State of New Mexico

Rural Health Transformation Program Application

November 4, 2025

State of New Mexico

Michelle Lujan Grisham
Governor

November 3, 2025

Dear Administrator Oz:

As Governor of the State of New Mexico, representing the nearly 700,000 rural, frontier, and tribal community residents across our State, I am honored to endorse our Rural Health Transformation (RHT) Plan and commit to its implementation. Our RHT Plan presents a comprehensive and community-centered strategy to help every New Mexican, regardless of their zip code, access the care and support they need. In New Mexico, we know that our rural, frontier, and tribal communities are the backbone of our State. Their resilience inspires us and the challenges facing their communities demand our attention and action.

Every New Mexican deserves quality health care close to home. My Administration has consistently pursued opportunities to improve health care in rural communities. This RHT Plan and the six initiatives we have outlined will help accelerate our impact and meet the most pressing needs of New Mexicans across our State. The RHT Plan is the product of extensive collaboration and partnership with health and human services agencies, tribal leaders and community members, rural providers, and community voices from every corner of New Mexico. We solicited feedback and input through several methods, including a Request for Information through which the State received over 140 responses, and multiple forums for individuals to provide verbal input on the State's plan. We developed this plan together, and we will deliver it together.

The New Mexico Health Care Authority (HCA) will lead our State's rural health transformation effort, working hand in hand with a Stakeholder Advisory Committee made up of leaders representing state agencies, legislators, associations, rural provider organizations, community-based organizations, and community members to oversee implementation. We will regularly engage our Stakeholder Advisory Committee, as well as communicate with the public, throughout the implementation process. We will also facilitate quarterly meetings with the Stakeholder Advisory Committee and maintain an online platform for community members to submit real-time feedback on RHT Program implementation.

The RHT Program Stakeholder Advisory Committee will help guide implementation of the State's initiatives, including:

- **Healthy Horizons**: Expanding specialty care access and chronic disease management in rural communities through expanded networks, evidence-based prevention programs,

innovative care models, and supplemental technology, with a special focus on maternal health and high-burden conditions facing rural community members.

- **Rooted in New Mexico**: Building tomorrow's rural health care workforce by recruiting, training, and retaining clinicians and caregivers through K-12 pathways, rural rotations, incentives, and mentorship programs, for care to remain local and culturally responsive.

- **Rural Health Innovation Fund**: Empowering rural communities to design and lead local initiatives that address non-medical drivers of health, prevention, and behavioral health needs, building long-term ownership and sustainability for community-tailored programs.

- **Bridge to Resilience**: Establishing the Rural Health Sustainability & Innovation Center, a statewide hub to coordinate technical assistance, partnerships, provider education, and data support, strengthening the operational and financial sustainability of rural providers.

- **Rural Health Data Hub**: Creating a secure, integrated health analytics platform to deliver timely, actionable data that guides rural access, quality, equity, and financial oversight.

Our RHT Plan is more than policy—it is a critical lifeline for our rural, frontier, and tribal communities. Rural New Mexicans face real health challenges, including higher rates of chronic illness, fewer providers, and longer travel times to receive care. Our critical rural health infrastructure, including hospitals, clinics, and independent providers, often operate on thin or negative margins. Too many of our New Mexican families struggle to find care for their children, elders, and loved ones. Our RHT Plan will help us change that. We intend to invest in people, workforce, technologies, and partnerships to drive access and outcome improvements while meeting communities and community members where they are.

Implementing our RHT Plan also means pursuing required legislative and regulatory changes. My Administration is committed to the actions outlined in our RHT Plan, including pursuing expanded licensure compacts and leveraging New Mexico's broad scope of practice requirements to enhance access to rural, frontier, and tribal communities. Implementing this plan will also require ensuring that every dollar is spent wisely and in compliance with federal requirements. We will effectively manage this grant program, responsibly using this funding in a way that drives immediate and long-term sustainable impact while also holding ourselves accountable and sharing results with the public.

Above all, our RHT Plan is about opportunity. We will use and distribute this funding fairly, prioritizing the hardest hit communities, and empowering our rural frontier, and tribal community leaders to help shape and implement this program. Our goal for implementing this plan is simple: improve access, drive better health outcomes, support stronger providers, and build a future where all rural New Mexicans thrive.

I am proud to stand with our rural communities, the partners who helped craft this plan, and our State's leadership team. Together, we will implement our RHT Plan in a way that reflects the best of New Mexico. We will be resilient, innovative, and ultimately rooted in caring for one another.
In summary, by submitting this application, I certify that:

- I support and am committed to implementing New Mexico's Rural Health Transformation Plan.

- The New Mexico Health Care Authority will serve as the lead agency for our State's Rural Health Transformation Program implementation.

- New Mexico developed this application in collaboration with the New Mexico Department of Health (including the State Office of Primary Care & Rural Health), New Mexico Health Care Authority (State Medicaid Agency), New Mexico Indian Affairs Department, and additional key stakeholders (e.g., associations, rural providers, tribal leaders and community members).

- New Mexico engaged stakeholders throughout the application development process and will continue to partner and communicate with stakeholders throughout implementation.

- New Mexico will commit to State policy actions as defined in the Rural Health Transformation Program application.

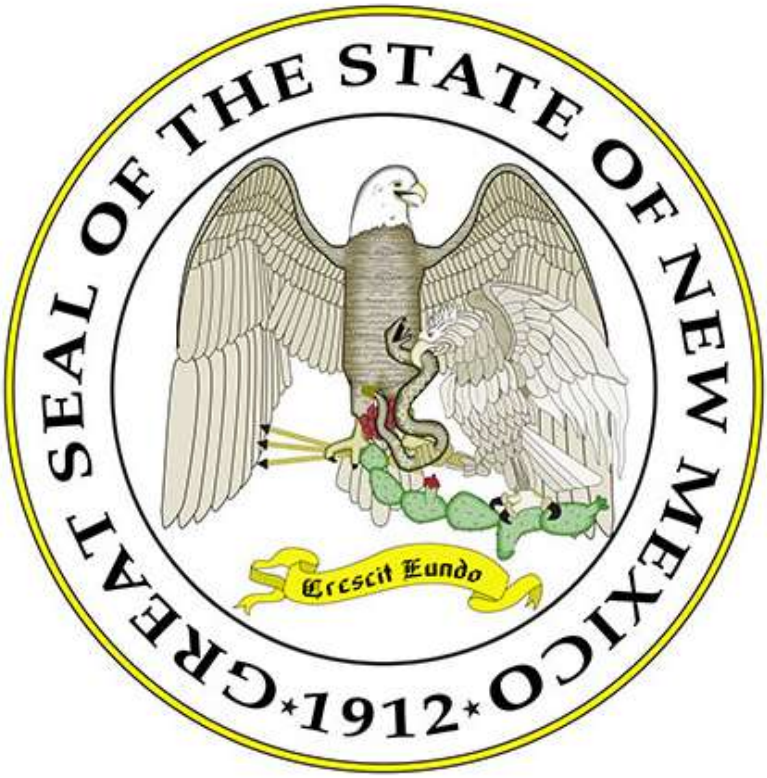
- New Mexico will not spend any award funds on activities prohibited under 42 U.S.C. 1397ee(h)(2)(A)(ii).

- New Mexico will use Rural Health Transformation Program funding to benefit rural communities across the State.

Thank you for your partnership and your trust. We are happy to answer any questions that CMS may have regarding our application and look forward to working with you.

Sincerely,

Michelle Lujan Grisham
Governor



Project Summary

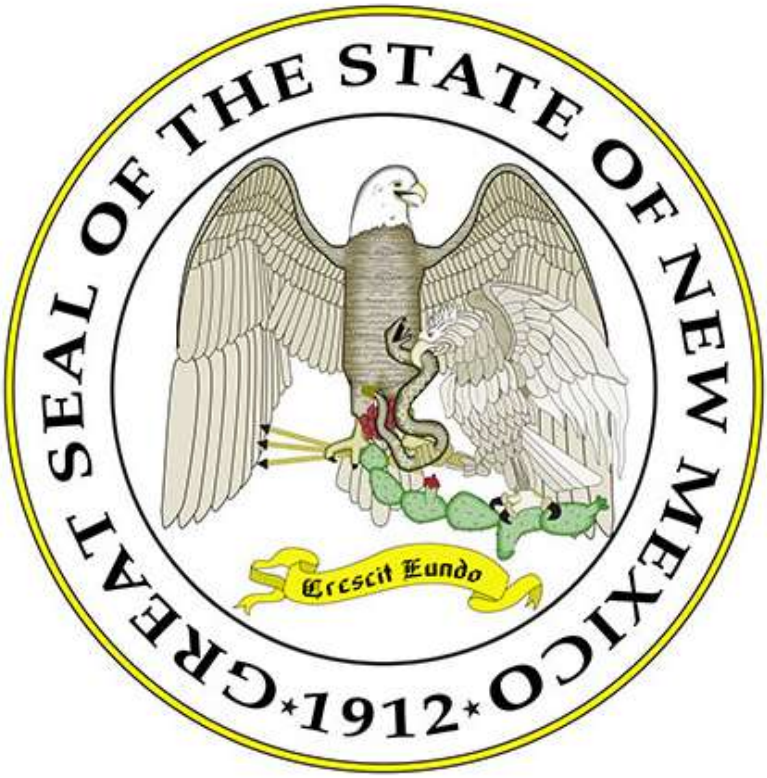
Project Summary

The State of New Mexico Health Care Authority (HCA) is proud to present the State of New Mexico's Rural Health Transformation Plan.

New Mexico is ready to lead a bold transformation of rural health – one that expands access, strengthens outcomes, and ensures lasting equity for rural, frontier, and tribal communities. Through frontier ingenuity, data-driven innovation, and community partnership, we will build a resilient system that sustains local providers, empowers families, and redefines what it means to deliver quality care in every corner of the State.

Summary of New Mexico's Rural Health Transformation Plan Initiatives

#	Initiative Name	State Goal / CMS Goal	High-Level Initiative Summary
1	**Healthy Horizons: Expanding Access to Care in Rural Communities** 5-Year Budget: $393,290,280	Expand Access to Care / Make Rural America Healthy Again	Strengthen specialty care and chronic disease management for high-risk rural populations by implementing regionalized specialty and maternal care networks, provider training, and remote care technologies to expand access, improve local capacity, and reduce hospital readmissions for rural community members.
2	**Rooted in New Mexico: Building Tomorrow's Rural Health Workforce** 5-Year Budget: $243,166,440	Expand and Sustain Rural Health Care Workforce / Workforce Development	Build and sustain a rural and tribal health workforce by expanding local career pathways, strengthening clinical training pipelines and educational opportunities, and supporting long-term retention through housing, mentorship, and community-based incentives.
3	**Rural Health Innovation Fund: Enabling Community-Designed, Community-Led Change** 5-Year Budget: $187,508,220	Support Community-Led Rural Health Solutions / Make Rural America Healthy Again	Launch a competitive grant program that empowers rural, frontier, and tribal communities in New Mexico to design and lead locally tailored health initiatives addressing unique challenges such as preventive care, behavioral health, non-medical drivers of health, and provider facility needs.
4	**Bridge to Resilience: Rural Health Sustainability & Innovation Center** 5-Year Budget: $122,644,440	Stabilize and Sustain Rural Health Care Providers / Sustainable Access	Establish a Rural Health Sustainability & Innovation Center to deliver tailored technical assistance, provider education, and operational support that strengthens financial stability, fosters regional partnerships, and equips rural New Mexico's providers to navigate long-term challenges and improve care delivery.
5	**Rural Health Data Hub: Establishing a Health Analytics Platform** 5-Year Budget: $53,390,620	Connect Community Members with Health Care Data / Tech Innovation	Build a statewide health analytics platform that integrates siloed data sources to improve rural health planning, enable predictive insights, and expand transparent access to timely, actionable information for providers, policymakers, and communities.

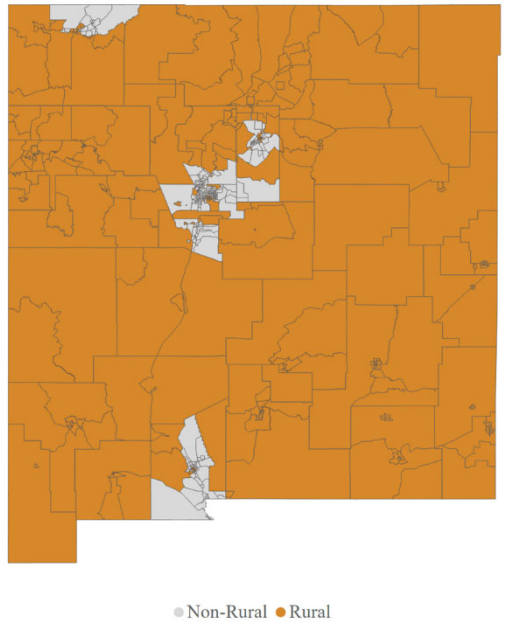


Project Narrative

Rural Health Needs and Target Population

New Mexico's rural communities face distinct demographic, health, and health care challenges. About one-third of New Mexicans (~698,000 people) live in non-metro areas.[1] Our State is the fifth largest state geographically and one of the least densely populated (17 persons per square mile vs. 87 persons per square mile nationally).[2] Roughly 10 percent of our State's population lives in Frontier and Remote (FAR) Zip Code Level 2 areas (i.e., remote from urban areas of 25,000 or more people).[3] New Mexico's rural communities are unique with individual cultures, needs, and governance structures, including respect for sovereign tribal nations. This application strives to promote local autonomy while identifying scalable solutions to improve rural health. When this application refers to "rural," unless otherwise indicated, we are leveraging the Health Resources and Services Administration (HRSA) definition of rural, which applies to at least one census tract in each of New Mexico's 33 counties. We further acknowledge the importance of our frontier and remote areas as defined above and significance of the State's 23 sovereign tribes, nations, and pueblos, each of which contributes significantly to our rural and frontier communities.[4] While all counties in New Mexico have rural areas, the State will maintain a targeted focus on HRSA-defined rural census tracts, as outlined in **Figure 1**.[5]

Figure 1. Rural Communities in New Mexico



Our State's rural regions face high poverty, elevated chronic disease burdens, and limited access to health care, contributing to poorer outcomes than those observed in urban areas.[6] Care delivery in these communities often depends on a small number of facilities and clinics, so closures can be devastating, forcing patients to travel long distances for essential services. Below, we describe data across four key areas – demographics, health outcomes, health care access, and rural facility financial health – that underscore the urgency for positive change.

Demographics

Compared with New Mexico's urban centers, rural New Mexico is characterized by sparse population, lower income levels, an aging workforce, and a greater share of residents who rely on public insurance or have no coverage at all. The combination of our State's rural demographics drives rural health disparities and affirms why tailored rural strategies are needed.

Population

New Mexico ranks among the nation's most rural states, with 33 percent of residents living in rural counties.[7] Twenty-six of the 33 counties are defined as rural (non-Metropolitan Statistical Area (MSA)) counties.[8] Many rural residents must travel long distances (often 50–100 miles or more) to reach basic health care services.[9] **Table 1** summarizes the population distribution in rural vs. urban areas.

Table 1. Population Distribution – Rural vs. Urban

Population Metric	Rural NM	Urban NM
Total population[10]	698,183 people *(~33% of State)*	1,416,585 people *(~67% of State)*
Number of counties[11]	26 rural counties	Seven (7) urban counties
Typical distance traveled for routine care[12]	50–100+ miles	Shorter distances (care often within city of residence)[13]
Population growth (2010–2018) [14]	Decline in 20 of 26 rural counties	Overall growth (+~2–3% in metro areas); some urban counties had slight declines

Socio-Economic Factors

Rural New Mexicans tend to have lower incomes and higher poverty rates than their urban counterparts. Educational attainment is also lower in rural areas. Fewer rural adults have college degrees, and high school graduation rates are lower on average compared to urban New Mexico. Rural parts of New Mexico experience slightly higher uninsurance rates. Many rural jobs (e.g., farming, self-employment, service work) do not include employer-provided insurance, leading to greater reliance on Medicaid, Medicare, or remaining uninsured. **Table 2** summarizes the key disparities related to socio-economic factors between urban and rural areas.

Table 2. Socio-Economic Indicators – Rural vs. Urban[15]

Indicator	Rural NM	Urban NM
Poverty rate (individuals)	20.7%	15.0%
Median household income	$55,000	$67,000
Unemployment rate (2023)	3.9%	3.7%
% Adults without high school diploma	15.1%	10.9%
% Adults with college degree (Bachelor's+)	22.0%	34.1%
Uninsurance rate	12.5%	11.4%

Health Outcomes

Rural New Mexico experiences worse health outcomes overall compared to urban areas. Rates of chronic diseases and associated mortality are higher, maternal and child health metrics are poorer, and life expectancy is shorter.[16] These disparities illustrate the urgent need for many Rural Health Transformation (RHT) Program initiatives.

Chronic Disease and Mortality

Rural communities bear a disproportionate burden of chronic illnesses like heart disease, diabetes, and chronic respiratory disease. They also suffer higher mortality rates from these conditions compared to urban areas. **Tables 3 and 4** highlight key chronic disease and mortality

indicators. In comparison to neighboring states, rural New Mexico holds similar or higher prevalence of adult diabetes (11.7 percent in rural Arizona; 8.2 percent in rural Colorado; 9.4 percent in rural Texas) and adult obesity (31.5 percent in rural Arizona; 21.4 percent in rural Colorado; 21.3 percent in rural Texas).[17, 18]

Table 3. Chronic Disease Prevalence, 2021 – Rural vs. Urban[19]

Chronic Disease	Rural NM	Urban NM	Disparity
Adult diabetes prevalence (diagnosed)	11.2%	9.9%	Higher rurally
Adult obesity prevalence	32.5%	29.1%	Higher rurally

Table 4. Mortality Rates – Rural vs. Urban[20]

Mortality Measure	Rural NM	Urban NM	Rural US Average (2019)[21]	Internal NM Disparity
Diabetes deaths (age-adjusted, 2018-2020)	26.0 per 100,000	20.6 per 100,000	27.3 per 100,000	~26% higher in rural NM
Suicide deaths (age-adjusted, 2017-2021)	33.4 per 100,000	23.5 per 100,000	18.9 per 100,000	~42% higher in rural NM

Maternal and Child Health Outcomes

Rural New Mexico struggles with poor maternal health outcomes compared to the national average. New Mexico's maternal mortality rate is 28.0 per 100,000, which is ~22% higher than the national rate.[22] Of pregnancy-associated deaths, nearly 40% are rural or micropolitan (mixed rural/urban) residents where emergency obstetrics (OB) care is lacking.[23] Rural infant mortality is also elevated. **Table 5** presents maternal and child health metrics, contrasting rural vs. urban disparities.

Table 5. Maternal and Child Health Metrics – Rural vs. Urban

Maternal/Child Metric	Rural NM	Urban NM
Prenatal care in the 1st trimester (percent of births, 2023)[24]	57.8%	69.4%
Infant mortality rate (under 1 year)[25]	5.6 per 1,000 live births	5.2 per 1,000 live births

Maternal/Child Metric	Rural NM	Urban NM
Prevalence of preterm birth (2012-2015)[26]	9.3%	7.3%

Healthcare Access

Access to health care in rural New Mexico is limited by long travel distances to provider locations, provider shortages, and scarce public transportation options. Rural residents often travel far for care, wait longer for appointments, or simply go without certain services.[27] The following data points highlight why RHT Program initiatives focus on bringing care to rural residents.

Provider Shortages

Rural New Mexico has severe shortages of health care professionals. Nearly the entire State is designated a Health Professional Shortage Area (HPSA) for primary care, mental health, or dental care.[28] In addition, 24 of 26 rural counties lack enough primary care physicians by federal standards. Specialists are in especially short supply, with many rural counties lacking any local psychiatrists, cardiologists, and other key specialists.[29] Further, 14 counties have zero obstetrics and gynecologists (OB/GYNs).[30] The lack of providers forces many patients to travel, or simply forgo treatment, while those providers who stay in rural practice manage long waitlists for appointments and services.[31] Exacerbating existing workforce shortages, 38.5 percent of active New Mexico physicians were aged 60 or older in 2018, the highest percentage among U.S. states.[32] The anticipated exit of many physicians from the active workforce will worsen health care access particularly in rural areas and for specialty care if new and expanded workforce pipelines are not created. While New Mexico has invested in several health care workforce pipeline projects, including the Healthcare Leadership High School, these efforts are not anticipated to fill the gap without additional support.

Rural New Mexico's health care infrastructure is sparse, as highlighted in **Figure 2**.[33]

Figure 2. Rural Communities in New Mexico

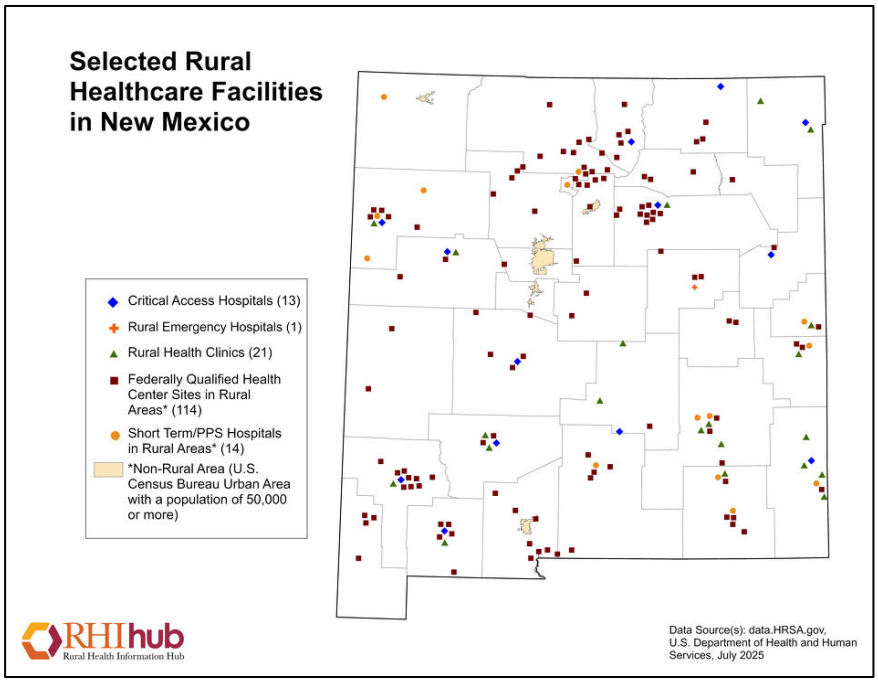


Table 6 summarizes health care provider and facility availability in rural areas in New Mexico compared to neighboring states.

Table 6. Healthcare Provider and Facility Availability[34]

Provider / Facility Type	Rural NM	Rural AZ	Rural CO	Rural NV	Rural OK
Critical Access Hospitals (CAHs)	13	17	32	13	39
Rural Health Clinics (RHCs)	21	52	63	19	143
Federally Qualified Health Centers (FQHCs)	114	74	102	20	138
Rural Emergency Hospitals (REH)	1	0	0	0	4
Short Term / Prospective Payment System (PPS)_Hospital	14	12	11	1	43

Rural Facility Financial Health

Many rural health care facilities in New Mexico, mostly small hospitals, clinics, and long-term care centers, operate on fragile financial margins. Low patient volumes, high uninsured rates or unfavorable payer mix, and operational costs (i.e., workforce) put them at risk of service reduction or closure. Supporting financial viability is essential for preserving access, which is why it is a key component of New Mexico's RHT Program application.

Facility Closures and Risk

A 2025 analysis found that eight out of 27 (i.e., 30%) rural New Mexico hospitals (i.e., CAHs and rural non-CAHs) are at risk of closure, with four of those hospitals facing immediate risk absent intervention.[35] Additionally, at least four of New Mexico's FQHCs have closed in recent years, with staffing costs rising despite a reduction in clinical workforce.[36]

Utilization and Patient Volume

A major contextual challenge to achieve financial stability is low patient volume at rural facilities. Rural facilities often have low occupancy. For example, New Mexico CAHs report an average daily census (acute patients) of 5.12 in 2022.[37] Clinic visit volume can also be inconsistent. Such low volumes mean fixed costs (e.g., staff, utilities) are not offset, which leads to losses or hardship even under cost reimbursement methodologies for CAHs. Additionally, many rural residents bypass local facilities in favor of larger, more urban hospitals, further reducing volume and revenue in rural facilities.[38]

Payer Mix and Financial Performance

Rural New Mexico hospitals and clinics are often heavily reliant on public programs including Medicare and Medicaid, which typically pay lower than private insurance, and regularly deliver uncompensated care, creating an unfavorable payer mix and reducing margins. In 2022, New

Mexico CAHs reported a median Medicaid payer mix (i.e., the percent of patient days attributable to Medicaid patients) of 28.3 percent compared to 14.11 percent nationally and a higher percent of uncompensated care (3.93 percent median) compared to the national average (2.91 percent).[39] Many rural hospitals survive through local tax support or subsidies.

Target Populations

We have designed the RHT Program initiatives to specifically benefit:

1. Rural, frontier, and sovereign tribes, nations, and pueblo community members who need improved access to health care services, with a specific focus on pregnant women, children (especially those in State custody), aging population, individuals with behavioral health conditions or disabilities, individuals with chronic conditions, tribal population, and justice-involved individuals.
2. The current and future health care workforce, including school-aged children, clinicians in training, current health care professionals, and educational partners (e.g., academic medical centers, universities, technical colleges, K-12 schools).
3. Rural health care facilities and provider organizations, including all rural hospitals, clinics, FQHCs, long-term care facilities, in-home providers, home- and community-based services agencies, and additional organizations delivering health care services.

Rural Health Transformation Plan: Goals and Strategies

State of New Mexico Rural Health Transformation Vision

New Mexico is ready to lead a bold transformation of rural health — one that expands access, strengthens outcomes, and ensures lasting equity for rural, frontier, and tribal communities. Through frontier ingenuity, data-driven innovation, and community partnership, we will build a resilient system that sustains local providers, empowers families, and redefines what it means to deliver quality care in every corner of the State.

