title: Rural Health Transformation Grant Guide — New Mexico version: 1.0 date: 2025-10-14 audience: State health agencies, Medicaid, rural providers, collaboratives

1. Executive Summary New Mexico can leverage the Rural Health Transformation (RHT) Program to stabilize rural access, strengthen primary and behavioral care, and modernize data and cybersecurity over FY26–FY30. The RHT Collaborative's members—spanning technology platforms, rural provider networks, retail health, tele-specialty services, analytics, and workforce support—can support New Mexico with configurable capabilities aligned to every scored pillar and use-of-funds category in the NOFO. Examples include statewide virtual hospital coverage (tele-ER/ICU/behavioral) via Avel eCare; continuous remote physiologic monitoring for high-risk chronic disease via BioIntelliSense; pharmacist-enabled hypertension/diabetes management in rural towns through CVS Health and Walgreens; AI-supported acute pathways (e.g., Viz.ai for stroke); and HIPAA/FHIR cyber-hardened cloud, data exchange, and analytics on Microsoft platforms delivered with systems integrators (Accenture, KPMG, PwC, AVIA).

The CMS NOFO funds up to 50 states via five budget periods (FY26–FY30), split 50% baseline (equal shares) and 50% workload based on rural/population factors and technical factors that can be improved through initiatives and State policy actions. First-year conditional technical points are available for policy commitments, with enactment required by Dec 31, 2027 (Dec 31, 2028 for two factors) to retain funds tied to those points. Application is due Nov 5, 2025; earliest start Dec 31, 2025. (files.simpler.grants.gov) (files.simpler.grants.gov)

New Mexico's rural context underscores the fit. Using 2025 data, New Mexico has 13 Critical Access Hospitals (CAHs), 1 Rural Emergency Hospital (REH), 21 Rural Health Clinics (RHCs), and 114 rural FQHC sites; an estimated 33% of residents live in nonmetro areas (ACS 2019–2023). Under the Census rural definition, 26% of New Mexicans lived in rural areas in 2020, highlighting definitional differences that matter for denominator setting and targeting. (ruralhealthinfo.org) (edd.newmexico.gov) (primary.ers.usda.gov)

The highest-leverage near-term opportunities are: (1) a rural provider High Value Network (HVN) to coordinate investments and contracting while extending tele-hospital services statewide; (2) a cardio-kidney-metabolic (CKM) initiative combining retail pharmacy care, community screening (kiosks, vision-based screening), and remote monitoring; (3) a rural behavioral health and crisis-telepsychiatry network; and (4) data modernization and cybersecurity to meet the NOFO's tech and reporting expectations. These map to scored technical factors (partnerships, EMS, remote care, data infrastructure) and to allowed categories A, C, D, F, G, H, I, J. (files.simpler.grants.gov)

One-page printable summary

- Program fit: Cooperative agreement; five budget periods FY26–FY30; 50% baseline + 50% workload distribution; conditional policy points with enactment deadlines; application due Nov 5, 2025. (files.simpler.grants.gov)
- Highest-impact options for New Mexico:
  - Tele-enabled rural hospital network (Avel eCare), HVN governance (Cibolo Health), payment and analytics support (systems integrators).
  - CKM initiative: retail pharmacy hypertension/diabetes programs (CVS Health, Walgreens), community screening (Higi/Topcon), RPM (BioIntelliSense).
  - Behavioral health and SUD: tele-behavioral coverage, crisis support, analytics for risk identification (Avel eCare, Teladoc, Humetrix).
  - Data/cyber modernization: secure cloud/data exchange, TEFCA-aligned interoperability, dashboards, and reporting.
- Medicaid alignment: Turquoise Care (managed care) started July 1, 2024; 1115 waiver renewed in 2024; four MCOs (BCBSNM, Molina, Presbyterian, UnitedHealthcare). (hca.nm.gov) (hca.nm.gov)
- Rural context (2025): 13 CAHs, 21 RHCs, 114 rural FQHC sites; 33% nonmetro; 16% of locations un/underserved for broadband (8% unserved + 8% underserved). (ruralhealthinfo.org) (governor.state.nm.us)
- Guardrails: Provider payments ≤15%; capital/infra ≤20%; EMR replacement ≤5% (if HITECH-certified system existed 9/1/2025); admin ≤10%. (files.simpler.grants.gov)

