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New Hampshire Rural Health Transformation Program Application

Funding Opportunity: CMS Rural Health Transformation Program (RHTP) – NOFO #CMS-RHT-26-001
Applicant: State of New Hampshire (Governor-Designated Lead Agency)
Funding Request: \$1,000,000,000 total (FY 2026–FY 2030)

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workforce, technology, capital), provider payment and capital expenditure shares, subawards, and compliance with funding caps (e.g. ≤15% for provider payments[1], ≤10% for administration).

- **D) Attachments** – *Supplementary documents as required:*
- **D1) Governor's Endorsement Letter** (draft, 4 pages) – *Letter from Governor Kelly A. Ayotte endorsing the plan and committing state support.*
- **D2) Indirect Cost Agreement** – *Summary of the State's federally negotiated indirect cost rate (reference document).*
- **D3) Business Assessment** (draft, 12 pages) – *Analysis of the business impact and financial model, demonstrating how initiatives will improve rural provider sustainability and efficiency.*
- **D4) Program Duplication Assessment** (draft, 5 pages) – *Review ensuring RHTP funding does not duplicate other federal or state programs, and detailing coordination with existing resources.*
- **D5) Other Supporting Materials** – *Brief resumes of key personnel, organizational charts, detailed work plan Gantt chart, timeline graphics, county-level rural designation table (with FIPS codes), etc.*
- **E) Required Forms List** – *Checklist of all required federal forms (SF-424, SF-424A, SF-424B, SF-424C as applicable, SF-424 Project Abstract, SF-LLL Disclosure of Lobbying, etc.) and assurances included in the application package.*

A) Project Summary

Project Title: *New Hampshire Rural Health Transformation Initiative (RHTI)*
Applicant: *New Hampshire Department of Health and Human Services (NH DHHS)* – **Governor-Designated Lead Agency** for RHTP.
Target Population: Rural residents of New Hampshire (approx. 500,000 people, ~37% of state population), including those in designated rural counties and underserved areas. The focus is on communities in New Hampshire's North Country, Lakes Region, Upper Valley, and other rural areas facing limited healthcare access, workforce shortages, and health disparities.

Summary of Needs: New Hampshire's rural communities have an older population (median age ~46 in rural areas) and face higher rates of chronic illness and health professional shortages. All seven of the state's predominantly rural counties are designated as primary care Health Professional Shortage Areas (HPSAs), and five have mental health HPSA designations, indicating widespread provider shortages in rural areas. Rural patients must often travel long distances for care, and many small hospitals and clinics struggle financially – about one-third of rural hospitals in NH operate at a loss (negative margins) in recent years (**Source:** National Rural Health Association, 2024). These challenges are exacerbated by recent federal Medicaid funding cuts, which are projected to reduce federal Medicaid spending in rural New Hampshire significantly over

the next decade. Without intervention, rural residents risk losing local access to essential services.

Project Description: In response, New Hampshire proposes a **comprehensive Rural Health Transformation Plan** designed to **"make rural New Hampshire healthy again"** by reimagining care delivery and investing in sustainable solutions. This five-year initiative (FY 2026–2030) will deploy \$1 billion in federal RHTP funding across a portfolio of strategic programs that align with CMS's RHTP goals and the allowable funding activities. Major focus areas include:

- **Improving Access and Outcomes:** Expanding **primary care, preventive services, and chronic disease management** programs in rural areas, including mobile health units and community-based care teams, to address root causes of disease and reduce avoidable hospitalizations.
- **Strengthening the Rural Healthcare Workforce: Recruiting and retaining clinicians** in rural communities via incentives (e.g. loan repayment, rural residency programs) and training pipelines, coupled with investments in community health workers and telehealth to extend specialist access.
- **Advancing Innovative Care Models and Technology:** Implementing **telehealth, remote patient monitoring, health IT upgrades, and data-driven care models** to increase efficiency and specialty access in rural hospitals and clinics. This includes piloting new payment models (such as rural value-based care arrangements) to improve sustainability.
- **Enhancing Behavioral Health and Substance Use Services: Expanding mental health, substance use disorder (SUD), and opioid treatment services** in rural regions by integrating behavioral health into primary care, increasing tele-psychiatry, and supporting community-based recovery programs.
- **Right-Sizing Infrastructure and Strengthening Hospitals: Investing in critical facility needs** (clinic upgrades, modern equipment, expanded telemedicine infrastructure) and fostering hospital partnerships (e.g. Critical Access Hospitals partnering with larger health systems) to ensure rural patients have local access to essential services like emergency care, while "right-sizing" service lines to community needs. Small rural hospitals will receive support to transition toward new service models (such as rural emergency hospitals or outpatient-focused centers) where appropriate for long-term viability.

Key Initiatives: The plan is organized into four synergistic initiatives (detailed in Section B3) that collectively address at least **three of the CMS-designated priority categories** for RHTP funding. These initiatives are: **(1) Rural Preventive Health & Primary Care Initiative**, **(2) Rural Digital Health & Workforce Initiative**, **(3) Rural Behavioral Health Access Initiative**, and **(4) Rural Hospital Transformation & Sustainability Initiative**. Each initiative comprises evidence-based interventions and "shovel-ready" solutions identified through stakeholder input and expert collaboration, and each is mapped to specific RHTP allowed activities (such as prevention, workforce, IT modernization, etc.). We have

ensured that collectively these initiatives utilize funds for more than the minimum three required categories – in fact, New Hampshire's plan addresses **seven** of the RHTP priority categories in a coordinated portfolio (see Portfolio Summary Table below).

Anticipated Outcomes: Over the five-year period, New Hampshire expects to **improve health outcomes** (e.g. better control of diabetes, hypertension, reduced overdose deaths), **increase access to care** (more primary care visits and mental health services delivered in rural areas, reduced travel times), **stabilize rural healthcare facilities** (no net rural hospital closures, improved financial performance by Year 5), and **build lasting capacity** (expanded workforce, upgraded health IT and telehealth infrastructure). Specific targets include reducing avoidable hospital readmissions in target rural populations by 20%, increasing the number of practicing rural primary care providers by 15%, and improving patient satisfaction/access metrics across all rural clinics and hospitals. A rigorous evaluation plan with measurable indicators is in place (see Section B6).

Alignment with RHTP Goals: This proposal strongly aligns with the five strategic goals outlined by CMS for the RHT Program. It emphasizes preventive health and addressing social determinants (Goal 1: make rural communities healthier), fosters **coordination and networking** among rural providers and larger systems (Goal 2: sustainable access through collaboration), invests heavily in **workforce development** (Goal 3: strengthen rural workforce), introduces **innovative care models** such as value-based payment and mobile integrated health (Goal 4), and drives **technology innovation** by expanding telehealth and digital health tools in rural settings (Goal 5). The Governor and state leadership are fully committed to this plan, as evidenced by the attached endorsement letter (Attachment D1), which highlights the "New Hampshire way" of approaching the RHTP – engaging stakeholders at every step and focusing on sustainable, community-driven solutions.

Funding and Administration: New Hampshire requests the full **\$1.0 billion** over FY 2026–2030 to execute this transformation. Funds will be managed through a cooperative agreement with CMS, with NH DHHS as the lead administrator ensuring compliance and effective monitoring. The budget dedicates ~85% of funds to direct programmatic investments (initiatives and sub-grants) and ≤15% to provider payments (in line with the federal cap[1]), with state administrative costs capped at 10% of the award. We have structured the financial plan to take advantage of the program's two funding components: **baseline funding** (equal-share, ensuring at least \$100 million/year to NH if all states participate) and **workload funding** (competitive, based on need and merit). Our application maximizes New Hampshire's points for the discretionary "workload" allocation by demonstrating significant rural need and proposing robust initiatives and policy commitments (e.g. joining interstate licensure compacts, repealing restrictive policies) to enhance our score. As such, while NH's conservative estimate of total funding was \$500 million (assuming equal-share only), this request for \$1 billion reflects our confidence in securing additional need-based funds through a high-scoring proposal.

In summary, **New Hampshire's Rural Health Transformation Initiative** is an ambitious, data-driven plan to invest in the people, providers, and systems that serve our rural

communities. By targeting the root causes of rural health disparities and building up local capacity – **from prevention and primary care to hospitals and technology** – this initiative will create a stronger, healthier future for rural New Hampshire that endures beyond the life of the grant. The sections below provide detailed documentation of the needs, strategies, initiatives, budget, and commitments that comprise our application.

Table: New Hampshire RHTP Portfolio Summary and Alignment

Initiative (FY26–FY30)	Description	Key RHTP Categories Addressed	5-Year Budget (millions)
1. Rural Preventive Health & Primary Care Initiative	Expand rural primary care access, mobile clinics, preventive screening programs, chronic disease management (e.g. diabetes, heart disease) in community settings. Includes community health worker outreach and integration of social support services.	- Prevention & chronic disease management - Right-sized care delivery (appropriate ambulatory, preventive services locally) - Partnerships to integrate services (e.g. FQHCs, hospitals)	\$300
2. Rural Digital Health & Workforce Initiative	Deploy telehealth networks, remote patient monitoring, and upgrade health IT for rural providers; recruit and train rural healthcare workforce (loan repayment, residencies, tele-mentoring). Introduce **consumer-facing health apps** and decision support tools for self-management.	- Technology-driven solutions (telehealth, RPM, AI) - Workforce recruitment & retention (5-year service commitments) - Training & technical assistance for tech adoption	\$250
3. Rural Behavioral Health Access Initiative	Expand mental health and SUD treatment in rural areas: integrate behavioral health into primary care clinics, launch tele-mental health services, support opioid treatment programs. Partner with community organizations to address stigma and	- Mental health & SUD treatment expansion - Workforce (behavioral health specialists recruitment) - Prevention	\$200

Initiative (FY26–FY30)	Description	Key RHTP Categories Addressed	5-Year Budget (millions)
	transportation.	(address root causes, e.g. ACEs, via community programs)	
4. Rural Hospital Transformation & Sustainability Initiative	Stabilize and transform rural hospitals and EMS: invest in critical capital improvements (modernize equipment, telemedicine carts, minor facility renovations), develop **innovative care models** (e.g. establishing rural emergency medical hubs, implementing value-based payment models like rural ACOs or global budgets), and facilitate strategic partnerships (CAHs affiliating with larger health systems for specialty coverage and operational efficiencies). Includes limited **provider payment support** to aid in transitions (<=15% of funds)[1].	- Innovative care/payment models - Infrastructure upgrades for rural facilities - Strategic partnerships between rural and larger providers[2]	\$250
Program Administration & Evaluation (≤10% of total)	Grant management, monitoring, data collection, independent evaluation, and reporting activities led by NH DHHS. Leverages existing State Office of Rural Health resources.	- (Oversees all categories; ensures compliance with RHTP requirements and inter-agency coordination.)	\$100
****Total Requested Funding** ** **			**\$1,000**

(Note: Budget allocations are rounded; see Budget Narrative in Section C for detailed breakdown by year and category. All initiatives collectively address 7 out of 10 RHTP priority activity categories, exceeding the minimum requirement of 3.)

B) Project Narrative

B1) Rural Health Needs and Target Population

State Rural Profile: New Hampshire is a largely rural state, with approximately **37% of its 1.38 million residents living in non-metropolitan areas**. These rural communities are dispersed across **7 predominantly rural counties** (e.g. Coös, Grafton, Carroll, Sullivan, Belknap, Cheshire, and parts of Merrimack County), characterized by small towns and substantial travel distances to full-service medical centers. According to the USDA and Census definitions, over half a million Granite Staters reside in areas considered rural or small-town, and many of these areas have aging populations; the median age in rural NH is in the mid-40s, notably higher than in urban areas, reflecting an out-migration of younger adults and a concentration of older adults. This demographic reality contributes to a higher prevalence of chronic conditions (such as diabetes, COPD, and cardiovascular disease) in rural populations, and underscores the need for robust primary and preventive care systems.

Healthcare Facilities and Workforce Shortages: New Hampshire's rural health infrastructure, while robust for the state's size, faces significant strain. The state has **13 Critical Access Hospitals (CAHs)** and **5 other small rural hospitals** (Prospective Payment System hospitals located in rural areas) that provide essential acute and emergency care. In addition, there are **18 Rural Health Clinics (RHCs)** and **29 Federally Qualified Health Center (FQHC) sites** serving rural communities with primary care and behavioral health services. Despite this network, provider shortages are pervasive. **All 7 rural counties are designated Primary Care HPSAs**, indicating that primary care physician supply is insufficient for the population's needs, and **5 of 7 rural counties are Mental Health HPSAs** (mental health provider shortages) (NRHA State Fact Sheet, 2024). Dental care access is also limited in some areas (e.g. North Country). Overall, rural practices struggle to recruit physicians, nurse practitioners, behavioral health specialists, and other clinicians. Workforce shortages lead to long wait times for appointments and require patients to travel to more populated areas for certain services, exacerbating access issues for those with transportation challenges.

Health Status and Disparities: Rural residents in New Hampshire generally experience **poorer health outcomes on key measures** compared to their urban counterparts. For example, rates of **preventable hospitalizations** (for conditions like asthma, diabetes complications) are higher in rural NH, indicating gaps in primary care access. The opioid crisis has acutely impacted rural areas; some of the highest per-capita rates of opioid overdose deaths are in rural NH counties, where access to medication-assisted treatment (MAT) and recovery services has lagged. Mental health outcomes also reflect disparities: rural adults report higher frequency of poor mental health days. Contributing factors include isolation, fewer local behavioral health providers, and stigma in small communities. Additionally, **chronic diseases** such as diabetes and hypertension have higher prevalence in parts of rural NH, partly due to an older population and socioeconomic factors. Rural counties have higher percentages of residents 65+, higher

rates of disability, and pockets of poverty – for instance, Coös County (the northernmost county) has one of the highest poverty and uninsured rates in the state, and its health rankings are consistently among the lowest in NH. These **social determinants of health** (transportation, income, education) negatively impact rural health outcomes and are being addressed through multi-sector efforts (e.g. local public health networks, community coalitions) that our RHTP plan will build upon.

Challenges with Healthcare Access: Rural New Hampshire residents face multiple access barriers: **geographic distance** (many residents live 30+ minutes from the nearest hospital or specialist), **transportation limitations** (minimal public transit in rural areas), and **limited service availability** (some rural hospitals have had to reduce services like obstetrics, ICU, or surgical care due to low volumes and cost). Specialty care such as psychiatry, endocrinology, and cardiology often requires referral to Dartmouth-Hitchcock (in Lebanon) or other urban centers, meaning long travel or wait times. Telehealth usage surged during the COVID-19 pandemic and proved invaluable in bridging some gaps, but broadband connectivity remains spotty in certain mountainous or remote areas, and not all providers or patients have fully adopted virtual care. Part of the need is to upgrade digital infrastructure and train both providers and patients in telehealth.

Financial Vulnerability of Rural Providers: The rural hospital financial crisis is a pressing need. **Approximately 33% of rural hospitals in NH operate on negative margins** (i.e. expenses exceed revenue) in recent analyses (Chartis Group, 2024). With small patient volumes and a payor mix that leans heavily on Medicare and Medicaid, these hospitals have slim operating margins. The recent federal Medicaid cuts (through the 2025 budget law) are projected to cost rural providers in NH tens of millions of dollars over the next decade. Two of New Hampshire's rural hospitals have been classified "at risk of financial distress" in national reports, raising concern for potential closure or service cuts. While none have closed to date (NH has fortunately had **0 rural hospital closures since 2010**), maintaining operations is increasingly difficult, especially for services like obstetrics or inpatient psychiatry which are costly. Similarly, many RHCs and FQHCs cite funding and staffing challenges that limit their capacity to expand services. The state's Office of Rural Health notes that increasing **operational efficiency and new payment models** are needed to sustain these facilities (e.g. exploring a global budget or rural emergency hospital designation for vulnerable hospitals).

Community Input on Needs: In developing this plan, New Hampshire leaders actively solicited input from rural stakeholders. In September 2025, Governor Ayotte and NH DHHS held community listening sessions in the North Country (Littleton) and other regions, where residents, healthcare providers, and local leaders voiced their priorities. Common themes included: **keeping primary care local**, **improving transportation for specialty care**, **expanding behavioral health services (especially for youth and substance use)**, and **supporting the local workforce** so clinics don't have to rely on short-term contract staff. An online survey conducted by NH DHHS (with over 300 responses from rural citizens and providers) reinforced these themes – respondents highlighted the lack of mental health providers, difficulty finding dental care, and concerns about potential hospital

service losses. These community-identified needs directly shaped our proposed initiatives. For example, the emphasis on "keeping care local" led to plans for mobile clinics and tele-specialty programs, and workforce concerns led to the robust recruitment/retention strategies in this application. The **Governor's endorsement letter (Attachment D1)** further summarizes the input received and the state's commitment to addressing it.

In summary, **New Hampshire's rural health needs are significant and multifaceted**: a large and aging rural population with chronic disease burdens, critical shortages of healthcare professionals, financial fragility of rural providers, and barriers to accessing care (geographic and technological). At the same time, the state has strengths to leverage – a tight-knit network of rural hospitals and health centers, strong community organizations, and recent momentum from initiatives such as the State Loan Repayment Program and local telehealth expansions. This Rural Health Transformation Plan is designed to address these needs holistically, ensuring that federal RHTP funds serve as a **"catalytic investment" to support reforms and innovations that strengthen rural health care systems beyond the life of the grant**.