The State of New Mexico is proud to present our Rural Health Transformation Plan for the Centers for Medicare and Medicaid Services (CMS) consideration. Our transformation plan is purpose-built and tailored to drive positive outcomes across New Mexico's rural, frontier, and tribal communities. The Health Care Authority (HCA), inclusive of Medicaid, will lead and oversee the RHT program. This includes direct responsibility for program implementation, strategic direction, and coordination with key partners across the State. The HCA will also manage oversight of any contractors engaged to support the program, ensuring alignment with the State's goals and CMS' expectations.

To support initiative implementation, the HCA will allocate the majority of program funds through two primary mechanisms: direct subawards and competitive procurements or applications. These funding pathways will be governed by clear criteria, performance expectations, and reporting requirements to ensure transparency, accountability, and alignment with federal and state regulations, further described in this narrative and the Budget Narrative. Sub-awardees and contractors will be identified beginning in Year 1 of the program.

As noted in **Table 7**, our RHT Plan includes five initiatives aligned with CMS' strategic goals and designed to make progress towards several key performance objectives.

Table 7. RHT Plan Initiative Summary

Initiative Name	State Goal / CMS Goal	Key Performance Objective(s)
1. **Healthy Horizons:** *Expanding Specialty Care Access and Chronic Disease Management*	Expand Access to Care / Make Rural America Healthy Again	• Increase timely rural specialty consults (in person or virtual) by 15% • Decrease chronic disease risk factors by 10% • Decrease 30-day readmission rates in rural hospitals by 5%
2. **Rooted in New Mexico:** *Building Tomorrow's Rural Health Workforce*	Expand and Sustain Rural Health Care Workforce / Workforce Development	• Increase rural trainees by 10% • Increase tele-mentoring (or similar models) in rural settings by 10% • Reduce counties that are fully federally designated HPSAs by 5%
3. **Rural Health Innovation Fund:** *Enabling Community-Designed, Community-Led Change*	Support Community-Led Rural Health Solutions / Make Rural America Healthy Again	• Increase volume of community-specific health programs by 30%
4. **Bridge to Resilience:** *Rural Health Sustainability & Innovation Center*	Stabilize and Sustain Rural Health Care Providers / Sustainable Access	• Improve collective rural hospital operating margin by 3% • Reduce number of facilities (e.g., hospitals, clinics) in financial distress by 10%
5. **Rural Health Data Hub:** *Establishing a Health Analytics Platform*	Connect Community Members with Health Care Data / Tech Innovation	• Increase provider participation in Health Information Exchange by 30% • Increase provider participation in Closed Loop Referral System (CLRS) by 30%

The following sections outline how New Mexico's RHT Plan will address each of the statutory program requirements through each initiative. Additional detail on specific actions aligned with each program requirement can be found in "Proposed Initiatives and Use of Funds," "Metrics and Evaluation Plan," and "Sustainability Plan," respectively.

Improving Access:

Improving access to health care services and supports is a known need across New Mexico's rural, frontier, and tribal communities. **Table 8** outlines specific initiatives, actions, and measurable outcomes included in the transformation plan to improve access to care.

Table 8. RHT Program Initiatives to Improve Access to Care

Relevant Initiative(s)	Example of Specific Actions	Example of Measurable Outcomes
• **Initiative 1: Healthy Horizons** • **Initiative 4: Bridge to Resilience**	• Expand specialty services via rotational clinics, telehealth wraparound, and school-based health programs • Launch statewide provider-to-provider specialty consults (e.g., cardiology, psychiatry, maternal health, behavioral health) • Distribute remote patient monitoring (RPM) devices for post-discharge care • Deliver strategic and operational technical assistance, partnership facilitation, and shared services to rural providers • Maintain and enhance emergency departments in high-risk counties	• Number of counties with new specialty services available • Number of providers with provider-to-provider consults available • Number of RPM devices distributed • Number of facilities receiving technical assistance • Number of emergency departments maintained

Improving Outcomes:

The State has purposefully designed the RHT Plan to address known challenges across rural, frontier, and tribal communities. Our initiatives, as outlined in **Table 9**, will help drive both short- and long-term outcome improvements aligned with our highest needs (e.g., chronic disease management, maternal health, behavioral health).

Table 9. Example Health Outcome Improvements by Initiative

Relevant Initiative(s)	Example Targeted Health Outcome Improvements	Example Activities to Improve Health Outcomes
• **Initiative 1: Healthy Horizons** • **Initiative 2: Rooted in New Mexico** • **Initiative 3: Rural Health Innovation Fund**	• Improved chronic disease management (e.g., diabetes, depression, arthritis, heart disease) • Reduced hospital admissions and missed appointments, and improved post-acute care follow-up • Enhanced access to specialty and behavioral health services • Reduced maternal mortality and improved prenatal care rates • Improved access to healthy food, transportation services, and preventive care	• Increase access to specialty and maternal care networks coupled with virtual care solutions (e.g., provider-to-provider e-consults) • Fund community-designed, community-led programs to address non-medical drivers, substance use, preventive care needs, patient safety, and equipment (e.g., diagnostic equipment) needs

Relevant Initiative(s)	Example Targeted Health Outcome Improvements	Example Activities to Improve Health Outcomes
	• Improved access to substance use disorder and opioid use disorder services • Improved patient safety	• Expand digital health solutions to improve chronic disease management and reduce readmission rates

Technology:

Three of New Mexico's RHT Program initiatives specifically leverage technology to enhance access to care and improve health outcomes. The initiatives are designed holistically to enhance access to health care services and help rural New Mexicans receive care closer to home. The initiatives will emphasize prevention and chronic disease management as outlined in **Table 10**.

Table 10. Technology-Focused RHT Program Initiatives and Use Cases

RHT Program Initiative	Use of Technology
Initiative 1: Healthy Horizons	• Expand access to provider-to-provider e-consult platforms to enhance access to specialty consultations in rural communities. • Support deployment of in-person specialty care with HIPAA-compliant virtual care platforms when in-person care is unavailable (e.g., preventive care or periodic touch points between in-person appointments based on patient preference). • Establish HIPAA-compliant telehealth sites in community settings (e.g., rural clinics, FQHCs, tribal health centers, senior centers, libraries, schools). • Expand telehealth and RPM for chronic disease management, post-discharge care, and specialty consults. • Implement consumer-facing and natural support accessible mobile apps to assist with health management. • Upgrade provider electronic health record (EHR) systems and cybersecurity infrastructure.
Initiative 5: Rural Health Data Hub	• Enable predictive analytics to support care gap identification and promote proactive care that leads to less frequent and lower acuity needs. • Implement consumer-facing platforms for rural health metrics and to increase awareness of health care options.

Throughout implementation, the State will support providers and community members to evaluate suitability of new technologies for their specific populations and communities through the Rural Health Sustainability and Innovation Center's (RHSIC's) technical assistance services. The State understands that there is not a one-size-fits-all solution for technology implementation,

and some communities or providers may be better suited for one solution vs. another. We will allocate funding in a way that allows for community-tailored solutions that support effective implementation, coupled with robust technical assistance to support long-term sustainability.

In addition to technical assistance to support sustainable adoption, New Mexico has a favorable regulatory and reimbursement structure related to telehealth and consult implementation. New Mexico Medicaid maintains payment parity for virtual care, supporting sustainable adoption. The State will continue to evaluate the need for additional policy adjustments to sustain long-term technology implementation as needed.

Partnerships:

The State has specifically designed the **Bridge to Resilience** initiative to establish a RHSIC to help foster and establish both local and regional partnerships. The RHSIC will serve as a central hub for RHT Program implementation, coordinating technical assistance, partnership development and coordination, and shared services among rural providers (e.g., hospitals, clinics, FQHCs, tribal health centers). The RHSIC will help create partnerships that support referral pathways, joint contracting for administrative and/or clinical services, and collaborative learning events with high-need topics ranging from workforce development, technology use, and financial sustainability. The partnerships that the RHSIC facilitates will enhance financial stability and performance, clinical service availability, and outcome improvement (e.g., chronic disease management).

The RHSIC will have direct involvement with all partnership models and will regularly meet with partner facility leaders to align on the plans identified in partnership agreements and implementation progress. The RHSIC will report on progress to the State's RHT Program

governance structure during quarterly RHT Program Stakeholder Advisory Committee meetings (see "Stakeholder Engagement") and through the regular annual CMS reporting cycle.

Workforce:

The State has designed the **Rooted in New Mexico** initiative to address New Mexico's rural, frontier, and tribal community workforce needs. The plan includes using funding to launch K-12 health career pathway programs in rural, frontier, and tribal communities, expand rural clinical rotations, apprenticeships, and residency tracks for high-need professions, and provide targeted outreach and mentorship to inspire students to pursue health care careers. Our approach also includes incentives such as paid training time, certification support, and defined career ladders for licensed practical nurses (LPNs), community health workers (CHWs), peer support workers, and home and community-based services (HCBS) caregivers. We will implement five-year rural service commitments paired with incentives such as housing stipends or retention bonuses to help retain individuals recruited to rural New Mexico. When possible, we will promote health care professions for Medicaid Members subject to new community engagement requirements. Additionally, to further support clinicians practicing in rural communities, we propose using funding to enhance technology support that extends access to specialists (e.g., tele-supervision, mentoring networks). We will also commit to additional training (e.g., culturally responsive training for tribal care delivery) and further leveraging New Mexico's expansive scope of practice policies to enhance community impact.

Data-Driven Solutions:

The State designed the **Rural Health Data Hub** initiative to provide data transparency, analytic capabilities, and predictive modeling to better plan rural health needs. The Rural Health Data Hub will include a public facing resource and actionable insights based on the State's health and

human services data sets (e.g., Medicaid claims, health information exchange (HIE) clinical data, public health, closed loop referral system). The Rural Health Data Hub will also include a public facing interface that will allow rural community members to better understand services available near them or in their communities and where to receive quality care aligned with their specific needs.

Financial Solvency Strategies:

The State designed the **Bridge to Resilience** initiative to establish the RHSIC with a core function of strategically and operationally supporting rural, frontier, and tribal community providers (e.g., hospitals, clinics, long-term care facilities). The RHSIC will deliver hands-on technical assistance and training to improve provider operations, including revenue cycle management, supply chain management, information technology (IT) and cybersecurity, and clinical documentation. Providing this level of direct support will provide rural hospitals and other providers with the tools to enhance bottom line performance and stabilize or further strengthen their financial standing. Additionally, RHSIC-facilitated partnerships will help independently operated hospitals and clinics collectively negotiate to improve pricing on supplies or reimbursement rates with commercial insurers, for example. A core objective of the RHSIC is to provide services and supports that will help hospitals and clinics remain open through direct, sustainable training and support that will last beyond the five-year funding period.

Cause Identification:

New Mexico's independent rural hospitals face similar challenges as many independent rural hospitals nationally. New Mexico's independent rural hospitals often face low patient volume, significant outmigration to urban centers, and a payer mix that heavily favors government-

sponsored health care coverage (e.g., Medicare, Medicaid). Additionally, many independent rural hospitals do not have the formalized structures in place to maximize revenue capture and recognition due to lack of a health system's operational support. Rural hospital leaders often fill many roles and may not have the expertise to fully carry out all duties to maximize bottom line performance.[40] The State's proposal to deliver high impact, hands-on operational technical assistance and facilitate partnerships will help independently operated hospitals and clinics collectively negotiate to improve pricing on supplies or reimbursement rates and formalize their processes and maximize revenue capture, improving bottom line performance and enhancing stability within their communities.

State Policy Actions and Legislative Engagement:

Table 11 outlines New Mexico's current state related to the optional RHT Program State Policy Actions and a summary of next steps, which may include legislative or regulatory actions to align with policy changes. Preliminary consultation with legislative and executive leadership confirms alignment and feasibility for the proposed policy actions, positioning New Mexico to advance the required statutory and regulatory changes on schedule.

Table 11. State Policy Actions – Current State and Next Steps

B.2 Health and Lifestyle – Presidential Fitness Test (PFT)	
Current State	**Next Steps**
• New Mexico schools are not currently required to implement the PFT. • New Mexico schools primarily follow the Comprehensive School Physical Activity Programs (CSPAP) and health guidelines from the Centers for Disease Control and Prevention (CDC). • Many New Mexico schools also adopted the Presidential Youth Fitness Program (PYFP) after 2012.	• The State will pursue legislative and regulatory changes to implement the PFT in schools by December 31, 2028. • Policy implementation will require New Mexico Administrative Code (NMAC) updates as part of K-12 education standards (e.g., Title 6). • New Mexico will implement reporting structures to align with Executive Order 14327 requirements.

B.3 SNAP Waivers	
Current State	**Next Steps**
• New Mexico does not currently have a SNAP food restriction waiver. • New Mexico's SNAP program includes robust educational opportunities and resources to encourage and incentivize healthy food choices. • New Mexico engages eligible populations, early child through seniors, through Direct Education, Policy, Systems, and Environmental Changes, and Social Marketing where target audiences live, work, shop, play, eat, and learn.[41]	New Mexico does not plan to pursue a SNAP food restriction waiver at this time but will continue to leverage opportunities to incentivize healthy food choices in SNAP. Examples include New Mexico's Double-Up Food Bucks program, which matches NM-grown fruit and vegetable purchases dollar for dollar, but will continue to leverage opportunities to incentivize healthy food choices in SNAP. Examples include New Mexico's Double-Up Food Bucks program, which matches NM-grown fruit and vegetable purchases dollar for dollar.
B.4 Nutrition Continuing Medical Education (CME)	
Current State	**Next Steps**
• New Mexico does not currently require nutrition CME for physicians.	• New Mexico plans to pursue legislation requiring nutrition CME for physicians during the 30-day legislative session in SFY 2026. • Pending approval, New Mexico will implement before December 31, 2028.
C.3 Certificate of Need	
Current State	**Next Steps**
• New Mexico does not currently require Certificates of Need.	• New Mexico does not plan to adjust the Certificate of Need approach and will remain aligned with RHT Program goals.
D.2 Licensure Compacts	
Current State	**Next Steps**
• New Mexico participates in licensure compacts for nurses. • New Mexico does not currently participate in licensure compacts for physicians, physician assistants, Emergency Medical Services (EMS), and psychologists.	• New Mexico plans to pursue approval for physicians, physician assistants, EMS, and psychologist licensure compacts during the 30-day legislative session in SFY 2026. • New Mexico is currently performing a formal study of all RHT compact types to enable a full legislative plan for the 2026 legislative session. • Pending approval, New Mexico will implement before December 31, 2028.
D.3 Scope of Practice	
Current State	**Next Steps**
• New Mexico policy allows for full scope of practice for nurse practitioners, as defined by the American Association of Nurse Practitioners. • Pharmacists have formulary-based authority according to Cicero Institute's 2025 Policy Strategies for Full Practice Authority. • The American Academy of Physician Associates identifies New Mexico as an "Advanced" scope of practice state.	• New Mexico already has a broad scope of practice for each of these provider types and therefore will not be pursuing additional changes.

• Dental hygienists have unrestricted scope of practice according to the 2024 Oral Health Workforce Research Center data.	
E.3 Short-Term, Limited Duration Insurance (STLDI)	
Current State	**Next Steps**
• New Mexico limits STLDI plans to nonrenewable three-month terms and prohibits consecutive policies within 12 months (i.e., more restrictive than federal guidance).	• New Mexico does not plan to amend STLDI policy.
F.1 Remote Care Services	
Current State	**Next Steps**
• New Mexico HCA (Medicaid) reimburses telehealth services at the same rate as in-person services. • New Mexico HCA also reimburses for store-and-forward telehealth. • RPM, while reimbursed, is not heavily utilized under Medicaid. • Licensing exceptions are in place related to out-of-State consultations (N.M. Admin. Code § 16.10.2.11).	• New Mexico intends to increase utilization of codes for RPM aligned with RHT Program initiatives to promote long-term sustainability following the funding period.

Other Required Information:

Table 12 below lists the Certified Community Behavioral Health Clinics (CCBHCs) in New Mexico, organized by demonstration year, as of September 1, 2025. Each demonstration year includes five participating CCBHCs. The **Other Supporting Documentation** attachment provides the address for each care site, as required by factor A.2.

Table 12. New Mexico CCBHCs

Demonstration Year	CCBHC [42]
Demonstration Year 1	• Carlsbad LifeHouse Inc. • FYI+ • Presbyterian Medical Services • Santa Fe Recovery • University of New Mexico Hospitals
Demonstration Year 2	• New Mexico Solutions • Guidance Center of Lea County • La Clinica De Familia • Mental Health Resources • Presbyterian Medical Services

In State Fiscal Year (SFY) 2024, 21 hospitals in New Mexico received **Disproportionate Share Hospital (DSH)** payments (A.7). The State is currently collaborating with CMS following passage of New Mexico Senate Bill 17 (Health Care Delivery and Access Act [HDAA]), which requires the State to combine annual DSH funding with existing HDAA funding.[43] Therefore, the State did not make DSH payments in SFY 2025.

Proposed Initiatives and Targeted Investments

The State will establish the **New Mexico Rural Health Sustainability and Innovation Center** (RHSIC), embedded in the HCA, which will serve as the central operational hub for the RHT Program. Under the leadership of the HCA, the RHSIC will coordinate and execute the RHT program, ensuring alignment with statewide priorities and CMS objectives. The RHSIC will deliver integrated support services to rural communities and providers, and will provide the infrastructure to implement the following initiatives:

1. Healthy Horizons (Initiative #1)
2. Rural Health Innovation Fund (Initiative #3)
3. Bridge to Resilience (Initiative #4)

The RHSIC will also lead cross-department coordination efforts needed to implement Rooted in New Mexico (Initiative #2) and Rural Health Data Hub (Initiative #5). Additional information regarding the purpose and objectives of these initiatives can be found in subsequent sections of this application. The RHSIC, under the HCA's oversight, will also serve as the organizational entity responsible for all administrative activities associated with the RHT Program including stakeholder engagement, legislative liaison activities, federal reporting, and budget management. Additional information regarding the structure of the RHSIC can be found in the Implementation Plan section of this application.

Subawards and Subcontracts

To support initiative implementation, the State intends to allocate approximately 95 percent of RHT Program funds toward programmatic activities rather than administrative functions. Beginning in Year 1, the HCA will identify and engage subrecipients and contractors to support implementation. Funding will be distributed through two primary mechanisms: direct subawards and competitive procurements or applications, depending on the nature of each initiative. All funding mechanisms will include clear expectations for scope, deliverables, timelines, and reporting requirements. Additionally, as applicable, the terms and conditions of the RHT award will flow down to subawards and subrecipients, including relevant cost limitations, as specified in 2 CFR 200.101(b)(1). **Table 13 and Table 14** provide sample activities by initiative that may be funded through direct subawards and competitive procurements or applications.

Table 13. Sample Activities Funded Through Direct Subaward

Initiative	Sample Activities
Healthy Horizons	• Developing in-person specialty and maternal care networks through rotational clinics. • Supporting providers to secure and adopt new technology (e.g., provider-to-provider e-consult, RPM, consumer tech) to deliver care when in-person care is not available. • Providing funding for providers to enhance or adopt a new EHR platform.
Rooted in New Mexico	• Establishing new or expanding existing rural-specific workforce development programs (e.g., rural residencies, rural rotations, apprenticeships). • Funding new K-12 career pathway programs. • Providing paid training, certification support, and career ladders for health care professionals.

Table 14. Sample Activities Funded Through Competitive Procurements / Applications

Initiative	Sample Activities
Rural Health Innovation Fund	• Developing community-led prevention programs (screenings, counseling, education) and local chronic disease initiatives. • Expanding preventive services such as dental, vision, and hearing. • Improving behavioral health access, including substance use disorder / opioid use disorder services and mental health screening integration. • Making minor renovations or purchasing medical equipment for rural facilities (e.g., hospitals, clinics, Skilled Nursing Facilities).

Initiative	Sample Activities
Bridge to Resilience	• Facilitating training and technical assistance engagements with subject matter experts, customized provider technical assistance plans, learning collaboratives, and training materials. • Facilitating workforce-focused technical assistance (e.g., recruitment / retention strategies, role optimization, leadership development). • Supporting IT advances that integrate analytics with provider systems and build provider data literacy. • Implementing efforts that foster collaboration (shared service models, regional referral pathways, convenings).
Rural Health Data Hub	• Developing a secure statewide analytics platform. • Creating interfaces and automated ingestion / update pipelines and integrating telehealth / RPM data. • Delivering training and technical assistance to agencies, managed care organizations, and providers on using the Rural Health Data Hub. • Supporting cross-sector collaboration to integrate data sources and align data transparency / planning.

Further detail on the funding approach and oversight is provided in the Budget Narrative.

Initiative 1. Healthy Horizons: Expanding Specialty Care Access and Chronic Disease Management

Description:

The **Healthy Horizons** initiative will expand access to specialty care through a combination of enhanced in-person services, e-consults, and other remote solutions. This approach will strengthen chronic disease management for rural and tribal communities in New Mexico, where limited specialty provider availability often means patients either go without the right care or face long, costly travel to urban centers. To close these gaps and promote sustainable access to high-quality care, the State will implement strategies that expand access to specialty care (e.g., in-person specialist rotations and e-consults as a key tool to connect local clinicians with specialists), improve prevention and chronic disease management, and integrate remote care solutions where they add the greatest value. By leveraging e-consults, primary care providers and hospitals can work at the top of their license and obtain timely specialist input without requiring patients to leave their communities, ensuring care remains accessible and coordinated. New

Mexico will also integrate behavioral health within chronic and maternal care networks, ensuring whole-person care across all rural and tribal communities.

A core principle of this initiative is keeping care close to home and reducing unnecessary travel and delays in specialty care. This initiative will support use of remote care tools (e.g., e-consults, telehealth, RPM) to expand access, support continuity, and reduce long travel times. The State recognizes that technology is not a universal solution. Telehealth and virtual care will be used to strengthen care for patients and providers, but never as a replacement for in-person services when those are preferred or clinically necessary. Technology will complement community-based care by enabling ongoing monitoring between visits and strengthening local provider capacity, not substituting the relationships and services rural communities rely on. Patient choice and community-based care remain top priorities for the State.

The State will prioritize the chronic conditions with greatest prevalence statewide and that demand the need for specialty care, such as arthritis (26 percent of State population), depression (23 percent), diabetes (13 percent), asthma (9.7 percent) cardiovascular diseases (8.5 percent), cancer (7.7 percent), and chronic obstructive pulmonary disease (5.0 percent).[44] The State will also prioritize specialties with the greatest projected shortages. These specialties are critical for managing high-risk populations and addressing complex conditions locally. **Table 15** illustrates the inadequacy of specialist supply by 2030, underscoring the urgent need for targeted interventions. The State will maintain flexibility to adjust priorities as disease prevalence or provider shortages shift over time.

Table 15. New Mexico Specialist Adequacy (Supply/Demand) by 2030[45]

Specialty	% Adequacy by 2030
Psychology	29%
Allergy & Immunology	33%

Specialty	% Adequacy by 2030
Ophthalmology	42%
Radiation Oncology	50%
Adult Psychiatry	52%
Cardiology	52%
Anesthesiology	54%
Child & Adolescent Psychiatry	56%
Neurology	56%
Dermatology	57%

Potential uses of funds could include:

1. **Specialty Care Expansion**
    a. Deploy and strengthen regionalized in-person specialty and maternal care networks, supported by rotational clinics and asynchronous and synchronous consults, including video visits, EHR-integrated e-consults, emergency department (ED)-based tele-consults, and HIPAA-compliant texting. E-consults allow primary care providers to seek timely input from specialists within the EHR, helping them manage complex conditions locally and avoid unnecessary referrals or delays in care. To promote effectiveness, the State will invest in building rotational programs by incentivizing provider participation in rural and tribal areas, expanding training and support, and aligning value-based payment models that reward collaborative, community-based care.
    b. Build regional collaborative partnerships (e.g., Centers of Excellence) among hospitals, FQHCs, tribal health programs, Indian Health Service (IHS) facilities, behavioral health providers, pharmacists, EMS/EDs, and academic partners to coordinate specialty (e.g., maternal health) access and care transitions.

c. Coordinate ancillary care (e.g., physical therapy, occupational therapy, speech therapy, in-home nursing) for post-acute discharge to rural communities.

d. Develop and implement incentive payment models for rural hospitals and clinics that establish and sustain specialty and maternal care service lines while meeting quality metrics tied to high-need, high-cost populations. This will include targeted incentives for high-need specialty providers to deliver in-person services in rural communities, providing patients with access to critical care locally. By aligning financial incentives with quality outcomes and provider participation, the State will promote collaborative, community-based care and reduce reliance on distant facilities.

e. Establish complex care transition pathways, linking hospitals, emergency departments, and community providers to ensure safe, timely discharges, expedited specialty follow-up, and coordinated social supports.

f. Provide clinical training and targeted technical assistance for implementing specialty and maternal care service lines, including behavioral health integration.

2. Prevention and Chronic Disease Management

a. Implement evidence-based screening and management programs for targeted chronic conditions (e.g., diabetes, cardiovascular disease, arthritis, depression, asthma, cancer, and chronic obstructive pulmonary disease), as well as maternal and behavioral health. This includes routine behavioral health screening to identify conditions (e.g., depression, anxiety, and substance use disorders) early. Specialty escalation will be supported through EHR-integrated e-consults, video visits, and HIPAA-compliant texting.

b. Integrate behavioral health services, including screening and treatment for mental health conditions and substance use disorder, into maternal and chronic care models. This includes perinatal mental health and substance use disorder screening, with streamlined referral pathways across regional partners to promote continuous access to care.

c. Deliver targeted provider training for integrating perinatal mental health screening, referral, and treatment into maternal care workflows.

d. Support school-based health programs for early screening of chronic conditions, behavioral health interventions, and telehealth triage for maternal and pediatric needs, integrating quick-turn e-consults and secure texting for school-based health professionals.

