NC ROOTS Lead Entity Q&A Draft

North Carolina Department of Health and Human Services

Division of Rural Health

RFA Addendum 2

RFA#: 2026-NCROOTS

RFA Title: North Carolina Rural Organizations Orchestrating Transformation for Sustainability ("NC ROOTS") Hubs

Addendum#: 2

Date Issued: March 20, 2026

Purpose: This Addendum 2 serves to answer submitted questions regarding the RFA# 2026-NCROOTS. Questions have been grouped into topics and similar questions have been combined.

Q1: Can NCDHHS share a list of entities planning to apply as ROOTS Hub Leads?

A: No. NCDHHS will not make public the list of organizations submitting a Notice of Intent. The list of contracted Hub Leads will be made public by NCDHHS on the NCRHTP webpage.

Q2: Are LME/MCOs eligible to apply?

A: Yes. LME/MCOs are eligible to apply. This was clarified in the posted RFA Addendum 1.

Q3: Given Addendum 1's removal of the MCO exclusion confirmation, may a Medicaid Managed Care Organization apply as a Hub Lead entity? If so, how does NCDHHS envision managing potential conflicts of interest in subgrant distribution?

A. See response to Q2.

Q4: Can you confirm if an organization must be fully registered in SAM.gov (System for Award Management) in order to apply for and receive funding under the NC ROOTS Hub Lead application? Or does the organization just need to request the Unique Entity Identifier (UEI) but does not need to be fully registered?

A: An UEI is required for submission. Full SAM registration is not a requirement.

Q5: May an organization headquartered outside a Medicaid Standard Plan region apply as Hub Lead for that region if it demonstrates substantial operational presence and established partnerships within the region?

A: Yes. Organizations may apply for a region even if headquartered elsewhere, provided they demonstrate meaningful operational presence, partnerships, and capacity to meet all Hub Lead requirements.

Q6: What is NCDHHS's expectation regarding the minimum number of Hub Network partners an applicant must identify at the time of application versus partners added post-award?

A: Applicants should include all required partner categories listed in the RFA. Additional partners may be added during onboarding after award.

Q7: Does the 10% administrative cap apply to Hub Leads and subrecipients?

A: Yes, the 10% cap applies to administrative costs across the program including Hub Lead subrecipients. All costs must be reasonable, allocable, and necessary. Additionally see response to Q8.

Q8: Could DHHS provide examples of which costs it expects applicants to classify as administrative versus programmatic for purposes of the 10% administrative cost cap, especially for backbone staffing, community engagement, data/reporting infrastructure, contract management, technical assistance, and referral system operations?

A: For purposes of the 10% administrative cost cap, NCDHHS expects ROOTS Hubs Leads (subgrantees) and any subrecipients they partner with to classify as administrative those activities that fall within core organizational functions such as leadership and governance, financial management, human resources, information technology, internal communications and coordination, and all evaluation and monitoring. These functions typically include strategic planning, policy development, budgeting and audits, compliance oversight, HR and benefits administration, staff training, IT security and system maintenance, and internal planning and communication structures, as well as both internal and external evaluation activities. Additionally, any program component that does not directly support, fund, or affect the intended population (i.e., when the hub is responsible for managing, governing, evaluating, or monitoring that work) is considered administrative. All hub–subrecipient relationships must be approved by NCDHHS, and hubs must include the administrative costs of any subrecipients within their own administrative total. Applicants must clearly identify in their budgets which costs they consider administrative versus programmatic to support accurate review and ensure compliance with the cap. Administrative costs may appear in either direct or indirect expense categories, but total administrative spending may not exceed 10% of the award for the budget period. Evaluation will not be scored based on the specific methodology proposed in the application; instead, administrative costs will be finalized during contracting to ensure CMS approval and compliance. Complete and detailed classification of administrative and programmatic costs are required in the application narrative and budget. For federal requirements on subrecipient versus contractor determinations and pass-through responsibilities, applicants should consult 2 CFR 200.331 and 2 CFR 200.332. Salary limitations apply to all subrecipients.

Q9: May Hub Leads use a mix of subawards, contracts, stipends, and reimbursement mechanisms depending on the activity and partner type? When is a competitive downstream process expected, and when may a Hub Lead directly contract with or subaward to named anchor partners?

A: Yes, Hub Leads have the flexibility to use a mix of funding mechanisms based on the partner's role and activity type, following federal Uniform Guidance 2 CFR 200 standards: Subawards are for partners who help carry out the main goals of the grant, while Contracts are for purchasing goods or services (§200.331). Stipends are generally allowed as "Participant Support Costs" (§200.456) and Reimbursement is the

standard way both subrecipients and contractors get paid after showing proof of their expenses or completed work.

Non-government grantees should follow the guidance provided in Title 2 Part 200.317-320 when hiring contractors or procuring goods to ensure the best value, fairness and compliance with federal regulations (§200.318–.320). For subawards, competition is not strictly required but it is highly recommended if there are several qualified partners to choose from. State government grantees or Tribal organizations should follow their own procurement policies and procedures and §§ 200.318 through 200.327, whichever is the most restrictive. Hub Leads can work directly with "named anchor partners" if those partners were already identified as subrecipients in the original grant application and approved by NCDHHS. Direct (sole-source) contracting with a vendor without bidding is allowed but in rare cases, such as when no other source exists or the agency gives express permission. Additionally, see response to Q8.

Q10: Does DHHS expect the majority of initiative funds to flow through subawards, contracts, or reimbursement arrangements to network partners? Are there expectations regarding the percentage of funds that should flow to community partners or provider organizations?

A: NCDHHS does not prescribe a fixed percentage. Hubs should allocate funds based on regional needs, initiative scope, partner capacity, and equity considerations. A mix of subawards, contracts, or reimbursement arrangements is acceptable. Additionally, see response to Q8.

Q11: Section III:B Funding Restrictions includes state salary caps and federal salary limits. Please confirm that these caps apply only to portion of an individual's salary being charged to RHTP and not the portion of salary covered by other funding sources or the individual's fringe benefits.

A: State mandated salary caps apply only to the NCRHTP-charged portion. Federal salary limits apply to all federal sources utilized by the entity. The amount of salary which exceeds the federal salary limit must be paid from non-federal sources.

Q12: Do salary limitations apply to contracted vendors?

A: State salary caps and federal salary limits apply to staff of the Hub Lead entity and must be passed down to the staff of any Subrecipient or Subcontractor of the Hub Lead.

Q13: Can you provide more detail on how to apply the indirect rate to the budget if we do not have a Federal Rate established?

A: Entities without a negotiated federal indirect cost rate may elect to use the 15% rate on Modified Total Direct Costs (MTDC) in accordance with 2 CFR 200.414(f) to assist in their calculation of Indirect Cost. This must be applied consistently and documented appropriately. Existing internal cost-allocation methodologies may continue if compliant with federal cost principles. However, the 10% cap on administrative costs (both direct and indirect) must be applied to the overall budget.

Q14: Can a hub organization or its affiliates apply for and receive funding under the same regional structure they are helping administer, assuming required conflict-of-interest protections are in place?

A: Yes, provided the Hub Lead has strong conflict-of-interest controls in place and, most importantly, ensures that funding opportunities go through a competitive process.

2 CFR 200 requires good stewardship of federal funds, transparency, and arrangements that are, and appear to be, fair. A competitive process is the best way to achieve this, ensuring funds go to the most qualified organizations while creating genuine opportunities for community-based organizations to participate, which is a core purpose of federal assistance. A foundational principle of federal assistance is broadening access and strengthening community capacity. Hubs that are intentional about opening opportunities to community-based organizations, rather than concentrating resources within affiliated entities, reflect both the letter and spirit of that principle and will be better positioned to fulfill the goals of the NCRHTP.

With this in mind, prospective Hubs should demonstrate in their application how they will structure open, transparent sub-award processes and maintain appropriate conflict-of-interest policies. All sub-recipients must comply with 2 CFR 200 and work with DHHS to obtain approval of their action plans prior to implementing funded activities.

