HEALTH CARE AUTHORITY

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Rural Health Innovation Fund (RHIF) in support of New Mexico's Rural Health Transformation (RHT) program

RFP# 27-630-1000-0004

July 10, 2026

Q&A

	Submitted Question	Answer
1	On page 14, Section III. RESPONSE FORMAT AND ORGANIZATION, A. Number of Responses, it states that *an offeror may submit more than one proposal only if each proposal is for a distinct RHIF project*. What are the criteria that will be used to determine the level of distinction between projects?	A project will generally be considered distinct if it has a separate purpose, scope of work, implementation approach, budget, workplan, and expected outcomes and can be evaluated and implemented independently. Differences in service area, target population, or project activities may support a finding that projects are distinct, but simply dividing one integrated project into separate components or submissions would not make them distinct. HCA will review the full content of each proposal to determine whether it represents a separate project.
2	It further states that *each proposal must be submitted separately through Submittable unless HCA issues alternative written instructions*. What is the mechanism for submitting more than one proposal? It appears we are only able to submit one Form 1, leading to one Form 2. How are multiple proposals to be submitted?	Offerors submitting more than one distinct RHIF project must create a separate Submittable submission for each project. Each submission must include its own completed Form 1, Form 2, required attachments, Cost Proposal, and Project Workplan. After submitting or saving one application, the Offeror should return to the RHIF opportunity page and select the option to begin a new submission. The same Submittable account may be used for multiple submissions. If the portal does not display an option to begin an additional submission, the Offeror should contact the Procurement Manager for technical assistance before the proposal deadline.
3	Under Part C. Proposal Content Detail - 1. Proposal Summary - b. Project Service Area and Rural Area Explanation, it says that "separate rural designation documentation is not required". Does this indicate that we do not need to fit a specific rural designation to be eligible, but can	For purposes of the RHT Program, HCA uses the Health Resources and Services Administration (HRSA) definition of rural. At least one census tract in each of New Mexico's 33 counties is designated as rural, but not every census tract within each county is rural. Eligibility is based on the location where services will be delivered and where the intended population, impact, and outcomes will occur—not the location of the applicant's headquarters. RHIF-funded services and activities must occur in, or directly benefit, HRSA-defined rural census tracts or New Mexico's frontier or Tribal

	rather make the case for the area we are working in being rural narratively?	communities. Services outside those eligible areas may not be supported with RHIF funds. Applicants are not required to submit separate rural designation documentation, but they must clearly identify the service locations and target population and explain how the project will benefit eligible rural, frontier, or Tribal communities.
4	Would HCA consider a proposal from a technology/equipment vendor that does not yet have executed local provider letters of intent, if the proposal requests funding for a state-directed deployment of validated health screening technology in HCA-approved rural public health, community, Tribal, or State-affiliated sites, with final site selection and placement coordinated with HCA and appropriate site authorities after award?	Yes. The RFP allows vendors, technology partners, and equipment suppliers to apply as Lead Offerors when they have a direct role in implementing the proposed project. Executed letters of intent are not a mandatory submission requirement. However, the proposal must be sufficiently developed to identify the proposed service area, target population, implementation approach, responsible parties, and how the project will directly benefit eligible rural, frontier, or Tribal communities. Applicants should not assume that HCA will design the deployment model or select project sites after award. Any proposed role for HCA or other site authorities must be clearly described and will be evaluated under the requirements and evaluation factors stated in the RFP.
5	Relatedly, may an Offeror propose deployment in State-owned or State-affiliated community/public health locations if final site approvals, access agreements, and operating workflows are completed during contract development or early implementation?	Yes. An Offeror may propose deployment at State-owned or State-affiliated locations even if final site approvals, access agreements, and operating workflows are not complete at the time of proposal submission. The proposal must clearly identify the proposed site types or locations, required approvals, responsible parties, anticipated timeline, and any related dependencies or risks. Selection for award does not guarantee access to a State-owned or State-affiliated site. All required approvals and agreements must be completed before deployment, and HCA does not commit to identifying sites or securing access on behalf of the Offeror.
6	While reviewing the guidelines for the Rural Health Innovation Fund (RHIF), we noted that the New Mexico Health Care Authority highlights technology innovation, maternal care networks, and remote care technologies as key priorities. Because the guidelines indicate that eligible offerors may include technology partners and vendors, we were wondering whether the program maintains a vendor directory, technology partner registry, or similar mechanism for organizations to	HCA does not maintain a vendor directory, technology partner registry, or formal matchmaking process for RHIF applicants. Technology partners and vendors, including out-of-state entities, may apply directly if they meet the RFP requirements, have a direct role in project implementation, and clearly demonstrate how the proposed project will benefit eligible rural, frontier, or Tribal communities in New Mexico. The RFP does not require a New Mexico-based partner and does not identify either direct application or partnership as the preferred approach. HCA cannot facilitate connections between potential applicants, vendors, or Regional Hub organizations during an active procurement. Interested organizations should monitor HCA's public websites and procurement portals for program updates, award announcements, and future opportunities.

	express interest in supporting RHIF-funded projects. If a formal vendor pool is not maintained, we would appreciate any guidance on the best way for an out-of-state technology partner to connect with prospective RHIF applicants or Regional Hub organizations seeking specialized maternal health solutions. We would also welcome any guidance on whether technology partners are encouraged to apply directly to RHIF opportunities or whether partnering with New Mexico-based organizations is the preferred approach.	
7	Can grant funding be used to compensate clinicians for blocking dedicated time in their schedules for crisis appointments? This would allow our organization to guarantee same-day or near-immediate availability for clients presenting in crisis, rather than requiring them to wait for the next open slot in a clinician's regular caseload. Reserving this capacity in advance helps ensure timely intervention during acute periods, which can be critical for client safety and can reduce reliance on higher-cost emergency or inpatient services.	No. RHIF funds may not be used to compensate clinicians for reserved appointment time, clinician salaries, or other clinician wage support. RHIF funds also may not be used to pay for clinical services that are reimbursable through Medicaid, Medicare, private insurance, or another payer, unless expressly approved by CMS. Applicants may propose other allowable, non-clinician costs needed to establish or support a crisis-access model, subject to HCA review and approval.
8	Can grant funding be used to support telehealth appointments?	Yes. RHIF funds may support allowable costs needed to establish or expand telehealth services, such as technology, equipment, implementation, training, and related operational support. RHIF funds may not be used to pay for telehealth clinical services that are reimbursable through Medicaid, Medicare, private insurance, or another payer, or for prohibited clinician salary or wage support. All proposed costs remain subject to HCA review and approval.
9	I am reviewing RFP# 27-630-1000-0004 and wondering how HCA is defining rural or if that is left to applicants in the proposal.	Please see the response to Question 3 regarding HCA's use of the HRSA definition of rural and the requirement that proposed services, impact, and target populations be located in or directly benefit eligible rural, frontier, or Tribal communities.

10	Section IV.E, Funding Restrictions, and Section IV.D, Allowable Uses. Our project uses RHIF funds to build and deploy navigation infrastructure, training, and data systems, while the navigation services themselves are reimbursable to providers under the CMS Principal Illness Navigation codes and sustain the program after the grant period. Can HCA confirm that funding the infrastructure, deployment, and training for a navigation program is an allowable use, where the reimbursable services function as the sustainability mechanism rather than the grant-funded activity?	Potentially. RHIF funds may support allowable, non-reimbursable costs needed to establish or expand a navigation program, including infrastructure, technology, deployment, training, and data systems. RHIF funds may not be used to pay for services that are reimbursable through Medicaid, Medicare, private insurance, or another payer. The proposal should clearly distinguish the RHIF-funded implementation costs from the reimbursable navigation services and explain how duplication of payment will be avoided. Reimbursement may be included as part of the project's sustainability approach. All proposed costs remain subject to HCA review and approval.
11	Section V.B.3.b, Organizational Overview, Qualifications, Experience, and Capacity. For a technology company serving as Lead Offeror with a New Mexico academic medical center as a named clinical partner, will the evaluation of organizational capacity and rural community experience consider the combined capabilities and experience of the Lead Offeror and its named partners, or only those of the Lead Offeror?	Section V.B.3.b evaluates the qualifications, experience, and capacity of the Lead Offeror. The experience and capabilities of named partners may be considered where relevant to the proposed project, including under the evaluation of partnerships and the implementation approach, but they do not replace the Lead Offeror's responsibility to demonstrate that it has the capacity to manage and successfully implement the project. The proposal should clearly distinguish the qualifications, roles, and responsibilities of the Lead Offeror and each named partner.
12	Section IV.D, Allowable Uses, and Section III.C.5, Cost Proposal. When a named clinical partner will receive RHIF funds for defined project roles such as clinical leadership and data and evaluation work, are those partner costs treated as direct program delivery costs, and are there any restrictions specific to passing funds to an academic or public institution partner?	Costs paid to a named partner may be treated as Direct Program Delivery Costs when they directly support the substantive activities of the approved project. Cost classification is based on the function performed, not the type of organization receiving the funds. Costs for general management, oversight, compliance, reporting, or other administrative functions must be identified as Administrative Costs, even when incurred by a partner. The RFP does not impose a separate restriction solely because a partner is an academic or public institution. All partner costs must be necessary, reasonable, allowable, included in the approved budget, and consistent with applicable funding restrictions. The Lead Offeror remains responsible for oversight, expenditures, reporting, and compliance for all funded partner activities.

13	Section I.G, Additional Cost Definitions, and Section IV.D. The RFP notes that data collection, evaluation, and community engagement may be treated as direct program delivery. For a project where the Lead Offeror's personnel perform both platform deployment and project oversight, how does HCA distinguish direct program delivery from administrative cost when the same personnel perform both, and is a documented allocation methodology acceptable?	HCA will classify costs based on the function performed, not the employee's title. Time spent carrying out substantive project activities, such as platform deployment, project-specific data collection, evaluation, or community engagement, may be treated as Direct Program Delivery Costs. Time spent on general project management, contract administration, financial oversight, compliance, or general reporting must be treated as Administrative Costs. When the same personnel perform both types of work, a documented allocation methodology is acceptable if it is reasonable, consistent, and based on the relative benefit to each function. The proposal should explain the methodology used, and the Contractor must maintain records supporting the allocation.
14	Section III.C.4, Project Workplan, and Section III.C.5, Cost Proposal. The Workplan and Cost Proposal cover October 2026 through September 2027. For a project designed to scale across the state over multiple years, should the budget and workplan present only the year-one funded scope, while the multi-year scaling vision is described in the Project Narrative and Sustainability Plan?	Yes. The required Project Workplan and Cost Proposal should cover only the proposed scope and RHIF funding requested for October 2026 through September 2027. Applicants may describe a longer-term scaling strategy in the Project Narrative and Sustainability Plan, but should clearly distinguish the funded project period from future phases. Any future expansion should not assume additional RHIF funding unless separately approved by HCA.
15	Section III.C.1.b, Project Service Area, and the referenced HRSA rural-eligibility tool. For a site located in a county that is designated rural for federal purposes but is part of an academic health system, will the HRSA tool designation be the controlling determination of rural status, or should offerors provide additional documentation?	Please see the response to Question 3. Rural status will be based on the location where the proposed services, target population, impact, and outcomes will occur, using the applicable HRSA rural designation. An affiliation with an academic health system does not change the rural status of an otherwise eligible service location. Applicants are not required to submit separate rural designation documentation but should clearly identify the proposed service location or locations.
16	Section I.F.17 and Section IV.C. May an out-of-state technology vendor serve as Lead Offeror when partnered with a New Mexico based clinical entity, and in that case does the required direct implementation role and connection to New Mexico's rural, frontier, or Tribal communities attach to the Lead Offeror, to the	Please see the response to Question 6. An out-of-state technology vendor may serve as the Lead Offeror if it meets the RFP requirements. The required direct implementation role applies to the Lead Offeror. The required connection to New Mexico's rural, frontier, or Tribal communities applies to the proposed project as a whole, but the Lead Offeror must clearly demonstrate its own implementation role and explain how it will manage the project and its New Mexico partner. A partner's experience or presence does not replace the

	partner, or to the project as a whole?	Lead Offeror's responsibility for project performance, funding, reporting, and compliance.
17	Section I.A and Section V.B.3.c.i. When the New Mexico connection is provided through a partner or subcontractor rather than the Lead Offeror itself, how will HCA weigh operational presence, service delivery role, community relationships, and implementation capacity in scoring the New Mexico Project Connection factor?	Please see the response to Question 16. The New Mexico Project Connection factor will be evaluated based on the proposal's demonstrated connection to, and capacity to implement the project within, New Mexico's rural, frontier, or Tribal communities—not solely on the Lead Offeror's headquarters. Evaluators may consider the operational presence, service-delivery responsibilities, community relationships, and implementation capacity of the Lead Offeror and its named partners, as described in the proposal. The existence of a New Mexico partner alone does not establish the required connection; the proposal should clearly describe the partner's substantive role and how the project team will engage and serve the identified communities. Scoring will be based on the evaluation criteria and points published in the RFP. HCA has not established additional weighting among these elements.
18	Appendix E, Section 11, Product of Service Copyright. Does the provision that all materials developed or acquired under the agreement become State property, and that the Contractor may not claim copyright, apply to a vendor's pre-existing, proprietary software platform and underlying intellectual property, or only to project-specific deliverables created for the State? Will HCA accept alternative language that grants the State a license to use the platform for the funded project while the vendor retains ownership of its pre-existing platform and IP?	The provision applies to materials developed or acquired under the agreement. It does not automatically transfer ownership of a vendor's pre-existing proprietary software platform or underlying intellectual property developed independently of the RHIF project. Offerors should clearly identify all pre-existing proprietary materials and distinguish them from project-specific deliverables, configurations, customizations, documentation, or other work products developed with RHIF funds. An Offeror requesting different treatment must identify the exception and submit specific proposed alternative language with its proposal. HCA may consider a license-based approach on a case-by-case basis, but exceptions or revisions to the standard contract language are not routinely granted and should not be assumed. Any approved language must preserve the State's rights to use funded project deliverables and comply with applicable State and federal requirements.
19	Section IV.E.3 and IV.E.4, and Appendix A Other Funding and Non-Duplication. The RFP restricts paying for services reimbursable through Medicaid, Medicare, or insurance. Are one-time implementation and infrastructure costs, such as platform configuration, EHR integration, device purchase, staff training, and standing up remote monitoring, allowable even when the ongoing	Please see the response to Question 10. Potentially. RHIF funds may support one-time, non-reimbursable implementation and infrastructure costs, such as platform configuration, EHR integration, equipment, staff training, and establishment of remote-monitoring capabilities. The proposed costs must be allowable, necessary, reasonable, within applicable technology and equipment restrictions, and not reimbursable or otherwise funded by another source. The proposal should clearly distinguish these build-out costs from recurring clinical services and explain how duplication or supplantation will be avoided.

