Request for Information
Issued by New Mexico Health Care Authority
Medical Services Division

For

Rural Health Transformation Program Initiatives

RFI-26630-8000-0011

I. General Instructions

A. Purpose

The State of New Mexico Health Care Authority (HCA) is issuing this Request for Information (RFI) to stakeholders including health care providers, vendors, payers, community organizations, advocates, members, Information Technology (IT) firms, and all other New Mexicans, to provide public input to inform its development of a Rural Health Transformation Plan in support of its grant application for the Rural Health Transformation Program (RHTP) as authorized by Section 71401 of H.R. 1 (2025), codified at 42 U.S.C. 1397ee(h).

This RFI invites submission of project concepts and initiatives that align with the grant funding priorities and will support a competitive state grant application. This RFI also invites feedback on specific state policy options under consideration for this application. **Any entity that has already submitted feedback to HCA in anticipation of the RHTP funding opportunity is encouraged to submit a formal proposal in response to this RFI and in the requested format to ensure consideration of their proposal.**

HCA may use responses to inform its application design, funding priorities, and legislative planning as well as to support eventual selection of implementation partners, vendors, or recipients of RHTP funds.

B. Background Information

The CMS Notice of Funding Opportunity (NOFO) CMS-RHT-26-001 is available for review at:
https://www.grants.gov/search-results-detail/360442

In addition, the grant application can be viewed on Grants.gov at:
https://www.grants.gov/search-results-detail/360442

Applications are due to CMS on November 5, 2025 and CMS will approve or deny all applications no later than December 31, 2025. If approved, states are eligible for annual allotments for federal fiscal years 2026 through 2030.

C. Funding Availability

Total funding available to all 50 states is $50 billion over five years, federal fiscal years (FFY) 2026 through 2030, to be allocated via two mechanisms:

- $25 billion distributed equally among all states with an approved application
- $25 billion distributed based on competitive scoring and rural factors

Funding will be allocated to all states with an approved application, but there is no guarantee that all state applicants will be awarded. Once allocated, states are anticipated to engage a combination of vendors, health care providers, and other community partners to implement approved initiatives.

Expenditures cannot supplant existing funding, including Medicaid reimbursement, and must not be duplicative of other state programs.

All funding is also subject to the following limits:

- No more than 15% for direct payments to providers
- No more than 20% for infrastructure activities
- No funding will be approved for new construction
- No more than 10% for administrative expenses

Funding availability for RHTP initiatives will be dependent upon an approved federal allotment and associated implementation plans.

D. Effective Date

CMS posted the RHTP NOFO on September 15, 2025 with a state grant application due date of November 5, 2025. HCA is posting this RFI on September 23, 2025 and the deadline for responses is 5:00pm MDT on October 3, 2025. Responses will be reviewed continuously as they are received. HCA encourages early submission of responses to support timely consideration. Responses received after the October 3 deadline will not be considered.

New Mexico Health Care Authority
Open RFPs | New Mexico Health Care Authority Department (state.nm.us)

HCA may publish a summary of public input received via this RFI.

E. Project Description and Target Population

The RHTP requires states to submit a grant application that includes a detailed rural health transformation plan to the Centers for Medicare & Medicaid Services (CMS):

1. To improve access to hospitals, other health care providers, and health care items and services furnished to rural residents of the State of New Mexico
2. To improve health care outcomes for rural residents of the State

3. To prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management
4. To initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other health care providers in order to promote measurable quality improvements, increase financial stability, maximize economies of scale, and share best practices in care delivery
5. To enhance economic opportunity for, and the supply of, health care clinicians through enhanced recruitment and training
6. To prioritize data and technology driven solutions that assist rural hospitals and other rural health care providers in delivering high-quality health care services as close to a patient's home as possible
7. That outlines strategies for managing long-term financial solvency and operational models of rural hospitals in the State
8. That identifies specific causes driving the accelerating rate of stand-alone rural hospitals becoming at risk of closure, conversion, or service reduction

Amounts allotted to a State can be used for three or more of the following health-related activities:

1. Promoting evidence-based, measurable interventions to improve prevention and chronic disease management
2. Providing payments to health care providers for the provision of health care items or services, as specified by CMS
3. Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases

This RFI invites submission of ideas for specific projects and initiatives that align with the grant funding priorities and will support a competitive state grant application.

The target populations to be served are individuals accessing healthcare services in New Mexico, including especially those residing in rural and frontier communities that experience limited access to healthcare services, workforce shortages, and are working to modernize their healthcare and technology infrastructure. Submitted initiatives should explicitly address structural barriers and demonstrate how the initiative will improve access to care or quality of care for rural and frontier communities.