3. Community-Centered Remote Care

a. Implement virtual mentorship and consultation models (e.g., tele-mentoring and e-consults) that connect rural providers with specialists and peers. These ongoing, collaborative relationships build local provider confidence and clinical knowledge, enabling more care to remain in the community. This approach expands access to both primary and specialty services (e.g., behavioral health, perinatal, pulmonology, cardiology, and hospice care), keeping patients closer to home and family.

b. Explore and pilot technology-enabled care models (e.g., RPM and virtual care tools) that support patients in managing their health from home. These models can strengthen engagement, support proactive care, and reduce unnecessary travel for facility-based services.

c. Invest in digital tools and communication platforms that keep patients, caregivers, and families connected and involved. These tools provide real-time updates, shared care calendars, medication tracking, and secure messaging to support coordination and engagement.

d. Upgrade and integrate EHR systems across facilities to improve efficiency, reduce costs, and ensure complete patient records. Linking EHRs with platforms such as the Closed Loop Referral Systems and HIE will enable seamless care coordination, timely referrals, and better data sharing.

e. Enhance cybersecurity infrastructure to protect clinical operations and data integrity across rural and tribal systems. This mission-critical investment will focus on preventative measures against ransomware and data breaches, supported by statewide cost-sharing and training models coordinated by the RHSIC to ensure long-term resilience.[46]

f. Establish HIPAA-compliant sites (e.g., rural clinics, FQHCs, tribal health centers, pharmacies, libraries, schools, childcare centers, senior centers) with telehealth kiosks and/or dedicated spaces for specialty consults.

g. Introduce mobile apps and portable diagnostic tools for chronic disease self-management and prenatal care tracking.

h. Enable tele-consult capabilities across rural care settings (e.g., emergency departments, primary care clinics, urgent care sites) to reduce avoidable transfers and expedite time-sensitive decisions. Specialty consults in areas such as neurology, cardiology, psychiatry, and maternal-fetal medicine will be supported through secure video, EHR-integrated e-consults, and HIPAA-compliant clinical messaging.

To bolster adoption of funded technologies, the State will emphasize education and technical assistance, as technology is a tool reliant on usability to make impact and become sustainable practice. Additionally, to enhance participation in **Healthy Horizons** activities, the State will provide incentive payments for implementing new specialty care models (e.g., in-person specialty rotations, e-consult platforms, remote care solutions).

Other Considerations:

The State prioritizes patient choice and recognizes the limitations of remote care tools, including broadband access and clinical appropriateness. Telehealth will be used to expand access and support providers, while in-person care options will remain available for those who prefer it. The initiative will also promote ongoing monitoring between visits and tailor interventions to the specific needs of each rural and tribal community. Compliance with funding caps for electronic medical record investments will be maintained through program integrity protocols. As needed, the State will conduct access analyses to identify geographies and populations with the greatest need, while seeking scalable solutions that can be adapted statewide.

Table 16 provides required details regarding this initiative.

Table 16. Initiative 1. Healthy Horizons – Component Details

Initiative Component	Detail
Main Strategic Goal	Make Rural America Healthy Again
Use of Funds	A, B, C, D, F, G, H, J, K (non-exhaustive)
Technical Score Factors	B.1, B.2, C.1, C.2, E.1, F.1, F.2, F.3 (non-exhaustive)
Key Stakeholders	New Mexico residents, providers (hospitals, clinics, tribal health centers, FQHCs, specialty clinics), rural and frontier community organizations and leaders, tribal organizations and leaders, partner agencies (e.g., NM Department of Health, NM Children, Youth, and Families Department, NM Aging and Long-Term Services), technology vendors, technical assistance vendors, payers (Medicaid, managed care organizations (MCOs)), schools, Connect New Mexico (Broadband partner)
Outcomes	The State of New Mexico will use the following metrics to assess the impact of this initiative. The State will define targets in Year 1.

Initiative Component	Detail
	1. **Specialty Care Completion Rate:** Percentage of provider-to-provider specialty consults requests that result in a completed encounter within 30 days of referral *(county-level)* ***Baseline:*** *To be established in Year 1* ***Estimated Time Period to Observe Changes:*** *9-18 months* 2. **Hemoglobin A1c Control for Patients with Diabetes:** The percentage of adults aged 18–75 with diabetes (type 1 or type 2) whose most recent HbA1c level during the measurement year is <8.0% ***Baseline*****:** 48.22%[47, 48] ***Estimated Time Period to Observe Changes:****12-18 months* 3. **Depression Screening and Follow-Up for Adolescents and Adults:** 1) *Depression Screening* – percentage of persons who were screened for clinical depression using a standardized instrument; 2) *Follow-Up on Positive Screen* – percentage of persons who received follow-up care within 30 days of a positive depression screen finding ***Baseline:*** *10.00%; 75.85%*[49,50] ***Estimated Time Period to Observe Changes:****12-18 months* 4. **Postpartum Depression Screening and Follow-up:** 1) *Depression Screening* – percentage of deliveries in which persons were screened for clinical depression using a standardized instrument during the postpartum period; 2) *Follow-Up on Positive Screen* – percentage of deliveries in which persons received follow-up care within 30 days of a positive depression screen finding ***Baseline:*** *11.57%; 76.49%*[49,50] ***Estimated Time Period to Observe Changes:****12-18 months* 5. **Utilization of RPM:** Percentage of patients enrolled in RPM who transmit data at least once within a defined period (e.g., weekly or monthly) ***Baseline:*** 10,577 (claims between 7/1/2024 – 6/30/2025) ***Estimated Time Period to Observe Changes:*** *6-12 months* 6. **Hospital Readmission Rates:** Percentage of patients participating in a remote care program that return to the hospital within 30-days of discharge ***Baseline:*** *To be established in Year 1* ***Estimated Time Period to Observe Changes:*** *12 months*
Impacted Counties	All counties, with targeted focus on HRSA-defined rural census tracts
Estimated Required Funding	$393,290,280.00

Initiative 2. Rooted in New Mexico: Building Tomorrow's Rural Health Workforce

Description:

The **Rooted in New Mexico** initiative seeks to strengthen and sustain the recruitment, training, and retention of health professionals so that care remains local for rural, frontier, and tribal communities in New Mexico.

New Mexico faces persistent and evolving workforce challenges, with several critical health professional shortages projected through 2037, as shown in **Table 17**. While workforce gaps are prominent across several disciplines, including maternal health, EMS, dental, and pediatric services, there are particularly high shortages among nursing, school-based, and behavioral health professions. Consistent with national trends, the State is also widely understood to experience significant shortages of direct care and personal care assistants who provide essential HCBS, even though detailed data on these roles is limited compared to other health professions. Workforce shortages are exacerbated by other issues like limited residency slots, high turnover, and other barriers to practicing in rural areas like housing availability, infrastructure for families (e.g., childcare, healthy food availability, schooling, jobs), and reliable transportation.

Table 17. Top 10 Workforce Shortages in New Mexico by 2037[51]

Health Profession	2026 Shortage	2037 Shortage	% Change
Registered Nurses	6,800	3,920	-42%
Licensed Practical Nurses	2,190	2,460	12%
Addiction Counselors	670	1,230	84%
Psychologists	420	800	90%
School Counselors	470	780	66%
Respiratory Therapists	430	570	33%
Diagnostic Medical Sonographers	400	530	33%
Mental Health Counselors	90	460	411%
Physical Therapists	490	430	-12%

Health Profession	2026 Shortage	2037 Shortage	% Change
Dental Hygienists	180	280	56%

To address these challenges and build an adequate and sustainable rural health workforce, the State will implement a set of strategies related to 1) Fostering Local Interest in Health Careers, 2) Strengthening the Workforce Pipeline, and 3) Mobilizing the Rural Health Workforce.

The State will prioritize high-need professions and geographies, including regions with persistent HPSA designations. The State requests flexibility to adjust focus areas as workforce needs evolve due to retirement, relocation, or population health trends.

Potential uses of funds could include:

1. **Fostering Local Interest in Health Careers**
    a. Launch K-12 health career pathway programs in rural and tribal school districts by modifying the Health Leadership High School curricula and creating additional sites, including expanding dual-credit pathways statewide (e.g., increasing high school partnerships with community colleges and offering more courses), health career exploration, and pre-apprenticeships (e.g., CHW).
    b. Conduct targeted outreach and mentorship in schools to inspire students to consider health care professions.
    c. Host community health career fairs, shadowing opportunities, and informational sessions with local providers and educators.
    d. Engage families, community leaders, and local organizations to promote health care careers and build awareness of opportunities in rural and tribal communities.

2. Strengthening the Workforce Pipeline

a. Establish a new scholarship program to cover medical school and/or graduate program tuition for in-state, prospective clinicians who commit to five years of service in a rural community.

b. Expand or establish new rural clinical rotations, apprenticeships, preceptorships, and residency tracks for physicians, nurse practitioners, physician assistants, registered nurses (RNs), LPNs, pharmacists, behavioral health professionals, EMS, physical therapy, occupational therapy, speech therapy, respiratory therapy, dental hygiene, and/or allied health professionals.

c. Support faculty stabilization, preceptor pools, and simulation labs to increase rural training capacity.

d. Provide paid training time, certification support, and career ladders for LPNs, CHWs, Peer Support workers, and direct care workers / personal care aides.

e. Deliver culturally responsive training for care of tribal communities, including tribal residency / rotation tracks and school-based nursing strategies.

f. Provide funding to schools to hire and retain nurses (where not currently available).

g. Advance interstate licensure reciprocity for clinicians such as physicians, physician assistants, and EMS.

h. Consider modifying EMS services to include mobile integrated health services, point-of-care testing, treat-in-place authority, and enhanced telehealth-support clinical procedures.

i. Create incentives for providers to practice at the top of their license.

3. **Mobilizing the Rural Health Workforce**
    a. Implement five-year rural service commitments paired with relocation / housing stipends, and retention bonuses, including a shared cost approach for rural hospitals and clinics.
    b. Develop housing solutions with local partners, such as down-payment assistance and agency-leased apartments in rural areas.
    c. Fund additional tele-supervision and mentoring networks to accelerate licensure (e.g., licensed clinical social worker (LCSW)), including Project Extension for Community Healthcare Outcomes (ECHO).
    d. Support provider burnout mitigation through team-based models, peer support, and flexible hybrid practice options.
    e. Connect trained community members to local care settings, so newly developed talent is deployed where it is most needed and retained for at least five years in rural service.
    f. Optimize existing rural facilities (e.g., local Department of Health facilities) for multi-purpose use, such as training, care delivery, and community engagement, and integrate telehealth capabilities to extend specialty and primary care access in community-based settings.

Other Considerations:

This initiative is designed to build on the momentum and infrastructure established by successful programs already operating in New Mexico, such as FORWARD NM and Project ECHO, without being duplicative.

Table 18 provides required details regarding this initiative.

Table 18. Initiative 2. Rooted in New Mexico – Component Details

Initiative Component	Detail
Main Strategic Goal	Workforce Development
Use of Funds	B, D, E, H, I, J, K (non-exhaustive)
Technical Score Factors	C.1, C.2, D.1, D.2, E.1 (non-exhaustive)
Key Stakeholders	New Mexico residents, providers (e.g., hospitals, clinics, tribal health centers, FQHCs, specialty clinics), tribal organizations and leaders, technology vendor(s), technical assistance vendor(s), schools (e.g., K-12, vocational, and higher education), professional associations
Outcomes	The State of New Mexico will use the following metrics to assess the impact of this initiative. The State will define targets in Year 1. 1. **Rural Training Pipeline Volume and Placement:** Number of rural rotations/residency slots filled, new rotation/residency slots created, apprenticeship completions, and graduates placed into rural practice (by discipline) ***Baseline:*** *To be established in Year 1* ***Estimated Time Period to Observe Changes:*** *18-60 months* 2. **Workforce Engagement:** Number of health professionals participating in tele-supervision, individual consultations, asynchronous learning, mentoring networks, or Project ECHO sessions to support rural practice readiness *(county-level)* ***Baseline:*** *To be established in Year 1* ***Estimated Time Period to Observe Changes:*** *12-18 months* 3. **Five-Year Retention of Rural Health Workforce:** Percentage of newly trained and recruited primary care, behavioral health, dental, pharmacy, EMS, allied health professionals, CHWs, peer support workers, and HCBS caregivers who commit to rural and tribal community practice for at least five years ***Baseline:*** *To be established in Year 1* ***Estimated Time Period to Observe Changes:*** *60 months* 4. **Reduction in HPSA designations:** Percentage decrease in federally designated HPSAs (at least part of or the whole county) within non-metro counties (as defined by HRSA) *Note: The reported percentage reflects non-metro counties that are either fully designated as HPSAs or have partial HPSA designation within their boundaries* ***Baseline:*** • Primary Care: 32 out of 33 non-metro counties [52] • Dental: 32 out of 33 non-metro counties [52] • Mental Health: 32 out of 33 non-metro counties [52] ***Estimated Time Period to Observe Changes:*** *36-60 months*
Impacted Counties	All counties, with targeted focus on HRSA-defined rural census tracts
Estimated Required Funding	$243,166,440.00

Initiative 3. Rural Health Innovation Fund: Enabling Community-Designed, Community-Led Change

Description:

The **Rural Health Innovation Fund** initiative will establish a grant program to support community-designed and community-led initiatives that respect and reflect the unique practices and priorities of different pueblos, tribal nations, and rural communities. New Mexico's RHT Program application includes initiatives specifically designed to address known statewide rural and frontier challenges including varying access to a variety of health care services and supports, workforce recruitment and retention, and data infrastructure needs. The **Rural Health Innovation Fund** initiative will provide opportunities for rural communities to design and address community-specific challenges that require local solutions rather than a one-size-fits-all statewide approach.

For example, many rural, frontier, and tribal communities across New Mexico face challenges related to non-medical drivers of health, including food insecurity and transportation. Although these may be common statewide challenges, a solution for one community may not be fully applicable or best suited to serve another. The **Rural Health Innovation Fund** initiative will allow specific communities, providers, or community-based organizations to apply for grant funding to implement community-driven and community-led initiatives to address local health care challenges.

The State will establish specific **Rural Health Innovation Fund** participation guardrails, including:

- Parameters for receiving subgrant funding, including requiring a clear rationale for how the proposed program would benefit the rural organization and the community members they serve.

- A competitive application structure and review methodology to evaluate each subgrant application.
- An annual funding cycle to implement activities throughout each RHT Program year.
- A methodology to assess and avoid duplication of effort between the Rural Health Innovation Fund and other RHT Program activities or existing State-facilitated rural grants (e.g., New Mexico Rural Health Care Delivery Fund).

Each approved subgrantee would be eligible to receive one-time (i.e., non-recurring for the same initiative) funding and would be subject to all reporting requirements to submit data to the State as required by Federal guidance.

Potential uses of funds will be contingent upon specific subgrantee applications. As defined above, the intent of the **Rural Health Innovation Fund** is for specific communities, providers, or community-based organizations to apply for grant funding to implement community-driven and community-led projects to address local health care challenges.

Potential uses of funds could include:

1. Expanding access to supports targeting non-medical drivers of health improvements, including improved access to nutritious food or enhanced transportation services.
2. Implementing a community-tailored program to improve substance use disorder or opioid use disorder services.
3. Enhancing preventive care services or programming, such as screening programs, counseling, and educational services (e.g., mental health screenings, smoking cessation), or other preventive measures (e.g., dental cleanings, vision and hearing tests, skin tests).
4. Improving patient safety and experience at urgent care centers and emergency departments, including creating separate entrances and/or waiting rooms, upgrading or

retrofitting existing facilities, and other eligible measures tied to patient safety, comfort, and overall member experience when seeking care.

5. Upgrading and/or retrofitting skilled nursing and rehabilitation centers to improve patient safety, comfort, and quality of care, including facility enhancements and equipment upgrades that support better recovery environments and patient experience.

Other Considerations:

Through the request for information (RFI) process, the State received 306 proposed uses of RHT Program funding. The **Rural Health Innovation Fund** initiative will help the State provide an opportunity to fund critical, community-level projects that may not be captured by the defined statewide RHT Program initiatives. Additionally, the initiative approach will help build community-level ownership in the outcomes, supporting long-term sustainability and potential follow-on investment from alternative local or statewide organizations upon successful implementation.

This fund will differ from the State's existing Rural Health Care Delivery Fund. The Rural Health Care Delivery Fund is specifically designed to provide financial support to rural Medicaid providers to help offset operational costs in the expansion of health care services. The **Rural Health Innovation Fund** would be open to additional entities (e.g., community-based organizations) with a specific focus on improving non-medical drivers of health needs, enhancing behavioral health, increasing access to preventive care services, or upgrading existing facilities. This fund also differs from the CMS-proposed "Rural Tech Catalyst Fund" and associated limitations as the **Rural Health Innovation Fund** is focused on improving access to health care services versus serving as a technology incubator.

Table 19 provides required details regarding this initiative.

Table 19. Initiative 3. Rural Health Innovation Fund – Component Details

Initiative Component	Detail
Main Strategic Goal	Make Rural America Healthy Again
Use of Funds	A, H, I, J (non-exhaustive)
Technical Score Factors	B.1, B.2 (non-exhaustive)
Key Stakeholders	New Mexico residents, providers (e.g., hospitals, clinics, tribal health centers, FQHCs, specialty clinics), rural and frontier community leaders, rural and frontier community organizations and leaders, vendor(s), tribal organizations and leaders
Outcomes	The State of New Mexico will use the following metrics to assess the impact of this initiative. The State will define targets in Year 1. 1. **Number of Community-Designed and Community-Led Projects Funded:** Total number of funded projects that have reached full implementation within the reporting period *(county level)* ***Baseline:*** *To be established Year 1* ***Estimated Time Period to Observe Changes:*** *12 months* 2. **Percentage of Funded Projects Achieving Stated Objectives:** Percentage of funded projects that meet at least 80% of proposed goals (as defined in the organization's approved subgrant application) within the reporting period ***Baseline:*** *To be established Year 1* ***Estimated Time Period to Observe Changes:*** *12-24 months* 3. **Community Reach of Community-Designed Projects:** Number of community members served by community-designed programs ***Baseline:*** *To be established Year 1* ***Estimated Time Period to Observe Changes:*** *12 months* 4. **Reported Access to Additional Community Resources**: Number of community members who report additional supports available in their communities ***Baseline:*** *To be established Year 1* ***Estimated Time Period to Observe Changes:*** *12 months*
Impacted Counties	All counties, with targeted focus on HRSA-defined rural census tracts
Estimated Required Funding	$187,508,220.00

Initiative 4. Bridge to Resilience: Rural Health Sustainability & Innovation Center

Description:

In addition to assisting the HCA with managing RHT Program initiatives, the RHSIC will also directly support rural providers by coordinating and delivering high-impact technical assistance (e.g., operations, finance, service optimization, regional partnership coordination) to rural providers. Rural providers face several contextual and environmental challenges that make for

unfavorable economic conditions. Declining population (e.g., 21 out of 33 rural New Mexico counties have lost population), economic stagnation, and heavy reliance on public programs (e.g., 37 percent of New Mexico Medicaid Members live in rural areas) present challenges and unique opportunities to innovate.[53, 54] The RHSIC will provide a suite of services aimed at supporting financially distressed rural providers with the tools and knowledge to operate more effectively and achieve sustainability.

Potential use of funds may include:

1. **Strategic Technical Assistance**: Support and facilitate the identification, engagement, and set up of affiliations and partnerships between interested entities. For example, establishing referral pathways and agreements between rural entities and large regional health care systems, or facilitating opportunities for independent facilities and clinics to come together to share services and expenses (e.g., collectively contracting for back-office revenue cycle functions, establishing regional maternal service infrastructure) to achieve more favorable pricing.
2. **Operational Technical Assistance**: Provide access to experts in patient workflows, unit management, supply chain management, and revenue cycle management, among other areas to deliver one-on-one support to eligible providers. Services will be geared towards developing leave-behind tools, establishing new processes, and training health care staff so lessons learned, and best practices can be carried forward independently by providers and reduce the need for future hands-on support.
3. **Provider Education and Learning Collaboratives**: Develop materials and facilitate events focused on high-priority topics including workforce recruitment and retention,

emerging technologies, digital tools, financial sustainability, and policy, programs, and funding impacting rural providers.

4. **Data Analytics Platform Access**: As outlined in Initiative #5 (Rural Health Data Hub), the State's investment in robust data analytics and tailored rural community profiles and queries may be linked or accessible through the RHSIC's website with additional support to help analyze and interpret the data.
5. **Policy Advocacy:** Support the HCA in pursuing RHT state policy action commitments, including licensure reciprocity with border states.

Services and programs offered through the RHSIC will be tailored to rural providers specifically rather than parent organizations or large health systems. Providers owned by or affiliated with larger systems may access services and participate in RHSIC events, but guardrails will be in place to ensure benefits and services are delivered directly to rural areas. The State will incentivize providers to engage with and sustain technical assistance learnings through direct payment tied to meeting specified outcome metrics (e.g., operating margin improvement).

Other Considerations*:*

The RHSIC is central to the State's RHT Program and the future of rural health in New Mexico. The RHSIC will also function as the entity responsible for all reporting, monitoring and evaluation associated with the RHT Program.

Table 20 provides required details regarding this initiative.

Table 20. Initiative 4. Bridge to Resilience – Component Details

Initiative Component	Detail
Main Strategic Goal	Sustainable Access
Use of Funds	B, D, F, G, K (non-exhaustive)
Technical Score Factors	C.1, E.1 (non-exhaustive)

Initiative Component	Detail
Key Stakeholders	New Mexico residents, providers (e.g., hospitals, clinics, tribal health centers, FQHCs, specialty clinics), rural and frontier community organizations and leaders, technology vendor(s), and technical assistance vendor(s)
Outcomes	The State of New Mexico will use the following metrics to assess the impact of this initiative. The State will define targets in Year 1. 1. **Providers Requesting RHSIC Services:** Number of providers that request a technical assistance service from the RHSIC *(county-level)* ***Baseline:*** *To be established in Year 1* ***Estimated Time Period to Observe Changes****: 12 months* 2. **Proportion of Providers Accessing Center Services to Experience Improved Operating Margin:** Percent of providers that complete a service with the RHSIC to see operating margin improvement ***Baseline:*** *To be established in Year 1* ***Estimated Time Period to Observe Changes:*** *36 months* 3. **Rural Facilities in Financial Distress:** Number of facilities (e.g., hospitals, clinics, FQHCs, tribal health centers, etc.) in financial distress based on assessment of key financial indicators (e.g., operating margin, days cash on hand, etc.) and audited financial statements ***Baseline:*** *To be established in Year 1* ***Estimated Time Period to Observe Changes:*** *36 months* 4. **Rural Facilities Closures:** Number of facilities (e.g., hospitals, clinics, FQHCs, tribal health centers, etc.) that close each year. ***Baseline:*** *0 facilities* ***Estimated Time Period to Observe Changes:*** *36 months*
Impacted Counties	All counties with rural and tribal communities
Estimated Required Funding	$122,644,440.00

Initiative 5. Rural Health Data Hub: Establishing a Health Analytics Platform

Description:

The **Rural Health Data Hub** initiative will build or expand secure and reliable internal (i.e., State) and external (i.e., provider) data infrastructure that enhances data informatic capabilities and capacity, improves the accuracy of predictive analytics, and provides data and health transparency across the State. It will also enable full integration of patient information across medical, behavioral, and social services, promoting a unified care experience for rural residents. In alignment with New Mexico's HHS IT Enterprise Project of 2020, the statewide analytics platform will bring together critical but disparate data sources into a unified picture, enabling

identification of the highest-need rural geographies and populations, providing enhanced oversight and strategic planning capabilities (e.g., health care landscape and Medicaid contract negotiations), and improving outcome tracking, especially for difficult-to-manage chronic diseases.[55] Leveraging secure, statewide longitudinal health and human services data, the system will include Medicaid claims, SYNCRONYS Health Information Exchange (HIE) clinical data, the State's all-payer data, public health data sources, behavioral health, closed loop referral system, and other state-owned data to produce timely analytics that improve rural access, quality, and financial sustainability. Through the Rural Health Data Hub, New Mexico will advance the following:

- **Clarify the New Mexico health care landscape, needs, and drivers**: Bringing siloed data sets into one centralized system offers the opportunity for in-depth data analysis to identify and fill gaps in the rural health landscape, and pinpoint and develop programs centered around the non-medical drivers of health.
- **Predictive analytics**: New Mexico is constantly evolving and, bringing together historical data and trends paired with predictive analytic capabilities, allows the State, providers, and the public to anticipate and prepare for shifts.
- **Consumer and provider facing health care data transparency**: Key to this initiative will be readily available interfaces so the data can be accessed, analyzed, and used to inform decision-making at the consumer, provider, region, and State level. The data system, housed within the HCA, will be publicly accessible through the RHSIC website and/or other public entry points, while ensuring the protection and security of all private, protected, and sensitive information.[56]

- **Financial transparency and patient empowerment:** The initiative will explore tools such as a patient-facing cost calculator to provide clear, upfront information on care costs, supporting informed decision-making and provider sustainability.

Potential uses of funds could include:

1. Incorporating data from the New Mexico Department of Health into the platform.
2. Implementing identity resolution and master data management across people, providers, and places, including privacy-preserving record linkage and geocoding to enable rural analyses and small-area reporting.
3. Developing standard rural health analytics focused on health access in rural areas to identify gaps in care or high-priority services, and disease prevalence.
4. Establishing mechanisms to publicly share data sets and promote data transparency including making data available to download as appropriate.
5. Designing and launching a suite of rural-specific data visualizations aligned to RHT Program expectations, including metrics for primary care access, maternal and behavioral health outcomes, avoidable ED use and readmissions, transportation barriers, and provider stability, with training for State, managed care organizations, and provider users.
6. Creating visualizations, and query interface capabilities for external users (e.g., rural residents and providers) to easily access, filter, and understand reports.
7. Developing automated processes and reproducible procedures that allow for expansion of data sources, changes to dashboards and reports, queryable interfaces for external users, and deployment of patient accessible mobile apps, remote monitoring solutions, and telehealth.

8. Incentivizing rural providers with an interoperable EHR platform to participate in the HIE.

Other Considerations:

Data security and privacy is a top priority for the State. New Mexico will expand or establish data security protocols and processes to ensure compliance with state and federal law regarding interagency data sharing and data shared with the public. Processes will include limited data access, establishing data request protocols, and data security planning.

Table 21 provides required details regarding this initiative.