	clinical service later becomes reimbursable through a payer? In other words, may RHIF fund the build-out while reimbursement sustains the recurring service?	Payer reimbursement may serve as the sustainability mechanism for ongoing services, but RHIF funds may not be used to pay for reimbursable clinical services. All proposed costs remain subject to HCA review and approval.
20	Section IV.E.8 and IV.D.1. The RFP prohibits clinician salary or wage support prohibited under the CMS cooperative agreement. Which clinician cost categories are allowable and which are prohibited? Specifically, may RHIF fund contracted specialist or behavioral health clinician time used to deliver telehealth coverage to rural sites through the project?	RHIF funds may not be used for clinician salaries, wages, stipends, contracted clinical coverage, reserved availability, or other compensation for clinicians furnishing patient care. This prohibition applies whether the clinician is an employee or independent contractor. Accordingly, RHIF may not fund specialist or behavioral health clinician time used to deliver telehealth coverage to rural sites. RHIF may support allowable non-clinician costs needed to establish or expand telehealth services, such as technology, equipment, connectivity, platform implementation, workflow development, training, and data or evaluation activities. Proposals must clearly separate these costs from clinician compensation and reimbursable clinical services.
21	Section I.G.11 and Section IV.D.6. Please confirm that EHR integration, interface, and interoperability costs that do not replace an existing certified system are treated as ordinary Direct Program Delivery Costs and are not counted against the five percent Electronic Medical Record Replacement limit.	EHR integration, interface, interoperability, and related connectivity costs that do not involve replacement of an existing certified EHR system are not automatically counted toward the five-percent EMR replacement limit. Such costs may be allowable under RHIF when they are necessary to implement a distinct community-designed project and are not duplicative of the Rural Health Data Hub or another RHT initiative. Projects primarily focused on statewide data integration, HIE participation, shared data infrastructure, or Rural Health Data Hub connectivity may fall within the scope of the Rural Health Data Hub. HCA will determine the appropriate cost classification and initiative alignment based on the purpose, scope, and detailed costs of the proposed project.
22	Section I.G.1 and Section III.C.5.c. The ten percent Administrative Cost limit is described as a statewide cap that does not create an automatic ten percent allowance per award. Will HCA establish a specific award-level Administrative Cost limit that Offerors should use when building their Cost Proposal?	No uniform award-level Administrative Cost percentage will be established for proposal preparation, and Offerors should not assume that 10 percent is available for each award. HCA anticipates that the substantial majority of each award, and potentially all awarded funds, will support Direct Program Delivery Costs. Administrative Costs should be limited to amounts that are necessary, reasonable, and clearly justified for the proposed project. HCA will review proposed costs and may reduce or reclassify Administrative Costs during budget review or contract negotiations. Any award-specific limit will be reflected in the final approved budget.

23	Appendix E, Section 2 and Section 2.B, and Section IV.I. How will RHIF contracts pay, through cost reimbursement, milestone-based payments, or a fixed amount, and will payment be tied to performance measures? Given that invoices must reach the Agency within 15 days after the end of the fiscal year in which services were delivered, how should an Offeror handle costs incurred in the July through September 2027 period so they remain payable?	RHIF contracts will span State Fiscal Years 2027 and 2028 to cover the federal project period and will include separate funding allocations for each State fiscal year. Payments will be made in accordance with the executed contract, approved budget, accepted deliverables, and applicable invoicing and documentation requirements. HCA may tie payment to completion and acceptance of specified milestones or deliverables, as appropriate. Costs incurred through June 30, 2027, must be invoiced against the SFY27 allocation within the applicable invoicing deadline. Costs incurred from July through September 2027 will be charged to the SFY28 allocation and should be submitted through the regular invoicing process and by the final invoice deadline established in the contract.
24	Appendix E, Section 4.D and Section 11. For connected medical devices and remote patient monitoring hardware purchased with RHIF funds and placed in patients' homes or partner clinics, how does the requirement that equipment purchased with contract funds becomes State property on termination apply, and how are leased or cellular-connected devices treated?	Connected medical devices and remote patient monitoring hardware purchased with RHIF funds must be treated as contract-funded equipment and, upon termination of the contract, become State property as provided in Appendix E. Placement in a patient's home or partner clinic does not transfer ownership. The Contractor must maintain appropriate inventory, placement, safeguarding, maintenance, and retrieval records. HCA will provide final disposition instructions during contract closeout, and devices may not be permanently transferred to patients or partner organizations without prior written approval. Leased devices remain the property of the lessor unless the applicable agreement provides otherwise. Cellular connectivity, software subscriptions, and similar recurring services are treated as service costs rather than State-owned property. When hardware is bundled with a lease or connectivity agreement, the Offeror must clearly identify who holds title to the device and what happens when the agreement ends. The proposal should describe the purchase or lease structure, device ownership, asset tracking, retrieval and replacement procedures, data removal, termination of connectivity, and proposed final disposition. Section 11 governs ownership of materials and intellectual property developed under the agreement; it does not independently determine ownership of physical equipment.
25	Under Section I.A, Purpose of this Request for Proposals, and Section IV.B, Eligible Project Types, are pediatric dental clinics eligible Lead Offerors for RHIF projects that directly benefit rural New Mexico children and Medicaid-enrolled families through access,	Yes. A pediatric dental clinic may serve as the Lead Offeror if it meets the RFP requirements and proposes a project that directly benefits eligible rural, frontier, or Tribal communities in New Mexico. Projects addressing pediatric preventive-care access, equipment, technology, care coordination, or provider capacity may be eligible when the proposed activities are necessary, reasonable, allowable, and aligned with RHIF objectives. RHIF funds may not be used to

	equipment, technology, care coordination, and capacity improvements?	pay for Medicaid- or otherwise reimbursable clinical services, prohibited clinician compensation, or costs supported by another funding source.
26	If an Offeror has a pending application under another HCA rural health funding opportunity, what level of disclosure or budget separation should be included in the RHIF proposal to demonstrate that RHIF funds will not duplicate, supplant, or reimburse the same costs requested under another application?	A pending application under another HCA funding opportunity does not automatically make an Offeror ineligible. The RHIF proposal must disclose the other application and provide enough information to identify any potential overlap in scope, activities, service area, personnel, equipment, or other costs. The Cost Proposal should clearly separate the costs requested from RHIF from those requested or funded through the other opportunity. Shared costs must be supported by a reasonable allocation methodology, and the same cost may not be charged to more than one funding source. If the Offeror later receives another award that creates an overlap, it must notify HCA and revise the RHIF scope or budget as necessary before the affected costs are incurred or invoiced. HCA may request additional documentation during evaluation, contract development, or monitoring to verify that RHIF funds will not duplicate or supplant other funding.
27	If a practice has a pending Rural Health Care Delivery Fund Stabilization Grant application focused on preserving existing services at rural clinic sites. May the practice submit a separate Rural Health Innovation Fund proposal for an implementation-focused project involving access infrastructure, equipment, technology, care coordination, patient engagement, and data/reporting improvements, provided that RHIF funds are not used for any costs included in the pending RHCDF application and the proposal discloses the pending application?	Yes. A pending Rural Health Care Delivery Fund Stabilization application does not prevent a practice from submitting a separate RHIF proposal for a distinct implementation-focused project. The RHIF proposal must disclose the pending application and clearly distinguish the proposed scope, activities, personnel, equipment, technology, service area, and costs from those included in the Stabilization request. RHIF funds may not duplicate, replace, or reimburse costs supported through the Rural Health Care Delivery Fund or another source. If the Offeror later receives both awards and any overlap is identified, it must promptly notify HCA and revise the RHIF scope or budget before the affected costs are incurred or invoiced.
28	Does HCA anticipate a minimum or maximum individual award size for RHIF projects? The total available funding is approximately $47 million. Does HCA have a target number of awards or a preferred award range that prospective offerors should	HCA has not established a minimum or maximum individual award amount, a target number of awards, or a preferred award range for this solicitation. Offerors should propose a budget that is necessary, reasonable, and proportionate to the proposed scope, implementation period, anticipated impact, and capacity to perform the work. The number and amount of awards will depend on the proposals received, evaluation results, project scope and feasibility, portfolio

	consider when developing their proposed budgets?	needs, and available funding. The approximately $47 million available does not imply that all funds will be awarded or divided equally among selected Offerors.
29	Are out-of-state healthcare providers eligible to apply directly as Lead Offerors, or must applicants maintain a physical operational presence in New Mexico? Specifically, for telehealth-based clinical service projects delivered by providers licensed through the Interstate Medical Licensure Compact (IMLC), does HCA consider the direct delivery of clinical services to New Mexico patients as sufficient implementation in New Mexico, or does HCA expect additional local presence beyond the clinical service delivery itself?	Please see the responses to Questions 6, 16, 17, and 20. An out-of-state healthcare provider may serve as the Lead Offeror. RHIF does not require the Lead Offeror to maintain a physical office in New Mexico, but the Lead Offeror must have a direct implementation role and demonstrate a substantive and workable connection to the rural, frontier, or Tribal communities the project will serve. Direct delivery of telehealth services to New Mexico patients may contribute to that connection, but remote service delivery alone does not establish the full New Mexico Project Connection. The proposal should clearly describe the service area, identified community need, patient access and referral pathways, local coordination, operational capacity, and responsibility for implementation. All clinicians must be appropriately licensed or otherwise authorized to practice in New Mexico before furnishing services. HCA is not directly involved in implementation of the Interstate Medical Licensure Compact and therefore cannot provide guidance regarding its timing, processes, or applicability. Offerors are responsible for confirming all applicable licensure requirements with the appropriate licensing authority. RHIF funds may not be used for clinician salary or wage support, contracted clinical coverage, or telehealth clinical services reimbursable by Medicaid, Medicare, private insurance, or another payer.
30	Can telehealth and specialty care access projects be proposed as standalone RHIF projects, or must such projects be embedded within a broader community health initiative? The eligible project types listed in Section IV.B include "Technology Supporting Care Delivery" and "Locally Designed Service Improvements" as distinct categories. We seek confirmation that a focused specialty telehealth access project addressing a documented service gap qualifies as a standalone eligible project type.	Yes. A focused telehealth or specialty care access project may be proposed as a standalone RHIF project under “Technology Supporting Care Delivery” or “Locally Designed Service Improvements.” It is not required to be embedded within a broader community health initiative. The proposal must independently identify the documented rural service gap, eligible service area and population, implementation approach, budget, expected outcomes, and sustainability strategy. The project must also be distinct from and not duplicate activities funded through Healthy Horizons or another Rural Health Transformation initiative. As noted in Questions 8 and 20, RHIF may support allowable technology, equipment, implementation, training, care coordination, and related infrastructure costs, but may not fund prohibited clinician compensation or clinical services reimbursable by another payer.

