inclusive of the subordinate numbered items listed under that question. Offerors should address the primary question and applicable subordinate items within the stated word limit for that response field.

	answered within the 600-word limit?	
118	Section XII, Questionnaire Specifications, 10. Proposed Success Metrics and Targets, page 37: NM's Rural Health Transformation Program is structured around five core initiatives, including Healthy Horizons which aims to expand specialty care, material health, and chronic disease management. The proposed success metrics, however, are only aligned with financial sustainability, operational performance, workforce stability, and access to care. Does HCA envision any priority clinical quality measures of success for the RHTP?	Yes. HCA anticipates that clinical quality measures may be part of RHT Program performance monitoring, including measures related to specialty care access, maternal health, chronic disease management, behavioral health, preventive care, and other priority areas identified through RHT Program implementation. For CRHSI specifically, the proposed success metrics focus on the Contractor's role in supporting provider sustainability, operational performance, workforce stability, access to care, technical assistance utilization, provider engagement, and provider readiness for transformation. However, CRHSI may also support HCA and other contracted support organizations in refining, operationalizing, and tracking clinical quality measures where those measures relate to CRHSI-supported providers, provider incentives, or broader RHT Program goals. HCA has not finalized all RHTP or CRHSI-specific clinical quality measures, technical specifications, baselines, denominators, benchmarks, or targets at this time. Final measures will be established by HCA during implementation and may involve coordination among HCA, CRHSI, the Rural Health Data Hub, ASO, PMO/reporting support, Healthy Horizons partners, and other RHT Program implementation partners. Offerors should propose a flexible performance measurement approach that can support both sustainability-focused and clinical quality-related metrics as HCA's RHT Program measurement framework is refined.
119	Please clarify whether HCA has established eligibility criteria for participating providers and whether such criteria will be finalized before contract start.	HCA has not finalized all eligibility criteria for participating CRHSI providers at this time. CRHSI is expected to support rural, frontier, and tribal providers across New Mexico, with eligibility and prioritization informed by provider type, geography, rural/frontier status, tribal community needs, provider readiness, financial and operational sustainability indicators, access-to-care concerns, available funding, and HCA direction. HCA may provide initial eligibility criteria, provider priorities, risk indicators, or target provider categories during implementation. The selected Contractor will be expected to work with HCA and other contracted support organizations, such as the ASO, Rural Health Data Hub, PMO/reporting support, or other implementation partners, to refine provider eligibility, prioritization, outreach sequencing, and service tiers. Final eligibility criteria may not be fully finalized before contract start. Offerors should propose a flexible approach that can support start-up planning, initial provider outreach, baseline assessment,

		and phased implementation as HCA finalizes eligibility and prioritization criteria.
120	Please clarify the anticipated expectations for on-site versus virtual technical assistance and learning collaboratives, including any minimum on-site presence requirements.	HCA expects CRHSI technical assistance and learning collaboratives to use a combination of virtual and in-person engagement. HCA is not establishing a minimum on-site presence requirement through this FAQ. The appropriate mix of on-site and virtual support will depend on provider needs, geography, service type, technical assistance intensity, provider readiness, travel considerations, and HCA direction. Offerors should propose an engagement model that explains when technical assistance and learning collaboratives would be delivered virtually, when in-person support would be recommended, and how the Offeror would ensure meaningful access for rural, frontier, and tribal providers across New Mexico. In-person engagement may include provider site visits, regional convenings, stakeholder meetings, technical assistance sessions, implementation planning meetings, trainings, or other activities where in-person support is necessary or beneficial. Virtual engagement may be appropriate for routine technical assistance, follow-up meetings, learning collaboratives, document review, data discussions, and other support activities that can be effectively delivered remotely. Final expectations for on-site support, virtual delivery, travel, and learning collaborative format will be established by HCA during contract negotiation and implementation planning.
121	Is there a monthly timeline associated with the list of deliverables?	HCA has not established a fixed monthly timeline for all CRHSI deliverables at this time. Offerors should propose a deliverable timeline in the Workplan that includes anticipated monthly or phased milestones for start-up, planning, service delivery model development, assessment methodology, provider outreach, risk stratification, metrics framework, reporting, technical assistance launch, learning collaboratives, and other required deliverables. HCA anticipates that some deliverables will be due during the initial planning and ramp-up period, while others will be recurring, quarterly, annual, or tied to specific implementation milestones. Final deliverable due dates, review timelines, revision cycles, and approval processes will be established during contract negotiation and implementation planning. The selected Contractor should expect to work with HCA to develop a detailed implementation and deliverables calendar that aligns with the final Workplan, CMS reporting timelines, provider

