



To advocate for, broaden, and strengthen the health center network

NVPCA BOARD RETREAT AGENDA

Tuesday, September 9, 2025

9:30 am – 4:30 pm

IN-PERSON Meeting

Tahoe Blue Event Center

Stateline, Nevada

2024-25 NVPCA Board Members:

President: Steve Flores, Hope Christian Health Center	CJ Hansen, Canyonlands Healthcare
Vice President: Walter Davis, Nevada Health Centers	Angela Quinn, FirstMed Health and Wellness
Secretary/Treasurer: Teri Gilbert Eisenga, Washoe Tribal	John Packham, Office of Statewide Initiatives
Tina Alicea, Safe Harbor Medical	David Robeck, Bridge Counseling Associates
Sharon Chamberlain, Northern Nevada HOPES	Randy Smith, Southern Nevada Health District
Oscar Delgado, Community Health Alliance	Ex-officio: Nancy J. Bowen, NVPCA

9:30 am Coffee & Bagels / Networking

10:00 am **1. Call to Order** Steve Flores
 a) Approval of the Agenda *(vote)*

10:05 am **2. Consent Agenda *(vote)*** Steve Flores
 a) Approval of Board Meeting Minutes for July 1, 2025
 b) Chief Executive Officer’s Report

10:10 am **3. NVPCA Finance** Steve Flores / Nancy Barklage/
 a) Budget to Actual YTD Financial Reports with Financial Dashboard and Balance Sheet *(vote)*

10:20 am **4. NVPCA Governance** Steve Flores/
 Nancy Bowen
 a) Board Self-Assessment
 b) Election of Officers - Nov. 2025 – Oct. 2026 *(vote)*
 c) Board Meeting Calendar - Nov. 2025 – Oct. 2026 *(vote)*
 d) Selection of Committee Members – Nov. 2025 – Oct. 2026 *(vote)*

10:45 am **5. GPO “A” Presentation** Rod Peredo, CH Collective

11:00 am **6. NVPCA Overview** NVPCA Leadership Team
 a) Updated Strategic Plan *(vote)*
 b) Organizational Dashboard Update
 c) REACCHH Update & Federal Program Review
 d) HCCN Update

12:00 pm Lunch – Open Discussion

NVPCA BOARD RETREAT AGENDA

Tuesday, September 9, 2025

12:45 am	7. 2024 UDS NV Data Overview	Steve Messinger/ Kim Lambrecht
1:15 pm	8. Policy Plan for Interim & 2027 Legislative Session	Nancy Bowen/ Steve Messinger
1:45 pm	9. GPO "B" Presentation	Tom Whelan, Commonwealth Purchasing
2:00 pm	10. Topics for Strategic Discussion <ul style="list-style-type: none">➤ Rural Health Transformation Fund – Discussion for survey response➤ AI – future of healthcare➤ Immigration status➤ Medicaid work requirements➤ PCA legal entity➤ Out of state health centers CEOs on the board – bylaws change➤ FQHC Expansion and How to Finance it➤ PACE Program – Field trip to CA PACE programs	Nancy Bowen
4:00 pm	11. Open Forum	Steve Flores / Nancy Bowen
4:30 pm	12. Meeting Adjournment <ul style="list-style-type: none">a) Next meeting: Tuesday, November 4, 2025, at 8:30 am - Virtual	
5:30 pm	Dinner <ul style="list-style-type: none">• Riva Grill on the Lake - 900 Ski Run Blvd Ste 3, South Lake Tahoe, CA 96150	



Nevada Primary Care Association
Board Meeting – September 9, 2025
Item 2a

NVPCA Board of Directors Board Meeting Minutes July 1, 2025

Board Members Present	Steve Flores, Walter Davis, Sharon Chamberlain, John Packham, Randy Smith, Christopher (CJ) Hansen, David Robeck, Oscar Delgado, Angela Quinn, and Nancy Bowen (Ex Officio)
Board Members Absent	Teri Gilbert Eisenga and Tina Alicea
Also Present	NVPCA Staff: Nancy Barklage, Kim Lambrecht, Karen Ford Manza, Steve Messinger, and Lisa Scurry (Note Taker)

1. Call to Order

President Steve Flores called the meeting of the NVPCA Board of Directors to order at 8:32 am. The meeting was conducted electronically via Zoom. A quorum of members was established.

a) Approval of the Agenda

The agenda was reviewed with no questions or suggested changes. It was moved by CJ Hansen, and seconded by Randy Smith, to approve the agenda as presented. The motion passed unanimously.

2. Consent Agenda

a) Approval of Minutes from Board Retreat on May 6, 2025

b) Chief Executive Officer’s Report and Organizational Dashboards

The consent agenda, consisting of the minutes of the May 6, 2025, Board of Directors meeting, the CEO report, and the organizational dashboard, was presented for approval. There were no comments or questions.

It was moved by David Robeck, and seconded by Randy Smith, to approve the consent agenda. The motion passed unanimously.

3. Board Governance Moment

a) Board Governance Moment

Nancy Bowen provided the members with an article from SmartBrief entitled, “The quiet leader: How to lead with presence, not volume.”

b) Member Meeting Attendance Record

As an ongoing information item, attendance of members at regularly scheduled meetings for the past year was provided.

c) Board Self-Assessment Reminder

Nancy Bowen reminded the Board that the 2025 Board self-assessment would be sent via email on that day. The anonymous survey tool would remain open for submission through July 25, 2025. The results will be presented for discussion at the September Board Retreat.

4. Administrative and Financial Reports

a) Budget to Actual YTD Financial Reports with Financial Dashboard and Balance Sheet

Nancy Barklage, Director of Administration and Finance, reviewed the Year-to-Date financial report through May 2025, including the approved budget versus actual revenues and expenses. She stated that both expenses and revenues are on target and within the expected budgeted range. The review included a presentation of the financial dashboard and the balance sheet as of May 31, 2025.

It was moved by Sharon Chamberlain, and seconded by David Robeck, to accept the Budget-to-Actual Financial Reports for Fiscal Year 2025, through May 2025. The motion passed unanimously.

5. NVPCA Organizational Policies

a) Personnel Policy Manual - Approval of Revisions

Nancy Bowen reviewed recommended changes to five of the Board policies within the Personnel Policy Manual. The five policies to be revised were PP100-01, Prohibited Harassment, Discrimination, Intimidation and Retaliation; PP100-02, Equal Employment Opportunity; PP120-15, Holidays; PP120-16, Paid Time Off (PTO); and PP150-08, Whistleblower Policy. There were no questions or suggestions related to the proposed revisions. An explanation of each revision was included in the manual for future reference.

It was moved by Randy Smith, and seconded by John Packham, to approve revisions to the Personnel Policy Manual. The motion passed unanimously.

b) Title X Policies Manual – Approval of Revisions

Karen Ford Manza reviewed the recommended changes to the Title X Policy Manual. She explained that the policy related to “clinical leadership” was out of compliance with the current practice of NVPCA and was, therefore, recommended for revision. An explanation of the revision was included in the manual for future reference.

It was moved by Sharon Chamberlain, and seconded by CJ Hansen, to approve revisions to the Title X Policy Manual. The motion passed unanimously.

c) Artificial Intelligence Governing Framework

Nancy Bowen reviewed a draft governing framework for the use of artificial intelligence (AI) at NVPCA. At the May meeting she mentioned the document was being drafted and the Board requested to see it. The document was presented for information only.

There was discussion about acceptable uses of AI and that staff have been informed that AI output must be verified and never used as a final product due to the possibility of outdated and/or incorrect information. The group discussed the need for, and availability of trainings related to understanding AI.

6. Strategic Discussion & Policy Committee Update

Steve Messinger, Policy Director, provided updates on the following items:

a) 2025 Nevada Legislative Session Review

An update on the status of the Nevada Legislative Session was provided, including bills signed by the governor that may impact the health centers, Medicaid, and associated topics. There was also discussion regarding 340B Legislation, expansion of education funding, and insurance concerns.

Senate Bill 207 established a PACE program (“Program of All-Inclusive Care for the Elderly”) in the state. There was discussion about how and when the program could be implemented. The development of regulations was in progress at the state level. Nancy Bowen stated NVPCA staff would

be meeting with organizations in other states about their PACE programs and would bring additional information back to the Board.

b) Federal updates

Federal updates were provided including current and pending policy work, as well as the US Senate’s reconciliation bill.

c) Lobbyist Search

Nancy Bowen asked the Board members for guidance regarding staying with the current lobbyist or putting out an RFP, to potentially contract with a new lobbyist. Discussion included the value brought to the association and members by the current lobbyist, and what potential positives a new lobbyist group could bring. In the end, the Board recommended going out for bid.

7. Board Retreat Topics

Bowen reviewed the potential agenda topics for the September 9 Board Retreat. Steve Flores suggested a discussion about artificial intelligence in healthcare.

8. Meeting Adjournment

There being no further business, President Flores adjourned the meeting at 10:06 am.

NOTES

Next Meeting	The Board will conduct an in-person Board Retreat on Tuesday, September 9, 2025, at 10:00 a.m. (Pacific)
Approved By	

ROLL CALL


President: Steve Flores, Hope Christian Health Center	Present
Vice President: Walter Davis, Nevada Health Centers	Present
Secretary/Treasurer: Teri Gilbert Eisenga, Washoe Tribal Health	Absent - Excused
Tina Alicea, Safe Harbor Medical	Absent - Excused
Sharon Chamberlain, Northern Nevada HOPES	Present
Oscar Delgado, Community Health Alliance	Present
C.J. Hansen, Canyonlands Healthcare	Present
John Packham, Office of Statewide Initiatives	Present
David Robeck, Bridge Counseling Associates	Present



CEO Report

July - August 2025

Policy -

- Staff met with two organizations who conduct PACE programs in their states: AltaMed and Bold Age Pace. NVPCA is exploring opportunities for FQHC CEOs to visit/tour the AltaMed facility in California. More details to come...
- The Managed Care Roundtable series continues with the next meeting scheduled for the afternoon of Monday, October 20. Two in-person locations in Las Vegas and Reno will be announced soon. As always, representatives from health centers, managed care organizations, Nevada Medicaid and Nevada Welfare will be present. 
- The Managed Care Roundtable Workgroups continue to meet monthly.
 - The Contact Information Workgroup has been focused on creating a patient information sheet that will include ways individuals can update their information with Nevada Medicaid. The sheet will include a QR code that will take patients/members directly to the appropriate site.
 - The Diabetes Performance Measure Workgroup is working on ways to increase patient awareness of resources, particularly what is available through their MCO. This includes information about the disease and related conditions.
- NVPCA's Policy Director is moving forward with the RFP to hire a lobbyist for the 2026 interim and 2027 Legislative Session. Any recommendations will come to the Board for consideration.

Organizational Excellence –

- CEO and Policy Director attended NACHC's Community Health Conference in Chicago. In conjunction with the event, the NACHC Board of Directors, of which the CEO is a member, conducted their regular meetings.
- CEO attended a PCA CEO meeting on July 28-30. Then, on July 31-August 1, CEO and members of the Leadership staff attended the PCA VBC Collaborative Conference. Both events were held in Denver, Colorado.