31	Section IV.E.4 states that RHIF funds may not be used for clinical services reimbursable by Medicaid, Medicare, commercial insurance, or another payer unless expressly approved by CMS. For a telehealth project that includes an initial deployment phase (provider training, workflow integration, equipment, and technology configuration) followed by ongoing clinical services that transition to payer reimbursement, can RHIF fund the deployment and ramp-up costs while the ongoing clinical services are sustained through standard payer reimbursement? We want to ensure our budget structure appropriately distinguishes between RHIF-funded deployment activities and self-sustaining clinical operations.	Please see the responses to Questions 10 and 19. RHIF may support allowable, non-reimbursable deployment and implementation costs, including technology configuration, equipment, workflow integration, training, and related infrastructure needed to establish the project. The proposal and Cost Proposal must clearly distinguish these activities from ongoing clinical operations. RHIF funds may not be used for clinician compensation or clinical services reimbursable through Medicaid, Medicare, commercial insurance, or another payer. Transitioning ongoing clinical services to standard payer reimbursement may be included as the project's sustainability approach. All proposed costs remain subject to HCA review and approval.
32	Will awardees be considered "Contractors" or "Subrecipients" as defined in 2 CFR 200 which indicates whether or not these funds are subject to Single Audit?	For purposes of State procurement and contract administration, selected Offerors will enter into agreements with HCA and may be referred to as Contractors in the RFP and resulting agreement. For purposes of 2 CFR Part 200, HCA will determine the appropriate federal classification based on the substance of the relationship, rather than the title of the agreement. Because RHIF awardees will carry out portions of the federal Rural Health Transformation Program by implementing community-designed projects for the benefit of rural, frontier, or Tribal communities, HCA anticipates that RHIF awards will generally be treated as subawards and awardees as subrecipients for federal purposes. Final classification will be documented in the resulting agreement. A non-Federal entity that expends $1,000,000 or more in total Federal awards during its fiscal year as a recipient or subrecipient is generally subject to the Single Audit or program-specific audit requirements of 2 CFR Part 200, Subpart F. Entities expending less than $1,000,000 remain subject to applicable records-access, monitoring, and audit provisions.
33	The de minimis rate is currently 15%. Does CMS limit this funding to 10%, disqualifying the de minimis rate for this program. If administrative costs are limited to 10% do these costs have to be billed based upon actual incurred administrative costs rather than a	For RHIF, Administrative Costs are costs incurred to administer and oversee the award itself, rather than to carry out the approved project. Examples include general executive oversight, accounting and financial management of RHIF funds, payroll and personnel administration, procurement or contract administration, invoicing, required HCA grant reporting, compliance monitoring, audit support, and general office administration.

	flat 10% indirect rate which does not require detailed tracking of indirect costs?	Costs directly tied to implementing or delivering approved project activities may instead be classified as Direct Program Delivery Costs. For example, project-specific training, community engagement, workflow implementation, technical assistance, data collection, evaluation, and performance measurement may be programmatic when they are substantive components of the approved project. Classification is based on the function performed, not the employee's title or the general name of the expense. The 10 percent Administrative Cost limit applies to the combined total of direct and indirect administrative costs. It is a cap and does not create an automatic 10 percent allowance or indirect-cost rate. An eligible subrecipient without a current federally negotiated indirect cost rate may elect a de minimis rate of up to 15 percent of modified total direct costs under 2 CFR 200.414. Use of the de minimis rate is not disqualified; however, the indirect costs charged to RHIF, together with all direct Administrative Costs, must remain within the 10 percent Administrative Cost limit. Direct Administrative Costs must reflect actual allowable costs incurred. Indirect costs charged through an approved or de minimis rate may be calculated by applying the rate to the allowable modified total direct cost base and do not require itemization of each underlying indirect expense. The Offeror must document the applicable cost base, apply its methodology consistently, and ensure that no cost is charged both directly and indirectly.
34	Please confirm whether the Offeror is able to view whether a reference has completed their response in the Submittable platform.	Yes. Offerors can view whether a reference request has been completed in Submittable. The status is available by opening the applicable submission and selecting the Forms tab. Submittable also sends the Offeror an email notification when the reference response has been received.
35	Regarding the section that covers Product of Service-Copyright, please confirm that this clause applies only to deliverables specifically created for the State under the resulting agreement, and does not transfer ownership of Contractor's pre-existing software, platform, tools, workflows, documentation, templates, know-how, or other intellectual property, including any modifications, enhancements, or derivative works of Contractor's pre-existing intellectual property used to provide the services.	Please see the response to Question 18. The clause does not automatically transfer ownership of a Contractor's pre-existing intellectual property developed independently of the RHIF project. Offerors should clearly identify all pre-existing software, platforms, tools, workflows, documentation, templates, know-how, and other proprietary materials in their proposals. HCA cannot confirm that all modifications, enhancements, configurations, or derivative works involving pre-existing intellectual property will be excluded from the clause. Ownership and usage rights will depend on the nature of the work and the applicable contract terms, including whether it was developed with RHIF funds as a project-specific deliverable. Any requested exception or license-based approach must be expressly identified with proposed alternative contract language. HCA will consider such requests on a case-by-case basis, but

		revisions to the standard contract language are not routinely granted and should not be assumed.
36	For clarification, does "For the most recent independently audited financial statements and financial statements for the preceding three years, if available" mean you need the independent audit, including audit opinion, balance sheet, statements of income, retained earnings, and cash flows, and notes from the financial statements. If so, do you need the audits for the past three years?	The Offeror should submit its most recent independently audited financial statements, including the auditor's opinion, balance sheet, statements of income, retained earnings or changes in equity, cash flows, and accompanying notes. HCA is not requiring independently audited statements for each of the preceding three years. Offerors should also provide the financial statements available for those three years. When audited versions exist, the audited statements should be submitted; otherwise, the available financial statements may be provided.
37	The Initial Information Form in Submittable identifies the New Mexico BTIN as a required field. For out-of-state organizations that deliver services in New Mexico but do not maintain a physical presence in the state, is a NM BTIN required at the time of proposal submission, or may it be obtained prior to contract execution? We want to ensure our submission is complete and responsive.	A New Mexico Business Tax Identification Number (BTIN) is not required solely to submit a responsive proposal. An out-of-state Offeror that does not yet have a New Mexico BTIN may indicate "Pending" in the required field. If the field does not accept text, the Offeror should contact the Procurement Manager for technical assistance before the proposal deadline. A selected Offeror must obtain any required New Mexico tax registration, including a BTIN when applicable, before contract execution and payment. This does not waive any registration or tax obligations that may apply to an organization conducting business in New Mexico.
38	We would value an option for additional uploads in Form 2. Our RFP will be a partnership approach, and we'd like to show our partner's commitment to the proposed project (in addition to the 3 references required). We understand if this is not possible.	HCA does not currently have an optional upload section in Form 2 for partner documentation. HCA will issue an amendment and update Submittable to allow Offerors to upload optional letters of support, letters of commitment, memoranda of understanding, or similar documents. These materials are optional and do not replace the three required organizational references or any required proposal content. Offerors should use the designated upload field once the amendment and updated Form 2 are available.
39	In reviewing the RFP, the opportunity appears to be structured in some respects for grantees or subrecipients of federal funds. However, given the level of direction and oversight the State would provide over the awardee's services, it seems this work could also be structured as a contractor or vendor engagement.	Please see the response to Question 32 regarding the distinction between the State agreement and the federal classification of the award. HCA does not anticipate restructuring an RHIF award as a vendor procurement solely based on an Offeror's preferred classification. RHIF is intended to fund community-designed projects that carry out an approved portion of the Rural Health Transformation Program.

	Would the State consider an approach in which services for this project are procured through a vendor contract rather than a grant agreement?	The resulting State agreement may refer to the selected Offeror as a Contractor for State contracting purposes. However, for federal purposes, HCA will determine whether the relationship is a subaward or procurement contract based on the substance of the arrangement under 2 CFR Part 200. Because RHIF awardees will generally have programmatic responsibility for implementing an approved project, HCA anticipates that most RHIF awards will be treated as subawards and the awardees as subrecipients. If a proposed relationship is limited to providing goods or services for HCA's own use, HCA may determine that a procurement relationship is more appropriate. Final classification will be made by HCA during pre-award review and documented in the resulting agreement.
40	Is the purchase of trucks, cars, forklifts and trailers authorized as EQUIPMENT (Para: I.G.6 RFP Page 8)? This equipment has a potential 5-year life span and can be used for continuing ramp building activities. If not, what are the authorized ways to obtain these resources to cover the large distances traveled over the state? Who owns the equipment/vehicles at the end of the RFP period. Under what budget category should these purchases be reported, and what prior approvals would be required?	Trucks, cars, forklifts, and trailers are not automatically allowable merely because they meet the definition of Equipment. Motor vehicles and similar assets are generally considered general-purpose equipment, and their purchase is allowable only when specifically approved, necessary for the approved project, reasonable in cost, and directly allocable to project activities. General organizational transportation or operational convenience would not be sufficient justification. An Offeror proposing a purchase should include the item in the Equipment budget category and provide the unit cost, intended use, project need, anticipated utilization, useful life, and an explanation of why purchase is more economical and practical than leasing, renting, mileage reimbursement, or contracted transportation. An item is considered Equipment when it has a useful life of more than one year and a per-unit acquisition cost equal to or greater than the lesser of the Offeror's capitalization threshold or $10,000. Items below that threshold should be classified under the appropriate Supplies or Other Direct Costs category. Alternatives may include: • Mileage reimbursement or vehicle rental for staff travel, reported under Travel; • Leasing or renting vehicles, trailers, or forklifts, reported under the budget category appropriate to their project use; or • Contracting for transportation, delivery, or related services under Contractual Services. Any purchase of general-purpose equipment requires prior written HCA approval and may also require CMS approval or an amendment to the federally approved budget. Offerors should not purchase or commit RHIF funds for such equipment before the applicable approvals are documented.

		Under Appendix E, non-expendable equipment purchased with RHIF funds is subject to HCA's property and disposition requirements and becomes State property upon termination of the agreement. Awardees must maintain inventory, location, use, condition, safeguarding, and maintenance records and follow HCA's written disposition instructions. Continued use or retention after the award period should not be assumed. Federal equipment requirements also restrict disposal or encumbrance while the equipment remains needed for the funded project.
41	May an awardee provide funding to participating rural provider organizations through structured subawards or subcontracts with defined statements of work and deliverables—for example, to support non-clinician staff time dedicated to project implementation, workflow redesign, data collection and evaluation, and training and capacity building activities? We understand clinician salaries and general operating support are prohibited and are seeking to confirm the permissibility of defined, deliverable-based support to providers.	Yes. An awardee may provide funding to participating rural provider organizations for defined, approved project activities, including non-clinician staff time dedicated to implementation, workflow redesign, data collection and evaluation, training, and capacity building. The proposal must clearly identify each provider's role, statement of work, deliverables, budget, and payment methodology. The appropriate mechanism—subaward or subcontract—will be determined based on the substance of the relationship and must be approved by HCA. Funding may not be used for general operating support, clinician salaries or wages, reimbursable clinical services, or costs supported by another funding source. The Lead Offeror remains responsible for oversight, performance, reporting, and compliance for all participating providers.
42	May an awardee issue subawards or subcontracts to partner organizations (e.g., universities, community colleges, nonprofit organizations) for defined components of the project scope? Are there restrictions on the mechanism (subaward vs. subcontract vs. mini grant) or on the proportion of the total budget that may be passed through to subrecipients?	Yes. An awardee may issue subawards, subcontracts, or partner payments to universities, community colleges, nonprofit organizations, or other partners for defined components of the approved project. The proposed arrangements must be identified in the proposal, budget, workplan, and partner documentation and are subject to HCA approval. The appropriate mechanism depends on the substance of the relationship. An organization carrying out a portion of the federally funded project would generally be treated as a subrecipient, while an organization providing goods or services to support the project would generally be treated as a contractor. "Mini-grant" is not a separate federal classification and must be structured as an appropriate subaward or contractual arrangement. HCA has not established a fixed limit on the proportion of an award that may be provided to partners. However, the Lead Offeror must retain a substantive direct implementation and oversight role and remains responsible for project performance, financial management, reporting, compliance, and all partner activities. HCA will review proposed partner funding for necessity, reasonableness, and alignment with the approved project.

43	The proposed project anticipates expanding participation over the implementation period. How should applicants describe participating provider organizations that will be recruited through a defined engagement and selection process after award while still demonstrating project readiness at the time of application?	Applicants may distinguish between confirmed participants and provider organizations that will be recruited after award. The proposal should describe the anticipated number, types, and geographic distribution of participating providers; eligibility and selection criteria; recruitment and onboarding process; timeline and milestones; expected provider roles; and the staff and resources responsible for engagement. Applicants should also identify any existing provider relationships, commitments, or recruitment pipeline that demonstrate the feasibility of the proposed approach. Project readiness does not require every participating provider to be finalized at the time of application, but the proposal must present a sufficiently developed and achievable plan for timely recruitment and implementation. Any funded provider arrangements or material additions or changes to participating organizations after award will be subject to HCA approval and must remain consistent with the approved scope, budget, workplan, and project outcomes.
44	For projects where technology selection depends on provider needs identified during implementation, what level of specificity does HCA expect regarding proposed technology solutions or implementation partners at the time of application?	Applicants are not required to identify a final technology product or implementation partner at the time of application when selection reasonably depends on provider needs identified during implementation. The proposal must nevertheless describe the intended use cases, required functional and technical capabilities, provider assessment and selection process, procurement approach, implementation timeline, responsible parties, budget assumptions, and applicable interoperability, privacy, security, and accessibility requirements. The proposed approach must be sufficiently developed for HCA to evaluate feasibility, cost reasonableness, readiness, and expected outcomes. Any technology or implementation partner selected after award must remain within the approved scope and budget and receive any required HCA approval before funds are committed or expended.
45	How should costs for hands-on project delivery activities—such as pilot coordination, implementation support, technical assistance, and evaluation support performed by the awardee's project staff—be classified relative to the administrative cost cap? We are seeking to confirm these activities are considered direct program delivery rather than administrative costs.	Please see the responses to Questions 13 and 33. Costs for substantive, hands-on project activities (such as pilot coordination, implementation support, technical assistance, provider training, project-specific data collection, and evaluation) may be classified as Direct Program Delivery Costs when they directly support implementation of the approved project. Costs associated with general management or administration of the award (such as financial administration, invoicing, contract management, compliance oversight, and required HCA reporting) must be classified as Administrative Costs.

