



Rural Health Care Delivery Fund

Rural communities in New Mexico face persistent healthcare access challenges related to geography and provider supply; previous LFC reports, including a 2023 brief on rural healthcare, have documented poorer health outcomes in rural areas. In response, the Legislature has made significant investments to improve access to healthcare, including increasing Medicaid provider rates—reflecting Medicaid's outsized role in financing healthcare statewide—and making direct investments to support the expansion of rural healthcare through initiatives such as the rural health care delivery fund (RHCDF).

Within this context, the rural health care delivery fund was created by the Legislature in 2023 to improve access to quality healthcare in rural communities, including Medicaid beneficiaries and the broader rural population. Since its inception, the program has appropriated \$196 million to healthcare providers and facilities across New Mexico, with \$146 million committed to providers across three funding cycles. Awards have supported the establishment of new clinics and the expansion of services within existing facilities, across a wide range of provider types, including behavioral health, primary care, dental, and specialty clinics. The Legislative Finance Committee staff prepared this brief to better understand how RHCDF funds have been allocated and spent, and how program design and administration affect accountability and oversight.

Preliminary review indicates that RHCDF operates as a flexible, provider-driven funding source, with limited prescriptive direction regarding expected outcomes. While this flexibility supports local discretion, it also limits comparability across recipients and hinders statewide assessment of program performance and outcomes.

The program is not currently guided by clearly articulated state-level goals or a comprehensive analysis of statewide needs and access gaps, making it difficult to determine whether RHCDF investments are improving access to care in rural New Mexico or aligning with geographic need and broader policy priorities. Although the Health Care Authority has implemented process improvements since the program's inception, including application rubrics and scoring criteria and enhanced reporting, these changes have not been accompanied by a framework for systematically measuring and tracking provider outcomes or clearly differentiating the RHCDF's role from other state health funding streams. Establishing clear outcome measures and tracking provider performance would strengthen accountability and enable the state to differentiate between short-term capacity and longer-term progress towards sustainable access, workforce stability, and service availability in rural communities.

Key Points

- Since 2023, the Legislature has appropriated \$196 million to the RHCDF; HCA has obligated \$146 million across three funding cycles and has spent roughly \$69.4 million to date.
- Providers report spending the majority of RHCDF operating costs on staffing, which may present a sustainability risk.
- A lack of standardized outcome measures at the program level result in inconstant, noncomparable data, limiting oversight and making it difficult to assess statewide impact.
- HCA has strengthened some of its processes between funding cycles, but the program lacks unified outcome performance measures and goals.
- Administration of the RHCDF through a statewide price agreement, rather than a contract with defined deliverables, may limit oversight, accountability, and cost efficiency.

Health Notes are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.

Background

Selected LFC Reports on Rural Healthcare, Medicaid, and Health Access

- [Medicaid Accountability Report \(September 2025\)](#)
- [Legistat: Medicaid Access to Healthcare and Evidence-Based Services \(June 2025\)](#)
- [Health and Human Services Brief: Medicaid Physical Health and Behavioral Health Workforce \(June 2024\)](#)
- [Rural Healthcare in New Mexico Hearing Brief \(August 2023\)](#)
- [Program Evaluation: Medicaid Network Adequacy, Access, and Utilization \(December 2022\)](#)

Rural communities across New Mexico face persistent health access challenges driven by geography, population demographics, constrained provider supply, and uneven reimbursement and accountability systems. Compared with urban areas, rural residents experience poorer health outcomes and greater barriers to care, including higher rates of chronic disease, mental health conditions, and substance use disorders, as well as lower life expectancy and more limited maternal and child health outcomes. These patterns have been documented in a 2023 LFC brief on rural healthcare brief and the 2022 program evaluation on Medicaid access. These challenges are compounded by older population profiles, long travel distances to care, and reduced or absent local services in many communities, including hospital-based, maternity, and behavioral health services.

Federal health professional shortage area (HPSA) designations underscore the concentration of healthcare workforce shortages in rural New Mexico. According to the Health Resources and Services Administration, the counties designated as geographic or high-needs geographic HPSAs are overwhelmingly rural, even as access challenges persist across both urban and rural communities statewide. For primary care, eight counties are currently designated as geographic or high-needs geographic HPSAs, all of which are classified as rural; an additional 11 counties are proposed for withdrawal from geographic designation, 10 of which are rural and one of which is partially rural. Similar patterns appear across other service areas. Three counties are designated for dental care and 13 for mental healthcare; 14 of these 15 are rural and one is partially rural. While nearly every county in the state—including Bernalillo, Santa Fe and others with urban areas—has HPSA designations for specific subpopulations, particularly low-income populations, these designations indicate that when healthcare shortages rise to the level of affecting entire communities, rural areas may be particularly vulnerable.

Table 1. “Designated” Geographic or High-Needs Geographic Health Professional Shortage Area

Primary Care	Harding, Lea, Mora, Catron, Hidalgo, Quay, Sierra, Torrance
Dental Care	Catron, Sierra, Torrance
Mental Care	Torrance, Cibola, Colfax, DeBaca, Guadalupe, Mora, Roosevelt, Taos, Union

Note: 32 of 33 counties contain multiple HPSA designations for different population subgroups or facilities; these are merely geographic designations.

Source: Health Resources and Services Administration

While rural and frontier populations include both Medicaid and non-Medicaid residents, Medicaid's large enrollment share and role as an outsized payer shape access conditions across much of New Mexico. Medicaid currently covers nearly 38 percent of New Mexicans—down from roughly 50 percent at the peak of pandemic-era continuous coverage—and continues to influence provider capacity and service availability statewide. Although this report is not an evaluation of Medicaid, persistent provider shortages, limited service availability, and gaps in managed care organization (MCO) reporting continue to hinder effective service delivery for many residents, particularly in rural and frontier counties. Within this context, the Legislature has invested in a range of access-focused strategies, including provider loan repayment and other workforce incentives, as well as more than \$2.2 billion across funds to increase Medicaid provider reimbursement rates and support startup costs for new or expanded services. According to LFC's *Medicaid Accountability Report*, reimbursement rates for primary care, behavioral health, and maternal and child health providers increased to between 120 percent and 150 percent of Medicare rates in FY25, including approximately \$90 million in behavioral health rate increases approved over the past three years. Despite these investments, access constraints persist, particularly in behavioral health, where provider attrition and limited appointment availability continue to constrain timely access.

The rural health care delivery fund (RHCDF) was created by the Legislature to further improve access to quality healthcare, specifically in rural communities.

In 2023, the Legislature created the Rural Health Care Delivery Act. This legislation created the rural health care delivery fund as a nonreverting fund in the state treasury. Per statute, the Human Services Department, now the Health Care Authority (HCA), is designated to administer the fund and oversee the appropriation of funds consistent with the act's statutory requirements.

RHCDF awards are designed to provide support for private for-profit, private nonprofit, and public rural healthcare facilities providing new or expanded healthcare services in counties with fewer than 100 thousand residents. More specifically, the RHCDF was established to offset operating losses incurred by rural providers expanding or initiating new services in designated rural counties. Per statute, grant funding must be used to defray operating losses—including staffing, legal fees, depreciation of equipment, and startup costs not including construction or purchase of facilities—incurred in providing inpatient, outpatient, primary, specialty, or behavioral healthcare services to New Mexicans.

Eligible applicants for grant funding include rural healthcare providers and facilities that are licensed by the state of New Mexico and are qualified Medicaid providers. As a condition of receiving funding, the providers must commit to actively serving Medicaid recipients throughout the duration of the grant period.

While the RHCDF statute identifies broad program goals, such as considering local need and prioritizing sustainability, it does not specify uniform outcome measures or reporting standards to evaluate the program's effectiveness. This means that specific improvements in outcomes or services against which to measure progress are not defined at the statutory level.

RHCDF awards were disbursed into three, multi-year funding cycles; the first two accepted applications from a broad range of service providers, while the third funding cycle focused funding eligibility and limited applications to primary care services. With the creation of the RHCDF, the Legislature appropriated \$80 million to be distributed by HCA starting in FY 24. (General Appropriation Act of 2023). In fall 2023, HCA issued a request for applications from eligible rural healthcare providers and facilities for the first funding cycle. A total of 50 providers were selected to receive funding, with 11 of those providers receiving funding early. This funding cycle runs from January 1, 2024, through June 30, 2026.

In 2024, the Legislature appropriated an additional \$46 million to the RHCDF. (General Appropriation Act of 2024). With this money, HCA established a second funding cycle. Twenty-nine providers received funding from the second funding cycle, which runs from January 1, 2025, through June 30, 2027.

In 2025, the Legislature made a third appropriation to the RHCDF of \$20 million (General Appropriation Act of 2025). Grant awards for this latest funding cycle were finalized in December 2025, and the governor announced that 31 rural healthcare providers will receive funding to expand primary care services.

“Operating losses” means the projected difference between recognized revenue and allowable costs for a grant request period.

Source: § 24A-1-17(E), NMSA 1978.