Community Engagement – National and State

- On August 12, CEO presented to the NOMHE Advisory Committee. She provided the group with information about applicable legislation, both what passed and what did not.
- CEO and staff attended "Camp Homegrown: Nurturing Nevada's Families from Roots to Resilience" on September 4. The event was hosted by the Nevada Statewide Maternal and Child Health Coalition, and sponsored by NVPCA, Northern Nevada HOPES, United Healthcare, and Molina Healthcare.

Membership

- CEO and staff met with Pinnacle Primary Group in early August. Pinnacle is exploring the possibility of becoming an FQHC in the future. They currently provide primary care services in the Northern

To advocate for, broaden, and strengthen the health center network.



CEO Report

July - August 2025

Nevada area, with a possible expansion to Fernley.

- The Annual NVPCA Member Meeting took place on Wednesday, September 3 at 8:30 am. Current members Walter Davis and Randy Smith were re-elected to new 2-year terms for the period November 1, 2025 – October 31, 2027.

Program Management and New Projects

- NVPCA continues its work to develop an FQHC Handbook. The document will be available later this Fall and posted on a newly developed Member SharePoint Resource Drive.

Upcoming Events CEO will attend representing NVPCA

- [2025 Workforce Conference](#), hosted by NACHC, will be held in Las Vegas on October 21-22.
- [2025 NACHC Partner Conference](#) will be held in Minneapolis, MN on November 17-18.
- [2026 NACHC Policy & Issues Forum](#) will be held February 9-12 in Washington, DC.



NVPCA Financial Statement

YTD Target 100.0%

* Notes provided for variances + / - 25% of YTD target
 75%
 125%
 NB= Not Budgeted

REVENUE

Federal Grants

BPHC Cooperative Agreement 821,802 839,410 839,410 100%
 BPHC Maternal Health NB 144,500 -
 REACCHH Title X 2,052,050 2,419,450 2,465,830 102%

Contracts

State- TPP PREP 92,758 92,758 101,497 109%
 State- MACH 342,836 162,472 136,769 84%
 HCCN 71,905 71,905 65,874 92%
 CareSource NB 300,000 300,000 100%
 Transitions of Care NB 80,000 80,000 100%
 Huntsman NB 5,000 5,000 100%

Other

Training & Events 24,750 24,750 30,795 124%
 Sponsorship/Contributions 95,000 95,000 116,500 123%
 Membership Dues 50,925 50,925 53,750 106%
 NVCC 20,000 20,000 20,443 102%
 GPO/Misc NB NB 3,808
 Interest 7,500 7,500 16,940 226%

Total Revenue

APPROVED BUDGET Jul 2024-Jun 2025	WORKING BUDGET* Jul 2024-Jun 2025	YTD Jun-25	% of Working Budget	Notes
3,579,526	4,313,670	4,236,616	98%	21% increase in revenue from approved to working budget

Increase to 330 base for additional IPV activities
 To support T/TA aimed at improving maternal health outcomes; will be carried over to next FY
 Addition of one time supplemental funding
 Budget reduced due to number of MAs registering for training
 Funding contract runs Aug-July
 Rural primary and mental health services project
 Azara TOC project funded by Molina & SSHP
 Food insecurity project
 AC24 registrations
 AC24 sponsorships \$28,500; AC25 sponsorship \$88,000
 New members

EXPENSES

Personnel/Salary & Fringe Benefits

1,394,774	1,407,844	1,393,867	99%
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Travel

Airfare 18,230 25,308 19,017 75%
 Hotel 20,778 22,928 24,758 108%
 Ground transport/Car Rental 8,267 7,918 6,980 88%
 Conference Registration 10,073 14,880 24,897 167%
 Per diem 8,844 8,834 7,441 84%
 Mileage/Gas 3,176 2,635 1,169 44%
 Total Travel 69,368 82,503 84,263 102%

Sponsored 10 Region IX 2025 Conference Registrations (\$9750) with Title X and BPHC funding

Supplies

Program Supplies- Direct Cost 1,752 1,840 3,225 175%
 Computer/equipment 4,720 8,720 9,296 107%
 Total Supplies 6,472 10,560 12,520 119%

Purchased tests for subrecipient with Title X supplemental funding

Contractual

Computer & Web Support 5,180 1,750 1,750 100%
 Consulting 56,589 83,767 119,104 142%
 Reports and Projects 271,377 383,141 254,357 66%
 Total Contractual 333,146 468,658 375,211 80%

Moved funds to IT Services under shared costs
 Title X supplemental funding paid for budget forecasting and consulting services
 Increased for Azara and TOC projects; TOC expenses will be recognized next FY



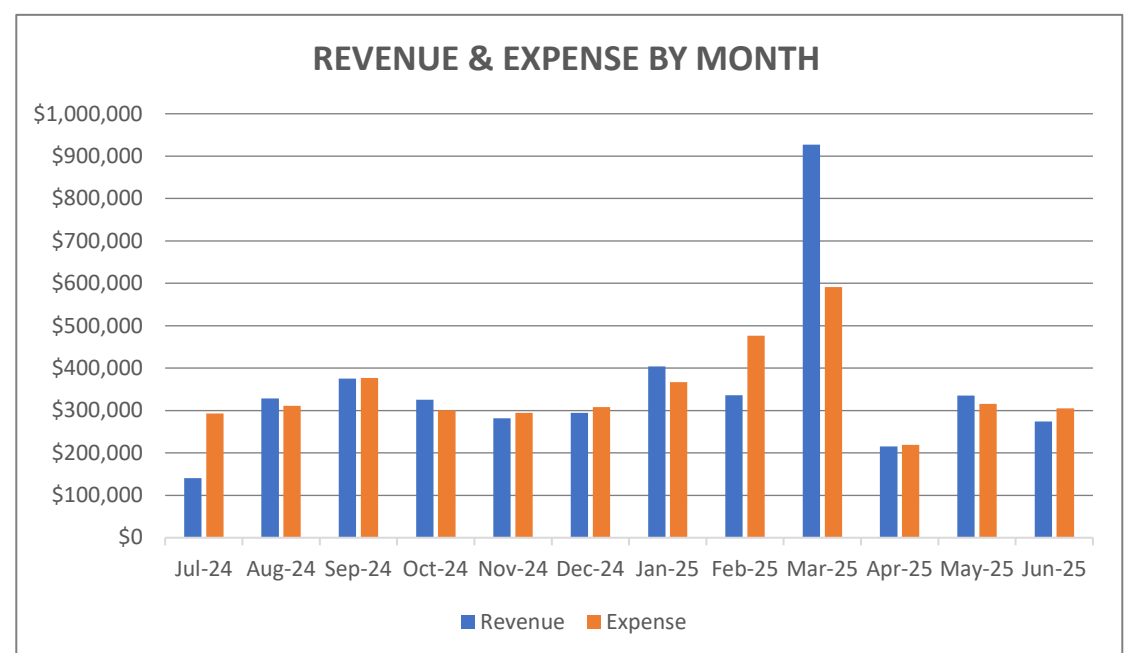
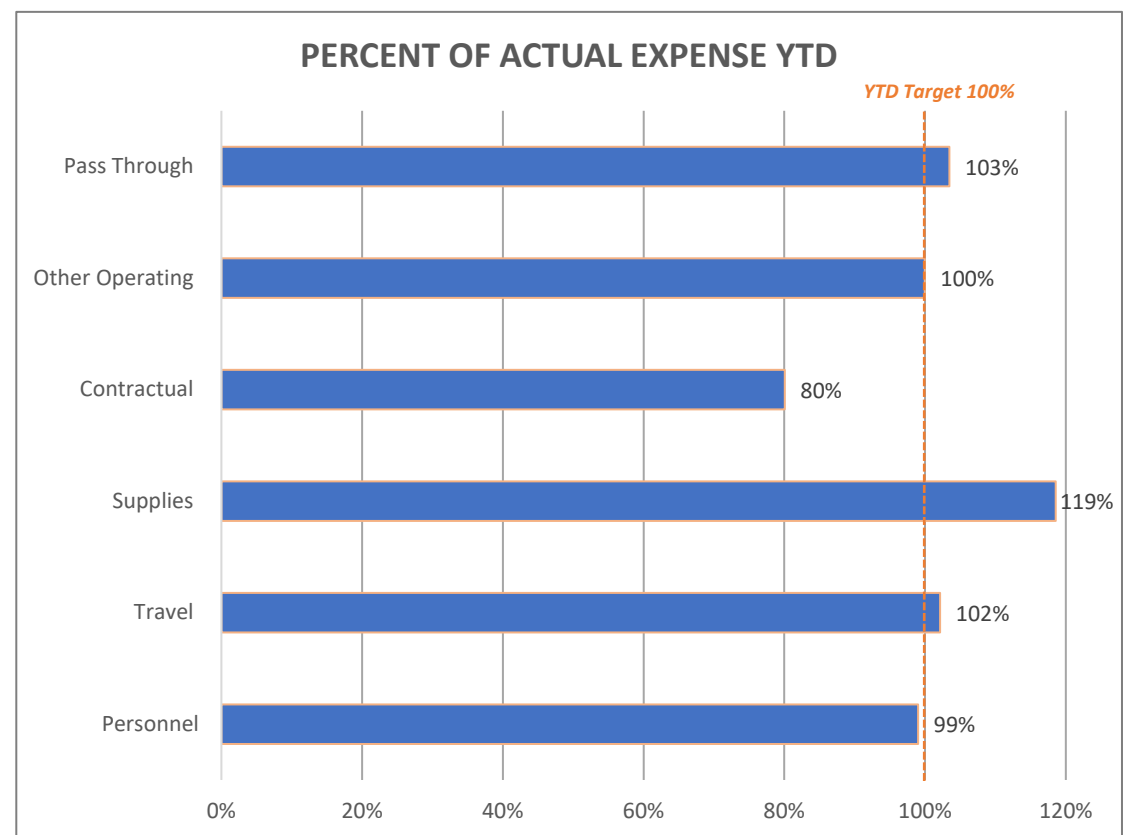
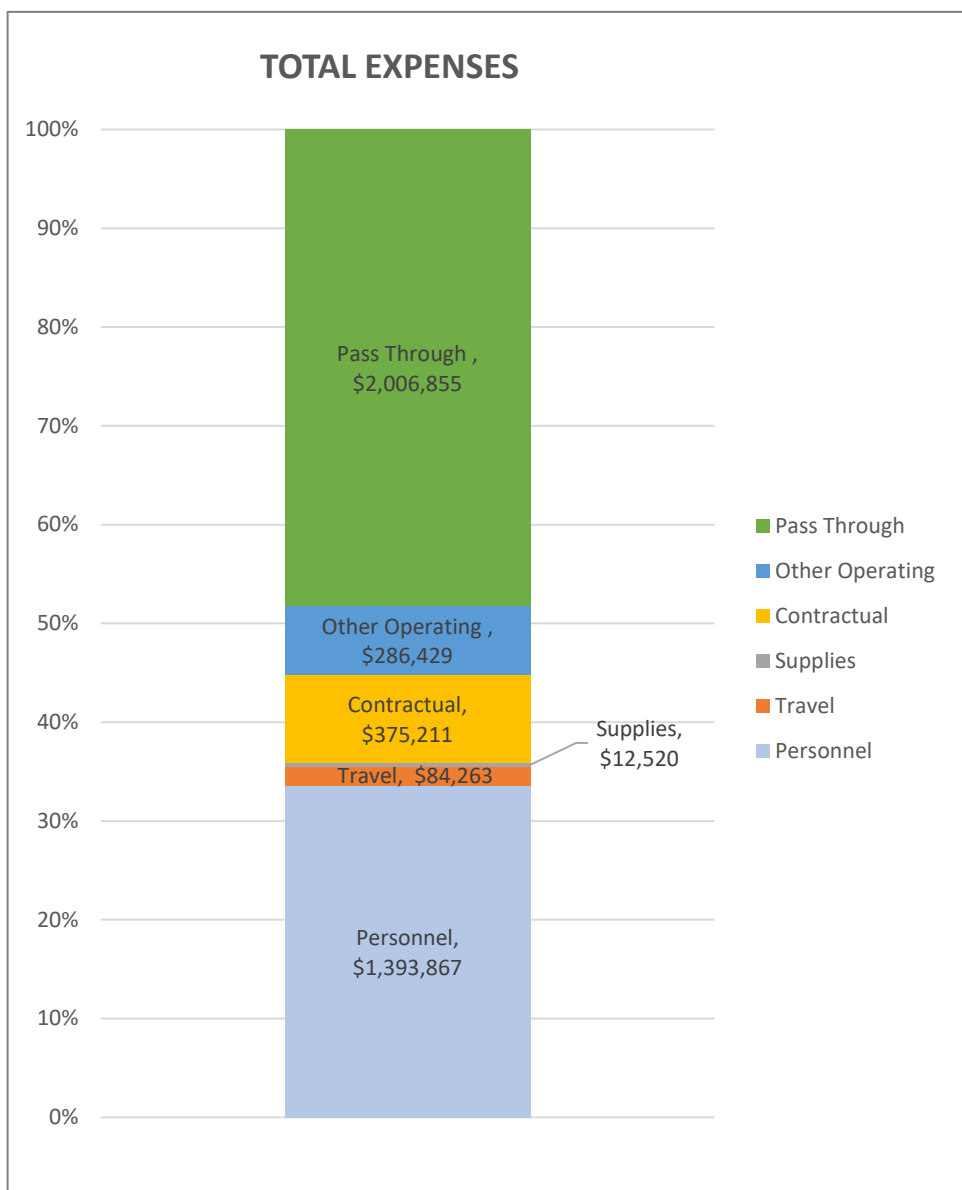
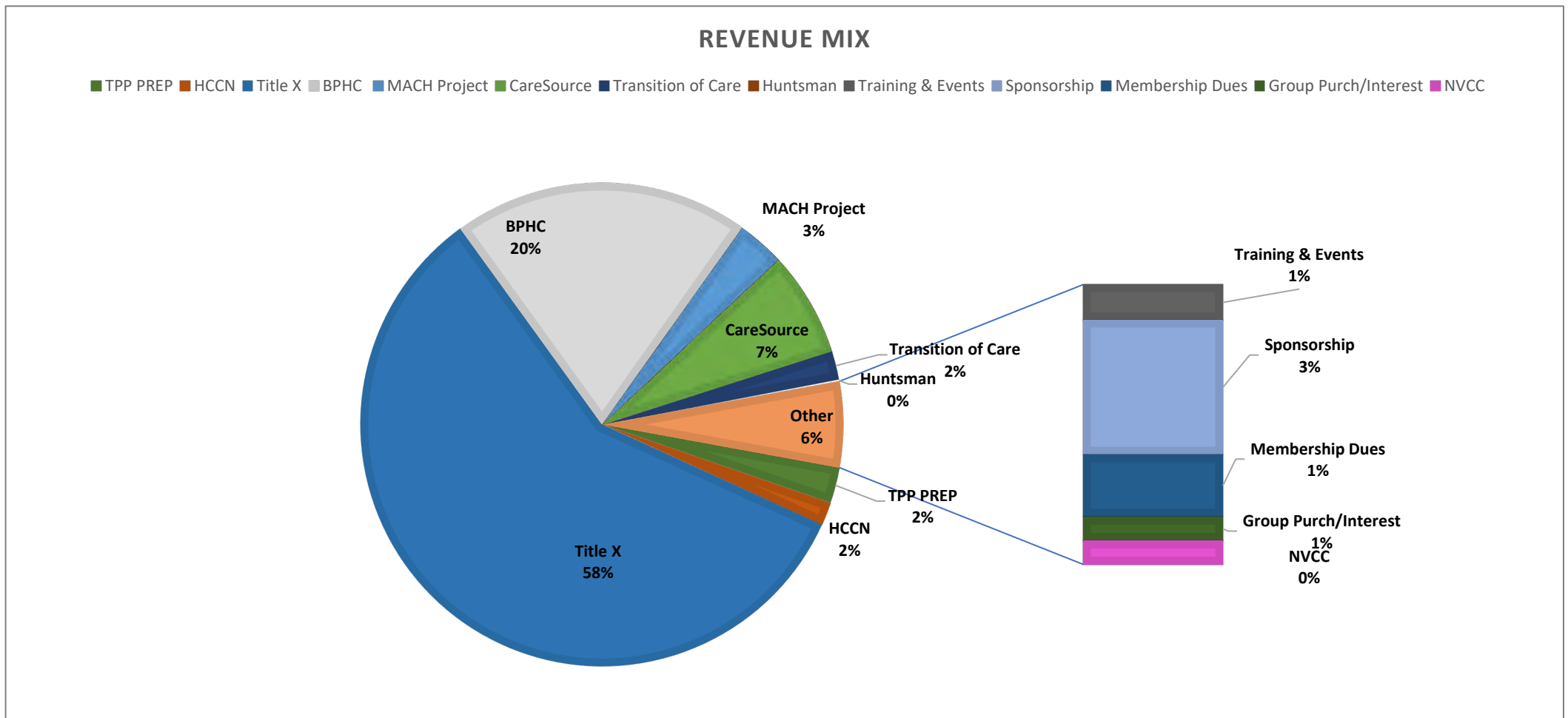
NVPCA Financial Statement