2. Eligibility and RFP Fit

- Applicant: Only States (not DC/territories); Governor-designated lead; single official application; no cost sharing. (files.simpler.grants.gov)
- Key dates: Optional LOI (Sep 30, 2025); application due Nov 5, 2025 11:59 p.m. ET; award and earliest start Dec 31, 2025; webinars Sep 19 and 25, 2025. (files.simpler.grants.gov)
- Funding structure: Five budget periods; each year's funds available to spend through end of following fiscal year; 50% baseline equal split; 50% workload via points (Rural facility/population + technical factors). (files.simpler.grants.gov)
- Scoring and policy deadlines: Technical points recalculated annually; rural data set once using Q4 2025; conditional policy points converted upon enactment by Dec 31, 2027 (by Dec 31, 2028 for B.2 Health &

lifestyle and B.4 Nutrition CME). (files.simpler.grants.gov)
- Application contents and page limits: Summary (1), Narrative (≤60), Budget narrative (≤20), Attachments (Governor letter ≤4; Business assessment ≤12; Program duplication assessment ≤5; other support ≤35). Forms: SF-424, SF-424A, SF-LLL, Performance Site. (files.simpler.grants.gov)
- Allowable uses and caps: Use ≥3 categories; provider payments ≤15%; capital & infrastructure ≤20%; EMR replacement ≤5% (if prior HITECH-certified EMR as of 9/1/2025); "tech catalyst"-type initiatives ≤ the lesser of 10% or $20M; administrative (incl. indirect) ≤10%. (files.simpler.grants.gov)

Requirement → Collaborative capability → Evidence (selected)

- Statewide tele-enabled acute and specialty support → Avel eCare 24/7 virtual hospitalist/ICU/ED; tele-pharmacy; tele-behavioral → improves access, keeps care local.
- Chronic disease prevention/management incl. consumer tech → Higi/Topcon screening; pharmacist-enabled care at CVS/Walgreens; RPM via BioIntelliSense → supports categories A, C, D and factors B.1, F.1-F.3.
- Rural provider strategic partnerships and HVN governance → Cibolo Health High Value Networks (HVNs) with transparent fund stewardship and shared services → aligns with C.1 partnerships and sustainability.
- Data/cyber and interoperability → Microsoft cloud and cyber programs; integrators for architecture, governance, dashboards and OBA/T-MSIS reporting → aligns with F.2 data infrastructure.
- Value-based models and payment integrity → Integrators (Accenture/KPMG/PwC) for APM design, claims modernization, analytics → aligns with E.1 incentives.

3. New Mexico Context Snapshot

- Rural share (two federal definitions):
  - Census rural: 26% of NM residents lived in rural areas in 2020. (edd.newmexico.gov)
  - OMB nonmetro (ACS 2019–2023): 33% of residents live in nonmetro areas (2023). (ruralhealthinfo.org)
  - Why they differ: USDA explains Census rural vs OMB nonmetro uses and implications for planning. (primary.ers.usda.gov)
- Rural facility mix (2025):
  - 13 CAHs, 1 REH, 21 RHCs, 114 rural FQHC sites, 14 PPS hospitals (rural locations). (ruralhealthinfo.org)
  - UDS awardees: 16 Health Center Program awardees served 296,801 patients in 2024. (data.hrsa.gov)
- Workforce shortages (HPSAs; HRSA summarized via quarterly reports):
  - Primary care HPSAs: 106 designations; 1,027,943 residents in HPSAs; estimated 200 FTE practitioners needed (as of Mar 31, 2025). (commentary.healthguideusa.org)
  - Dental HPSAs: 106 designations; 865,757 residents; estimated 171 dentists needed (as of Mar 31, 2025). (commentary.healthguideusa.org)
  - NM is a Nurse Licensure Compact member (supports cross-state telehealth nursing). (ncsbn.org)
- Medicaid landscape:
  - Turquoise Care (managed care) launched July 1, 2024; MCOs: BCBS New Mexico, Molina, Presbyterian, UnitedHealthcare. 1115 waiver renewed/approved July 25, 2024. (hca.nm.gov) (hca.nm.gov)
- Broadband and telehealth readiness:
  - 2024: About 16% of serviceable locations un/underserved (8% unserved; 8% underserved) statewide; BEAD investment approved. (governor.state.nm.us)
- Behavioral health/SUD:
  - Overdose deaths declined for the second straight year: 948 deaths in 2023 (997 in 2022; 1,029 in 2021); fentanyl involved in ~65% of 2023 overdose deaths (NMDOH data, 2025 media summaries). (kob.com)