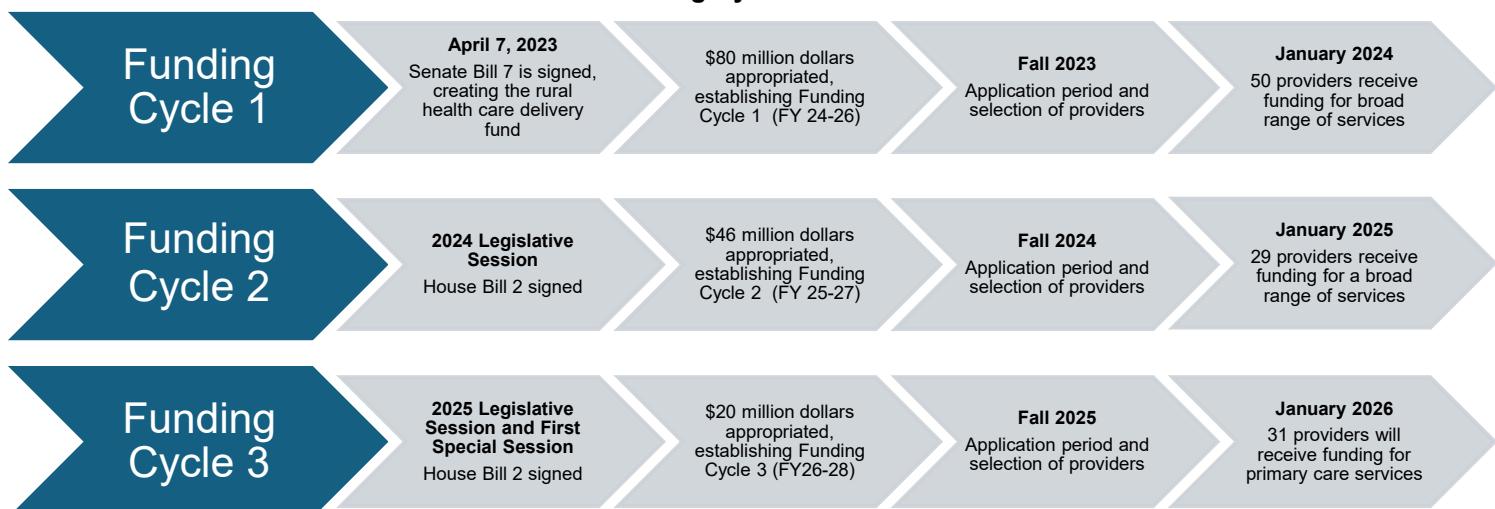
Table 2. RHCDF Funds Obligated by HCA to Date

Funding Cycle	Contract Period	Amount Appropriated
1	FY 24-26 1/1/24 – 6/30/26	\$80M
2	FY 25-27 1/1/25 – 6/30/27	\$46M
3	FY 26-28 Funding Begins 1/1/26	\$20M
Total Obligated Funds:		\$146M

Source: HB 2 (2023), (2024) and (2025)

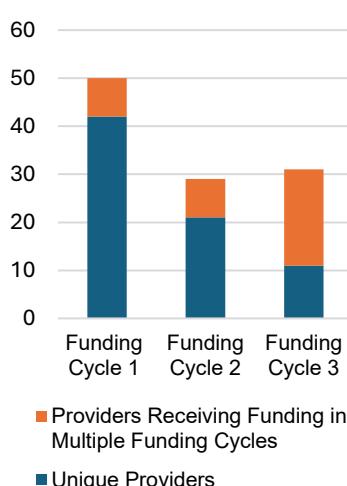
Additionally, during the first special session in 2025, the Legislature expanded the use and eligibility of funds and appropriated an additional \$50 million from the general fund to the RHCDF. The legislative action authorized the use of grant funds to stabilize the provision of existing healthcare services when those services are at risk of reduction or termination, whereas previously RHCDF funds were limited to providing startup costs and defraying operating losses. The bill also expands the definition of a rural healthcare facility and provider to include those in high-needs geographic health professional shortage areas as designated by the U.S. Health Resources and Services Administration. As stated above, the law previously limited funding eligibility to providers located in counties with fewer than 100 thousand people. [Laws 2025 (1st Special Session)].

Figure 1. Rural Health Care Delivery Fund Funding Cycle Timeline



Source: LFC Analysis

Chart 1. Number of Providers by Funding Cycle



Allocation of Rural Health Care Delivery Fund Grants

To date, the Legislature has appropriated \$196 million to the RHCDF, of which HCA has allocated \$146 million across approximately 112 contracts; as of fall 2025, \$69.4 million has been disbursed (see Appendix A). These contracts include some providers receiving funding in more than one funding cycle. Funding has been distributed across a wide range of eligible counties and provider types, with provider-reported encounters and hires occurring throughout the state, largely outside the five most populous counties. Grant awards have primarily supported behavioral health, primary care, and maternal and child health services, with a smaller share supporting specialty care providers. Grant recipients report plans to use the largest share of their funding for staffing, In FY25, the bulk of grant funding supported recurring costs, with 59 percent going toward anticipated staffing salaries, followed by equipment and office space.

Source: LFC analysis of HCA Data

RHCDF grants have largely funded Medicaid- and insurance-reimbursable services—primarily behavioral health (37 providers), primary care (17), and maternal and child health (9)—indicating the fund is supporting services providers will ultimately need to sustain through other revenue sources once grant funding ends. Early awards span a broad mix of provider types, with behavioral health representing the largest share of funding: 37 awards totaling \$47 million. The most common billable behavioral health services include therapy (individual, group, and family), psychiatric evaluations, and medication management, delivered primarily through outpatient and intensive outpatient (IOP) models and increasingly via telehealth. Substance use disorder treatment—including medication assisted treatment/ medication for opioid use disorder counseling, detoxification, and recovery supports—also features prominently, alongside pediatric and developmental services, such as autism diagnostics, applied behavioral analysis therapy, and early childhood mental healthcare. Many providers additionally bill for care coordination, crisis response, and peer or family support services.

Primary care was the next most common category, with 17 providers receiving more than \$25 million in funding, although this share may increase given that the most recent application cycle (fall 2025) focused primarily on primary care expansion. Reported primary care encounters largely reflect routine and preventive services, including adult and pediatric visits, wellness and well-child exams, immunizations, and chronic disease management. Providers also report integrated services, such as behavioral health and substance use disorder treatment, dental care, diabetes education, and community health worker-led care coordination, delivered across clinic, mobile, urgent care, and extended-hours settings. Maternal and child health (10 providers receiving \$13 million) and specialty care (six providers receiving \$11 million) round out the remaining major service categories.

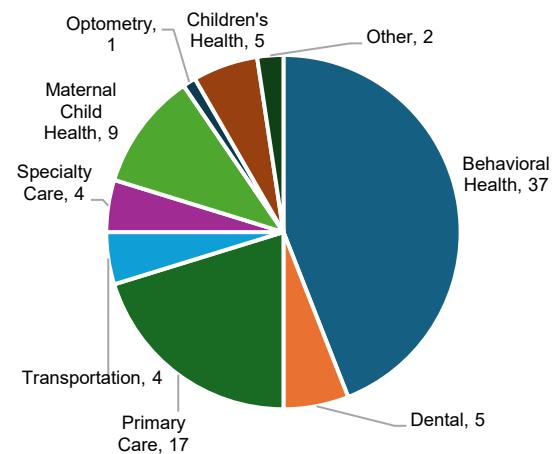
Table 3. Top 10 Providers by Overall RHCDF Award Amount

Provider	Patient Encounters	Primary county served	Funding
Roswell Surgery Center	Ambulatory surgical procedures, anesthesia encounters, related post-operative care visits	Chaves, Eddy, Lea, Lincoln, Roosevelt, De Baca, Otero, Guadalupe	\$7,461,277
Picuris Pueblo	Primary care, dental, behavioral health, and emergency transport	Taos	\$4,975,903
Covenant Hobbs Hospital	Prenatal visits, OB/GYN, deliveries, post-partum follow-ups	Lea	\$4,496,434
Jumpstart	Telehealth autism evaluations, ASD screenings, ABA referrals, autism specialty provider encounters	Otero, Lincoln, Carlsbad, Eddy, Lea, and Chaves	\$4,101,400
Meridian Behavioral Health Inc	Therapy sessions, group sessions, CCSS encounters, IOP visits, and behavioral health support encounters for justice-involved individuals	Valencia, Cibola, Torrance, San Miguel	\$3,881,733
The Psychiatric Care Center	Adult behavioral health services, psychiatric evaluations, medication management, coordinated care	Roosevelt	\$3,401,905
New Mexico Premier Health	Adult and geriatric primary care, preventive screenings, vaccinations, chronic disease follow-up	Valencia	\$3,296,709
Justice Access Support & Solutions for Health	MOUD visits, therapy sessions, psychiatric evaluations, and addiction treatment encounters for justice-involved patients	Valencia	\$2,667,694
Cañoncito Band of Navajos Health Center	Medical visits, dental encounters, behavioral health sessions, pharmacy consultations, and nursing care encounters	Bernalillo, Cibola, Sandoval (Tribal Lands)	\$2,542,135
Breath of My Heart Birthplace	Prenatal visits, home visits, maternity classes, deliveries, and postpartum follow-up visits	Taos, Los Alamos, Rio Arriba	\$2,500,000

Note: Funding amount as of October 9, 2025. Most providers report delivering services to multiple, surrounding counties.