Table 21. Initiative 5. Rural Health Data Hub– Component Details

Initiative Component	Detail
Main Strategic Goal	Tech Innovation
Use of Funds	B, D, F, I, K (non-exhaustive)
Technical Score Factors	E.1, F.2, F.3 (non-exhaustive)
Key Stakeholders	Technology vendor(s), providers (e.g., hospitals, clinics, tribal health centers, FQHCs, specialty clinics), partner agencies (e.g., NM Department of Health, NM Children, Youth, and Families Department, NM Aging and Long-Term Services)
Outcomes	The State of New Mexico will use the following metrics to assess the impact of this initiative. The State will define targets in Year 1. 1. **Provider Participation in HIE:** Number of providers enrolled in HIE and actively contributing data (*county-level)* ***Baseline:*** 105 data providers, 101 HIE subscribers (as of October 31, 2025) ***Estimated Time Period to Observe Changes:*** *12 months* 2. **Provider Participation in CLRS:** Number of providers enrolled in CLRS and actively contributing data (*county-level)* ***Baseline:*** *0 providers* ***Estimated Time Period to Observe Changes****: 12 months* 3. **Rural Health Data Hub Usage:** Number and type of users that access the Rural Health Data Hub ***Baseline:*** *To be established on Day 1 of Rural Health Data Hub launch* ***Estimated Time Period to Observe Changes****: 24 months* 4. **Rural Health Data Hub Outages:** Number of outages or downtime when the Rural Health Data Hub is unavailable for standard system maintenance or to address issues ***Baseline:*** *To be established on Day 1 of Rural Health Data Hub launch* ***Estimated Time Period to Observe Changes:*** *24 months*

Initiative Component	Detail
Impacted Counties	All counties, with targeted focus on HRSA-defined rural census tracts
Estimated Required Funding	$53,390,620.00

Implementation Plan and Timeline

The State is prepared to take action immediately following RHT Program award in January 2026. As detailed in our implementation plan in **Table 22**, New Mexico will prioritize planning and infrastructure in 2026 followed by key program launches and funding distribution in 2027.

Table 22. New Mexico RHT Program Implementation Plan and Timeline

#	Milestone	Stage (0-5)	First Quarter	Last Quarter
Initiative 0. Administrative RHT Program Activities				
0.1	Develop Detailed Innovation Center Timeline and Implementation Plan	Stage 0	FY26Q1	FY26Q2
0.2	Hire RHSIC Staff	Stage 0	FY26Q1	FY26Q2
0.3	Establish Partnership(s) or Procure Vendor(s) for RHSIC	Stage 1	FY26Q1	FY26Q2
0.4	Design and Establish Management Tools as needed	Stage 2	FY26Q1	FY26Q2
0.5	Introduce RHT Program Legislation in January 2026 Session	Stage 1	FY26Q1	FY26Q1
0.6	Open RHSIC	Stage 2	FY26Q3	FY26Q3
0.7	Submit RHT Program Reports to CMS	Stage 5	FY27Q1	FY31Q4
Initiative 1. Healthy Horizons: Expanding Specialty Care Access and Chronic Disease Management				
1.1	Design Healthy Horizons Programs	Stage 0	FY26Q1	FY26Q1
1.2	Establish Partnership(s) or Competitively Award Providers for Healthy Horizons Programs	Stage 1	FY26Q2	FY26Q2
1.3	Launch Healthy Horizons Programs	Stage 3	FY26Q3	FY26Q3
1.4	Collaborate with Providers to Implement Healthy Horizons Programs	Stage 4	FY26Q4	Ongoing
1.5	Collect Provider Reports Participating in Healthy Horizons Programs	Stage 4	FY27Q1	Ongoing
1.6	Refine Healthy Horizons Programs	Stage 5	FY27Q2	Ongoing
1.7	Design EHR Funding Program	Stage 0	FY26Q1	FY26Q1
1.8	Establish Competitive Process for EHR Funding Program	Stage 1	FY26Q2	FY26Q2
1.9	Launch EHR Funding Program	Stage 3	FY26Q3	FY26Q3
1.10	Collaborate with Providers to Implement EHR Funding Program	Stage 4	FY26Q4	Ongoing
1.11	Collect Provider Reports Participating in EHR Funding Program	Stage 4	FY27Q1	Ongoing
1.12	Refine EHR Funding Program	Stage 5	FY27Q2	Ongoing
1.13	Assess NM Department of Health Clinical Locations for Capacity Enhancement and Remodel	Stage 1	FY27Q1	FY27Q1

#	Milestone	Stage (0-5)	First Quarter	Last Quarter
1.14	Determine NM Department of Health Clinical Locations for Capacity Enhancement and Remodel	Stage 2	FY27Q1	FY27Q1
1.15	Initiate NM Department of Health Clinical Location Capacity Enhancement and Remodel	Stage 3	FY27Q1	FY27Q2
1.16	Complete NM Department of Health Clinical Location Capacity Enhancement and Remodel	Stage 4	FY27Q3	FY27Q4
1.17	NM Department of Health Clinical Locations Deliver Enhanced Services	Stage 5	FY28Q1	Ongoing
1.18	Design Incentive Payment Models	Stage 0	FY26Q1	FY26Q2
1.19	Secure Needed Authorities and Update Contracts to Include Incentive Payment Models	Stage 1	FY26Q2	FY26Q4
1.20	Launch Incentive Payment Models	Stage 3	FY27Q1	FY27Q2
1.21	Monitor Incentive Payment Models	Stage 4	FY28Q1	Ongoing
1.22	Refine Incentive Payment Models	Stage 5	FY29Q1	Ongoing
Initiative 2. Rooted in New Mexico: Building Tomorrow's Rural Health Workforce				
2.1	Align on Initial Rooted in New Mexico Focus Areas / Programs (e.g., training programs, K-12 pipeline)	Stage 0	FY26Q1	FY26Q1
2.2	Coordinate with Potential Partners to Establish Rooted in New Mexico Framework	Stage 1	FY26Q2	FY26Q3
2.3	Begin Policy Modifications to Align with Workforce Development Goals and Objectives	Stage 1	FY26Q2	FY26Q2
2.4	Establish Technical Assistance and Training Programs	Stage 1	FY26Q2	FY26Q2
2.5	Communicate Initial Rooted in New Mexico Program Framework and Availability	Stage 2	FY26Q4	FY26Q4
2.6	Begin Delivering Technical Assistance and Training	Stage 2	FY26Q4	Ongoing
2.7	Launch Provider Incentive Payment Models to Support Program Participation	Stage 2	FY26Q4	Ongoing
2.8	Monitor Partner Implementation of Initial Rooted in New Mexico Programs	Stage 2	FY27Q3	Ongoing
2.9	Evaluate Initial Rooted in New Mexico Program Implementation	Stage 3	FY27Q3	FY28Q2
2.10	Refine Rooted in New Mexico Programs	Stage 3	FY28Q3	FY29Q2
2.11	Monitor Partner Implementation of Revised Rooted in New Mexico Programs	Stage 4	FY29Q3	FY30Q2
2.12	Evaluate Revised Rooted in New Mexico Programs	Stage 5	FY30Q3	FY30Q4
2.13	Coordinate with Partners to Identify Sustainable Models Post RHT Program Period	Stage 5	FY29Q3	FY30Q4
Initiative 3. Rural Health Innovation Fund: Enabling Community-Designed, Community-Led Change				
3.1	Define, Design, and Prepare Innovation Fund Parameters	Stage 0	FY26Q1	FY26Q1
3.2	Solicit Innovation Fund Submissions for Review	Stage 1	FY26Q2	FY26Q2
3.3	Evaluate Innovation Fund Submissions	Stage 1	FY26Q3	FY26Q3
3.4	Select and Announce Innovation Fund Awards	Stage 1	FY26Q4	FY26Q4
3.5	Negotiate and Onboard Innovation Fund Awardees	Stage 2	FY26Q4	FY26Q4
3.6	Start Innovation Funds Project Implementation	Stage 2	FY27Q1	FY28Q4
3.7	Continuously Monitor Innovation Fund Projects	Stage 3	FY27Q1	Ongoing
3.8	Identify Promising Pilots for Further Investment	Stage 4	FY29Q1	FY29Q1

#	Milestone	Stage (0-5)	First Quarter	Last Quarter
3.9	Scale Promising Practices by Coordinate across New Mexico Government on Future Investment	Stage 5	FY29Q1	Ongoing
Initiative 4. Bridge to Resilience: Rural Health Sustainability & Innovation Center				
4.1	Design Technical Assistance Request Process and Service Offering	Stage 0	FY26Q3	FY26Q4
4.2	Launch Technical Assistance Program	Stage 1	FY26Q4	FY26Q4
4.3	Begin Accepting Requests for Services	Stage 1	FY27Q1	FY27Q1
4.4	Initiate One-on-One Technical Assistance Projects	Stage 2	FY27Q2	FY27Q2
4.5	Conduct One-on-One Technical Assistance Projects	Stage 3	FY27Q3	Ongoing
4.6	Complete One-on-One Technical Assistance Projects	Stage 4	FY27Q4	Ongoing
4.7	Monitor Sustainable Impact of Technical Assistance Projects	Stage 5	FY27Q4	Ongoing
4.8	Design Educational Opportunities	Stage 0	FY26Q3	FY26Q3
4.9	Develop Materials and Coordinate Logistics for Educational Opportunities	Stage 1	FY26Q4	Ongoing
4.10	Launch Educational Opportunities	Stage 2	FY27Q1	FY27Q1
4.11	Deliver Educational Opportunities	Stage 3	FY27Q1	Ongoing
4.12	Evaluate and Refine Educational Opportunities	Stage 4	FY27Q2	Ongoing
4.13	Monitor Sustainable Impact of Educational Opportunities	Stage 5	FY27Q3	Ongoing
4.14	Assess Rural Health Landscape for Collaboration and Strategic Partnership Opportunities	Stage 1	FY26Q1	FY26Q3
4.15	Initiate Coordination of Rural Health Collaborations and Partnerships Across the Landscape	Stage 2	FY26Q4	FY27Q1
4.16	Stand-up Rural Health Collaborations and Partnerships Across the Landscape	Stage 4	FY27Q2	Ongoing
4.17	Monitor Impact of Rural Health Collaborations and Partnerships	Stage 5	FY27Q2	Ongoing
Initiative 5. Rural Health Data Hub: Establishing a Health Analytics Platform				
5.1	Conduct Data Inventory and Infrastructure Assessment	Stage 0	FY26Q1	FY26Q1
5.2	Design Platform Architecture Changes and Vendor Procurement Documents	Stage 1	FY26Q1	FY26Q2
5.3	Procure Platform Vendor	Stage 1	FY26Q2	FY26Q4
5.4	Initiate Vendor Contract	Stage 2	FY27Q1	FY27Q1
5.5	Establish Data Ingestion Pipelines and Begin Ingesting New Data Sources	Stage 2	FY27Q2	FY27Q4
5.6	Refine And Begin Ongoing Ingestion of New Data Sources	Stage 2	FY28Q1	FY28Q2
5.7	Design Rural-Specific Data Queries, Visualizations, And Reports	Stage 2	FY28Q3	FY28Q3
5.8	Develop And Finalize Rural-Specific Data Queries, Visualizations, And Reports	Stage 2	FY28Q4	FY28Q4
5.9	Design Public-Facing Interface and Capabilities	Stage 3	FY29Q1	FY29Q1
5.10	Build Public-Facing Interface and Capabilities	Stage 3	FY29Q2	FY29Q4
5.11	Launch Public-Facing Interface and Capabilities	Stage 3	FY30Q1	FY30Q1
5.12	Design Secure Data-Sharing Portal with Downloadable Data Sets and Metadata Documentation	Stage 3	FY29Q2	FY29Q4
5.13	Launch Public-Facing Data Sharing Mechanism	Stage 4	FY29Q4	FY29Q4
5.14	Develop Feedback Mechanism for Ongoing Improvement	Stage 4	FY29Q4	FY29Q4
5.15	Expand and Scale Reports, Queries, Reports, And Interfaces	Stage 5	FY30Q1	Ongoing

#	Milestone	Stage (0-5)	First Quarter	Last Quarter
5.16	Implement Continuous Integration/Continuous Deployment (CI/CD) for Analytic Updates	Stage 5	FY30Q1	Ongoing
5.17	Provide Ongoing Education and Technical Assistance On Data Hub Capabilities	Stage 3	FY26Q3	Ongoing

Governance and Project Management Structure

Lead Agency: New Mexico HCA will serve as the State's lead agency.

Interagency Team Members: The HCA will be supported by sister agencies to implement the RHT Program as listed in **Table 23**.

Table 23. RHT Program Sister Agencies

#	Sister Agency
1	Aging and Long-Term Services Department
2	Children, Youth & Families Department
3	Early Childhood Education & Care Department
4	Department of Health
5	Tribal health departments

Key State Personnel: New Mexico's RHT Program will be supported by 20 key personnel housed within the HCA. The roles and responsibilities are provided in Table 24.

Table 24. Proposed RHT Program Positions

Position Title	Brief Job Description
RHT Program Director	Provides strategic leadership and oversight for the RHT Program, ensuring all initiatives are implemented in alignment with New Mexico's transformation goals and CMS requirements. Coordinates cross-departmental efforts and stakeholder engagement to drive measurable improvements in rural health access, outcomes, and sustainability.
RHT Finance Director	Oversees financial planning, budgeting, and compliance for the RHT Program, ensuring all expenditures meet CMS guidelines and support program sustainability. Manages funding allocations across initiatives and monitors financial performance to maximize impact and avoid duplication of existing funding streams.
RHT Operations Manager	Manages day-to-day operations of the RHT Program, coordinating logistics, staffing, and resource deployment to support effective implementation of all initiatives. Ensures operational processes are efficient, compliant, and responsive to evolving program needs.
RHT Program Implementation Manager 1	Leads the execution of Healthy Horizons and Rooted in New Mexico initiatives, tracking milestones, outcomes, and reporting requirements. Collaborates with internal and external partners to ensure timely delivery of program activities and continuous improvement based on evaluation findings.

Position Title	Brief Job Description
RHT Program Implementation Manager 2	Leads the execution of Rural Health Innovation Fund, Bridge to Resilience, and Rural Health Data Hub initiatives, tracking milestones, outcomes, and reporting requirements. Collaborates with internal and external partners to ensure timely delivery of program activities and continuous improvement based on evaluation findings.
Administrative Aide	Provides administrative support for the RHT Program team, including scheduling, documentation, and coordination of meetings and communications. Assists with record-keeping and ensures compliance with program documentation standards.
Finance Manager	Supports the Finance Director in managing budgets, tracking expenditures, and preparing financial reports. Ensures all financial activities adhere to CMS requirements and contribute to the program's fiscal integrity.
Finance Analyst	Conducts financial analysis to inform decision-making, monitors spending trends, and evaluates cost-effectiveness of program activities. Provides data-driven insights to optimize resource allocation and support sustainability.
Data and Evaluation Manager	Designs and oversees the program's data collection, analysis, and evaluation framework, ensuring robust measurement of outcomes and compliance with CMS reporting standards. Leads efforts to use data for continuous improvement and strategic planning.
Data and Evaluation Analyst	Supports the Data and Evaluation Manager by collecting, analyzing, and interpreting program data. Prepares reports and visualizations to communicate progress and inform program adjustments.
Communications Manager	Develops and implements communication strategies to engage stakeholders, disseminate program updates, and promote transparency. Ensures messaging aligns with program goals and CMS requirements and supports outreach to rural communities.
RHSIC: *Rural Technical Assistance & Systems Support Manager*	Leads the RHSIC's technical assistance efforts, providing operational, financial, and strategic support to rural providers. Facilitates partnerships and shared services to strengthen provider sustainability and program impact.
Healthy Horizons: *Specialty Access & Remote Care Manager*	Manages initiatives to expand specialty care access and remote care solutions, including telehealth and e-consults. Works to reduce travel burdens, improve chronic disease management, and integrate behavioral health services in rural communities.
Rooted in New Mexico: *Rural Health Workforce Pipeline Manager*	Oversees workforce development strategies, including recruitment, training, and retention of rural health professionals. Implements programs to build local talent pipelines and support long-term workforce sustainability.
Rural Health Innovation Fund: *Subgrant Manager*	Administers the Rural Health Innovation Fund, managing the competitive subgrant process for community-designed initiatives. Ensures funded projects address local needs, comply with CMS requirements, and support program objectives.
Rural Health Innovation Fund: *Community Health Innovation Liaison*	Engages with community-based organizations and stakeholders to support the design and implementation of innovative health projects. Facilitates collaboration and ensures initiatives are responsive to local priorities and program goals.
Rural Health Data Hub: *Rural Health Data Lead*	Leads the development and management of the Rural Health Data Hub, integrating data sources to support analytics, transparency, and informed decision-making. Ensures data security, privacy, and compliance with federal standards.

Key Non-State Personnel: Additional non-State staff may be identified throughout the performance period as needed.

Advisory Committee Representatives: Additional information regarding the State's engagement with the RHT Program Advisory Committee are detailed in the Stakeholder Engagement section below. However, we anticipate Advisory Committee Representatives to include representatives outlined in **Table 25.**

Table 25. Advisory Committee Representative Organizations

#	Organization
1	Governor's Office
2	New Mexico Health Care Authority
3	New Mexico Department of Health (including State Office of Primary Care & Rural Health)
4	New Mexico Department of Indian Affairs
5	New Mexico Aging and Long-Term Services Department
6	New Mexico Children, Youth & Families Department
7	New Mexico Early Childhood Education & Care Department
8	Legislators
9	Association Leadership
10	Tribal Healthcare Providers
11	Health System Leadership
12	Rural / Frontier Hospital and Clinic Leadership
13	Health Plan Leadership
14	Community-Based Organization Leadership
15	A minimum of 5 (20% of members) tribal, rural, and/or frontier community members

Internal and External Coordination: Coordination across entities inside and outside of New Mexico State Government will be key to ensuring the success of the RHT Program. **Table 26** presents the State's intended coordination and engagement methods with internal and external entities.

Table 26. Internal and External Coordination Methods

Coordination Method	Description
Internal	
Monthly Cross-Departmental Meetings (FY26)	• Provide a forum to discuss design decisions as programs launch. • Align and coordinate activities as needed across departments.
Quarterly Cross-Departmental Meetings (FY27 – FY31)	• Provide progress reports regarding all initiatives to department and other government leadership. • Communicate departmental requests for support. • Discuss promising practices and future areas of state investment.

Coordination Method	Description
Weekly Initiative Meetings	• Discuss ongoing status of respective initiatives. • Raise potential risks and discuss mitigation strategies. • Determine next steps.
External	
Quarterly Stakeholder Advisory Committee Meeting	• Provide progress reports regarding all initiatives to external partners and advisors. • Solicit feedback from trusted advisors on key decisions of the programs and activities. • Discuss emerging themes and potential modifications to plans and programs.
Public Website	• Establish a record of RHT Program activities. • Share promising practices and case studies. • Announce opportunities and updates.
Annual Legislative Reports	• Provide progress reports regarding all initiatives to the Legislature. • Summarize the impact of the RHT Program. • Articulate legislative asks and strategies for sustainability.
Public Feedback and Forums	• Collect feedback from the public. • Collect emerging and innovative ideas for further investment. • Identify barriers and best practices.

Stakeholder Engagement

The State of New Mexico places an incredibly high value on regularly and effectively engaging our stakeholders on health care-related initiatives. The State implemented a robust process to solicit both written and verbal feedback from stakeholders on potential uses for RHT Program funding aligned with needs in rural, frontier, and tribal communities across New Mexico. Additionally, the State has designed a framework to continuously engage with and seek feedback from community partners throughout implementation.

Stakeholder Engagement Through the Application Development Process

The State implemented a multi-faceted approach to solicit and receive feedback from stakeholders during the application development process. **Table 27** outlines the strategies the State implemented to receive feedback.

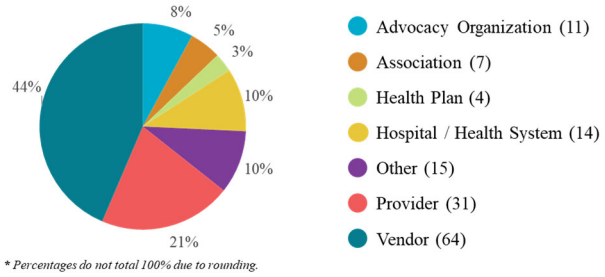
Table 27. RHT Program Application Development – Stakeholder Engagement Methods

Stakeholder Engagement Method	Description
RFI[57]	• Opened RFI from September 23 – October 10, 2025. • Invited submission of project concepts, potential initiatives, and feedback on State policy options. • Received 146 responses and 306 potential initiatives.
Public Forums and Listening Sessions	• Facilitated a tribal Listening Session on October 21, 2025 to solicit feedback on tribal-specific needs and potential uses for RHT Program funding (41 attendees). • Facilitated a Public Forum on October 22, 2025 to solicit feedback on rural and frontier community needs and potential uses for RHT Program funding (354 attendees).
Individual Meetings and Written Outreach	• Facilitated individual meetings with associations (e.g., New Mexico Hospital Association) and legislators to discuss RHT Program opportunities. • Received additional written feedback that helped inform RHT Program application approach.
Cross-Department Collaboration	• Prepared application in partnership with multiple departments, including (but not limited to): o Governor's Office o Aging and Long-Term Services Department o Children, Youth & Families Department o Early Childhood Education & Care Department o Department of Health o Health Care Authority o Legislative Finance Committee

Figure 3 reflects a summary of stakeholders that submitted responses to the State's RFI. The State identified several key themes across various feedback methods and used feedback to inform RHT Program application initiatives. At a summary level, stakeholders submitted and/or shared the following thematic suggestions for RHT Program initiatives, which are fully reflected across the initiatives included in the State's RHT Plan: Access and Care Delivery Innovations; Workforce Development and Training; Data Infrastructure and Interoperability; Telehealth and

Digital Health; Behavioral Health and Chronic Disease Management; and Rural and Frontier Provider Stability and Sustainability.

Figure 3. RFI Respondents by Stakeholder Type



The State collaborated across departments to review and synthesize feedback received throughout the stakeholder engagement process and appropriately incorporate into the proposed initiatives. The State will plan to partner with several statewide, tribal, and rural community-based stakeholders to implement the RHT Program initiatives and continuously engage to solicit regular feedback and input throughout the implementation period as outlined in the Implementation Plan.

RHT Program Governance and Ongoing Stakeholder Engagement

The New Mexico HCA will be the agency responsible for administering the RHT Program. As defined in Initiative #1, the HCA plans to develop the RHSIC that will maintain day-to-day operations of RHT Program initiatives and subsequent activities (e.g., deliver technical assistance, training, coordinate sub-recipient grants) as defined in the application.

The RHSIC, in partnership with the HCA leadership, will establish two primary methods to regularly engage both State agency leadership and stakeholders throughout the implementation process. The RHSIC will facilitate a quarterly RHT Program Stakeholder Advisory Committee, which will reflect a robust group of public and private leaders and community members to advise on program implementation. The State recognizes that for rural health initiatives to be successful, the State, providers, payers, and community organization leaders must collaborate and contribute. **Figure 4** outlines proposed RHT Program Stakeholder Advisory Committee members, which may be expanded as needed to reflect implementation progress or needs. Each

quarter, the workgroup will review implementation progress and milestones, discuss outcome metrics and reporting data, and align on the next quarter's goals and activities. Additionally, the workgroup will align any necessary communications needs to assist implementation efforts.

The State will annually evaluate the RHT Program Stakeholder Advisory Committee membership to ensure the group aligns with and reflects the communities and populations served through RHT Program initiatives. Each year, the State (in partnership with the RHSIC), will recruit and onboard five new tribal, rural, and/or frontier community members to support the Committee for a 1-year term. This rotational basis will help promote variety of thought and communities represented to ensure broad representation of perspectives and communities, while not overburdening community members with the pressure of program oversight and management. The State values directly engaging the community members we serve and will prioritize a RHT Program governance structure that fully reflects our varied rural, frontier, and tribal communities.

Figure 4. RHT Program Stakeholder Advisory Committee Members

- Governor's Office
- New Mexico Health Care Authority
- New Mexico Department of Health (including State Office of Primary Care & Rural Health)
- New Mexico Department of Indian Affairs
- New Mexico Aging and Long-Term Services Department
- New Mexico Children, Youth & Families Department
- New Mexico Early Childhood Education & Care Department
- Legislators
- Association Leadership
- Tribal Health Care Providers
- Health System Leadership
- Rural / Frontier Hospital and Clinic Leadership
- Health Plan Leadership
- Community-Based Organization Leadership
- A minimum of 5 (or ~20% of members) Tribal, rural, and/or frontier community members and leaders

The second method to engage stakeholders will be an online public input forum maintained by the HCA and the RHSIC and available on the RHSIC webpage. This public input forum will allow rural and frontier community members to submit regular feedback on rural, frontier, and tribal community needs, implementation progress or outcomes, or other pertinent feedback to help more effectively implement the RHT Program initiatives.

Each month, the RHSIC will compile feedback received through the online public forum and prepare consolidated feedback summaries to share with the RHT Program Stakeholder Advisory Committee. During each quarterly RHT Program Stakeholder Advisory Committee meeting, the group will review consolidated feedback summaries and align on necessary implementation plan adjustments to align with emergent community needs (where allowable per federal requirements).

In summary, the State prioritized stakeholder engagement throughout the application development process. As the State begins implementing the RHT Program initiatives, the State will continue to regularly engage stakeholders to advise on implementation progress and activities, promoting an efficient, and ultimately successful, program roll out across rural, frontier, and tribal New Mexican communities.

Metrics and Evaluation Plan

New Mexico designed its RHT Plan to drive measurable improvements for rural communities in alignment with CMS priorities, including access, quality, financial sustainability, and health outcomes. The evaluation will assess how well the initiatives advance these goals and generate insights to guide real-time adjustments and continuous improvement.

The following RHT Evaluation Plan provides a framework for how New Mexico will measure progress and impact across all initiatives. This framework aligns with CMS guidance by:

- Defining quantifiable performance measures.
- Establishing milestones.
- Accounting for data collection at both statewide and county levels.

The State commits to cooperating fully with any evaluation or monitoring conducted by CMS and/or third parties and will leverage its own analytic capabilities to inform continuous

improvement and demonstrate accountability to CMS. Evaluation findings will be reviewed quarterly by the RHSIC to inform real-time strategy adjustments, funding allocations, and technical assistance priorities. This feedback loop ensures continuous learning and alignment with CMS performance goals throughout the five-year implementation period.

Evaluation Framework and Approach

Evaluation Roles and Accountability

The State will lead evaluation activities, including data collection, analysis, monitoring, reporting to CMS, and publishing updates for the public and key stakeholders. The State will integrate evaluation activities into routine program oversight to promote accountability, transparency, and continuous improvement through the five-year program period and beyond.