B2) Rural Health Transformation Plan: Goals and Strategies

Vision and Goals: The State of New Hampshire's vision for the Rural Health Transformation Program is **"Healthy Rural Communities, Sustainable Rural Healthcare."** This vision aligns closely with CMS's RHTP purpose to transform how care is delivered in rural America. We have adopted the **five broad strategic goals** defined by CMS as guiding pillars for our state plan:

- **Goal 1: Make Rural New Hampshire Healthy Again.** Emphasize **prevention and health promotion** to address root causes of disease. We aim to improve population health through preventive screenings, management of chronic conditions, and addressing social determinants. This goal drives strategies like expanding community-based preventive programs and integrating nutrition/physical activity initiatives (e.g. exploring reinstating youth fitness programs in schools, as encouraged by CMS). Success means rural residents have more opportunities to stay healthy without needing hospital care.

- **Goal 2: Ensure Sustainable Access through Coordination and Networks. Coordinate and strengthen rural healthcare delivery** by breaking down silos. Our strategy is to foster **regional partnerships**: linking rural hospitals with larger health systems (for tele-specialty consults, resource sharing), networking Critical Access Hospitals together for joint purchasing or shared services, and integrating EMS, clinics, and hospitals into a cohesive emergency and primary care continuum. This also involves **right-sizing services** – ensuring each community has the appropriate level of care locally (critical services like primary care and emergency stabilization) and efficient referral pathways for higher-level care. The plan includes establishing formal **rural health collaboratives** in each region to sustain this coordination.

- **Goal 3: Expand the Rural Health Workforce. Attract, develop, and retain healthcare professionals in rural areas.** Our workforce strategy features incentive programs (e.g. enhanced loan repayment for physicians, dentists, mental health providers who serve at rural sites for 5+ years), expanded **training opportunities** (rural residency rotations, tele-mentoring for rural clinicians, scholarships for local students in health professions), and support for non-traditional workers like community health workers and peer recovery specialists. We will also pursue policy levers: for instance, joining the Interstate Medical Licensure Compact and Nurse Licensure Compact to ease recruitment (one of the CMS technical score factors[3][4]), and working with academic institutions on pipeline programs. The goal is a significant net increase in the rural workforce and reduced vacancy rates at rural facilities by program's end.

- **Goal 4: Enable Innovative Models of Care and Payment. Implement new care delivery models** tailored for rural environments that improve outcomes and value. Strategies include launching **mobile health clinics** (to bring care to remote locations), integrating primary and behavioral health care (co-location and telehealth), establishing community paramedicine programs (EMS providing in-home care to prevent hospital trips), and piloting **value-based payment models** such as rural Accountable Care Organizations (ACOs) or global budgeting for rural hospitals. These models aim to improve care coordination and quality while controlling costs. We are also exploring a **Medicaid demonstration** for an alternative payment methodology for rural hospitals that would offer stable funding in exchange for meeting quality and access benchmarks (subject to CMS approval). By testing and evaluating these innovations under RHTP funding, we intend to identify sustainable models that can be scaled or permanently adopted via Medicaid State Plan amendments or waivers.

- **Goal 5: Drive Technology and Infrastructure Innovation. Modernize rural health infrastructure and leverage technology** to overcome geographic barriers. This involves upgrading health IT systems (EHRs, HIE connectivity) for interoperability and efficiency, expanding **telehealth** capabilities (telemedicine carts, remote monitoring devices for patients with chronic conditions), implementing **AI-powered analytics** to support population health (for example, risk stratification tools to identify high-risk patients, as offered by some RHTP partners), and improving cybersecurity and resiliency of rural providers' systems. Additionally, infrastructure innovation includes minor capital projects like renovating clinic space for integrated care or simulation labs for training, and ensuring all rural facilities can connect to robust broadband. Recognizing the NOFO's cap on replacing EHR systems (max 5% of funds for wholesale replacement of certified EHRs), our approach focuses on **enhancements** and add-on tools (patient portals, telehealth platforms, analytics dashboards) to existing systems. By program's end, rural providers will be far more "digitally enabled," allowing them to deliver high-quality care regardless of distance.

Core Strategies and Theory of Change: Our plan's strategy set can be summarized in a theory of change: *If New Hampshire invests in preventive care, workforce, technology, and new care models in rural areas, and if we engage communities and providers in a coordinated effort, then we will improve health outcomes and access for rural residents while making our rural health systems more financially sustainable.* The key strategic approaches include:

- **Investing in Primary Care and Prevention** – building a stronger foundation of rural primary care (the most cost-effective care) through funding expansions of RHCs/FQHC capacity, mobile clinics, and preventive health outreach. This preemptively addresses illness to reduce later high-cost interventions.

- **Local Capacity Building** – rather than continuously transferring rural patients to distant providers, bring resources to rural areas: train local people as health workers, equip local clinics with tele-specialty links, and empower rural hospitals to provide as much care locally as safely possible.

- **Collaboration and Integration** – encourage rural providers to **collaboratively innovate** instead of operating in isolation. This includes pooling resources across hospitals (shared staff or telehealth arrangements), integrating services (like behavioral health in primary care), and public-private partnerships (e.g., working with community organizations on social needs). The plan explicitly leverages multi-sector collaboration; for example, we will partner with the **Rural Health Transformation Collaborative** (a national multi-sector coalition) to access ready-to-deploy solutions and technical expertise. The RHT Collaborative has offered its assistance with proven strategies that meet CMS standards (HIPAA-compliant tech, etc.) and can be scaled quickly. This kind of collaboration mitigates risk and speeds implementation.

- **Evidence-Based Interventions** – Each initiative is built on models that have shown success in rural or similar settings. For instance, care coordination programs (like community health workers helping chronic disease patients) are proven to reduce admissions; tele-ICU and tele-specialty programs have preserved rural hospital capabilities elsewhere; Medication-Assisted Treatment integration in primary care is evidence-based for SUD; and rural residency programs are known to increase provider retention. We will implement these with fidelity to evidence, while tailoring to local context. Attachment D3 (Business Assessment) includes references to the evidence base for major project components, ensuring our strategies are grounded in best practices.

- **Data-Driven Management and Continuous Improvement** – We will use data to target interventions (e.g., using GIS and hospital data to identify "hot spots" of unmet need such as towns with high ER usage due to lack of local clinic) and to measure performance. The plan includes establishing a Rural Health Program Dashboard to track key indicators in real time. We will hold quarterly strategy

reviews with stakeholders to assess progress and adjust tactics as needed (adaptive management).

- **Policy and Regulatory Alignment** – Our strategy doesn't rely solely on direct funding; it also pursues policy changes to reinforce the transformation. For example, to sustain telehealth, we will make permanent certain flexibilities (state will support legislation to mandate payment parity for telehealth in private insurance and Medicaid). We also plan to coordinate with our Medicaid program to align RHTP initiatives with Medicaid Managed Care requirements (such as incentivizing MCOs to invest in rural provider quality improvements). Additionally, as mentioned, we commit to joining interstate licensure compacts and revisiting any state regulations (like Certificate of Need laws) that could impede expansion of services – indeed, repealing or loosening CON laws to remove barriers for new rural facilities is one of the scoring criteria and something we are actively exploring. These policy moves will enhance the impact of RHTP investments and help secure longevity.

In essence, New Hampshire's strategy is **comprehensive and synergistic**: it addresses supply (providers, facilities), demand (community health needs, patient engagement), and the enabling environment (technology, policy, partnerships). By pursuing these strategies simultaneously, we expect multiplicative effects – e.g., new technology enables new care models; new workforce allows more preventive care; preventive care reduces strain on hospitals, improving their sustainability, etc. This virtuous cycle is depicted in a logic model (see Attachment D5 for a Logic Model diagram) that connects our activities to short-, medium-, and long-term outcomes.

Rural Resiliency and Emergency Preparedness: An additional strategic consideration is ensuring rural areas are resilient in the face of emergencies (pandemics, natural disasters). Our plan's technology upgrades (e.g. telehealth, remote monitoring) and network-building will create more redundancy and flexibility in the system. For example, if one rural site is down, telehealth can connect patients to others. We also include training for rural providers in emergency response and have budgeted funds to improve emergency medical services (training volunteer EMS, equipment for ambulances). This aligns with CMS's interest in strengthening emergency services coordination as part of sustainable access.

Finally, our strategy is grounded in the **"New Hampshire way"** – a pragmatic, community-focused approach. We recognize that each rural community is unique; thus, while we have a statewide framework, implementation will be community-driven. We will empower local advisory groups in each region to guide how initiatives roll out locally, ensuring respect for local culture and maximizing community buy-in. By engaging those on the ground, we turn our strategies into shared strategies, increasing the likelihood of success and sustainability.

B3) Proposed Initiatives and Use of Funds

New Hampshire's RHTP plan comprises **four major initiatives**, each of which contains specific projects and activities. Collectively, these initiatives cover a broad range of the **allowable RHTP funding categories** (at least three are required; our plan covers seven categories as noted). Below, we describe each initiative, the problems it addresses, key activities, partners, the RHTP categories utilized, and the intended outcomes. (For reference, the relevant RHTP categories from Section 71401 are italicized in parentheses the first time they are mentioned for each initiative.)

Initiative 1: Rural Preventive Health & Primary Care Initiative

Categories Addressed: *Promoting evidence-based prevention and chronic disease management*; *Assisting rural communities to right-size healthcare delivery systems (develop needed ambulatory and preventive services)*; *Initiating strategic partnerships to extend care* (e.g. between community organizations and providers).

Rationale & Objectives: This initiative targets the foundational gap in rural healthcare: access to **primary care and preventive services**. As noted in our needs assessment, many rural residents forgo preventive care due to distance or limited clinic hours, leading to higher rates of unmanaged chronic conditions. In some communities, the local hospital ER becomes the de facto primary care provider after hours. The objective of this initiative is to **improve health outcomes and reduce avoidable acute care use** by bringing primary care, preventive screenings, and chronic disease management closer to where people live. We also aim to "right-size" the delivery system by filling service gaps (e.g., ensuring every rural region has access to basic imaging, lab services, routine specialty consults via partnership).

Key Activities:
- **Mobile Health Units:** Launch **2 mobile health clinics** (van-based) that travel to underserved towns on a regular schedule. These units will provide preventive services like blood pressure, cancer screenings, immunizations, and basic acute care. Each mobile unit will be staffed by a nurse practitioner, medical assistant, and community health worker from a partnering RHC/FQHC. We will prioritize areas that currently lack a local clinic. (Category: prevention/chronic disease management)
- **Community Health Worker (CHW) Outreach Program:** Hire and deploy **15 CHWs** across rural communities to conduct outreach and health education. CHWs will focus on chronic disease coaching (e.g. diabetes prevention programs, nutrition counseling) and link residents to services (like smoking cessation, exercise programs). This evidence-based model is aimed at improving control of conditions like diabetes (measured by A1c levels) and hypertension in target populations. CHWs will also assist patients with care coordination, e.g., ensuring those with complex needs attend their follow-ups (to reduce readmissions). (Category: prevention/chronic disease management)
- **Expanded Clinic Hours & Rotating Clinics:** Fund rural primary care clinics (RHCs, FQHCs) to offer **extended hours (evenings/weekends)** and periodic **rotating specialty**

clinics. For example, a cardiology NP or endocrinologist from Dartmouth Health will travel monthly to a rural site (or connect via telemedicine to multiple sites) for specialty consultations. Grant funds will cover the cost of provider time and telehealth technology to facilitate these rotations. This addresses access to specialty preventive care (like diabetic foot exams, cardiac check-ups) in rural settings.
- **Preventive Services Vouchers:** Establish a "Rural Preventive Health Fund" to provide **vouchers or subsidies for preventive services** not covered or hard to access. This can pay for things like transportation for a mammogram at the regional hospital, or dental cleanings if dental access is a gap, or lifestyle programs (e.g., a diabetes prevention program fee at a local YMCA). While relatively small in cost, these supports remove barriers for patients to actually utilize preventive care.
- **Right-Sizing Local Services Planning:** Conduct community-driven planning in each rural hospital service area to **identify needed services and gaps** (as per RHTP category on right-sizing systems). Through facilitated workshops including hospital leaders, primary care providers, EMS, public health, and patients, develop a local service plan. For instance, a community might decide to establish an urgent care center if the hospital ER closed, or to convert unused hospital space into an outpatient behavioral health clinic. Funds will support technical assistance for these plans and initial implementation of identified projects.
- **Partnerships for Social Determinants:** Formalize **partnerships with community organizations** (schools, food banks, senior centers). For example, we will partner with local Food Pantries to offer nutrition programs alongside health screenings (addressing diet-related chronic disease). Another partnership is with schools to reintroduce health and fitness assessments for kids (aligning with the concept of Presidential Fitness Test reinstatement, which CMS encourages) as part of a preventative approach starting at a young age. These partnerships extend care beyond clinic walls, making health improvement a community effort.

Use of RHTP Funds: Funds in this initiative will flow primarily as **sub-grants** or contracts to local entities: FQHCs, RHCs, community nonprofits, and health systems that operate mobile units or clinics. For example, the mobile units will be acquired and operated by a consortium led by the North Country Health Consortium (a local rural health network), which will receive a subaward for this purpose. We will ensure that none of these funds duplicate existing programs; rather they augment or expand capacity (see Program Duplication Assessment in Attachment D4). Importantly, **provider payments** under this initiative are minimal – e.g., covering costs of extended hours or visiting specialists – and will be counted toward the allowed provider payment share (cumulatively kept ≤15%). Most funding is for programmatic expenses like salaries of new staff (CHWs, etc.), equipment (mobile clinic vans), and training.

Partners Involved: Key partners include: **New Hampshire's FQHCs** (Bi-State Primary Care Association will coordinate involvement of community health centers in expanded services), the **State Office of Rural Health** (providing technical assistance and oversight), **Dartmouth Health** (for specialty outreach and telehealth support), and local organizations like the **North Country Health Consortium** and the **Community Health Institute/JSI**

which will assist with CHW training and program evaluation. We will also engage the **Rural Health Transformation Collaborative (RHTC)** for their expertise in population health analytics and consumer engagement tools – for instance, RHTC partners like Humetrix and Topcon have tools for community screening and patient engagement which we could deploy in health fairs or mobile clinic visits (e.g., tablet-based vision and health screenings in retail or community settings, feeding data into care management systems). The initiative is designed to be collaborative, leveraging these multi-sector partners to maximize reach and effectiveness.

Expected Outcomes: Over five years, this initiative will bring preventive care to thousands of rural residents who previously lacked access. We expect an increase in preventive service utilization (e.g. colorectal cancer screening rates in rural areas up by at least 10 percentage points, annual wellness visits up significantly), improved management of chronic diseases (measured by clinical indicators like blood pressure control rates, or diabetes A1c – aim for a reduction in average A1c among program participants by 1 percentage point), and ultimately a reduction in potentially avoidable ER visits and hospitalizations from those conditions (targeting a 15% reduction in PQI – Prevention Quality Indicator – admissions in participating regions by Year 5). Qualitatively, rural residents should report better access and satisfaction. We will monitor outcomes such as: number of patient encounters on mobile clinics, number of CHW client interventions and their outcomes, and changes in health outcomes in communities served versus control populations (if available). This initiative directly supports RHTP's preventive health goal and will contribute to long-term reduction in healthcare costs by catching problems early.

Initiative 2: Rural Digital Health & Workforce Initiative

Categories Addressed: *Consumer-facing, technology-driven solutions* (telehealth, remote monitoring, health apps); *Training and technical assistance for adoption of advanced technologies*; *Recruiting and retaining clinical workforce with service commitments*; *Enhancing IT capacity, efficiency, and cybersecurity in rural hospitals*.

Rationale & Objectives: This initiative tackles two critical, intertwined needs: modernizing technology in rural healthcare and building the **human workforce** to use that technology and serve rural patients. New Hampshire's rural providers vary in their tech capabilities – some CAHs have up-to-date EHRs and telehealth, others are using older systems and have limited interoperability. Cybersecurity is a growing concern, as small hospitals have faced cyber threats and need support to bolster defenses. Meanwhile, workforce shortages threaten all transformation efforts; without enough doctors, nurses, and allied health professionals, even the best technology can't ensure access. The objective here is to **equip rural providers with cutting-edge tools and the knowledge to use them**, and to **significantly expand the healthcare workforce pipeline into rural areas**, leveraging technology as an attraction and force-multiplier. We want to create a virtuous cycle where technology eases provider workload (reducing burnout) and extends reach (through telehealth), making rural practice more appealing, which in turn helps retention.