YTD Target 100.0%

* Notes provided for variances + / - 25% of YTD target
75%
125%
NB= Not Budgeted

	APPROVED BUDGET Jul 2024-Jun 2025	WORKING BUDGET* Jul 2024-Jun 2025	YTD Jun-25	% of Working Budget	Notes
Other Operating Expenses					
Dues & Memberships	13,000	16,763	18,350	109%	
Credit Card Processing Fees	1,100	2,120	1,947	92%	
Legal Services	1,000	1,350	732	54%	Expenses less than anticipated
Trainings/Events (6500)	128,156	128,200	123,500	96%	
Meeting Staff/Board (6608)	2,900	3,240	1,826	56%	Expenses less than anticipated
Printing/Outreach	500	2,325	13,438	578%	Additional funds from Title X supplemental funding for outreach
Staff/Board Development (6615)	2,760	2,760	1,915	69%	
Recruitment Expenses	500	600	964	161%	Recruitment for bookkeeper position
Taxes, Licenses & Fees	75	75	78	104%	
NVCC Operating Expenses	8,000	10,000	9,630	96%	
Shared Costs					
Audit	19,000	19,000	18,700	98%	
Auto Lease	7,453	7,453	4,135	55%	
Alarm	678	678	682	101%	
Bank Charges	144	144	131	91%	
General office supplies	3,000	3,000	2,368	79%	
IT Services	NB	9,900	11,935	121%	Outsourcing IT services
Janitorial	3,000	-	0	#DIV/0!	No longer using a service; funds will be moved to IT Services
Insurance	11,000	15,150	12,212	81%	
Occupancy Costs	32,256	32,256	35,970	112%	
Software Subscriptions	23,000	23,000	20,641	90%	
Telephone & Internet	8,543	8,543	7,275	85%	
Total Other Operating & Shared	266,065	286,557	286,429	100%	
Pass Through					
Pass through Contracts- Title X	1,455,166	1,626,798	1,696,072	104%	
Pass through Contracts- TPP PREP	64,404	63,812	68,550	107%	
Pass through Contracts- MACH	140,000	24,500	17,500	71%	
Pass through Contracts- CareSource	NB	205,133	205,133	100%	
Pass through Contracts- CGM	19,600	19,600	19,600	100%	
Total Pass Through	1,679,170	1,939,843	2,006,855	103%	
Total Expenses	3,748,995	4,195,965	4,159,144	99%	
INCOME OR LOSS	(169,469)	117,705	77,472	66%	
Net assets released from purpose restrictions (Population Health Project, Intermountain Project, Molina, and SilverSummit Community Investment Project)	200,256	196,697	149,180	74%	
Estimated restricted income recognized this FY and expenses will incur next FY (TOC, Huntsman, CareSource projects)	NB	284,000	156,120		
Adjusted Income or Loss	30,787	30,402	70,533	229%	Income from NVCC, interest, Annual Conference 2024 sponsorship/registrations, & dues

Financial Dashboard Report July 1, 2024 – June 30, 2025



	8-24	9-24	11-24	1-25	3-25	6-25	Avg
Days cash on hand* Goal = 60	63	59	60	59	62	58	61
Current ratio*	2.1	1.9	2.2	2.3	2.0	1.9	2.1

*Days cash on hand & current ratio are calculated without restricted funds.