Metric (year) → Source → Collaborative capability linkage

- 26% rural (2020 Census) → NM EDD citing Census → Retail/clinic screening + RPM to reach dispersed populations. (edd.newmexico.gov)
- 33% nonmetro (ACS 2023) → RHIhub state overview → Tele-hospital coverage, remote care to reduce

transfers. (ruralhealthinfo.org)
- 13 CAHs, 21 RHCs, 114 rural FQHC sites (2025) → RHIhub → HVN governance and shared services to coordinate investments. (ruralhealthinfo.org)
- Primary care HPSAs 106; need ~200 FTE (Q1-2025) → HRSA summary via Health Guide USA → Tele-support, ambient documentation, recruitment pipelines. (commentary.healthguideusa.org)
- 16% locations un/underserved for broadband (2024) → Governor's Office/OBAE → Cyber-hardened cloud; offline-tolerant RPM; retail Wi-Fi points. (governor.state.nm.us)
- Overdose deaths 948 (2023), ≥65% fentanyl involvement → NMDOH via media summaries (2025) → Crisis tele-behavioral, pharmacy naloxone workflows, analytic targeting. (ksfr.org)

Assumptions and Open Questions

- Confirm current NM participation status in the Interstate Medical Licensure Compact (IMLC) for physicians before claiming points under D.2 licensure compacts; this guide cites national compact sources but defers to State confirmation. (imlcc.com)
- CCBHC inventory as of Sep 1, 2025 and count of hospitals receiving Medicaid DSH for the most recent State Plan Rate Year (SPRY) must be sourced from New Mexico HCA/DOH for the application narrative. (files.simpler.grants.gov)
- Frontier county definition and counts vary (FAR vs state definitions); NM DOH notes >1/3 of population in frontier areas; a definitive list should be appended for factor A.5. (nmhealth.org)

4. Strategy Aligned to RFP Proposed model for New Mexico

- Organizing construct: A State-sponsored, provider-led High Value Network (HVN) convened by Cibolo Health to coordinate rural hospitals/clinics, integrate retail and EMS partners, manage shared services (tele-hospital services, RPM operations center, analytics), and link to MCO value-based arrangements. This structure supports transparent spend tracking and sustainability.
- Clinical-access stack: 24/7 virtual hospital services (Avel eCare) for ED/ICU/hospitalist, tele-behavioral, and pharmacy; RPM (BioIntelliSense) for high-risk chronic cohorts; retail pharmacy hypertension/diabetes programs; community screening (Higi/Topcon); targeted AI pathways (Viz.ai for stroke).
- Data/cyber stack: Microsoft HIPAA/FHIR-aligned cloud, identity, threat protection, and data lake; eCW/TEFCA connectivity; SI-implemented dashboards for NOFO KPIs and T-MSIS OBA reporting.
- Workforce stack: Ambient documentation and patient intake tools; tele-mentoring; pharmacist scope optimization; statewide training with NACHC and academic partners.

How the strategy maps to NOFO scoring and pillars

- Rural facility/population factors (A.1–A.7): New Mexico's frontier share and land area support baseline rural points; inclusion of DSH counts and facility rosters ensures accurate A.2/A.7 inputs. (files.simpler.grants.gov)
- Technical factors (B–F):
  - B.1/B.2/B.4: CKM program with measured BP/HbA1c improvement; nutrition CME via partners to claim conditional points, converting to full upon enactment. (files.simpler.grants.gov)
  - C.1/C.2: HVN + EMS tele-support and community paramedicine workflows.
  - D.1/D.2/D.3: Recruitment and licensure compacts (verify IMLC), pharmacist scope optimization pilots.
  - E.1/E.2/E.3: Value-based incentives and duals integration; eliminate short-term, limited-duration insurance exposure if applicable.
  - F.1/F.2/F.3: Remote care, data infrastructure, consumer tech—RPM, HIE, and patient apps.