Source: Health Care Authority, Provider Contracts, and SHARE Voucher Review

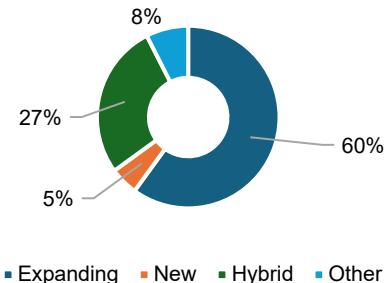
Chart 2. RHCDF Providers by Service Type



Note: other includes providers conducting mobile health visits, home modifications, accessibility evaluations, and other various services.

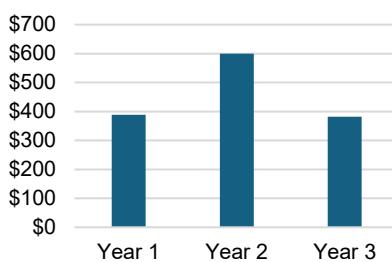
Source: Health Care Authority

Chart 3. Distribution of RHCDF Recipients Providing Expanded vs. New Services FY24-26 and FY25-27



Note: "Other" represents the recipient providers that lacked contract data in SHARE.
Source: LFC analysis of SHARE Data

Chart 4. RHCDF Average Provider Disbursement by Fiscal Year in the First Funding Cycle (in thousands)



Note: Year 1 is typically 6 months, beginning halfway through the fiscal year in January

Source: LFC analysis of HCA Data

Nearly 90 percent of rural health care delivery fund recipients used the money to expand existing services, with only five percent of providers establishing brand new facilities and services.

Analysis of contracts for recipients of RHCDF money across the first two funding cycles (FY24-26 and FY25-27) shows the majority of recipient providers elected to expand existing services. With 60 percent expanding services and 27 percent establishing services within existing facilities (hybrid), only 5 percent of providers used RHCDF money to create brand new facilities. The use of RHCDF awards to scale proven providers may be more sustainable in the long term and may reduce implementation risk of facility closure.

Spending trends among providers suggest contracts front load costs and vary widely in how funds are used. The RHCDF was designed to offset operating losses for rural providers that are expanding or initiating new services, including covering the cost of startup needs, such as planning, credentialing, equipment, and legal or accounting services. These costs are often front-loaded by design, as capital, equipment, and infrastructure investments are typically prerequisites for initiating service delivery. Across the first two funding cycles, provider funding was structured to ramp up and then decline over time: On average, providers were contracted for \$389 thousand (31 percent) in year one (a half fiscal year), \$600 thousand (46 percent) in year two, and \$382 thousand (23 percent) in year three. Funding trajectories varied considerably, however; three providers were contracted for more than 95 percent of their total funding in the first year, while 11 providers were contracted for between 1 percent and 10 percent of funding in year one as services gradually ramped up. Two providers from the first cycle also ended the program early, an encouraging move, because their revenues surpassed expenses.

Because statute requires funded services to be sustainable, these divergent funding structures highlight the importance of understanding when operating losses are most acute and whether award structures align with provider startup, stabilization, and long-term capacity needs. Examining funding trajectories alongside staffing, service delivery, and expenditure patterns may help clarify risks related to sustainability, funding cliffs, and uneven service scaling across providers.

Providers anticipate spending the largest share of RHCDF operating costs on staffing, at 59 percent, though this varies widely, suggesting the importance of distinguishing startup staffing from ongoing operational costs. A review of mid-cycle provider invoices (FY25) shows staffing as the largest cost driver, averaging 59 percent of new or expanded operating expenses. This proportion varied considerably—with four providers spending under 20 percent and 10 spending over 80 percent—potentially reflecting differences in reporting, staffing models, the types of services being added, or whether funding supported ongoing operations versus new clinical capacity. Staffing represents an appropriate and often necessary startup cost, particularly during initial hiring and service ramp-up; however, long-term sustainability depends on providers’ ability to transition staffing costs to billable revenue once services are operational. Reconciliation and reporting data provided to LFC did not consistently verify revenue sources or distinguish between startup staffing and ongoing operational staffing, limiting HCA’s ability to assess whether funded positions are likely to be sustained after RHCDF support ends. While provider flexibility makes some variation appropriate, improved visibility into how staffing costs evolve would help HCA assess sustainability and inform future funding decisions.

Outside of staff expenditures, providers most commonly spent funds on equipment and office space, followed by smaller categories, such as IT, furniture, insurance, repairs, and non-reimbursed services (unpaid or unbilled patient care). Some providers also invested in strategies aimed at strengthening service sustainability: 14 engaged in community outreach totaling \$511 thousand during this one year and seven used recruitment tools totaling \$282 thousand. These patterns are consistent with expected startup phases; however, the lack of detail in invoices, provider quarterly reports, and reconciliation data make it difficult to verify these costs. Given state investment within these initial funding cycles, clearer documentation and more precise categorization of expenditures would help ensure the fund is supporting long-term, sustainable improvements in rural access to care.

Table 4: Sample Provider Receipts to Illustrate Major Reported Expense Types in FY25:
(in thousands)

Provider 1:	
\$203	Payroll wages and taxes; positions not specified
\$20	13 individuals with out-of-state addresses (TX/OK); HCA indicated these costs may reflect recruitment activity, though documentation provided to LFC did not specify the purpose.
\$9.5	Phillips Ultrasound Machines – 3-month rent
\$6.6	Additional Medical Equipment: ECG, Echo, Vital Monitors
\$13	Rent, Utilities, Rent, Travel, IT
Provider 2:	
\$81	Healthcare consulting firms in Illinois and Washington
\$13	Exam Tables
\$281	Patterson Dental Supplies: line item details included
\$127	LLCs registered to three different individuals for consulting; services not specified
\$77	Medical Supplies from McKesson Medical Supplies
\$11	Lynx Security Systems
\$22	Other, including window covers, treadmill, sweatshirts, etc.
Provider 3	
\$241	Staff
\$66	Facilities upgrade (electric, plumbing)
\$60	Zoning compliance upgrade
\$26	Contract Services (Pharmacist, Scripts, Lactation Consultant, and Staff Assistant)

Note: 3 sample providers for whom LFC received receipts and reconciliation documentation

Source: LFC Analysis of HCA Data

Chart 5. Average Yearly Expenses for New or Expanded Services, FY25



Note: Includes first funding cycle providers with complete Q4 invoice payment breakdowns in SHARE: 41 providers, for a total of \$47 million and \$1.2 million in average expenditures

Source: LFC Analysis of Provider Invoices

Encounters are documented interactions between a patient and a qualified healthcare provider for the purpose of delivering a covered health service.

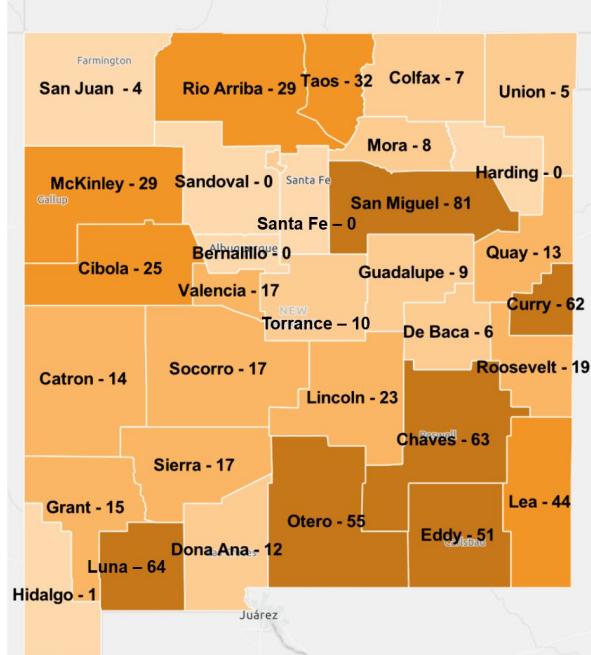
Source: Centers for Medicaid and Medicare Services (CMS)

Providers, funding, and reported encounters are distributed across much of the state, with the highest reported volumes concentrated in parts of southeastern and northwestern New Mexico. As defined in statute, eligible providers were originally rural healthcare facilities operating in counties with fewer than 100 thousand residents and seeking to provide new or expanded services in those areas. Legislation enacted during the 2025 first special session expanded geographic eligibility to include providers in high-need geographic health professional shortage areas, allowing additional counties to qualify and extending the program's scope to include stabilization of providers at risk of reduction or closure. Because encounter definitions and reporting practices vary by provider and reported data is not independently verified, reported encounters and hires should be interpreted as indicative of activity and geographic presence rather than as standardized or comprehensive measures of utilization or access.