Statement of Financial Position

Nevada Primary Care Association

As of June 30, 2025

Nevada Primary Care Association
Board Meeting – September 9, 2025
Item 3a

DISTRIBUTION ACCOUNT	TOTAL
Assets	
Current Assets	
Bank Accounts	
1020 BofA Checking- 5407	100,808.97
1025 BofA Checking- 5689	1,000.00
1030 Live Oak Savings	479,710.47
Total for Bank Accounts	\$581,519.44
Accounts Receivable	
1200 Accounts Receivable	361,062.83
Total for Accounts Receivable	\$361,062.83
Other Current Assets	
1300 Undeposited Funds	\$20,300.47
1320 Prepaid Expense	10.84
1340 Petty Cash	10.84
2120 Payroll Asset	
2130 Payroll Corrections	
Total for Other Current Assets	\$20,311.31
Total for Current Assets	\$962,893.58
Fixed Assets	
1410 Equipment	-\$0.00
Total for Fixed Assets	-\$0.00
Other Assets	
1500 Rent Deposits	2,498.00
1510 ROU Asset	94,468.68
Total for Other Assets	\$96,966.68
Total for Assets	\$1,059,860.26
Liabilities and Equity	
Liabilities	
Current Liabilities	
Accounts Payable	
2000 Accounts Payable	206,093.40
Total for Accounts Payable	\$206,093.40
Credit Cards	
2100 BofA Credit Card VISA 6161	0
2105 B of A MASTER CARDS 1454	\$20,481.01

Statement of Financial Position

Nevada Primary Care Association
Board Meeting – September 9, 2025
Item 3a

Nevada Primary Care Association

As of June 30, 2025

DISTRIBUTION ACCOUNT	TOTAL
Total for Credit Cards	\$20,481.01
Other Current Liabilities	
2115 Direct Deposit Payable	
2250 NVCC Reserve	
2300 Goni Lease Liability	96,437.48
2301 Lease Liabilities	
2500 Payroll Liabilities	\$29,760.57
2530 Accrued Retirement Benefit (IRA)	643.90
2540 Accrued PTO	32,356.76
2700 Accrued Expense	
2900 Deferred Income	
Total for Other Current Liabilities	\$159,198.71
Total for Current Liabilities	\$385,773.12
Long-term Liabilities	
Total for Liabilities	\$385,773.12
Equity	
3000 Equity	0
3030 Net Investment in Equipment	9,942.41
Total for 3000 Equity	\$9,942.41
3020 Accumulated Earnings	61,034.31
4000 Retained Earnings	525,638.23
Net Income	77,472.19
Total for Equity	\$674,087.14
Total for Liabilities and Equity	\$1,059,860.26



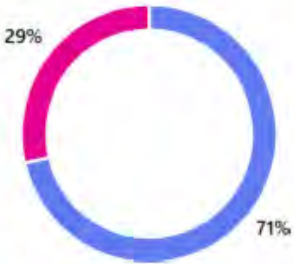
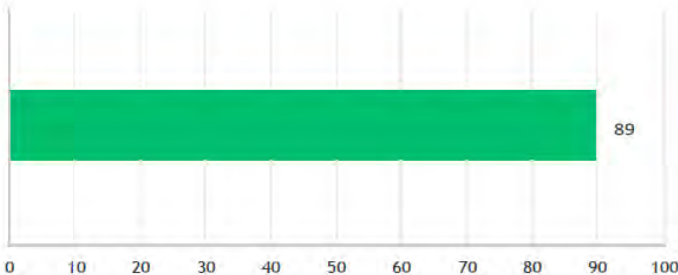
2025 Board Self-Assessment w/2024 Comparison








The 2025 Board Self-Assessment has been successfully completed, providing valuable insights into the Board’s performance, governance practices, and strategic alignment. This year’s results are presented on the following pages with a side-by-side comparison to the 2024 assessment. We seek to identify trends, improvements, and areas requiring continued attention. The Board demonstrated measurable progress in some areas, while consistency was observed in others. The comparative analysis also highlighted opportunities for further development. These findings will inform upcoming governance initiatives and help shape the Board’s priorities as we move forward.

Six responses were received in 2025; nine in 2024.

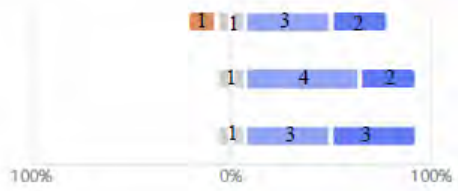
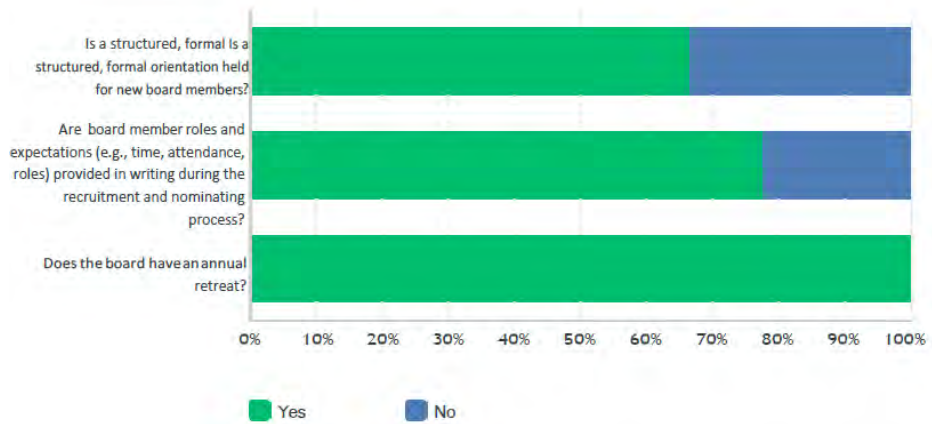
YEAR	QUESTION / RATING								
2025	<p>1. How many years have you served on the NVPCA Board of Directors?</p> <table border="1"> <tr> <td>1-2 Years</td> <td>1</td> </tr> <tr> <td>3-5 Years</td> <td>3</td> </tr> <tr> <td>6-9 Years</td> <td>2</td> </tr> <tr> <td>10 or More Years</td> <td>1</td> </tr> </table>	1-2 Years	1	3-5 Years	3	6-9 Years	2	10 or More Years	1
1-2 Years	1								
3-5 Years	3								
6-9 Years	2								
10 or More Years	1								
2024	<p>Q1 How many years have you served on the NVPCA Board of Directors?</p> <p>Answered: 9 Skipped: 0</p> <table border="1"> <tr> <td>Less than 1 ...</td> <td>1-2 years</td> <td>3-4 years</td> <td>5-6 years</td> </tr> <tr> <td>7-8 year</td> <td>9 or more y...</td> <td></td> <td></td> </tr> </table>	Less than 1 ...	1-2 years	3-4 years	5-6 years	7-8 year	9 or more y...		
Less than 1 ...	1-2 years	3-4 years	5-6 years						
7-8 year	9 or more y...								

<p>2025</p>	<p>3. How well do you think the Board's strategic planning process works?</p> <p>0 = Poor 1 = Fair 2 = OK 3 = Good 4 = Excellent</p> <p>Setting the association's strategic direction - in partnership with the chief executive.</p> <p>Engaging in an effective strategic planning process.</p> <p>Tracking progress toward meeting the association's strategic goals.</p> <p>Comments:</p> <ul style="list-style-type: none"> • Sometimes we need details then provided for specific goals. • I especially like the regular updates on strategic plan progress.
<p>2024</p>	<p>Q2 How well do you think the Board's strategic planning process works?</p> <p>Answered: 9 Skipped: 0</p> <p>Setting the association's strategic direction - in partnership with the chief executive.</p> <p>Engaging in an effective strategic planning process.</p> <p>Tracking progress toward meeting the association's strategic goals.</p> <p>0 = Poor 1 = Fair 2 = OK 3 = Good 4 = Excellent</p>

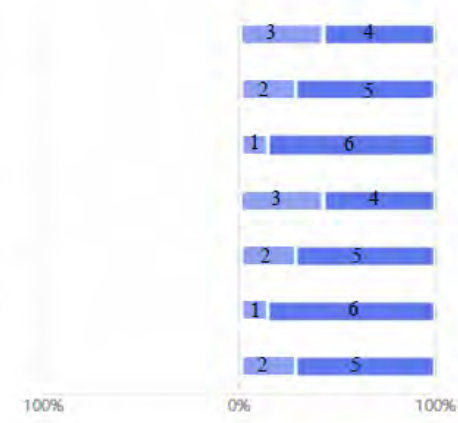
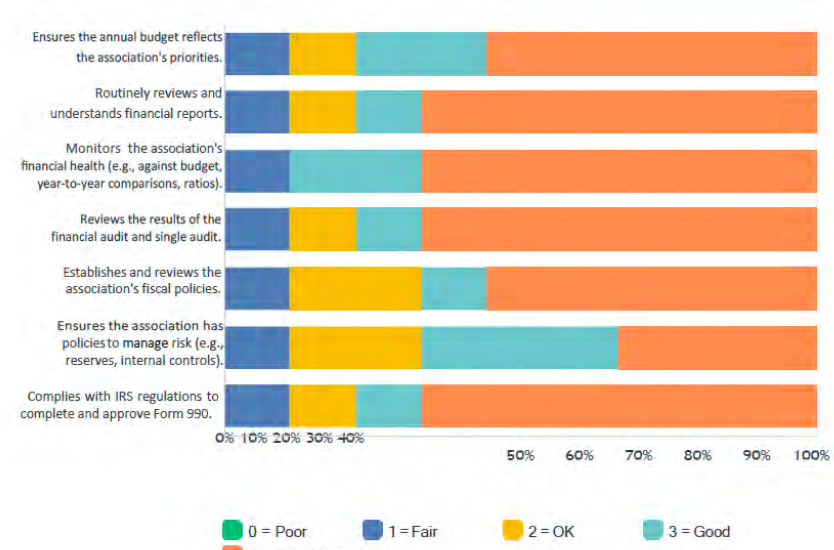
2025	<p>2. How well do you understand NVPCA's mission, vision, and values?</p> <table data-bbox="527 441 795 661"><tr><td>● 5 = Extremely well</td><td>5</td></tr><tr><td>● 4</td><td>2</td></tr><tr><td>● 3 = Neutral</td><td>0</td></tr><tr><td>● 2</td><td>0</td></tr><tr><td>● 1 = Not well at all</td><td>0</td></tr></table>  <p>A donut chart with two segments: a large blue segment representing 71% and a smaller pink segment representing 29%.</p>	● 5 = Extremely well	5	● 4	2	● 3 = Neutral	0	● 2	0	● 1 = Not well at all	0
● 5 = Extremely well	5										
● 4	2										
● 3 = Neutral	0										
● 2	0										
● 1 = Not well at all	0										
2024	<p>Q3 How well do you understand NVPCA's mission, vision, and values?</p> <p>Answered: 9 Skipped: 0</p>  <p>A horizontal bar chart with a single green bar extending to the 89 mark on a scale from 0 to 100.</p>										

<p>2025</p>	<p>5. How well do you engage in NVPCA's public image and advocacy?</p> <p>● 0 = Poor ● 1 = Fair ● 2 = OK ● 3 = Good ● 4 = Excellent</p> <p>Advocating on behalf of the association and its members. </p> <p>Helping to build a positive public image of the association. </p> <p>Maintaining an open dialogue with the association's members related to public image and advocacy issues. </p> <p>100% 0% 100%</p> <p>Comments:</p> <ul style="list-style-type: none"> This is an area I could be better. Advocacy is not really my strong suit.
<p>2024</p>	<p>Q4 How well do you engage in NVPCA's public image and advocacy?</p> <p>Answered: 9 Skipped: 0</p> <p>Advocating on behalf of the association and its members. </p> <p>Helping to build a positive public image of the association. </p> <p>Maintaining an open dialogue with the association's members related to public image and advocacy issues. </p> <p>Defining the role of board members related to critical association activities (e.g., official spokesperson, access to media). </p> <p>0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%</p> <p>0 = Poor 1 = Fair 2 = OK 3 = Good 4 = Excellent</p>