Key Activities:

- **Telehealth Expansion:** Invest in **telehealth infrastructure** for all 13 CAHs and affiliated clinics. This includes purchasing telemedicine carts or kits for hospitals (high-resolution cameras, scopes for tele-ENT, tele-derm, etc.), software licenses for secure video platforms, and establishing dedicated telehealth rooms in clinics. We will create a centralized **Telehealth Coordination Center** at NH DHHS that helps schedule and route tele-specialty consultations. Additionally, we will join with the RHT Collaborative's technology partners (like Avel eCare for virtual specialty consults, Teladoc for direct-to-consumer telehealth, etc.) to quickly stand up services. For example, a rural ED at night could connect with an Avel eCare critical care specialist via our telehealth equipment – this has immediate patient care benefits and is a workforce extender (allowing on-site staff to consult experts instead of transferring patients). (Categories: technology-driven solutions; innovative models of care support)
- **Remote Patient Monitoring (RPM) and Home Telehealth:** Launch an RPM program for high-risk chronic disease patients in rural areas. We will provide **home monitoring kits** (e.g. for blood pressure, glucose, pulse ox) supplied by RHTC partner BioIntelliSense or similar, and integrate their data into local provider workflows. A centralized nurse care manager (possibly at a CAH or regional PHO) will track alerts from these devices and coordinate follow-up (e.g., a rising blood sugar triggers telehealth consult or CHW home visit). This keeps patients stable at home and prevents hospitalizations. We plan to enroll at least 500 patients across rural NH in RPM by Year 3. (Categories: technology-driven solutions; chronic disease management)
- **Health Information Technology (HIT) Modernization Grants:** Offer **mini-grants to rural hospitals and clinics** for critical HIT projects. Based on initial assessments, needs include upgrading EHR modules for interoperability (e.g., connection to the state's Health Information Exchange), implementing or enhancing patient portals (to improve patient engagement, which is a consumer-facing tech solution), and adding decision support tools (like clinical AI for risk scoring). Given the NOFO's guidance, we will avoid wholesale EHR replacements unless absolutely needed (and cap any such project to 5% of funds). Instead, funds will cover things like **AI-driven population health software** (one idea is to use an AI tool to analyze rural health data for care gaps; RHTC's Pangaea Data offers AI to close care gaps that could be piloted in a few hospitals), **tele-pharmacy systems** to help small hospitals manage pharmacy remotely, and **cybersecurity enhancements** (firewall upgrades, security training) to protect patient data. Each participating hospital/clinic will submit a HIT plan and receive TA to ensure compliance and best practices (we will coordinate with HHS/ONC as needed). (Category: IT capacity and cybersecurity)
- **Workforce Incentive Program ("NH Rural Scholars and Healers"):** Establish a comprehensive program to **recruit and retain clinicians**. Key components:
- **Loan Repayment & Incentives:** Use RHTP funds to augment the state's existing loan repayment program by offering enhanced awards for providers (MDs, NPs, dentists, mental health counselors, etc.) who commit to rural practice for **5-year service terms**. For example, a physician could get \$100k toward loans for a 5-year commitment in a rural primary care practice. We anticipate funding ~50 such awards over 5 years. Additionally, we'll provide relocation bonuses or housing stipends as needed to attract candidates.

- **Grow-Your-Own Workforce:** Partner with the University of New Hampshire, Dartmouth's Geisel School of Medicine, and community colleges on pipeline programs. RHTP funds will support rural clinical rotation slots (stipends for medical residents or NP students to do month-long rotations in CAHs and RHCs, to expose them to rural practice). We'll also fund a Rural Health Fellows program for recent graduates to spend a year in a rural area working on a project (e.g. quality improvement or telehealth implementation) while practicing clinically part-time – an innovation to both provide service and possibly entice them to stay long-term.
- **Training & Continuing Education:** Provide **technical assistance and training** for rural providers to adopt new care models and technologies. We will organize training on using telehealth effectively, on integrating behavioral health, on team-based care. Some training will use Project ECHO or similar virtual mentorship models connecting rural clinicians with specialists (e.g., a monthly ECHO session on complex diabetes management). RHTP funds cover the coordination and CME costs. Notably, one policy we plan to pursue (and claim points for) is requiring or encouraging **nutrition and lifestyle training for clinicians** – aligning with CMS's scoring factor on nutrition continuing education – to ensure providers have the latest skills in guiding preventive health.
- **Interstate Licensure & Regulatory Relief:** While not a direct use of funds, we highlight as part of this initiative that the state will join licensure compacts (funds might cover any administrative costs of implementation or outreach to providers about it). This will allow NH to quickly recruit telehealth providers from other states and allow our providers more flexibility to serve across state lines if needed.

- **Digital Literacy for Patients:** In tandem with tech deployment, we will run a **"Digital Health Literacy" campaign** to ensure patients can effectively use telehealth and patient portals. This includes community workshops at libraries or senior centers teaching people how to use video visits or health apps, and deploying "digital navigators" (could be an added role for CHWs or volunteers) who can assist patients one-on-one. By improving patient comfort with technology, we maximize uptake of our telehealth and portal investments (no one gets left behind due to lack of tech savvy).

Use of RHTP Funds: This initiative will use a combination of **state-level procurement** (for things like telehealth platform licenses, where a statewide approach yields efficiency) and **subawards** (for hospital-specific or clinic-specific projects, and for loan repayment which might be administered via existing state programs). We will ensure compliance with caps: for example, the loan repayment funds technically count as payments to providers, but we will structure them likely as "incentive payments" that fall under the workforce category rather than direct service reimbursement, and regardless we will keep total direct compensation payments within the 15% cap[1]. Most technology costs are one-time or short-term investments, not ongoing service funding, thus not considered provider payments. Administrative costs for this initiative (like running the Telehealth Center or coordinating training) are part of the overall admin which is capped at 10%.

Partners Involved: We will heavily involve **technology partners** and **educational institutions**. The **Rural Health Transformation Collaborative (RHTC)** will be a key ally: multiple RHTC member companies offer the exact solutions we need – e.g., **Microsoft** (and its partners) for secure cloud, AI, and possibly even the development of a rural health **"Digital Front Door" app that interfaces with CMS** (the HIMSS fact sheet noted a CMS app developed by Microsoft for navigation – we could pilot that in NH to help rural patients navigate services). **Viz.ai** could bring AI algorithms for early disease detection to our hospitals (the RHTC documentation mentions 50+ FDA-cleared AI algorithms for conditions like abnormal heart rhythms – implementing some of these in rural imaging or monitoring could drastically improve early diagnosis). **Accenture or KPMG** (as part of RHTC's digital advisory) might assist with complex system integration and ensuring our solutions meet standards. On the workforce side, we will partner with the **New Hampshire Area Health Education Center (AHEC)** and **academic institutions** (Dartmouth, UNH, and MCPHS for pharmacy, etc.) to implement training and pipeline components. The **New Hampshire Medical Society** and **Board of Nursing** will be engaged to facilitate licensure compacts and support outreach to recruits.

Expected Outcomes: This initiative aims to transform the capacity of rural providers. **Telehealth Utilization**: We anticipate a 200% increase in telehealth visits from rural sites by Year 2 (compared to baseline), ultimately making telehealth a normal part of care (target: each rural hospital or clinic conducts dozens of tele-specialty or tele-consult visits per month). **IT Improvements**: All CAHs will achieve enhanced interoperability (measured by connection to HIE and quality of data submission to state systems) and improved cybersecurity postures (measured by completing security risk assessments and addressing high-risk gaps). **Workforce Growth**: We expect to recruit at least 20 new primary care physicians, 10 psychiatrists/psychologists, 15 nurse practitioners/physician assistants, and dozens of nurses and allied health professionals to rural NH over 5 years through our incentive programs. Retention of those in incentive programs should exceed 80% at 5 years (meaning they stay beyond their commitment). **Provider Satisfaction**: By reducing isolation (through tele-mentoring) and easing workload (through technology like ambient documentation or AI decision support), we strive to lower burnout. We will survey clinicians; a goal is improved scores on metrics of burnout or intention to leave. Overall, this initiative supports sustainability: technology and workforce are fundamental enablers for everything else. If successful, rural sites will be fully staffed with a mix of on-site and telehealth resources, running modern, efficient operations. This in turn should improve patient outcomes (via better care continuity and specialist input) and support financial health (via increased service capacity and avoidance of costly travel or outsourced services).

Initiative 3: Rural Behavioral Health Access Initiative

Categories Addressed: *Supporting access to opioid use disorder, substance use disorder, and mental health services*; *Recruiting and retaining workforce (behavioral health providers)*; *Promoting innovative care models* (integration of behavioral health in primary

care, tele-behavioral health); *Other uses to promote sustainable rural access* (e.g. leveraging partnerships with regional mental health centers).

Rationale & Objectives: Mental health and addiction treatment gaps in rural New Hampshire have reached a critical point. Many rural communities lack even a single psychiatrist or addiction medicine physician; counseling services are limited and waitlists long. The opioid epidemic and rising mental health needs (especially post-pandemic) mean that without intervention, outcomes will worsen (overdoses, suicide rates, etc.). The objective of this initiative is to **dramatically increase the availability of behavioral health services in rural areas** and integrate those services into existing care settings. By bringing behavioral health into the fold of primary care and emergency care, and expanding telehealth, we aim to reduce the unmet need. Another objective is workforce development in this sector, overlapping with Initiative 2 but focusing on behavioral health specialists (therapists, psychiatrists, etc.). In short, the initiative intends to ensure that **no rural resident is more than a phone call or short drive away from mental health support or SUD treatment**.

Key Activities:
- **Behavioral Health Integration (BHI) in Primary Care:** Provide funding and TA for at least **10 rural primary care practices (RHCs/FQHCs or hospital-owned practices)** to implement the Collaborative Care Model or other evidence-based integration of behavioral health. This includes hiring **behavioral health clinicians (e.g. licensed clinical social workers)** to be embedded in these practices, and use of a psychiatric consultant (remote or shared among sites) to advise on cases. We will subsidize the salaries of these embedded clinicians on a sliding scale (higher in year 1-2, taper as billing revenue picks up). The expected result is that routine mental health conditions (mild/moderate depression, anxiety) and SUD issues are managed in the familiar primary care setting, increasing access and reducing stigma. (Category: mental health/SUD services expansion)
- **Tele-Psychiatry Network:** Establish a statewide **Tele-psychiatry network** linking rural emergency departments, primary care clinics, and community mental health centers to a pool of psychiatric specialists. We will contract with either an academic hub (Dartmouth's psychiatry department) or a tele-mental health vendor to ensure that any rural provider can, 24/7, get a psychiatrist on video to assess a patient in crisis or consult on medication management. This is crucial for CAH emergency rooms that often board psychiatric patients due to lack of access. Using RHTP funds, we'll cover the startup and per-consult costs not reimbursed by insurance. Over 5 years, we expect to make this service partially self-sustaining via billed encounters, but will plan for state funding to continue it if needed (sustainability plan addresses this). (Category: mental health services, tech-driven solutions)
- **Opioid Use Disorder (OUD) Treatment Expansion:** Expand capacity for **Medication-Assisted Treatment (MAT)** in rural areas. Strategies: Provide **grants to at least 5 rural health clinics or hospital outpatient departments** to start or expand MAT programs (including hiring or contracting waivered buprenorphine prescribers, training existing staff, and adding tele-counseling options). We will also partner with established **Opioid Treatment Programs (OTPs)** in the state to create satellite services or mobile MAT units

that visit rural communities. For example, the OTP in Manchester could operate a mobile unit to the Lakes Region once a week for methadone distribution, funded by our grant. Additionally, support **peer recovery support** programs by funding 5 new peer recovery coach positions placed in hospital ERs or community centers to engage individuals after overdoses or in treatment. (Category: SUD/OUD services)
- **School and Youth Behavioral Health:** Recognizing the youth mental health crisis, allocate funds to pilot **tele-mental health in schools** for rural districts. We'll collaborate with the NH Department of Education to enable 2-3 school districts (covering rural towns) to have a telehealth setup where students can speak with a counselor or psychologist virtually if on-site ones are not available. This will be accompanied by training school nurses or counselors to identify needs and refer. (Category: mental health services, preventive)
- **Community-Based Programs and Stigma Reduction:** Work with community coalitions (like the "Recovery Friendly Communities" initiative that some NH towns have) to fund **public awareness and stigma reduction campaigns** around mental health and addiction in rural areas. Small grants will support activities like Mental Health First Aid training for community members, anti-stigma media campaigns featuring local voices, and workshops connecting law enforcement, healthcare, and community on responding to mental health crises (improving coordination). These efforts create a more supportive environment for individuals seeking help. (Category: other – supporting sustainable access via community partnerships)
- **Workforce – Behavioral Health Focus:** As part of Initiative 2's workforce efforts but specifically in this initiative, dedicate some incentive slots to **behavioral health professionals**: e.g., student loan repayment for 5 psychologists or psychiatrists and 5 licensed drug and alcohol counselors to serve rural NH. We will also coordinate with state's existing programs like the NH Loan Repayment for mental health workers (which is often underfunded relative to need).

Use of RHTP Funds: This initiative's funds will primarily be distributed as **subawards to providers and community organizations** to implement services. For BHI in primary care, clinics will get implementation grants. For tele-psych network, the state may directly contract a service provider and then provide the service free or at low cost to sites (like a utility model). MAT expansion funds cover staffing and training costs that are not fully billable initially. We will ensure no supplanting: e.g., if Medicaid already reimburses MAT, we only fund the non-reimbursed portions (like uninsured patient care, additional counseling beyond limits, etc.). The initiative may involve some provider payment-like activities (e.g., paying for a psychiatrist consultation might be considered a provider payment), but these will be carefully tracked. The majority goes to program development, not ongoing clinical billing. We also ensure to keep these within the allowable categories (mental health and SUD services clearly allowed).

Partners Involved: We will coordinate with the **New Hampshire Department of Health and Human Services, Bureau of Behavioral Health** and the state's network of **Community Mental Health Centers (CMHCs)**. The CMHCs (like Northern Human Services in the North Country, West Central Behavioral Health in Upper Valley, etc.) are

key – we anticipate they will partner with primary care for integration and also possibly host some of the new clinicians hired. **Hospitals and FQHCs** in rural areas (e.g. Weeks Medical Center, Littleton Regional, Upper Connecticut Valley Hospital, etc.) are expected partners for tele-psych in ED and MAT programs. We will also engage **law enforcement and EMS** agencies in rural areas for crisis response improvements (the state's Doorway program for SUD will be linked in). The **Governor's Office** and legislature will be partners on any needed policy changes (like credentialing rules to allow easier integration). Additionally, RHTC partners like **CVS Health or Walgreens** (which have retail pharmacies in rural areas) could support OUD efforts by providing space for counseling or training pharmacists to identify and refer patients – expanding touchpoints for help. The American Heart/American Stroke Association (listed in RHTC) might help with mental health first aid as they are branching to broader health. Finally, organizations such as **NAMI NH** (National Alliance on Mental Illness) and **Recovery Community Organizations** will be involved through contracts or MOUs to assist with community outreach and peer support components.

Expected Outcomes: We expect **substantial improvements in access to behavioral health care**. Metrics and targets include: Increase the number of rural primary care sites offering integrated behavioral health from a baseline of ~2 to at least 12. Reduce wait time for a non-urgent psychiatry appointment in targeted areas from several months to under 2 weeks through tele-psych availability. Increase the number of individuals receiving MAT in rural NH by 50% (and aim for a proportional decrease in opioid overdose deaths or opioid-related ER visits in those communities). For mental health, we aim to reduce the rate of mental-health-related ER visits and crisis events by providing earlier intervention (target maybe a 10% reduction in ER psych visits by Year 4 in regions with new services). Patient outcomes such as depression remission rates in collaborative care will be tracked (e.g., percentage of patients with PHQ-9 depression score improvement). On the workforce side, by bringing new providers, the ratio of population to mental health provider in rural areas should improve (we'll measure HPSA scores pre/post). Qualitatively, success means a resident in, say, rural Carroll County can access counseling or addiction treatment in their community rather than driving to Concord or Manchester. Over the long term, better mental health and SUD care will contribute to overall healthier communities and potentially workforce participation (as untreated mental illness and addiction are major economic burdens).

Initiative 4: Rural Hospital Transformation & Sustainability Initiative

Categories Addressed: *Developing innovative models of care including value-based arrangements*; *Investing in rural healthcare facility infrastructure (minor renovations, equipment)*[5]; *Providing payments to healthcare providers for services (limited portion)*; *Initiating partnerships between rural facilities and others to promote quality and financial viability*[2].

Rationale & Objectives: Rural hospitals and EMS providers form the backbone of emergency and inpatient care in rural NH. However, as documented, many are at financial risk due to low volumes, payer mix, and the inability under current models to cover fixed

costs. The closure or downgrading of any rural hospital can have devastating impacts on access to emergency care (time to trauma care, etc.) and the local economy. The objective of this initiative is to **ensure the sustainability of rural hospitals and essential services** through transformation – which means shifting the business model from fee-for-service to value-based or alternative payment models where feasible, streamlining operations and regionalizing services to avoid redundancies, and investing in needed infrastructure improvements that can reduce costs or open new revenue streams (like outpatient service expansion). Additionally, enhancing EMS and critical care capabilities is part of sustaining access (so that even if not all services are local, emergencies can be handled locally and stabilized). We also aim to use partnerships to help small facilities gain efficiencies (e.g. shared specialty staffing, telehealth, group purchasing).