Submissions that identify clear, measurable opportunities for improvement and propose scalable, evidence-based solutions that can be scaled statewide will be prioritized.

F. RFI Manager Information

The RFI Manager, or designee, is responsible for managing/administering the RFI process, and is listed below as follows:

Wenona Padgett
Health Care Authority

Medical Assistance Division
Email: Wenona.padgett@hca.nm.gov

Any submissions, inquiries, or requests regarding this RFI shall be submitted in writing via email to the RFI Manager. The emails shall have a subject line that reads: "RFI: Rural Health Transformation" and shall be sent to the email address above. The submitting organization may contact ONLY the RFI Manager, or designee, for inquiries or requests regarding this RFI. Other HCA employees do not have the authority to respond on behalf of the RFI Manager.

II. Definition of Terminology

This section contains definitions of terms used throughout this RFI document, including appropriate abbreviations:

"CMS" means the Centers for Medicare & Medicaid Services, the federal agency responsible for administration of Medicaid, Medicare, and related health programs.

"EMS" means Emergency Medical Services.

"HCA" means the New Mexico Health Care Authority, the single state agency responsible for the Medicaid program in New Mexico.

"NOFO" means Notice of Funding Opportunity, the official federal grant solicitation that sets forth program terms, eligibility, and evaluation criteria.

"RFI" means Request for Information.

"RHTP" means the Rural Health Transformation Program, a federal initiative authorized at 42 U.S.C. § 1397ee(h) to support rural health system modernization.

III. Requirements

A. General Requirements

a. This RFI in no manner obligates the HCA, the State of New Mexico, or any of its agencies to issue a Request for Proposals (RFP) or to fund or implement any initiatives submitted.
b. Respondents are solely responsible for any costs incurred in preparing a response.
c. All information, documentation, and any specific content or approaches included in this RFI will be analyzed, may appear in various reports, and may be used in the resulting solicitation. Therefore, do not submit any copyrighted, proprietary, or confidential information. The State of New Mexico cannot guarantee the confidentiality of the information submitted
d. All materials submitted in response to this RFI become the property of the State of New Mexico and may be subject to public inspection under the New Mexico Inspection of Public Records Act (NMSA 1978, Chapter 14, Article 2).

B. Rural Health Transformation Initiatives

This RFI invites submission of project concepts and initiatives that align with the grant funding priorities and will support a competitive state grant application. Each initiative should include anticipated costs, outcomes, and statewide scalability.

Please note that CMS has identified technical scoring factors that prioritize initiatives that focus on:

i. Population health clinical infrastructure
ii. Health and lifestyle
iii. Rural provider strategic partnerships
iv. Emergency Medical Services (EMS)
v. Talent recruitment
vi. Medicaid provider payment incentives
vii. Individuals dually eligible for Medicare and Medicaid
viii. Remote care services
ix. Data infrastructure
x. Consumer-facing technology.

Each respondent may submit a response that includes one or more initiatives. For each initiative, the response should include the following information:

1. Title

2. Summary

3. CMS Program Goals Advanced (indicate up to 3)
    a. Improve access to hospitals, other healthcare providers, and healthcare items and services furnished to rural residents.
    b. Improve healthcare outcomes of rural residents.
    c. Prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management.
    d. Initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other healthcare providers to promote measurable quality improvement, increase financial stability, maximize economies of scale, and share best practices in care delivery.
    e. Enhance economic opportunity for, and the supply of, healthcare clinicians through enhanced recruitment and training.
    f. Prioritize data- and technology-driven solutions that help rural hospitals and other rural healthcare providers furnish high-quality healthcare services as close to a patient's home as possible.
    g. Other (please describe).

4. Allowable RHTP Activity Categories (indicate up to 3)
    h. Prevention and chronic disease: Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.

i. Provider payments: Providing payments to healthcare providers for the provision of health care items or services.
j. Consumer tech solutions: Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.
k. Training and technical assistance: Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.
l. Workforce: Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.
m. IT advances: Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.
n. Appropriate care availability: Assisting rural communities to right size their healthcare delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
o. Behavioral health: Supporting access to opioid use disorder treatment services, or other substance use disorder treatment services, and mental health services.
p. Innovative care: Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models.
q. Additional uses designed to promote sustainable access to high quality rural healthcare services.
r. Other (please describe).