		onboarding, ASO coordination, Data Hub development, and other RHT Program implementation activities.
122	The Offeror respectfully requests that the State consider extending the proposal due date for this procurement. Given the breadth and complexity of the CRHSI scope—including statewide provider engagement, performance analytics integration, and coordination with multiple stakeholders and potential subcontractors—additional time would support the development of more comprehensive and high-quality proposals. Could the State please advise whether it is considering an extension to the proposal due date?	Yes. HCA intends to extend the proposal submission deadline. The updated proposal due date, along with any related procurement schedule changes, will be provided through an amendment to the RFP. Offerors should continue to monitor Submittable and the procurement posting for the official amendment and revised deadlines.
123	Will the CRHSI contractor be conflicted out from bidding on the planned New Mexico HCA Health Data Hub procurement (per Microsoft Word - Approved_New Mexico RHT Budget Narrative - Revised - 03.26.2026 (002) page 19. Table 15)	No. Award of the CRHSI contract does not automatically preclude the CRHSI Contractor from submitting a proposal for the planned Rural Health Data Hub procurement. However, participation in multiple RHT Program roles may require conflict of interest review and appropriate safeguards. HCA may evaluate actual, potential, or perceived conflicts of interest, including access to non-public information, involvement in developing requirements or evaluation materials, ability to obtain an unfair competitive advantage, or roles that could impair independent judgment, objectivity, or program oversight. If the CRHSI Contractor, or any subcontractor or affiliated entity, intends to pursue the Rural Health Data Hub procurement or another RHT Program opportunity, the entity should disclose any actual, potential, or perceived conflicts and describe proposed mitigation strategies. HCA reserves the right to determine whether a conflict exists and what mitigation, limitation, recusal, firewall, or other safeguard is necessary. Participation as the CRHSI Contractor will not provide preferential treatment, priority access, or guaranteed eligibility for the Rural Health Data Hub procurement or any other RHT Program funding, procurement, application, or award.
124	RFP states: “Each biography must include education, work experience, relevant/applicable certifications or licenses, and any other qualifications demonstrating the individual’s capacity to perform the required work.” Can the State extend the word limit or allow	HCA will not extend the stated word limit for the narrative response. Offerors should provide concise biographies within the applicable response field and word limit, including education, work experience, relevant certifications or licenses, and other qualifications necessary to demonstrate capacity to perform the required work.