Q15: If so, what limitations or oversight requirements will apply when a hub-related entity seeks access to funds?

A: When a Hub-related entity seeks funding, the Hub must:
- follow the same documented, transparent criteria used for all partners;
- ensure recusal of any individuals with decision-making authority who have an interest in the affiliated program;
- maintain written justification demonstrating that the selection was necessary, reasonable, and met competitive or sole-source standards; and
- comply with all state and federal monitoring, documentation, and audit requirements

NCDHHS may impose additional oversight or documentation expectations to ensure fairness and avoid conflicts.

Q16: If a hub organization is also an applicant, subrecipient, or implementer of funded initiatives, what conflict-of-interest safeguards will the state require to ensure neutral and equitable funding decisions?

See responses to Q14 and Q15.

Q17: Will the state permit or encourage a neutral funding review structure, such as an independent advisory committee or third-party review body, when the hub organization may also seek funding for its own initiatives?

A: Yes. See responses to Q14 and Q15.

Q18: Can a NC ROOTS Hub Lead also serve as a Hub Network Partner and provide services to fulfill the NC RHTP initiatives?

A: Yes. A NC ROOTS Hub Lead may also serve as a Hub Network Partner and deliver services under the NCRHTP, as long as appropriate conflict-of-interest safeguards are established and fully documented.

Hub Leads are responsible for building and managing the Hub Network, onboarding providers, awarding subgrants, and overseeing implementation across initiatives. If a Hub Lead also provides services, it must:

- Maintain a separate, transparent process for evaluating, selecting, and funding service partners;
- Demonstrate that subgrant decisions are based on need, quality, and capacity, not organizational affiliation;
- Establish governance processes that prevent the Hub Lead from self-dealing or influencing funding decisions for its own programs;
- Comply with all State and federal grant management requirements.

Hubs that are intentional about opening opportunities to community-based organizations, rather than concentrating resources within affiliated entities, reflect both the letter and spirit of that principle and will be better positioned to fulfill the goals of the NCRHTP. NCDHHS may require additional oversight or documentation to ensure a fair and competitive environment for all partners participating in the Hub Network.

Q19: Hub Lead Role: The RFA sometimes describes the Hub Lead as directly implementing activities and elsewhere as coordinating partners who implement them. Does DHHS expect the Hub Lead to function primarily as a regional backbone/convener and grantmaking entity, or as a direct program operator? By initiative, where does DHHS expect direct Hub Lead implementation versus partner implementation?

A: NCDHHS expects the Hub Lead to function primarily as a regional backbone organization, responsible for governance, coordination, partner alignment, subaward management, and reporting. The Hub Network is expected to serve as the primary implementer of community-facing and clinical activities. NCDHHS allows direct Hub Lead implementation when needed to fill service gaps, support centralized functions, or where uniquely positioned. Downstream partners are expected to deliver most initiative-specific services, especially clinical and community interventions. Hubs that are intentional about opening opportunities to community-based organizations, rather than concentrating resources within affiliated entities, reflect both the letter and spirit of that principle and will be better positioned to fulfill the goals of the NCRHTP.

Q20: For the required Attachment K: FFATA Data Form, should we enter "N/A" in the "contract number" field? If not, what should we put?

A: Applicants may enter "2026-NCROOTS"; NCDHHS will update this field post-award.

Q21: Regarding letters of commitment, since NCDHHS is listed as a key network partner under Initiative 1 in the RFA (pg.19), do we need to provide a letter of commitment from NCDHHS? Additionally, do you expect letters from other NC State offices and departments, such as NC ORH, NC Medicaid, NC Dept of Public Instruction, and NC Dept of Commerce, as they were listed as key stakeholders under initiatives in the RFA? Will including these letters impact scoring in any way?

A: No, a letter of commitment from any NCDHHS entity is not required. Only letters from required network partners and community partners are needed.

Q22: In the provided budget form, there is a Subcontractor Budget Worksheet tab. If we plan to have multiple subcontractors, should we include narrative and costs for multiple subcontractors in the same Subcontractor Budget Worksheet tab, or should we create separate budget tabs for each subcontractor?

A: Applicants should not create separate budget tabs for each subcontractor/subrecipient. Per the instructions on page 10 of the posted [Applicant Budget Worksheet Instructions](#) document, "There is only one tab for all the Subcontractors. Where more than one Subcontractor exists, each line item must be subtotaled by Subcontractor." Please see the example given in the linked instruction document for how to format the budget narrative for line items shared across multiple subcontractors.

Q23: Is the April 2, 2026 application deadline only for Hub Lead applicants only?

A: Yes. Hub Lead applicants (only) must submit their application by 5pm EST on April 2, 2026.

Q24: Does NCDHHS specify required content for Letters of Commitment (Attachment A), and are there categories of partners that must be represented in the initial application?

A: Letters must identify the partner's commitments, responsibilities, and role. Required categories listed in the RFA must be included.

Q25: Is there an option for an extension for the application deadline?

A: NCDHHS has not extended the RFA deadline at this time. Applicants should assume the published deadline is final unless a subsequent RFA Addendum is issued.

Q26: Budget, Narrative Justification for Expenses requests that, "each line item must first be broken down by NCRHTP Initiative." Is North Carolina looking for a budget form by initiative or a single budget form where the single figure for Salary/Wages or Advertising is broken down by initiative in the narrative

A: Use the single provided budget form and break down each line item by initiative in the narrative.

Q27: NCROOTS-HUB-Budget Form - It is likely that hub will engage with multiple professional service contractors and multiple subrecipients in the execution of the RHTP initiatives. Should these costs be consolidated within the provided line items with detail in the narrative?

A: The narrative for those costs should be separated and must identify the service contractor where known (or else specify to be named). Subrecipients and other formal subcontracts must be entered in the Subcontractor tab of the Budget Form. Per the instructions on page 10 of the posted Applicant Budget Worksheet Instructions document, "*There is only one tab for all the Subcontractors. Where more than one Subcontractor exists, each line item must be subtotaled by Subcontractor.*" Please see the example given in the linked instruction document for how to format the budget narrative for line items shared across multiple subcontractors.

Q28: If the response includes references to external data sources, can the respondent include a table of citations as an attachment (outside of page limits)?

A: Follow RFA rules; citation tables may be added if allowed within attachment/page-limit guidance.

Q29: Should organizational chart reflect current operations or anticipated investments if organization is awarded Hub Lead role?

A: Provide both the current chart and a proposed chart showing anticipated changes if awarded.

Q30: For questions only requiring an attachment (e.g. 1-4e requesting the entity's most recent 990 or financial statement as part of Attachment B), is the respondent required to include the question header and provide a response within the section response?

A: Reference the attachment unless a narrative is explicitly requested.

Q31: Can you provide detail on the process for ROOTS Hubs to be funded through a reimbursement model? How frequently can Hubs expect to receive reimbursement? Will there be any initial seed money? Will the state provide any support for "floating" several million dollars/month throughout the grant period, for example letters of support for structured debt and/or social capital funds?

A: Funding will be provided on a reimbursement basis for costs that are allowable, allocable, and reasonable in accordance with 2 CFR 200 cost principles. Typically, NCDHHS reimburses on a monthly basis, though more frequent reimbursement cycles, such as every two weeks, may be considered if justifiable, reasonable, and mutually agreed upon. Reimbursement periods will be outlined in the awarded contract, and supporting documentation of approved expenses will be required.

NCDHHS recognizes that organizations interested in serving as a Hub may have varying financial structures and capacities. While the standard model is cost reimbursement, NCDHHS may consider advance payment options on a case-by-case basis for awarded Hubs. Applicants who believe they may need an advance are encouraged to include that in their application and be prepared to discuss it during contract negotiations.

Q32: If the hub distributes funds to subrecipients before receiving reimbursement from the state, is the hub expected to absorb that interim cash-flow burden?

A: See response to Q31.