Evaluation Timeline

The timeline in **Table 28** outlines example evaluation activities throughout the grant period. Quarterly monitoring will identify trends and guide initiative refinements, while annual reporting to CMS, the public, and key partners will promote transparency and accountability. This timeline provides CMS with consistent insight into implementation progress and program impact, while giving the State the flexibility to adjust measurement approaches as initiatives evolve.

Table 28. Example Evaluation Activities by Year

Time Period	Example Evaluation Activities
Year 1	• Establish evaluation infrastructure. • Finalize performance measures and targets. • Set up provider/partner data submission process. • Collect baseline data.
Years 2-3	• Gather provider feedback to interpret results and identify barriers and/or additional needs. • Refine reporting tools, as needed.
Late Year 3	• Conduct midpoint assessment and validate findings with rural and tribal partners. • Use findings to inform refinements. • Confirm updated initiatives for Years 4-5.

Time Period	Example Evaluation Activities
Years 4-5	• Measure full impact of initiatives. • Promote long-term data collection among rural providers/partners.
Post-Grant Period	• Develop and submit Final Evaluation Report to CMS. • Share results widely with the public.

Initiative-Specific Metrics and Targets

The State will evaluate the success of its five RHT initiatives using the metrics outlined in **Table 29**, each tailored to measure implementation progress and impact. The State will use a mixture of provider-submitted data and State health data systems to ensure comprehensive reporting. Timing of data updates will align with quarterly monitoring and annual reporting cycles, and the State will leverage its analytic capabilities to collect, validate, and interpret data efficiently. The State will define appropriate targets in Year 1.

Table 29. Metrics and Data Sources by Initiative

Metric	Data Source	Baseline Data
Healthy Horizons: Expanding Specialty Care Access and Chronic Disease Management		
1. **Specialty Care Completion Rate:** Percentage of provider-to-provider specialty consults requests that result in a completed encounter within 30 days of referral *(county-level)*	Referral and encounter data	To be established in Year 1
2. **Hemoglobin A1c Control for Patients with Diabetes:** The percentage of adults aged 18–75 with diabetes (type 1 or type 2) whose most recent HbA1c level during the measurement year is <8.0%	Healthcare Effectiveness Data and Information Set (HEDIS)	48.22%[58, 59]
3. **Depression Screening and Follow-Up for Adolescents and Adults:** 1) *Depression Screening* – percentage of persons who were screened for clinical depression using a standardized instrument; 2) *Follow-Up on Positive Screen* – percentage of persons who received follow-up care within 30 days of a positive depression screen finding	HEDIS	10.00%; 75.85%[60,61]
4. **Postpartum Depression Screening and Follow-up:** 1) *Depression Screening* – percentage of deliveries in which persons were screened for clinical depression using a standardized instrument during the postpartum period; 2) *Follow-Up on Positive Screen* – percentage of deliveries in which persons received follow-up care within 30 days of a positive depression screen finding	HEDIS	11.57%; 76.49%[60,61]
5. **Utilization of RPM:** Percentage of patients enrolled in RPM who transmit data at least once within a defined period (e.g., weekly or monthly)	Medicaid Claims	10,577 (claims between 7/1/2024 – 6/30/2025)

Metric	Data Source	Baseline Data
6. **Hospital Readmission Rates:** Percentage of patients participating in a remote care program that return to the hospital within 30-days of discharge.	Medicaid Claims	To be established in Year 1
Rooted in New Mexico: Building Tomorrow's Rural Health Workforce		
1. **Rural Training Pipeline Volume and Placement:** Number of rural rotations/residency slots filled, new rotation/residency slots created, apprenticeship completions, and graduates placed into rural practice (by discipline)	Training program records	To be established in Year 1
2. **Workforce Engagement:** Number of health professionals participating in tele-supervision, individual consultations, asynchronous learning, mentoring networks, or Project ECHO sessions to support rural practice readiness *(county-level)*	Program participation logs	To be established in Year 1
3. **Five-Year Retention of Rural Health Workforce:** Percentage of newly trained and recruited primary care, specialists, behavioral health, dental, pharmacy, EMS, allied health professionals, CHWs, peer support workers, and HCBS caregivers who commit to rural and tribal community practice for at least five years	Licensure data	To be established in Year 1
4. **Reduction in HPSA designations:** Percentage decrease in federally designated HPSAs (at least part of or the whole county) within non-metro counties (as defined by HRSA) ***Note: The reported percentage reflects non-metro counties that are either fully designated as HPSAs or have partial HPSA designation within their boundaries***	HRSA HPSA data	Primary Care: 32 out of 33 non-metro counties[62] Dental: 32 out of 33 non-metro counties [62] Mental Health: 32 out of 33 non-metro counties [62]
Rural Health Innovation Fund: Enabling Community-Designed, Community-Led Change		
1. **Community-Designed and Community-Led Projects Funded:** Total number of funded projects that have reached full implementation within the reporting period *(county-level)*	Subgrant reports	To be established in Year 1
2. **Percentage of Funded Projects Achieving Stated Objectives:** Percentage of funded projects that meet at least 80% of proposed goals (as defined in the organization's approved subgrant application) within the reporting period	Subgrant reports	To be established in Year 1
3. **Community Reach of Community-Designed Projects:** Number of community members served by community-designed programs	Subgrant reports	To be established in Year 1
4. **Reported Access to Additional Community Resources:** Number of community members who report additional supports available in their communities	Subgrant reports	To be established in Year 1
Bridge to Resilience: Rural Health Sustainability & Innovation Center		
1. **Providers Requesting RHSIC Services:** Number of providers that request a technical assistance service from the RHSIC *(county-level)*	RHSIC service request logs	To be established in Year 1
2. **Proportion of Providers Accessing Center Services to Experience Improved Operating Margin:** Percent of providers that complete a service with the RHSIC to see operating margin improvement	RHSIC service outcomes; financial reports	To be established in Year 1
3. **Rural Facilities in Financial Distress:** Number of facilities (e.g., hospitals, clinics, FQHCs, tribal health centers, etc.) in financial distress based on assessment of key financial	Financial assessments; facility reports	To be established in Year 1

Metric	Data Source	Baseline Data
indicators (e.g., operating margin, days cash on hand, etc.) and audited financial statements		
4. **Rural Facilities Closures:** Number of facilities (e.g., hospitals, clinics, FQHCs, tribal health centers, etc.) that close each year	State and federal facility closure data	0 facilities
Rural Health Data Hub: Establishing a Health Analytics Platform		
1. **Provider Participation in HIE:** Number of providers enrolled in HIE and actively contributing data (*county-level)*	Participation logs	105 data providers, 101 HIE subscribers (as of October 31, 2025)
2. **Provider Participation in CLRS:** Number of providers enrolled in CLRS and actively contributing data (*county-level)*	Participation logs	0 providers
3. **Rural Health Data Hub Usage:** Number and type of users that access the Rural Health Data Hub	Participation logs	To be established on Day 1 of Rural Health Data Hub launch
4. **Rural Health Data Hub Outages:** Number of outages or downtime when the Rural Health Data Hub is unavailable for standard system maintenance or to address issues	System logs	To be established on Day 1 of Rural Health Data Hub launch

Sustainability Plan

To sustain initiatives beyond the RHT Program funding period, the State will implement a strategy specifically tailored to each initiative, both upon initial roll-out and throughout the implementation period. The RHSIC, which will serve as the foundation of RHT Program roll-out and implementation, is a key component of our strategy to sustain facilities long-term. New Mexico has two State Directed Payment programs that will phase down through FFY 2032. The RHSIC will help providers build additional internal capacity and enhance business operations to minimize impact of reduced funding. By FFY 2031, our objective is for at least 80 percent of facilities supported by the RHSIC to have maintained positive operating margin for at least two fiscal years following participation. To sustain the RHSIC long-term, the State will explore a revenue-sharing model whereby participating rural facilities could contribute a modest percentage of net patient revenue in exchange for continued access to technical assistance and/or shared services (e.g., revenue cycle management, supply chain optimization). We will design this

model to scale across facility sizes and types, promoting affordability and value for all participating facilities.

For technology-enabled initiatives such as **Connecting Communities** and **Healthy Horizons**, the State will pursue long-term investments through Medicaid reimbursement policy enhancements, including permanent coverage for RPM and telehealth services. The State may also evaluate opportunities for legislative appropriations and public-private partnerships to support infrastructure upgrades and cybersecurity improvement. We will select specific technology solutions (e.g., remote care, e-consult platforms) with sustainability in mind, emphasizing interoperability, user-friendliness, and alignment with existing systems to reduce long-term maintenance costs.

The **Rural Health Innovation Fund** will require subgrant applicants to include detailed sustainability plans in their grant applications to outline how they will maintain implementation post-funding. This may include engaging local philanthropic support, integrating the funded program into existing programs, or forming partnerships with other community partners to sustain operations. We will provide technical assistance to help subgrantees identify and secure alternative funding sources, including federal grants, Medicaid waivers, and local government support, throughout the implementation period. By FFY 2031, our objective is for at least 70 percent of funded projects to have secured ongoing revenue streams or local matching funds to continue operations post-grant distribution.

Workforce development efforts under **Rooted in New Mexico** will be sustained through expanded partnerships with academic institutions, licensure compacts, and incentive programs. The State will work with educational entities to embed rural training tracks into permanent curricula and will explore shared-cost models with rural providers to continue offering housing

stipends and retention bonuses. Additionally, the State will pursue policy changes to expand scopes of practice and licensure flexibility, enabling providers to operate at the top of their license and remain in rural communities.

We will integrate the **Rural Health Data Hub** into the HCA's long-term data infrastructure and support long-term sustainability with funding through existing State appropriations (as needed) and potential federal data modernization grants. We will design the platform for modular expansion, allowing us to add future data sources and analytics capabilities with minimal disruption or cost. We will maintain public facing resources and application programing interfaces (APIs) to promote transparency and usability for providers, policymakers, and rural community members.

Finally, we will embed RHT Program lessons into broader health policy and planning efforts. While we will look to identify opportunities on an ongoing basis, we will also leverage the Stakeholder Advisory Committee. During each quarterly Stakeholder Advisory Committee meeting, one of the agenda items will be to identify and discuss lessons learned through each initiative and provide recommendations for the HCA's consideration regarding potential opportunities to incorporate these lessons into State policy initiatives, including updates to the State Health Improvement Plan, Medicaid managed care contracts, and other relevant State regulations (as needed). By aligning RHT initiatives with existing State priorities and funding mechanisms, we plan to embed the changes driven through the RHT Program into practice that lasts beyond the five-year funding period.

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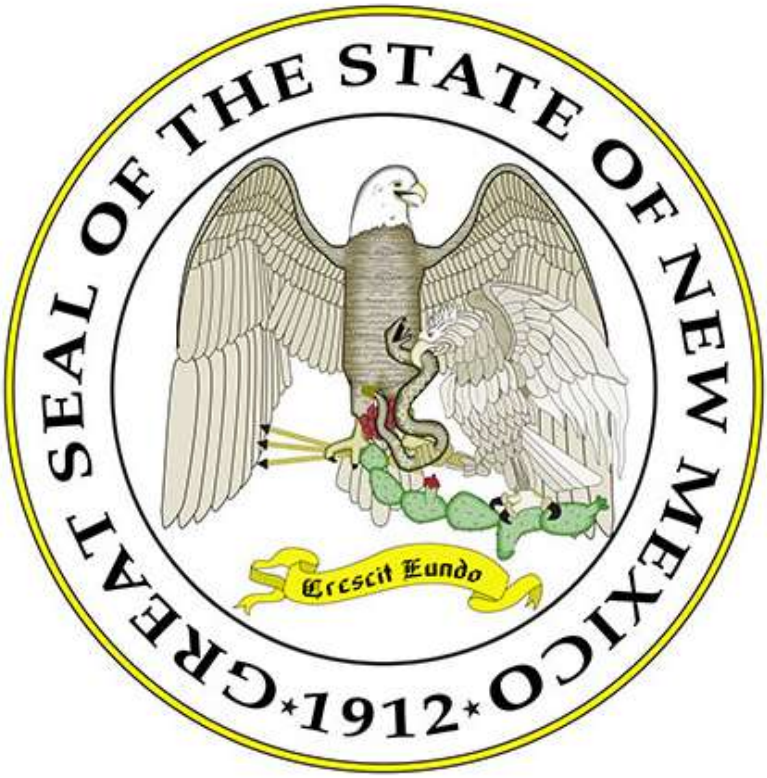


Budget Narrative

Executive Summary

The New Mexico Health Care Authority (HCA) submits this Budget Narrative to accompany its application to the Centers for Medicare & Medicaid Services (CMS) for the Rural Health Transformation (RHT) Program. The narrative aligns with the Standard Form 424A (SF-424A) and provides detail for each cost component and how each applies to our proposed initiatives.

Aligned with CMS guidance, New Mexico has assumed a total budget of $200 million per budget period for Federal Fiscal Year (FFY) 2026 through FFY2030. Our budget outlines administrative and programmatic costs for the following five initiatives:

1. Healthy Horizons: Expanding Specialty Care Access and Chronic Disease Management
2. Rooted in New Mexico: Building Tomorrow's Rural Health Workforce
3. Rural Health Innovation Fund: Enabling Community-Designed, Community-Led Change
4. Bridge to Resilience: Rural Health Sustainability & Innovation Center (RHSIC)
5. Rural Health Data Hub: Establishing a Health Analytics Platform

The budget proposal we define below will help New Mexico substantially transform rural healthcare across the State, while maintaining compliance with applicable Federal and State requirements. Across each of the five funding periods, we maintain administrative expenses (including indirect costs) at roughly 5 percent (below the 10 percent threshold) per year. Through administrative funding, we plan to establish 17 new positions to administer RHT Program activities and provide thorough oversight to support effective implementation and meet all Federal reporting requirements.

The State will allocate programmatic funding (i.e., funding not assigned to administrative overhead) through two primary methods dependent on the initiative and use of funding:

1. Direct Subawards: Allocate funding directly to sub-recipients to establish new clinical or workforce development programs as defined in the Healthy Horizons and Rooted in New Mexico initiatives.
2. Competitive Procurement and/or Application: Receive proposals or applications that the State will competitively evaluate and award funding to implement programs as defined in the Rural Health Innovation Fund, Bridge to Resilience, and Rural Health Data Hub initiatives.

These funds are identified and described under the "Contractual" SF-424A category. In instances where the HCA will operate as a pass-through entity (i.e., Direct Subawards), the State will establish robust oversight methods aligned with 2 CFR 200.332 requirements. When competitively procuring support, the State will align with both 2 CFR 200.317 – 2 CFR 200.327 requirements and New Mexico's procurement code. As defined in the following narrative, New Mexico's lead agency (the HCA) will retain thorough and complete oversight over all implementation activities, funding distribution, and funding utilization.

This budget includes direct payment to providers, remodeling expenses, and support for Electronic Health Record (EHR) implementation. As defined in subsequent sections, our annual

and total budget for each of these activities remains below the defined funding caps (e.g., 15% provider payments).

Table 1. Proposed Budget by CMS Strategic Goal and Initiative by Program Year (FFY2026 – 2030)

Initiative	CMS Goal	FFY2026	FFY2027	FFY2028	FFY2029	FFY2030
Healthy Horizons	Make Rural America Healthy Again	$76,580,845	$83,666,674	$82,466,674	$79,466,674	$71,109,413
Rooted in New Mexico	Workforce Development	$41,787,788	$51,353,898	$50,853,898	$51,836,916	$47,333,940
Rural Health Innovation Fund	Make Rural America Healthy Again	$45,570,516	$26,731,415	$30,731,415	$35,798,397	$48,676,477
Bridge to Resilience	Sustainable Access	$20,516,709	$26,032,186	$26,032,186	$25,032,186	$25,031,173
Rural Health Data Hub	Tech Innovation	$15,544,142	$12,215,827	$9,915,827	$7,865,827	$7,848,997
	Totals:	$200,000,000	$200,000,000	$200,000,000	$200,000,000	$200,000,000

A. (Personnel) Salaries and Wages

Budget allocated to Personnel includes funding to establish positions that will oversee and support RHT Program implementation. [redacted] will serve as the Rural Health Transformation Program Director. The State may identify an alternative full-time RHT Program Director once the program has been initiated (if necessary).

The State has identified the need for 17 additional staff, covering key programmatic functions such as financial management, operations, implementation, data analysis, and communications. Each position description is defined below. **Table 2** summarizes total Personnel costs by initiative across each program year.

Additionally, Personnel costs include assumed, prospective costs for potential subrecipients and / or contractors. As the State has not yet identified subrecipients or contractors to support implementation, the HCA assumed that roughly 34 percent of subrecipient / contractor administrative costs would be attributable to Personnel. Through the subaward and/or contracting process, we will specifically require all subrecipients or contractors to submit a detailed budget aligned with Federal requirements, and we will further refine budgets with actuals in subsequent budget narrative updates.

Table 2. Personnel Costs by Initiative (FFY 2026 – FFY 2030)

Initiative	FFY2026	FFY2027	FFY2028	FFY2029	FFY2030
Healthy Horizons	$808,613.50	$1,617,226.99	$1,617,226.99	$1,617,226.99	$1,617,226.99
Rooted in New Mexico	$467,175.12	$934,350.23	$934,350.23	$934,350.23	$934,350.23

Initiative	FFY2026	FFY2027	FFY2028	FFY2029	FFY2030
Rural Health Innovation Fund	$322,677.87	$645,355.74	$645,355.74	$645,355.74	$645,355.74
Bridge to Resilience	$304,303.02	$608,606.05	$608,606.05	$608,606.05	$608,606.05
Rural Health Data Hub	$141,432.83	$282,865.67	$282,865.67	$282,865.67	$282,865.67
Totals:	$2,044,202.34	$4,088,404.68	$4,088,404.68	$4,088,404.68	$4,088,404.68

New Mexico intends to include the positions outlined in **Table 3**. Each proposed staff member, unless specifically assigned to a specific initiative, will support all RHT Program initiatives. For staff that will require establishing a new position and hiring, we anticipate the process to take roughly six months for budgeting purposes.

Table 3. RHT Program Roles and FTE Allocations (Year 1 / FFY 2026)

Position Title	Name	Annual	Time	Months	Amount Requested
Staff Supporting All Initiatives					
RHT Program Director *	[redacted]	$92,702.00	100%	6	$46,351.00
RHT Operations Manager	To Be Determined	$83,517.00	100%	6	$41,758.50
RHT Program Implementation Manager 1	To Be Determined	$83,517.00	100%	6	$41,758.50
RHT Program Implementation Manager 2	To Be Determined	$83,517.00	100%	6	$41,758.50
Administrative Aide 1	To Be Determined	$74,331.00	100%	6	$37,165.50
Administrative Aide 2	To Be Determined	$74,331.00	100%	6	$37,165.50
Finance Manager	To Be Determined	$83,517.00	100%	6	$41,758.50
Finance Analyst	To Be Determined	$83,517.00	100%	6	$41,758.50
Data and Evaluation Manager	To Be Determined	$83,517.00	100%	6	$41,758.50
Data and Evaluation Analyst	To Be Determined	$83,517.00	100%	6	$41,758.50
Communications Manager	To Be Determined	$83,517.00	100%	6	$41,758.50
Staff Assigned to Specific Initiatives					
RHSIC: Rural Technical Assistance & Systems Support Manager	To Be Determined	$83,517.00	100%	6	$41,758.50
Healthy Horizons: *Specialty Access & Remote Care Manager*	To Be Determined	$83,517.00	100%	6	$41,758.50
Rooted in New Mexico: *Rural Health Workforce Pipeline Manager*	To Be Determined	$83,517.00	100%	6	$41,758.50
Rural Health Innovation Fund: *Subgrant Manager*	To Be Determined	$83,517.00	100%	6	$41,758.50
Rural Health Innovation Fund: *Community Health Innovation Liaison*	To Be Determined	$83,517.00	100%	6	$41,758.50
Rural Health Data Hub: *Rural Health Data Lead*	To Be Determined	$83,517.00	100%	6	$41,758.50

* We used six months allocation for estimate purposes only and understand that this individual may begin supporting the RHT Program in FFY 2026 Q2, pending funding allocation timeline.

Concise position descriptions for each of the above positions can be found in **Table 4**. New Mexico has also identified specific job "grades" when applicable to assist with budget assumptions (e.g., fringe, supplies) through the remainder of our narrative.

Table 4. Proposed Positions and Job Descriptions

Position Title	Brief Job Description
RHT Program Director	Provides strategic leadership and oversight for the RHT Program, ensuring all initiatives are implemented in alignment with New Mexico's transformation goals and CMS requirements. Coordinates cross-departmental efforts and stakeholder engagement to drive measurable improvements in rural health access, outcomes, and sustainability.
RHT Finance Director	Oversees financial planning, budgeting, and compliance for the RHT Program, ensuring all expenditures meet CMS guidelines and support program sustainability. Manages funding allocations across initiatives and monitors financial performance to maximize impact and avoid duplication of existing funding streams.
RHT Operations Manager	Manages day-to-day operations of the RHT Program, coordinating logistics, staffing, and resource deployment to support effective implementation of all initiatives. Ensures operational processes are efficient, compliant, and responsive to evolving program needs.
RHT Program Implementation Manager 1	Leads the execution of Healthy Horizons and Rooted in New Mexico initiatives, tracking milestones, outcomes, and reporting requirements. Collaborates with internal and external partners to ensure timely delivery of program activities and continuous improvement based on evaluation findings.
RHT Program Implementation Manager 2	Leads the execution of Rural Health Innovation Fund, Bridge to Resilience, and Rural Health Data Hub initiatives, tracking milestones, outcomes, and reporting requirements. Collaborates with internal and external partners to ensure timely delivery of program activities and continuous improvement based on evaluation findings.
Administrative Aide	Provides administrative support for the RHT Program team, including scheduling, documentation, and coordination of meetings and communications. Assists with record-keeping and ensures compliance with program documentation standards.
Finance Manager	Supports the Finance Director in managing budgets, tracking expenditures, and preparing financial reports. Ensures all financial activities adhere to CMS requirements and contribute to the program's fiscal integrity.
Finance Analyst	Conducts financial analysis to inform decision-making, monitors spending trends, and evaluates cost-effectiveness of program activities. Provides data-driven insights to optimize resource allocation and support sustainability.
Data and Evaluation Manager	Designs and oversees the program's data collection, analysis, and evaluation framework, ensuring robust measurement of outcomes and compliance with CMS reporting standards. Leads efforts to use data for continuous improvement and strategic planning.
Data and Evaluation Analyst	Supports the Data and Evaluation Manager by collecting, analyzing, and interpreting program data. Prepares reports and visualizations to communicate progress and inform program adjustments.
Communications Manager	Develops and implements communication strategies to engage stakeholders, disseminate program updates, and promote transparency. Ensures messaging aligns with program goals and CMS requirements, and supports outreach to rural communities.
RHSIC: Rural Technical Assistance & Systems Support Manager	Leads the Rural Health Sustainability & Innovation Center's technical assistance (TA) efforts, providing operational, financial, and strategic support to rural providers. Facilitates partnerships and shared services to strengthen provider sustainability and program impact.
Healthy Horizons: Specialty Access & Remote Care Manager	Manages initiatives to expand specialty care access and remote care solutions, including telehealth and e-consults. Works to reduce travel burdens, improve chronic disease management, and integrate behavioral health services in rural communities.

Position Title	Brief Job Description
Rooted in New Mexico: Rural Health Workforce Pipeline Manager	Oversees workforce development strategies, including recruitment, training, and retention of rural health professionals. Implements programs to build local talent pipelines and support long-term workforce sustainability.
Rural Health Innovation Fund: Subgrant Manager	Administers the Rural Health Innovation Fund, managing the competitive subgrant process for community-designed initiatives. Ensures funded projects address local needs, comply with CMS requirements, and support program objectives.
Rural Health Innovation Fund: Community Health Innovation Liaison	Engages with community-based organizations and stakeholders to support the design and implementation of innovative health projects. Facilitates collaboration and ensures initiatives are responsive to local priorities and program goals.
Rural Health Data Hub: Rural Health Data Lead	Leads the development and management of the Rural Health Data Hub, integrating data sources to support analytics, transparency, and informed decision-making. Ensures data security, privacy, and compliance with federal standards.

B. Fringe Benefits

HCA calculated fringe benefits based on the State assigned fringe rate aligned to each position's employment grade. Fringe benefits include FICA (7.7%), Group Insurance (5.9%), and Retirement (21.2%). **Table 5** outlines the salary requested and resulting fringe benefits amount requested for each proposed position for program Year 1 (FFY 2026).

Table 5. Proposed Positions and Job Descriptions

Position Title	Salary Requested	Fringe Rate	Fringe Amount Requested
RHT Program Director	$92,702.00	35%	$31,816.00
RHT Operations Manager	$83,517.00	35%	$29,162.00
RHT Program Implementation Manager 1	$83,517.00	35%	$29,162.00
RHT Program Implementation Manager 2	$83,517.00	35%	$29,162.00
Administrative Aide 1	$74,331.00	35%	$29,162.00
Administrative Aide 2	$74,331.00	35%	$29,162.00
Finance Manager	$83,517.00	35%	$29,162.00
Finance Analyst	$83,517.00	35%	$29,162.00
Data and Evaluation Manager	$83,517.00	35%	$29,162.00
Data and Evaluation Analyst	$83,517.00	35%	$29,162.00
Communications Manager	$83,517.00	35%	$29,162.00
RHSIC: Rural Technical Assistance & Systems *Support Manager*	$83,517.00	35%	$29,162.00
Health Horizons: *Specialty Access & Remote Care Manager*	$83,517.00	35%	$29,162.00
Rooted in New Mexico*: Rural Health Workforce Pipeline Manager*	$83,517.00	35%	$29,162.00
Rural Health Innovation Fund: *Subgrant Manager*	$83,517.00	35%	$29,162.00
Rural Health Innovation Fund: *Community Health Innovation Liaison*	$83,517.00	35%	$29,162.00
Rural Health Data Hub: *Rural Health Data Lead*	$83,517.00	35%	$29,162.00

Additionally, fringe benefits include assumed, prospective costs for potential subrecipients and / or contractors. As the State has not yet identified subrecipients or contractors to support

implementation, the HCA assumed that roughly 12 percent of subrecipient / contractor administrative costs would be attributable to fringe. Through the subaward and/or contracting process, we will specifically require all subrecipients or contractors to submit a detailed budget aligned with Federal requirements, and we will further refine budgets with actuals in subsequent budget narrative updates. **Table 6** identifies Fringe benefits for each initiative by program year.