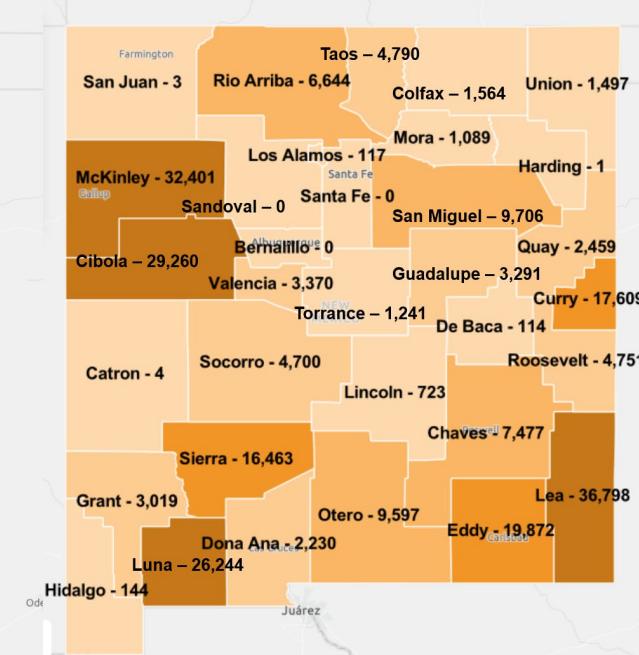
Reported encounters were distributed across a wide range of rural counties, with the highest volumes in the southeastern and northwestern regions of the state. Lea County reported the highest number of encounters (approximately 36 thousand), followed by McKinley (32 thousand), Cibola, Eddy, and Curry counties. All rural counties reported at least some new encounters, though a small number—such as Harding and Catron counties—reported very low volumes, all within behavioral health services. Reported hires showed a similar geographic pattern, with concentrations in southeastern counties and parts of the northwest, as well as a comparatively high number of hires in San Miguel County. While HCA reports considering geographic shortages and access challenges when reviewing RHCDF applications—including by combining Medicaid Service Area Gap data from the state's managed care organizations—available data does not indicate whether funding decisions are systematically aligned with areas of greatest provider shortages or unmet need, nor whether the program proactively targets specific geographies to address clearly defined access gaps.

Figure 2. Self-Reported New Encounters and New Hires by County

Hires (270,781)



Encounters (770)



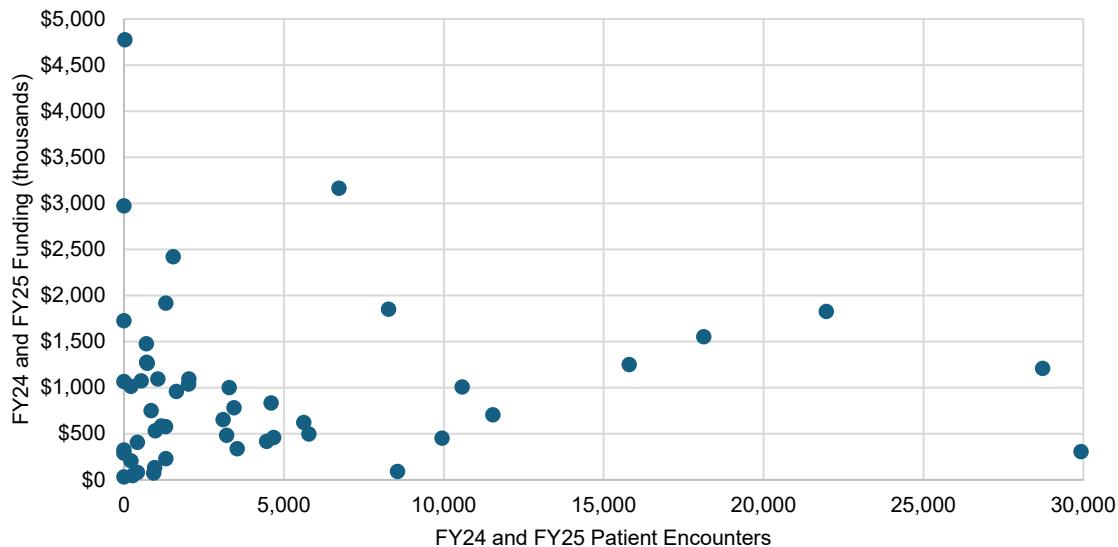
Note: As of Fall 2025. Totals include tribal exemption areas as well, and Dona Ana and San Juan include exemption areas.

Source: HCA Data

According to self-reported provider data, RHCDF grants have supported 270 thousand encounters since 2024, though funding levels do not yet appear correlated with increased encounters. At the end of each quarter, providers submit self-reported data documenting the number of encounters, individuals served, and hires attributed to RHCDF support. Providers reported roughly 75 thousand new encounters in FY24 and 195 thousand in FY25, totaling approximately 270 thousand new encounters over the first two years of the program. While this information provides useful descriptive insight, it is self-reported through an online form without standardized definitions for encounters or clear guidance on what should be counted. LFC is unable to independently verify these figures, and some reporting discrepancies—for example, one small behavioral-health clinic reports more than 150 hires, which HCA identified as a clerical error—suggest that reporting categories may be interpreted inconsistently or entered inaccurately.

Analysis of these data for the first funding cycle (FY24–FY26) shows no statistically significant or meaningful relationship between award size and the number of new encounters reported. This lack of correlation may be expected for several types of projects. Many of the largest funding recipients during this cycle are establishing entirely new services and, therefore, have minimal or no encounters during construction and early implementation phases; additionally, comparison across service types may be misleading as some services generate higher encounter volumes due to intensity, length-of-stay, and overhead. Still, a connection between funding and reported encounters or outcomes warrants attention, especially for contracts that do not consistently specify service initiation timelines. Going forward, tracking which projects generate comparatively high numbers of new encounters per dollar invested may help identify strategies that most effectively expand access to care, though any interpretation should continue to account for the self-reported nature of the underlying data and the lack of standardized reporting requirements.

Chart 6. RHCDF Award Funding vs. Reported Patient Encounters, FY24 and FY25



Note: Only providers for the first funding cycle are included

Source: LFC analysis of HCA Data

Performance Measures and Outcome Tracking

Table 5. Example of Variation in RHCDF Contract Goals FY 24 Q3 and Q4

Provider A	Provider B
Goal 1: Increase the capacity and reach of oral health care providers in the service area by hiring and sustaining dental staff. Project Director is in place and ready to start by March 31, 2024.	Goal 1: Expand accessibility <ul style="list-style-type: none"> a. Broaden telehealth services b. Open clinic full time, Monday through Friday c. Offer licensed therapists services d. Providing medication assisted-treatment to a larger geographic area e. Community engagement & awareness
Goal 2: Recruit and staff oral healthcare services	Goal 2: Therapy <ul style="list-style-type: none"> a. Individual therapy b. Group therapy c. Family therapy d. Cognitive behavioral therapy (CBT) e. Trauma informed care
	Provider C
	Goal 1: Initial Set-Up <ul style="list-style-type: none"> a. Hire a manager b. Find a location c. Set up location, furniture, and equipment d. Hire rest of staff e. Go live f. Advertisement Goal 2: Evaluation for hiring new Provider and support staff <ul style="list-style-type: none"> a. Evaluation b. New hires
	Provider D
	Goal 1: Hire clinicians Hire CSW Receptionist Goal 2: Set up hubs Recruitment Relationships

Note: These goals were the first two goals listed in the sample Providers' applications. The goals were adopted verbatim into the Providers' contracted workplans. Each of these providers received more than \$1 million dollars in the first funding cycle.

Source: Provider Contracts (SHARE Data)

The RHCDF is intended to support and stabilize healthcare delivery in rural and underserved communities across New Mexico by expanding access to services and promoting sustainable healthcare infrastructure. The RHCDF supports highly diverse projects with varying clinical focus, service models, and populations served. HCA is responsible for administering and overseeing the fund, including monitoring provider performance, measuring outcomes, and ensuring compliance with RHCDF requirements. In this oversight role, HCA is tasked with evaluating whether funded investments are achieving their intended goals and contributing to sustainable and improved access to care statewide. However, under the current structure, providers largely propose their own goals and then self-report their progress to HCA during quarterly reconciliations. HCA utilizes corrective action plans when providers are not meeting their goals or reporting requirements, but these plans do not clearly identify the underlying issues or specify the performance goals to be achieved. While it is inherently difficult to standardize programmatic goals given the diverse and individualized nature of the projects, without them, it is difficult to determine if the program is making a measurable impact on rural healthcare access.

Self-reported provider performance measures do not adequately measure the impact of the rural health care delivery fund, and HCA lacks overall program goals. Available documentation indicates that outcome reporting varies substantially across funding recipients and program types, which limits HCA's ability to assess overall program effectiveness. Although HCA requires grant recipients to submit quarterly progress reports through online reporting platforms (such as SurveyMonkey and Submittable), the agency does not consistently aggregate, analyze, or independently verify provider-reported data to evaluate performance across recipients or identify statewide trends.