Key Activities:

- **Global Budget / Value-Based Payment Pilot:** Work with one or more rural hospitals (on a volunteer basis) to pilot a **global budget model** akin to those used in Pennsylvania or Maryland rural hospitals. Under this, a hospital gets a fixed annual revenue (possibly combining Medicaid, Medicare, and a portion of commercial payments via agreements) in exchange for meeting certain quality and access metrics and transforming its service lines to focus on community needs. RHTP funds can help offset initial shortfalls and technical work to set this up (consulting actuaries, facilitation with payers). If full global budget is too ambitious, alternatively implement a **small-scale value program**: e.g., shared savings contracts for rural Accountable Care Organization (ACO) participation or a **Medicaid value-based payment** where rural hospitals get bonuses for keeping patients healthy (potentially using RHTP funds as the bonus pool). The goal is to test and demonstrate that new payment models can stabilize revenue and incentivize the right care. (Category: innovative models of care/payment)
- **Facility Modernization Grants:** Provide **capital improvement grants** to each of the 13 CAHs and other key rural providers for priority infrastructure projects. This may include: renovation of outdated emergency departments to improve patient flow, conversion of unused acute care wings into other uses (like skilled nursing or rehab or primary care clinic space), upgrades to HVAC or telecommunication systems for efficiency and resilience, and purchase of modern medical equipment (for example, a CT scanner or lab equipment to ensure diagnostic capability locally). Each hospital will complete a capital needs assessment (many have them already) and apply for funds; we expect to fund projects in the \$5–10M range per facility on average. **Minor construction/renovation** is explicitly allowed in RHTP[5], and we will adhere to that (no new hospitals built, but renovations and equipment). These investments will help hospitals improve quality of care (new equipment) and potentially open new revenue-generating services (like outpatient specialty clinics in newly renovated spaces).
- **Emergency Medical Services (EMS) Enhancement:** Rural EMS is often volunteer-based and underfunded. We will allocate funds to shore up **EMS services**, such as providing advanced training for EMS personnel (e.g. community paramedic certification so they can do home visits as part of Initiative 1), purchasing equipment like new ambulances or simulation training tools, and piloting **tele-EMS** (paramedics connecting to ER docs en

route). One specific project: equip 10 ambulances across rural NH with telehealth tablets and diagnostic tools to transmit patient data to hospitals while in transit, improving pre-hospital care. This not only improves outcomes but also ties into the hospital network (ensuring patients get to the right facility in time).

- **Hospital Collaboration and Shared Services:** Fund a **Rural Hospital Collaborative** program where hospitals formalize agreements to share certain services. For instance, two neighboring hospitals might share one general surgeon (with telehealth support), or collectively contract for specialty telemedicine coverage as a group (cheaper per site). Another example is sharing an IT or billing workforce, or jointly investing in a centralized specialty clinic that serves multiple towns. We will provide facilitation and seed funding for at least 3 collaborative projects among hospitals. Additionally, encourage partnerships with larger health systems: e.g., expanding the existing Dartmouth-Hitchcock and MaineHealth outreach, or involving Boston-based systems to support North Country via telehealth. These partnerships align with the RHTP priority of "strengthening local and regional strategic partnerships"[2].
- **Targeted Operating Support (Transitional Payments):** Recognizing some hospitals may need short-term financial relief to undertake transformation, we will allocate a **limited pool of funds (no more than 10-15% of total)** for **transitional provider payments**. These payments could, for example, subsidize a hospital's operating losses while it implements a new efficiency plan or covers the salary of a needed provider (like an OB/GYN) for a period until volumes increase. We will strictly ensure these payments meet RHTP rules: they will **not exceed 15% of our annual award**[1] and will not supplant payments available from insurance (i.e., they won't pay for something that could be billed – instead they cover gaps or new services). Each payment will be tied to transformation conditions (e.g. hospital must maintain service X or achieve improvement Y). By structuring it as a cooperative agreement deliverable, we ensure it's not just a bailout but a purchase of value (like "pay to keep OB unit open this year while we recruit new staff and implement a new prenatal program"). This approach is consistent with legislative intent to not simply backfill Medicaid cuts but to assist in transition.

Use of RHTP Funds: This initiative is where **capital and provider payment categories** play a role. We will track capital projects separately (likely requiring pre-approval by CMS for any construction-related activity to ensure NEPA and other compliance). The funds used for equipment and renovations are considered **allowable capital uses**. For provider payments, as stated, we will manage tightly to stay under 15% annually (and likely less over the 5-year average). We also note the guidance that funds cannot directly offset Medicaid cuts or keep a facility open without transformation. Our design aligns with this: any direct support is coupled with transformation actions. Most funds in this initiative will be disbursed as **grants to hospitals** (with terms and conditions on use), and some via state-level contracts for things like consultancy on payment models. We will coordinate with CMS on any needed waivers or approvals (for example, a global budget model might need CMMI or CMS approval if involving Medicare funds – if so, we'll use RHTP to simulate the effects or to cover just the non-Medicare portion etc.).

Partners Involved: All **13 Critical Access Hospitals and other rural hospitals** are primary partners and beneficiaries here. The **New Hampshire Hospital Association (NHHA)** will be a key partner in managing the hospital collaborative efforts and disseminating best practices. We will work with **payers**: New Hampshire Medicaid and its managed care organizations will be at the table for payment model discussions, as will major private insurers in the state (Harvard Pilgrim, Anthem, etc.) because their cooperation might be needed for a global budget or value approach. Also, **the Centers for Medicare & Medicaid Services (CMS) Regional Office and CMMI** will be partners if we develop a model that could involve Medicare alignment. On the infrastructure front, we may partner with the **USDA Rural Development** program or others for co-funding opportunities (some hospitals might also apply for USDA community facilities loans for larger projects – RHTP funds can help match). The RHT Collaborative's industry members like **GE Healthcare or similar (for equipment)** and **digital integrators** could assist, and advisors from RHTC like **PwC or Accenture** have deep expertise in payment and operations improvement – we may engage them through technical assistance contracts to support hospitals in redesign (for instance, an Accenture team could help a hospital deploy AI to find efficiencies in billing or staffing).

Expected Outcomes: The ultimate outcome is **no rural hospital closures in NH during the program and improved financial outlook for each**. We aim for all rural hospitals to achieve a positive operating margin by Year 5 (or at least break-even with improved stability). We will monitor metrics like operating margin, days cash on hand, etc., for each hospital (provided confidentially to us as the grantee). Another outcome is **maintaining or expanding key services**: e.g., if any hospital was on the verge of cutting OB or surgery, our interventions should help retain those if they are essential, or replace them with alternative local options if not (like if OB cannot be sustained, ensure robust prenatal care and EMS for deliveries). Access metrics: travel time for emergency care remains acceptable (no increase in distance to ER for any resident). Quality metrics: improved outcomes such as lower transfer rates because more can be treated locally, or better 30-day readmission rates due to care coordination improvements. For the new models, an outcome is a blueprint that could be permanent: for instance, a successful global budget pilot could become a model the state seeks to continue beyond 2030. Another intangible but critical outcome: **increased confidence in rural healthcare** among residents (we can gauge via community surveys whether people feel more secure that they can get care locally). By focusing on sustainability, we ensure the investments from RHTP yield enduring benefits beyond the grant.

Each of these initiatives is designed not in isolation but to reinforce one another. For instance, the workforce and telehealth from Initiative 2 support the success of behavioral health in Initiative 3 and hospital sustainability in Initiative 4; the preventive care in Initiative 1 will reduce strain on hospitals (Initiative 4) and tie into value models. Collectively, they form a comprehensive Rural Health Transformation portfolio that uses at least three (in fact, seven) of the eligible funding categories of RHTP, as required, and aims to exceed expectations in improving rural health outcomes and system viability.

(Placeholder: Additional initiatives or sub-initiatives can be described here if needed, e.g., a prenatal care initiative for rural mothers, or a dental health outreach initiative, depending on further input. The above four cover the broad requirements and available information.)

B4) Implementation Plan and Timeline

Overview: New Hampshire will implement the RHTP plan in a phased manner over the five-year period FY 2026–FY 2030. We have developed a detailed **work plan and Gantt chart** (see Attachment D5) outlining tasks, responsible parties, and timelines. The approach is front-loaded in planning and capacity-building in Year 1 (FY26), ramping up to full implementation in Years 2–4, and focusing on evaluation, adjustments, and sustainability in Year 5. We will use a **governance structure** (described below) to oversee implementation, and adaptive management to adjust course based on feedback and interim results. The high-level timeline is as follows:

- **Q1 FY26 (Oct–Dec 2025)** – **Award initiation and planning:** Upon award (expected by Dec 31, 2025), convene the core project team and stakeholders to kick off. Establish the **Rural Health Transformation Steering Committee** (representatives from NH DHHS, Governor's Office, rural providers, etc.) to govern the effort. Immediately stand up project management office (PMO) within NH DHHS for RHTP. Begin procurement processes for key contracts (e.g. telehealth platform, evaluation partner) following state rules. Start data collection for baseline metrics.

- **Q2–Q4 FY26 (early-mid 2026)** – **Detailed design and initial rollouts:**

- Launch community engagement/planning under Initiative 1 (schedule community meetings for needs planning in each region).
- Initiate recruitment for new positions (CHWs, behavioral health clinicians, etc.) – coordinate with HRSA and others to advertise loan repayment incentives widely.
- Telehealth expansion: form Telehealth Workgroup, conduct needs assessment at each hospital for equipment, release RFP for telehealth hardware procurement (aim to have devices shipping by Q4).
- By Q4 FY26, begin a **pilot mobile clinic service** in one region as a proof of concept (with borrowed/leased van if needed before purchased units arrive). Also, possibly start a pilot of tele-psych in 2 hospitals in Q4.
- Finalize MOUs with partner organizations (e.g., academic institutions for workforce programs, mental health centers for integration).
- **Milestone (end of FY26):** All foundational plans completed (evaluation plan, communication plan, sustainability framework initial draft), at least 10 subawards or contracts executed to kick off key programs, initial service delivery begun in one or two focus areas (like a mobile clinic pilot or first batch of CHWs hired and trained).

- **FY27 (2026–2027)** – **Scale-up year 1:**

- By early FY27, deploy both **mobile health units** fully (covering scheduled circuits of communities).
- CHW program fully operational (all 15 CHWs hired and active by mid FY27).
- Telehealth infrastructure in at least half of rural hospitals installed; initial tele-specialty services (like e-ICU or tele-stroke) online by end of FY27.
- Behavioral health integration: at least 5 primary care practices have behavioral health staff integrated and seeing patients; tele-psych network covering all CAH EDs on off-hours by end of year.
- Workforce: first cohort of loan repayment awardees in place (e.g. 10 providers signed contracts and started working), rural residency rotations begun (e.g. 3 residents rotating).
- EMS enhancements: training sessions conducted, tele-EMS pilot in one region.
- Payment model pilot: form Payment Model Taskforce; by late FY27, design of global budget model done, ready to simulate or implement in coming year (target maybe implement for hospital(s) in FY28).
- **Milestone:** By end of FY27, most initiatives have moved from planning to active implementation in at least pilot sites, and we conduct the first annual performance review to learn and refine.

- **FY28–FY29 (2027–2029) – Full Implementation and Refinement:**

- All programs reach full geographic coverage. For instance, mobile clinics covering all target regions on rotation; telehealth and RPM available to essentially all rural primary care and hospital sites; integrated behavioral health in 10+ practices; MAT programs running in multiple communities.
- Continuous quality improvement cycles: use data from Year 1-2 to tweak programs (maybe adjust CHW deployment to where outcomes lag, or add a third mobile unit if demand high, etc.).
- Expand successful pilots: If global budget pilot in one hospital shows positive trends in FY28, consider expansion to another by FY29 (with CMS permission).
- By FY29, start institutionalizing programs: e.g. get state legislature to consider funding streams to continue loan repayment beyond grant, negotiate with payers to take over telehealth network financing, etc. (Sustainability planning moves into action).
- **Milestone (mid FY29):** Mid-term evaluation report completed by external evaluator, showing progress toward outcomes, identifying any need for major course corrections. Use this to make adjustments in FY30 plan if needed.

- **FY30 (Oct 2029 – Sep 2030) – Transition and Sustainability:**

- Gradually taper RHTP funding on some programs while alternative support kicks in (for example, ideally by FY30 many new hires' salaries are covered by billing

revenue or other grants; RHTP funds might shift to final capital or evaluation expenses).

- Focus on evaluation: conduct final outcomes measurement (some data may lag into 2031 if measuring full-year 2030 outcomes).
- Write final Rural Health Transformation Report for NH, summarizing improvements, lessons, and laying out the plan for post-2030 (which might involve state budget requests, private funding, or new federal programs if any).
- Work with CMS to ensure any unspent funds are properly dispositioned or extended if needed to complete projects by their nature (the law allows spending until end of FY31 possibly, but we aim to finish by FY30 with maybe a short no-cost extension for evaluation).
- **Milestone (Dec 2030):** No later than this, have secured commitments/legislation for sustaining critical components (for e.g., a dedicated line item in state budget or hospital contributions for telehealth network, integration of our workforce incentives into ongoing programs, etc.). Essentially, an exit strategy that leaves behind a stronger, self-sustaining rural health system.

Governance and Management: - **Lead Agency (NH DHHS)** – will house the Project Management Office (PMO) for day-to-day coordination. The PMO will include a Project Director (likely a senior official at NH DHHS, full-time on RHTP), a financial manager, and initiative leads for each major area (e.g., a Lead for Workforce/Telehealth, a Lead for Hospital Transformation, etc.). We will use professional project management tools to track tasks (Attachment D5 includes a project org chart and RACI matrix delineating roles). - **Steering Committee** – meets monthly or quarterly, chaired by the NH DHHS Commissioner or her designee, and includes representatives from key stakeholders: Governor's policy office, State Office of Rural Health, hospital leaders, FQHC leaders, community reps, etc. This body will guide strategic decisions, resolve high-level issues, and ensure cross-sector alignment. - **Workgroups/Subcommittees** – we will have specialized workgroups (some already mentioned): e.g., Telehealth Workgroup (CTO/CIOs of hospitals, etc.), Workforce Workgroup (HR folks, AHEC, etc.), Payment Model Taskforce (payers, hospital CFOs, etc.), Behavioral Health Integration collaborative (CMHC and FQHC folks). These meet more frequently (bi-weekly or monthly as needed) during implementation and feed into decisions and best practice sharing. - **Local Implementation Teams** – In each region or for each major sub-project, local teams (like a hospital project team for their capital project, or a FQHC team for integrating BH) will execute on the ground. They will report progress to the PMO and highlight any needs or barriers. The PMO's job is to facilitate support (like connect them to TA, troubleshoot regulatory issues, etc.).

Monitoring & Communication: We will utilize a robust **program monitoring system** with regular reporting from sub-recipients. The PMO will collect monthly data on key process indicators (e.g., # telehealth visits, # of new recruits signed, etc.) as well as quarterly fiscal reports from subrecipients to monitor burn rate and compliance. Regular check-in calls with each sub-grantee will identify issues early. Internally, we'll maintain a risk register and

update it quarterly, with mitigation plans for each risk (for example, if staff turnover is an issue in CHW program, adjust strategy or intensify recruitment). We'll also keep CMS informed through required reports and more frequent communications if desired, given this is a cooperative agreement. The NOFO indicates that CMS may adjust funding annually based on our reporting, so we will ensure timely and comprehensive performance reports each year (and the crosswalk to scoring factors to maximize our continued funding).

In terms of communications, a **public dashboard or website** will be launched to show community members what is happening (transparency and to generate continued buy-in). This site will have a timeline of activities, success stories, and a way for the public to submit feedback.

Below is a **summary timeline table** for key milestones by year (for brevity, showing major deliverables):

Timeframe	Milestones & Deliverables
FY26 (2025-26)	- Establish project governance (Steering Committee, PMO) by Oct 2025 - Initial stakeholder kickoff summit (Nov 2025) - Execute key contracts (telehealth platform, evaluation) by Feb 2026 - Community needs workshops in all 7 rural counties (Jan–Jun 2026) - Launch pilot mobile clinic (Mar 2026) - Begin CHW training and deployment (by Jun 2026, first cohort active) - Complete baseline data collection and finalize evaluation plan (Sep 2026)
FY27 (2026-27)	- Mobile clinics fully operational (2 units on routes by Dec 2026) - Telehealth equipment installed in ≥7 hospitals (half) by Mar 2027 - Tele-psych network live in all CAH EDs nights/weekends (by Jun 2027) - 5 primary care sites with integrated BH clinicians (by Apr 2027) - 10 providers recruited under incentive program (by Sep 2027) - First annual performance report to CMS (Sep 2027) – demonstrate ramp-up progress
FY28 (2027-28)	- All initiatives at full scale: CHWs at capacity, telehealth in all 13 hospitals (by early 2028) - MAT programs running in 5 new locations (by mid 2028) - Rural hospital payment model pilot launched (Jan 2028, if regulatory approval done) - Mid-point evaluation completed (Jun 2028) – assess outcomes, adjust plan - Legislative engagement for sustainability starts (budget proposals drafted by Sep 2028)
FY29 (2028-29)	- Expand/replicate effective models: e.g., add 2 more integration sites if successful, or second hospital in payment pilot (by 2029) - Capital projects largely completed (most renovations and equipment installations done by mid-2029)

Timeframe	Milestones & Deliverables
	- Demonstrable outcomes: e.g., measured drop in hospital readmissions, etc. (mid-2029 data review) - Begin transition of certain costs to other payers (e.g., negotiate Medicaid coverage for CHW services by 2029 if possible) - Third annual report to CMS (Sep 2029) – focus on outcomes achieved and funding justification for final year
FY30 (2029-30)	- Phased hand-off of programs: State picks up critical positions in budget (by Jul 2030 all essential roles funded ongoing) - Final evaluation (outcome analysis) completed (mid 2030) with dissemination of results (conference presentations, etc.) - Wind-down RHTP grant reporting; complete all activities by Sep 2030 - Submit final closeout report to CMS (late 2030) and conduct public forum on accomplishments and next steps for rural health in NH.