Q33: Given the financial risk/burden and uncertainty of sustainable funding, what is the incentive of becoming an NCROOTS hub? Is there opportunity to shift the reimbursement model and provide some up front capital?

A: Becoming a ROOTS Hub provides strategic advantages, including:

- Regional leadership and policy-shaping authority
- Multi-year federal investment in backbone infrastructure
- Opportunity to steer regional workforce and care-delivery innovation

See response to Q31 for more details.

Q34: Will funds be provided in advance, on a reimbursement basis, or through milestone-based payments?

A: See response to Q31.

Q35: Will the State create an escrow account, in effect appropriating funds, to provide funding for subrecipients if conditions are satisfied by that subrecipient?

A: No. The RFA does not authorize the creation of escrow accounts or other advance-funding mechanisms. All payments will follow the standard reimbursement-based structure, consistent with federal cooperative-agreement rules.

Q36: Will the state provide any startup or advance funding to support implementation, staffing, and contracting before reimbursement begins?

A: See response to Q31.

Q37: What is the timetable for reimbursement for costs incurred to the Hub Lead?

A: NCDHHS generally processes complete, approved reimbursement requests within 30 days of receiving a complete reimbursement request with all required documentation. Contract terms may specify biweekly or monthly cycles if justified.

Q38: What is the expected reimbursement timeline?

A: See response to Q37.

Q39: What is the anticipated timeframe between submission of approved expenses and reimbursement?

A: See response to Q37.

Q40: For the required sustainability plan, does DHHS expect applicants to demonstrate committed long-term funding or formal resource commitments from partners at the application stage, or is identification of plausible future funding streams, reimbursement pathways, and institutional sustainability strategies sufficient?

A: Identification of plausible future funding streams and sustainability strategies is sufficient. Firm commitments are helpful but not required at this time. The successful applicants will be required to submit a further detailed Sustainability Plan after award (*see Anticipated Deliverables Table, pg. 15*).

Q41: Because the Regional Needs Assessment and Hub Action Plan occur after award, what level of specificity does DHHS expect in the proposed Hub Action Plan, partner-level implementation plan, and line-item budget at the application stage? May applicants budget by initiative or functional category now and finalize specific downstream awards after the needs assessment and DHHS approval?

A: Provide initiative-level plans and budgets at this stage. Downstream award details may be finalized post-assessment with NCDHHS approval. Letters of Commitment must indicate roles of proposed partners in the work and governance of the Hub.

Q42: Can the Department provide a fully completed budget narrative example?

A: NCDHHS does not have a sample budget narrative example specific to the NCRHTP. Detailed instructions and samples of generic narratives are included in the Applicant Budget Worksheet Instructions document which was posted with the RFA.

Q43: Does the Department anticipate future budget changes or reallocations between initiatives?

A: Yes. Budget reallocations may be proposed post-award pending funding and budget approvals from CMS.

Q44: Does the Department expect reserve or contingency budgeting?

A: Reasonable contingencies may be included in program lines. Unallocated reserves should be minimized and justified.

Q45: Section 4: Budget provides an Illustrative Funding table for Hub Lead GAP 1 (June. 1, 2026 - Oct. 30, 2027). Is there flexibility to move funding between the initiatives and sub-initiatives based on the needs of the region or are these amounts fixed?

A: The Illustrative Funding Table guides planning. Budget reallocations may be proposed post-award and will require NCDHHS/CMS approval. Changes to the proposed workplan and performance measures outlined in the executed contracts between NCDHHS and Hub Leads will require a contract amendment.

Q46: Section 4: Budget provides an Illustrative Funding table for Hub Lead GAP 1 (June. 1, 2026 - Oct. 30, 2027). Should the Hub lead plan to utilize all funding allocated by Region?

A: Yes. Hubs should plan to utilize the full funding allocated for their region within the defined budget period, in a manner that is consistent with the outcomes, deliverables, and compliance requirements outlined in the executed contract. In addition, awards for future budget periods are contingent upon appropriate and timely spending in prior periods, as evaluated by NCDHHS.

Q47: Section 4: Budget references the 10% administrative cap and requests that "ADMIN" be included in the budget narrative. If a staff member's time is split between administrative and programmatic / direct initiative costs should this be described only in the narrative or should that Staff members salary costs be provided on separate lines?

A: Yes. Provide separate salary lines where feasible and explain the allocation in the narrative for each.

Q48: Since the engagement of subrecipients / subcontractors will be a competitive process for the HUB, a detailed breakout of subrecipient / subcontractor costs may not be available. In that case, how should this be represented in the Subcontract Budget tab?

A: If specific subrecipient or subcontractor details are not yet available due to the Hub's competitive procurement process, applicants should use placeholders (such as "to be selected") in the Subcontract Budget tab and include reasonable assumptions. Each placeholder entry must still identify the anticipated period of performance, expected scope of work, planned method of selection, and method of accountability, along with any estimated cost breakdown available. Required elements include: the expected start and end dates of the subaward; a description of the planned services in outcome-focused terms; an explanation of how the Hub will monitor progress and performance, including who is responsible; and an estimated itemized budget with justification, including indirect costs if applicable. For federal requirements on subrecipient versus contractor determinations and pass-through responsibilities, applicants should consult **2 CFR 200.331** and **2 CFR 200.332**. See RFA Section III, Paragraph B., Funding Restrictions for limits on salary.

Q49: With certain line items representing both administrative and direct program expenses (as delineated in the narrative), for the sake of clarity would the state consider adding a total line for admin costs in the budget template?

A: No. The Budget Form is based on the fixed manner in which NCDHHS's contracts system requires budget entry.

All administrative expense line items must include the notation "ADMIN" in the budget narrative. When tabulated, the total of all administrative expenses, including any indirect costs, must not exceed 10% the total budget for the Grantee Award Period.

Q50: Can the Department define the scope covered by the "Roots Hub Lead Entity Core Funding" initiative/activity in the illustrative funding table?

A: Core Funding supports backbone functions including governance, partner onboarding, grants administration, reporting, and technical assistance.

Q51: In the illustrative funding table, what initiative/activity should elective components be funded from (e.g. would the perinatal ECHO program be funded from the ROOTS Driven Perinatal Health Access Expansion amount)?

A: Electives should be funded from the initiative most closely tied to the program objective. Elective components of Initiative 2 are included in Table 2 and Table 3.

Q52: NCROOTS hubs are expected to function on a cost-reimbursement basis. What does the Department anticipate the monthly invoicing amount/range per hub will be? Please describe the invoicing/reimbursement workflow and timelines.

A: Monthly reimbursement amounts will vary by region, initiative sequencing, and staffing levels. NCDHHS does not prescribe a target monthly reimbursement amount but the amount must be based on actual expenditures. Expenditures means payments made by the Hub Leads (including allowable reimbursements to their Subrecipients.) Encumbrances and obligations are not expenses (e.g., if the Hub Lead issues a purchase order to a vendor in the amount of $100,000, it is an obligation until a payment against that amount is actually made by the Hub Lead). Hub Leads should anticipate that expenditures will fluctuate—typically lower during early ramp-up and increasing as subrecipient activities launch.
Reimbursements follow a cost-reimbursement model:

- The Hub Lead incurs allowable costs and expends funding in accordance with their executed budget and workplan.
- The Hub Lead submits a complete reimbursement request with supporting documentation for expenses.
- NCDHHS reviews for allowability, accuracy, and alignment with approved budgets.
- Payments are typically processed within 30 days of reimbursement request approval.

More frequent reimbursement cycles (e.g., bi-weekly) may be established if justified and agreed to in contract.

Q53: Is there a set percentage or a cap percentage of the Lead Entity Core Funding that can be used on the Lead Entity? Does that answer change in future years?

A: There is no additional cap on Lead Entity Core Funding beyond the 10% administrative cap, applicable program-wide. Hubs must ensure expenditures are reasonable, necessary, and tied to backbone functions. This expectation remains consistent across award periods unless federal or state guidance changes.