In addition, HCA has not established standardized, program-level outcome measures related to access to care, service utilization, patient waiting times, workforce retention, or population-level health outcomes. Instead, grant recipients propose their own outcomes and performance goals in their applications, which vary widely in scope, specificity, and rigor. While this approach provides flexibility to providers, it results in inconsistent and noncomparable data that does not support comprehensive analysis. As a result, HCA has limited ability to monitor progress toward program goals and assess whether RHCDF investments are improving access to care or health outcomes statewide. In turn, it is difficult for the Legislature to evaluate the impact of its investments in the RHCDF.

When providers fail to meet the goals identified in their contracted workplans, HCA may place them on corrective action plans. The reviewed corrective action plans establish requirements and penalties; however, they do not clearly identify the underlying issue or issues that prompted the plans or specify the performance goals to be achieved. HCA reports it is developing a tiered system to track provider performance and progress across recipients, but the system has not yet

been implemented. However, without consistent performance metrics or validated data, these measures might not effectively address underlying performance issues. Until a framework is operational, performance monitoring will continue to rely largely on unverified, provider-defined and project-specific self-reported data. Moving forward, the Legislature should consider amending the statute to require HCA to set clear performance metrics and regularly report progress toward targeted goals back to the Legislature.

Across providers, the most frequently cited project goals focused on expanding access or service capacity (approximately 28 percent of goal statements), followed by equipment or facility investments (23 percent) and workforce recruitment or training (21 percent). Across reviewed providers, project goals consistently emphasize expanding service capacity, addressing workforce constraints, and investing in infrastructure necessary to deliver care in rural and underserved communities. Of all articulated project goals, under one-third focused on increasing access or service capacity, including opening new service lines, expanding hours, adding clinic locations, or increasing encounter volume. Nearly a quarter of goals related to equipment, facilities, or technology investments, reflecting the role of RHCDF funding in supporting one-time or startup costs that are difficult to finance through traditional reimbursement. Approximately one-fifth of all goal statements centered on workforce recruitment, training, or retention, underscoring persistent challenges in hiring and sustaining clinical and support staff across rural New Mexico.

When examined at the provider level, nearly half of providers identified equipment or facility investments as a core component of their project, while more than 40 percent explicitly referenced expanding access or service capacity, and roughly 38 percent cited workforce-related goals. Fewer providers articulated stand-alone goals related to quality measurement, operational workflow improvements, outreach, or long-term financial sustainability. While many access, workforce, and infrastructure investments may ultimately support quality improvement, the distribution of stated goals suggests that providers are primarily using RHCDF funding to address immediate structural and capacity constraints—such as staffing shortages, limited physical space, or missing equipment. These categorizations reflect the types of goals identified in provider proposals and do not capture the relative magnitude, duration, or intensity of effort devoted to each goal area, which are discussed separately in the descriptive statistics and funding analyses.

Systematic measurement and tracking of provider outcomes can help the state assess whether these investments are aligning with broader policy priorities, geographic need, and intended access improvements over time. Clear outcome measures also support accountability and learning by enabling the state to distinguish between short-term capacity stabilization and longer-term progress toward sustainable access, workforce stability, and service availability in rural communities.

The agency should adopt short-, mid- and long-term outcomes to ensure the RHCDF drives measurable, sustainable impact. The short-term outcomes focus on immediate capacity building by expanding patient access, strengthening workforce retention, extending service ability, and implementing telehealth solutions. Midterm outcomes emphasize improvements in care delivery and population health, including increased preventive service utilization, reduced

Table 6. Provider Quarterly Goals

Share of goal statements by theme	
Access / capacity / opening or expanding services	28.4%
Equipment / facilities / technology	23.3%
Workforce (hire/recruit/train/credential)	20.8%
Quality / outcomes / metrics /ER reduction	5.5%
Outreach / Marketing / Community Education	4.2%
Sustainability / Financial Independence	1.7%
Care Coordination/ navigation	0.4%
Other / uncategorized	13.1%
Share of providers that mention each theme	
Equipment / facilities	46.8%
Access / capacity	42.6%
Workforce	38.3%
Quality / data	12.8%
Operations / workflow	6.4%
Outreach	6.4%
Sustainability	6.4%
Care coordination	2.1%

Note: many goals naturally overlap (e.g. increased workforce to enhance quality or access); this chart attempts to categorize broad, articulated goal purposes.

Source: LFC Analysis of HCA Data

appointment waiting times, and higher provider retention rates. Long-term outcomes are designed to advance health equity and system sustainability by reducing disparities suffered by rural communities, improving chronic disease control, and managing a stable workforce. Together, these outcomes provide a clear, phased framework for accountability, continuous improvement and long-lasting benefits for rural populations.

Table 7. Provider Quarterly Report Revenue Responses

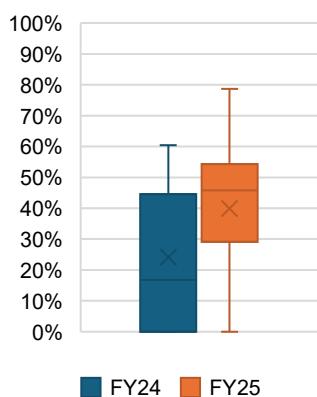
"Did you reach your expected revenue this quarter?"	
Below	51%
Met	34%
Exceeded	6%
N/A	9%
Are you "on track in terms of expected operational expenses..."	
Within	83%
Above	8%
Under	8%

Note: Sample size is 237 for question 1, and 132 for question 2 (not asked each quarter)

Source: LFC analysis of HCA Data

Beginning in FY25, quarterly provider reports show revenue below projected levels in 51 percent of cases for RHCDF-supported services. Quarterly provider reports beginning in FY25 indicate that revenue generation for RHCDF-supported services frequently falls short of expectations. Across 237 quarterly observations, providers reported revenue below projected levels in 51 percent of cases: 34 percent met expectations, 6 percent exceeded expectations, and 9 percent reported no expected revenue. While most quarterly reports showed providers operating within their overall budgets in a given quarter (83 percent), these patterns suggest that revenue generation—rather than cost overruns—is a primary source of operating losses exceeding initial projections. Early revenue alone is not a reliable indicator of long-term sustainability. Startup factors such as recruitment and credentialing processes may impact revenue projections and timelines. However, because quarterly revenue reporting is tied to provider expectations for supported services and likely reflects billed activity, these data raise early concerns about whether funded services are progressing toward financial sustainability.

Chart 7. Percent of Operating Costs Covered by Revenue



Note: the box represents the 25th–75th percentile range, the center line marks the median, the "X" indicates the mean, and whiskers show the non-outlier range.

Source: LFC analysis and SHARE Data

Invoice-level data from the first funding cycle provides additional context but limit definitive conclusions. For providers with complete financial data in FY24 and FY25, provider-reported revenue covered an average of 32 percent of operating costs for new or expanded services, implying that RHCDF grants covered the remaining 68 percent of reported costs. However, provider invoices classify these amounts as “revenue (non-billed item),” indicating they reflect grants, subsidies, internal transfers, or other non-patient revenue rather than billed clinical services. As a result, invoice-level revenue figures do not reliably demonstrate progress toward self-sustaining operations based on patient utilization.

A review of fourth-quarter payment breakdowns—generally the most complete prior to reconciliation—shows that non-billed revenue covered 24 percent of operating costs in FY24 and 39 percent in FY25, corresponding to RHCDF grant support covering roughly 76 percent and 61 percent of costs, respectively. While this shift may reflect changes in revenue composition as services ramp up, it does not demonstrate increased reliance on billed services. In addition, a subset of providers reported no revenue through the end of their second fiscal year, which may be reasonable for early-stage services but further limits the ability to assess long-term financial viability. Taken together, these data suggest, while the RHCDF appropriately offsets early operating losses, current reporting does not allow HCA to reliably determine whether supported services are on a sustainable trajectory or remain dependent on ongoing grant support.

Application and Administration Processes

HCA administers RHCDF grants through an application process that has evolved across three funding cycles. While early applications and materials indicate limited standardization in HCA’s evaluation methods, HCA subsequently revised application requirements and introduced more structured scoring criteria for the

second and third funding cycles. These changes reflect an effort to improve consistency and transparency in the application process. The quarterly financial reconciliation process data reviewed by LFC staff, however, did not clearly or consistently substantiate the recipient providers' operating losses. Overall, the process appears to be driven by provider flexibility as opposed to an agency or statewide strategy.

Award decisions in the first funding cycle did not rely on a standardized scoring rubric or formal point-based evaluation process. HCA provided the LFC with a narrative description of the application evaluation process and 60 of the 186 applications submitted during the first funding cycle. These application packets were to include providers' organizational charts, workplans, budgets, letters of support, and audited financial statements. Where information was provided, applications varied greatly in the level of specificity related to the proposed activities, timelines, and outcomes. After eliminating applicants who were not eligible for RHCDF funding and whittling down the remaining applications, HCA worked with final applicants to define their budget and clarify their goals during the contracting period. As a result, during this initial cycle, it appears that recipients were afforded substantial discretion in identifying proposed services and defining costs.

Although the FY24-26 funding cycle application process lacked standardized rubrics for determining awards, HCA has since established and refined scoring criteria and application processes for RHCDF grants.