5. Expected Outcomes

6. Cost Estimates

7. Funding Category Alignment

C. State Policy Actions

This RFI also seeks feedback on the specific state policy actions that may be included in the application.

The CMS NOFO states:

> "We will score state applications more favorably if they include a commitment to adopt one or more of the following policies or, if applicable, identify these policies as already implemented in the state."

These state level policy actions are not mandatory but directly affect the application's competitiveness and award amount. In addition, they create prospective performance obligations and if a state commits to actions it does not adopt funding will be recouped.

The state policy actions as proposed in the NOFO are excerpted below. Note that not all CMS-proposed policy solutions are germane to or under consideration for New Mexico, but they are all reproduced here for awareness as part of this RFI.

1. Health and lifestyle

   Prevention-focused initiatives based on nutrition, diet, and exercise are relevant to rural health needs because they address prevalent health disparities and unique socioeconomic challenges in rural areas. Rural populations are disproportionately impacted by chronic diseases like obesity, diabetes, and heart disease, with one of the drivers being food and diet. Rural communities can benefit from initiatives promoting prevention through physical activity and proper nutrition, which can reduce overall cost of care burden and improve health outcomes.

   For State Policy Action Factor, factor captures whether a State requires schools to reestablish the Presidential Fitness Test. The Presidential Fitness Test must be reinstated in a way that is aligned with any announced federal guidance associated with Executive Order 14327. This factor will not contribute to a State's overall points score until the budget period beginning after October 31, 2026. States will have until December 31, 2028 to enact this policy change.

2. SNAP waivers

   Rural populations are disproportionately impacted by chronic diseases like obesity, diabetes, and heart disease, with one of the drivers being food and diet. In addition, rural areas have higher rates of poverty and higher participation in SNAP benefits than urban areas. Restricting the use of SNAP benefits on non-nutritious foods can help improve dietary intake and clinical indicators associated with long-term disease in rural populations.

   State to include in application whether a State has USDA SNAP Food Restriction Waiver that prohibits the purchase of non-nutritious items, to include one or more of soda (including sweetened drinks), candy, energy drinks, fruit and vegetable drinks with less than 50% natural juice, and prepared desserts.

   Sources: Rural Health Disparities, CDC, Rural SNAP Participants and Food Insecurity, USDA SNAP Food Restriction Waivers page

3. Nutrition Continuing Medical Education

   Research has revealed physicians in the United States widely lack sufficient education in nutrition, despite the demonstrable links between proper nutrition and improved health outcomes. One area in which nutrition education can be improved for physicians is within state continuing medical education (CME) requirements. Given the disproportionate impact of chronic disease on rural America, improved nutrition education among physicians through CME requirements can directly contribute to improving the health of Americans who live in rural areas.

State to include in application whether a State has a requirement for nutrition to be a component of continuing medical education (CME). This factor will not contribute to a State's overall points score until the budget period beginning after October 31, 2026. States will have until December 31, 2028 to enact this policy change.

Example of qualifying state policies: Louisiana Senate Bill 14, Texas Senate Bill 25

Sources: Rural Health Disparities, CDC Addressing the Urgent Need for Clinical Nutrition Education in Postgraduate Medical Training: New Programs and Credentialing, Advances in Nutrition

4. Certificate of Need

Certificate of Need is an additional expense and burden on rural facilities. In addition to increasing cost and decreasing choice and competition, CON laws tend to favor established providers, creating a barrier to new entrants, thus preventing innovation and growth in rural settings. Eliminating or loosening CON laws allows providers to establish new facilities in underserved rural regions without increased burden, addressing the scarcity of local care options.

A Policymaking Playbook for Certificate of Need Repeal: Ranking Certificate of Needs Laws in All 50 States is a report created by Cicero Institute revieing all relevant statutes in all 50 States as of January 1, 2024.

Report ranks each State CON laws from least to most restrictive, categorizing by nine facility types with CON restrictions: medical inpatient, medical outpatient, behavioral inpatient, behavioral outpatient, long-term care facilities, day services, ancillaries, imaging, and other. Report assigned points pursuant to each CON or CON-equivalent barrier present across facility types in that State's statutes on a 100-point basis. The most restrictive States are burdened with 100 points, reflecting CON barriers in every category measured. Meanwhile, the States with 0 points do not have any CON or CON-equivalent statutes limiting market entry in the measured categories.