		Classification is based on the function performed rather than the employee's title. When the same staff perform both programmatic and administrative activities, costs must be allocated using a reasonable, consistent, and documented methodology.
46	How does HCA view the relationship between projects funded under this RFP and the other pillars of the Rural Health Transformation Program (e.g., technical assistance and sustainability support)? Should applicants describe how their proposed work complements those efforts, and will awardees receive information about other funded projects to facilitate coordination and avoid duplication?	Applicants should describe how the proposed project complements other Rural Health Transformation Program initiatives when relevant, including potential coordination opportunities and how duplication of activities or funding will be avoided. Proposals should remain independently feasible and should not assume access to specific technical assistance, funding, data, or other resources unless expressly stated in the RFP. Following award, HCA anticipates sharing relevant program information and facilitating coordination among RHIF awardees and other RHT initiatives, including available technical assistance and sustainability supports, as appropriate. Awardees may be required to participate in cross-initiative coordination activities.
47	Projects may include implementation support activities such as pilot evaluation, performance measurement, workflow assessment, feasibility analysis, and validation activities that directly inform project delivery and continuous improvement. Are these implementation and quality improvement activities considered allowable under the RFP?	Yes. Pilot evaluation, performance measurement, workflow assessment, validation, and other quality-improvement activities may be allowable when they are directly tied to implementation of an approved RHIF project and are used to guide project delivery, refinement, or continuous improvement. These activities must be necessary, reasonable, proportionate to the implementation work, and included in the approved scope, workplan, and budget. RHIF may not fund independent research and development or a project primarily consisting of planning, feasibility analysis, product validation, or evaluation without implementation of an eligible community-designed intervention.
48	Can HCA share the anticipated number of awards and/or an expected award size range under the $47.05 million available through this funding opportunity?	Please see the response to Question 28. HCA has not established a target number of awards or an expected award-size range. Offerors should propose a budget that is necessary, reasonable, and proportionate to the proposed scope, implementation period, anticipated impact, and organizational capacity. The number and amount of awards will depend on the proposals received, evaluation results, project feasibility, portfolio needs, and available funding. The approximately $47.05 million available does not imply that all funds will be awarded or divided equally among selected Offerors.
49	Can funding be used to cover outpatient mental health counseling services for individuals who are uninsured, including those who do not qualify for or are not enrolled in Medicaid or Medicare?	Please see the responses to Questions 7, 20, and 31. RHIF funds may not be used for clinician salaries or wage support or to routinely pay for outpatient counseling services. Counseling provided to uninsured individuals would be considered a direct health care service or provider payment and may be funded only if expressly approved by CMS. Any proposed use would need to

		demonstrate that the services are not reimbursable through another payer, fill a documented gap in coverage, and do not duplicate or supplant another funding source. For proposals HCA determines it would like to advance, HCA will seek any required CMS approval before authorizing these costs. Offerors should not assume the costs are allowable unless and until CMS approval is obtained.
50	Can funding be used to cover outpatient mental health counseling co-pays for individuals who cannot afford the portion of costs not covered by their insurance?	Please see the response to Question 49. No. RHIF funds may not be used to pay or reimburse patient copayments, coinsurance, deductibles, or other cost-sharing obligations for outpatient mental health counseling or other clinical services covered by Medicaid, Medicare, commercial insurance, or another payer. Because the underlying clinical service is reimbursable, payment of the patient's cost-sharing obligation would not be an allowable RHIF expense under the duplicate-payment restrictions.
51	For for-profit entities, are audited financial statements required to demonstrate financial stability, or are other forms of financial documentation (e.g., reviewed financials, bank statements, investor disclosures) acceptable?	Please see the response to Question 36. For-profit Offerors should submit independently audited financial statements when available. If audited statements are not available, the Offeror may submit other financial documentation sufficient for HCA to evaluate financial stability, such as reviewed or internally prepared financial statements, balance sheets, income statements, cash-flow statements, relevant investor or regulatory disclosures, and evidence of available liquidity. Bank statements or investor disclosures alone may not provide sufficient information. The documentation should collectively demonstrate the Offeror's financial condition and capacity to perform the proposed project. HCA may request additional financial information or clarification during evaluation or prior to award.
52	Can HCA confirm that ongoing per-member platform and software costs directly tied to project implementation are appropriately classified under "Technology and Systems" in the Cost Proposal Template?	Yes. Ongoing per-member platform, software licensing, or subscription costs may be reported under Technology and Systems when they directly support implementation and delivery of the approved project during the project period. The Cost Proposal should identify the unit price, number of members or users, duration, included functionality, and total requested cost. When a bundled price includes implementation, consulting, staffing, clinical services, or other non-technology components, those costs should be separately identified and classified under the appropriate budget categories. Technology costs must support an eligible RHIF project and may not be used for independent product development, reimbursable clinical services, or costs funded through another source. The proposal should also address how recurring platform costs will be sustained after RHIF funding ends.

53	Section E lists "financial assistance to households for broadband installation or monthly internet costs" as an unallowable cost. Can HCA clarify whether this restriction is limited to general consumer subsidies, or whether it also applies to connectivity-related costs that are directly tied to an approved project's care delivery or health engagement activities?	The restriction prohibits RHIF funds from paying or reimbursing households for broadband installation or recurring household internet service, even when intended to facilitate access to care. It is not limited only to broad consumer-subsidy programs. Connectivity costs may be allowable when they are incurred by the awardee or participating provider as a necessary and directly allocable component of an approved project—for example, connectivity at a provider or community telehealth site or dedicated cellular service incorporated into project-owned equipment. Such costs must not function as general household internet assistance and must comply with the prohibition on covered telecommunications equipment and services. The proposal should clearly describe the connectivity arrangement, ownership of any equipment, intended users, duration, and how the cost is limited to the approved project. Allowability will be determined based on the specific proposed use and remains subject to HCA review.
54	Under which budget category should member outreach, enrollment support, and digital literacy assistance provided to project participants be classified in the Cost Proposal Template?	Costs should be classified based on the nature of the expense: • Awardee staff time should be reported under Personnel and Fringe Benefits. • Services performed by a partner or subcontractor should be reported under Subcontractor and Funded Partner Costs or Contractual Services, as applicable. • Participant-facing digital literacy training may be reported under Training and Capacity Building. • Outreach materials or other related expenses should be reported under Supplies or Other Direct Program Delivery Costs, as appropriate. When these activities directly support participant outreach, enrollment, engagement, or use of the approved project, they may be treated as Direct Program Delivery Costs rather than Administrative Costs. Offerors should avoid reporting the same cost in more than one category.
55	The Cost Proposal Template includes separate line items for "Contractual Services" and "Subcontractor and Funded Partner Costs." Can HCA clarify the distinction — specifically, whether a named health system or health plan partner that does not receive RHIF funds but whose member population is the project's target	Contractual Services should include payments to external vendors or consultants providing goods or services in support of the project. Subcontractor and Funded Partner Costs should include RHIF funds provided to organizations carrying out defined portions of the approved project scope. A named health system or health plan partner that will not receive RHIF funds should not be included in either budget line solely because its patients or members are the project's target population. The organization and its role should instead be described in the proposal's partnership and implementation sections and, as

	should be reflected in either line, or neither?	appropriate, documented through a letter of support or memorandum of understanding. Any in-kind contribution or other funding provided by that partner should be identified as leveraged support or other project funding, but not as an RHIF-funded cost.
56	It was confirmed at the pre-proposal conference that HCA retains ownership of purchased equipment and technology during the contract term, with ownership transferring to the awardee upon successful completion. For member-facing devices provided to enrolled participants as part of a care delivery program — where the device is in the participant's possession throughout the contract — how does HCA envision the ownership and custody arrangement working in practice during the contract term?	During the contract term, HCA will retain ownership of purchased equipment and technology, while the awardee will be responsible for custody, inventory control, and appropriate use of the devices, including devices placed in participants' homes. Awardees should establish written participant agreements and procedures addressing device assignment, serial-number tracking, permitted use, safeguarding, maintenance, replacement, return or retrieval, data security, and loss or damage. Participant possession during the contract term does not transfer ownership to the participant. Upon successful completion of the contract and required closeout, ownership may transfer to the awardee as described during the pre-proposal conference. Any continued placement of devices with participants after that transfer will be the awardee's responsibility and must comply with applicable program, privacy, security, and property requirements.
57	At the pre-proposal conference, it was mentioned that optional letters of support are not currently available in the application but may be added via amendment. We would like to request that this be added. Can HCA confirm whether an amendment will be issued to allow optional letter of support uploads in Submittable?	Yes. HCA will issue an amendment and update Form 2 in Submittable to allow Offerors to upload optional letters of support, letters of commitment, memoranda of understanding, or similar partner documentation. These materials are optional and do not replace the three required organizational references.
58	For purposes of the Partnerships scoring criterion, will HCA evaluate a described partnership where no formal agreement (e.g., an executed contract) exists at submission, or is documentary evidence required to receive credit? If documentation is required, is a letter of support sufficient?	HCA will evaluate partnerships based on the information provided in the proposal, including each partner's role, responsibilities, level of commitment, and contribution to project implementation. An executed contract or other formal agreement is not required at the time of proposal submission unless specifically required elsewhere in the RFP. Please also see the response to Question 57. An optional letter of support, letter of commitment, or memorandum of understanding may be submitted as evidence of a partnership. A letter of support may be sufficient to document current commitment, but it does not replace the proposal's responsibility to clearly describe the partnership and implementation approach.

		Any formal agreements required to implement funded activities must be completed before the applicable work or expenditure begins and may be subject to HCA approval.
59	The non-duplication certification requires disclosure of all other funding supporting the proposed project. For projects where post-grant sustainability depends on a commercial arrangement not yet executed, does HCA expect anticipated future revenue streams to be disclosed at the proposal stage, or only funding that is currently committed?	The non-duplication certification should disclose funding that is committed, awarded, pending, or otherwise expected to support costs during the RHIF project period. An anticipated commercial arrangement that would begin only after RHIF funding ends is not considered current project funding solely because it is part of the sustainability strategy. Applicants should describe anticipated future revenue streams in the Sustainability Plan, including the expected source, timing, current status, and any assumptions or dependencies, and should not present them as committed unless an agreement is in place. If the arrangement is executed during the RHIF project period or begins supporting project costs, the awardee must notify HCA and ensure that the same costs are not charged to RHIF and another source. The approved application specifically contemplates future revenue streams and alternative financing as sustainability mechanisms.
60	Can HCA confirm whether RHIF awardees will be classified as contractors or subrecipients for purposes of 2 CFR Part 200 and single audit applicability?	Please see the response to Question 32. For purposes of State procurement and contract administration, selected Offerors may be referred to as Contractors in the RFP and resulting agreement. For purposes of 2 CFR Part 200, the substance of the relationship controls rather than the title of the agreement. HCA anticipates that RHIF awardees will generally be treated as subrecipients and the awards as subawards for federal purposes. Federal funds expended as a recipient or subrecipient count toward the applicable Single Audit threshold.
61	Can an Offeror that receives a RHIF award in this cycle apply for future-year RHIF funding for the same or an expanded program in Years 2–5 of the RHT Program?	Yes. HCA recognizes that transformative projects may require more than one year of funding. HCA intends to establish a process through which awarded projects may request continuation funding in future years of the RHT Program. Continuation funding will not be automatic and will remain subject to available funding, CMS approval, satisfactory performance, compliance with award requirements, demonstrated progress and continued need, and HCA approval of an updated scope, workplan, and budget. Awardees should still include a sustainability strategy and should not assume that future funding is guaranteed.
62	Section III.A. If an organization is the Lead Offeror on one proposal and also a named partner or subcontractor on separate proposals led by other Offerors, does that participation count	Participation as a named partner or subcontractor on a proposal led by another Offeror does not, by itself, count as a separate award to that organization for purposes of Section III.A. The award-concentration provision primarily applies when the organization is the Lead Offeror or when separate Lead Offerors are affiliated

	toward the award-concentration or affiliation limits in Section III.A?	through common ownership, control, or another material organizational relationship. HCA may nevertheless consider an organization's total participation and proposed funding across multiple projects when evaluating capacity, duplication, conflicts, portfolio balance, and concentration of RHIF funds. Offerors should disclose all proposed roles and funding arrangements across RHIF proposals.
63	Section I.C. Is there a minimum or maximum RHIF award amount per project or per Offeror?	Please see the response to Question 28. HCA has not established a minimum or maximum RHIF award amount per project or per Offeror. Offerors should request an amount that is necessary, reasonable, and proportionate to the proposed scope, implementation period, anticipated impact, and organizational capacity. The number and size of awards will depend on the proposals received, evaluation results, project feasibility, portfolio needs, and available funding.
64	Sections IV.A.5, IV.B, and IV.C.9. Will the Healthy Horizons Regional Hub Organizations have any role in the implementation, coordination, funding recommendation, or oversight of RHIF projects, or are RHIF awards contracted and managed directly between the Contractor and HCA?	RHIF awards will be selected, contracted, and managed directly by HCA through the RHT Program Management Office. Healthy Horizons Regional Hub Organizations will not have authority to recommend RHIF awards, approve funding, manage RHIF contracts, or oversee awardee performance solely by virtue of their role as Regional Hubs. HCA may facilitate coordination between RHIF awardees and Regional Hubs to align regional activities, share relevant information, engage local stakeholders, and avoid duplication. A Regional Hub may also participate in an RHIF project as an applicant, partner, or subcontractor if that role is included in an approved proposal. Such participation does not change HCA's funding, contracting, and oversight authority.
65	Sections IV.B, IV.C.9, IV.E.3. How will HCA assess whether an RHIF project duplicates activities funded under another RHT initiative? May an organization that is funded under another RHT initiative also receive an RHIF award for a distinct project in the future?	Please see the responses to Questions 26, 27, and 46. HCA will assess potential duplication by comparing the proposed project's purpose, scope, service area, target population, activities, deliverables, personnel and partner roles, equipment and technology, budget, timeline, and expected outcomes with activities funded through other Rural Health Transformation Program initiatives. Similar goals, populations, or complementary activities do not necessarily constitute duplication, but the same activities or costs may not be funded through multiple sources. Yes. An organization funded under another RHT initiative may also receive an RHIF award for a materially distinct project, provided it meets the RHIF requirements and demonstrates sufficient capacity, clear separation of scopes and budgets, and no duplication or supplantation. Offerors should disclose current or pending RHT funding and explain how the proposed RHIF project differs from and