Q54: What proportion of funding must be re-granted or sub-awarded to partners?

A: See responses to Q14, Q15, and Q53.

Q55: What is the timeline for announcing future years funding? How far in advance will notification be sent so funds can be committed to the work being undertaken?

A: Federal funding for future years is contingent on:

- Federal Budget Period (FBP) awards, and
- State performance and funding availability.

NCDHHS will share updated funding levels as soon as federal approvals are confirmed, typically aligned with the federal grant cycle. Hubs should anticipate annual updates and plan for adjustments in later years.

Q56: Does the State expect the Roots Hub to make all contracts contingent on future funding? This will cause a significant increase in price of services and difficulty signing contracts with a termination clause required. What timeline can hubs be assured as a notice period if funding is not approved at budgeted levels?

A: Yes. Because NCROOTS funding is contingent on federal appropriations and performance-based continuation, NCDHHS expects Hub Leads to include appropriate fiscal contingency language in downstream agreements. NCDHHS understands that contingent contracts may affect pricing and procurement but is unable to guarantee federal continuity. Hub Leads will receive notice if funding levels change, aligned with federal notices of award, budget announcements, and CMS decisions, per established FBP timelines.

Q57: Does NC have first year funds or is it a reimbursement model for the state as well?

A: Funding from CMS to NCDHHS for NCRHTP operates on a cost-reimbursement basis, consistent with federal cooperative-agreement rules.

Q58: Regarding examples of successful rural health projects (Section 1, Question 1-1.c-e), what types of metrics or outcomes (e.g., quantitative like cost savings and improved access rates, or qualitative like community engagement stories) are most valued for these examples?

A: NCDHHS values both quantitative measures (access improvements, outcomes, workforce expansion) and qualitative evidence (community engagement, collaboration).

Q59: Will the state require written recusal, disclosure, and scoring policies for hub organizations making or recommending funding decisions?

A: Yes. The RFA requires Hubs to maintain written conflict-of-interest policies, which include clear procedures for disclosure, recusals, and decision-making. Hubs must document mitigation steps and

maintain audit-ready processes to demonstrate impartial evaluation, consistent with federal procurement standards and state subcontracting expectations.

Q60: What are the expectations after funding ends?

A: As described in the RFA, Hubs are expected to design models that can be sustained through future funding streams, reimbursement pathways, or other durable supports identified during the regional planning and Hub Action Plan process. After NCROOTS funding ends, affiliated and non-affiliated partners are expected to continue operating to the extent that ongoing financing, capacity, and regional demand support the work. The RFA does not guarantee continued funding for Hub-led or partner-led initiatives after the federal award period concludes. Sustainability Plans, due within the first quarter of implementation, must outline strategies for maintaining Hub operations beyond the five-year project period, including funding diversification and long-term governance.

Q61: If a hub distributes funds to subrecipients and a subrecipient later fails to perform, comply, or meet required deliverables, under what circumstances would the hub be at risk of non-reimbursement or recoupment?

A: The Hub Lead is responsible for ensuring that all subrecipient expenditures meet federal and state requirements. If a subrecipient's costs are determined to be unallowable, unsupported, or out of compliance with the RFA, NCDHHS will seek repayment from the Hub Lead.
The Hub Lead is at risk of non-reimbursement or recoupment when the failure is tied to insufficient oversight, inadequate documentation, or non-compliance with allowable expenses, required monitoring, eligibility, and contracting requirements and processes. Recoupment may also result from audit findings.

Q62: Will participating organizations be required to disclose proprietary or competitively sensitive information, including payer contract terms, reimbursement rates, or other market-sensitive financial data?

A: State records (including RFA responses) are subject to public records requests. Confidential Information is defined in North Carolina General Statute 132-1.2. If the application contains Confidential Information in accordance with the NCGS definition, please follow the guidance in RFA Section IV, Paragraph 13, Proprietary Information, and mark the appropriate sections as "CONFIDENTIAL." Contracts initiated by awarded Hub Leads should also contain similar guidance for their subcontractors and subrecipients.

Q63: Will the state provide technical assistance or guidance related to long-term sustainability, reimbursement alignment, or transition planning for successful initiatives?

A: Yes. As with reporting and implementation guidance described elsewhere in the RFA Q&A, NCDHHS will provide technical assistance and guidance as part of contract implementation. This may include support on sustainability planning, reimbursement pathways, and alignment with long-term state priorities.

Q64: What minimum administrative, reporting, and compliance infrastructure will be expected of hub organizations, and will the administrative funding structure be sufficient to support those responsibilities?

A: See RFA Section III, Paragraph, E., Required Reporting for more guidance. Hubs must maintain administrative and reporting systems capable of meeting state and federal grant requirements, including:
- data reporting and performance tracking;
- subrecipient monitoring and compliance;

- financial management aligned with 2 CFR 200;
- procurement, contracting, and documentation standards;
- governance and partner engagement frameworks.

The RFA establishes a 10% administrative cost cap for both the Hub and subrecipients, which must cover these functions. Applicants should design staffing and infrastructure models that fit within this cap while ensuring compliance.

Q65: For paid work-based learning and tuition-free certification programs (Behavioral Health Workforce Development Certification), does this payment come from the Hub's budget or from direct NCDHHS funding?

A: These costs are expected to come from the Hub's Initiative 4 budget, unless NCDHHS specifies otherwise in future guidance. The RFA describes these as Hub responsibilities. Hub Leads may contract with training partners, including community colleges, but the costs associated with Initiative 4 should be included in the Hub Lead's overall budget and total grant amount.

Q66: For supporting program graduates who commit to 5 years of rural service (Social Work Rural Scholar Program), is this support financial? Can/should it be tied to the Rural Clinical Workforce Incentive Package? If financial, does the funding come from the Hub or the State?
At this time, for the Social Work Rural Scholar Program, support may be financial or programmatic, as the RFA does not prescribe a specific form; if the Hub chooses to provide financial support, it must comply with all federal and state cost-allowability rules, including the prohibition on loan repayment. The support may be tied to the Rural Clinical Workforce Incentive Package if this alignment strengthens rural workforce retention and is justified in the Initiative 4 strategy. Unless NCDHHS later designates a particular benefit as state-funded, the expectation is that any financial or programmatic support for graduates committing to five years of rural service will be funded through the Hub's Initiative 4 budget, consistent with the workforce development responsibilities outlined in the RFA and Initiative 4 scopes.

Q67: For the Community Doula & CHW program and the Expansion of EMS Professionals (page 35), is NCDHHS offering direct funding, or is the Hub responsible for funding training, placements, and other supports?

A: NCDHHS envisions that the Community Doula & CHW program and the Expansion of EMS Professionals will be funded by the Hubs. Unless NCDHHS issues future guidance identifying specific State-funded components, Hubs should assume these activities must be resourced directly from their own Initiative 4 budgets. Regions may elect to use Initiative 2 funds for Perinatal Health Access Expansion for implementation of the CHW-Doula Model.

Q68: Can a NC ROOTS Hub Lead contract partners it already has pre-existing relationships with to fulfill NC RHTP initiatives?

A: Hub Leads must follow the contracting and procurement practices required by State and Federal Requirements and the RFA Terms and Conditions. If the Hub Lead is a local governmental organization, it must follow Local contracting and procurement requirements using the "most restrictive rule."

Please reference the following sections of the RFA for requirements which govern how Hub Leads must further subcontract with grantees and vendors:

- Section III. C., Federal Terms and Conditions (p. 43)
- Section III.D., NCDHHS Terms and Conditions (p. 43)
- Section IV.12., Subcontracting (p. 47)
- Section VII., Attachment I State Certifications, subparagraph 2 (p. 85)
- Section VII., Attachment J Federal Certifications, subparagraph 5 (p. 87)
- Appendix A.1., North Carolina General Terms & Conditions, Subcontracting (p. 99)
- Appendix A.2., NCDHHS PSO Terms & Conditions, subparagraph 7 (p. 105)
- Appendix A.4., CMS Standard Grant & Cooperative Agreement Terms & Conditions
- Subparagraph 20 (p. 135
- Cost Principles (p. 137)
- Subparagraph 29.B. (pp. 139-140)
- Subrecipient Pass-Through Requirements (p. 145)
- Subparagraph 31 (p. 145)
- Subparagraph 32 (p. 146)

In addition to these requirements, a set of best practices must be followed to:

- Use documented, equitable criteria for partner selection.
- Ensure all required partner categories in the RFA are represented.