<p>2025</p>	<p>7. How effective is the Board related to the following items?</p> <p>● 0 = Poor ● 1 = Fair ● 2 = OK ● 3 = Good ● 4 = Excellent</p> <table border="1"> <caption>2025 Board Effectiveness Data</caption> <thead> <tr> <th>Item</th> <th>0 (Poor)</th> <th>1 (Fair)</th> <th>2 (OK)</th> <th>3 (Good)</th> <th>4 (Excellent)</th> </tr> </thead> <tbody> <tr> <td>Establishing and enforcing policies of board service (e.g. attendance, length of terms and number of terms).</td> <td>1</td> <td>2</td> <td>0</td> <td>4</td> <td>0</td> </tr> <tr> <td>Ensuring the current board has the capacity to effectively govern and lead the association.</td> <td>1</td> <td>2</td> <td>0</td> <td>4</td> <td>0</td> </tr> <tr> <td>Utilizing the skills and talents of individual board members.</td> <td>2</td> <td>0</td> <td>4</td> <td>1</td> <td>0</td> </tr> <tr> <td>Planning for board officer succession</td> <td>1</td> <td>0</td> <td>5</td> <td>1</td> <td>0</td> </tr> <tr> <td>Identifying and cultivating potential board members from NVPCA membership</td> <td>2</td> <td>0</td> <td>3</td> <td>2</td> <td>0</td> </tr> </tbody> </table> <p>Comments:</p> <ul style="list-style-type: none"> • There is room for improvement. • NVPCA has worked diligently in this area. I have definitely noticed better board meeting attendance. 	Item	0 (Poor)	1 (Fair)	2 (OK)	3 (Good)	4 (Excellent)	Establishing and enforcing policies of board service (e.g. attendance, length of terms and number of terms).	1	2	0	4	0	Ensuring the current board has the capacity to effectively govern and lead the association.	1	2	0	4	0	Utilizing the skills and talents of individual board members.	2	0	4	1	0	Planning for board officer succession	1	0	5	1	0	Identifying and cultivating potential board members from NVPCA membership	2	0	3	2	0						
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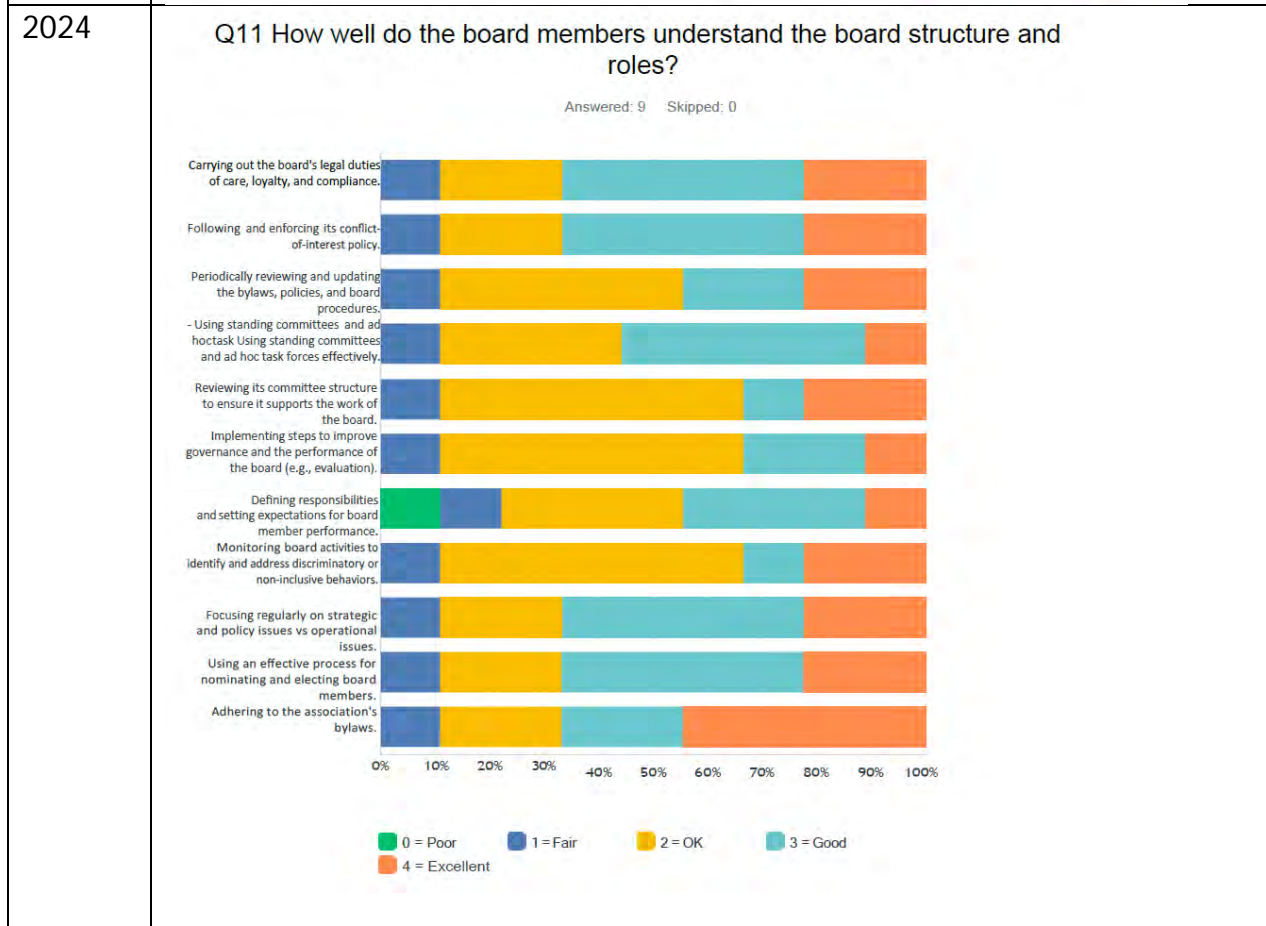
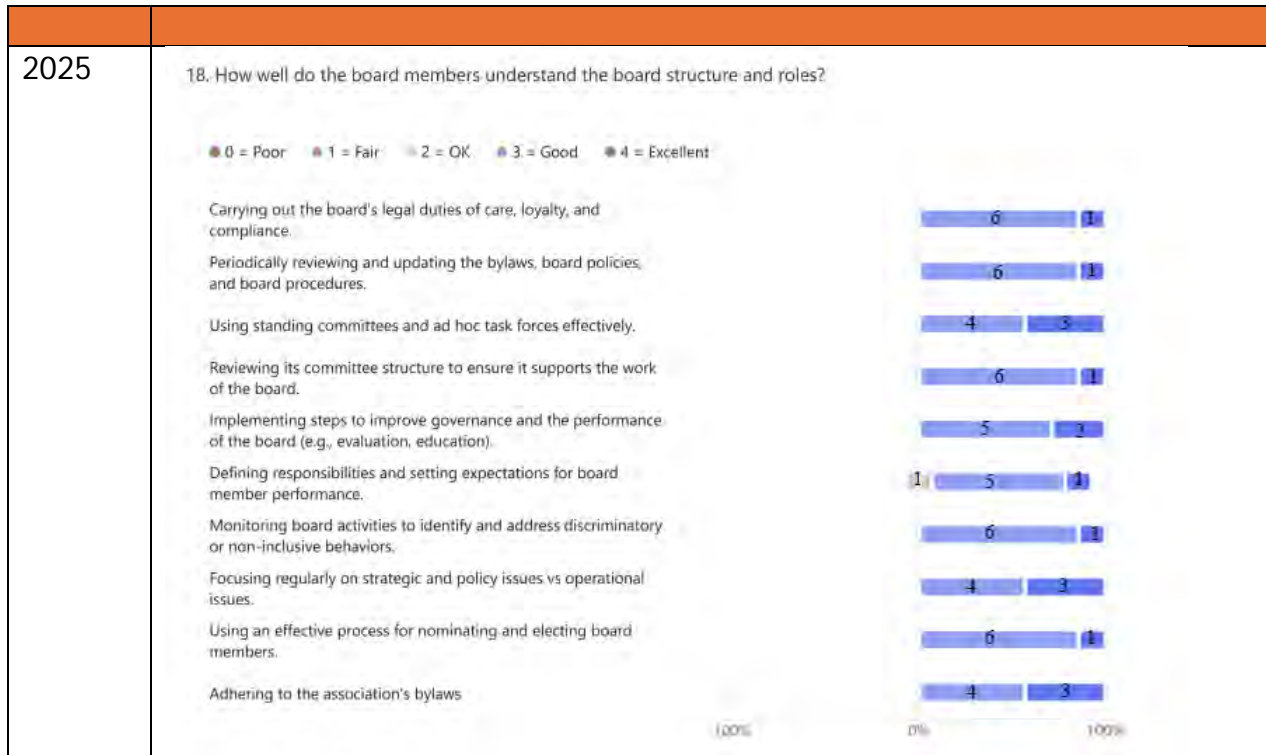
<p>2025</p>	<p>9. NVPCA's Board Member Training:</p> <p>● 0 = Poor ● 1 = Fair ● 2 = OK ● 3 = Good ● 4 = Excellent</p> <p>The board orientation held for new board members is structured and formal.</p> <p>The board member responsibilities and expectations (e.g., time, attendance, roles & responsibilities) are provided in writing to...</p> <p>The past board retreat(s) training sessions and discussions were valuable and informative.</p>  <p>Comments:</p> <ul style="list-style-type: none"> • I do not remember the Board orientation lol!~ Long time ago. • I marked good on the first two questions, but honestly I'm not sure what board member orientation looks like. It was nearly 10 years ago when I joined the board.
<p>2024</p>	<p>Q6 NVPCA's Board Member Training</p> <p>Answered: 9 Skipped: 0</p>  <p>Is a structured, formal orientation held for new board members?</p> <p>Are board member roles and expectations (e.g., time, attendance, roles) provided in writing during the recruitment and nominating process?</p> <p>Does the board have an annual retreat?</p> <p>0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%</p> <p>Yes No</p>

<p>2025</p>	<p>11. How does the Board do on program oversight?</p> <p>● 0 = Poor ● 1 = Fair ● 2 = OK ● 3 = Good ● 4 = Excellent</p> <p>Knowledge of the association's programs and services.</p> <p>Monitor the quality of the association's programs and services.</p> <p>Identify standards against which to measure NVPCA's organizational performance.</p> <p>Measure impact of critical programs and initiatives.</p> <p>100% 0% 100%</p> <p>Comments:</p> <ul style="list-style-type: none"> • More information would be nice and direct contact with staff. • There may be some opportunity to continue to improve in some of these areas.
<p>2024</p>	<p>Q7 How well does the Board do on program oversight?</p> <p>Answered: 9 Skipped: 0</p> <p>Knowledge of the association's programs and services.</p> <p>Receive and discuss sufficient information related to programs and services.</p> <p>Monitor the quality of the association's programs and services.</p> <p>Identify standards against which to measure NVPCA's organizational performance.</p> <p>Measure impact of critical programs and initiatives.</p> <p>0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%</p> <p>■ 0 = Poor ■ 1 = Fair ■ 2 = OK ■ 3 = Good ■ 4 = Excellent</p>