		coordinates with those activities. HCA may request clarification or require revisions to the proposed scope or budget before award.
66	Section III.C.2.c.ii. If an Offeror does not have independently audited financial statements, what alternative documentation will HCA accept as sufficient evidence of solvency, and will the same standard apply to smaller community-based or Tribal organizations?	Please see the responses to Questions 36 and 51. If independently audited financial statements are not available, an Offeror may submit other reliable financial documentation sufficient to demonstrate solvency and the capacity to manage and perform the proposed project. This may include reviewed or internally prepared financial statements, balance sheets, income and cash-flow statements, budget-to-actual reports, recent tax filings or equivalent governmental records, and evidence of available liquidity. HCA will apply the same underlying standard to all Offerors, including smaller community-based and Tribal organizations, while considering the organization's size, legal structure, and the financial records ordinarily available to it. An Offeror is not required to obtain a new independent audit solely for this proposal. HCA may request additional documentation or clarification if the materials submitted are insufficient to evaluate financial stability.
67	Section I.C and I.G.12. Must RHIF funds awarded under this RFP be fully obligated and expended within the October 2026 to September 2027 period, or may unexpended funds carry into a subsequent CMS Budget Period?	The October 2026 through September 2027 RHIF project period reflects CMS's allowance for Budget Period 1 funds to be spent through September 30, 2027. Funds awarded through this RFP must be used for allowable costs incurred during the approved project period and fully expended by September 30, 2027. Unexpended balances will not automatically carry forward to a later CMS Budget Period or future RHIF award. Any continuation funding beyond the initial award period would be addressed through the separate continuation process described in the response to Question 61 and would be subject to available funding, CMS and HCA approval, satisfactory performance, and an approved updated scope, workplan, and budget. Awardees should not assume an extension or carryover of unspent funds.
68	Section I.B identifies "Rooted in New Mexico" as the RHT Program initiative dedicated to building and retaining the rural health workforce pipeline. Section IV.B does not exclude workforce-related projects from RHIF eligibility, and this was confirmed on today's pre-proposal call. Can HCA clarify how RHIF will evaluate workforce-related proposals against the Section IV.B requirement that projects avoid duplication with other RHT initiatives? Specifically, should Offerors expect RHIF to fund	Workforce-related projects are not excluded from RHIF and are not required to include a technology, equipment, or other non-workforce component to be eligible. HCA will evaluate whether the proposed project is a distinct, community-designed response to a documented local need or whether it substantially duplicates workforce pipeline activities planned under Rooted in New Mexico. Rooted in New Mexico is focused on statewide rural workforce strategies such as education and training pathways, clinical rotations and residencies, apprenticeships, K–12 pipeline activities, certification and career advancement, recruitment, and retention. RHIF is intended to support community-level projects that are not otherwise captured by the defined statewide initiatives.

	workforce projects only where they include a distinct innovation, technology, or equipment component beyond core workforce pipeline development, given that a separate Rooted in New Mexico RFP is anticipated to address workforce development directly?	Offerors proposing workforce-related activities should clearly describe the project's local need, scope, target population, implementation approach, expected outcomes, and how it differs from or complements Rooted in New Mexico. Similar subject matter does not automatically constitute duplication, but the same activities or costs may not be funded under both initiatives.
69	We have a clinic in Las Cruces and are expanding to Deming (which is the rural location we chose). We have different lines of business that we offer right now including family practice, urgent care, podiatry , x-ray and lab and wc services. We are a small, locally owned clinic and we are not associated with any hospitals. We want to expand our provider services to include Ortho, Gastro, Endocrinology and Rheumatology. The problem with all the providers in town right now is that they are signed up with one of the hospitals and they schedule their patients first before entertaining patients from other groups. Since we are independent, we want to have these different specialties so we can cater to offering faster specialty care. Is this something that would be supported? We wanted to have a surgery center, along with that comes MRI and CT. Would this grant allow us to add all these items if possible?	Potentially. HCA cannot determine in advance whether a particular proposal will be selected, but a project expanding specialty-care access at an eligible rural location in Deming may be considered if it addresses a documented community need, is feasible and sustainable, and does not duplicate activities funded through Healthy Horizons or another Rural Health Transformation initiative. RHIF may support allowable implementation costs such as equipment, technology, workflow development, care coordination, and limited improvements to an existing rural facility. New Mexico's approved application specifically identifies diagnostic equipment as a potential RHIF-supported need. RHIF funds may not be used for clinician salaries, general operating support, or clinical services reimbursable through Medicaid, Medicare, commercial insurance, or another payer. Construction of a new surgery center would not be allowable; capital funding is limited to equipment upgrades and minor renovations or alterations to existing rural health care facilities and may require prior HCA and CMS approval. MRI and CT equipment may be proposed, but such purchases are not automatically allowable. The proposal must demonstrate that the equipment is necessary and reasonable for the rural service volume, directly supports the approved project, can be staffed and maintained, and has a sustainable operating and reimbursement model. The proposal should clearly identify which services, costs, and benefits will occur at the eligible Deming location rather than the Las Cruces site.
70	We are interested in setting up a Surgery Center in Deming; currently there is none and so many patients have to travel to Las Cruces or Albuquerque for any procedures. Would this be possible?	Please see the response to Question 69. A project to establish surgical access in Deming may be proposed; however, RHIF funds may not be used for new construction, building expansion, facility purchase, or significant retrofitting of a building. RHIF may potentially support allowable equipment purchases and minor renovations or alterations to an existing rural health care facility when directly tied to improving access, patient safety, or quality of care. Minor renovations require prior HCA and CMS approval.

		The proposal must demonstrate community need, facility and licensing readiness, operational feasibility, sustainable staffing and reimbursement, and the ability to maintain the equipment and services after the RHIF funding period. RHIF funds may not be used for clinician salaries or reimbursable surgical services.
71	There are many patients that cannot travel to the clinic in Deming and we would like to offer mobile services by purchasing a mobile unit. Would this be allowed?	Potentially. A purpose-built mobile health unit may be proposed as Equipment when it is directly necessary to deliver approved health services in eligible rural, frontier, or Tribal communities. The purchase is not automatically allowable and will require prior written HCA approval; additional CMS approval may also be required. The proposal should demonstrate the documented access need, communities and service routes, services to be delivered, anticipated utilization, licensing and operational readiness, staffing, maintenance, storage, insurance, and long-term sustainability. It should also explain why purchasing the unit is more reasonable and cost-effective than leasing, renting, or using a shared mobile resource. A mobile health unit should be clearly distinguished from a general-purpose vehicle. A unit designed and used specifically for medical service delivery may qualify as special-purpose equipment under federal requirements. RHIF funds may not be used for prohibited clinician compensation, general operating support, or reimbursable clinical services.
72	We would like funds to cover patients copays, coinsurance and deductibles. Unfortunately even many patients have insurance thru Be Well, they still can't afford their out of pocket and it really is putting a stress on us financially. How could we offer this service?	Please see the response to Question 50. RHIF funds may not be used to pay or reimburse patient copayments, coinsurance, deductibles, or other cost-sharing obligations, including for patients with coverage through BeWell or another insurer. These amounts are associated with clinical services reimbursable by another payer and cannot be charged to RHIF as patient assistance, provider reimbursement, or operating support. Any financial assistance program covering patient cost-sharing would need to be supported through non-RHIF funding.
73	Is cost share or matching funds required?	No. Cost sharing or matching funds are not required for RHIF eligibility or proposal submission. Offerors may identify other funding, in-kind contributions, or leveraged resources supporting the project, but those resources must be clearly distinguished from RHIF-requested costs and may not result in duplication or supplantation.
74	Is there an award floor or ceiling, or an average award amount per award?	Please see the responses to Questions 28, 48, and 63. HCA has not established an award floor, award ceiling, or anticipated average award amount.

		Offerors should request an amount that is necessary, reasonable, and proportionate to the proposed scope, implementation period, anticipated impact, and organizational capacity. Award amounts will depend on the proposals received, evaluation results, project feasibility, portfolio needs, and available funding.
75	In the Cost Proposal Template, there's a tab for Supporting Docs. What are examples of supporting documents that may be included?	The Supporting Docs tab may be used to provide documentation that supports the assumptions, calculation, or reasonableness of proposed costs. Examples include: • Vendor quotes or cost estimates for equipment, technology, supplies, facility improvements, or contractual services; • Partner or subcontractor budgets, scopes of work, or rate schedules; • Salary, fringe-benefit, staffing, or cost-allocation calculations; • A negotiated indirect cost rate agreement or documentation of the indirect cost methodology used; • Lease, rental, licensing, subscription, travel, or other pricing documentation; and • Other materials needed to explain unusually large, specialized, or restricted costs. Supporting documentation is not required for every budget line unless specifically requested. Offerors should upload only materials relevant to the proposed budget and should ensure the Cost Proposal and Budget Narrative remain complete without relying solely on attachments. HCA may request additional documentation during budget review or before contract execution.
76	Applicants may include 15% de minimis, as allowed by 200 CFR, if they don't have a negotiated rate agreement, correct? The applicant we are working with typically includes 15% de minimis in their federal grants.	Please see the response to Question 33. An eligible recipient or subrecipient that does not have a current federally negotiated indirect cost rate may elect a de minimis rate of up to 15 percent of modified total direct costs (MTDC) under 2 CFR 200.414(f). The rate is not automatically applied to the total award or total direct costs. The 15 percent de minimis rate remains subject to the RHT Program's administrative-cost limitation. All direct and indirect costs classified as program administration must remain within the applicable 10 percent Administrative Cost cap. The de minimis rate does not create an additional allowance above that cap. The Offeror should identify the elected rate, calculate it using the appropriate MTDC base, and ensure that costs are consistently classified and are not charged both directly and indirectly. New Mexico's approved application anticipated use of the 15 percent de minimis rate for eligible subrecipients without negotiated rates.
77	For the 3 required organizational references, once we enter the contact information for the references in Submittable and	Yes. Once the Offeror enters the contact information for each of the three required organizational references in Submittable and submits the reference requests, Submittable will send each

	follow the applicable steps, Submittable will send the reference a link to complete the required information, correct? Additionally, the references contacted will need to complete and submit the information by 5:00 PM, July 20, 2026, correct?	reference a link to complete and submit the required information directly. All three reference responses must be submitted through Submittable by 5:00 p.m. MDT on July 20, 2026. Offerors are responsible for monitoring completion and ensuring all required references are submitted by the deadline.
78	Please confirm if the Offeror needs to have a physical address in New Mexico.	No. An Offeror is not required to maintain a physical office or business address in New Mexico to submit a proposal. An out-of-state organization may apply if it has a substantive implementation role and demonstrates the capacity and relationships necessary to carry out the proposed project. The project's activities and benefits must occur in or directly serve eligible rural, frontier, or Tribal communities in New Mexico. A mailing address alone, whether inside or outside New Mexico, does not establish project eligibility. A selected Offeror must obtain any New Mexico business registration, tax identification, or other documentation required before contract execution or payment.
79	Can the Offeror provide the New Mexico BTIN prior to the contract award instead of during the initial submission process? (To acquire a BTIN, the Offeror must first register with the Secretary of State in New Mexico and the timeline may prevent obtaining a BTIN in the time allotted)	Yes. An Offeror that has not yet obtained a New Mexico Business Tax Identification Number (BTIN) may submit a proposal without it. The BTIN field is required only if applicable and available at the time of submission. The Offeror should enter "Pending" or "Not yet issued," where the Submittable field permits. A selected Offeror must complete any required New Mexico registration and provide its BTIN before contract execution and payment.
80	Is the awardee considered a Contractor? What constitutes a Lead Offeror, subcontractor, partner or collaborator? And are any of the last four reimbursed by us through this contract? If so, I would presume then that we would list them in our cost proposal.	The selected Lead Offeror may be referred to as the Contractor in the resulting State agreement. However, the organization's federal classification is determined by the substance of the relationship under 2 CFR Part 200. HCA anticipates that RHIF awardees will generally function as subrecipients because they are carrying out an approved portion of the federally funded RHT Program. For purposes of this RFP: • The Lead Offeror submits the proposal, enters into the agreement with HCA, receives RHIF payments, performs a substantive implementation role, and remains responsible for the entire project, including its budget, reporting, compliance, and the work of all other participating entities. • A subcontractor generally provides specified goods or services to the Lead Offeror under a procurement relationship.