Document how potential conflicts of interest are mitigated.

Q69: The NCRHTP application references a "state-selected vendor" for remote patient monitoring and chronic care management services integrated with NC HealthConnex. Will this vendor selection be conducted through a separate procurement process from the Hub Lead RFA? If so, what is the anticipated timeline? What is the criteria for vendor selection?

A: Yes. NCDHHS will release details in a future announcement. Initiative 6 currently falls outside the scope of the hub lead entity per this RFA.

Q70: The RFA lists many Initiative 1 stakeholder categories. Which partner types does DHHS consider required for every Hub Network, which are strongly preferred, and which are illustrative examples only? Are there minimum expectations for Hub Network size, governance composition, or required representation by sector?

A: Hubs must show adequate coverage, how selected partners align with regional demographics and needs and governance representation.

Q71: At the time of application, what level of commitment does DHHS expect from core network partners? Are letters of commitment expected from all required partner types, or only from those expected to receive funds or hold governance roles in Award Period 1?

A: Letters of commitment are intended to demonstrate the applicant's existing depth of partnerships, especially in rural areas. Applicants are encouraged to include letters from as many core and active regional partners as are relevant to their proposed model. While there is no required minimum number of letters, applicants that demonstrate broader, well-established partnerships may be viewed more favorably during

evaluation.

At the time of application, NCDHHS expects letters from:

- Required partner categories identified in the RFA, and
- Any core partners anticipated to receive funds or hold governance roles during Award Period 1.

As the Hub is stood up, the Needs Assessment, regional planning, and development of the Hub Action Plan will naturally lead to additional partnerships. NCDHHS expects the Hub Network to expand over time as regional needs are clarified, and implementation phases mature.

Q72: Does the Department require a standardized RFA template for subrecipients?

A: NCDHHS may provide core required elements. Hub Leads may tailor templates if all federal/state terms, conditions, and requirements are retained.

Q73: For 1st Quarter Anticipated NC ROOTS Lead Entity Deliverables – Agreement/Contracts (Deliverable 3). Will model contracts/agreements be provided by NCDHHS or are ROOTS hubs expected to develop contracts/agreements? What about other initiatives such as the Draft Grants Manual (Deliverable 5) – will the Department have a framework or is each hub drafting a separate/siloed manual? Will the state develop any model contracts/agreements/frameworks to support standardization efforts across NC ROOTS hubs?

A: NCDHHS intends to provide a program guide following award detailing guidance on mandatory deliverables. NCDHHS will also provide technical assistance to Hub Leads so required terms and conditions, certifications, and requirements are passed through to subcontractors and subrecipients.

Q74: Can a hub establish a governance structure that includes neutral community, public health, academic, and non-provider stakeholders to help protect against the appearance of self-favoring allocations?

A: Yes. Hubs are encouraged to implement governance models that reflect regional representation and community trust, consistent with the RFA's emphasis on inclusive, multi-sector collaboration. Incorporating neutral stakeholders can strengthen transparency, reduce the appearance of bias, and improve regional alignment. Governance structures must still meet all federal and state oversight requirements.

Q75: What governance structure is expected to occur between the Hub Lead, state agencies, regional partners, and community organizations? What decisions are centralized vs. distributed?

A: The ROOTS governance framework described across planning documents is a shared-governance model:
Centralized at the Hub:

- regional coordination and governance functions
- grants administration and subaward processes
- reporting, data management, and monitoring
- partner onboarding, technical assistance, risk management

Distributed among partners:

- clinical and community service delivery
- workforce training and local program implementation

- community outreach and engagement
- initiative-specific models aligned to local strengths

DHHS oversight:

- statewide standards, technical assistance, reporting templates
- contract oversight and monitoring
- cross-Hub learning and statewide alignment

This structure ensures consistency while enabling local flexibility.

Q76: What role, if any, do FQHCs, RHCs, local health departments, and social services play in governance—do they have to have formal representation?

A: While the RFA does not mandate specific seats, hospitals, FQHCs, LHDs, CBOs, and others are essential partners who should be involved in governance or advisory processes appropriate to the region. Hubs should demonstrate representation that ensures balanced, rural-focused decision-making.

Q77: Will the state distinguish between hub oversight failures and subrecipient execution failures when determining financial liability?

A: No. The State has no legal relationship with any of the Hub Leads' subrecipients or subcontractors. NCDHHS's legal relationship is with the Hub Lead. The Hub Lead is responsible both programmatically and financially for oversight and execution of the NCRHTP.

Q78: If the hub followed all required contracting, monitoring, documentation, and reporting processes, will the state hold the subrecipient—rather than the hub—responsible for repayment in cases of nonperformance or misuse of funds?

A: No. See response to Q75. The Hub Lead is contractually obligated to return unearned/misused funds to the State and the Hub Leads may attempt to recoup those funds from their subrecipient that committed the misuse.

Q79: What level of monitoring and oversight will be required of the hub to reasonably protect it from financial exposure related to subrecipient actions?

A: Hubs are expected to follow federal subrecipient monitoring standards, including:

- risk assessments;
- written subaward agreements containing all required terms;
- regular financial and programmatic reviews;
- documentation of deliverables and performance; and
- corrective action when issues arise.

These expectations are consistent with 2 CFR 200 requirements referenced throughout the RFA, including 2 CFR 200, Subpart D, Subrecipient Monitoring and Management.

Q80: How will we know who our regional Hub Lead is?

A: NCDHHS will publish the list of contracted Hub Leads on the NCRHTP webpage.

Q81: Does NCDHHS envision a single statewide telehealth and virtual care platform deployed across all six Hub regions, or will each Hub Lead have autonomy to select technology partners for virtual care delivery within their region?

A: Final guidance will be provided by NCDHHS upon contract award. There is no single platform mandated at this time.

Q82: The RFA requires standardized referral pathways and asks applicants to describe systems that can be leveraged. Does DHHS expect all Hubs to use a particular statewide referral platform, or may regions use alternative systems based on existing infrastructure and regional readiness?

A: See response to Q81.

Q83: Is the state procuring any technology and, if so for what (specific to RFA and initiatives)? Unite Us was named in application but there is no detail in RFA. What are the hubs responsible for vs. UU/tech platform?

A: See response to Q81.

Q84: What are the specific interoperability and data exchange requirements for technology partners operating within Hub Networks? Does NCDHHS require FHIR compliance, HL7 integration with NC HealthConnex, or other specific technical standards?

A: Platforms must support NC HealthConnex exchange standards. FHIR, HL7, and additional standards will be described in upcoming technical guidance.

Q85: Will Hub Leads be expected to deploy consumer-facing digital health tools as part of their Hub Network infrastructure, or will Initiative 6 digital health tools be deployed centrally by NCDHHS?

A: The Hub Lead is NOT responsible for the direct implementation or oversight of digital health tools in initiative 6. Hub Leads will facilitate communication between local providers and state-led digital health programs. Digital health tools, including remote monitoring, digital literacy supports, and statewide platforms, will be developed and deployed centrally by NCDHHS through separate implementation processes. Hub Leads will support adoption by:

- Making regional providers aware of state-led digital tools
- Facilitating communication between local partners and NCDHHS digital health teams
- Identifying regional needs or barriers related to digital access

Q86: The application references an existing partnership with Hazel Health for school-based telehealth behavioral health services. May Hub Networks deploy additional or alternative school-based telehealth behavioral health providers alongside or independent of this existing arrangement?