<p>2025</p>	<p>13. How well does the board monitor and understand NVPCA's finances and budget?</p> <p>● 0 = Poor ● 1 = Fair ● 2 = OK ● 3 = Good ● 4 = Excellent</p> <p>Ensures the annual budget reflects the association's priorities.</p> <p>Monitors the association's financial health (e.g. financial reports, year-to-year comparisons, ratios).</p> <p>Reviews the results of the independent financial audit and single audit.</p> <p>Establishes and reviews the association's fiscal policies, as needed.</p> <p>Ensures the association has policies to manage risk (e.g., reserves, internal controls, personnel policies, emergency preparedness).</p> <p>Complies with IRS regulations to complete and approve Form 990.</p> <p>Following and enforcing its conflict-of-interest policy.</p>  <p>Comments:</p> <ul style="list-style-type: none"> I feel NVPCA is great here and open to feedback and ideas. I like the financial stuff so I feel good about this area.
<p>2024</p>	<p>Q8 How well does the board monitor and understand NVPCA's finances and budget?</p> <p>Answered: 9 Skipped: 0</p>  <p>0 = Poor 1 = Fair 2 = OK 3 = Good 4 = Excellent</p>

<p>2025</p>	<p>15. Does the board provide effective oversight of and feedback to the Chief Executive Officer?</p> <p>● 0 = Poor ● 1 = Fair ● 2 = OK ● 3 = Good ● 4 = Excellent</p> <table border="1"> <thead> <tr> <th>Item</th> <th>0</th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> </tr> </thead> <tbody> <tr> <td>Cultivates a climate of mutual trust and respect between the board and the CEO.</td> <td>0</td> <td>0</td> <td>0</td> <td>3</td> <td>4</td> </tr> <tr> <td>Gives the CEO enough authority to lead the staff and manage the association successfully.</td> <td>0</td> <td>1</td> <td>0</td> <td>6</td> <td>0</td> </tr> <tr> <td>Discusses and constructively challenges recommendations made by the CEO.</td> <td>0</td> <td>1</td> <td>0</td> <td>5</td> <td>1</td> </tr> <tr> <td>Establishes priorities and sets performance goals by mutual agreement with the CEO.</td> <td>0</td> <td>0</td> <td>5</td> <td>0</td> <td>2</td> </tr> <tr> <td>Ensures that the CEO is appropriately compensated.</td> <td>0</td> <td>0</td> <td>5</td> <td>0</td> <td>2</td> </tr> <tr> <td>Assesses the performance of the CEO and provides feedback.</td> <td>0</td> <td>0</td> <td>5</td> <td>0</td> <td>2</td> </tr> <tr> <td>Plans for the absence or departure of the CEO (e.g., succession planning).</td> <td>1</td> <td>1</td> <td>0</td> <td>4</td> <td>1</td> </tr> <tr> <td>Respects the distinct roles of the CEO, board, and staff.</td> <td>0</td> <td>0</td> <td>0</td> <td>3</td> <td>4</td> </tr> </tbody> </table> <p>Comments:</p> <ul style="list-style-type: none"> I feel a little more out of touch with this. When I was the chair I felt more involved. I would be interested to see how Nancy feels. I'm not sure if the board provides really useful feedback. 	Item	0	1	2	3	4	Cultivates a climate of mutual trust and respect between the board and the CEO.	0	0	0	3	4	Gives the CEO enough authority to lead the staff and manage the association successfully.	0	1	0	6	0	Discusses and constructively challenges recommendations made by the CEO.	0	1	0	5	1	Establishes priorities and sets performance goals by mutual agreement with the CEO.	0	0	5	0	2	Ensures that the CEO is appropriately compensated.	0	0	5	0	2	Assesses the performance of the CEO and provides feedback.	0	0	5	0	2	Plans for the absence or departure of the CEO (e.g., succession planning).	1	1	0	4	1	Respects the distinct roles of the CEO, board, and staff.	0	0	0	3	4
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<p>2025</p>	<p>17. How well does the board foster an environment that builds trust and respect among board members?</p> <table border="1"> <tr> <td>5 = Extremely well</td> <td>2</td> </tr> <tr> <td>4</td> <td>3</td> </tr> <tr> <td>3 = Neutral</td> <td>1</td> </tr> <tr> <td>2</td> <td>1</td> </tr> <tr> <td>1 = Not well at all</td> <td>0</td> </tr> </table>	5 = Extremely well	2	4	3	3 = Neutral	1	2	1	1 = Not well at all	0
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4	3										
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2	1										
1 = Not well at all	0										
<p>2024</p>	<p>Q10 How well does the board foster an environment that builds trust and respect among board members?</p> <p>Answered: 9 Skipped: 0</p> <p>71</p>										



<p>2025</p>	<p>20. Please rate how well the board members and board meetings adhere to the following.</p> <p>● 0 = Poor ● 1 = Fair ● 2 = OK ● 3 = Good ● 4 = Excellent</p>
<p>2024</p>	<p>Q12 Please rate how well the board members and board meetings adhere to the following.</p> <p>Answered: 9 Skipped: 0</p>

<p>2025</p>	<p>22. How satisfied are you with...</p> <p>0 = Poor 1 = Fair 2 = OK 3 = Good 4 = Excellent</p> <p>The size of the board meeting the current needs of the association?</p> <p>The level of commitment and involvement demonstrated by most board members?</p> <p>The overall effectiveness of the board?</p> <p>Serving on this Board of Directors?</p> <p>Comments:</p> <ul style="list-style-type: none"> • There is room for improvement. • I really enjoy serving on this board. I have a tremendous amount of respect for the other board members. I feel we have shown improvement over the last year or so.
<p>2024</p>	<p>Q14 How satisfied are you with...</p> <p>Answered: 9 Skipped: 0</p> <p>The size of the board meeting the current needs of the association?</p> <p>The level of commitment and involvement demonstrated by most board members?</p> <p>The overall effectiveness of the board?</p> <p>Serving on this Board of Directors?</p> <p>0 = Poor 1 = Fair 2 = OK 3 = Good 4 = Excellent</p>



Election of Officers

2025-2026

The following slate is presented for the vote to elect officers for the 2025-2026 board term, effective November 1, 2025 through October 2026:

Nominee	Center	Position
Steve Flores	Hope Christian Health Center	President
Walter Davis	Nevada Health Centers	Vice President
Teri Gilbert Eisenga	Washoe Tribe of NV & CA, Tribal Health	Secretary/Treasurer

Per the NVPCA bylaws:

ARTICLE IV OFFICERS AND THEIR DUTIES

- 4.1 OFFICERS. The officers of the Corporation shall be, at a minimum, a President, a Vice President, and a Secretary/Treasurer. The Corporation may also have, at the discretion of the Board, one or more vice presidents, one or more assistant vice presidents, one or more assistant secretaries, one or more assistant treasurers, and such other officers as may be elected or appointed in accordance with the provisions of these bylaws.
- 4.2 ELECTION AND TERM. The officers of the Corporation, except such officers as may be elected or appointed in accordance with the provisions of Section 3 or Section 5 of this Article, shall be chosen annually by the Board at the first meeting following the annual meeting of members for one-year terms, and shall hold their respective offices until their resignation, removal, or other disqualification from service or until their respective successors shall be elected.

Required Action:

Approve proposed officers for new term, effective November 1, 2025, through October 30, 2026.



Board Meeting Calendar 2025-26

Below is the proposed NVPCA Board of Directors meeting schedule for 2025-2026. The spring Board retreat has been adjusted from an all-day in-person meeting to a 3-hour virtual meeting.

- Four virtual board meetings bi-monthly on the first Tuesday in November, January, May and July
- One virtual 3-hour Board Retreat in March
- One in-person full-day Board Retreat in September in conjunction with the 2026 Annual Healthcare Conference

Meeting Dates	Time	Location
Tuesday, November 4, 2025	8:30-10:00 am	Virtual
Tuesday, January 6, 2026	8:30-10:00 am	Virtual
Tuesday, March 3, 2026	8:30 – 11:30 pm	Virtual Board Retreat
Tuesday, May 5, 2026	8:30-10:00 am	Virtual
Tuesday, July 7, 2026	8:30-10:00 am	Virtual
September 2026 Date is TBD	9:30 am – 4:30pm; dinner 5:30pm	In-person – Location TBD

Required Action:

The Board shall take action to approve the proposed Board meeting calendar for 2025-26.



Committees of the Board 2025-2026

The composition of the NVPCA 2024-25 Committees of the Board is listed below. Committee membership is annual from October – September.

Committee	Members	Chair/Staff
Finance Committee – bi-monthly meetings	Teri Gilbert Eisenga, CJ Hansen, Walter Davis, Randy Smith, Nancy Bowen, Nancy Barklage	Teri Gilbert Eisenga (Secretary-Treasurer)/ Nancy Barklage
Policy Committee– bi-monthly meetings	Steve Flores, Oscar Delgado, David Robeck, John Packham, Angela Quinn, Steve Messinger, Nancy Bowen, TBD (Lobbyist)	Steve Flores/ Steve Messinger
Bylaws & Membership Committee – ad hoc	Walter Davis, C.J. Hansen Sharon Chamberlain, Nancy Bowen, Nancy Barklage	Walter Davis/ Nancy Barklage
Strategic Growth & Networking Task Force – ad hoc	Sharon Chamberlain, Walter Davis Teri Gilbert Eisenga, Tina Alicea Nancy Bowen, Steve Messinger	Sharon Chamberlain/ Nancy Bowen

Required Action:

The Board will take action to keep committee membership the same, make changes to committee membership, and/or add any new members of the Board to at least one committee.

NVPCA 2025-2026 NVPCA Strategic Plan

5	20	29
Pillars	Priorities	Goals

Policy

<i>Pillar</i>	<i>Definition</i>	<i>Strategic Priority</i>	<i>Measurable Goals</i>
<i>Policy</i>	Elevate the status of and improve the health policy environment for community health centers (CHCs).	Protect the 340B Program at the state level	Pass a law at the state level to protect contract pharmacies by June 30, 2025
		Protect the 340B Program at the national level	Work with members of Congress to co-sponsor a 340B bill by June 2026
		Increase federal and state funding for community health centers and other NVPCA programs to support them.	Increase participation with National and State coalitions to influence advocacy and education of legislators to match or exceed the ongoing needs of the health centers
		Reduce time required for provider credentialing and payer credentialing. (rolled over from 2023 plan)	Decrease the amount of time it takes for a health center to receive reimbursement for a provider encounter to 60 days or less by January 31, 2026
		Promote policy improvements to increase reimbursement of services in FQHCs (i.e. unbundling OB, adult dental)	By June 30, 2026, unbundle OB global delivery package by building/joining coalition including providers, pharmacies, hospitals with common goal. By June 30, 2025 Adult dental services are reimbursed to FQHCs
		Promote health center workforce pathways	Secure mandate at Medicaid for primary care training SPA development in 2025 Legislative Session by June 30, 2025 Establish first GME accreditation grant by December 31, 2026
		Develop and implement a comprehensive policy plan	Multi-year policy plan will be delivered to Board by September 2025

Organizational Excellence

<i>Pillar</i>	<i>Definition</i>	<i>Strategic Priority</i>	<i>Measurable Goals</i>
		Diversify funding for the NVPCA	By December 31, 2026 diversify funding to ensure reduced dependency of not more than 40% on any one funding source