Table 6. Total Fringe Benefits by Initiative (FFY 2026 – FFY 2030)

Initiative	FFY2026	FFY2027	FFY2028	FFY2029	FFY2030
Healthy Horizons	$282,723.85	$565,447.71	$565,447.71	$565,447.71	$565,447.71
Rooted in New Mexico	$163,343.24	$326,686.49	$326,686.49	$326,686.49	$326,686.49
Rural Health Innovation Fund	$112,821.18	$225,642.37	$225,642.37	$225,642.37	$225,642.37
Bridge to Resilience	$106,396.60	$212,793.19	$212,793.19	$212,793.19	$212,793.19
Rural Health Data Hub	$49,450.62	$98,901.23	$98,901.23	$98,901.23	$98,901.23
Total	$714,735.49	$1,429,470.99	$1,429,470.99	$1,429,470.99	$1,429,470.99

C. Travel

The State recognizes that in-state travel to rural, frontier, and tribal communities across New Mexico will be necessary to support effective program implementation. We anticipate varying travel needs across initiatives, which may include, for example:

- **Healthy Horizons:** Site visits to rural providers (e.g., hospitals, clinics) to assess specialty rotations and/or remote care adoption
- **Rooted in New Mexico:** Travel to observe newly established rural rotational programs, observing and/or participating in newly established K-12 pipeline program activities
- **Rural Health Innovation Fund:** Site visits to community-based organizations to assess implementation of new community-designed programs
- **Bridge to Resilience:** Travel to observe technical assistance vendors providing direct support, attending in-state rural health conferences and/or association meetings to encourage engagement with RHSIC programs and support
- **Rural Health Data Hub**: Onsite provider visits to support data hub adoption and participation

Specific destinations for in-state travel will be dependent on how each initiative is implemented. To develop an assumption for a standard trip for budgeting purposes, as a proxy we projected travel from Albuquerque to Carlsbad, including one overnight and reimbursement for meals using the General Services Administration (GSA) rates for Carlsbad, New Mexico. We assume approximately 400 miles round trip driven in a privately owned vehicle to account for travel to communities surrounding Carlsbad. **Table 7** identifies our estimated average cost per trip. In future RHT Program years, the State will update travel assumptions to align with refreshed GSA rates and actual travel required for implementation.

Table 7. Estimated Average Cost Per Trip

	Lodging	M&IE	Mileage (Round Trip)
Assumptions	GSA - Carlsbad	GSA - Carlsbad	Privately Owned Vehicle
Rates	$155.00	$74.00	$0.67
Multiplier	1	1.50	400
Total	$155.00	$111.00	$268.00
		Cost per Trip:	**$534.00**

To arrive at an estimate, we assumed a specific number of trips based taking into account the responsibilities for various proposed position as outlined in **Table 8**. For directors and managers, we assumed more frequent trips to oversee implementation efforts. For administrative staff, we assume fewer trips to assist with meeting facilitation (e.g., notes, equipment set up). We have assumed roughly half the volume of annual trips in FFY2026 due to time to onboard staff.

Table 8. Assumed Number of Trips per Year

RHT Program Initiative	Assumed Number of Trips per Year
Healthy Horizons	43
Rooted in New Mexico	15
Rural Health Innovation Fund	22
Bridge to Resilience	35
Rural Health Data Hub	5

Additionally, travel costs include assumed, prospective costs for potential subrecipients and / or contractors. As the State has not yet identified subrecipients or contractors to support implementation, the HCA assumed that roughly 2 percent of subrecipient / contractor administrative costs would be attributable to travel. Through the subaward and/or contracting process, we will specifically require all subrecipients or contractors to submit a detailed budget aligned with Federal requirements, and we will further refine budgets with actuals in subsequent budget narrative updates.

Using this methodology and assumed FTE allocation for each position across initiatives, we developed the travel cost estimates for each initiative as identified in **Table 9**.

Table 9. Travel Expenses by Initiative (FFY 2026 – FFY 2030)

Initiative	FFY2026	FFY2027	FFY2028	FFY2029	FFY2030
Healthy Horizons	$43,082.47	$85,630.95	$85,630.95	$85,630.95	$85,630.95
Rooted in New Mexico	$12,387.35	$22,104.70	$22,104.70	$22,104.70	$22,104.70
Rural Health Innovation Fund	$14,264.31	$27,460.63	$27,460.63	$27,460.63	$27,460.63
Bridge to Resilience	$14,450.70	$33,707.41	$33,707.41	$33,707.41	$33,707.41
Rural Health Data Hub	$2,088.27	$3,642.55	$3,642.55	$3,642.55	$3,642.55
Total	$86,273.10	$172,546.24	$172,546.24	$172,546.24	$172,546.24

D. Equipment

The State does not assume any equipment costs associated with projected personnel. Equipment that may be required by contractors or subrecipients will be identified as such per 2 CFR 200 requirements as part of the State's application or procurement process. Current costs for potential equipment (e.g., e-consult platforms / technology, remote patient monitoring solutions, telehealth platforms) are currently captured under "F. Consultant/Subrecipient/Contractual Costs" as the State has not identified specific vendors and/or equipment investments. The State will evaluate all sub-recipient and/or vendor agreements to confirm alignment with Federal requirements and will amend this budget proposal as needed in future cycles to reflect equipment.

E. Supplies

The State assessed supply costs associated with each New Mexico job grade to identify projected costs per individual. Supply costs could include new laptop computers and associated tools (e.g., keyboard, mouse), printers, pricing for general office supplies, and/or supplemental materials. New Mexico extrapolated this estimate based on State-defined assumptions for each job grade. **Table 10** reflects projected Supply costs for each initiative by program year.

Additionally, supply costs include assumed, prospective costs for potential subrecipients and / or contractors. As the State has not yet identified subrecipients or contractors to support implementation, the HCA assumed that roughly 3 percent of subrecipient / contractor administrative costs would be attributable to supplies. Through the subaward and/or contracting process, we will specifically require all subrecipients or contractors to submit a detailed budget aligned with Federal requirements, and we will further refine budgets with actuals in subsequent budget narrative updates.

Table 10. Supply Costs by Initiative (FFY 2026 – FFY 2030)

Initiative	FFY2026	FFY2027	FFY2028	FFY2029	FFY2030
Healthy Horizons	$72,135.30	$144,270.61	$144,270.61	$144,270.61	$144,270.61
Rooted in New Mexico	$41,676.05	$83,352.10	$83,352.10	$83,352.10	$83,352.10
Rural Health Innovation Fund	$28,785.65	$57,571.30	$57,571.30	$57,571.30	$57,571.30
Bridge to Resilience	$27,146.45	$54,292.91	$54,292.91	$54,292.91	$54,292.91
Rural Health Data Hub	$12,617.03	$25,234.06	$25,234.06	$25,234.06	$25,234.06
Total	$182,360.48	$364,720.98	$364,720.98	$364,720.98	$364,720.98

F. Consultant/Subrecipient/Contractual Costs

The State intends to use roughly 95 percent of RHT Program funds towards initiative implementation (i.e., not administrative). The State intends to use two primary methods to allocate funding to implementation partners:

1. Direct Subawards: Allocate funding directly to sub-recipients to establish new clinical or workforce development programs as defined in the Healthy Horizons and Rooted in New Mexico initiatives.
2. Competitive Procurement and/or Application: Receive proposals or applications that the State will competitively evaluate and award funding to implement programs as defined in the Rural Health Innovation Fund, Bridge to Resilience, and Rural Health Data Hub initiatives.

Direct Subawards

The HCA will function as a pass-through entity with robust oversight of subrecipients in accordance with 2 CFR 200.332. The HCA will have dedicated staff supporting financial oversight and meeting all Federal compliance requirements, including the RHT Program Director, RHT Finance Director, RHT Program Implementation Manager(s), and Finance Manager.

To retain oversight and support effective implementation, the State will implement the following controls for all subrecipients:

- Pre-award risk assessments
- Verification of allowability and performance prior to approval / disbursement
- Sub-award agreements with all required data elements for annual reporting
- Monthly programmatic and financial reporting
- Desk reviews and on-site monitoring
- Audit and records retention (throughout 5-Year RHT Program period)

Competitive Procurements / Applications

The HCA will conduct competitive procurements consistent with 2 CFR 200.317–200.327 and the New Mexico Procurement Code. The State may use methods such as micro-purchases and small purchases (as defined under 2 CFR 200.320) and formal requests for proposals (RFPs) for higher-value acquisitions. Additionally, for the Rural Health Innovation Fund, the State will establish a grant application process to solicit responses for potential use of funds. The State will establish guardrails and parameters as defined in the Project Narrative to confirm compliance with Federal requirements (e.g., RHT Program requirements, 2 CFR 200).

No vendors have been selected at this time. All HCA solicitations and associated contracts/agreements will define specific scope, deliverables, timelines, performance measures / service level agreements (SLAs), data-sharing and security requirements, and acceptance criteria. Solicitations will specifically refer to and align with RHT Program requirements and Federal / State regulation.

In addition to initiative-specific qualifications, the HCA will regularly assess overall technical merit, rural health experience, scalability, cybersecurity posture, and value of each applicant prior to selection. The HCA will design contracts to incorporate oversight provisions, milestone reviews, invoice validation against deliverables, and closeout checklists, each tying back to RHT Program requirements and the annual reporting cycle.

Funding allocation method is contingent on specific initiative uses of funds as described in the Project Narrative. We have provided two tables (**Table 11**, **Table 12**) to include sample activities that could be funded under "Consultant / Subrecipient / Contractual Costs" for each initiative, by disbursement method.

Table 11. Sample Activities Funded Through Direct Subaward

Initiative	Sample Activities Funded Through Direct Subaward
Healthy Horizons	• Developing in-person specialty and maternal care networks through rotational clinics • Supporting providers to secure and adopt new technology (e.g., provider-to-provider e-consult, remote patient monitoring, consumer tech) to deliver care when in-person care is not available • Providing funding for providers to enhance or adopt a new EHR platform.
Rooted in New Mexico	• Establishing new or expanding existing rural-specific workforce development programs (e.g., rural residencies, rural rotations, apprenticeships) • Funding new K-12 career pathway programs • Providing paid training, certification support, and career ladders for health care professionals

Table 12. Sample Activities Funded Through Competitive Procurements / Applications

Initiative	Sample Contractor / Sub-Grant Recipient Activities
Rural Health Innovation Fund	• Developing community-led prevention programs (e.g., screenings, counseling, education) and local chronic disease initiatives • Expanding preventive services such as dental, vision, and hearing • Improving behavioral health access, including substance use disorder (SUD)/opioid use disorder (OUD) services and mental health screening integration • Making minor renovations or medical equipment for rural facilities (e.g., hospitals, clinics, Skilled Nursing Facilities)
Bridge to Resilience	• Facilitating training and TA engagements with subject-matter experts, customized provider TA plans, learning collaboratives and training materials. • Facilitating workforce-focused TA (e.g., recruitment/retention strategies, role optimization, leadership development) • Supporting IT advances that integrate analytics with provider systems and build provider data literacy • Implementing efforts that foster collaboration (shared service models; regional referral pathways; convenings)
Rural Health Data Hub	• Developing a secure statewide analytics platform • Creating interfaces and automated ingestion/update pipelines and integrating telehealth/remote patient monitoring (RPM) data • Delivering training & TA to agencies, managed care organizations (MCOs), and providers on using the Rural Health Data Hub • Supporting cross-sector collaboration to integrate data sources and align data transparency/planning

"Consultant / Subrecipient / Contractual Costs" also includes direct provider payments. Direct payments will be used to incentivize participation with specific RHT Program initiatives. **Table 13** defines how the State intends to use provider payments for specific initiatives.

Table 13. Summary of Proposed Direct Provider Payments

Initiative	Provider Payment Methods
Healthy Horizons	• Incentive payment models for rural hospitals and clinics to establish specialty and maternal care service lines • Value-based care arrangements to sustain specialty and maternal care delivery • Incentives for high-need specialty providers to deliver in-person services in rural communities • Incentive payments for providers for technology onboarding and utilization
Bridge to Resilience	• Incentive payments for providers that meet outcome metric targets
Rural Health Data Hub	• Incentive payments to encourage provider onboarding / participation and aligned with quality of submitted data

In summary, **Table 14** identifies the roughly 95 percent of total assumed RHT Program funding that we intend to use to drive health outcome improvements across New Mexico's activities through our proposed RHT Program initiatives.

Please note that the costs included in **Table 14** do not include subrecipient and / or contractor administrative costs that have been allocated to the Direct Cost factors described in sections A – E of this Budget Narrative.

Table 14. Subrecipient and Contractor Costs (Non-Administrative) by Initiative (FFY 2026 – FFY 2030)

Initiative	FFY2026	FFY2027	FFY2028	FFY2029	FFY2030
Healthy Horizons	$73,700,000.00	$78,675,600.00	$77,475,600.00	$74,475,600.00	$66,118,339.00
Rooted in New Mexico	$40,166,982.00	$48,500,000.00	$48,000,000.00	$48,983,018.00	$44,480,042.00
Rural Health Innovation Fund	$44,500,000.00	$24,783,973.00	$28,783,973.00	$33,850,955.00	$46,729,035.00
Bridge to Resilience	$19,363,000.00	$24,105,000.00	$24,105,000.00	$23,105,000.00	$23,103,990.00
Rural Health Data Hub	$15,000,000.00	$11,320,600.00	$9,020,600.00	$6,970,600.00	$6,953,770.00
Total	$192,729,982.00	$187,385,173.00	$187,385,173.00	$187,385,173.00	$187,385,176.00

G. Construction

Not applicable.

H. Other

We are requesting non-programmatic costs that support implementation, oversight, and sustainability of the State's RHT Program. These expenses are necessary to successfully coordinate, monitor, and administer activities aligned with the program's goals. These administrative functions (e.g., project management, stakeholder engagement, office operations,

grant management systems, compliance support) are critical to maintaining program integrity, facilitating collaboration, and supporting the successful implementation of the RHT Program. The types of costs this funding will support are provided in **Table 15**.

Additionally, other costs include assumed, prospective costs for potential subrecipients and / or contractors. As the State has not yet identified subrecipients or contractors to support implementation, the HCA assumed that roughly 34 percent of subrecipient / contractor administrative costs would be attributable to other costs. Through the subaward and/or contracting process, we will specifically require all subrecipients or contractors to submit a detailed budget aligned with Federal requirements, and we will further refine budgets with actuals in subsequent budget narrative updates.

Table 15. Other Cost Categories and Descriptions

Category	Description
Program Coordination and Administrative Oversight	Costs for contracted or other state staff responsible for supporting the management and coordination the RHT Program. These would be in addition to the staff described in the Personnel Section above. Covers activities such as project planning, subaward administration, procurement, compliance tracking, reporting, and overall program governance.
Office Space and Lease Costs	Expenses associated with leasing and maintaining new administrative office space that may be required support overall program operations. This includes rent, utilities, insurance, and basic facility services necessary for housing program staff, hosting planning sessions, and coordinating statewide rural health transformation activities.
Training and Capacity Building for Administrative Staff	Costs for professional development, training modules, and workshops to enhance internal capacity for managing grant activities and supporting rural health transformation.
Policy and Regulatory Compliance Support	Legal and policy consulting services to ensure adherence to federal and state regulations.
Data Governance and Reporting Infrastructure	Development and maintenance of systems for collecting, analyzing, and reporting performance metrics across initiatives.
Communications and Outreach Materials	Design and dissemination of public-facing materials (e.g., newsletters, infographics, digital content) to inform stakeholders and rural communities about program goals, progress, and opportunities.
Stakeholder Engagement Facilitation	Costs for organizing and managing listening sessions, community forums, and tribal consultations to gather input and maintain transparency throughout program implementation.
Evaluation and Continuous Improvement	Engagement of evaluators or consultants to assess program effectiveness, identify areas for improvement, and refine administrative processes.
Grant Management Systems and Implementation Technologies	Costs for acquiring, customizing, and maintaining grant management software and digital platforms necessary for tracking program activities, managing subawards, monitoring performance metrics, and ensuring compliance with federal and state reporting requirements. Includes licenses, subscriptions, and IT support services essential for effective program oversight and data-driven decision-making.
Auditing and Program Integrity Support	Costs associated with audits, internal controls, and program integrity functions to ensure fiscal accountability and compliance with federal and state regulations. This includes expenses for audit services, fraud prevention systems, and staff time dedicated to monitoring subrecipient activities, verifying allowable use of funds, and maintaining transparency throughout the RHT Program lifecycle.

Table 16 reflects projected Other costs for each initiative by program year.

Table 16. Other Costs by Initiative (FFY 2026 – FFY 2030)

Initiative	FFY2026	FFY2027	FFY2028	FFY2029	FFY2030
Healthy Horizons	$1,215,689.27	$1,841,298.54	$1,841,298.54	$1,841,298.54	$1,841,298.54
Rooted in New Mexico	$679,966.09	$1,064,892.19	$1,064,892.19	$1,064,892.19	$1,064,892.19
Rural Health Innovation Fund	$425,638.03	$703,756.06	$703,756.06	$703,756.06	$703,756.06
Bridge to Resilience	$514,992.21	$734,944.43	$734,944.43	$734,944.43	$734,944.43
Rural Health Data Hub	$249,937.54	$352,355.09	$352,355.09	$352,355.09	$352,355.09
Total	$3,086,223.14	$4,697,246.31	$4,697,246.31	$4,697,246.31	$4,697,246.31

I. Total Direct Costs

Table 17 includes a summary of total direct costs and each cost component category for each RHT Program Year for the full funding period (FFY2026 – FFY2030). **Table 18** defines administrative vs non-administrative costs by program year.

Table 17. Total Direct Costs for the RHT Program Funding Period by Program Year (FFY2026 – FFY2030)

Cost Component	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030	Total
Personnel	$2,044,202.34	$4,088,404.68	$4,088,404.68	$4,088,404.68	$4,088,404.68	$18,397,821.06
Fringe Benefits	$714,735.49	$1,429,470.99	$1,429,470.99	$1,429,470.99	$1,429,470.99	$6,432,619.45
Travel	$86,273.10	$172,546.24	$172,546.24	$172,546.24	$172,546.24	$776,458.06
Equipment	$-	$-	$-	$-	$-	$-
Supplies	$182,360.48	$364,720.98	$364,720.98	$364,720.98	$364,720.98	$1,641,244.40
Contractual	$192,729,982.00	$187,385,173.00	$187,385,173.00	$187,385,173.00	$187,385,176.00	$942,270,677.00
Construction	$-	$-	$-	$-	$-	$-
Other	$3,086,223.14	$4,697,246.31	$4,697,246.31	$4,697,246.31	$4,697,246.31	$21,875,208.38
Total Direct Charges	$198,843,776.55	$198,137,562.20	$198,137,562.20	$198,137,562.20	$198,137,565.20	$991,394,028.35

Table 18. Total Administrative vs. Non-Administrative Costs by Program Year (FFY2026 – FFY2030)

Administrative vs. Non-Administrative	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030	Total
Direct Administrative Costs	$6,113,794.55	$10,752,389.20	$10,752,389.20	$10,752,389.20	$10,752,389.20	$49,123,351.35
Indirect Administrative Costs	$1,156,223.45	$1,862,437.80	$1,862,437.80	$1,862,437.80	$1,862,434.80	$8,605,971.65
Total Administrative Costs	$7,270,018.00 (3.64%)	$12,614,827.00 (6.31%)	$12,614,827.00 (6.31%)	$12,614,827.00 (6.31%)	$12,614,824.00 (6.31%)	$57,729,323.00 (6.31%)
Non-Administrative Costs	$192,729,982.00 (96.36%)	$187,385,173.00 (93.96%)	$187,385,173.00 (93.96%)	$187,385,173.00 (93.96%)	$187,385,176.00 (93.96%)	$942,270,677.00 (93.96%)
Total Costs	$200,000,000.00	$200,000,000.00	$200,000,000.00	$200,000,000.00	$200,000,000.00	$200,000,000.00

J. Indirect Costs

The State does not have an approved negotiated indirect cost rate agreement (NICRA), but the State does have an approved Public Assistance Cost Allocation Plan that will be updated to reflect RHT Program funding. To calculate indirect costs, we assumed to charge a de minimis rate of 15% of administrative costs as outlined above. **Table 19** includes all indirect costs by RHT Program year.

Additionally, indirect costs include assumed, prospective costs for potential subrecipients and / or contractors. As the State has not yet identified subrecipients or contractors to support implementation, assumed that 15 percent of subrecipient / contractor administrative costs would be attributable to indirect costs (i.e., de minimis rate). Through the subaward and/or contracting process, we will specifically require all subrecipients or contractors to submit a detailed budget aligned with Federal requirements, and we will further refine budgets with actuals in subsequent budget narrative updates.

Table 19. Total Indirect Costs for the RHT Program Funding Period (FFY2026 – FFY2030)

Initiative	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030	Total
Indirect Charges	$1,156,223.45	$1,862,437.80	$1,862,437.80	$1,862,437.80	$1,862,434.80	$8,605,971.65

Business Assessment of Applicant Organization

State of New Mexico
Rural Health Transformation Program Application
Business Assessment of Applicant Organization

A. General Information

Question	State's Response
1. Provide organization's: a. Legal name b. EIN (include PMS prefix and suffix, if applicable-ex. 1-12356789-A1) c. Organizational Type	a. Legal name: New Mexico Health Care Authority b. EIN (include PMS prefix and suffix, if applicable-ex. **1**-12356789-**A1)**: 1856000570A5 c. Organizational Type: State governmental agency, and the Single State Agency for Medicaid
2. What percentage of your organization's capital is from Federal funding? (percentage = total Federal funding received in previous fiscal year / organization's total gross revenue in previous fiscal year).	Seventy-four percent (74%) of the Health Care Authority's revenue is from federal funds.
3. Does/did your organization receive additional oversight (examples include: Correction Action Plan, Responsibility and Qualification (R/Q) findings, reimbursement payments for enforcement actions) from a Federal agency within the past 3 years due to past performance or other programmatic or financial concerns with the organization)? a. If yes, please provide the following information: Name of the Federal agency and the reason for the additional oversight as explained by the Federal agency. b. If resolved, please indicate how the issue was resolved with the Federal agency.	No
4. Does your organization currently manage grants with other U.S. Department of Health and Human Services components or other Federal agencies?	The Healthcare Authority manages grants from other DHHS components such as SAMHSA, ACF, and OCSS. Also, grants from other Federal agencies including USDA (SNAP).
5. Explain your organization's process to ensure annual renewal in SAM.gov including R/Q and Reps and Certs.	The Health Care Authority's Chief Financial Officer and Grants Management Bureau Chief renew SAM registration annually by October 24th.

Question	State's Response
6. Explain your organization's process to comply with (a) 2 CFR 200.113 "Mandatory Disclosures" and (b) your organization's process to comply with FFATA requirements.	2a. Mandatory Disclosures are submitted through the Health Care Authority's Office of General Counsel. 2b. The Health Care Authority has policies and procedures in place for ensuring FFATA compliance by timely reporting sub-awards over $25,000 in FSRS. Also, see Health Care Authority Model Accounting Practices (HMAP) Section 7.2.2 for FFATA compliance.
7. Do you have conflict of interest policies? Does your organization or any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds? If yes, please explain and provide a mitigation plan.	The State of New Mexico has a conflict-of-interest policy that is reviewed and signed by every employee annually. We have no organizational or personal conflicts of interest with receipt of the CMS award funds.
8. Does your organization currently, or in the past, had delinquent Federal debt in the last 3 years? If yes, please explain.	The Health Care Authority has had no delinquent Federal debt in the last 3 years.
9. Have you filed bankruptcy or entered into proceedings for bankruptcy, whether voluntarily or involuntarily?	The Health Care Authority has not filed for bankruptcy.
10. Has your organization obtained fidelity bond insurance coverage for responsible officials and employees of the organization in amounts required by statute or organization policy? What is that amount?	Not applicable to New Mexico State governmental agencies.
11. Do you have (and briefly describe) policies and procedures in place to meet the requirements below? If not, explain your plan and estimated timeline for establishing these policies and procedures if selected for award. a. Determinations between subrecipients versus contracts in accordance with 2 CFR 200.331?	Yes, see Health Care Authority Model Accounting Practices (HMAP) Section 7.2.2 for responses to 11.a., 11.b, and 11.c.

Question	State's Response
b. Compliance with 2 CFR 200.332 "Requirements for pass-through entities"? c. Manage, assess risk, review audits, and monitor the subrecipients as necessary to ensure that subawards are used for authorized purposes in compliance with laws, regulations, and terms and conditions of the award and that established subaward performance goals are achieved (2 CFR 200.331-200.333)?	