Application requirements introduced in July 2025 before the second funding cycle applications are more prescriptive and require expanded narrative responses, clearer budget documentation, and more structured explanations of proposed activities. HCA established a rubric for the second and third funding cycles. The associated rubric outlines multiple evaluation categories, including sustainability (16 percent of points), relevance and alignment (13 percent), budget and financial Justification (13 percent), and service gap area considerations (3 percent). Developing this rubric represents a positive step toward increased structure and transparency in the application process, the standards or statewide goals guiding the criteria remain unclear. HCA reports considering geographic shortages and access challenges when reviewing applications but should also consider proactively setting goals and outcomes to ensure funding is targeted based on those identified needs and gaps. While it is too early to assess how consistently these criteria are applied or whether they materially affect funding decisions, the introduction of more explicit requirements and evaluation categories represents a step toward greater structure and transparency in the application process.

RHCDF awards appear to operate as capped grants, with reconciliation practices that do not consistently substantiate actual operating losses.

Statute frames RHCDF funding as a mechanism to offset documented operating losses associated with initiating or expanding rural health services—including startup and ramp-up costs—and, therefore, requires rural healthcare providers to submit adequate cost data verifiable by qualified auditors and requires HCA to reconcile grant amounts to audited operating losses. Nearly two-thirds of providers from the first funding cycle received the maximum contracted amounts for multiple years, indicating either operating losses worse than anticipated or inadequate reconciliation.

Review of reconciliation data for a sample of three providers indicates that, in practice, providers received the full amount stipulated in their contracts for

Table 8. RHCDF Application Rubric for Second Funding Cycle (FY25-27)

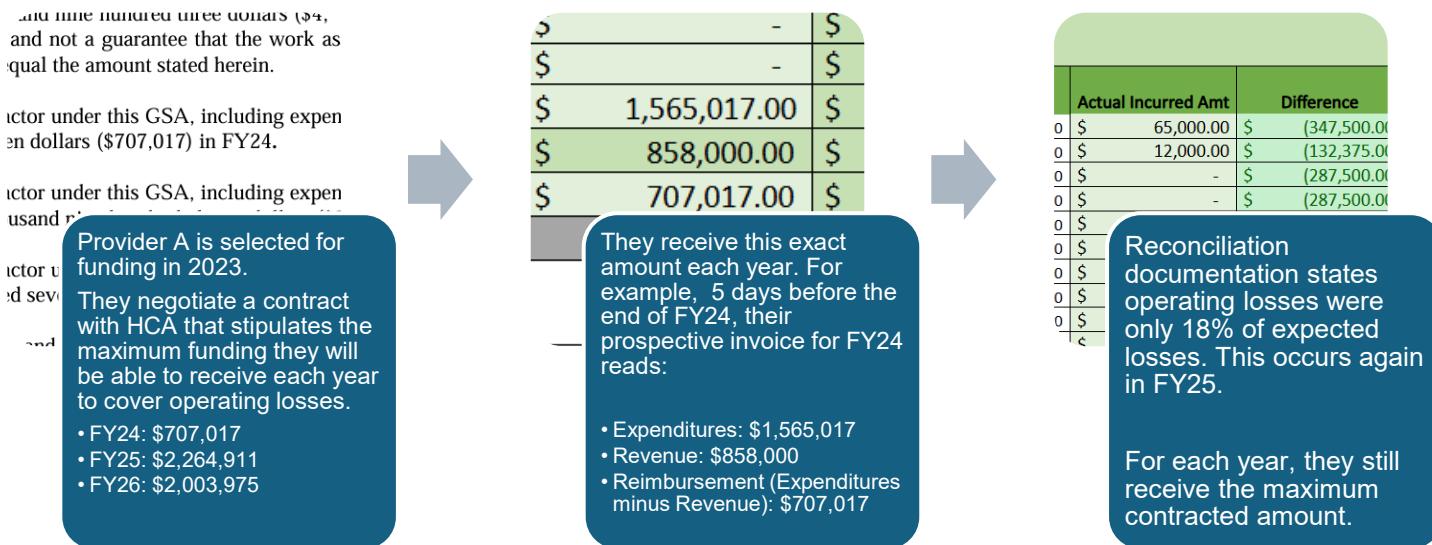
Scoring Type	Potential Points
Relevance and Alignment	20
Project Design and Methodology	25
Community Impact	20
Capacity and Expertise	10
Budget and Financial Justification	20
Sustainability	25
Special Populations Served	Up to 15
Service Gap Area Considerations	5
Total Potential Points	160

Source: HCA

different reasons. In one case, reported operating losses exceeded the contractual award amount, effectively capping reimbursement rather than reflecting a precise reconciliation to the losses incurred. In a second case, reported expenses fell below the annual award amount, but unspent funds were rolled forward into a subsequent contract year, resulting in receipt of the same total funding over time. In the third case, reconciliation data did not substantiate operating losses; however, invoices submitted through the state’s online purchasing platform indicate the provider continued to receive the maximum amount stipulated in its contract.

However, reconciliation documentation reviewed by LFC staff did not consistently demonstrate that reported expenditures and revenues were supported by complete or internally consistent financial records. Across reviewed providers and fiscal years, reconciliation forms frequently showed large discrepancies between prospective estimates—even when submitted near the end of a fiscal year—and reported actuals, including significant reductions in reported expenditures, elimination of previously anticipated revenues, or reporting of zero revenue despite documented service activity. Where documentation was submitted, it often consisted primarily of high-level or vague consulting expenses, sometimes involving out-of-state entities, with limited evidence linking costs to measurable progress or service delivery. Timing issues—such as prospective, estimated submissions made near the end of a fiscal year or reporting period but still materially different from eventual reconciled amounts—further limited the reliability of reconciliation data.

Figure 3. Illustration of How RHCDF Contract Amounts Shape Reported Expenditures/Revenues



Source: LFC Analysis of SHARE Contracts, Invoices

In November 2025, HCA issued a request for proposals to procure independent audit services for the RHCDF, as required by statute. The request for proposals (RFP) contemplates a phased approach that includes upfront audit-readiness and advisory support, financial and compliance audits of funding recipients at the conclusion of their contract periods, and the capacity to conduct targeted forensic audits when warranted. Under the proposed scope, the selected auditor would assess the allowability of expenditures under the Rural Health Care Delivery Act, review internal controls and documentation, evaluate reported revenues and service delivery, and reconcile RHCDF funding with audited

operating losses, while also providing actionable recommendations to both HCA and providers. Importantly, the RFP also emphasizes standard-setting, training, and improvements to reporting systems to ensure records are audit-ready and comparable across recipients. While variability in provider reporting practices remains a consideration, the initiation of a formal, independent audit framework represents a constructive step toward enhancing accountability, transparency, and confidence in the administration and outcomes of RHCDF-funded projects as the program matures.

Third-party administration of the rural health care delivery fund costs \$697 thousand annually. Administration of RHCDF has been largely outsourced to a third-party vendor, TEK Systems, contracted through a statewide price agreement for information technology services. Although the statewide price agreement includes a business consulting services category focused on providing specialized expertise for process analysis, organizational improvement, and performance enhancement, its scope appears oriented toward discrete advisory engagements rather than ongoing, multi-year program management. Vendor invoices indicate responsibilities that now include application review, daily meetings with grantees, regular office hours with providers, review of invoices and supporting documentation, and facilitation of webinars and other technical-assistance activities.

TEK Systems invoices show substantial variation in consultant staffing levels month to month, ranging from two to five consultants depending on project needs, with hourly rates between \$80 and \$160. In some instances, multiple contract staff experienced mid-month hourly rate increases of approximately 25 to 50 percent, contributing to cost volatility. As a result, the program's administrative costs are considerable. While the vendor's average monthly fee has been approximately \$57.7 thousand since they began in July 2024, the two most recent months with complete invoice data show significantly higher payments of \$100 thousand and \$89 thousand.

Since the first funding cycle, provider reporting has improved, and expanded administrative support may be contributing to these gains. However, because key program operations, data management, and provider interactions are now heavily concentrated within a third-party contractor operating under an IT-focused price agreement, HCA may have limited visibility into program risks, implementation challenges, and emerging trends. An open procurement process with an RFP designed specifically for oversight of the RHCDF with explicit contract deliverables, especially because recipients will be receiving funding for several more years, could offer cost management and oversight. HCA should consider building more transparent and explicit deliverables specifically tailored to the program into the contract.