A: No. School-based telehealth behavioral health services fall outside the scope of responsibilities for NCROOTS Hub Leads. These services are being coordinated at the state level as part of broader NCRHTP behavioral health strategy and are not a Hub-managed function. Hub Leads are not expected to select, contract with, or manage school-based behavioral health vendors, including Hazel Health or any

alternatives. Hubs may collaborate with NCDHHS and local stakeholders to ensure alignment with regional priorities, but implementation, procurement, and vendor management for school-based behavioral health remain centralized with NCDHHS.

Q87: Does the State have preferred systems/tools for use by Hub Leads?

A: NCDHHS does not mandate systems or tools at this time.

Q88: To what extent are Hub Leads expected to coordinate with other regional hubs, particularly for workforce training, specialty care access, and referral pathways that may cross regional boundaries? May the Hub formally include or fund cross-region partners when they are necessary to serve rural residents in the Hub's region?

A: Coordination is expected where service patterns cross boundaries. Cross-region contracting is permissible when justified and aligned with program rules.

Q89: Can the state clarify how a hub organization may continue advancing its own rural health strategies without creating the appearance that the program is favoring internal projects over regional partners?

A: Hubs may implement activities directly only when justified, for example, to fill service gaps, carry out centralized functions, or perform roles uniquely suited to the Hub, consistent with NCDHHS guidance on backbone responsibilities. To avoid the appearance of favoritism, Hubs must:

- document the rationale for direct implementation;
- ensure subaward criteria are uniform and transparent;
- apply COI safeguards (recusal, independent review, third-party validation where appropriate); and
- maintain governance processes demonstrating that internal initiatives do not receive preferential treatment.

This reflects NCDHHS's expectation that most initiative-specific services are delivered by downstream partners, not the Hub itself. Hub Network Partner and deliver services under the NCRHTP, as long as appropriate conflict-of-interest safeguards are established and fully documented.

Q90: How does the state envision preserving collaboration among hospitals, health systems, FQHCs, local health departments, and other rural stakeholders when one organization serves as the regional hub?

A: The NCROOTS model is explicitly designed as a multi-sector, region-wide network, not a single-entity delivery system. The Hub Lead functions as a backbone organization that convenes partners, coordinates across sectors, and supports collaboration rather than centralizing service delivery. Hubs must demonstrate inclusive engagement and facilitate collaboration across all required and optional partners.

Q91: Will the program support a model in which multiple provider organizations participate in designing and implementing regional strategies, rather than concentrating execution within a single entity?

A: Yes. NCROOTS requires a network-based implementation model. Most community-facing and clinical services are expected to be delivered by downstream partners, not by the Hub Lead itself. The Hub Lead coordinates strategy, alignment, and reporting, while partners execute services within their areas of expertise.

Q92: Can participating organizations retain their own operational models and strategic approaches to serving rural communities, provided they align with the regional plan and program goals?

A: Yes. The Hub model allows partner organizations to maintain their own operational structures. The RFA encourages leveraging existing regional capacity, partnerships, and delivery models so long as they align with the Hub's regional action plan and NCRHTP objectives. Documents describing ROOTS engagement emphasize building on existing systems rather than replacing them.

Q93: Does the hub decide what type of formal agreements are in place with partners, or will the state be providing a document template?

A: The RFA requires Hub Leads to use agreements that comply with all applicable state and federal requirements, including 2 CFR 200 rules for procurement and subrecipient management. NCDHHS may provide required elements or templates for certain documents as part of contract guidance, but Hubs are responsible for developing and tailoring their own agreements to fit their regional network. Any agreements the Hub uses must incorporate all mandatory state and federal terms and conditions.

Q94: How does the state distinguish between a permissible allocation to a hub-affiliated initiative that serves a clear regional need and an impermissible appearance of self-dealing?

A: A permissible allocation must be clearly supported by:

- evidence that the activity meets a documented regional need;
- demonstration that the Hub-affiliated entity is uniquely positioned or the most capable partner to deliver the service;
- adherence to required procurement or subaward processes, including competitive processes when multiple qualified partners exist; and transparent governance and recusal procedures so that affiliated entities do not influence their own selection or funding level.

An allocation may be viewed as self-dealing if these conditions are not met or if the justification is not clearly documented.

Q95: What shared technology infrastructure is required for the regional network?

A: The RFA requires applicants to describe how they will support technology infrastructure, including:

- data exchange and interoperability standards;
- referral management systems;
- secure data storage and privacy protocols;
- systems that comply with statewide technical guidance.

Please reference Appendix A.1., North Carolina General Terms & Conditions and Appendix A.2., NCDHHS PSO Terms & Conditions for state-specific IT and Privacy & Security requirements.

Further details will be provided in contract guidance, along with standards for interoperability and data security.

Q96: Will hubs and participating organizations have flexibility to implement locally tailored models, such as mobile clinics, telehealth networks, home-based care, maternal health outreach, and integrated chronic disease strategies, so long as they align with program objectives?

A: Yes. The RFA allows and encourages Hubs to design models that reflect regional needs and local capacity, as long as they align with NCRHTP goals and RFA requirements. Consistent with program design principles, initiatives must be evidence-based, outcomes-driven, and responsive to rural community needs. Hubs may propose locally tailored solutions such as mobile services, telehealth expansions, or chronic disease interventions as long as they support the approved initiatives and metrics.

Q97: Will there be an opportunity for stakeholders who are not Hub Lead applicants—such as technology vendors, telehealth platforms, or statewide service delivery organizations—to present capabilities directly to NCDHHS or to the Hub Lead evaluation committee?

A: No. To ensure fairness, transparency, and procurement integrity, NCDHHS cannot receive direct capability presentations specific to ROOTS Hubs Lead from vendors, technology platforms, or other stakeholders during an active competitive process. The Hub Lead evaluation committee is not permitted to engage with external entities outside the formal procurement channels.

Any procurement opportunity issued directly by NCDHHS or any other State Agency will be posted on the state's electronic procurement portal, NC e-Procurement. To bid or submit proposals for procurements, the entity must first be registered as a vendor in our vendor portal, NC eVP.

When the entity registers in NC eVP, certain categories of goods or services may be selected for which you can opt to receive automatic email notifications of posted procurements.

Q98: Will DHHS provide a standard reporting platform, data dictionary, dashboard template, or metric definitions for NCRHTP reporting? Are Hub Leads expected to collect encounter-level or clinical data from providers, or will reporting rely primarily on aggregate metrics and partner reporting?

A: NCDHHS intends to provide core metric definitions and templates. Hubs should support aggregate reporting. Final requirements will be specified in contract guidance.

Q99: Will the Department provide a standard reporting template or data dictionary?

A: Yes. NCDHHS intends to provide KPI definitions, templates, and reporting requirements. Key data reporting requirements will be submitted to a NCDHHS Data Reporting Platform.

Q100: What data elements will participating organizations be required to submit to the state and to the hub, and at what frequency (e.g., quarterly, annually)?

A: Required data elements will be tied to the NCRHTP performance metrics, initiative-specific outcomes, and contractual reporting requirements. Examples of required elements, as listed in the program's draft performance and metrics materials, include:

- metrics for Hub establishment, safety-net partner participation, referral success rates, and initiative-specific outputs;
- numerators, denominators, baselines, targets, and related data sources;
- reporting cadences such as annual, quarterly, or yearly (depending on the indicator).

The RFA states that the Hub must submit a Data Management & Network Monitoring Plan outlining how data will be collected, stored, validated, and reported. Final data elements and submission frequencies will be defined in the Hub's contract and technical guidance.

Q101: Will the state be sharing data it has access to with the hub to assist with the efforts required of the hub lead under the application?

A: Yes. The RFA indicates that the State will provide technical assistance, performance expectations, guidance, and, where appropriate, state-held data needed to support Hub functions. Distribution of state-held data will follow privacy, security, and data-use requirements included in the Hub's contract.

Q102: Does the state have data around what workforce gaps exist in the regions that the hub lead can use as it conducts its needs assessment?