		• A partner participates in defined project activities or contributes personnel, expertise, facilities, services, or other resources. A partner receiving RHIF funds should be identified as a funded partner. Whether that relationship is treated as a subaward or subcontract will depend on the substance of the role. • A collaborator supports the project through activities such as coordination, referrals, stakeholder participation, data sharing, outreach, or in-kind contributions and may or may not receive RHIF funding. HCA will generally make payments only to the Lead Offeror under the RHIF agreement. The Lead Offeror is responsible for paying its approved subcontractors and funded partners. Any subcontractor, partner, or collaborator that will receive RHIF funds must be identified in the proposal and included in the Cost Proposal under the appropriate category, such as Contractual Services or Subcontracts/Partner Payments. An unfunded partner or collaborator should be described in the proposal but should not be included as an RHIF-requested cost. The Lead Offeror remains responsible for ensuring that all participating entities comply with applicable project, contract, State, and federal requirements.
81	ii. Financial Statements and Evidence of Solvency Section: What is a 10-K form? How do we know if one is required by our agency?	A Form 10-K is an annual financial and business report filed with the U.S. Securities and Exchange Commission (SEC), generally by publicly traded companies and other entities subject to SEC reporting requirements. It includes audited financial statements and information about the organization's operations, financial condition, and risks. A 10-K is required for this proposal only if the Offeror is already required to file one with the SEC. Governmental entities, Tribal governments, nonprofit organizations, and most privately held organizations generally do not file Form 10-K. An organization can confirm its status with its finance or legal staff or by checking whether it has filings in the SEC's EDGAR database. If a 10-K is not applicable, the Offeror should submit the financial statements and other evidence of solvency ordinarily available to its type of organization, consistent with the responses to Questions 36, 51, and 66.
82	Section D. Allowable Use of Funds has a bullet that reads: … 1. Personnel and fringe benefits for project staff, excluding prohibited clinician salary or wage support. Please describe in more detail	The exclusion applies to compensation for clinicians when it supports the delivery of patient care or routine clinical operations. RHIF funds may not be used for clinician salaries, wages, fringe benefits, stipends, contracted clinical coverage, on-call or reserved availability, or similar compensation when the clinician is furnishing patient care, maintaining clinical coverage, or performing services reimbursable through Medicaid, Medicare, private insurance, or

	what about clinician salary or wage support is excluded?	another payer. This applies whether the clinician is employed by the Lead Offeror, a partner, or a subcontractor. A person is not automatically excluded from all RHIF-funded work solely because they hold a clinical license. Compensation for discrete, nonclinical project implementation activities—such as workflow design, technology implementation, staff training, project management, quality improvement, or data and evaluation—may be considered when the time is directly tied to the approved project, is not reimbursable, does not supplant existing funding, is separately documented, and is included in the HCA-approved budget. HCA will evaluate the function being performed rather than the individual's job title. Offerors should clearly separate any proposed nonclinical implementation time from clinical service delivery or routine staffing costs.
83	Section D. Allowable Use of Funds has a bullet that reads: 4. Provider Payments approved by HCA and CMS and compliant with applicable payment limits and non-duplication requirements.	"Provider payments" are payments made to a health care provider for furnishing health care items or services. This may include direct payments or incentives tied to defined services, participation requirements, milestones, or performance outcomes. Not every payment made to a provider organization is a provider payment; costs for allowable equipment, technology, training, workflow implementation, data activities, or other nonclinical project work are classified according to the nature of the activity. An Offeror may propose provider payments but must separately identify and justify them in the Cost Proposal, including the proposed recipients, payment methodology, eligible activities, performance or payment conditions, and safeguards against duplicate payment. The proposal must explain why the payment would not replace or duplicate a service reimbursable by Medicaid, Medicare, commercial insurance, or another funding source. Provider payments are not automatically approved. HCA will review any proposed arrangement and, for a proposal HCA seeks to advance, obtain required CMS approval before the payments may be made. Provider payments are also subject to a 15 percent program-wide limit for each CMS budget period; this is not a 15 percent allowance for each RHIF award. They may not be used to alter existing fee schedules, pay patient cost sharing, duplicate billable services, or provide prohibited clinician salary or wage support.
84	Where can we find those HCA and CMS approved and compliant payment limits? This comes up again in 5. Cost Proposal, d. CMS-Limited Cost Summary which reads: Costs	"Provider payments" are payments made to a health care provider for furnishing health care items or services. This may include direct payments or incentives tied to defined services, participation requirements, milestones, or performance outcomes. Not every payment made to a provider organization is a provider payment; costs for allowable equipment, technology, training, workflow

	subject to CMS limits, restrictions, or prior approval are clearly identified; what are the CMS limits?	implementation, data activities, or other nonclinical project work are classified according to the nature of the activity. An Offeror may propose provider payments but must separately identify and justify them in the Cost Proposal, including the proposed recipients, payment methodology, eligible activities, performance or payment conditions, and safeguards against duplicate payment. The proposal must explain why the payment would not replace or duplicate a service reimbursable by Medicaid, Medicare, commercial insurance, or another funding source. Provider payments are not automatically approved. HCA will review any proposed arrangement and, for a proposal HCA seeks to advance, obtain required CMS approval before the payments may be made. Provider payments are also subject to a 15 percent program-wide limit for each CMS budget period; this is not a 15 percent allowance for each RHIF award. They may not be used to alter existing fee schedules, pay patient cost sharing, duplicate billable services, or provide prohibited clinician salary or wage support.
85	Section D. Allowable Use of Funds has a bullet that reads: 10. Limited Administrative Costs necessary to manage the project, subject to applicable limits. What are the applicable limits for administrative costs?	The applicable federal limitation is a 10 percent program-wide cap on administrative costs, including both direct and indirect administrative costs. This is a statewide RHT Program limit and does not create an automatic 10 percent allowance for each RHIF award. Offerors should budget only those administrative costs that are necessary, reasonable, allocable, and clearly justified for the proposed project. Administrative costs may include general award management, executive oversight, accounting, payroll administration, procurement and contract administration, invoicing, compliance, audit support, and reporting performed primarily to meet HCA or federal grant-management requirements. HCA will review proposed administrative costs across the RHIF portfolio and may reclassify, reduce, or negotiate costs during budget review. The final allowable administrative amount for each award will be reflected in the HCA-approved budget. Use of a negotiated indirect cost rate or the 15 percent de minimis rate does not provide an additional allowance above the applicable administrative-cost limitation.
86	What will reporting constitute for the grant, if awarded?	Reporting requirements and submission mechanisms are currently being designed and will be incorporated into the final contract. The frequency, format, content, performance measures, and method of submission may be modified at HCA's discretion based on project-specific needs and applicable CMS requirements. Awardees should anticipate regular programmatic and financial reporting addressing project activities, milestones, deliverables, populations served, performance measures, expenditures, partner

		or subcontractor activities, implementation challenges, corrective actions, and sustainability. Awardees will also be required to maintain supporting documentation for monitoring, audit, and closeout and may be required to submit a final project and financial report.
87	iii. Proposed Innovation Project — we are asked to identify community needs. We understand needs specific by our consumers, but would it be helpful to also reflect city, county or statewide findings to reflect how we are also understanding the broader need as outlined in our project?	Yes. Offerors may use city, county, regional, or statewide findings to provide context and corroborate needs identified by consumers and the communities to be served. Relevant information may include demographic and health indicators, service utilization, access barriers, workforce or provider shortages, travel distances, wait times, and gaps in available services. The proposal should clearly explain how the broader findings relate to the specific target population, geographic area, and proposed project. Broader data should complement—not replace—direct evidence of locally identified need, such as consumer feedback, community engagement, organizational service data, partner input, or other information specific to the population being served. RHIF is intended to support locally tailored projects grounded in community priorities.
88	Someone in the preproposal conference today asked about alignment with Senate Bill 3 and some other state funding. I didn't quite understand the question or the response that HCA will be "mindful of the overlap of State funding requirements". Is there something we should be reviewing to understand this more clearly in drafting a proposal?	Please see the responses to Questions 26, 27, and 65. The reference to Senate Bill 3 and other State funding relates to HCA's responsibility to ensure that RHIF funds do not duplicate, supplant, or replace activities or costs supported by another State, federal, or local funding source. Offerors are not required to conduct a comprehensive review of every State funding program. However, they should review any funding opportunity, award, or pending application that is relevant to their proposed project, including funding available through Senate Bill 3, the Rural Health Care Delivery Fund, other RHT initiatives, or another HCA program. The proposal should disclose relevant current, pending, or anticipated funding and explain how the RHIF request is distinct in terms of its activities, costs, populations, geographic area, deliverables, and funding period. Similar goals or complementary activities are not automatically considered duplication, but the same activity or cost may not be charged to more than one funding source. HCA will review proposed projects and available State funding to identify and resolve potential overlap before an award is finalized.
89	Regarding the possibility of writing a proposal specific to transportation: We have individuals in services who request assistance with scheduling and attending appointments, including	How the New Mexico Department of Transportation (NMDOT) should be represented depends on its role in the proposed project. If NMDOT is only a current or prior funding source for vehicle acquisition, the Offeror should disclose that support as other funding or an in-kind resource and explain how the RHIF request is distinct and does not duplicate those costs. NMDOT would not

	transportation, which we currently support but do not get reimbursed for. We work with NMDOT but mostly for the acquisition of vehicles. How would NM DOT need to be represented?	need to be identified as a funded partner unless it will perform project activities or receive RHIF funds. If NMDOT will actively coordinate transportation planning, referrals, vehicle use, data sharing, or other implementation activities, it may be described as an unfunded partner or collaborator. If NMDOT or another transportation entity will receive RHIF funds, its role, scope, and costs must be included in the proposal and Cost Proposal under the appropriate funded-partner or contractual category. A transportation-focused proposal may include allowable coordination, scheduling, technology, equipment, or other project costs, but it must distinguish those activities from transportation services reimbursable through Medicaid, another payer, or another State or federal program. Any vehicle purchase would be subject to the equipment requirements and prior HCA approval described in the responses to Questions 40 and 71.
90	Please confirm that RHIF funds may support the monitoring platform, devices, onboarding, non-billable care-coordination and navigation time, and monitoring furnished to uninsured or underinsured patients, consistent with Section IV.D.6 and IV.B.6.	Potentially. RHIF funds may support an approved monitoring platform, patient devices, technology onboarding, and non-billable care-coordination or navigation activities when those costs are necessary to implement the proposed project, directly benefit eligible rural, frontier, or Tribal communities, and are not reimbursable through Medicaid, Medicare, private insurance, or another payer. Technology-enabled models supporting remote monitoring, care coordination, and patient navigation are identified as eligible project types. Clinical monitoring services furnished to uninsured or underinsured patients are not automatically allowable solely because the patient lacks adequate coverage. If the proposed monitoring constitutes patient care, clinician compensation, or a direct provider payment, it must be separately identified and may require HCA and CMS approval. RHIF funds may not duplicate available insurance reimbursement, pay patient cost sharing, or subsidize routine clinical operations. Offerors should distinguish the platform, devices, onboarding, navigation, nonclinical monitoring support, and any clinical services in the scope and budget and explain the reimbursement status and sustainability of each component.
91	Where remote fetal monitoring is not reimbursable by Medicaid, Medicare, or a commercial payer for the population served, please confirm that funding the monitoring service does not constitute duplication or supplantation under Section IV.E.3 and E.4.	If remote fetal monitoring is not reimbursable by Medicaid, Medicare, commercial insurance, or another payer for the population served, and the same service or cost is not supported by another funding source, RHIF funding would generally not constitute duplication of payment. However, non-reimbursability alone does not make the cost automatically allowable. Payment to a health care provider for furnishing remote fetal monitoring would generally constitute a provider payment. Any such

		payment must be separately identified and justified in the proposal and would be subject to HCA review, required CMS approval, and the applicable 15 percent program-wide provider-payment limitation. CMS will make the final determination regarding allowability. The Offeror should separately identify the technology platform, devices, onboarding, nonclinical support, and clinical monitoring services in the scope and budget. The proposal must also explain how the monitoring service will be sustained after RHIF funding ends, particularly if no ongoing reimbursement mechanism is available.
92	Please clarify the process and standard for the "expressly approved by HCA/CMS" exception in Section IV.E.4, including whether Provider Payments in the CMS-Limited Cost Summary would be the mechanism.	Yes. The **Provider Payments** line in the CMS-Limited Cost Summary is the mechanism Offerors should use to identify proposed payments to health care providers for furnishing health care items or services. The Offeror must also separately describe and justify the payment structure in the proposal and budget narrative, including the recipients, services or activities funded, payment methodology, amount, eligibility or performance conditions, and safeguards against duplication. Inclusion in the Cost Summary identifies the request for review; it does not constitute approval. HCA will evaluate whether the proposed payments: • Address a documented gap in care or transform the existing care-delivery model; • Support services that are not otherwise reimbursable and do not duplicate billable services; • Do not alter existing payer fee schedules or replace another available funding source; • Are necessary, reasonable, sustainable, and aligned with the approved project; and • Can be accommodated within the 15 percent program-wide provider-payment limit for the applicable CMS budget period. For a proposal HCA seeks to advance, HCA will submit the required justification and budget information to CMS through the applicable approval or budget-modification process. Offerors will not seek CMS approval directly. CMS retains final authority to determine whether the proposed provider payments or direct health care services are allowable. No provider payment may be implemented or incurred unless it is included in the final HCA-approved budget and all required CMS approvals have been obtained in writing.
93	We currently are in year three of our HCA rural health funding although the grant funds in year three are much lower. For example, we only have $3,000 in grant funds for the year for our mobile health unit. This was due to our projected	Please see the responses to Questions 26, 27, and 65. An organization that currently receives Rural Health Care Delivery Fund or other HCA funding may apply for RHIF. However, RHIF may not be used simply to replace reduced grant funding, cover an existing project's operating deficit, or backfill patient-revenue projections that were not achieved.