Equity strategy for rural and Tribal communities

- Prioritize counties with highest overdose and CKM risk; ensure Tribal engagement and data governance; deploy multilingual front-door (Humetrix) and community health worker training aligned to NM DOH programs. (nmhealth.org)

Data use and privacy

- Align with 2 CFR Part 200/300 and HHS GPS; cyber performance goals; TEFCA/QHIN data exchange; T-MSIS OBA outcomes integration for factor F.2 scoring. (files.simpler.grants.gov)

5. Program Design Options Option A. Rural Tele-hospital + HVN (primary)

- Target: All rural hospitals/clinics; EMS.
- Problem: Rural staffing and transfer burden; broadband pockets. NM: 13 CAHs; 16% un/underserved locations. (ruralhealthinfo.org) (governor.state.nm.us)
- Capabilities: Avel eCare (tele-ED/ICU/hospitalist/behavioral), HVN governance (Cibolo), EMS tele-consult.

- Payment logic: Medicaid APMs/shared savings for rural networks; State can claim conditional points for partnerships/EMS; provider payments under 15% cap; capital under 20% cap (e.g., tele rooms, devices). (files.simpler.grants.gov)
- Enabling policy: Licensure compacts (verify IMLC); EMS protocols for tele-consult. (ncsbn.org)
- Staffing/IT: Virtual command center; hospitalist/ICU panel agreements; SI-run PMO; cyber hardening.
- Pros/risks: Rapid access gains; risk—connectivity gaps mitigated by phased deployment, BEAD coordination. (governor.state.nm.us)

Option B. CKM (cardio-kidney-metabolic) community care

- Target: Adults with HTN/diabetes/CKD in high-burden counties.
- Problem: CKM drivers of mortality; pharmacist access is local.
- Capabilities: Retail pharmacy programs (CVS, Walgreens), Higi/Topcon screening, RPM (BioIntelliSense), virtual primary/specialty consults.
- Payment logic: Value-based bonuses with MCOs; limited gap-filling provider payments (<15%); consumer tech and RPM (A, C, D, F). (files.simpler.grants.gov)
- Policy: Nutrition CME (B.4), SNAP-related waivers (B.3) for healthy food pilots (conditional points). (files.simpler.grants.gov)
- Pros/risks: Broad reach via pharmacies; risk—data exchange—address via TEFCA/QHIN and consent tooling.

Option C. Rural behavioral health and crisis response

- Target: Rural EDs, primary care, EMS, law enforcement partners.
- Problem: 2023 overdose deaths 948; fentanyl 65% involvement; frontier gaps. (ksfr.org) (nmhealth.org)
- Capabilities: Tele-behavioral 24/7, crisis tele-teams, naloxone and adherence programs via pharmacies, analytics for risk.
- Payment logic: Care management + integration in MCO benefits; investments in data/cyber; alignment with category H. (files.simpler.grants.gov)
- Pros/risks: Reduces ED burden; risk—workforce; mitigate via tele-psychiatry and training.

Option D. Maternal access and tele-OB

- Target: Rural prenatal/postpartum; HALO events.
- Problem: Travel distances; limited obstetrical support.
- Capabilities: Tele-OB consults; remote monitoring bundles; tele-simulation for HALO training. (files.simpler.grants.gov)
- Payment logic: MCO quality incentives; infrastructure ≤20% for tele-rooms, fetal monitoring. (files.simpler.grants.gov)

Recommendation: Pursue Option A as the program spine, with Option B as a co-primary initiative; add C and D in targeted regions where outcomes and equity gaps are largest.

6. Governance and Collaborative Roles Partner role diagram (described)

- State lead (HCA/DOH): strategy, approvals, reporting to CMS; stewards cooperative agreement.
- HVN (Cibolo Health): provider-owned governance, fund allocation transparency, shared services.
- Tele-hospital/virtual care (Avel eCare; Teladoc): service coverage and protocols.
- Retail health (CVS, Walgreens): CKM protocols, adherence, immunizations, data integration.
- Technology (Microsoft, eClinicalWorks): secure cloud/HIE/TEFCA connectivity, analytics dashboards.
- Systems integrators (Accenture/KPMG/PwC/AVIA): PMO, data/architecture, procurement support, value tracking.
- NACHC/Universities: training, CHW programs, rural workforce pipelines.

RACI (selected deliverables)

- NOFO application, governance charter: R=State lead; A=HCA; C=HVN/SI; I=providers.
- Tele-hospital rollout plan: R=Avel/HVN; A=HCA; C=SI/hospitals; I=MCOs.
- CKM initiative design: R=Retail partners/HVN; A=HCA; C=NACHC/RPM vendor; I=MCOs.
- Data/cyber architecture and dashboards: R=SI; A=HCA; C=Microsoft/HIE; I=providers.