Context and Moving Forward

Separate from the state-funded RHCDF, the federal Rural Health Transformation Program (RHTP) is a five-year, \$50 billion initiative focused on promoting innovation, strategic partnerships, infrastructure development, and workforce investment to support rural healthcare access, quality, and outcomes. The RHTP was authorized under the federal budget reconciliation bill, or H.R. 1. It will distribute \$10 billion annually from 2026 through 2030, with \$25 billion of those payments to be distributed equally across states with an approved RHTP plan and the remaining \$25 billion to be distributed to states at the discretion of CMS. The

Table 9. Monthly Vendor Payments to Manage RHCDF

July 2024	\$55,504
August 2024	\$55,504
September 2024	\$51,373
October 2024	\$62,445
November 2024	\$55,651
December 2024	\$50,155
January 2025	\$57,469
February 2025	\$54,007
March 2025	\$52,622
April 2025	\$44,746
May 2025	\$41,717
June 2025	\$37,735
July 2025	\$100,443
August 2025	\$89,111

Source: SHARE

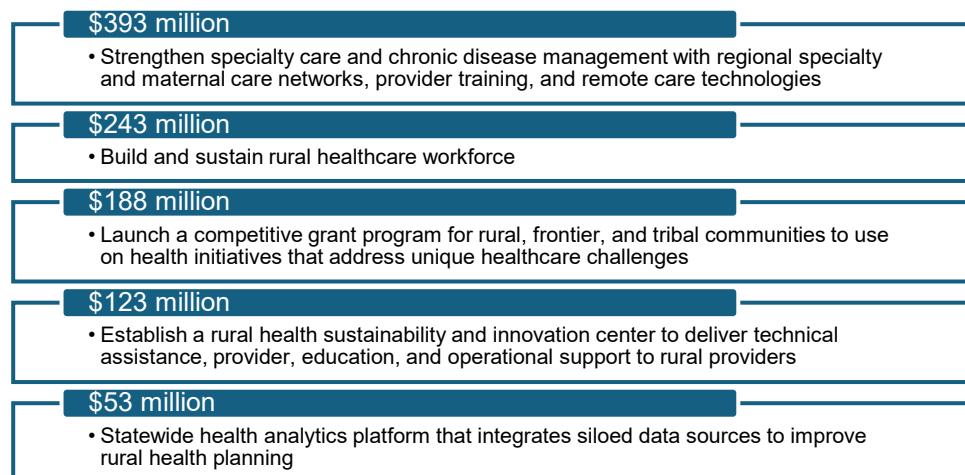
In December 2025, CMS announced New Mexico will receive \$211 million from the federal Rural Health Transformation Program in 2026.

Source: Center for Medicare and Medicaid Services

application was open from September 15 through November 5, 2025. On November 5, 2025, the Centers for Medicare and Medicaid Services (CMS) announced that all 50 states submitted applications for their share of the \$50 billion Rural Health Transformation Program.

On December 29, 2025, CMS announced that New Mexico will receive just over \$211 million from the RHTP to fund rural health programs in 2026. In 2026, all 50 states will receive the first of five years of RHTP awards. First-year awards ranged from \$147 million to \$281 million. New Mexico will receive the 13th largest award at \$211.5 million, above the national average award of \$200 million. With the announcement of the 2026 awards, federal administration officials indicate they will recoup funds if states fail to meet certain criteria or do not carry out pledged actions. Funding is based on federal appropriations, program performance, and compliance with federal reporting and accountability requirements. To facilitate RHTP implementation, CMS is dedicating project officers to each state to provide ongoing guidance and technical assistance. HCA reports this first-year award will permit New Mexico to start all five of the initiatives outlined in its program application.

Figure 4. New Mexico's RHTP Proposed Funding Initiatives



Note: These amounts were requested in New Mexico's RHTP Application, which asked for \$1 billion over five years.

Source: New Mexico's Rural Health Transformation Program Application (HCA)

Federal RHTP funds carry statutory and administrative restrictions that explicitly prohibit states from using the funds to supplant existing state or local funding, limiting allowable uses and constraining program flexibility. Federal guidance generally restricts RHTP expenditures to time-limited transformation activities rather than ongoing clinical operations or the permanent expansion of services. Funds cannot supplant existing state or local funding, support routine Medicaid reimbursement, or cover capital construction unrelated to transformation objectives. In their applications for RHTP funding, states were required to include a “program duplication assessment” that verified they would not use RHTP funds to replace or duplicate existing funding sources. These restrictions require states to align their proposed activities with clearly defined transformation goals and measurable milestones and limit the state’s ability to use funding to address immediate operational shortfalls or sustain services once federal support expires. As a result, to stay in bounds of the federal restrictions,

New Mexico will have to strategically appropriate any funding awarded in new, sustainable ways that support longer-term systems.

HCA states that RHTP funding will not be duplicative of RHCDF funding but instead “will build off of the success of RHCDF”. The program duplication assessment in New Mexico’s RHTP application acknowledges the state currently makes several investments in rural health. HCA identified existing programs that leverage state and local funding and that may overlap with the federal RHTP funding. Notably, the RHCDF is listed as one of these existing programs. To prevent duplication of funding between RHTP and RHCDF (and other existing funding streams), HCA asserts that it will adhere to the best practices and customary activities identified in Table 10. HCA states that RHTP funding will “build off of the success of the RHCDF with an alternative focus on nonmedical drivers of health, behavioral health, preventive care, and minor provider facility enhancements.” The award of RHTP funding could support the sustainability of the work accomplished by the RHCDF.

Therefore, with this award, it is important HCA carefully monitor the state RHCDF and the federal RHTP’s funding streams to ensure compliance with federal reporting requirements and restrictions on allowable uses for funding.

Table 10. HCA-Identified Strategies to Prevent Duplication of Funding

Establish clear funding parameters and guardrails for RHT funded programs
Effectively communicate funding guidance to partners, vendors, and subrecipients
Establish centralized application or funding determination processes
Coordinate review processes across departments and agencies
Communicate award decisions and document approved expenses clearly
Make technical assistance available to preemptively address potential duplications
Monitor implementation and establish detailed reporting processes
Review and escalate potential duplications for potential recoupment
Annually report to the New Mexico Legislative Finance Committee
Regularly identify newly established funding streams to incorporate into the procedure

Source: New Mexico’s Rural Health Transformation Program Application (HCA)

Recommendations

The Health Care Authority should:

- Establish statewide performance goals for the rural health care delivery fund;
- Establish standardized reporting definitions and processes for grantees;
- Establish processes and procedures to verify accuracy of provider-reported data;
- Collect and analyze program data in the aggregate to determine the program's strengths, challenges, and identify state-wide trends;
- Issue a request for proposals to third-party vendors who can assist with Rural Health Care Delivery Fund Program oversight and administration via a contract with deliverables;
- Implement other best practices, including the use of deliverable-based contracts rather than hourly consulting arrangements, to ensure clearer expectations, stronger oversight, and better value for the administration of public funds; and
- Carefully monitor the state's rural health care delivery fund and the federal Rural Health Transformation Program funding streams to ensure compliance with federal restrictions on allowable uses for funding.

The Legislature should:

- Consider amending the statute to require HCA to set clear performance metrics and regularly report progress toward targeted goals back to the Legislature.

Appendix A – RHCDf Recipients for Funding Cycles 1 and 2

RHCDf Recipient	Funding Cycle	Amount Requested	Amount Awarded	Type of Service	Counties Served
Affirming Heart Victim Services	1	\$87,600.00	\$81,114.00	Behavioral Health	Eddy and Lea
Aspire Healthcare	1	\$2,025,900.00	\$1,241,800.00	Pediatric Cardiology	Chaves, Eddy, and Luna
BCA Medical Associates	1	\$94,095.00	\$86,510.00	Infant Jaundice Testing	Chaves, Eddy, and Luna
Ben Archer Health Center	1	\$1,899,387.00	\$706,538.00	Dental Services	Sierra, Otero, and Luna
Breath of My Heart Birthplace	1	\$1,662,375.00	\$2,500,000.00	Midwifery	Taos, Los Alamos, and Rio Arriba
Building Bridges Counseling Services LLC	1	N/A	\$200,161.10	Intensive Outpatient Program for Youth	Lea and Eddy
Carlsbad LifeHouse, Inc.	1	\$1,750,837.00	\$1,653,564.16	Behavioral Health Mobile Crisis Team	Eddy and Lea
Casa de Salud	1	\$1,478,213.00	\$2,478,212.50	Primary Care and Behavioral Health	Valencia and Socorro
CHRISTUS Health, Southern NM	1	N/A	\$957,839.25	Behavioral Health	Otero
Christus St. Vincent	1	N/A	\$1,148,596.01	Primary Care, Obstetrics, Behavioral Health, Oncology, and Orthopedics	Mora, Guadalupe, and Harding
Cibola Family Health Center	1	\$922,410.00	\$651,550.00	Community Health Workers	Cibola and McKinley
Coronado Care Center, LLC	1	\$2,089,072.00	\$2,061,381.10	Behavioral Health	Roosevelt
Covenant Health	1	N/A	\$4,496,434.23	Maternal Child Health	Lea
De Baca Family Practice Clinic	1	\$32,040.00	\$32,040.00	Dental Services	De Baca and Guadalupe
El Centro Family Health (Espanola)	1	\$1,681,710.00	\$1,300,000.00	Dental Services	Rio Arriba
El Centro Family Health (Penasco)	1	N/A	\$864,829.00	Dental Services	Taos
Elite Primary Care	1	\$1,286,730.00	\$854,700.00	Behavioral Health	Sierra, Socorro, Grant, Catron, Otero, Lincoln, Eddy, and Luna
Family Medicine Associates	1	\$55,364.00	\$26,730.71	Ultrasound Services	McKinley
First Nations Community HealthSource	1	\$213,300.00	\$240,000.00	Mobile Health Services	McKinley and Rio Arriba
Frontera Health	1	N/A	\$1,250,000.00	Behavioral Health	28 rural counties
Gallup Community Health	1	N/A	\$1,209,978.31	Primary Care	McKinley
GD Psych Services, LLC	1	N/A	\$550,553.00	Behavioral Health	Valencia
Greeg Family Healthcare	1	N/A	\$435,389.32	Primary Care	Luna, Otero, and Hidalgo
Guidance Center of Lea County	1	\$1,947,551.00	\$1,986,295.00	Behavioral and Physical Health	Lea
Heart & Soul of NM, Inc.	1	\$42,089.00	\$46,766.00	Substance Abuse Intensive Outpatient Program	Valencia
Hospital Services Corporation & American Medical Response	1	\$1,869,848.00	\$1,869,850.00	Emergency Behavioral Health Transportation	28 rural counties
JumpStart, LLC	1	\$4,128,871.00	\$4,101,400.00	Autism Services	Otero, Lincoln, Carlsbad, Eddy, Lea, and Chaves
Krossroads Integrative Health and Recovery Solutions, Inc.	1	\$1,227,648.00	\$2,432,651.51	Behavioral Health and Substance Use Services	Colfax, Union, San Miguel, Mora, Guadalupe, Taos, and Harding