Sources: Certificate of Need Laws in Health Care: Past, Present, and Future, Certificate-of-Need Laws: How They Affect Healthcare Access, Quality, and Cost,

5. Licensure compacts

Compared to non-rural areas, rural areas have more limited access to health care professionals. As mentioned previously, the per capita supply of health professionals is lower in rural areas compared to urban areas. By providing clinicians with the opportunity to serve patients across State borders, licensure compacts increase the supply of accessible rural health providers. This also increases the reach and effectiveness of telehealth in enhancing rural access.

- For Physician Score: State participation in the Medical Licensure Compact, which covers physicians who hold an MD (Doctor of Medicine) or DO (Doctor of Osteopathic Medicine) degree (Source: Interstate Medical Licensure Compact. (2025). U.S. State Participation in the Compact. Available at Interstate Medical Licensure Compact (includes links to primary State legislative sources)
    - The Interstate Medical Licensure Compact is an agreement among 40 participating U.S. States, the District of Columbia and the Territory of Guam to work together to significantly streamline the licensing process for physicians who want to practice in multiple States. The Interstate Medical Licensure Commission serves as an independent coordinating organization that administers the Compact on the States' behalf. The Commission is made up of representatives from each participating Compact State. Last updated July 2025.

- For Nurse Score: State participation in the Nurse Licensure Compact (Source: National Council of State Boards of Nursing (NCSBN). (2025). NLC Nurse Licensure Compact
    - The Interstate Commission of Nurse Licensure Compact Administrators (ICNLCA) facilitates cross-border nursing practice through the implementation of the nationally recognized multistate license via the Nurse Licensure Compact (NLC)
      The NLC enables registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) to hold one multistate license, with the authority to practice in person or via telehealth in both their home State and other NLC states
      In FY24, 42 jurisdictions were members of the NLC.

- For EMS Score: Compact Member States that have legislatively unified: EMS Personnel Licensure Standards, Background Checks, and Public Protection and Investigation Standards under the EMS Compact (Source: The EMS Compact. (2025). The United States Emergency Medical Services Compact
    - The EMS Compact is a State law that functions as a contractual agreement between States and State law. It is a legal agreement enacted by State legislation in 25 States
      The Compact is governed by the Interstate Commission for EMS Personnel Practice, a governmental body established under the model legislation enacted by each member State. Website updated 2025.

- For Psychology Score: States participating in the Psychology Interjurisdictional Compact (PSYPACT), States with enacted PSYPACT legislation, States with PSYPACT legislation introduced, and Non-PSYPACT States/States with no active legislation
  Source: PSYPACT. (2025). PSYPACT Map. (Includes list of primary State sources)
    - The Psychology Interjurisdictional Compact (PSYPACT®) is an interstate compact designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across State boundaries. The PSYPACT Commission is the governing body of PSYPACT responsible for creating and finalizing the Bylaws and Rules and Regulations. The Commission is also responsible for granting psychologists the authority to practice telepsychology and temporary in-person, face-to-face practice of psychology across State boundaries. Data updated in 2025.

- For Physician Assistant Score: States participating as members in the Physician Assistants (PA) Compact, States with legislation filed to become members, and non-member States with no active legislation (Source: PA Compact. (2025). PA Licensure Compact
    - The Physician Assistants Compact is an interstate occupational licensure compact for physician assistants (PAs). The compact facilitates multistate practice for PAs, improves health care access for patients, and enhances public protection
      Data updated in 2025.

6. Scope of practice

   There are less physicians in rural areas, creating barriers to access for rural patients. These physician supply challenges could be mitigated, especially in the context of primary care, by expanding the scope of practice of other clinicians such as nurse practitioners and physician assistants who have training and competency in caring for many of the cases currently limited to physician care. By allowing clinicians to practice at the top of their license, States can increase health service supply. Rural populations will benefit from the preventive health impact of increased primary care options as well as decreased time to wait for appointments.

   - For PAs: The State scope of practice environments for PAs on a scale from Optimal, to Advanced, to Moderate, to Reduced (Source: American Academy of Physician Associates (AAPA). (2025). PA State Practice Environment.) Data updated as of July 2025.

   - For NPs: The State scope of practice environments for NP licensure ranging from full practice, to reduced practice, to restricted practice (Source: American Association of Nurse Practitioners (AANP). (2024). State Practice Environment). Data updated as of October 2024.
     For Pharmacists: Variation in pharmacist scope of practice and ability to operate independently by

   - For Pharmacists: Variation in pharmacist scope of practice and ability to operate independently by State, scored by classifying State laws based on authority to administer drugs, order and perform laboratory testing, and prescribe drugs or devices as described in the Cicero report (Source: Cicero Institute. (2025). 2025 Policy Strategies for Full Practice Authority). The report was created by Cicero Institute reviewing all relevant statutes in all 50 States as of August 2025.