(Note: The above timeline assumes immediate start in late 2025; if award announcements or funding availability shift, the timeline will adjust accordingly, compressing or extending initial activities. The plan is one-time – if we miss the Nov 2025 app deadline, we miss the program – so we are committed to this timeline.)

The timeline demonstrates an **organized, feasible schedule** that addresses the NOFO's requirement that while work plans can evolve, the overall strategy and timing should remain consistent. New Hampshire has deliberately built in some buffer time for complex pieces (like payment model pilot requiring external approvals), and will utilize technical assistance from CMS's webinars and any RHTP support (noting CMS planned informational webinars in Sept 2025 which we have attended to inform this plan).

Our team is experienced in managing large federal grants, and this timeline builds on lessons from similar projects (e.g., NH's Delivery System Reform Incentive Payment (DSRIP) program timeline in the past). We are confident we can meet or beat these milestones, ensuring timely and effective use of the RHTP funds.

B5) Stakeholder Engagement

New Hampshire recognizes that **broad stakeholder engagement** is essential for the success of this Rural Health Transformation effort. From planning through implementation and evaluation, we have and will continue to involve a wide range of stakeholders: rural residents, healthcare providers, community organizations, local government, and others. This inclusive approach not only strengthens the plan (with diverse insights) but also fosters buy-in and collaboration necessary for sustainability.

Engagement in Plan Development: As described in the needs section, the state undertook significant outreach in developing this application. In late Summer and Fall 2025, NH DHHS and the Governor's Office held multiple engagement activities: - **Regional Town Hall Meetings:** e.g., the September 2025 meeting in Littleton that convened North

Country healthcare and community leaders. Participants included hospital CEOs, clinicians, public health network reps, county officials, and citizens. Similar forums were held in the Lakes Region and Southwest NH. At these forums, state officials presented the RHTP opportunity and solicited feedback on priorities. Common themes recorded were the need for workforce support, preserving hospital services, and addressing social determinants. We incorporated these into initiative design (e.g., the workforce incentive program directly responds to pleas from hospital leaders for help recruiting staff). - **Online Public Survey:** NH DHHS launched an online survey (open Sept 15 – Oct 2, 2025) asking rural residents and providers for input. Over 300 responses were received, representing all rural counties. Key findings: 68% of respondents said access to mental health care was a top concern; 55% highlighted difficulty accessing specialty care; many personal stories were shared (like a parent traveling hours for a child's specialist or an older adult skipping meds due to cost). We've summarized these in planning documents and they influenced decisions such as including tele-specialty and vouchers for preventive services. - **Stakeholder Workgroup Meetings:** NH DHHS convened working sessions with specific stakeholder groups: one with **Critical Access Hospital administrators**, one with **FQHC and RHC leaders**, one with **EMS and first responders**, and one with **behavioral health providers**. In these meetings (Aug–Sept 2025), we discussed possible initiatives and got technical feedback on feasibility. For instance, EMS folks emphasized the need for better integration with hospitals – this led to including EMS telehealth in Initiative 4. FQHCs stressed support for care coordination roles – reinforcing CHW inclusion. - **Written Comments and Letters of Support:** The state invited major organizations to submit letters of support or recommendations. We received inputs from entities like the NH Medical Society, Bi-State Primary Care Association, the Community Behavioral Health Association, etc., which are attached in Attachment D5 (Other Supporting Materials). These letters articulate support and sometimes specific suggestions. For example, Bi-State's letter urged robust investment in dental care; while this plan focuses more on medical, we did allocate preventive vouchers that could be used for dental, and we mention dental in CHW outreach.

The result of this development engagement is a plan that stakeholders feel they have shaped. The **Governor's endorsement letter (Attachment D1)** explicitly notes that this application was crafted "the New Hampshire way – through meeting with providers and collecting feedback directly from the public".

Engagement During Implementation: We will continue meaningful stakeholder involvement through: - **Governance Structure Inclusion:** Our **Steering Committee** includes non-state stakeholders such as rural hospital CEOs, a representative of FQHCs, a rural community leader (possibly a county commissioner or similar), and a patient advocate. They will have a voice in oversight decisions. Similarly, our working groups (telehealth, workforce, etc.) are largely composed of stakeholders from those domains working in partnership with state staff. - **Community Advisory Councils:** Building on the regional approach, we will establish **Regional Rural Health Advisory Councils** in (at least) three regions of NH – North, Central/West, and South/East rural areas. These councils will consist of local stakeholders: healthcare leaders, business owners, patients, local

government reps. They will meet quarterly to hear progress updates specific to their region, discuss challenges, and advise on local adjustments. For example, if the North Country council finds that transportation remains a huge barrier, they might suggest shifting some funds to expand a volunteer driver program (which we could accommodate). These councils provide ground-truth feedback and help adapt the plan to local nuances. - **Provider Engagement and Training:** Ensuring those on the front lines are engaged will happen via regular communications and involvement in project design. Each participating provider (hospital, clinic) will identify a point person who liaises with the project team. We will hold monthly or bi-monthly **Learning Collaborative calls or webinars** for all implementation sites to share experiences (e.g., all sites doing behavioral health integration join a call to share what's working or ask questions of an expert facilitator). This peer engagement builds a community of practice among rural providers, which is an outcome in itself (breaking isolation). - **Transparency and Public Engagement:** The project's public-facing elements include the website/dashboard where we will post updates, success stories, and even raw data on performance metrics in user-friendly form. We will also host an **annual Rural Health Transformation Summit** (likely each fall starting 2026) where stakeholders gather to review progress, celebrate successes, and refine strategies. This summit will be open to the public and press, doubling as outreach and accountability. - **Patient and Community Feedback Loops:** We plan to conduct **patient satisfaction surveys** targeted at those using new services (e.g., telehealth patients, mobile clinic patients) to gauge their experience. Additionally, we might convene focus groups of community members mid-project to discuss if they feel the changes in their community (for example, ask a group of seniors if access to care improved). These qualitative inputs will be reported to the Steering Committee and influence mid-course corrections. - **Tribal or Special Populations Engagement:** New Hampshire does not have federally recognized tribes, but we will ensure to reach other special populations in rural areas, such as immigrant or refugee communities that might be present (in some rural areas there are migrant farm workers or new American communities). We'll involve organizations like the NH Minority Health Coalition as needed to tailor outreach.

Key Stakeholders and Roles: - **Rural Hospitals (CAHs)** – both beneficiaries and active implementers; they've committed via NH Hospital Association to participate and provide data. Their role: execute projects (like telehealth, new payment models) and contribute to Steering Committee. - **Primary Care Providers (RHCs, FQHCs, private practices)** – implement expanded services, integration, etc. They are engaged via Bi-State PCA and direct grant relationships. Role: offer insight on primary care needs, hire staff, and integrate programs. - **Community Mental Health Centers** – partnering to implement integration and telehealth, engaged via the Community Behavioral Health Association. - **Patients and Consumer Advocates** – represented in councils and possibly via groups like AARP NH (for older adults) or family voices for disabled; they ensure patient perspective. - **Local Government/Regional entities** – County commissioners or regional health network leaders on committees, aligning our efforts with broader regional development (for example, Coös County officials have interest in how this program helps local economy – their input ensures synergy with economic initiatives). - **State Legislators** – While not

direct “implementers,” we involve some legislators (especially from rural districts) as ex-officio stakeholders to keep them apprised. This pays off for sustainability if they see the positive results and champion support when federal funds end.

Communications Plan: We have a communications sub-plan (Attachment D5 outlines this) to keep stakeholders informed and engaged. It includes: - Monthly email newsletter to all interested stakeholders with highlights. - Press releases at major milestones (for general public awareness – e.g., announce the launch of mobile units). - Utilizing social media and possibly partnering with local media to showcase stories (success story of a life saved via tele-stroke at a CAH, etc.). - Recognizing contributions – e.g., giving shout-outs to community partners or volunteers in public forums to incentivize ongoing involvement.

Stakeholder Support and Commitments: We have formal support from all major players – letters of support in Attachment D5 demonstrate widespread buy-in. Notably: - The **Governor’s Office** is fully backing this (which means high-level convening power and alignment across state agencies). - The **Executive Council** (which in NH has to approve contracts) has been briefed; while initially some Councilors questioned hiring outside consultants, the plan now leverages internal capacity plus targeted partnerships, which has been better received. We will keep them in loop to avoid delays in contract approvals. - Provider organizations have in many cases agreed to cost-share or in-kind contributions: e.g., some hospitals might contribute staff time or cover operational costs after initial grant-funded equipment is provided; FQHCs might offer space for mobile clinic parking, etc. These commitments, though not required match, show engagement and will be documented.

In conclusion, stakeholder engagement is not a one-time box to check for New Hampshire; it is ingrained in how we operate. We believe this collective approach will drive the success of the RHTP initiatives. As Commissioner Lori Weaver said: *“We look forward to the ideas of residents, healthcare providers, and community leaders on how we can better focus on prevention and keep primary care and behavioral health care local while growing and strengthening our rural healthcare workforce.”* This philosophy underpins our ongoing engagement plan.

B6) Metrics and Evaluation Plan

A robust **metrics and evaluation plan** is in place to track progress, ensure accountability, and measure the impact of New Hampshire’s RHTP initiatives. Our plan includes clearly defined metrics aligned with each initiative’s goals, data collection methods, responsible parties, and an independent evaluation component to assess outcomes and inform course corrections. We are committed to an **outcomes-driven approach**, consistent with the RHTP’s emphasis on evidence-based, measurable interventions.

Performance Metrics: We have identified a comprehensive set of metrics across structure, process, and outcomes. Key examples include:

- **Access Metrics:**

- Number of primary care visits delivered in rural areas (total and per 1,000 population) – expecting increase due to mobile clinics and expanded hours (tracked quarterly via clinic reports).
- Telehealth utilization: Telehealth visits per month at each rural site (baseline and targets for increase).
- Specialist service availability: e.g., % of recommended specialist consults that can be done via telehealth locally (target increase).
- Mental health access: wait time for psychiatry or therapy appointments in rural clinics (target decrease, measured via provider surveys).
- Geographic access: % of rural residents with access to a primary care or urgent care within 30 minutes drive (target: maintain or improve, using mapping analysis annually).

- **Workforce Metrics:**

- Number of providers recruited/retained in rural areas through program (by type: MD, NP, etc.), tracked against targets (e.g., 20 physicians by year 5).
- Vacancy rates at rural hospitals and clinics (should decrease; we will gather this from HR data yearly).
- Retention rate of incentive program participants after 2 and 5 years.
- Training outputs: number of clinicians trained in telehealth or integrated care, number of CHWs certified, etc.

- **Service Delivery/Process Metrics:**

- Mobile clinic outputs: visits per month, services provided (e.g., 200 screenings per quarter per unit).
- CHW outreach: number of community members engaged, referrals made, follow-ups completed.
- Integration: number of patients screened for depression in primary care (should go up), number of those receiving treatment or referral.
- Tele-psych: number of tele-psych consultations done in EDs or clinics, and whether they prevented transfers.
- RPM: patient enrollment count, percentage of days patients' readings are in range, etc.
- EMS: response times in rural areas (maintain/improve), number of community paramedicine visits.

- **Outcome Metrics:**

- **Health Outcomes:** e.g., average HbA1c level among diabetic patients in CHW program (target reduction), hypertension control rate (BP <140/90) in participating clinics (target increase by X%). We'll get these from EHR data or chart sampling.

- Hospital utilization: potentially avoidable ER visits (tracked via diagnosis codes like non-emergent visits, hoping to reduce), all-cause 30-day readmission rates for rural hospitals (target reduction, indicating better care transitions).
- Preventable hospitalization rates (PQI measures for chronic conditions) in rural counties (target a measurable decrease relative to baseline and control trends).
- Mental health outcomes: patient-reported outcomes like PHQ-9 depression scores (target a certain % with >=50% improvement at 6 months in integrated care program).
- SUD outcomes: number of opioid overdose deaths in rural NH (aim to reduce), or more proximate: number of patients in sustained recovery at 1-year (tracked through recovery program data).
- Financial health outcomes: number of rural hospital closures = 0 (a critical outcome), operating margin improvements (we'll track median operating margin of CAHs, aim for positive by end). Also measure uncompensated care as a % of expenses (target stabilize or reduce as more people get early care, though that's influenced by insurance coverage).
- Patient experience: patient satisfaction scores in participating rural clinics/hospitals (we can use standardized surveys like CG-CAHPS for clinics, HCAHPS for hospitals, or custom questions; target improvement by certain points).
- Population health: depending on data available, maybe track overall life expectancy or disease prevalence in rural vs urban over time (though that's long-term, beyond 5 years likely minimal change; but we might track shorter term proxies like % of population up-to-date on preventive screenings, etc., which we expect to improve).

A table of major metrics with baselines and 5-year targets will be included in the full evaluation plan (Attachment D5 or D3). For example:

Metric	**Baseline (2025)**	**Year 3 Target**	**Year 5 Target**
Adult primary care visits per 1,000 pop (rural)	2,100 (est.) 【*Placeholder*】	2,300	2,500
% rural diabetics with A1c > 9	18% 【*Placeholder*】	15%	12%
Avoidable hosp. for CHF (rate/100k)	55 【*Placeholder*】	45	40
Telehealth visits/month (total rural)	200 (low usage now)	1,000	1,500
Mental health provider FTEs in rural NH	50 FTE 【*Placeholder*】	65 FTE	80 FTE
% of ED psych patients transferred to state hospital	30% 【*Placeholder*】	20%	15%
Average CAH operating margin	-1% (negative)	+1% (break-	+3%

Metric	Baseline (2025)	Year 3 Target	Year 5 Target
		even)	

etc…

(*Note: Baselines marked as placeholder will be finalized with actual data in Q1 of the project. Targets are preliminary and will be refined with evaluator input.*)

Data Collection and Management: - We will use a combination of **state data systems** (e.g., hospital discharge data, all-payer claims database for utilization metrics, HIE for some clinical measures), **program-specific reporting** (grant subrecipients will report data as part of their contract, like CHWs reporting outreach logs, telehealth vendors providing usage stats), and **surveys** (for patient/provider reported measures). - The evaluation team will likely build a data warehouse or use our existing DHHS data infrastructure to integrate these sources. For instance, the NH Health Information Exchange (NH Health Information Organization) might help gather EHR-based quality metrics across sites. Our team will ensure compliance with HIPAA for any patient-level data, using de-identified or aggregate data for evaluation where possible. - **Frequency:** Many process metrics will be collected monthly or quarterly for monitoring. Outcome metrics often annually (some perhaps semiannually). We will align with any CMS-required reporting frequency as well – the NOFO likely requires at least annual progress reports including both qualitative and quantitative results. - **Tools:** We will create dashboards using business intelligence software to allow near real-time tracking of some metrics by the PMO. If possible, we'll connect directly with certain data sources (e.g., our Medicaid claims system to track ED visits or hospitalizations by rural residents, updated quarterly). - We will also use **qualitative methods**: focus groups, key informant interviews, and case studies to capture context behind the numbers. These will be planned in years 3 and 5 mainly to supplement the quantitative evaluation.

Independent Evaluation: We plan to engage an **independent evaluator** (most likely an academic partner such as the University of New Hampshire's Institute for Health Policy or a third-party research firm) to conduct a formal evaluation of the program's effectiveness. We have budgeted funds specifically for evaluation activities, recognizing the scale of this program warrants rigorous assessment. The evaluator will be tasked with: - Refining the evaluation design and methodology in an Evaluation Plan (due early Year 1). - Establishing baseline measures (some retrospective analysis of pre-2026 trends will be done). - Using appropriate comparison groups where possible. While this is not a randomized intervention, the evaluator might use methods like difference-in-differences, comparing rural NH outcomes to urban NH or to similar rural areas in other states (if data allow) to attribute changes to the program. - Conducting interim evaluation (likely at end of Year 3) and a final evaluation report at end. The interim evaluation gives us time to adjust; final will inform post-2030 policy. - Addressing both process evaluation (how well implementation went, facilitators/barriers) and summative evaluation (did we achieve outcomes). - Providing recommendations for sustainability and scalability.

Scoring and Reporting Alignment: We are mindful that CMS will recalc annual workload funding based on our performance and policies. We have thus aligned some of our metrics to the **technical scoring factors** CMS outlined (like prevention initiatives, policy actions, etc. as seen in the NOFO Appendix). We will explicitly crosswalk our progress to those factors in reports. For example: - If one factor is "nutrition initiatives" worth X points, we will report on our school fitness and nutrition programs implementation. - If another factor is "strategic partnerships", we'll document the partnerships we initiated (like CAH-network integrations). - "Licensure compacts joined" is a state policy factor[6]; we will include evidence of joining such compacts by the deadline to secure those points. - This approach will not only maximize our funding each year (important for the discretionary half distribution) but also ensures our evaluation covers what CMS cares about in terms of program goals and not just our own internal goals.

Continuous Improvement: The metrics aren't just for accountability; they feed a **continuous quality improvement (CQI) process**. The PMO and Steering Committee will review performance data at least quarterly. If something is off track – e.g., mobile clinic visits are lower than expected – we ask why (maybe schedule or locations not optimal) and adjust (change routes or add community outreach for awareness). We'll employ techniques like Plan-Do-Study-Act (PDSA) cycles in sub-initiatives to test minor changes. Each workgroup will have access to relevant data to drive micro-level improvements (like the Behavioral Health group seeing referral conversion rates and brainstorming how to improve them). We have also built an early warning system: some key metrics will have threshold triggers (if below a certain level for two quarters, flag to Steering Committee) – e.g., if by end of FY27 fewer than X providers recruited, we might intensify recruitment efforts or up incentives.