B. Accounting System

Question	State's Response
1. Does your organization have updated (last two years) written accounting policies and procedures to manage Federal awards in accordance with 2 CFR 200? a. If no, please provide a brief explanation of why not. b. Describe the management of Federal funds and how funds are separated (not co-mingling) from other organizational funds.	1: Yes – see Health Care Authority Model Accounting Practices (HMAP) Section 7. 1.a.: N/A 1.b.: General fund appropriations, interagency transfers, and other non-federal funds are recorded using specific revenue accounting codes. Grant federal funds are recorded in federal revenue accounts along with Project and Activity codes related to the specific grant.
2. Briefly describe budgetary controls in effect to preclude incurring obligations in excess of: a. Total funds available for an award. b. Total funds available for a budget cost category.	2.a.: The New Mexico Department of Finance and Administration has final approval on all budgetary changes. The Budget Bureau and designated budget liaisons monitor expenditures and reconcile budget status reports monthly to ensure that obligations do not exceed the total funds available

Question	State's Response
	for an award. Divisions and offices are required to review financial transactions and notify the Budget Bureau if expenditures are projected to exceed budget authority, ensuring compliance with approved budgets. Also, see Health Care Authority Model Accounting Practices (HMAP) Section 1. 2.b.: The New Mexico Department of Finance and Administration has final approval on all budgetary changes. Budget liaisons and program managers maintain internal tracking sheets and regularly review expenditure data by cost category, reconciling these with official system reports. Any projected overages must be addressed through budget adjustments or modifications, with all changes processed by the Budget Bureau in accordance with established guidelines. Also, see Health Care Authority Model Accounting Practices (HMAP) Section 1.
3. Has any government agency rendered an official written opinion within the last 3 years concerning the adequacy of the organization's accounting system for the collection, identification, and allocation of costs under Federal awards? a. If yes, please provide the name and address of the agency that performed the review. b. Provide a summary of the opinion. c. How did your organization resolve any concerns?	No. The Health Care Authority annual financial audits and Single Audits have been issued with unmodified opinions. The New Mexico Office of the State Auditor website is the repository for all agency audits. The Health Care Authority is business unit 630. osaconnect.osa.nm.gov/auditreportsearch.aspx
4. How does the accounting system provide for recording the non-Federal share and in- kind contributions (if applicable)	General fund appropriations, interagency transfers, and other non-federal funds are recorded using specific revenue accounting codes.
5. Does the organization's accounting system provide identification for award funding by Federal agency, pass-through entity, Assistance Listing (CFDA), award number and period of funding? a. If yes, how does your organization identify awards?	5: Yes 5.a.: Within the financial management system, SHARE, staff use charts of account fields to identify grant funding by Project and

Question	State's Response
b. If not, please explain why not.	Activity coding. Project and Activity codes are established with a beginning and ending date in SHARE.

C. Budgetary Controls

Question	State's Response
1. What are your organization's controls used to ensure that the Authorized Organizational Representative (AOR), as identified on the SF-424, approves all budget changes for the Federal award?	Project Director/Principal Investigators are responsible for management of grant budgets including any changes. Budget Bureau staff have authority to increase/decrease budgetary amounts in the financial management system, SHARE, with approval by PD/PI. The New Mexico Department of Finance and Administration has final approval on all budgetary changes. Also, see Health Care Authority Model Accounting Practices (HMAP) Section 1.
2. Describe your organization's procedures for minimizing the time between transfer of funds from the U.S. Treasury (e.g. Payment Management System) and disbursement for grant activities (See 2 CFR 200.305, "Federal Payment.").	The Health Care Authority draws down grant funds weekly, subsequent to disbursements. No funds are drawn prior to disbursement.

D. Personnel

Question	State's Response
1. Does your organization have a current organizational chart or similar document establishing clear lines of responsibility and authority? a. If yes, please provide a copy. b. If no, how are lines of responsibility and authority determined?	Yes, the Health Care Authority has an organizational chart. It is included in Other Supporting Documentation.

Question	State's Response
2. Does your organization have updated (last two years) written Personnel and/or Human Resource policies and procedures? If no, provide a brief explanation.	The Health Care Authority has written Personnel and Human Resources policies and procedures that are updated as needed. They are reviewed by each employee during annual competencies.
3. Does your organization pay compensation to Board Members?	Not applicable to State governmental agencies.
4. Are staff responsible for fiscal and administrative oversight of HHS awards (Grants Manager, CEO, Financial Officer) familiar with Federal rules and regulations applicable to grants and cooperative agreements (e.g. 2 CFR 200)?	Yes, the primary staff responsible for fiscal and administrative oversight of HHS award are the Health Care Authority Chief Financial Officer and Grants Management Bureau Chief who review and apply federal rules and regulations to all grants awarded.
5. Please describe how the payroll distribution system accounts for, tracks, and verifies the total effort (100%) to determine employee compensation.	The Health Care Authority uses an enterprise system for financial and human resource management, SHARE. Employees use SHARE to record daily work hours through either task profiles or combo codes that apply worked hours to a particular grant based on level of effort.

E. Payroll

Question	State's Response
1. In preparation of payroll is there a segregation of duties for the staff who prepare the payroll and those that sign the checks, have custody of cash funds and maintain accounting records? Please describe.	Yes. The Health Care Authority's Payroll Bureau creates payroll entries to the agency's financial resource management system, SHARE. All payroll is issued via ACH. Payroll Bureau staff do not have access to cash or authority to sign checks. Also, see Health Care Authority Model Accounting Practices (HMAP) Section 5.

F. Consultants

Question	State's Response
1. Are there written policies or consistently followed procedures regarding the use of consultants which detail the following (include an explanation for each question below): a. Briefly describe your organization's method or policy for ensuring consultant costs and fees are allowable, allocable, necessary and reasonable. b. Briefly describe your organization's method or policy to ensure prospective consultants prohibited from receiving Federal funds are not selected.	1.a.: Contract managers, in consultation with Grants Management Bureau and Budget Planning and Reporting Bureau, review consultants' contract scopes of work to determine allowability, allocability, necessity, and reasonableness of all consultant costs. 1.b.: The Health Care Authority uses The System for Award Management (SAM).

G. Property Management

Question	State's Response
1. Briefly describe the system for property management (tangible or intangible) utilized for maintaining property records consistent with 2 CFR 200.313. Refer to (2 CFR 200) for definitions of property to include personal property, equipment, and supplies.	The Health Care Authority utilizes a Fixed Asset Management System (FAMS) to document, track, and manage both tangible and intangible property, including personal property, equipment, and supplies, in accordance with federal and state regulations. Each asset is assigned a unique identifier, and detailed records are maintained for acquisitions, transfers, and disposals, with annual inventories conducted and certified by local asset coordinators. Property control forms are used to record assets based on their value, and all disposals require approval from a designated committee and notification to the State Auditor. Also, see Health Care Authority Model Accounting Practices (HMAP) Section 11.
2. Does your organization have adequate insurance to protect the Federal interest in equipment and real property (see 2 CFR 200.310 "Insurance coverage.")? How does the organization calculate the amount of insurance?	Risk assessment and insurance policy procurement is managed for the State of New Mexico's agencies at the General Services Department's Risk Management Division.

H. Property Standards

Question	State's Response
1. Describe the organization's property standards in accordance 2 CFR 200.310-327 "Procurement Standards")? If there are no procurement procedures, briefly describe how your organization handles purchasing activities. a. Include individuals responsible and their roles. b. Describe the competitive bid process for procurement purchases of equipment, rentals, or service agreements that are over certain dollar amounts.	1. The Health Care Authority's Chief Procurement Officer follows New Mexico's procurement code. Also, see Health Care Authority Model Accounting Practices (HMAP) Section 8. 1.a.: Procurement activities are managed by the Contract Management and Procurement Bureau (CMPB) within the Administrative Services Division, with oversight from the Budget Bureau and the Chief Financial Officer (CFO). Division or Office authorized representatives initiate requisitions, CMPB reviews and converts them to purchase orders, and the Budget Bureau provides final approval in the SHARE system before purchases are made. 1.b.: For purchases over $20,000, at least three written quotations are solicited from vendors, and for purchases over $60,000, an Invitation to Bid (ITB) or Request for Proposal (RFP) is issued through the State Purchasing Division. The process ensures compliance with state and federal procurement codes, with awards made to the lowest responsive bidder after public advertisement and bid opening.

I. Transportation Costs

Question	State's Response
1. Describe your organization's written travel policy. Ensure, at minimum, that: a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates (see 2 CFR 200.474, "Transportation costs."). b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred. c. Subsistence and lodging rates are equal to or less than current Federal per diem and mileage rates. d. Commercial transportation costs incurred at coach fares unless adequately justified. Lodging costs do not exceed GSA rate unless adequately justified (e.g. conference hotel). e. Travel expense reports show purpose and date of trip. f. Travel costs are approved by organizational official(s) and funding agency prior to travel.	New Mexico's travel policy is defined within New Mexico Administrative Code and summarized at the following link: https://www.nmdfa.state.nm.us/wp-content/uploads/2025/07/NM-Travel-Policy-and-Procedure-FY24.pdf. See also Health Care Authority CFO Directive 102.7.5.

J. Internal Controls

Question	State's Response
1. Provide a brief description of your organization's internal controls that will provide reasonable assurance that the organization will manage award funds properly. (see 2 CFR 200.303, "Internal controls.")	The Health Care Authority follows Model Accounting Practices issued by the New Mexico State Department of Finance and Administration required for all state agencies' fiscal management. Manual of Model Accounting Practices
2. What is your organization's policy on separation of duties as well as responsibility for receipt, payment, and recording of cash transactions?	The Health Care Authority policy ensures that no single individual has control over all aspects of a cash transaction. Duties are segregated to prevent errors and fraud, and responsibilities for receiving, paying, and recording cash are

Question	State's Response
	clearly defined and documented. Also, see Health Care Authority Model Accounting Practices (HMAP) Section 2.
3. Does your organization have internal audit or legal staff? If not, how do you ensure compliance with the award? Please describe.	Yes. The Health Care Authority has the Office of General Counsel and Office of Inspector General.
4. If your organization has a petty cash fund how is it monitored?	All petty cash, change funds, and miscellaneous special funds are restricted to a designated state employee. Funds are reconciled monthly and independently reconciled annually and upon transfer of custody. Also, see New Mexico Department of Finance and Administration, Manual of Model Accounting Practices, Manual of Model Accounting Practices, Section FIN 5.13
5. Who in the organization reconciles bank accounts? Is this person familiar with the organization's financial activities? Does your organization authorize this person to sign checks or handle cash?	Bank account reconciliations are performed by the New Mexico State Treasury Office. Also, see Health Care Authority Model Accounting Practices (HMAP) Section 2.
6. Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?	Not applicable to New Mexico State governmental agencies.

K. Internal Controls

Question	State's Response
1. What is your organization's fiscal year?	New Mexico's fiscal year runs July 1 through June 30.
2. Did your organization expend $1,000,000 or more in Federal awards from **all** sources during its most recent fiscal year?	Yes.
3. Has your organization submitted; (a) an audit report to the **Federal Audit Clearing House (FAC)** in accordance with the Single Audit Act in the last 3 years? (see 2 CFR 200.501, "Audit requirements" and	Yes.

Question	State's Response
2 CFR 300.218 "Special Provisions for Awards to for-profit organization as recipients.") **or** (b) an independent, external audit? If no, briefly explain. If yes, address the following: a. The date of the most recently submitted audit report. b. The auditor's opinion on the financial statement. c. If applicable, indicate if your organization has findings in the following areas: i. internal controls ii. questioned or unallowable costs iii. procurement/suspension and debarment iv. cash management of award funds, and *v.* subrecipient *monitoring.* d. Include (if applicable): i. a description of each finding classified as Material Weakness. ii. a description of each finding classified as Significant Deficiency.	
4. Has your organization had corrective actions in the past 2 years for the findings identified above (3(iii))? a. If yes, describe the status (closed or open) and progress made on those corrective actions.	No. The Health Care Authority annual financial audits and Single Audits have been issued with unmodified opinions. The New Mexico Office of the State Auditor website is the repository for all agency audits. The Health Care Authority is business unit 630.

Program Duplication Assessment

The State of New Mexico is committed to administering effective and non-duplicative programs. As healthcare programs and funds across the State are diverse and complex, the State has performed a review of existing healthcare funding streams to confirm non-duplication of programs and align the Rural Health Transformation (RHT) Program activities to complement existing funds while remaining separate initiatives and purposes. The sections below outline New Mexico's responsibility to avoid program duplication, our understanding of non-duplication policies, existing aligned initiatives, and our approach to preventing non-duplication.

A. Ensuring Appropriate Use of RHT Program Award Funds

Throughout the RHT Program performance period, the State of New Mexico will be responsible for ensuring non-duplication of funding between the RHT Program and pre-existing or subsequent programs and payment mechanisms. RHT Program funds will not be used to duplicate, supplant, or replace existing state, federal, or local funding including the state-share of any federally matched funding programs (i.e., Medicaid).

B. Building on Existing Programs and Initiatives and Avoiding Duplication

The State of New Mexico currently makes several investments in rural health leveraging federal, state, and local funding that may overlap with the RHT Program. A list of rural health-related programs is listed below in Table 1 along with the State's RHT Program design decisions and guardrails to prevent duplication of funding.

Table 1. New Mexico Rural Health Programs and Program Duplication Guardrails

Existing Funding Stream	Lead Agency	Description	RHT Program Guardrails to Build Upon Programs and Prevent Duplication
Medicaid Program Reimbursement	Health Care Authority	Finances medical assistance to Medicaid eligible beneficiaries including children, individuals with disabilities, and other vulnerable populations. Provides payments to eligible providers via state-directed payment programs, disproportional share, or to cover indigent care.	RHT Program funds will be used for start-up costs and not directly finance delivery of services or supplant existing costs. While provider payments are included, payments will not be delivered through Medicaid federal match mechanisms such as state plan amendments or directed payment programs.
Medicare Rural Hospital Flexibility (Flex) Program	Office of Rural Health	A federal program that supports rural hospitals to improve quality of care, financial health, and expand emergency services.	New Mexico's Flex program provides targeted technical assistance and support specifically to critical access hospitals. RHT Program funding will serve additional provider types (e.g., FQHCs) and distinguish itself from Flex Program services by offering additional technical assistance services such as hands-on

Existing Funding Stream	Lead Agency	Description	RHT Program Guardrails to Build Upon Programs and Prevent Duplication
			operational and strategic support.
Title V Maternal and Child Health Block Grant	Department of Health	Program dedicated to improving health outcomes in New Mexico's maternal, infant and child populations. Examples of priority areas include promoting high-quality maternal care, growing and sustaining a birth and family care workforce, increasing access to oral health for all children, and increasing access to specialty medical care for children.	HCA will establish protocols as summarized below to prevent duplication.
Miners' Hospital of New Mexico	Health Care Authority	To provide quality acute care, long-term care, and related health services to the beneficiaries of the Miners' Trust Fund of New Mexico and the people of the region, so they can maintain optimal health and quality of life.	While Miners' Hospital of New Mexico will likely meet eligibility criteria for RHT Program Initiative funding, HCA will establish protocols as summarized below to prevent duplication.
Rural Health Care Delivery Fund	Health Care Authority	Dedicated fund to improve access to healthcare in rural areas. Grants and support for rural health providers and facilities.	Initiative 3- Rural Health Innovation Fund, will build off of the success of the Rural Health Care Delivery Fund with an alternative focus on non-medical drivers of health, behavioral health, preventive care, and minor provider facility enhancements.
Rural Health Capital Investments	Department of Finance and Administration	Construction in rural areas for the following projects: 1. Primary care facility in Taos County 2. Nursing home in Rio Arriba County 3. Hospital in Tucumcari-Quay County	Large capital projects are not eligible under the RHT Program. However, small remodeling efforts may be considered. New Mexico will confirm any existing funding streams prior to releasing small capital investments.
Healthcare Strategic Recruitment Program	Workforce Solutions Department	Recruitment of healthcare professionals for rural and underserved areas.	The healthcare strategic recruitment program addresses healthcare shortages. RHT Program efforts are intended to build additional recruitment pathways and focus on career ladders, professional

Existing Funding Stream	Lead Agency	Description	RHT Program Guardrails to Build Upon Programs and Prevent Duplication
			development, and improving the healthcare career pipeline.
Health Professional Loan Repayment Program	Higher Education Department	Loan repayment for health professionals, with priority for rural and underserved areas.	While loan repayment is not permitted under the RHT Program and is not included in New Mexico's Transformation Plan, Initiative activities will align with and complement this program.
Behavioral Health Investment Zones	Health Care Authority	Establish or expand behavioral health investment zones with rural eligibility.	HCA will establish protocols as summarized below to prevent duplication.
Mobile Crisis and Recovery Response Teams	Health Care Authority	Regional mobile crisis teams, including rural areas.	HCA will establish protocols as summarized below to prevent duplication.
Grants for Rural Behavioral Health Facilities	Health Care Authority	Regional transitional behavioral health facilities and certified community clinics, including rural locations.	HCA will establish protocols as summarized below to prevent duplication.
Aging Network	Aging and Long-Term Services Department	Provides nutrition and social services to older adults, including rural outreach.	HCA will establish protocols as summarized below to prevent duplication.
Family Support and Early Intervention	Early Childhood Education and Care Department	Home visiting and early intervention services, including rural families.	HCA will establish protocols as summarized below to prevent duplication.
Health Leadership High School (Albuquerque, MN)	Public Education Department	Public charter high school focused on preparing students for careers in healthcare through project-based and experiential learning including internships in rural healthcare delivery, and community health worker certification courses relevant to rural areas.	HCA may take inspiration from the Health Leadership High Schools programs to replicate at other locations or develop rural health-specific curricula.

As demonstrated in Table 1, New Mexico is aware of potential duplication with current rural health associated programs. New Mexico will actively monitor and establish RHT Program processes to prevent supplanting existing funds. In some cases, New Mexico's RHT Program initiatives may expand or complement existing funding streams. For example, New Mexico may replicate programs and curricula developed for the Health Leadership High School for additional locations across the State.

C. Standard Operating Procedures for Preventing Program Duplication Avoiding Duplication

The leading agency of this grant, the New Mexico Health Care Authority (HCA), regularly collaborates and coordinates across health and human services departments to design, implement, and monitor programs. HCA is therefore accustomed to assessing possible duplications of funding and identifying efficient and appropriate uses. To continuously monitor and align with RHT Program funding eligibility guidelines and prevent duplication, supplantation, or misuse of funds, HCA will adhere to the following best practices and customary activities:

1. **Establish Clear Funding Parameters and Guardrails for RHT Funded Programs**: Affiliated with every funding opportunity, HCA will provide clear written guidance articulating the intention of the funds, permissible and non-permissible funding categories and provide period training to further define funding guardrails.
2. **Effectively Communicate Funding Guidance to Partners, Vendors, and Subrecipients**: Provide written and verbal communication clarifying eligible funds including documenting examples. Clearly define and document eligible expenses and costs in contracts, approval letters, and notices of award.
3. **Establish Centralized Application or Funding Determination Processes**: Coordinate a centralized team to make funding determinations across RHT Programs that understand eligible and potentially duplicative funds.
4. **Coordinate Review Processes Across Departments and Agencies**: Regularly engage agencies across State government to clarify permissible funding are track funds already awarded to potential subrecipients.
5. **Communicate Award Decisions and Document Approved Expenses Clearly**: As needed, clearly document funded expenses in approval letters, agreements, and contracts.
6. **Make Technical Assistance Available to Preemptively Address Potential Duplications**: Make infoboxes, websites, and staff available as needed to resolve issues, make determinations, and answer questions regarding appropriate funding uses.
7. **Monitor Implementation and Establish Detailed Reporting Processes**: Require and collect regular reporting to reaffirm alignment with funding guidelines and document actual spending.
8. **Review and Escalate Potential Duplications for Potential Recoupment**: Conduct periodic audits to identify potential funding overlap and leverage cross-departmental escalation pathways to determine next steps.
9. **Annually Report to the New Mexico Legislative Finance Committee**: Develop an annual report for the New Mexico Legislative Finance Committee to articulate appropriate use of funding.
10. **Regularly Identify Newly Established Funding Streams to Incorporate into the Procedure**: Establish regular processes to review state government programs for new potential overlap and resolve potential duplications as soon as possible.

Other Supporting Documentation

New Mexico RHT CCBHC Data Submission Template

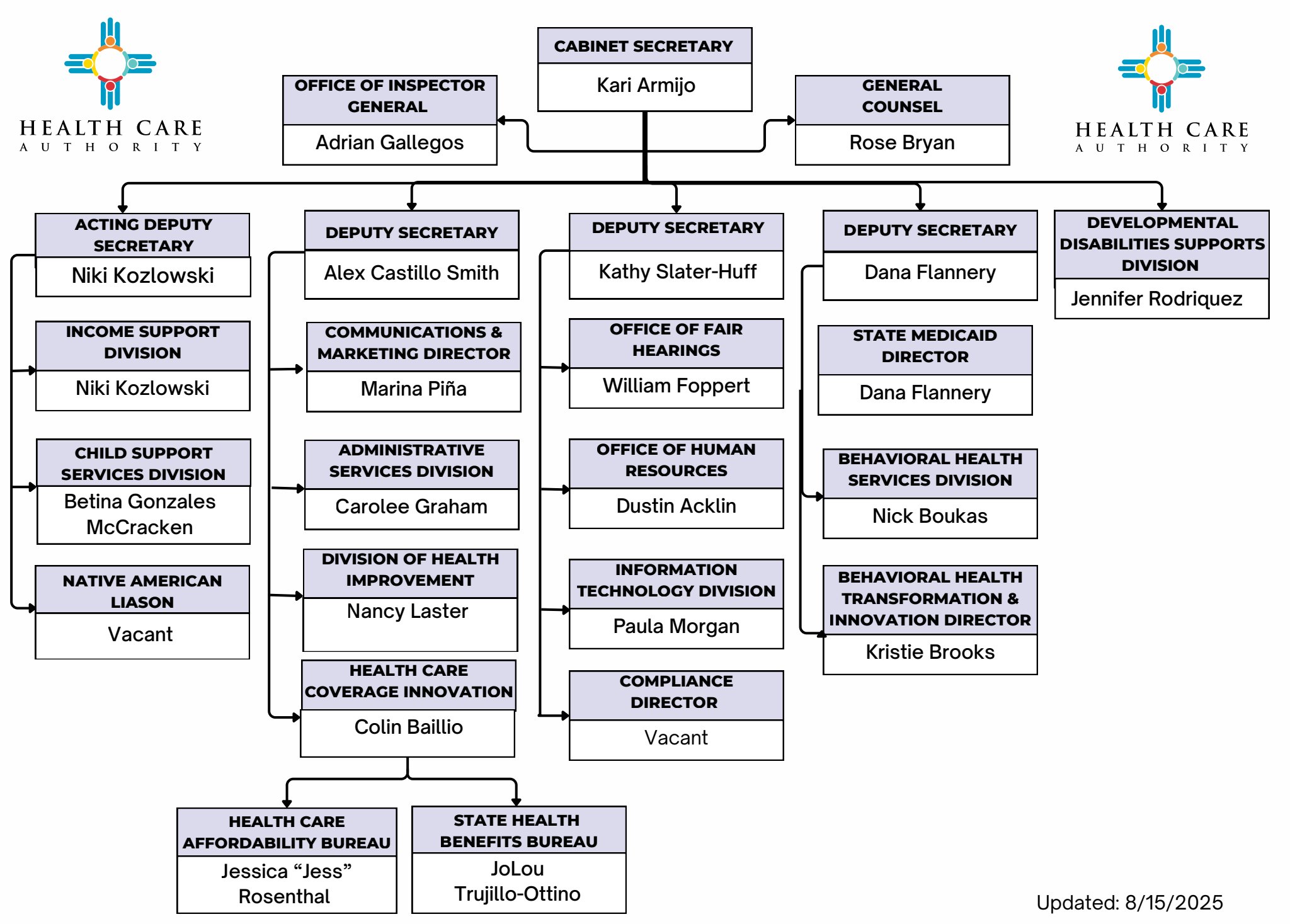
Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
LifeHouse - Carlsbad	1900 Westridge Road	Carlsbad	NM	88220	Carlsbad LifeHouse Inc.	Y	Y		Y
Families & Youth Innovations Plus - Las Cruces	1320 South Solano Drive	Las Cruces	NM	88001	FYI+	Y	Y	Y	N
Presbyterian Medical Services - Farmington	1001 West Broadway, Suite E & D	Farmington	NM	87401	Presbyterian Medical Services	Y	Y		N
Santa Fe Recovery Center - Sante Fe	2504 Camino Entrada	Santa Fe	NM	87507	Santa Fe Recovery Center	Y	Y	Y	N
Santa Fe Recovery Center - Gallup	2028 East Aztec Avenue	Gallup	NM	87301	Santa Fe Recovery Center	Y	Y	Y	Y
UNM Adult Psychiatric Center	2600 Yale Boulevard NE	Albuquerque	NM	87106	University of New Mexico Hospitals	Y	Y		N
UNM Children's Psychiatric Center	1031 Lamberton Place NE	Albuquerque	NM	87107	University of New Mexico Hospitals	Y	Y		N
UNM Adult Psychiatric Center	2600 Marble Avenue NE	Albuquerque	NM	87106	University of New Mexico Hospitals	Y	Y		N
UNM Center of Excellence for Orthopedic Surgery and Rehabilitation	3200 Broadmoor Boulevard NE	Rio Rancho	NM	87144	University of New Mexico Hospitals	Y	Y		Y
New Mexico Solutions - Albuquerque	707 Broadway NE, Suite #500	Albuquerque	NM	87102	New Mexico Solutions	Y	Y		N
Guidance Center of Lea County - Hobbs	920 West Broadway	Hobbs	NM	88240	Guidance Center of Lea County	Y	Y		Y
LCDF Wellness Center - Primary Facility	760 N. Motel Blvd, Suite A-C	Las Cruces	NM	88007	La Clinica De Familia	Y	Y		N
Las Cruces Behavioral Health - Access Site	535 S. Miranda	Las Cruces	NM	88005	La Clinica De Familia	Y	Y		N
Anthony Behavioral Health - Access Site	826 S. Anthony Dr	Anthony	NM	88021	La Clinica De Familia	Y	Y		N
Sunland Behavioral Health - Access Site	2625 McNutt Rd	Sunland Park	NM	88063	La Clinica De Familia	Y	Y		N
Anthony Medical Center - Access Site	855 Anthony Dr	Anthony	NM	88021	La Clinica De Familia	Y	Y		N
Central Medical Center - Access Site	575 Alameda Blvd	Las Cruces	NM	88005	La Clinica De Familia	Y	Y		N
Chaparral Medical Center - Access Site	510 E. Lisa	Chaparral	NM	88081	La Clinica De Familia	Y	Y		Y

New Mexico RHT CCBHC Data Submission Template

Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
East Mesa Medical Center - Access Site	8600 Bataan Memorial East	Las Cruces	NM	88011	La Clinica De Familia	Y	Y		Y
San Miguel Medical Center - Access Site	18420 Highway 28	La Mesa	NM	88044	La Clinica De Familia	Y	Y		Y
Pediatric Medical Center - Access Site	385 Calle de Algre LC 88005 SUITE B	Las Cruces	NM	88005	La Clinica De Familia	Y	Y		N
Women's Health Center - Access Site	386 Calle de Algre LC 88005 SUITE C								
Sunland Park Medical - Access Site	2624 McNutt Rd	Sunland Park	NM	88063	La Clinica De Familia	Y	Y		N
Warrior Wellness School Based Center-Access Site	100 Airport Road	Santa Teresa	NM	88008	La Clinica De Familia	Y	Y		N
Gadsden School Based Health Center-Access Site	6301 New Mexico Highway 28	Anthony	NM	88021	La Clinica De Familia	Y	Y		Y
Chaparral School Based Health Center - Access Site	800 S. County Line Dr	Chaparral	NM	88081	La Clinica De Familia	Y	Y		Y
Desert Pride School Based Health Center - Access Site	100 Shrode Rd	Anthony	NM	88021	La Clinica De Familia	Y	Y		Y
Centennial School Based Health Center-Access Site	1950 Sonoma Ranch Blvd	Las Cruces	NM	88011	La Clinica De Familia	Y	Y		N
Rio Grande Preparatory School Health Center - Access Site	2355 Avenida de Mesilla	Las Cruces	NM	88005	La Clinica De Familia	Y	Y		N
Lynn School Based Health Center- Access Site	950 S. Walnut Street	Las Cruces	NM	88011	La Clinica De Familia	Y	Y		N
Picacho School Based health Center - Access Site	1040 N. Motel Blvd	Las Cruces	NM	88007	La Clinica De Familia	Y	Y		N
Mental Health Resources, Inc. - Clovis	1100 West 21st Street	Clovis	NM	88101	Mental Health Resources	Y	Y		Y
Mental Health Resources, Inc. - Clovis	1621 Sutter Place	Clovis	NM	88101	Mental Health Resources	Y	Y		Y
Mental Health Resources, Inc. - Clovis	500 Pile Street	Clovis	NM	88101	Mental Health Resources	Y	Y		Y
PMS Espanola Family Wellness Center	1200 North Paseo De Onate	Española	NM	87532	Presbyterian Medical Services	Y	Y		Y

New Mexico RHT CCBHC Data Submission Template

Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
PMS Valley Community Health Center	835 Spruce St	Española	NM	87532	Presbyterian Medical Services	Y	Y		Y
Santa Fe Family Health Center	4730 Beckner Road	Santa Fe	NM	87507	Presbyterian Medical Services	Y	Y		Y
All Faiths Children's Advocacy Center - Albuquerque	1709 Moon St NE	Albuquerque	NM	87110	All Faiths Children's Advocacy Center	N	N	Y	N



Updated: 8/15/2025

SF-424: Application for Federal Assistance

WORKSPACE FORM

1-800-518-4726
SUPPORT@GRANTS.GOV

This Workspace form is one of the forms you need to complete prior to submitting your Application Package. This form can be completed in its entirety offline using Adobe Reader. You can save your form by clicking the "Save" button and see any errors by clicking the “Check For Errors” button. In-progress and completed forms can be uploaded at any time to Grants.gov using the Workspace feature.