	vendors to upload a file to accommodate the biographies?	To the extent Submittable provides upload fields for Question 9: Staffing and Organizational Structure, Offerors may use those upload fields for supporting staffing documentation, such as resumes, CVs, or expanded biographies. Supporting uploads should not replace the required narrative response and should be used only to supplement the information provided in the required response field. Offerors should ensure that all information necessary for evaluation is included in the appropriate response field or permitted upload location. HCA is not required to consider materials submitted outside the format or location required by the RFP or Submittable.
125	Can the State raise the word limit or offer separate spaces to address each of the 5 requirements? (Refers to section regarding performance monitoring)	HCA will not increase the stated word limit for this response at this time. Offerors should address the five listed requirements within the applicable response field and word limit. The response should be concise and should focus on the Offeror's proposed approach, relevant experience, tools, staffing, and ability to meet the performance monitoring requirements under the CRHSI Scope of Work. Supporting documentation may be submitted in the additional upload locations made available in Submittable. Supporting documentation may provide additional context, detail, or supporting information, but it should not replace the required narrative response. Offerors should ensure that the required narrative response is complete and responsive within the applicable response field and word limit. HCA is not required to consider materials submitted outside the format or location required by the RFP, as amended, or Submittable.
126	Can the State raise the word limit or offer separate spaces to address each of the 6 requirements? (Refers to Close-out, documentation, and Sustainability Transition)	HCA will not increase the stated word limit for this response at this time. Offerors should address the six listed requirements within the applicable response field and word limit. The response should be concise and should focus on the Offeror's proposed approach, relevant experience, tools, staffing, documentation processes, close-out support, and sustainability transition planning under the CRHSI Scope of Work. Supporting documentation may be submitted in the additional upload locations made available in Submittable. Supporting documentation may provide additional context, detail, or supporting information, but it should not replace the required narrative response. Offerors should ensure that the required narrative response is complete and responsive within the applicable response field and word limit.

		HCA is not required to consider materials submitted outside the format or location required by the RFP, as amended, or Submittable.
127	Can the State raise the word limit or offer separate spaces to address each of the 7 requirements? (Refers to Coordination, Systems, and Customer Support)	HCA will not increase the stated word limit for this response at this time. Offerors should address the seven listed requirements within the applicable response field and word limit. The response should be concise and should focus on the Offeror's proposed approach, relevant experience, tools, staffing, coordination processes, systems support, customer support model, and ability to meet the requirements under the CRHSI Scope of Work. If Submittable provides a separate upload field for the applicable section, Offerors may use that upload field for supporting documentation. Supporting documentation should not replace the required narrative response and should be submitted only in the upload locations permitted by Submittable. Offerors should ensure that all information necessary for evaluation is included in the appropriate response field or permitted upload location. HCA is not required to consider materials submitted outside the format or location required by the RFP or Submittable.
128	Can the State raise the word limit or offer separate spaces to address each of the 4 requirements? (Refers to Proposed Success Metrics and Targets)	HCA will not increase the stated word limit for this response at this time. Offerors should address the four listed requirements within the applicable response field and word limit. The response should be concise and should focus on the Offeror's proposed approach to success metrics and targets, including relevant experience, proposed metric categories, baseline and target-setting approach, data assumptions, validation methods, and alignment with CRHSI and RHT Program goals. Supporting documentation may be submitted in the additional upload locations made available in Submittable. Supporting documentation may provide additional context, detail, or supporting information, but it should not replace the required narrative response. Offerors should ensure that the required narrative response is complete and responsive within the applicable response field and word limit. HCA is not required to consider materials submitted outside the format or location required by the RFP, as amended, or Submittable.
129	Can the State raise the word limit or offer separate spaces to address all 7 requirements? (Refers to Federal Grant Management, Compliance, and Cooperative Agreement Experience)	HCA will not increase the stated word limit for this response at this time. Offerors should address the seven listed requirements within the applicable response field and word limit. The response should be concise and should focus on the Offeror's relevant federal grant management, compliance, cooperative agreement experience, proposed approach, staffing, tools, reporting processes, risk