Data Challenges and Mitigation: We anticipate some challenges, such as small numbers for certain measures (rural county statistics can be volatile year to year). We will use multi-year rolling averages or aggregate across regions to ensure statistical validity. Also, collecting certain outcomes (like community-level health outcomes) can be slow. Where direct measurement is delayed, we might use proxy measures (e.g., patient self-reported health status improvements). We are prepared to invest in necessary data systems (some admin funds can support better IT for data collection, like modifying our HIE or APCD feeds to easily extract rural-specific data).

We will comply with all CMS reporting requirements – likely including semi-annual or annual progress narratives and data reporting – and we'll incorporate those into our evaluation plan so as to not duplicate efforts (i.e., our internal tracking will produce the data needed for CMS reports seamlessly).

Dissemination of Results: Throughout the program, and especially at the end, we plan to share what we've learned: - Annual reports will be made public and shared with other states (NH will contribute to national learning on rural transformation). - Final evaluation findings will be presented to CMS, state policymakers, and stakeholder groups. We might publish results in a peer-reviewed journal or as a white paper in partnership with our

evaluator. - Success stories and outcome highlights will be communicated back to communities so they see the tangible benefits of the program (closing the loop on engagement).

By carefully measuring and evaluating our efforts, New Hampshire will be able to demonstrate the return on the federal investment and identify which interventions yield the best outcomes for rural health. This will not only justify continued funding (state or federal) for successful components but also provide a model for other states. The metrics we've chosen align well with the **RHTP's emphasis on outcomes and value**, positioning us strongly both for scoring and for actual health improvements.

(Placeholder: In the full application, a more detailed table of metrics, baselines, data sources, and responsible entity will be provided, as well as an appendix with the Evaluation Plan outline.)

B7) Sustainability Plan

Ensuring that the improvements and programs launched under the RHTP are **sustained beyond the 5-year funding window** is a high priority for New Hampshire. Our sustainability plan addresses how each major initiative will continue to benefit rural communities after 2030, through institutionalization into ongoing funding streams, policy changes, or self-sufficient models. As CMS and experts have noted, RHTP funds are **"a catalytic investment" not a permanent subsidy**, so from day one we are designing for durability.

Financial Sustainability Strategies: - **Incorporation into Medicaid and Insurance Payment:** We will work with NH Medicaid to **embed successful RHTP initiatives into the Medicaid program** financing. For example: - If community health workers (CHWs) prove effective in reducing costs, we will seek Medicaid State Plan Amendment or waiver to reimburse CHW services (some states use Medicaid to pay for CHWs; NH can follow suit, enabling continued funding beyond grant). - For telehealth, we'll push to maintain payment parity and coverage mandates in state law (already NH has supportive telehealth laws, we will ensure any sunset provisions are extended, etc.). The idea is that after grant, providers can bill telehealth to payers normally to sustain operations. - Integration efforts (like Collaborative Care Model) – advocate Medicaid (and commercial) to pay the psychiatric consultation codes and care management codes, providing revenue to continue those services. We might also explore value-based models where MCOs share savings for improved access. - MAT and behavioral health: ensure ongoing state opioid response grants or federal block grants can pick up some costs for peer recovery or mobile MAT if needed. - For innovative payment models (like global budgets), if our pilot is successful, we'll engage CMS (CMMI) and state legislature to continue or expand it. Possibly by 2030, a federal rural model might exist that we can join, or the state could do its own. - **State Budget Allocations:** The State of NH is prepared to assume financial responsibility for critical program elements. The Governor's Office and DHHS will begin early (by Year 3 or 4) to include in budget proposals funding for: - **Rural Provider Loan Repayment Program** –

to continue incentives. We may institutionalize this by merging with our existing State Loan Repayment Program but with a dedicated rural fund. - **Telehealth Network Operations** – after capital investment, the ongoing cost is mainly maintenance and provider time. We will consider a modest state appropriation or leveraging of FCC/USAC Rural Health Care funds to subsidize telecommunication costs. Also, hospitals themselves, seeing value, might collectively fund a telehealth hub service (perhaps through NHHA). - **Mobile Clinics** – we will have to plan for either transitioning them to FQHC ownership (so they can bill encounters to sustain) or state support. A likely route: by Year 5, if mobile clinics are FQHC-operated, they can receive cost-based reimbursement per visit. We are structuring the operations to meet FQHC look-alike requirements so that we can apply for that status or get them under an FQHC umbrella. - **Ongoing Coordination** – possibly maintain a Rural Health Transformation Office within DHHS beyond the grant to continue monitoring and supporting rural initiatives (with maybe a couple staff funded by state or other sources). - **Local and Private Sector Support:** We will engage local stakeholders (counties, towns, philanthropic organizations, businesses) to contribute. For instance, hospitals and health centers benefiting from increased volume might reinvest some of their revenue into keeping CHWs or extended hours. Some programs like the community health worker or peer recovery might find sustaining grants from foundations (we'll explore partnership with NH Charitable Foundation or Endowment for Health). Additionally, some initiatives might generate savings that can be reinvested – e.g., if avoidable ER visits drop, perhaps an insurer or ACO shares savings with providers to fund those CHWs. We will actively pursue **value-based contracts** that share savings to fund preventive positions.

Policy and Regulatory Changes for Longevity: - As part of our plan, we commit to policy actions (some already discussed like licensure compacts, CON law changes) that indirectly support sustainability by improving the environment. Some specific sustainability-focused policies: - **Rural Service Obligations:** We might propose extending the concept of a required service commitment beyond the grant's incentive. For example, work with licensing boards to create a program where new NH medical licensees are encouraged to serve in rural areas for some period – even if symbolic, it builds culture. - **Payment Policy:** If global budgets or ACOs work, we'll institutionalize them possibly via a **Section 1115 waiver** or state legislation requiring Medicaid to pay CAHs differently. We'll also coordinate with Medicare if possible (maybe by Year 5 we can convince CMS to allow a Medicare rural hospital payment model demonstration in NH). - **Certificate of Need (CON):** Should analysis show loosening CON in rural areas would help, we'll pursue legislative changes as a deliverable of our transformation (this would allow easier opening of new services, which fosters innovation and potentially more competition or access). - **Workforce Pipeline:** Encourage long-term funding for rural residency programs through federal Teaching Health Center funding or GME slots – we'll likely partner to apply for those so that beyond RHTP, the training pipeline is funded externally.

Institutional Sustainability: - **Capacity Building:** A big part of sustainability is leaving behind stronger institutions. By training local workforce and building collaborations, we expect rural providers to have greater capacity to continue initiatives. For example, once a clinic has integrated behavioral health and figured out billing for it, they can keep it going

with billing revenue. Or once hospitals have telehealth equipment and partnerships, they can maintain those relationships. - **Governance Continuation:** The stakeholder networks we form (Steering Committee, regional councils) we plan to continue in some form beyond the grant. Possibly, the State Office of Rural Health can take over convening the Rural Health Advisory group post-2030. This ensures continued collaboration and oversight on rural issues, preventing backslide. - **Documentation and Toolkits:** We will codify what works into toolkits and protocols. For instance, a telehealth implementation guide for small hospitals, or a guide on sustaining CHWs in primary care practice (with billing codes, etc.). These resources help institutionalize best practices so that even after grant technical assistance ends, the knowledge remains. We'll also standardize certain processes (like data collection and monitoring) such that providers might keep using them for internal QA after grant.

Contingency Planning: We also address the possibility that some initiatives may need adjustment or may not prove effective: - If something isn't working by mid-program and looks unsustainable, we will pivot funds to something with better outlook. For instance, if a mobile clinic route is underutilized, maybe convert that van to a mobile dental unit run by a FQHC which could then continue via billing. Or if a particular service doesn't show outcomes, reallocate resources to those that do. - We are intentionally avoiding funding any ongoing operational costs without a path to pickup. For example, direct provider salary support is limited-time. We use it to recruit with expectation that once providers are in place, their services generate revenue or other funding to keep them. Our plan to taper provider payments after year 3 ensures by year 5 they're weaned off RHTP support (or at least have a plan to be). - We'll maintain a **sustainability tracker** throughout the project – basically an evolving document listing each funded sub-program, its end of grant status (e.g., "embedding into Medicaid, needs rule change by X date, person responsible: …"). The Steering Committee will start discussing sustainability from Year 2 onward to ensure timely actions (like legislative proposals need lead time).

Leveraging Other Funding Streams: In addition to state and local sources, we will look to **other federal programs** to dovetail: - HRSA grants (like Rural Communities Opioid Response, or telehealth network grants) – we'll apply if appropriate to supplement RHTP for specific pieces and then use those to carry on aspects after RHTP. - FEMA or homeland security grants for EMS equipment (maybe offset some EMS costs in later years). - We'll also watch for any extension or follow-on of RHTP (though we assume one-time, it's possible Congress could extend if hugely successful; regardless, we plan not to count on that). - For capital, after initial infusion, hospitals can maintain through their depreciation/reserve cycles (we'll advise them to budget to replace equipment purchased via RHTP in future on their own).

Sustaining Outcomes vs. Sustaining Programs: We are cognizant that even if a specific program doesn't continue, the outcomes should. For example, if mobile clinics eventually transition patients to new brick-and-mortar clinics (if population grows), that's fine – as long as access remains. We thus focus on sustaining the **benefits**: improved access,

workforce presence, etc. The means might evolve. We'll measure outcomes after grant and if they start slipping, state can intervene with targeted support.

Commitment to No Cliff Effect: The worst scenario would be a hard stop of services in 2031. Our planning avoids that. If any critical service absolutely lacks a new funding source, NH is prepared to step in at least temporarily to avoid a gap, while a longer solution is found. But given the long lead time, we believe we can line up successors for nearly all.

Community Empowerment: Ultimately, sustainability is strongest when **the community values and owns the improvement**. By involving communities deeply (as in stakeholder engagement), we expect local advocacy to sustain changes. For instance, if a town has benefited from a mobile clinic or CHW, those residents might petition their county or nonprofit hospital to keep funding it. Building that local buy-in now (with positive experiences and demonstrated results) sets the stage for bottom-up pressure to maintain these services.

Monitoring Post-Grant: We will put in place a plan for **post-2030 monitoring** of key health indicators in rural NH (perhaps through the Office of Rural Health or a university). This ensures accountability beyond the grant – did we truly sustain and continue progress? This plan might include annual rural health reports to legislature or a permanent rural health advisory commission to track status. By institutionalizing the tracking, any backslide could prompt action from state leadership.

In summary, our sustainability plan is multi-faceted – financial, policy, community ownership. We start early to integrate and secure the future of these efforts. The Governor's endorsement letter explicitly commits the state to sustaining successful initiatives (citing the importance of lasting change, not just a "five-year fix"). The spirit of our application is to use the RHTP as **seed funding to plant trees that will keep bearing fruit** for rural health long after the federal dollars are spent. We are confident that with the foundation built by 2030, New Hampshire's rural health system will continue on a trajectory of strength and improvement, rather than reverting to the status quo.

C) Budget Narrative

Overview: New Hampshire requests a total of **\$1,000,000,000** in RHTP funding for the five-year period FY 2026–FY 2030. This section provides a detailed budget narrative, including the annual breakdown of costs, allocations by major initiative and funding category, planned subawards and contracts, and assurances of compliance with RHTP funding requirements such as caps on provider payments and administrative expenses. All amounts are rounded to the nearest \$100,000 for clarity. A detailed line-item budget and budget justification by object class is included in Attachment D5 (SF-424A and supplemental Excel budget workbook).

Budget Summary by Year (FY26–FY30):

We anticipate an initial award in late FY25 for start-up, but for budgeting we allocate the \$1B evenly over the fiscal years FY26–FY30 for planning purposes (assuming \$200M per year), with some rebalancing possible based on actual CMS funding formula outcomes (we used the high request scenario). The **annual budget distribution** is roughly:

- **FY2026:** \$150,000,000 (ramp-up year; lower as some hiring and procurement will phase in mid-year)
- **FY2027:** \$200,000,000 (full implementation)
- **FY2028:** \$220,000,000 (full implementation + increased scale of some programs)
- **FY2029:** \$220,000,000 (full implementation continued)
- **FY2030:** \$210,000,000 (slight taper as some activities wind down and other funds take over)

Total = \$1,000,000,000.

(Note: The above distribution may be adjusted once actual "baseline" vs "workload" funds are known. For instance, if NH receives exactly \$100M/year baseline plus varying bonus, we will adjust accordingly. The state will manage carryover between years as allowed, since per NOFO funds each year can be spent through the end of the next year without reverting. The budget is designed to meet the requirement that funds are obligated and used in a timely manner to achieve objectives.)

Budget by Initiative and Category: Below is a breakdown aligning with the initiatives described in Section B3, cross-referenced with RHTP categories:

- **Initiative 1: Rural Preventive Health & Primary Care – \$300M (30%)** over 5 years.
- *Major Cost Components:* Mobile clinic program (vehicles, medical equipment, operational staff) – ~\$50M; CHW workforce salaries, training, and supervision – ~\$30M; grants to clinics for expanded hours/rotations – ~\$20M; preventive services voucher fund – ~\$5M; local planning/right-sizing support (consultants, facilitation, small capital improvements for ambulatory care like outfitting a space for new clinic) – ~\$15M. Balance covers partnership programs, outreach, and overhead related to this initiative.
- *Categories:* Primarily Prevention/Chronic Disease Management. Some funds fall under "right-sizing systems" (e.g., planning and small clinic renovations). These are programmatic; minimal if any considered provider payments (payments for extended clinic hours could be seen as service payments, but we count them under program costs).

- **Initiative 2: Rural Digital Health & Workforce – \$250M (25%)** over 5 years.

- *Major Cost Components:* Telehealth and IT infrastructure – ~\$75M (equipment for hospitals and clinics, telehealth platform licensing for 5 years, broadband upgrades assistance, cybersecurity upgrades; note, any single hospital EHR replacement if needed is capped small, likely none planned due to 5% EHR cap); Remote Patient

Monitoring devices and subscriptions – ~$10M; Workforce incentive payments (loan repayment, bonuses) – ~$60M (e.g., 50 providers @ average $100k = $5M, repeated or staggered cohorts, plus some relocation funds; weighted more in early years to recruit ASAP); Training programs and technical assistance (AHEC, Project ECHO, compacts implementation) – ~$15M; Other HR development (residency rotations, internship stipends) – ~$10M. Program management and evaluation specific to workforce/tech – ~$5M. Contingency for tech refresh or additional needs – ~$15M.

- *Categories:* This covers Technology-Driven Solutions, Training/TA for tech adoption, IT capacity/cybersecurity, and Workforce recruitment/retention. We consider ~\$60M of this (the workforce incentives) as potentially "provider payments" in broad sense, but as they are tied to service commitments, CMS likely treats them as workforce expenditure. However, to be safe, we include them when tracking the 15% provider payment cap (see compliance section below).

- **Initiative 3: Rural Behavioral Health Access** – **\$200M (20%)** over 5 years.

- *Major Cost Components:* Behavioral Health Integration grants (10 sites @ ~$1M each over several years for salaries of embedded clinicians and start-up) – ~$10M; Tele-psychiatry network contract costs – ~$20M (covering 24/7 on-call psych for 5 years plus coordination); SUD/OUD program expansions – ~$25M (includes staff for MAT in clinics, mobile MAT van lease or operation, peer recovery coaches, etc. distributed across regions); School telehealth pilot and community outreach/stigma programs – ~$5M; Workforce incentives for BH providers included in Initiative 2's budget (not double counted here); Indirect support to CMHCs for increased rural capacity (small grants to hire or extend hours) – ~$5M. The largest portion is for direct service provision expansion: the balance ~$135M would subsidize new BH services delivery (e.g., offset initial losses of integrating BH until billing covers, covering uninsured care, etc.) primarily in years 2-4. This might include paying CMHCs for serving additional rural clients or providing grant funds that effectively act as provider subsidies to ensure capacity.
- *Categories:* Majority falls under Mental Health/SUD services. Some aspects (integration in primary care) could also be seen as innovative care models (collaborative care). A portion of tele-psych is technology-driven solution too. We will categorize expenditures in reports but all are allowable. We note that some funds here will be used to pay for clinical services (like tele-psych consults, MAT visits). We will include those in tracking provider payments cap, though many will be billed to insurance with RHTP covering only non-covered costs, which might not count as "payment" under the grant but rather program cost. We'll clarify with CMS on that accounting.

- **Initiative 4: Rural Hospital Transformation & Sustainability** – **\$250M (25%)** over 5 years.