Confidential

Organizational Excellence	Ensure organizational knowledge, financial sustainability and value of the NVPCA to its members through healthy organizational culture.	Systemize organizational knowledge, processes and procedures	By Dec 2025, document and organize at least 50% of unrecorded staff knowledge through processes and procedures
		Board: Improve trust among and between board members	The Board Officers and NVPCA Leadership will develop a plan to improve trust, with improved results reflected in the Summer 2025 Board survey
		Advance NVPCA along the continuum towards becoming an fair-minded, ethnically varied organization	Employee Engagement Committee will review and revise workplan for 2025 by June 30, 2025.
Strategic Growth			
<i>Pillar</i>	<i>Definition</i>	<i>Strategic Priority</i>	<i>Measurable Goals</i>
Strategic Growth	Increase access to care and strengthen the network of community health centers. (or "Strengthen the network of community health centers, whereby increasing access to care")	Develop, then implement an FQHC growth plan for NV	By September 30, 2025 the Strategic Growth Committee presents a growth plan for FQHCs in Nevada
		Continue to identify and advocate for improved health center opportunities and outcomes with HCCNs	By August 2025 & 2026, create and/or contribute to the annual HCCN workplan to address health center HIT needs.
		Board: NVPCA Board to decide on preferred health center network configuration	FQHCs agree to respond with requested information to NVPCA inquiries by July 1, 2025. NVPCA to develop material and scenarios for creating a FQHC network for board decision by March 31, 2026
Members Services			
<i>Pillar</i>	<i>Definition</i>	<i>Strategic Priority</i>	<i>Measurable Goals</i>
Members Services	Implement highly valued services designed to maximize the combined power of our members.	Improve the availability of shared information among members	Increase availability of documents, trainings, and information to support health centers clinical and operational needs as evidence by the creation of a member share drive/portal with at least 3-4 content areas by December 31, 2026
		Share unblinded member health center data and performance dashboards for benchmarking and quality improvement	Share unblinded data of 1-2 clinical measures during each NVPCA Board of Directors meeting to increase the availability of actionable data through December 31, 2026. By February 1, 2025 data sharing agreements and Business Associate Agreements (BAAs) are signed with health centers.

Confidential

		Explore possibility for a Group Purchasing Organization (GPO)	By March 31, 2025, health centers current purchasing data is collected for analysis. By September 30, 2025, Group Purchasing Organization options are presented to the Board for their approval or denial.
Outreach & Communication			
Pillar	Definition	Strategic Priority	Measurable Goals
Outreach & Communication	Effectively communicate the value of NVPCA and CHCs in the region.	NVPCA identifies standards and benchmarks for a CHC to be recognized as an Employer of Choice	By 12/31/25, NVPCA will identify an Employer of Choice partner for CHCs; if none emerges, NVPCA will develop and share standards and benchmarks for CHC Employer of Choice designation with badge for CHC and NVPCA use; By Leveraging the HR Peer Network NVPCA will provide regular/quarterly updates to member CHCs on how to achieve and promote the EOC designation and communicate CHC EOC standards to member CHCs. By 12/31/26, at least 25% of NV-based CHCs will have achieved EOC status and NVPCA will formalize longer-term collaboration with EOC partner (based on CHC uptake of the opportunity).
		Communicate the value of NVPCA's organizational members and Federally Qualified Health Centers generally	Create and implement a communication and outreach playbook by July 31, 2025
		Reinforce NVPCA's reputation as "go to" expert of healthcare for uninsured and underinsured individuals	NVPCA to establish baseline of Value Transformation Framework PCA Assessment by March 31, 2025. Increase the number of domains in NACHC's Value Transformation Framework PCA Assessment in which NVPCA scores at least 4.5 by September 30, 2026.

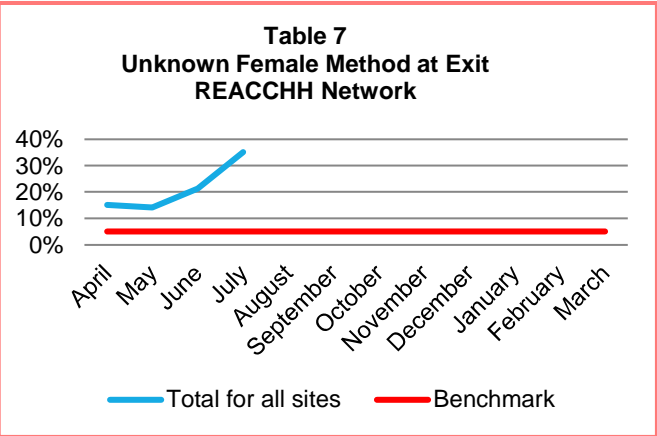
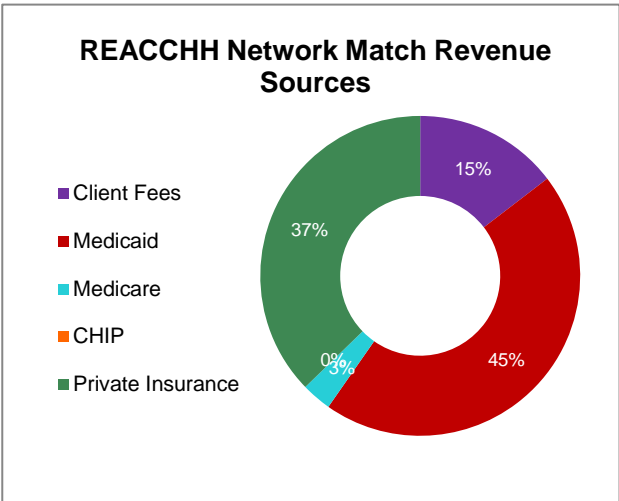
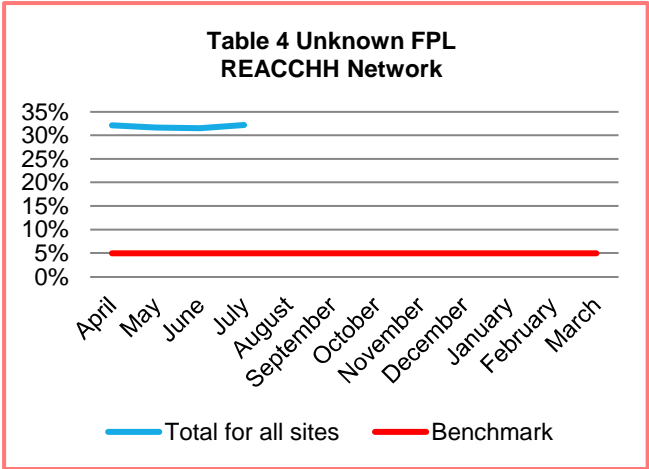
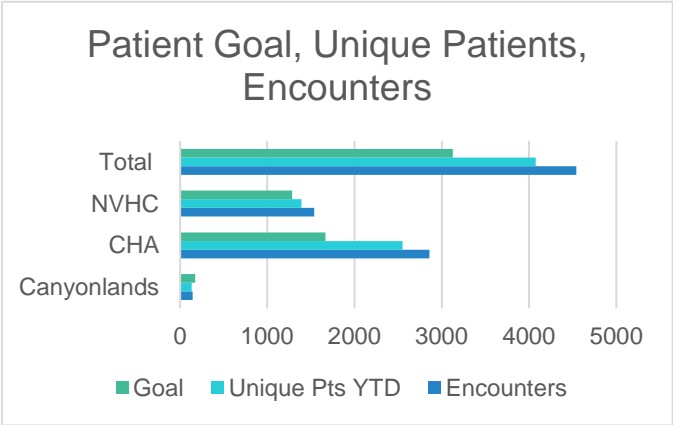
Confidential

NVPCA REACCHH Dashboard (YTD = 75%)

Year 3 Contract Amendment #1: April 1 - August 31

2024-2025 Contracted
 Canyonlands, CHA, NVHC

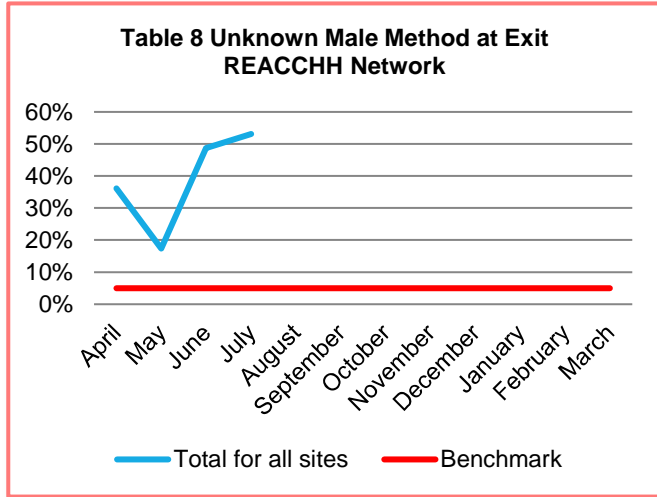
Data Quality - Unknown Rates*



At 80% of the Amendment #1 year...

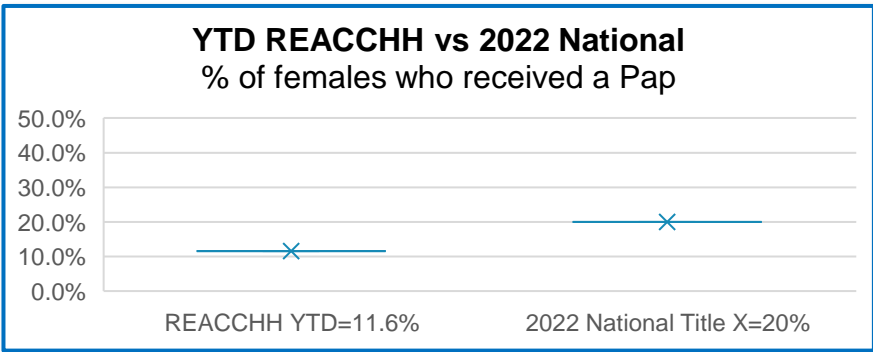
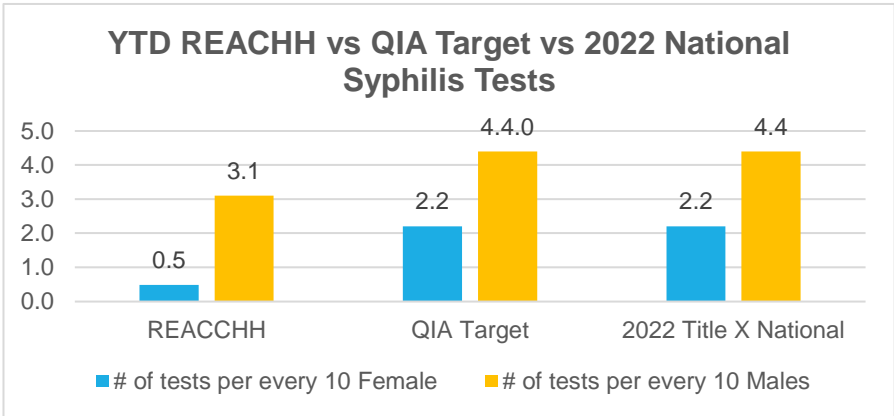
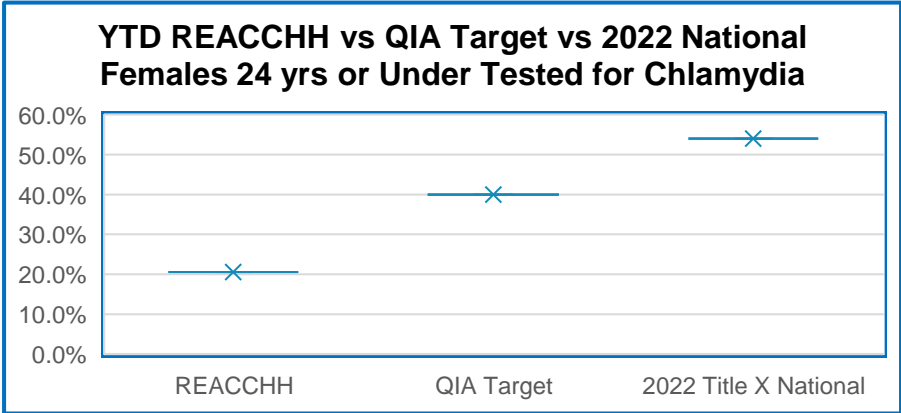
REACCHH Title X funds spent YTD = 78.2%