A: The RFA anticipates that Hub Leads will conduct a Regional Needs Assessment, which will include workforce analysis supported by available state data sources and technical assistance. The Needs Assessment is intended to incorporate state-provided information, partner input, and regional data.

Q103: May an application focus on a single chronic disease such as sickle cell, or must it address all chronic diseases within the region?

A: Hubs must meet all RFA requirements, including all required chronic disease components, but may emphasize regional priority conditions.

Q104: Should workforce initiatives primarily focus on training, education, and pipeline development, or is DHHS also encouraging direct workforce placement and service-delivery models such as residency programs, community-based workforce models, CHWs, peer support models, or other placement-based strategies?

A: Workforce initiatives under the NCRHTP are expected to include both training and education investments (such as supporting new EMS, behavioral health, or other clinical training programs at community colleges or regional institutions) and workforce pipeline development, as well as placement-based and service-delivery models such as residencies, community-based workforce models, CHWs, and peer-support models. NCDHHS anticipates that no single model will meet all regional needs. Instead, hubs should propose a balanced portfolio of workforce strategies that:

- Build training capacity, including new or expanded academic or certification programs;
- Grow the pipeline, particularly for rural and underserved communities;
- Strengthen and deploy the workforce, including CHWs, peer supports, clinical trainees, and other personnel needed to deliver program components; and
- Are customized to the specific shortages, infrastructure, and opportunities in the region, as identified through the Needs Assessment and partner engagement.

In short, both upstream workforce development (training and pipeline) and downstream workforce deployment (placement and service-delivery) are required elements. Hubs should articulate how these combined strategies will meet the region's immediate and long-term workforce needs.

Q105: In Section III.A.2.b the RFA states there are four required components however the following narrative and table only indicate that three of the programs (Risk Factor Gap Analysis, Provider Education and Engagement Strategy, and Expand Health Care Team for Chronic Disease Prevention and Management) are required. Which programs are required and which are elective?

A: The following three programs are required: Risk Factor Gap Analysis, Provider Education and Engagement Strategy, and Expand Health Care Team for Chronic Disease Prevention and Management, and the remainder are elective.

Q106: Implementation of the Community Health Worker - Model is listed as an elective program for Initiative 2a. Initiative 4d is Coordination of the Community Doula and Community Health Worker Model. Do these describe the same model? If so, can the state confirm the Hub lead is responsible for coordinating implementation of this model even if it is not a priority program for Initiative 2?

A: Initiative 2 and Initiative 4 reflect components of the CHW-Doula model. The RFA treats these as Hub-funded elective responsibilities.

Q107: Are implementation of the Rural Clinical Workforce Incentive Package and Child Care Subsidies for Rural Clinicians mandatory?

A: These are available strategies. Unless explicitly required, hubs may propose, scope, and sequence them based on regional needs and budget.

Q108: There are required sub-initiatives for each hub to complete however there are gaps in workflow at the state or federal level (not in control of the hub). For example, the required LOCATe Analysis under Initiative 2a. This assessment can be completed at the local level but it is not staffed at the CDC level to complete the evaluation and report. How does NC plan to solve for the inability to meet specific metrics?

A: NCDHHS acknowledges that certain Initiative metrics depend on federal or state partners (e.g., CDC evaluation of LOCATe results). NCDHHS will identify an alternate pathway for support should CDC technical assistance not be available. If external capacity creates unavoidable delays, NCDHHS will:

- Document the dependency,
- Coordinate with federal partners to accelerate processing, and
- Provide updated guidance if timelines require adjustment.

Hubs should still complete the local components (data gathering, assessments) on schedule and notify NCDHHS of barriers beyond their control.

Q109: Can state confirm using AHEC and how? What will AHEC be responsible for specific to the RFA and initiatives?

A: NCDHHS encourages Hub Leads to partner with existing entities, such as regional AHECs for their workforce components.

Q110: Are hubs required to choose some of the optional initiatives?

A: Hubs must implement all required components. Optional initiatives may be selected based on regional need, partner readiness, and budget capacity. Hubs are not required to select every optional initiative and may scale or phase implementation based on Needs Assessment findings.

Q111: Can participating organizations advance initiatives that build upon their existing rural strategies and infrastructure, rather than being required to adopt a single standardized model across the region?

A: Yes. The RFA does not require a single standardized model. Partners may continue using or expanding existing operational models if these approaches align with NCROOTS program requirements and the Hub's regional Action Plan. The program's guiding principles call for leveraging existing regional capacity and avoiding duplication, while ensuring coordinated governance and measurable impact.

Q112: What are the state's expectations regarding sustainability of funded initiatives after the grant period ends, particularly for programs that improve access but may not be immediately self-sustaining?

A: NCDHHS will provide technical assistance and guidance during contract implementation to support sustainability planning, reimbursement alignment, and transition strategies. However, the RFA makes clear that regions are best positioned to determine what can be sustained with these one-time federal funds based on their local capacity, partner landscape, and long-term needs. Hub Leads are therefore expected to serve as the primary stewards of sustainability, identifying realistic future funding pathways and designing models that can transition to durable support after the grant period.

Q113: Is there an expectation to include the Hypertension Reduction Initiative and Rural Tobacco Free Futures in our proposal?

A: Not universally. These initiatives are elective activities of the state's program menu for Initiative 2, but the Hub's final selection of strategies should be based upon regional needs.

Q114: Does the workplan need to include all Initiative 2 measures (including SMBP)?

A: No. The RFA requires each Hub to complete an assessment to identify regional burden and gaps across chronic disease areas, including hypertension, tobacco use, diabetes, cancer, physical activity, and others. Strategies identified in their hub action plans should be driven by those findings, rather than applied uniformly across all regions. The assessment determines which conditions are most pressing, which evidence-based programs are under-utilized, and where regional capacity is insufficient.
Appendix B includes a broad list of NCRHTP-level success measures, some of which correspond to elective components. Hubs are responsible for reporting on and supporting only those measures tied to the Initiative 2 components they select based on the gap assessment.

Q115: Is the Hub expected to have strategies for SMBP and decreasing tobacco use regardless of the results of the gap assessment?

A: See response to Q113.

Q116: Initiative 4: Are there expectations or restrictions on using funds to incentivize clinicians beyond rural location and the prohibition on loan repayment?

A: Yes. Workforce incentive funding must comply with RFA funding restrictions, including the prohibition on loan repayment (Funding Restriction #13). Incentives must support:

- Clinicians who physically practice in rural areas,
- Development of pipeline workforce enrolled in a certificate program
- Activities aligned with workforce development goals, and
- Reasonable, allowable compensation structures under federal rules.

No specific "expected" dollar amounts are prescribed. The RFA allows incentive design flexibility as long as the costs are necessary, reasonable, and justified, and incorporated into the Hub's Initiative 4 strategy.

Q117: Will the Rural Health Innovation Fund (RHIF) competitive grants be administered through the Hub Leads, or will NCDHHS issue a separate NOFO or RFA for RHIF applicants?

A: At this time, NCDHHS plans to administer RHIF through a separate process.

Q118: Please provide a list of each county considered rural for purposes of the RHTP.

A: The RFA does not define rurality using a fixed county list. Applicants must show how they serve rural populations using factors such as access barriers, provider shortages, and population density (See RFA Section II, page 10 "Defining Rural").

Q119: If multiple organizations have credible strategies to serve similar rural communities, how should hubs evaluate those opportunities in a manner that avoids duplication while preserving access and partner trust? Would a third party or arbitrator be involved in such decisions to ensure objectivity?

A: Hub Leads are responsible to use transparent, equitable, and documented selection criteria, including the disclosure of any conflict of interest consistent with federal regulations r found in the Uniform Guidance Title 2, Part 200.113 Mandatory Disclosures and 200.318 General Procurement Standards for any subcontracting efforts. Processes highlighted across enterprise files include:

- assessing alignment with regional needs,
- avoiding duplicative efforts,
- ensuring access for rural residents across counties, and
- documenting how partners were chosen based on quality, capacity, and needs.