- *Major Cost Components:* Capital improvement grants to rural hospitals – ~$130M (assuming average $10M for ~13 hospitals, though some might use less, some more; these cover construction, equipment, etc. possibly requiring phased draws by each hospital); EMS enhancements – ~$20M (ambulances, training, equipment); Shared services/partnership projects – ~$10M (small funds for consults, legal work to set up networks, etc. and seed money for initial operations of joint initiatives); Payment model pilot and transition support – ~$40M (this includes hiring consultants/actuary for global budget design, funding a transformation director at pilot hospital, and a reserve for performance-based payments to hospital if they hit targets – essentially simulating bonus payments under value model); Targeted operating relief payments – ~$50M (to be used very judiciously: e.g., cover OB unit costs in 2 hospitals for 3 years at ~$5M each = $30M, plus emergency subsidies for any facility in crisis. These will be contingent and might not all be used if not needed. They are budgeted to assure stakeholders we have a safety net during transformation).
- *Categories:* Innovative models of care/payment, Infrastructure investments[5], Provider payments (transitional support), Partnerships support[2]. We anticipate that **capital expenditures (~$130M)** and **transitional provider payments (~$50M)** are the two key categories requiring compliance checks. Capital spending must adhere to "minor construction/renovation" guidelines (we interpret minor as not building new entire facilities; our projects are mostly renovations/expansions of existing footprints and equipment purchase). We will coordinate with CMS grants management on any environmental/historic preservation reviews needed for these. Provider payments of ~$50M over 5 years averages 10% of total funding – below the 15% cap – but we also consider workforce incentives and possibly some BH payments in that cap, see below.

- **Program Administration & Evaluation: \$100M (10%)** reserved over 5 years.

- *Components:* Project management and admin staff salaries & benefits at NH DHHS – estimated ~$5M/year including fringe, so ~$25M total (covering project director, financial manager, data analyst, initiative coordinators, support staff, etc. – some existing staff partially allocated, plus new hires for project); Administrative expenses like office overhead, equipment, travel for monitoring rural sites, meeting costs – ~$5M over life; Comprehensive independent evaluation contract – ~$10M (assuming $2M/year average for university or contractor team to do robust evaluation and data management, including surveys, etc. This is higher than typical 1-2% but given large program, 1% of $1B is $10M, which we allocate to ensure thorough evaluation); Technical assistance contracts – ~$5M (if we need to bring in external experts from RHT Collaborative or others for specific guidance/training beyond what partners give in-kind); Contingency/Buffer – $5M (for unanticipated admin costs or possible extended reporting beyond 2030).
- This equates to exactly **10% of total funding** for "administrative" purposes, which is the maximum allowed for administrative expenses. We define administrative as

costs that do not directly fund services or infrastructure but rather manage the program (consistent with typical grant definitions). We will ensure to stay within this cap. Notably, some initiative costs (like training providers) might be considered "program" not admin; we categorize strictly to not exceed admin cap.

Compliance with Funding Caps and Requirements:

- **Provider Payment Cap (15%):** The NOFO explicitly limits using funds for provider payments for services to **15% of annual award**[1]. We interpret "provider payments" to mean direct payments for healthcare services or to subsidize providers' income that would normally come from billing (and cannot supplant insurance reimbursements). In our budget, the main items that potentially fall under this are:
- Transitional operating support to hospitals (~$50M total, allocated as needed).
- Loan repayment/incentives (~$60M, though these are arguably workforce investments, not payments for services rendered. We will seek clarification if these count toward the cap. Given they directly benefit providers financially, we conservatively will include them under the cap to be safe).
- Possibly any subsidized clinical services like paying CMHCs to see uninsured (but that might be considered program cost rather than provider payment since it's expanding access for uninsured).
- Tele-psych contract: paying psychiatrists for consults – those are provider payments too. But if they bill insurance for some, we only pay for uncovered portion. Still, to be safe, say we fund some consult time – we should count that.

We will maintain a detailed tracking of expenditures that qualify as provider payments. Summing up worst-case: $50M (hospital ops) + $60M (incentives) + maybe $20M tele-psych + a few million others = ~$130M over 5 years, which is 13% of $1B, under cap. On an annual basis, we'll time these such that any year we do not exceed 15%. For example, if a big hospital subsidy happens in FY28, we ensure other provider payments that year are limited. We have flexibility to shift timing with carryover if needed to meet cap each year (given we get funding annually).

Also, as noted in BPC summary, **we cannot use funds to supplant payments for reimbursable services**[1]. We will strictly enforce that: e.g., we won't pay a hospital for a procedure that Medicaid or Medicare would pay for. Funds only cover non-covered costs (like new services, uninsured care, or required transformation costs). Our financial manager will review subrecipient budgets to ensure no duplication of billable expenses.

- **Administrative Cap (10%):** As detailed, we budget 10% for admin. We will monitor this with the state accounting system and adjust if needed. If, say, some evaluation costs could be categorized as program (maybe quality improvement is programmatic), we will do so carefully to not inadvertently overspend on admin. But our plan is to keep pure admin at 10% or less. The majority of funds (>90%) go to direct program benefits, consistent with RHTP's intent.

- **HITECH EHR Replacement Cap (5%):** The NOFO/FAQ noted states should not spend more than 5% on replacing EHR systems. Our budget does not allocate significant funds to outright EHR replacement – we focus on upgrades. If one hospital absolutely needs a new EHR to integrate (and has no other funding), we may allow a portion, but we will stay under 5% ($50M) on any such IT overhaul costs. Given our IT budget, we expect EHR replacements to be minimal; if needed we may have them cost-share or use other funds.

- **No more than 25% to capital?** (While not explicitly stated in NOFO that we found, often grants caution not to overspend on bricks and mortar). We have ~13% ($130M) going to capital projects, which is moderate. So we comply there inherently. If CMS issues any formal cap on capital, we'll adhere (ours is well under 50%). We will also ensure any single project aligns with the "minor alteration/renovation" threshold – typically under HHS grants, if >$500k or >50% of building value might be considered major, but we believe each of our projects are relatively small (e.g., a new imaging suite, not building a brand new building).

- **Subawards and Procurements:** We plan significant subawards (to hospitals, clinics, etc.) and contracts. The state will follow federal grant regulations (45 CFR 75) and state procurement law in executing these. We will do competitive procurements for contracts (like telehealth vendor, evaluation, etc.). For subawards to known entities (like formula-based to each CAH), we'll ensure compliance by making those subrecipients subject to monitoring and single audit if applicable. Attachment D4 (Program Duplication Assessment) also addresses how funds won't duplicate other funding streams for subrecipients.

- **Budget by Object Class Highlights:**

- **Personnel:** Approximately \$20M of the admin budget is personnel for project management (state staff). Some initiative funds will also go to personnel but via subawards (counted under other categories).
- **Fringe Benefits:** Calculated at the state's average ~30% rate for DHHS staff.
- **Travel:** Included in admin for monitoring (est. \$200k/year for staff to visit rural sites and attend required CMS meetings).
- **Equipment:** Major equipment is in program budgets (mobile clinic vans, medical devices, telehealth hardware). All equipment purchases >$5,000 will be listed. We estimate equipment total ~$80M (most of which is hospital equipment under capital grants, plus vehicles, etc.).
- **Supplies:** Minor category, included within initiatives (e.g., medical supplies for mobile units, IT supplies).
- **Contractual:** A large portion falls here (evaluation contract, telehealth network contract, etc.). We will list major contracts individually. For example, Telehealth services contract \$15M, Evaluation \$10M, others like workforce TA \$2M, etc.

- **Construction:** If any minor construction like renovations is needed, we might categorize under "other" or construction. Will detail e.g., Hospital X renovation \$3M (year 2-3). We'll adhere to prior approval requirements.
- **Other:** Subawards to other agencies or organizations can be under "other" in SF-424A. We will clearly delineate subaward amounts per year (like "subgrants to providers: \$600M total across 5 years" broken by year).
- **Indirect Costs:** NH DHHS has a federally approved indirect cost rate (as per Attachment D2). However, we plan to charge minimal indirect to maximize program dollars. Possibly we will not charge any indirect on subawards, and at state level maybe just account for direct costs. If we do apply our rate (around X%), it would be within the 10% admin cap anyway. For now, budget shows direct costs; if indirect is taken, we'll reduce direct admin correspondingly to stay under 10%. (Attachment D2 provides the rate agreement reference).

- **Provider Payment vs Program Expense Clarification:** In budget, we will annotate items that count toward provider payment cap. E.g., "Hospital operational subsidy – counted as provider payment (cap 15%)". This helps track compliance each year.

Budget Narrative by Year:

- **FY2026 (\$150M):** Lower because Q1 is startup. Key expenses: project staff hiring (\$4M), initial mobile unit purchase (\$5M, 1 unit), telehealth initial procurement (\$10M equipment deployment for some sites), first wave of workforce bonuses (\$10M to sign on candidates early), ~\$20M in various subgrants kicking off (like planning grants to each region \$1M each, a few CHWs hired by mid-year, a couple integration pilots \$2M, etc.), evaluation planning \$1M, some capital design work but not much spend yet (maybe \$10M in down payments for equipment orders). Unspent baseline funds can roll to FY27 if any delayed.

- **FY2027 (\$200M):** Full programs in swing: pay for ongoing salaries (CHWs, etc.) and operations of mobile units (\$10M operations), telehealth second phase (\$20M more equipment or vendor costs as more hospitals on board, plus RPM devices rollout \$2M), more workforce incentives (\$15M as more sign on), BH programs (\$20M covering new hires at clinics and tele-psych usage fees), start of capital projects (\$30M disbursed to hospitals initiating renovations/equipment buys), hospital interim support (\$5M maybe to one that needed help by now), admin/eval \$10M, etc.

- **FY2028 (\$220M):** Likely peak capital spend (\$50M – multiple projects underway), global payment model launch support (maybe \$5M fund), continued program ops (mobile clinics fully year \$12M, CHWs \$6M, etc.), incentive and provider payments (peak year for possibly hospital support \$10M, workforce incentives still \$10M as we recruit more or retention bonuses), telehealth vendor recurring costs \$5M, evaluation ramping up data collection \$2M, etc.

- **FY2029 (\$220M):** Similar to FY28 as programs fully running. Possibly no new capital except finishing existing (maybe \$40M), shift more to sustaining operations: still have to pay CHWs, integrated care staff though by now billing covers some costs so maybe grant portion slightly reduces. Might increase transitional payment if any hospital still needs buffer (\$15M budgeted here e.g., for OB support last time). Workforce incentives taper (only retention bonuses left \$5M). Telehealth and RPM maintenance \$5-10M. Evaluation heavy this year for final analysis \$3M.

- **FY2030 (\$210M):** Tapering: Many positions ideally taken over by other funding mid-year. We keep funding through Q2-3 of 2030 then gradually transition. Still, we budget to ensure nothing falls off a cliff: e.g., cover CHWs through FY30 Q4 then Medicaid picks up following day. Some capital tail ($10M if projects finishing by early 2030), but more spending on wrapping up: final workforce payments to those finishing commitments \$5M, evaluation final activities \$3M, etc. Some funds might intentionally be left for carryover use in a no-cost extension for final evaluation or any final bills, but we plan full utilization by Sep 2030.

Provider Payment & Capital Shares: Summarizing approximate shares: - **Provider payments:** We estimate ~$130M total across 5 years as detailed (13%). Highest year maybe ~\$40M in FY28 (which is 18% if rest is 220 – we have to ensure to keep it to ~33M max if 220 total; we might schedule that $15M transitional in FY29 rather than FY28 to not break cap in any single year).

We will adjust disbursement so not >15% in any year. For instance, if baseline $100M, 15% is $15M; plus we hope for extra need-based to do up to e.g. $33M out of $220M (which is exactly 15%). So should be fine if we plan carefully.

- **Capital investments:** ~$130M (13%). Spread likely FY28 heavy. No formal cap given, but we believe 13% is justified to ensure structural improvements. Each capital dollar is tied to improved service capacity (like new equipment enabling new treatments).

- **Subawards:** We anticipate over 50% of funds will be subawards to non-state entities (hospitals, etc.). We will maintain oversight per federal regs (monitoring plans, site visits, requiring performance reports and invoices backup).

Cost Sharing/Match: Not required for RHTP (there is no state match requirement). However, our plan includes in-kind contributions: - Hospitals will contribute staff time and some matching funds on capital projects (we estimate at least $1 for every $3 of grant on average for larger projects – e.g., if we give $8M for a $10M project, hospital covers $2M). - FQHCs might contribute some administrative support for new programs out of their HRSA grants. - The state might use existing resources to cover some admin costs beyond the 10% (for example, using State Office of Rural Health HRSA grant to supplement evaluation).

These contributions aren't counted in the $1B but strengthen sustainability and commitment.

Budget Risk Management: Given the size, we plan conservative fiscal management: - Funds will be drawn from Payment Management System as needed; we'll avoid large unobligated balances. If a project is delayed, we have others to accelerate so funds keep moving. - We have a capable grants fiscal team; they'll ensure allowable cost, proper documentation. We will comply with single audit requirements and have internal audit involved for oversight due to scale. - We also have built a contingency in budgets (~5-10% in various categories) to handle cost overruns or new needs. If absolutely necessary, we can re-budget between initiatives with CMS approval (cooperative nature allows adjustments). E.g., if telehealth costs less, we can move savings to workforce or vice versa.

Line-Item Example (Year 1 for illustration):

- Personnel: Project Director @ \$150k, Financial Mgr \$100k, 3 Initiative Leads @ avg \$120k, Evaluator liaison \$80k, support staff \$60k (all with ~50% fringe) – total Y1 personnel \$600k, fringe \$300k.
- Travel: \$50k (site visits, mileage, some national conf).
- Equipment: 1 mobile clinic \$500k, telehealth units 50 kits @ \$20k each = \$1M, servers for HIE upgrades \$200k, total ~\$1.7M Y1.
- Supplies: \$100k (office, medical supplies for mobile).
- Contractual: Telehealth vendor startup \$2M, Eval contract \$1M, CHW training TA \$200k, etc.
- Other: Subgrants – Hospital planning grants 7*$500k* = *\$3.5M; FQHC extended hours grants 5*$200k = \$1M; initial workforce incentive payments (10 people @ \$50k signing) = \$500k; etc. We'd detail each subgrant program.
- Total direct Y1: ~$50M (just as an example subset).
- Indirect: if applied, ~\$100k (we might choose to waive claiming indirect to maximize direct though).

This is illustrative; actual Y1 we said \$150M because including more, like perhaps some capital drawdown for quick equipment needs or advanced purchase of second mobile unit, etc.

Narrative Justification Highlights:

- Each expense is tied to an activity described in narrative. For example, "Mobile clinic: needed to bring care to remote areas (Initiative 1), cost based on vendor quotes, will serve X encounters, etc." We justify staff as essential for oversight due to complexity. Travel for necessary on-site technical assistance and monitoring in rural communities.

- We also justify why costs are reasonable: e.g., telehealth costs based on market rates for telemedicine solutions, loan amounts align with typical loan balances, capital improvements costs align with engineering estimates from hospitals.
- No profit or fee since state is applicant; any contract with a for-profit (like telehealth vendor) will be procured competitively to ensure reasonable cost.

Budget Table by Category (5-year aggregate):

Category	RHTP Categories	Amount (5-year)	% Total	Notes
Personnel (State PMO staff)	Admin (≤10%)	\$20,000,000	2%	10 FTEs over 5 yrs, incl. fringe.
Contracts (Eval & TA)	Admin (Eval), Program (TA)	\$15,000,000	1.5%	\$10M eval, \$5M TA.
Subawards – Initiative 1 (Prevention)	Program – Prevention	\$280,000,000	28%	To clinics, orgs (mobile, CHW, etc.).
Subawards – Initiative 2 (Tech/Workforce)	Program – Tech/Workforce	\$230,000,000	23%	Equip purchases, provider incentives, etc.
Subawards – Initiative 3 (BH)	Program – BH Services	\$190,000,000	19%	Grants to clinics/CMHCs, tele-psych vendor.
Subawards – Initiative 4 (Hospitals)	Program – Infra/Models	\$240,000,000	24%	Capital grants, hospital payments.
Other Direct (Travel, supplies, etc.)	Admin/Program mix	\$15,000,000	1.5%	Travel \$2M, supplies \$3M, other minor.
Indirect (if applied)	Admin (in 10%)	\$10,000,000	1%	Will not exceed 10% total.
Total		**\$1,000,000,000**	**100%**	

(The above grouping is approximate; formal SF-424A categories might differ, but totals match. Program vs Admin split ~90/10.)

Narrative of Key Budget Considerations: - We have budgeted at a high level intentionally to accommodate fluctuations in the discretionary half of funding. If NH receives less than \$1B (e.g., only equal share \$500M), we would scale back accordingly, focusing on highest priority initiatives. Conversely, if more becomes available (unlikely beyond $1B request), we have additional projects identified. The current budget maximizes use of potential funds for transformative purposes. - The state will not use any RHTP funds for Medicaid state share or any prohibited uses (like matching other federal funds). Also, no RHTP funds

will pay for lobbying or bonuses of execs etc. Standard grant rules followed. - We will leverage existing programs: e.g., use free training resources from HHS where possible instead of spending new (cost-saving measure). - **Subrecipient Monitoring Cost:** included in admin staff duties. Possibly also outsource some financial monitoring if needed within admin budget.

Conclusion of Budget: This budget reflects a comprehensive plan to utilize \$1B to achieve the RHTP objectives in New Hampshire. It balances investment in human resources, technology, services, and infrastructure. It remains compliant with all federal requirements (provider payment cap, admin cap, etc.)[1]. The funding request is justified by the scope of needs and the ambitious initiatives proposed; each dollar is aimed at a sustainable improvement in rural health access or outcomes. New Hampshire has the financial management capacity to administer these funds responsibly, as evidenced by our prior successful management of federal grants of large size. Detailed backup for all line items is available in the appended budget worksheets and can be provided to CMS upon request.

D) Attachments

(Attachments are summarized below, with key points and any placeholder notes. Full documents are included in the application package PDF as separate sections or files. Citations are provided where content from attachments is referenced in the narrative.)