		management, and ability to comply with applicable federal requirements, including CMS Cooperative Agreement Terms and Conditions and 2 CFR Part 200. Supporting documentation may be submitted in the additional upload locations made available in Submittable. Supporting documentation may provide additional context, detail, or supporting information, but it should not replace the required narrative response. Offerors should ensure that the required narrative response is complete and responsive within the applicable response field and word limit. HCA is not required to consider materials submitted outside the format or location required by the RFP, as amended, or Submittable.
130	Can the State extend the feedback deadline for our reference contacts? It takes time to coordinate with references and then providing them ample time to provide the feedback and with the holiday some may be out of the office.	Yes. HCA has extended the organizational reference submission deadline as reflected in the amended Sequence of Events. The updated reference deadline, proposal due date, and any related procurement schedule changes will be provided through an amendment to the RFP. Offerors and reference contacts should follow the updated deadlines and submission instructions provided in the amendment and in Submittable.
131	Does the State have a not to exceed price for this contract?	No. HCA is not establishing a not-to-exceed price for the resulting CRHSI contract through this FAQ. Please see the responses to Questions 6, 17, 28, 40, 55, 78, 80, and 114. Amounts referenced in New Mexico's RHT Budget Narrative reflect planning estimates for the broader Bridge to Resilience / CRHSI initiative and should not be interpreted as a guaranteed contract value, maximum award amount, or not-to-exceed price. Offerors should submit a Cost Proposal and Workplan that reflect the costs, staffing, subcontractor support, provider-directed payment estimates, administrative costs, equipment costs, program-related costs, and other resources necessary to perform the full Scope of Work during the initial contract period. For purposes of Cost Proposal scoring, HCA will use the Offeror's proposed CRHSI Contractor operating/service delivery cost, excluding separately identified provider-directed payment estimates. HCA is not required to select the lowest-price offer. Award will be made to the responsible Offeror whose proposal is most advantageous to the State, taking into consideration the evaluation factors set forth in the RFP.
132	Can the State provide guidance on its expectations for data analysis, performance monitoring, and dashboard builds. Will these be done in a State environment or all on the Rural Health Data Hub, or will the contractor be responsible	Please see the responses to Questions 21, 32, 39, 46, 47, 57, 61, 62, 63, 68, 69, 70, 84, 98, 99, and 103. HCA has not finalized CRHSI-specific requirements for data platform ownership, dashboard hosting, system environment, or user access at this time. The Rural Health Data Hub is currently in

	for the data platform and for providing access to State users?	the planning phase and will be implemented separately from the CRHSI procurement. The CRHSI Contractor should not assume responsibility for building the Rural Health Data Hub or serving as the primary data infrastructure contractor under this RFP. The Contractor should also not assume that all data analysis, performance monitoring, or dashboarding will occur in a State-hosted environment, vendor-hosted environment, or Data Hub environment unless directed by HCA during implementation. The CRHSI Contractor is expected to support data-informed technical assistance, provider engagement, performance monitoring, and reporting within the CRHSI Scope of Work. This may include using available HCA-approved data, public data sources, provider-submitted information, approved reports or extracts, and future Rural Health Data Hub outputs as they become available. Offerors should propose a flexible, secure, and vendor-agnostic approach to data analysis, performance monitoring, dashboards, and reporting that can adapt to HCA direction, Data Hub development, ASO coordination, State requirements, and applicable federal and state privacy, security, confidentiality, accessibility, and data governance requirements. Final decisions regarding data platforms, dashboard hosting, State user access, reporting tools, data-sharing processes, and system integration will be established by HCA during contract finalization and implementation planning.
133	The SOW suggests a phased approach to delivering technical assistance to providers. Does the State expect the contractor to deliver all the technical assistance in year one to all participating providers in the State? Or can the workplan allow for additional phases in 2027 and beyond?	HCA does not expect all technical assistance to be fully delivered to all participating providers statewide in Year 1. HCA anticipates a phased implementation approach based on provider onboarding, risk stratification, provider readiness, available funding, service intensity, geographic priorities, and HCA direction. The Workplan may include additional phases in 2027 and beyond, recognizing that CRHSI implementation will occur over multiple years and future-year work will depend on federal funding availability, Contractor performance, operational need, and HCA approval. Offerors should propose a scalable phased approach that identifies Year 1 start-up and implementation activities, anticipated provider engagement and onboarding, initial technical assistance priorities, service tiers or intensity levels, staffing ramp-up, and how CRHSI services would expand in future phases. Final provider participation, rollout sequencing, technical assistance intensity, and future-year implementation phases will be established by HCA during contract negotiation and implementation planning.