7. Payment and Funding Payment paths consistent with NOFO

- Medicaid APMs/shared savings for rural networks; targeted incentive pools for CKM and tele-hospital performance; avoid supplanting reimbursable services; direct provider payments within 15% cap. (files.simpler.grants.gov)

Illustrative cost table (order-of-magnitude; planning placeholder only)

- Workstream → Cost type → Funding source → Timing → Collaborative deliverables
  - Tele-hospital core → Services/subawards → RHT categories F/H/I → BP1–BP5 → Coverage model, protocols, QA.
  - CKM (retail + RPM) → Devices, training, subawards → RHT A/C/D → BP1–BP5 → Screening, RPM ops, adherence.
  - Data/cyber → Software/platform/SI → RHT F → BP1–BP3 → Cloud, identity, dashboards, reporting.
  - Capital (tele rooms) → Equipment/minor renovations → RHT J (≤20%) → BP1–BP2 → Design, fit-out. (files.simpler.grants.gov)
  - Admin/PMO → State/PMO staffing/indirect → ≤10% admin → BP1–BP5 → PMO, FFATA/SAM/PMS. (files.simpler.grants.gov)

Medicaid alignment opportunities

- Support actuarial modeling for rural APMs; SPA drafting for pharmacy-based chronic care pilots where appropriate; T-MSIS OBA reporting quality improvement. (files.simpler.grants.gov)

8. Data, Measurement, and Evaluation Core measures (examples; NOFO-aligned)

- Access: Time to tele-ED consult; avoidable transfers; virtual behavioral response time.
- Quality/outcomes: BP control, HbA1c control, 30-day readmissions; stroke time-to-treatment for Viz.ai pathways.
- Financial: Total cost of care for rural MCO members; ED transfer costs avoided.
- Workforce: Vacancy/turnover; ambient documentation time saved.
- Program implementation: Site activations; cybersecurity posture (HHS CPG adoption). (files.simpler.grants.gov)

Data sources and integration

- Claims (MCOs), T-MSIS OBA, hospital EHRs, HIE feeds, RPM platforms, EMS CAD/EPCR, pharmacy systems, social services; integrated to HIPAA/FHIR cloud with TEFCA-aligned exchange.

Evaluation and learning system

- SI-led measurement plan; quarterly dashboards; annual independent evaluation in cooperation with CMS; use NOFO initiative scoring matrix (Strategy/Workplan/Outcomes/Impact/Sustainability). (files.simpler.grants.gov)

9. Implementation Plan Gantt-style table (indicative; 24 months)

- Workstream | Start | End | Owner | Outputs
  - HVN governance charter | Jan 2026 | Mar 2026 | HCA/Cibolo | HVN charter, bylaws.
  - Tele-hospital design & contracting | Jan 2026 | Jun 2026 | HCA/Avel | Coverage plan; SLAs.
  - CKM design (retail+RPM) | Feb 2026 | Jul 2026 | HCA/Retail/RPM | Protocols; device logistics.
  - Data/cyber architecture | Feb 2026 | Oct 2026 | SI/Microsoft | Cloud tenancy; HIE connectors.
  - Phase-1 go-lives (5–7 hospitals; 10–15 clinics) | Jul 2026 | Dec 2026 | HVN | Sites live; baseline KPIs.
  - Phase-2 scale (statewide) | Jan 2027 | Dec 2027 | HVN/HCA | 80% rural sites onboarded.
  - Policy enactment window | 2026 | 2027–2028 | HCA/Legislature | Policies for B.2/B.4 by 2028; others by 2027. (files.simpler.grants.gov)
  - Evaluation checkpoints | Semiannual | Ongoing | HCA/SI | Reports to CMS.

Procurement/legal

- Subawards and contracts flow down Federal terms; telecom/video surveillance restrictions; 2 CFR Part 200/300 compliance; administrative cost tracking ≤10%. (files.simpler.grants.gov) (files.simpler.grants.gov)

10. Risk Register

- Risk → Likelihood/Impact → Mitigation → Owner
  - Broadband gaps delay telehealth → Med/High → Phase activation with BEAD builds; use alternative links/device buffering → HCA/HVN. (governor.state.nm.us)
  - Policy commitments not enacted by deadlines → Med/High → Early bill drafting, stakeholder engagement; track NOFO B-factor timelines → HCA. (files.simpler.grants.gov)
  - Workforce burnout persists → Med/Med → Tele-mentoring; ambient documentation; incentives → HVN.
  - Data/privacy noncompliance → Low/High → SI security reviews; HHS CPGs; role-based access →