D1) Governor's Endorsement Letter (Draft, 4 pages)

Summary: A letter from Governor Kelly A. Ayotte addressed to the CMS RHTP Review Committee, expressing strong support for the application and verifying that NH's RHTP plan aligns with state health priorities. The letter highlights: - The severe impact of Medicaid cuts on rural NH and the importance of RHTP as partial relief. - The inclusive process ("New Hampshire way") used to develop the plan, with public input meetings and stakeholder engagement. - Commitment of the state to implement and sustain the plan, including coordination across agencies (Governor pledges to marshal resources of Labor, Commerce, etc., to support workforce and infrastructure efforts). - Specific initiatives the Governor is excited about: e.g., mobile health clinics, telehealth expansion, workforce incentives – tying them to stories heard from constituents (the letter references a North Country resident's testimony about needing to drive 2 hours for dialysis as impetus for mobile services). - Endorsement of required state commitment: The Governor, as the authorized official, assures that NH will adhere to all grant requirements, provide necessary state staff support, and not use funds for prohibited purposes. - Mention that the **Executive Council** has been informed and key legislators back the effort, indicating political support and likelihood of state policy facilitation (like passing licensure compact legislation in 2026 session). - The Governor's vision of success: "Healthy, thriving rural communities where no one is left behind" – reinforcing the vision and thanking CMS for the

opportunity. - The letter closes urging CMS to approve NH's ambitious proposal, noting that NH is ready to implement immediately and serve as a model for rural health transformation nationally.

(The actual letter will be signed by Governor Ayotte. Since this is a draft, final signature is pending, but the content has been agreed upon by the Governor's Office.)

D2) Indirect Cost Agreement (Reference Only)

- This attachment provides documentation of New Hampshire DHHS's Federally Negotiated Indirect Cost Rate. It includes the **rate agreement letter** from HHS (Cost Allocation Services), dated [Placeholder: date], which approves an indirect cost rate of **17.5%** of direct salaries and wages (or a simplified 10% de minimis for some sub-agencies) for the period covering FY2026.
- We reference this to affirm that any indirect costs charged will be in accordance with this agreement. In our budget, as noted, we have kept within allowed administrative caps. If any portion of the admin cost is recovered via the indirect rate, it will not exceed the 10% total admin limit.
- No action needed from CMS on this, provided for completeness. The document is included for auditors or grant officers verifying our compliance with 45 CFR Part 75 requirements on cost allocation.

D3) Business Assessment (Draft, 12 pages)

(The Business Assessment is a draft analysis conducted to ensure the financial and operational viability of the transformation plan. It was prepared by NH DHHS with assistance from consultants and will be finalized prior to award. Key sections include:)

- **Executive Summary:** Summarizes how the RHTP investments will strengthen the business model of rural healthcare in NH. It notes that while \$50B nationally won't fully offset losses, NH's plan specifically targets root causes of financial distress (like low volume and inefficient delivery) rather than just plugging fiscal holes, thus aiming for long-term solvency of providers.
- **Current State Financial Analysis:** Provides data on rural hospital financials (e.g., average operating margin, payer mix, volume trends) and clinic financial challenges (FQHC cost per visit vs reimbursement, etc.). Shows baseline that ~38% of rural hospitals have negative margins (citing Chartis data, similar to NRHA stat). Graphs of declining inpatient days, etc. This establishes the urgency.
- **Return on Investment Projections:** Presents projections that with RHTP funding, rural system can achieve cost savings and revenue enhancements:
- E.g., preventing avoidable hospitalizations saves \$X in uncompensated care; recruiting providers could bring \$Y additional revenue to local clinics (via more patient visits kept local).

- It projects that by Year 5, the interventions yield net annual savings or new revenue of about \$50M across the rural system – nearly making up for some of the Medicaid cuts at least in part through efficiency.
- There's a table showing costs vs. benefits of each initiative (e.g., Initiative 1 might reduce Medicare cost by reducing admissions, Initiative 4's payment model stabilizes revenue, etc.).
- **Hospital-specific Transformations:** Case studies or examples of two hospitals: one critical access and one larger rural hospital, detailing how RHTP-funded changes (like new outpatient service lines, telehealth adding volume, etc.) improve their financial outlook (with pro forma financial statements).
- **Risk Analysis:** Identifies potential business risks: e.g., "If volume still declines due to population loss, some hospitals may still struggle." It outlines mitigation (like right-sizing capacity, exploring hospital conversions if needed – one bullet says we might consider assisting a hospital to convert to a Rural Emergency Hospital (REH) designation if appropriate; RHTP funds could support that transition).
- **Sustainability (Financial):** Aligns with narrative B7, showing how ongoing costs will be covered by cost savings or reimbursement changes. For example, CHWs reduce ER costs – suggests Medicaid could share savings to pay for CHWs.
- **Conclusion:** Concludes that the plan is financially sound and positions rural providers for viability beyond the grant: by adopting value-based care, enhancing efficiency, and securing new revenue streams (like billing for telehealth or expanded outpatient services), the rural health system's "business health" will be improved. It notes that without RHTP, many of these changes wouldn't be possible in time to prevent closures – with RHTP, the business trajectory is realigned more favorably.

(This assessment will be updated with actual data and refined ROI estimates as implementation proceeds. It will also serve as a tool to manage and monitor that funds are used in ways that actually strengthen providers, not just temporarily inject cash.)

D4) Program Duplication Assessment (Draft, 5 pages)

Purpose: This document ensures that the RHTP plan is complementary to, and not duplicative of, other funding programs or initiatives. It lists related programs and how RHTP funds will be coordinated without overlap.

- **Medicaid DSH and UPL Programs:** Explains that while Medicaid Disproportionate Share Hospital (DSH) payments and any state supplemental payments support hospitals, those were cut by H.R.1. RHTP funds will not duplicate those (and indeed by law can't fill Medicaid funding holes directly). Instead, RHTP invests in transformation (e.g., telehealth) that DSH funds do not cover.
- **Other Federal Grants:** Inventory of relevant active grants in NH:
- HRSA's Rural Communities Opioid Response Program (RCORP) grants in Coös County – focus on opioid education and naloxone. RHTP's OUD activities will

coordinate (e.g., use RCORP for community training while RHTP funds clinical MAT expansion). No double-funding of same activity; clear delineation in contracts.

- USDA Distance Learning & Telemedicine grant (if any) – ensure if any hospitals got equipment via USDA, RHTP won't buy the same equipment, instead might fund integration or other sites.
- SAMHSA grants for mental health – e.g., NH has a Mental Health Block Grant funding some mobile crisis units. RHTP funds will build on those by focusing on integration and telehealth, not duplicating mobile crisis which is separately funded.
- CDC or Prevention grants – e.g., a Diabetes Prevention Program grant in one county. If that exists, RHTP's CHWs will coordinate but not replicate exact program.
- **State Programs:** The document notes any state-funded rural health initiatives. NH doesn't have a large state-only rural grant, but for instance:
- The NH State Loan Repayment Program (SLRP) – RHTP's workforce incentives will complement, possibly expand it; we won't use RHTP to pay for what SLRP already covers for a provider, but could add on to recruit more providers. Coordination plan: same office administers both to avoid double-dipping.
- State Opioid Response (SOR) grant (federal pass-through from SAMHSA) – funds some peer recovery and treatment access expansions. RHTP will coordinate so that, say, if SOR funds a peer coach in one region, RHTP might place coaches in other regions or focus on different aspects like telehealth MAT.
- **Private/Non-profit Initiatives:** If any notable philanthropy projects (like Endowment for Health funding a telehealth pilot), we ensure synergy. E.g., if an FQHC got a foundation grant for a behavioral health integration, RHTP might enhance that site with additional resources but not duplicate the same role.
- **Duplication Mitigation Strategies:** The assessment lays out how we'll keep an updated mapping of all funding streams at each participating site. The PMO will require subrecipients to disclose other similar funding. Subaward agreements will include language prohibiting using RHTP funds for costs already covered by another federal source (no double billing).
- **Supplant vs Supplement:** Emphasizes RHTP is used to supplement existing efforts, not supplant state or other funds. If a program is already mandated or funded, RHTP enhances or accelerates beyond baseline. For example, state law requires certain telehealth coverage but doesn't provide startup funds – RHTP provides that startup. Or existing Medicare reimbursement covers certain services; RHTP funds new services or gaps.
- **Examples:** It gives a couple of concrete examples:
- A rural hospital with an FCC grant for telehealth will use RHTP to add clinical services to use that capacity (not to buy the same equipment).
- RHTP workforce funds will not pay a provider's salary that is already paid by clinic billing; instead it pays loans or a bonus to attract them, which is distinct.

- **Conclusion:** The assessment concludes that NH's plan is well-coordinated with other efforts and fills genuine gaps. Any overlapping areas are by design additive (we'll work in concert with other programs). We will continue to review new funding opportunities and integrate them rather than duplicate (e.g., if during RHTP a new federal rural maternal health grant appears, we might adjust RHTP funds to avoid overlap if we apply for that too).

(This document will be finalized as part of pre-award negotiations, reflecting any new programs launched up to that point, to assure CMS reviewers that our funding request is tightly focused on unmet needs.)

D5) Other Supporting Materials

This section contains a compilation of supplementary documents and data in an organized manner:

- **Key Staff Resumes (Brief):** 1-2 page biographical sketches for the Project Director (Jane Doe, MPH, Rural Health Director at NH DHHS with 20 years experience), the Financial Manager (CPA with grant experience), and Initiative Leads (e.g., Telehealth Lead – former hospital CIO, etc.). These demonstrate we have the expertise to manage this large project.
- **Organizational Charts:** Diagram showing the governance and management structure described in B4/B5, with reporting lines between Steering Committee, PMO, workgroups, etc.
- **Work Plan Gantt Chart:** A visual timeline chart for major activities each quarter from Q1 2026 to Q4 2030, color-coded by initiative. Milestones (like mobile clinic launch, mid-term evaluation) are marked. This aligns with narrative timeline in B4.
- **Scoring Crosswalk Table:** (Per request to include crosswalk to scoring) A table that lists each CMS RHTP scoring factor (rural factors and technical factors as in NOFO Appendix) and references where in our application we address it. For example:
- *Factor A.1: Rural Hospitals at Risk* – NH's share is X, data in needs section B1. (Rural population, facilities, etc. are inherently given, not actions, but we list them).
- *Factor B.2: Prevention Initiatives (3.75%)* – Addressed by Initiative 1 (see B3 Initiative 1) and policy action Presidential Fitness (we commit via DOE, see B2).
- *Factor C.1: Rural provider partnerships (3.75%)* – Addressed by Initiative 4 (network collaborations).
- *Factor C.3: CON law (1.75%)* – NH commits to introduce legislation by 2027 to reform CON in ways supporting rural health (we check this box).
- *Factor D.2: Licensure compacts (1.75%)* – NH will join physician and nurse compacts in 2026 legislature (we outline in narrative B2/B3).
- *Factor E.1: Medicaid Value-based incentives (3.75%)* – We describe ACO/global budget pilot (Initiative 4).

- etc., covering all technical factors A-F from NOFO with either data or commitments. This crosswalk both helps reviewers and guides our implementation to not miss any scoring opportunities.
- **Portfolio Summary Table:** (An expanded version of the one in Project Summary or B3) possibly including each initiative, sub-initiatives, lead implementers, 5-year budget, and key outcome targets in one matrix.
- **Letters of Support:** Brief letters or statements from key organizations, for example:
- New Hampshire Hospital Association: pledging collaboration and describing how hospitals will engage.
- Bi-State Primary Care Association (representing FQHCs): supporting the plan for integration and workforce.
- Community Behavioral Health Association: supporting mental health initiatives.
- University of NH and Dartmouth: supporting workforce and evaluation partnership (some will be involved in residencies or analysis).
- AARP NH or similar representing rural consumers: supporting focus on telehealth and primary care access for seniors. Each letter typically states what the organization will contribute or how they'll participate.
- **County Rural Designation and FIPS Codes:** A table listing NH counties, their population, % rural, and FIPS codes (for CMS reference, since often applications include a list of areas served). Possibly also listing rural census tracts if needed. For example:
- Coös County – FIPS 33007 – Population X – 100% rural (no urbanized area).
- Grafton – FIPS 33009 – Pop Y – 60% rural, etc. We confirm all counties except maybe Hillsborough, Rockingham have significant rural populations that will be served. This table ensures clarity on geographic coverage.
- **Supplemental Data Charts:** Might include a map of NH highlighting healthcare facilities (CAHs, RHCs, etc.) to illustrate spread, or a chart showing the gap RHTP fills vs Medicaid cuts (maybe a bar chart of $ lost vs $ gained, echoing KFF's analysis that RHTP is ~1/3 of loss, to show need). Also possibly a figure of our theory of change logic model linking inputs to outcomes.
- **Optional**: If the RHT Collaborative provided any catalog of services, a brief summary sheet might be attached enumerating what partnerships we intend to use (but careful not to appear as endorsing vendors; we frame it as examples of solutions).

(Note: These supporting materials largely reinforce info from the narrative. They will be provided in the final application to give reviewers confidence in the thoroughness of our planning and readiness to execute.)

E) Required Forms List

New Hampshire's application package includes all required federal forms and assurances for the CMS RHTP funding opportunity. Below is a list of the forms that have been prepared and submitted as part of this application:

1. **SF-424: Application for Federal Assistance** – Completed and signed by the authorized state official. This form covers basic applicant information, budget summary, and assurances. (Included as the face pages of our application).
2. **SF-424A: Budget Information – Non-Construction Programs** – Since this program includes both non-construction and some construction elements, we have completed SF-424A for the overall budget (the majority is programmatic). Detailed budget breakdown by object class and by year is provided in this form.
3. **SF-424C: Budget Information – Construction Programs** – Provided because we have minor construction/renovation activities. We have filled out SF-424C for the subset of funds that will be used for infrastructure projects (approx. \$130M as detailed). This ensures compliance with any construction-specific requirements.
4. **SF-424B: Assurances – Non-Construction** and **SF-424D: Assurances – Construction** – These forms, signed by the authorized official, attest that New Hampshire will comply with all applicable federal laws and regulations (civil rights, environmental, labor standards, etc.) for non-construction and construction activities respectively. Both are included due to our mixed activities.
5. **Grants.gov Lobbying Form (Certification Regarding Lobbying)** – We have signed the certification that no federally appropriated funds have been or will be paid for lobbying activities, as required. If any non-federal funds are used for lobbying, we'd disclose, but none are in this project.
6. **SF-LLL: Disclosure of Lobbying Activities** – Not applicable (N/A) since the state has not engaged paid lobbyists with federal funds for this program; we submit a blank form indicating no reportable lobbying.
7. **Project Abstract Summary** – As required by the NOFO, we include a one-page project abstract (in Grants.gov template form if provided). It provides a succinct overview of the project's goal, population, and key activities, suitable for public release.
8. **Additional Program-specific forms if any:** The NOFO might require specific CMS forms or attachments (e.g., a Rural Health Plan Checklist or Key Contact form). We have reviewed NOFO instructions and included any such forms:
9. *Key Contacts Form:* Listing project director and financial official contact info.
10. *Subrecipient List or Network List:* (If CMS required listing all partnering entities, we have included a table of subrecipients/partners with name, city, and organizational type.)
11. *CMS Program Specific Certifications:* If any (e.g., certification that funds won't supplant Medicaid, etc.), we have signed letters for those.

12. **Indirect Cost Rate Agreement Documentation:** While not a "form," we include the aforementioned rate agreement (Attachment D2) as required proof for any indirect costs claimed.
13. **Letters of Commitment from Key Partners:** Again, not forms, but if the NOFO requested evidence of partner commitments, our support letters in Attachment D5 serve this purpose.

We have cross-checked the **grants.gov application package** to ensure all mandatory forms are completed. All forms have been filled out with consistent information (e.g., the SF-424 budget matches the SF-424A totals, the DUNS/UEI, etc., are correctly entered).

The State of New Hampshire acknowledges that the application must be **complete and include all forms** for consideration. A checklist was used to verify inclusion of each item required by Funding Opportunity CMS-RHT-26-001: - SF-424 (✓), SF-424A (✓), SF-424B/D (✓), SF-LLL (✓ or N/A), Project Narrative (this document), Budget Narrative (section C), and all attachments requested (✓).

All documents are assembled in order as instructed by CMS and labeled appropriately. Electronic submissions have been done via Grants.gov by the due date of November 5, 2025, 11:59 PM EDT[7], meeting the deadline requirement.

End of Application.

Sources Cited (in narrative):

- HIMSS Fact Sheet on RHTP
- NACo Summary of NOFO
- Bipartisan Policy Center analysis[1]
- Boston Globe article on NH input process
- News from the States/Daily Yonder on legislative intent
- RHIhub State Guide for NH
- RHT Collaborative document excerpts
- (Additional citations throughout as footnotes in text)

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[1] [3] [4] [6] Rural Health Transformation Program: Notice of Funding Opportunity | Bipartisan Policy Center

https://bipartisanpolicy.org/explainer/rural-health-transformation-program-notice-of-funding-opportunity/

[2] [5] Rural Health Transformation Collaborative. R1. 10-11-25.pdf

file://file-BiePJsZrbSKW21U66qC4Ta

[7] Fact Sheet: CMS Rural Health Transformation Program | HIMSS

https://www.himss.org/resources/fact-sheet-cms-rural-health-transformation-program/