	patient revenue although we lost year one of the projects due to timing, so we are very behind in our projections. Could we write to have additional grant funding to help cover the expenses of this project? Also, we applied for several projects through the sustainability funds. Can we apply for similar projects under this funding since we haven't received notification regarding the sustainability funding? If so, and we were awarded through the sustainability funding, could we then respectfully withdraw from this funding?	A proposal may request support for a distinct expansion, innovation, equipment purchase, technology component, or other allowable project activity associated with the mobile health unit, provided the Offeror clearly identifies the existing award, explains how the RHIF-funded scope and costs are different, and demonstrates that the request does not duplicate or supplant current funding or reimbursements. An Offeror may also apply for a similar project while another HCA funding application remains pending. All pending applications and potential areas of overlap must be disclosed. If the Offeror later receives another award supporting the same activities or costs, it must promptly notify HCA and withdraw or revise the RHIF proposal or award, as applicable. The same cost or activity may not be funded through both programs.
94	Can you please clarify how HCA intends to treat ownership in the following cases: 1. **Licensed software / SaaS platforms** procured with RHIF funds 2. **Custom-built software or platform functionality** developed using RHIF funds 3. **Underlying intellectual property**, including source code, configurations, and documentation 4. **Data ownership and access rights** for data collected or generated through the platform 5. Whether ownership remains with HCA only during the contract term, or whether it may transfer to the awardee upon successful completion 6. Whether applicants should assume any specific contractual terms related to technology ownership when preparing their proposals	Technology ownership will depend on the nature of the proposed acquisition and the terms approved in the final contract: 1. Licensed software or Software-as-a-Service (SaaS). The software and underlying intellectual property would ordinarily remain the property of the vendor or licensor. RHIF funds may purchase approved subscription, license, implementation, configuration, support, and data-access rights. The proposal should identify the license period, authorized users, renewal costs, data-export rights, and how continued access will be sustained after RHIF funding ends. 2. Custom-built software or functionality. Software, configurations, documentation, interfaces, or other work products developed specifically with RHIF funds may be considered materials developed under the agreement and subject to State ownership under Appendix E. HCA may consider an alternative licensing arrangement when appropriate, but it must provide HCA and the awardee sufficient rights to use, maintain, access, transition, and sustain the funded solution. 3. Underlying intellectual property. Pre-existing source code, tools, frameworks, methodologies, and other intellectual property are not automatically transferred merely because they are used in the project. Offerors should clearly identify all pre-existing and third-party intellectual property and distinguish it from functionality, configurations, documentation, and other materials developed with RHIF funds. 4. Data ownership and access. Data rights will depend on the source and type of data and applicable privacy, security, consent, and data-sharing requirements. The final contract may require HCA access to project data, reports,

		performance information, audit documentation, and appropriately protected aggregate or de-identified data needed for program oversight and CMS reporting. Proposals involving technology should describe data ownership, hosting, access controls, portability, retention, export, destruction, and transition procedures. There is no automatic transfer to the awardee at successful completion for software, intellectual property, or data rights. Any ownership transfer or continuing license must be expressly stated in the final contract. The equipment-transfer approach described elsewhere in the Questions and Answers should not be assumed to apply to software or intellectual property. Offerors should prepare proposals based on Appendix E and identify any requested deviation, alternative ownership arrangement, or license-based approach in their proposal, with specific alternative language and an explanation of its purpose and impact. HCA may consider proposed alternatives during contracting, but applicants should not assume that an exception will be approved.
95	If our organization was included in a regional request under Healthy Horizons, may we still apply for funding under the Rural Health Innovation Fund, as long as it is for a different project?	Yes. An organization's inclusion in a Healthy Horizons regional proposal does not prevent it from applying for RHIF funding for a separate project. The RHIF proposal should disclose the organization's anticipated Healthy Horizons role and clearly distinguish the proposed scope, activities, costs, deliverables, target population, and funding period. Similar or complementary goals are not automatically considered duplication, but the same activity or cost may not be funded through both initiatives. If the Healthy Horizons arrangement is finalized after the RHIF proposal is submitted, the Offeror must notify HCA of any resulting overlap and revise the RHIF scope or budget as necessary.
96	For behavioral health access expansion projects, may RHIF funds support a licensed clinical lead or therapist for non-reimbursable project implementation functions such as clinical workflow development, protocol development, supervision, staff training, consultation, care coordination oversight, quality assurance, and CQI?	Potentially. RHIF funds may support a licensed clinical lead or therapist for discrete, non-reimbursable project implementation activities when the work is directly tied to the approved project and is not part of routine clinical operations or patient care. Allowable functions may include project-specific workflow and protocol development, staff training, technology implementation, quality assurance, and continuous quality improvement. Clinical supervision, consultation, or care-coordination oversight may be allowable only when it supports project implementation and is not patient-specific, billable, or required for the routine delivery of clinical services. The proposal and budget should clearly describe the functions, level of effort, and allocation methodology and should separately document implementation time from clinical service delivery. RHIF

		funds may not support therapy, patient-specific clinical consultation, routine clinical supervision, clinician coverage, or other services reimbursable through Medicaid, Medicare, commercial insurance, or another payer.
97	Can one Lead Offeror submit more than one RHIF application if each proposal is for a distinct project? If yes, will each application be evaluated independently, and does HCA anticipate limiting the number of awards to a single organization?	Yes. A Lead Offeror may submit more than one RHIF proposal if each submission is for a distinct project. Each project must be submitted separately through Submittable with its own complete proposal, budget, workplan, performance measures, and required forms. Each responsive proposal will be evaluated and scored separately under the published evaluation criteria. However, HCA may also consider the Offeror's combined organizational capacity, potential duplication, geographic and project diversity, portfolio balance, program priorities, and the total amount of funding proposed across its applications. HCA has not established a fixed limit on the number of awards that may be made to one organization. HCA reserves the right to limit awards to a single Offeror or affiliated Offerors based on funding availability, applicant capacity, geographic distribution, project diversity, portfolio balance, and the best interests of the State.
98	Is there an anticipated minimum or maximum award amount per project, or an expected reasonable range for community-based behavioral health access projects?	Please see the responses to Questions 28, 48, 63, and 74. HCA has not established a minimum, maximum, average, or expected award range for community-based behavioral health access projects. Offerors should request the amount necessary and reasonable to implement the proposed project during the award period. The budget should be proportionate to the documented community need, proposed scope, anticipated number of individuals served, implementation readiness, expected outcomes, organizational capacity, and sustainability plan. Final award amounts will depend on the proposals received, evaluation results, allowable-cost review, available funding, and HCA's overall project portfolio. HCA may fund all or part of a proposed project or negotiate revisions to the scope and budget before award.
99	Should applicants budget only for the initial project period of October 2026 through September 2027, or may applicants describe/budget optional continuation activities if HCA extends the contract?	Applicants should budget only for the initial project period of October 2026 through September 2027. The Cost Proposal and workplan should include only the activities and costs proposed for that period. Applicants may describe potential continuation, expansion, or future-year activities in the project narrative and sustainability plan, but those activities should be clearly distinguished from the initial funded scope and should not be included as requested costs in the current Cost Proposal.

		Any continuation funding would require a separate HCA review and approval process and would be subject to available funding, CMS approval, satisfactory performance, continued need, and an updated scope, workplan, and budget. Applicants should not assume that the contract will be extended or that continuation funding will be available.
100	For community behavioral health projects, are peer support, recovery support, case management, care navigation, outreach, engagement, and referral coordination considered allowable Direct Program Delivery Costs when they are not otherwise reimbursable?	Potentially. Peer support, recovery support, case management, care navigation, outreach, engagement, and referral coordination may be classified as Direct Program Delivery Costs when they are participant-facing activities necessary to implement the approved project and are not reimbursable through Medicaid, Medicare, commercial insurance, or another payer. RHIF expressly contemplates community-designed projects that improve behavioral health and substance use disorder access. The Offeror must demonstrate that the proposed activities are not billable, do not duplicate or supplant existing funding, and are distinct from routine organizational operations. Costs should be categorized according to how the activities will be delivered, such as Personnel and Fringe Benefits for the Lead Offeror's project staff or funded-partner or contractual costs when another organization will perform the work. Non-reimbursability does not automatically make every activity allowable. Clinical services, clinician compensation, or payments to a health care provider for furnishing services may constitute provider payments and remain subject to applicable HCA and CMS review and approval requirements.
101	May RHIF funds support services or supports for uninsured or underinsured clients when those costs are not reimbursable by Medicaid, Medicare, commercial insurance, or another payer? If yes, what documentation or approval is required?	Potentially. RHIF funds may support services or other participant-facing supports for uninsured or underinsured individuals when the activities are allowable under the RFP, address a documented gap, are not reimbursable by Medicaid, Medicare, commercial insurance, or another payer, and do not duplicate or supplant another funding source. Non-reimbursability or a patient's insurance status alone does not make a cost allowable. Nonclinical supports—such as outreach, navigation, referral coordination, engagement, and other approved project activities—may be treated as Direct Program Delivery Costs through the standard HCA budget-approval process. However, payment to a health care provider for furnishing health care items or services generally constitutes a provider payment and must be identified in the CMS-Limited Cost Summary. Such payments require HCA review and CMS approval and are subject to the applicable 15 percent program-wide limitation. CMS retains final authority to determine whether proposed direct health care services are allowable. The proposal should document:

		• The specific service or support and the population to be served; • The basis for determining that the cost is not reimbursable; • The proposed recipient and payment methodology; • How eligibility and services will be documented; • Safeguards against duplication, supplantation, and payment of patient cost sharing; and • How the activity will be sustained after RHIF funding ends. No direct health care service or provider payment should be incurred until it is included in the final HCA-approved budget and all required CMS approvals have been obtained.
102	How does HCA define Provider Payments under this RFP, and would payments for non-reimbursable behavioral health access supports, care coordination, or gap services fall under that category?	Please see the responses to Questions 84, 89–91, 99, and 100. HCA applies the CMS definition of Provider Payments: payments made to a health care provider for furnishing health care items or services. Classification depends on the recipient and the activity being funded—not solely on whether the service is reimbursable. Accordingly: • Payments to a health care provider for behavioral health treatment, clinical monitoring, patient-specific clinical consultation, clinical care coordination, or other health care items or services would generally be considered Provider Payments, even when the service is not reimbursable. • Nonclinical outreach, engagement, navigation, referral coordination, peer or recovery support, and similar access activities may instead be classified as Direct Program Delivery Costs when they are performed as approved project activities and do not constitute health care items or services. • A payment to a provider organization for equipment, technology, training, workflow implementation, data activities, or other nonclinical work is not automatically a Provider Payment; the underlying purpose of the payment controls the classification. Non-reimbursability may help demonstrate that a payment does not duplicate insurance reimbursement, but it does not by itself determine classification or allowability. Proposed Provider Payments must be separately identified in the CMS-Limited Cost Summary, justified in the proposal and budget, approved by HCA and CMS before implementation, and accommodated within the applicable 15 percent program-wide limit. CMS retains final authority to determine whether the proposed payment is allowable.
103	What award-level administrative cost limit should applicants use for budgeting? Should applicants assume less than 10%, since the	HCA has not established a uniform award-level administrative cost percentage. Applicants should budget only the direct and indirect administrative costs that are necessary, reasonable, and allocable to their proposed project.

	10% administrative cap is statewide and not an automatic award-level allowance?	Applicants should not treat the statewide 10 percent cap as an automatic 10 percent allowance for each RHIF award. Administrative costs should be minimized and may need to be budgeted below 10 percent to preserve HCA's ability to remain within the program-wide limitation. HCA will review administrative costs across the RHIF portfolio and may reclassify, reduce, or negotiate proposed costs before award. The final allowable administrative amount will be established in each awardee's HCA-approved budget.
104	How should applicants classify project-specific data collection, evaluation, CQI, reporting, and performance monitoring - Direct Program Delivery or Administrative Costs?	Classification depends on the purpose of the activity. Project-specific data collection, evaluation, continuous quality improvement, performance monitoring, and reporting may be classified as Direct Program Delivery Costs when they are necessary to implement, assess, refine, or measure the approved project and are tied to its participants, activities, outputs, or outcomes. General grant administration—such as preparing invoices, maintaining award records, contract compliance, audit support, and routine reporting required solely for HCA or CMS oversight—should be classified as an Administrative Cost. When staff or systems support both functions, applicants should use a reasonable and documented allocation methodology and avoid charging the same cost to both categories. HCA may reclassify costs during budget review based on the underlying function.
105	Will an organization with past or current audit delays be disqualified?	No. Past or current audit delays will not automatically disqualify an organization. HCA will consider the circumstances of the delay, the organization's current financial condition, the status of any outstanding audits or findings, corrective actions taken, and the organization's capacity to manage federal funds and comply with reporting and audit requirements. The Offeror should disclose any material audit delay or unresolved finding and provide available documentation explaining its status. Failure to submit the required financial information, address significant unresolved concerns, or demonstrate financial and administrative capacity may affect HCA's responsibility determination or ability to make an award.
106	If our organization was included in a regional request under Healthy Horizons, may we still apply for funding under the Rural Health	Please see the response to Question 94. Yes. An organization's inclusion in a Healthy Horizons regional proposal does not prevent it from applying for RHIF funding for a separate project.