HCA/SI. (files.simpler.grants.gov)
    - Payment model misalignment → Med/Med → Co-design with MCOs; pilots with risk corridors → HCA/MCOs.
    - RPM adherence variable → Med/Med → Navigator support; device choice; pharmacist follow-up → HVN/Retail.
    - Hospital participation variability → Med/Med → HVN governance incentives; TA; shared savings → Cibolo/HCA.
    - Cyber threats → Med/High → Microsoft security stack; incident drills; immutable backups → SI/Microsoft.
    - Capital overruns → Low/Med → NOFO J cap controls; pre-bid scopes; owner's rep → HCA/SI. (files.simpler.grants.gov)
    - Reporting burden → Med/Med → Automated dashboards; T-MSIS OBA integration → SI/HCA. (files.simpler.grants.gov)

11. Draft RFP Response Language Note: The following paragraphs are written for direct use in New Mexico's application; adjust names and counts where the NOFO requests applicant-provided data.

- Program purpose and fit: "New Mexico proposes a statewide Rural Health Transformation program that expands access, improves outcomes, and modernizes the rural delivery system through tele-enabled hospital coverage, a cardio-kidney-metabolic community initiative, integrated behavioral health, and secure data infrastructure. This plan addresses NOFO strategic goals and uses at least three approved use-of-funds categories (A, C, D, F, G, H, I, J) and maintains compliance with program-specific caps (provider payments ≤15%; capital ≤20%; admin ≤10%)." (files.simpler.grants.gov)
- Target population and needs: "Approximately 33% of New Mexicans live in nonmetro areas (ACS 2023), with 26% classified rural by Census in 2020; 13 CAHs, 21 RHCs, 114 rural FQHC sites, and one REH serve these communities. Broadband remains a barrier in pockets where ~16% of locations are un/underserved (2024)." (ruralhealthinfo.org) (edd.newmexico.gov) (governor.state.nm.us)
- Goals and objectives (examples): "By end of BP2, reduce avoidable interfacility transfers by 10%; improve BP control among hypertensive enrollees engaged with pharmacist-enabled care by 8 percentage points; reduce stroke door-to-treatment intervals by 15% at participating sites; achieve 95% compliance with HHS cybersecurity performance goals." (files.simpler.grants.gov)
- Initiatives and outcomes (per NOFO matrix): "Each initiative includes ≥4 measurable outcomes, at least one at the county level, with baselines and BP-specific targets; monthly dashboards and semiannual reviews will be reported to CMS." (files.simpler.grants.gov)
- Policy commitments: "New Mexico will pursue nutrition CME credit recognition and SNAP-related flexibilities to support healthy food pilots (B.3/B.4), with timelines to enact by Dec 31, 2028 consistent with NOFO allowances; other policy commitments will be enacted by Dec 31, 2027." (files.simpler.grants.gov)
- Medicaid alignment: "Under Turquoise Care (effective July 1, 2024), the State will work with MCOs (BCBSNM, Molina, Presbyterian, UnitedHealthcare) to develop rural value-based arrangements and quality incentive pools that reinforce program objectives." (hca.nm.gov)
- Data/evaluation: "The program will use TEFCA-aligned data exchange, T-MSIS OBA outcomes, and cloud-based dashboards to satisfy NOFO reporting and enable continuous learning; we agree to participate in CMS/third-party evaluations." (files.simpler.grants.gov)
- Sustainability: "HVN governance, APMs with MCOs, and shared services models will sustain gains post-FY31; capital is right-sized per NOFO J and excluded from ongoing operating assumptions." (files.simpler.grants.gov)

12. References

1. Rural Health Transformation Program (CMS-RHT-26-001) NOFO (Final). CMS (files.simpler.grants.gov/opportunities/.../cms-rht-26-001_final.pdf). Accessed 2025-10-14. (files.simpler.grants.gov)
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15. Nurse Licensure Compact — status and overview. NCSBN. Accessed 2025-10-14. (ncsbn.org)

13. AI Generation Notice This guide was generated by the gpt-5 model on 2025-10-14. It is provided for planning purposes. All facts, figures, and citations should be independently validated with primary sources and current State and Federal guidance before use in any official submission.