When you open a form, required fields are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message. Additional instructions and FAQs about the Application Package can be found in the Grants.gov Applicants tab.

OPPORTUNITY & PACKAGE DETAILS:

Opportunity Number:	CMS-RHT-26-001
Opportunity Title:	Rural Health Transformation Program
Opportunity Package ID:	PKG00291485
Assistance Listing Number:	93.798
Assistance Listing Title:	Rural Health Transformation Program
Competition ID:	CMS-RHT-26-001-117822
Competition Title:	Rural Health Transformation Program
Opening Date:	09/15/2025
Closing Date:	11/05/2025
Agency:	Centers for Medicare & Medicaid Services
Contact Information:	Please refer to the Notice of Funding Opportunity

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS01585132
Application Filing Name:	Rural Health Transformation Program
UEI:	K49NN52HU4L7
Organization:	DEPARTMENT OF HUMAN SERVICES NEW MEXICO
Form Name:	Application for Federal Assistance (SF-424)
Form Version:	4.0
Requirement:	Mandatory
Download Date/Time:	Oct 27, 2025 11:17:44 AM EDT
Form State:	No Errors

FORM ACTIONS:

OMB Number: 4040-0004
Expiration Date: 11/30/2025

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received:
Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: New Mexico Healthcare Authority

* b. Employer/Taxpayer Identification Number (EIN/TIN): 856000570

* c. UEI: K49NN52HU4L7

d. Address:

* Street1: 1474 Rodeo Road
Street2:
* City: Santa Fe
County/Parish:
* State: NM: New Mexico
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 87505-6142

e. Organizational Unit:

Department Name:

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

* First Name:

Middle Name:

* Last Name:

Suffix:

Title:

Organizational Affiliation:

* Telephone Number:

Fax Number:

* Email:

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Centers for Medicare & Medicaid Services

11. Assistance Listing Number:

93.798

Assistance Listing Title:

Rural Health Transformation Program

*** 12. Funding Opportunity Number:**

CMS-RHT-26-001

* Title:

Rural Health Transformation Program

13. Competition Identification Number:

CMS-RHT-26-001-117822

Title:

Rural Health Transformation Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Rural Health Transformation Program

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: NM-003 * b. Program/Project: NM-All

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 01/01/2026 * b. End Date: 09/30/2030

18. Estimated Funding ($):

* a. Federal	1,000,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name: KARI

Middle Name:

* Last Name: ARMIJO

Suffix:

* Title: CABINET SECRETARY, NM HEALTHCARE AUTHORITY

* Telephone Number: (505) 827-7750 Fax Number:

* Email: KARI.ARMIJO@HCA.NM.GOV

* Signature of Authorized Representative: Completed by Grants.gov upon submission. * Date Signed: Completed by Grants.gov upon submission.

SF-424A: Budget Information for Non-Construction Programs

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 0348-0044

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. RHT Program Year 1	93.798	$ 0.00	$ 0.00	$ 200,000,000.00	$ 0.00	$ 200,000,000.00
2. RHT Program Year 2	93.798	0.00	0.00	200,000,000.00	0.00	200,000,000.00
3. RHT Program Year 3	93.798	0.00	0.00	200,000,000.00	0.00	200,000,000.00
4. RHT Program Year 4	93.798	0.00	0.00	200,000,000.00	0.00	200,000,000.00
5. Totals		$ 0.00	$ 0.00	$ 800,000,000.00	$ 0.00	$ 800,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) RHT Program Year 1	(2) RHT Program Year 2	(3) RHT Program Year 4	(4) RHT Program Year 4	(5)
a. Personnel	$ 2,044,202.34	$ 4,088,404.68	$ 4,088,404.68	$ 4,088,404.68	$ 14,309,416.38
b. Fringe Benefits	714,735.49	1,429,470.99	1,429,470.99	1,429,470.99	5,003,148.46
c. Travel	86,273.10	172,546.24	172,546.24	172,546.24	603,911.82
d. Equipment	0.00	0.00	0.00	0.00	0.00
e. Supplies	182,360.48	364,720.98	364,720.98	364,720.98	1,276,523.42
f. Contractual	192,729,982.00	187,385,173.00	187,385,173.00	187,385,173.00	754,885,501.00
g. Construction	0.00	0.00	0.00	0.00	0.00
h. Other	3,086,223.14	4,697,246.31	4,697,246.31	4,697,246.31	17,177,962.07
i. Total Direct Charges *(sum of 6a-6h)*	198,843,776.55	198,137,562.20	198,137,562.20	198,137,562.20	793,256,463.15
j. Indirect Charges	1,156,223.45	1,862,437.80	1,862,437.80	1,862,437.80	6,743,536.85
k. TOTALS *(sum of 6i and 6j)*	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 800,000,000.00
7. Program Income	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

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SECTION C - NON-FEDERAL RESOURCES				
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. RHT Program Year 1	$ 0.00	$ 0.00	$ 0.00	$ 0.00
9. RHT Program Year 2				0.00
10. RHT Program Year 3				0.00
11. RHT Program Year 4				0.00
12. TOTAL *(sum of lines 8-11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
13. Federal	$ 200,000,000.00	$ 200,000,000.00	$ 0.00	$ 0.00	$ 0.00
14. Non-Federal	0.00	0.00	0.00	0.00	0.00
15. TOTAL *(sum of lines 13 and 14)*	$ 200,000,000.00	$ 200,000,000.00	$ 0.00	$ 0.00	$ 0.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. RHT Program Year 1	$ 0.00	$ 0.00	$ 0.00	$ 0.00
17. RHT Program Year 2				
18. RHT Program Year 3				
19. RHT Program Year 4				
20. TOTAL *(sum of lines 16-19)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges: Additional information provided in the Budget Narrative.	22. Indirect Charges: Additional information provided in the Budget Narrative.
23. Remarks: Additional information provided in the Budget Narrative.	

INSTRUCTIONS FOR THE SF-424A

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

General Instructions

This form is designed so that application can be made for funds from one or more grant programs. In preparing the budget, adhere to any existing Federal grantor agency guidelines which prescribe how and whether budgeted amounts should be separately shown for different functions or activities within the program. For some programs, grantor agencies may require budgets to be separately shown by function or activity. For other programs, grantor agencies may require a breakdown by function or activity. Sections A, B, C, and D should include budget estimates for the whole project except when applying for assistance which requires Federal authorization in annual or other funding period increments. In the latter case, Sections A, B, C, and D should provide the budget for the first budget period (usually a year) and Section E should present the need for Federal assistance in the subsequent budget periods. All applications should contain a breakdown by the object class categories shown in Lines a-k of Section B.

Section A. Budget Summary Lines 1-4 Columns (a) and (b)

For applications pertaining to a *single* Federal grant program (Federal Domestic Assistance Catalog number) and *not requiring* a functional or activity breakdown, enter on Line 1 under Column (a) the Catalog program title and the Catalog number in Column (b).

For applications pertaining to a *single* program *requiring* budget amounts by multiple functions or activities, enter the name of each activity or function on each line in Column (a), and enter the Catalog number in Column (b). For applications pertaining to multiple programs where none of the programs require a breakdown by function or activity, enter the Catalog program title on each line in *Column* (a) and the respective Catalog number on each line in Column (b).

For applications pertaining to *multiple* programs where one or more programs *require* a breakdown by function or activity, prepare a separate sheet for each program requiring the breakdown. Additional sheets should be used when one form does not provide adequate space for all breakdown of data required. However, when more than one sheet is used, the first page should provide the summary totals by programs.

Lines 1-4, Columns (c) through (g)

For new applications, leave Column (c) and (d) blank. For each line entry in Columns (a) and (b), enter in Columns (e), (f), and (g) the appropriate amounts of funds needed to support the project for the first funding period (usually a year).

For continuing grant program applications, submit these forms before the end of each funding period as required by the grantor agency. Enter in Columns (c) and (d) the estimated amounts of funds which will remain unobligated at the end of the grant funding period only if the Federal grantor agency instructions provide for this. Otherwise, leave these columns blank. Enter in columns (e) and (f) the amounts of funds needed for the upcoming period. The amount(s) in Column (g) should be the sum of amounts in Columns (e) and (f).

For supplemental grants and changes to existing grants, do not use Columns (c) and (d). Enter in Column (e) the amount of the increase or decrease of Federal funds and enter in Column (f) the amount of the increase or decrease of non-Federal funds. In Column (g) enter the new total budgeted amount (Federal and non-Federal) which includes the total previous authorized budgeted amounts plus or minus, as appropriate, the amounts shown in Columns (e) and (f). The amount(s) in Column (g) should not equal the sum of amounts in Columns (e) and (f).

Line 5 - Show the totals for all columns used.

Section B Budget Categories

In the column headings (1) through (4), enter the titles of the same programs, functions, and activities shown on Lines 1-4, Column (a), Section A. When additional sheets are prepared for Section A, provide similar column headings on each sheet. For each program, function or activity, fill in the total requirements for funds (both Federal and non-Federal) by object class categories.

Line 6a-i - Show the totals of Lines 6a to 6h in each column.

Line 6j - Show the amount of indirect cost.

Line 6k - Enter the total of amounts on Lines 6i and 6j. For all applications for new grants and continuation grants the total amount in column (5), Line 6k, should be the same as the total amount shown in Section A, Column (g), Line 5. For supplemental grants and changes to grants, the total amount of the increase or decrease as shown in Columns (1)-(4), Line 6k should be the same as the sum of the amounts in Section A, Columns (e) and (f) on Line 5.

Line 7 - Enter the estimated amount of income, if any, expected to be generated from this project. Do not add or subtract this amount from the total project amount, Show under the program

narrative statement the nature and source of income. The estimated amount of program income may be considered by the Federal grantor agency in determining the total amount of the grant.

Section C. Non-Federal Resources

Lines 8-11 Enter amounts of non-Federal resources that will be used on the grant. If in-kind contributions are included, provide a brief explanation on a separate sheet.

Column (a) - Enter the program titles identical to Column (a), Section A. A breakdown by function or activity is not necessary.

Column (b) - Enter the contribution to be made by the applicant.

Column (c) - Enter the amount of the State's cash and in-kind contribution if the applicant is not a State or State agency. Applicants which are a State or State agencies should leave this column blank.

Column (d) - Enter the amount of cash and in-kind contributions to be made from all other sources.

Column (e) - Enter totals of Columns (b), (c), and (d).

Line 12 - Enter the total for each of Columns (b)-(e). The amount in Column (e) should be equal to the amount on Line 5, Column (f), Section A.

Section D. Forecasted Cash Needs

Line 13 - Enter the amount of cash needed by quarter from the grantor agency during the first year.

Line 14 - Enter the amount of cash from all other sources needed by quarter during the first year.

Line 15 - Enter the totals of amounts on Lines 13 and 14.

Section E. Budget Estimates of Federal Funds Needed for Balance of the Project

Lines 16-19 - Enter in Column (a) the same grant program titles shown in Column (a), Section A. A breakdown by function or activity is not necessary. For new applications and continuation grant applications, enter in the proper columns amounts of Federal funds which will be needed to complete the program or project over the succeeding funding periods (usually in years). This section need not be completed for revisions (amendments, changes, or supplements) to funds for the current year of existing grants.

If more than four lines are needed to list the program titles, submit additional schedules as necessary.

Line 20 - Enter the total for each of the Columns (b)-(e). When additional schedules are prepared for this Section, annotate accordingly and show the overall totals on this line.

Section F. Other Budget Information

Line 21 - Use this space to explain amounts for individual direct object class cost categories that may appear to be out of the ordinary or to explain the details as required by the Federal grantor agency.

Line 22 - Enter the type of indirect rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Line 23 - Provide any other explanations or comments deemed necessary.

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 0348-0044

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. RHT Program Year 5	93.798	$ 0.00	$ 0.00	$ 0.00	$ 200,000,000.00	$ 200,000,000.00
2.						0.00
3.						0.00
4.						0.00
5. Totals		$ 0.00	$ 0.00	$ 0.00	$ 200,000,000.00	$ 200,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) RHT Program Year 5	(2)	(3)	(4)	(5)
a. Personnel	$ 4,088,404.68	$	$	$	$ 4,088,404.68
b. Fringe Benefits	1,429,470.99				1,429,470.99
c. Travel	172,546.24				172,546.24
d. Equipment	0.00				0.00
e. Supplies	364,720.98				364,720.98
f. Contractual	187,385,176.00				187,385,176.00
g. Construction	0.00				0.00
h. Other	4,697,246.31				4,697,246.31
i. Total Direct Charges *(sum of 6a-6h)*	198,137,565.20	0.00	0.00	0.00	198,137,565.20
j. Indirect Charges	1,862,434.80				1,862,434.80
k. TOTALS *(sum of 6i and 6j)*	$ 200,000,000.00	$ 0.00	$ 0.00	$ 0.00	$ 200,000,000.00
7. Program Income	$	$	$	$	$ 0.00

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SECTION C - NON-FEDERAL RESOURCES				
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. RHT Program Year 5	$ 0.00	$ 0.00	$ 0.00	$ 0.00
9.				0.00
10.				0.00
11.				0.00
12. TOTAL *(sum of lines 8-11)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION D - FORECASTED CASH NEEDS					
	Total for 1st Year	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
13. Federal	$ 0.00	$ 200000000	$ 0.00	$ 0.00	$ 0.00
14. Non-Federal	0.00	0.00	0.00	0.00	0.00
15. TOTAL *(sum of lines 13 and 14)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16 RHT Program Year 5	$ 0.00	$ 0.00	$ 0.00	$ 0.00
17.				
18.				
19.				
20. TOTAL *(sum of lines 16-19)*	$ 0.00	$ 0.00	$ 0.00	$ 0.00

SECTION F - OTHER BUDGET INFORMATION	
21. Direct Charges: Additional information provided in the Budget Narrative.	22. Indirect Charges: Additional information provided in the Budget Narrative.
23. Remarks: Additional information provided in the Budget Narrative.	

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PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

General Instructions

This form is designed so that application can be made for funds from one or more grant programs. In preparing the budget, adhere to any existing Federal grantor agency guidelines which prescribe how and whether budgeted amounts should be separately shown for different functions or activities within the program. For some programs, grantor agencies may require budgets to be separately shown by function or activity. For other programs, grantor agencies may require a breakdown by function or activity. Sections A, B, C, and D should include budget estimates for the whole project except when applying for assistance which requires Federal authorization in annual or other funding period increments. In the latter case, Sections A, B, C, and D should provide the budget for the first budget period (usually a year) and Section E should present the need for Federal assistance in the subsequent budget periods. All applications should contain a breakdown by the object class categories shown in Lines a-k of Section B.

Section A. Budget Summary Lines 1-4 Columns (a) and (b)

For applications pertaining to a *single* Federal grant program (Federal Domestic Assistance Catalog number) and *not requiring* a functional or activity breakdown, enter on Line 1 under Column (a) the Catalog program title and the Catalog number in Column (b).

For applications pertaining to a *single* program *requiring* budget amounts by multiple functions or activities, enter the name of each activity or function on each line in Column (a), and enter the Catalog number in Column (b). For applications pertaining to multiple programs where none of the programs require a breakdown by function or activity, enter the Catalog program title on each line in *Column* (a) and the respective Catalog number on each line in Column (b).

For applications pertaining to *multiple* programs where one or more programs *require* a breakdown by function or activity, prepare a separate sheet for each program requiring the breakdown. Additional sheets should be used when one form does not provide adequate space for all breakdown of data required. However, when more than one sheet is used, the first page should provide the summary totals by programs.

Lines 1-4, Columns (c) through (g)

For new applications, leave Column (c) and (d) blank. For each line entry in Columns (a) and (b), enter in Columns (e), (f), and (g) the appropriate amounts of funds needed to support the project for the first funding period (usually a year).

For continuing grant program applications, submit these forms before the end of each funding period as required by the grantor agency. Enter in Columns (c) and (d) the estimated amounts of funds which will remain unobligated at the end of the grant funding period only if the Federal grantor agency instructions provide for this. Otherwise, leave these columns blank. Enter in columns (e) and (f) the amounts of funds needed for the upcoming period. The amount(s) in Column (g) should be the sum of amounts in Columns (e) and (f).

For supplemental grants and changes to existing grants, do not use Columns (c) and (d). Enter in Column (e) the amount of the increase or decrease of Federal funds and enter in Column (f) the amount of the increase or decrease of non-Federal funds. In Column (g) enter the new total budgeted amount (Federal and non-Federal) which includes the total previous authorized budgeted amounts plus or minus, as appropriate, the amounts shown in Columns (e) and (f). The amount(s) in Column (g) should not equal the sum of amounts in Columns (e) and (f).

Line 5 - Show the totals for all columns used.

Section B Budget Categories

In the column headings (1) through (4), enter the titles of the same programs, functions, and activities shown on Lines 1-4, Column (a), Section A. When additional sheets are prepared for Section A, provide similar column headings on each sheet. For each program, function or activity, fill in the total requirements for funds (both Federal and non-Federal) by object class categories.

Line 6a-i - Show the totals of Lines 6a to 6h in each column.

Line 6j - Show the amount of indirect cost.

Line 6k - Enter the total of amounts on Lines 6i and 6j. For all applications for new grants and continuation grants the total amount in column (5), Line 6k, should be the same as the total amount shown in Section A, Column (g), Line 5. For supplemental grants and changes to grants, the total amount of the increase or decrease as shown in Columns (1)-(4), Line 6k should be the same as the sum of the amounts in Section A, Columns (e) and (f) on Line 5.

Line 7 - Enter the estimated amount of income, if any, expected to be generated from this project. Do not add or subtract this amount from the total project amount, Show under the program

narrative statement the nature and source of income. The estimated amount of program income may be considered by the Federal grantor agency in determining the total amount of the grant.

Section C. Non-Federal Resources

Lines 8-11 Enter amounts of non-Federal resources that will be used on the grant. If in-kind contributions are included, provide a brief explanation on a separate sheet.

Column (a) - Enter the program titles identical to Column (a), Section A. A breakdown by function or activity is not necessary.

Column (b) - Enter the contribution to be made by the applicant.

Column (c) - Enter the amount of the State's cash and in-kind contribution if the applicant is not a State or State agency. Applicants which are a State or State agencies should leave this column blank.

Column (d) - Enter the amount of cash and in-kind contributions to be made from all other sources.

Column (e) - Enter totals of Columns (b), (c), and (d).

Line 12 - Enter the total for each of Columns (b)-(e). The amount in Column (e) should be equal to the amount on Line 5, Column (f), Section A.

Section D. Forecasted Cash Needs

Line 13 - Enter the amount of cash needed by quarter from the grantor agency during the first year.

Line 14 - Enter the amount of cash from all other sources needed by quarter during the first year.

Line 15 - Enter the totals of amounts on Lines 13 and 14.

Section E. Budget Estimates of Federal Funds Needed for Balance of the Project

Lines 16-19 - Enter in Column (a) the same grant program titles shown in Column (a), Section A. A breakdown by function or activity is not necessary. For new applications and continuation grant applications, enter in the proper columns amounts of Federal funds which will be needed to complete the program or project over the succeeding funding periods (usually in years). This section need not be completed for revisions (amendments, changes, or supplements) to funds for the current year of existing grants.

If more than four lines are needed to list the program titles, submit additional schedules as necessary.

Line 20 - Enter the total for each of the Columns (b)-(e). When additional schedules are prepared for this Section, annotate accordingly and show the overall totals on this line.

Section F. Other Budget Information

Line 21 - Use this space to explain amounts for individual direct object class cost categories that may appear to be out of the ordinary or to explain the details as required by the Federal grantor agency.

Line 22 - Enter the type of indirect rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Line 23 - Provide any other explanations or comments deemed necessary.

Project / Performance Site Location

WORKSPACE FORM

1-800-518-4726
SUPPORT@GRANTS.GOV

This Workspace form is one of the forms you need to complete prior to submitting your Application Package. This form can be completed in its entirety offline using Adobe Reader. You can save your form by clicking the "Save" button and see any errors by clicking the “Check For Errors” button. In-progress and completed forms can be uploaded at any time to Grants.gov using the Workspace feature.

When you open a form, required fields are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message. Additional instructions and FAQs about the Application Package can be found in the Grants.gov Applicants tab.

OPPORTUNITY & PACKAGE DETAILS:

Opportunity Number:	CMS-RHT-26-001
Opportunity Title:	Rural Health Transformation Program
Opportunity Package ID:	PKG00291485
Assistance Listing Number:	93.798
Assistance Listing Title:	Rural Health Transformation Program
Competition ID:	CMS-RHT-26-001-117822
Competition Title:	Rural Health Transformation Program
Opening Date:	09/15/2025
Closing Date:	11/05/2025
Agency:	Centers for Medicare & Medicaid Services
Contact Information:	Please refer to the Notice of Funding Opportunity

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS01585132
Application Filing Name:	Rural Health Transformation Program
UEI:	K49NN52HU4L7
Organization:	DEPARTMENT OF HUMAN SERVICES NEW MEXICO
Form Name:	Project/Performance Site Location(s)
Form Version:	4.0
Requirement:	Mandatory
Download Date/Time:	Oct 27, 2025 11:38:20 AM EDT
Form State:	No Errors

FORM ACTIONS:

OMB Number: 4040-0010
Expiration Date: 12/31/2026

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: NEW MEXICO HEALTHCARE AUTHORITY

UEI:

* Street1: 1474 RODEO ROAD

Street2:

* City: SANTA FE County:

* State: NM: New Mexico

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 87505-6142 * Project/ Performance Site Congressional District: NM-003

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

UEI:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

Disclosure of Lobbying Activities (SF-LLL)

WORKSPACE FORM

1-800-518-4726
SUPPORT@GRANTS.GOV

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OPPORTUNITY & PACKAGE DETAILS:

Opportunity Number:	CMS-RHT-26-001
Opportunity Title:	Rural Health Transformation Program
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Contact Information:	Please refer to the Notice of Funding Opportunity

APPLICANT & WORKSPACE DETAILS:

Workspace ID:	WS01585132
Application Filing Name:	Rural Health Transformation Program
UEI:	K49NN52HU4L7
Organization:	DEPARTMENT OF HUMAN SERVICES NEW MEXICO
Form Name:	Disclosure of Lobbying Activities (SF-LLL)
Form Version:	2.0
Requirement:	Mandatory
Download Date/Time:	Oct 27, 2025 11:24:58 AM EDT
Form State:	No Errors

FORM ACTIONS:

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

OMB Number: 4040-0013
Expiration Date: 06/30/2028

1. * Type of Federal Action:

- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:

- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:

- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

- [x] Prime
- [ ] SubAwardee

** Name:* NEW MEXICO HEALTHCARE AUTHORITY

** Street 1:* 1474 RODEO ROAD *Street 2:*

** City:* SANTA FE *State:* NM: New Mexico *Zip:* 87505-6142

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

CENTERS FOR MEDICARE & MEDICAID SERVICES

7. * Federal Program Name/Description:

Rural Health Transformation Program

Assistance Listing Number, *if applicable:* 93.798

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: ** First Name:* NON-APPLICABLE *Middle Name:*

** Last Name:* NON-APPLICABLE *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

b. Individual Performing Services (including address if different from No. 10a)

Prefix: ** First Name:* NON-APPLICABLE *Middle Name:*

** Last Name:* NON-APPLICABLE *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix:* ** First Name:* KARI *Middle Name:*

** Last Name:* ARMIJO *Suffix:*

Title: CABINET SECRETARY, NM HEALTHCARE AUTHORIT **Telephone No.:** (505) 827-7750 **Date:** Completed on submission to Grants.gov

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