	Innovation Fund, as long as it is for a different project?	The RHIF proposal should disclose the organization's anticipated Healthy Horizons role and clearly distinguish the proposed scope, activities, costs, deliverables, target population, and funding period. Similar or complementary goals are not automatically considered duplication, but the same activity or cost may not be funded through both initiatives.
107	Will awardees be treated as contractors or subrecipients under the resulting agreement? This determination affects our financial reporting requirements, audit exposure under 2 CFR Part 200, and how we structure partner agreements. The call deferred this to written follow-up.	HCA anticipates that RHIF awardees will be treated as subrecipients for federal grant-management purposes because they will carry out an approved portion of the Rural Health Transformation Program and have responsibility for implementing community-designed projects. The resulting State agreement may use the term "Contractor" or similar State contracting terminology, but that label does not determine the federal classification. The substance of the relationship will control under 2 CFR 200.331. Awardees should therefore prepare to comply with applicable 2 CFR Part 200 requirements, including federal cost principles, financial and performance reporting, records retention, monitoring, audit requirements, and the Single Audit requirements when the applicable federal expenditure threshold is met. Relationships between the awardee and other participating entities must also be classified based on their substance. An entity carrying out a portion of the approved RHIF project with programmatic responsibility would generally be treated as a subrecipient, while an entity providing goods or services for the awardee's use would generally be treated as a contractor. HCA will confirm applicable classifications during pre-award review and contracting and will incorporate the required federal terms into the resulting agreement.
108	The call noted that ownership terms for technology and equipment in final contracts are unresolved. For a SaaS platform deployment: does the state's standard contract (Appendix E) assert any ownership, licensing, or data rights over the technology platform itself? Or do standard terms cover only the deliverables and data generated during the performance period?	Please see the response to Question 93. Section 11 of Appendix E, Product of Service—Copyright, broadly provides that materials developed or acquired under the agreement become State property. It does not expressly distinguish between a pre-existing Software-as-a-Service (SaaS) platform, project-specific deliverables, custom development, or data rights. For a SaaS deployment, HCA does not intend the standard provision, by itself, to transfer ownership of a vendor's pre-existing platform, underlying source code, tools, or other pre-existing intellectual property merely because the platform is licensed or deployed using RHIF funds. Those assets would ordinarily remain subject to the vendor's licensing terms. However, project-specific configurations, interfaces, custom functionality, documentation, reports, and other materials developed or acquired with RHIF funds may be subject to the Appendix E ownership provision unless different terms are included in the final contract. Appendix E does not independently resolve all questions concerning ownership, access, hosting, portability, retention,

		security, and disposition of data collected or generated through a platform. Those requirements will be addressed through the final contract and, where applicable, data-use, privacy, security, or licensing terms. HCA will require access to the data and reporting information necessary for program oversight, audit, evaluation, and CMS reporting. Offerors should clearly identify pre-existing and third-party intellectual property, distinguish it from RHIF-funded deliverables, describe proposed licensing and data-access terms, and submit any requested contract deviation with specific alternative language. HCA will review proposed arrangements based on the particular project, but Offerors should not assume that a requested exception will be approved.
109	Is the New Mexico Business Tax Identification Number (BTIN) required at time of proposal submission, or only at contract execution/award? If required at submission, what is the acceptable documentation format?	Please see the responses to Questions 37 and 78. A New Mexico Business Tax Identification Number (BTIN) is requested at proposal submission only if applicable and available. The RFP identifies the BTIN field as conditional rather than a universal submission requirement. An Offeror that already has a BTIN should enter the number in the applicable Submittable field and include it in the Letter of Transmittal. No separate supporting document is required unless requested by HCA. An Offeror that has not yet obtained a BTIN may enter "Pending" or "Not yet issued," where the field permits. A selected Offeror must complete any required New Mexico registration and provide its BTIN before contract execution and payment.
110	The RFP requires three years of audited financial statements. For organizations that do not yet have three full fiscal years of audited financials, what alternative documentation of financial stability is acceptable? Can internally prepared financial statements, a CPA-reviewed statement, or a letter of solvency substitute?	Please see the responses to Questions 36, 51, and 66. The RFP does not require an organization to obtain three new independent audits solely for this proposal. Offerors should submit their most recent independent audit, if available, together with the financial information available for the preceding fiscal years. For organizations that do not have three full fiscal years of audited financial statements, acceptable alternatives may include: • CPA-reviewed or compiled financial statements; • Internally prepared balance sheets, income statements, and cash-flow statements; • Budget-to-actual reports; • Recent tax returns or equivalent governmental financial records; • Documentation of available cash, credit, reserves, or other liquidity; and • Other reliable records demonstrating the organization's solvency and capacity to manage the proposed award. A letter of solvency may be included as supporting documentation, but it generally should not be submitted as the sole evidence of

		financial stability. HCA may request additional documentation or clarification if the materials provided are insufficient to evaluate the Offeror's financial condition and capacity.
111	The call indicated there is currently no optional upload section in Submittable for supplementary materials such as letters of support, but that this could potentially be amended. Has a decision been made on whether to add this? If not, what is the preferred method for submitting partner letters of support: embedded in the proposal narrative or submitted separately?	Yes. HCA will amend the application materials and update Submittable Form 2 to include an optional upload field for partner letters of support, commitment letters, and memoranda of understanding. Applicants should submit these materials through the designated upload field once it becomes available rather than embedding them in the proposal narrative. The proposal must still independently describe each partner's role, responsibilities, contributions, and level of commitment. Partner letters are optional and do not replace the three required organizational references or any required proposal content. HCA will notify applicants when the amendment and updated Submittable form are available.
112	The call distinguished between billable clinical services (which RHIF cannot duplicate) and non-billable setup and support time (which may be includable). For a technology implementation project, can the budget include the following costs: workflow discovery and co-design sessions with clinical staff, staff time for user acceptance testing, and protected non-billable hours for champion and trainer development at partner sites?	Potentially. Workflow discovery and co-design, user acceptance testing, and champion or trainer development may be included as Direct Program Delivery Costs when they are project-specific, necessary for implementation, non-billable, reasonable, and not supported by another funding source. Clinical staff time may be allowable when it is limited to discrete, nonclinical implementation activities and is separately documented from patient care, routine operations, and reimbursable services. RHIF funds may not be used to compensate for lost clinical revenue, maintain clinical coverage, or support billable patient-care time. The proposal should identify the participating staff, activities, estimated hours, rates, deliverables, and allocation methodology. Lead Offeror staff should generally be budgeted under Personnel and Fringe Benefits; payments to partner sites should be included under the appropriate funded-partner or contractual category. HCA may reclassify proposed costs during budget review based on the underlying activity.
113	The call indicated flexibility for smaller organizations with cash-flow constraints. What is the process for requesting advance payment rather than reimbursement? Is this decided at the application stage, the contract negotiation stage, or post-award?	Applicants anticipating cash-flow constraints should identify the need for advance payment in their proposal and explain the estimated amount, timing, and why reimbursement would create an implementation barrier. The request is not approved through proposal submission alone. HCA will determine the payment method during pre-award review and contract negotiation based on the organization's financial systems, cash-management procedures, risk assessment, project schedule, and anticipated cash needs. The final contract may

		provide for reimbursement, milestone-based payments, advance payments, a working-capital advance, or a combination of methods. For awardees treated as subrecipients, HCA will apply 2 CFR 200.305. Advance payments must be limited to the minimum amount needed and timed to actual, immediate project cash requirements. When the requirements for advance payment are not met, reimbursement may be used; a working-capital advance may be considered when reimbursement is not feasible because the awardee lacks sufficient working capital. An awardee may raise an unanticipated cash-flow issue after award, but it should not assume that the payment method will be changed without HCA review and written approval.
114	The reference questionnaire is due July 20 via Submittable. Can you confirm: are references scored as part of the 550 technical points, or are they evaluated pass/fail for responsibility determination only? And is there a minimum number of references required, or is three the recommended number?	Three organizational references are required, not recommended. Each reference must be for the Lead Offeror. Failure to identify three references may result in the proposal being deemed nonresponsive, and failure of one or more references to submit the questionnaire by the deadline may affect the evaluation. References are not assigned a separate numerical point value under the published evaluation point summary, but they are not evaluated solely on a pass/fail basis. Completed questionnaires become part of the proposal and may be considered in evaluating the Offeror's organizational capacity and experience, as well as in HCA's responsibility determination. HCA may also contact references to validate the information provided. All three references should submit their completed questionnaires through Submittable by 5:00 p.m. MDT on July 20, 2026.
115	What is the accepted method for demonstrating that the proposed service area meets HRSA rural designation requirements? Is a screenshot from the HRSA Rural Health Grants Eligibility Analyzer acceptable, or does HCA require a specific format?	HCA does not require a specific certification form or documentation format. Offerors should identify the communities, counties, Tribal areas, and—where applicable—specific service addresses or census tracts included in the proposed service area. The proposal should clearly explain how the project will serve an eligible rural, frontier, or Tribal population. A screenshot or saved result from the HRSA Rural Health Grants Eligibility Analyzer is acceptable as supporting documentation, but it is not required and does not replace the service-area information requested in the proposal. HCA may independently verify rural eligibility and request clarification or additional documentation during evaluation or pre-award review. Offerors should note that at least one census tract in every New Mexico county meets the HRSA rural definition, but not every location within each county is necessarily HRSA-rural.

116	The call encouraged applicants to propose a credible 12-month entry point while noting the longer transformation horizon. Is it acceptable — or scored positively — to include a brief narrative section describing the multi-year vision and what continuation funding would require, even if only Year 1 is being funded?	Yes. Applicants may include a brief description of the project's multi-year vision, anticipated expansion, and conditions necessary for continuation. This may help evaluators understand the project's transformational potential and sustainability, but it will not receive separate bonus points beyond the published evaluation criteria. The workplan and Cost Proposal must include only activities and costs for the initial October 2026 through September 2027 project period, and applicants should not assume continuation funding will be available. Curriculum development for a rural or remote doctoral nursing program that prepares nurse practitioners may potentially be proposed. However, this is principally a rural workforce-pipeline activity and would be evaluated carefully for duplication with Rooted in New Mexico, which specifically supports rural education and training pathways for nurse practitioners and other health professionals. An RHIF proposal would need to demonstrate that the project is a distinct, community-designed response to a documented local need; identify meaningful curriculum-development or implementation outcomes achievable within the initial project period; and explain how it differs from or complements Rooted in New Mexico. A general or statewide degree-program development proposal may be more directly aligned with the Rooted in New Mexico initiative.
117	Can funds be used to develop curriculum for a rural remote doctoral degree in nursing that would yield Nurse Practitioners?	Potentially. Curriculum development for a rural or remote doctoral nursing program preparing nurse practitioners may be proposed; however, it is primarily a workforce-pipeline activity and would be evaluated carefully for duplication with Rooted in New Mexico. That initiative specifically supports rural education and training pathways, including expanded programs for nurse practitioners and other health professionals. To be considered under RHIF, the proposal must demonstrate that the project is a distinct, community-designed response to a documented rural need and is not duplicative of activities funded or planned through Rooted in New Mexico. It should identify meaningful curriculum-development and implementation outcomes achievable during the initial project period, the rural communities and students to be served, accreditation and institutional readiness, and a sustainable plan for operating the program after RHIF funding ends. A general or statewide degree-program development initiative may align more directly with Rooted in New Mexico than with RHIF. RHIF selection is not guaranteed merely because the proposed curriculum addresses a rural workforce shortage.
118	Can funds be used to develop cancer prevention curriculum for	Potentially. RHIF funds may support development and implementation of cancer-prevention curriculum for Community

	Community Health Workers (CHWs) to provide cancer prevention education to rural community members?	Health Workers (CHWs) when it is part of a community-designed preventive care project serving eligible rural, frontier, or Tribal communities. RHIF includes preventive education and other community-based early-intervention activities within its intended scope. The proposal should explain the documented community need, evidence base, cultural and linguistic adaptation, CHW training and implementation plan, communities to be served, connections to cancer screening and follow-up resources, measurable outcomes, and sustainability. Curriculum development should be linked to implementation and community education activities achievable during the award period. If the project's primary purpose is general CHW workforce education, certification, paid training time, or career advancement, it may align more directly with Rooted in New Mexico, which specifically includes CHW training and workforce development. The proposal should also distinguish the project from cancer-prevention or chronic-disease activities supported through Healthy Horizons and avoid duplication of the same activities or costs.
119	On the pending lawsuits or lawsuits over the past 5 years question, I assume you're not talking about tort claims or med mal claims since our malpractice insurance covers those?	The disclosure is intended to identify pending or recent legal matters that may materially affect the Offeror's responsibility, financial stability, licensure, operations, reputation, or ability to perform the proposed project. It is not intended to require disclosure of every routine incident report, insurance claim, or closed tort or medical malpractice matter. However, insurance coverage does not automatically exclude a tort or medical malpractice lawsuit from disclosure. Such matters should be disclosed when they involve significant potential uninsured liability, remain pending, could affect licensure or operations, reflect a material pattern of claims, or could otherwise affect the Offeror's capacity to perform. The Offeror may briefly describe the nature and status of the matter, available insurance coverage, expected organizational impact, and any corrective or risk-management actions taken.