Q120: How do FQHCs participate?

A: Federally Qualified Heath Centers (FQHCs) may apply as lead applicants or join through partnership with their region's awarded Hub Lead.

Q121: Is June 1 the required operational start date?

A: June 1 is the projected, official contract start date. A structured ramp-up period following award will allow Hubs to build capacity before full program delivery.

Q122: In regions where Tribal populations are limited, dispersed, or not represented by a federally or state-recognized Tribal entity within the region, what level and form of Tribal engagement does DHHS expect at the application stage and during implementation?

A: Engagement should be meaningful and proportional, including outreach to Tribal communities, consultation, and documented attempts when populations are limited. Applicants may reference the North Carolina Department of Administration, Division of American Indian Affairs' Map of NC Tribal Communities to assist in the identification of State and Federally Recognized Tribes as well as Urban Indian Communities in their Region.

Q123: How does the state define key staff?

A: Key staff are roles essential to program implementation, delivery, support and compliance (e.g., Program Director, Finance/Grants Manager, Data/Reporting Lead, Initiative Leads). Applicants should identify positions, FTE allocation, and core responsibilities. Policies may define minimum role content in contract; NCDHHS may request resumes or position descriptions at award.

Q124: Does the requirement to submit key staff include staff to be hired to complete Hub Lead responsibilities?

A: Yes. Include to-be-hired roles with position descriptions, anticipated start dates, and recruitment plans. If candidates are pending, provide minimum requirements and hiring timeline; NCDHHS may require updates before contract execution.

Q125: Can the Department provide additional detail on the scoring methodology for each section (e.g. how are 195 points in Section 1 divided between subsections?)

A: No. NCDHHS will not publish a scoring rubric addendum that breaks down points by subsection.

Q126: Can the Department offer details on how RFA responses will be evaluated (i.e. review teams for each region, review teams for each section)?

A: See RFA page 50, 10. Review of Applications. Applications are reviewed by a multi-disciplinary committee of public and private health and human services subject matter specialists. Staff from applicant entities may not participate as reviewers. Applications will be evaluated by a committee according to completeness, content, experience with similar projects, ability of the entity's staff, cost, etc. Evaluations will use qualified review teams with standardized rubrics. NCDHHS will apply conflict-of-interest protections.

Q127: Are minimum qualifications/requirements (including NC residency) defined for hub leadership positions?

A: NC residency may be preferred; applicants should document regional presence and capacity and that leadership positions possess skills and experience necessary to manage complex initiatives and deliver sustainable outcomes for rural health transformation in NC.

Q128: If an entity leverages existing infrastructure, what documentation is required?

A: Applicants are encouraged to leverage existing infrastructure wherever appropriate. However, per Section III, Paragraph B, Funding Restrictions, Item 2., Funding cannot be used to supplant programs funded by non-

federal sources. Applicants must describe how the existing infrastructure will be maintained without supplantation.

Q129: How will the Department evaluate financial risk in the scoring process? Can Department clarify definitions of financial stability and ability to float funds?

A: Specific financial evaluation criteria are outlined in Application Section I, Paragraph 1-4. Because the grant is based on a reimbursement model (from the federal grantor to NCDHHS and NCDHHS to the Hub Leads), Hub Leads must demonstrate the ability to pay for incurred expenses prior to receiving funds from NCDHHS. Considering the amount of funding proposed for each Region, monthly expenses are likely to be significant. Applicants must also demonstrate the ability to track and report expenses as part of the financial criteria.

Q130: Are timesheets or effort tracking required for all Hub personnel, including leadership?

A: Yes. Any entity receiving grant funding through NCRHTP must be able to justify expenses incurred related to the program, including staffing and personnel (including leadership). To accurately justify monthly expenses and satisfy the requirements of subrecipient monitoring and audits, timesheets and/or effort tracking will be necessary, unless 100% funded by the grant (payroll records would suffice).

Q131: Can the Department offer more detail on the criteria that will be used to review and approve requests for hospital feasibility studies?

A: Criteria include demonstrated need, alignment with program outcomes, stakeholder support, feasibility, and avoidance of duplication.

Q132: Is there a file size limit for submission?

A: NCDHHS accepts emails; large files may use links, zipped files, or split attachments. Follow instructions on the NCRHTP webpage.

Q133: How many weeks does DHHS anticipate it will take to fully reimburse ROOTS Hubs that correctly outlay and report spending?

A: See response to Q37.

Q134: What percent of outlays are fully reimbursed in other cooperative agreements administered by DHHS?

A: NCDHHS reimburses subrecipients based on allowability, funding restrictions, justification, and reasonableness. Reimbursement requests that require corrections are returned to NCDHHS subrecipients for resubmission, as a result, that percentage is not available.

Q135: Regarding (Section 1, Question 1-2.c), how does NCDHHS define "large scale" for evaluation purposes (e.g., by total project size, grant/award amount, project complexity, or multi-year duration), and what evidence (e.g., specific performance reports or audits) would best demonstrate compliance and success??

Large-scale initiatives may include multi-year funding, multi-sector partnerships, multi-county work, or complex implementation. Evidence includes performance reports, audits, and network management experience.

Q136: Please confirm the applicant is not required to choose from the "key approaches" suggested in section 2c Food is Medicine (Section III.A.2c.i - 2c.vi). Please confirm applicant may choose to propose a new approach with similar structure (e.g., strategy, outcome, and metrics).?

A: The listed approaches under Food is Medicine are illustrative. Applicants may propose alternative models with clear strategies, outcomes, and metrics. As noted in the RFA, NCRHTP funds may not be used to pay for meals or food as it is considered an unallowable cost to CMS.

Q137: Does the state already have collaborations in place that the hub should build upon rather than duplicate?

A: Yes. Hub Leads should build on existing regional partnerships and infrastructure rather than duplicate them. Throughout the RFA, applicants are asked to demonstrate meaningful engagement with hospitals, FQHCs, behavioral health providers, local health departments, community organizations, educational institutions, Tribal partners, and other stakeholders already active in their region. Applicants should therefore document the partnerships that currently support rural health, describe how these relationships will be integrated into the Hub Network, and explain how the proposed model strengthens, rather than replaces, collaboration already in place.

Q138: What safeguards will be in place to ensure confidential information shared through the hub structure is protected from access by competing provider organizations?

A: State records (including RFA responses) are subject to public records requests. Confidential Information is defined in North Carolina General Statute 132-1.2. If the application contains Confidential Information in accordance with the NCGS definition, please follow the guidance in RFA Section IV, Paragraph 13, Proprietary Information, and mark the appropriate sections as "CONFIDENTIAL." Contracts initiated by awarded Hub Leads should also contain similar guidance for their subcontractors and subrecipients.

 In addition to public records requests, the RFA requires Hubs to maintain a Data Management Plan that establishes:

- privacy and confidentiality protections;
- secure data storage and access controls;
- standards for data sharing and de-identification;
- procedures preventing inappropriate disclosure to competing entities.

These protections must align with federal and state requirements, including HIPAA, state privacy laws, and required contractual terms. Only aggregate or de-identified data may be shared where necessary to protect competitive information.

Q139: Are there educational institutions that the hub lead can leverage and partner with?

A: Yes. The RFA encourages Hubs to engage with regional educational partners, including community colleges, universities, and training programs, particularly for workforce planning and initiative implementation. These institutions can support training, pipeline development, certification programs, and workforce expansion strategies.

Q140: To what extent will North Carolina state sovereign immunity extend to the Hub? Will the Hub be required to obtain certain insurance coverage for general liability, acts and omissions, and if so, how will that insurance be funded?

A: State sovereign immunity is not extended to the State's Subrecipients. Hub Leads are independent entities and are expected to maintain any required insurance coverage, including general liability or errors and omissions insurance, consistent with state contract terms and their own organizational policies. Insurance costs must be incorporated into the Hub's budget and must comply with the RFA's 10% administrative cap for allowable administrative costs.