La Casa Family Health Center (La Casa de Buena Salud)	1	\$702,190.00	\$583,383.00	Optometry	Roosevelt and Curry
Laguna Healthcare Corporation	1	N/A	\$1,097,512.50	Primary Care	Cibola and tribal communities
Las Cruces Primary Care, LLC	1	\$2,685,600.00	\$1,279,250.00	Primary Care	Otero
Las Cumbres Community Services	1	\$931,632.00	\$701,162.83	Behavioral Health	Rio Arriba and Taos
Mental Health Resources, Inc.	1	\$214,843.00	\$290,282.69	Behavioral Health	De Baca, Harding, Quay, Roosevelt, and Curry
Meridian Behavioral Health Inc.	1	\$481,824.00	\$407,760.00	Behavioral Health	Cibola, Lea, and Guadalupe
Mimbres Memorial Hospital	1	\$614,408.00	\$486,305.00	Obstetrics, Gynecology, Surgical, Labor and Delivery, Nursing Home, Emergency, and ICU	Luna and Hidalgo
New Mexico Premier Health, LLC	1	\$570,871.00	\$992,069.63	Geriatric Health	Valencia
Nor-Lea Hospital District	1	\$2,239,559.00	\$1,866,000.00	Behavioral Health	Lea
Nurstead Consulting Services, LLC	1	N/A	\$417,350.00	Behavioral Health	Curry and Roosevelt
Picuris Pueblo	1	\$4,975,903.00	\$4,975,903.00	Primary Care, Behavioral Health, Dental, and Emergency Transportation	Taos
Pinnacle Gastroenterology	1	\$1,118,259.00	\$979,900.00	Gastroenterology	Otero and Lincoln
Presbyterian Medical Services	1	\$844,859.00	\$838,779.00	Community Health Workers	McKinley, Cibola, Luna, Otero, Torrance, and Quay
Renew Health	1	\$1,232,733.00	\$1,041,324.28	Behavioral Health	Chaves
Rio Grande ATP, Inc.	1	N/A	\$600,000.00	Behavioral Health	Taos
Roswell Surgery Center LLC	1	\$5,612,419.00	\$7,461,276.71	Ambulatory Surgery Center	Chaves, Eddy, Lea, Lincoln, Roosevelt, De Baca, Otero, Curry and Guadalupe
Southwest Counseling Center (Border Area Mental Health Services)	1	\$738,351.00	\$614,825.00	Behavioral Health	Grant, Luna, and Hidalgo
Southwest Pediatric and Family Care, LLC	1	\$21,247.00	\$837,089.85	Behavioral Health	Luna and Hidalgo
Sunrise Clinics	1	N/A	\$1,114,095.52	Pediatric Care	Colfax, Harding, Torrance, Taos, Guadalupe, Quay, and Mora
Telepsych 4 You, LLC	1	N/A	\$951,450.00	Behavioral Health	11 rural counties
The Learning Path, LLC	1	N/A	\$1,881,570.00	Behavioral Health	Socorro, Sierra, and Catron
The Psychiatric Care Center, LLC	1	N/A	\$3,401,905.00	Behavioral Health	Roosevelt, Curry, De Baca, Lea, and Quay
Three Suns Birth	1	\$157,040.00	\$337,000.00	Obstetrics, Gynecology, and Women's Health	Curry, Roosevelt, Lincoln, and Eddy
Behavior Change Institute	2	\$1,003,966.00	\$999,936.78	Behavioral Health	Chaves, Lea, Los Alamos, McKinley, Otero, Curry, Eddy, Lincoln, Luna, Catron, Cibola, Colfax, De Baca, Grant, Guadalupe, Harding, Hidalgo, Mora, Quay, Rio Arriba, Roosevelt, San Miguel, Sierra, Socorro, Taos, Torrance, Union, Valencia, and San Juan
Border Area Mental Health Services, Inc. dba Southwest Counseling Center	2	\$967,814.00	\$967,712.00	Behavioral Health	Grant, Hidalgo, Luna, and Dona Ana

Canoncito Band of Navajos Health Center (To'Hajiilee Navajo Chapter)	2	\$2,300,000.00	\$2,542,135.29	Primary Care	Bernalillo, Cibola, and Sandoval (Tribal Lands)
Changing Women Initiative	2	\$1,019,250.00	\$998,970.00	Maternal Child Health	McKinkley, Cibola, Bernalillo, Santa Fe, Sandoval (Tribal Lands)
Families and Youth, Inc.	2	\$905,248.00	\$905,248.00	Behavioral Health	Dona Ana
Family Practice Associates of Taos	2	\$1,000,000.00	\$1,169,224.77	Primary Care	Taos
Gallup Community Health	2	\$1,221,860.00	\$1,221,860.00	Primary Care	McKinley
Guidance Center of Lea County	2	\$432,783.00	\$1,061,017.59	Behavioral Health	Lea
Hatch Ambulance Service	2	\$354,204.00	\$396,246.00	Transportation	Luna, Otero, Sierra
Hidalgo Medical Services	2	\$960,272.00	\$1,852,517.66	Other/Specialty Care	Grant, Hidalgo, Catron, Luna, Sierra, Socorro
Home Modification Solutions LLC	2	\$216,980.00	\$547,601.00	Other/Specialty Care	Mora, San Miguel, Socorro, and Torrance
Jicarilla Apache Nation	2	\$2,100,000.00	\$1,284,153.50	Children's Health	Rio Arriba and Sandoval (Tribal Lands)
Justice Access Support & Solutions for Health dba Casa de Salud	2	\$3,263,484.00	\$2,667,694.00	Behavioral Health	Valencia
Lovelace Regional Hospital	2	\$502,000.00	\$502,000.00	Maternal Child Health	Chaves County
MECA Multicultural Evaluation and Consultation Associates	2	\$1,617,176.00	\$1,617,176.05	Maternal Child Health	Curry, Chaves, Lea, Roosevelt, Quay, and Dona Ana
Meridian Behavioral Health Inc.	2	\$4,449,500.00	\$3,881,732.71	Behavioral Health	Valencia, Cibola, Torrance, and San Miguel
Mimbres Valley Medical Group RHC a part of Mimbres Memorial Hospital	2	\$427,899.58	\$155,673.22	Primary Care	Luna
New Mexico Premier Health, LLC	2	\$3,296,709.00	\$3,296,709.00	Primary Care	Valencia, Socorro, Torrance, and Cibola
Pinwheel Healing Center LLC	2	\$461,600.00	\$737,331.00	Behavioral Health	Lincoln
Plains Regional Medical Center	2	\$658,000.00	\$941,792.00	Other/Specialty Care	Curry, De Baca, Quay, and Roosevelt
Presbyterian Espanola Hospital	2	\$912,600.00	\$1,094,453.00	Behavioral Health	Rio Arriba
Presbyterian Healthcare Services dba Lincoln County Medical Center	2	\$943,527.00	\$1,100,847.54	Behavioral Health	Lincoln
Quay County (in collaboration with Presbyterian Medical Services)	2	\$1,361,145.00	\$1,334,375.00	Dental/Optometry	Quay
Renew Health	2	\$997,000.00	\$997,000.00	Behavioral Health	Chaves, Curry, Eddy, Lincoln, Otero, and Roosevelt
Roadrunner Home Health LLC	2	\$4,489,500.00	\$1,542,693.89	Other/Specialty	Cibola, Socorro, Valencia, Torrance, and Rio Arriba
Santo Domingo Pueblo	2	\$2,300,000.00	\$1,308,390.51	Behavioral Health	Sandoval (Tribal Lands)
Sierra Vista Hospital and Clinics	2	N/A	\$811,446.00	Behavioral Health	Sierra
Sunrise Clinics	2	\$176,645.00	\$176,645.00	Behavioral Health	Mora, San Miguel, Torrance, and Guadalupe
Vida Midwifery	2	\$615,548.00	\$615,548.17	Maternal Child Health	Sierra, Luna, Grant, and Dona Ana