   - For Dental Hygienists: Variation in Dental Hygiene Scope of Practice by State, categorized by several allowable tasks (Source: Oral Health Workforce Research Center (OHWRC). (2024). Variation in Dental Hygiene Scope of Practice by State). Data updated as of November 2024.

     Sources: Reforming America's Healthcare System Through Choice and Competition—Section 3: Government Healthcare Policies and Their Effect on Competition

7. Short-term, limited-duration insurance (STLDI)

Rural populations consistently have higher uninsurance rates than their urban counterparts. Approximately 18% of adults living in nonmetropolitan counties are uninsured, leading to higher costs for patients. Rural adults are also more likely than urban adults to report delayed care due to cost and issues paying medical bills. STLDI plans may offer some rural individuals lower cost short-term coverage options to help address issues associated with being uninsured.

STLDI as defined in 45 CFR 144, and any latest federal guidance or regulation updates to STLDI definition. States must report in their applications any state-level policies on STLDI, including:

- Whether there are any State restrictions in place that limit STLDI plans beyond latest federal guidance;
- What the State's maximum allowable initial contract term for STLDI is; and
- What the State's maximum allowable total coverage period for STLDI is.

Sources: RHI Hub – Healthcare Access in Rural Communities, Geographic Variation in Health Insurance Coverage: United States, 2020

8. Remote care services

Rural areas often lack access to medical care due in part to distance from care and workforce shortages. Remote care services can help expand access to care by allowing clinicians of any type to provide rural residents with care from another location via telehealth, remote patient monitoring, or other modalities. While these services can be useful for rural residents, lack of Medicaid coverage for remote care services, lack of in-State providers, and limited infrastructure can all be limiting factors in providing remote care access for rural residents.

For State Policy Action Factor, metrics capture whether a State has broadly supportive State policies towards access to remote care and telehealth services. Based on categories of State Telehealth Laws and Reimbursement Policies (Source: Center for Connected Health Policy (CCHP). (2024, November). State Telehealth Laws and Reimbursement Policies Report, Fall 2024).

Sources: RHI Hub – Healthcare Access in Rural Communities, RHI Hub – Barriers to Telehealth in Rural Areas, Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Revi

IV. Format and Organization

A. Number of Submissions

Only one submission per organization shall be accepted in response to this RFI.

B. Submission

Must include:

1. One (1) electronic copy of the RFI Response by email to the RFI Manager identified in Section I, Paragraph F.
2. The subject line of the email shall read: "RFI: Rural Health Transformation."
3. All confidential information shall be clearly identified and segregated on the electronic version.

C. Narrative Guidelines

The Statement of Interest narrative must be typed using the standard 8 ½ x 11 format with one inch margins, and in 12-point Times New Roman font. All responses in the RFI must be complete and coincide with the appropriate section as listed below.

1. Signed RFI Cover Letter
   Complete the form and have it signed by the person authorized to obligate the organization.

2. Organizational Information (Limit 400 words)

   a. Mission
      Describe your organization's mission and how it aligns with this program.

   b. Experience
      Describe your specific experience advancing rural health and New Mexico and elsewhere.

   c. Operational Capacity
      Describe your capacity and operational readiness to execute initiatives.

3. Rural Health Transformation Initiatives Narrative

   Each submission may include one or more initiatives, each initiative should be numbered and include each of the following components (Limit 1,500 words per initiative):

   a. Title
      Descriptive name that identifies the initiative.

   b. Summary
      Narrative describing the purpose, goals, and strategy of the initiative. Include the problem to be address, the proposed solution, and how the initiative supports rural health transformation.

   c. CMS Program Goals Advanced (indicate up to 3)
      Indicate up to three of the program goals advanced by the initiative.

   d. Allowable RHTP Activity Categories (indicate up to 3)
      Identify up to three activities most applicable to the initiative.

e. Expected Outcomes
   Identify performance metrics or other measurable outcomes expected to be achieved.

f. Cost Estimates
   Provide a high-level summary of estimated one-time and ongoing costs for a five year period. A detailed cost estimate may also be submitted as an optional attachment.

g. Funding Category Alignment
   Note which expenses are subject to the restrictions on direct payments to healthcare providers (up to 15%), infrastructure-related expenses (up to 20%), and administrative expenses (up to 10%).

4. State Policy Actions

   Each submission may address one or more state policy action proposed by the NOFO. Each response should be numbered and responses are limited to 500 words per policy.