Unique Title X Patients Served by REACCHH = 130.3% of total contracted



4) Data submitted using the FPAR 2.0 template

Clinical Quality Standards



***Notes & updates for data through August 2025:**

- Quality Improvement Awards Period: 8/1-12/31/24;
 Considering 2025-26 QIA Goals (9/1/25)
- Permanent sterilization (vasectomy) in northern NV in fall/winter 2025



Title X Program Review - Preliminary Summary

The HHS Office of Population Affairs conducted a federal program review August 25-27, 2025. The review consisted of three consultants and our project officer asking for clarification and documentation. They reviewed NVPCA (the grantee) on Monday, Community Health Alliance Sun Valley location on Tuesday, and Nevada Health Centers Sierra location on Wednesday. The program review exit interview was held on Tuesday, September 2 and is summarized as follows.

Overall:

- OPA expressed gratitude to each entity for thorough preparation before the review and for quick responses during and after the review.
- No specific Areas of Improvement (AOIs) were noted during the exit interview.

Fiscal:

- CHCs praised for solid accounting, and consistent and accurate reporting
- CHCs received kudos for providing increased access to services regardless of ability to pay, a primary goal of the program
- The grantee has implemented a well-designed monitoring program
- Specific feedback regarding misidentification of source of funds on one subrecipient's audit and suggested language change on one section title of grantee's audit
- Noted inconsistency in delivering services to minors; subrecipient training or TA would be helpful

Clinical:

- CHCs and NVPCA lauded for excellent clinical leadership! Specific thanks to Dr. Hess, Dr. Walker, and Rebecca Sparks, PA-C.
- CHCs praised for all patients' ease of accessing emergency contraception
- Impressed with CHCs striving to train all providers in IUC and implant placement and removal



- Suggested grantee increase chart monitoring and clinical observation to identify and resolve inconsistencies (increased STI/IPV screening, improved sexual history taking, and adequate documentation)
- Suggested grantee provide TA to improve documentation of detailed adolescent counseling; can grantee help develop more thorough checklists to support the clinical conversations?

Administrative:

- In general, the consultant observed a ‘remarkable’ administrative program.
- REACCHH was praised for its work on
 - data quality improvement efforts
 - using data to inform programmatic decisions
 - workforce and training to maintain and strengthen the Title X and CHC teams
- Continue to develop and implement policies and procedures that reflect best *and actual* practice
- Continue to improve documentation
- Seize opportunities to engage the whole community in the Title X program (beyond existing patients)

OPA will provide a summary report in early October with AOI findings and program recommendations. NVPCA will then submit a plan to OPA within 30 days that addresses AOIs. Once OPA accepts the plan, NVPCA has 60 days to implement required changes (extensions possible).

We are grateful for our REACCHH partners, including leadership, for supporting this federal monitoring process.

HCCN Grant Objectives for Participating Health Centers (PHCs) 8/1/2025 – 7/31/2028

Data Management and Analytics

- **Goal:** Increase the percentage of PHCs that advance and optimize clinical, financial, and operations data to improve clinical quality, health outcomes, and operations.
- **Numerator:** Number of PHCs that advance and optimize clinical, financial, and operations data to improve clinical quality, health outcomes, and operations.

Interoperability and Data Sharing

- **Goal:** Increase the percentage of PHCs to optimize bidirectional interoperability with health care providers and community-based organizations to improve care coordination, reduce unnecessary testing, and improve provider workloads.
- **Numerator:** Number of PHCs that optimize bidirectional interoperability with health care providers and community-based organizations to improve care coordination, reduce unnecessary testing, and improve provider workloads.

Additional Value-Based Care

- **Goal:** Increase the percentage of PHCs that use data to update operational, financial, and clinical processes in health IT systems to prepare for delivering, participating, or updating VBC delivery plans to achieve improved better health outcomes or provider experience to address cost.
- **Numerator:** Number of PHCs that use data to update operational, financial, and clinical processes in health IT systems to prepare for delivering, participating, or updating VBC delivery plans to achieve improved better health outcomes or provider experience to address cost.

Artificial Intelligence

- **Goal:** Increase the percentage of PHCs that have successfully implemented AI tools to improve patient care and outcomes.
- **Numerator:** Number of PHCs successfully using AI tools to improve patient care and outcomes

Nevada Participating Health Centers: HOPES, HCHC, CHA; SNCHC, FPCC

2025 UDS Updates

CHQR Badge Eligibility Update from HRSA BPHC Office of Quality Improvement

Beginning with the 2025 cycle, only health centers whose submissions receive “Acceptable” ratings across all tables—and result in an overall acceptable UDS submission—are eligible for CHQR badges. This new eligibility requirement places emphasis on data quality and integrity and will remain in place through CY 2025-2027.

CALENDAR YEAR REPORTING

Who Reports UDS	What Is Reported	How to Report	When to Report
<ul style="list-style-type: none"> All health centers funded or designated, in whole or in part, before October 1, 2025, including New Access Point (NAP) awardee recipients, mergers, or acquisitions. 	<ul style="list-style-type: none"> Approved in-scope activities from January 1 through December 31, 2025. Report even if no grant funds were drawn down for some or all funding streams during the calendar year. 	<ul style="list-style-type: none"> Through the Electronic Handbooks (EHBs) starting January 1, 2026. Preliminary Reporting Environment (PRE) and offline tools are available in Fall 2025. 	<ul style="list-style-type: none"> January 1 through February 15, 2026. UDS Reports are to be submitted by February 15, 2026. UDS Report reviews are conducted and necessary revisions are made from February 15 through March 31, 2026.

Due Dates and Revisions to Reports

The period for submission of complete and accurate UDS Reports through EHBs is January 1 through February 15, 2026, 11:59 p.m. local time. From February 15 through March 31, 2026, a Health Center Program UDS Reviewer will review your report and as needed, help you in ensuring that reported data adheres to reporting requirements. **The UDS Reviewer sends communications and data change requests through EHBs via a non-HRSA.gov email address to the health center contact listed in the EHBs. Communicate directly with the assigned UDS Reviewer during this time to address questions they have raised.** It is critical to address questions raised by your UDS Reviewer within the timeframe assigned in order to meet the final submission timeline. Final corrected submissions are due no later than March 31, 2026.

Health centers are required to appoint one person as the UDS contact. The UDS contact receives all communications about the UDS Report. This person ensures that the report is submitted according to set deadlines, corrections to the report are made, and explanations of accurate data reported on the UDS tables are clear. **Be sure the UDS contact information in the EHBs is current to ensure receipt of important UDS related communications.**

Additional Information Provided by HRSA BPHC Office of Quality Improvement

Reviewer comments are completed primarily within EHBs. When emails are generated through the EHBs communications module, they always come from the grantsupport@hrsa.gov address, which will reach the health center contact listed in EHBs.

In the rare case when a Reviewer corresponds directly with a health center outside of EHBs, the email may come from an @ahpnet.com or @jsi.com/@jsi.org account. **To help avoid issues, we recommend health centers add these domains to your "safe senders" list and check with your IT/security teams to ensure such messages are not blocked or sent to spam.**

Updates to Tables

Table 3B: Updated Table

Demographic Characteristics: Previous Table 3B, Lines 13-26 are no longer reported.

Table 6A: Updated Codes

Selected Diagnosis and Services Rendered: 2025 Table 6A code changes will be [available for download](#).

Table 9E: Removed Lines

Other Revenues: Removed several COVID-19 grant lines, including lines 1l,1m,1n, and 1p. Removed Line 3b Provider Relief Fund.

Clarifications to Existing Data

- General and Demographic Tables
- Clinical Services and Outcomes Tables- Table 5
- Financial Tables
- Appendices

Changed to Align with eCQMs

Tables 6B and 7

Updated to align with the latest CMS eCQMs. The [UDS CQM Criteria](#) handout to review for 2025 updates.

Table 6B: Existing Measure Modified

Breast Cancer Screening- measure includes revised denominator exclusion language for advanced illness criteria.

BMI Screening and Follow-Up Plan- updates clarify the timing of documentation of exception criteria to the same day as the qualify encounter.

Colorectal Cancer Screening –measure includes revised denominator exclusion language for advanced illness criteria.

Screening for Depression and Follow-up Plan- the guidance statement has been updated to reflect the CY 2024 removal of the denominator exclusion for prior diagnosis of depression. The intent of the measure is to screen all patients for depression except those with a diagnosis of bipolar disorder.

Table 7: Existing Measure Modified

Controlling High Blood Pressure- includes revised denominator exclusion language for advanced illness criteria.

Diabetes: Glycemic Status Assessment Greater Than 9%- includes revised denominator exclusion language for advanced illness criteria.

Table 6B: New Data Reported

Line 26c2: Tobacco use cessation pharmacotherapies

Line 26c3: Medications for opioid use disorder (MOUD)

Line 26f: Alzheimer's disease and related dementias (ADRD) screening

Table 6B: New Measure

Initiation and Engagement of Substance Use Disorder Treatment

This measure will be reported across two new lines on Table 6B. Lines 23a and 23b:

Patients with a new SUD episode who initiated treatment will be reported on 23a.

Patients with a new SUD episode who engaged in ongoing treatment will be reported on Line 23b.

UDS Resources

Nevada Primary Care Association

Annual UDS Training

November 12th and 13th 9 AM – 12 PM,

Registration link:

<https://us02web.zoom.us/meeting/register/LK8NeVx8QWYgb-VAAEgwWg>

[UDS Webinar Series](#)

[2025 UDS Manual](#)

[UDS Training and Technical Assistance webpage](#)

[PAL](#)

[eCQI Resource Center](#)

[VSAC](#)

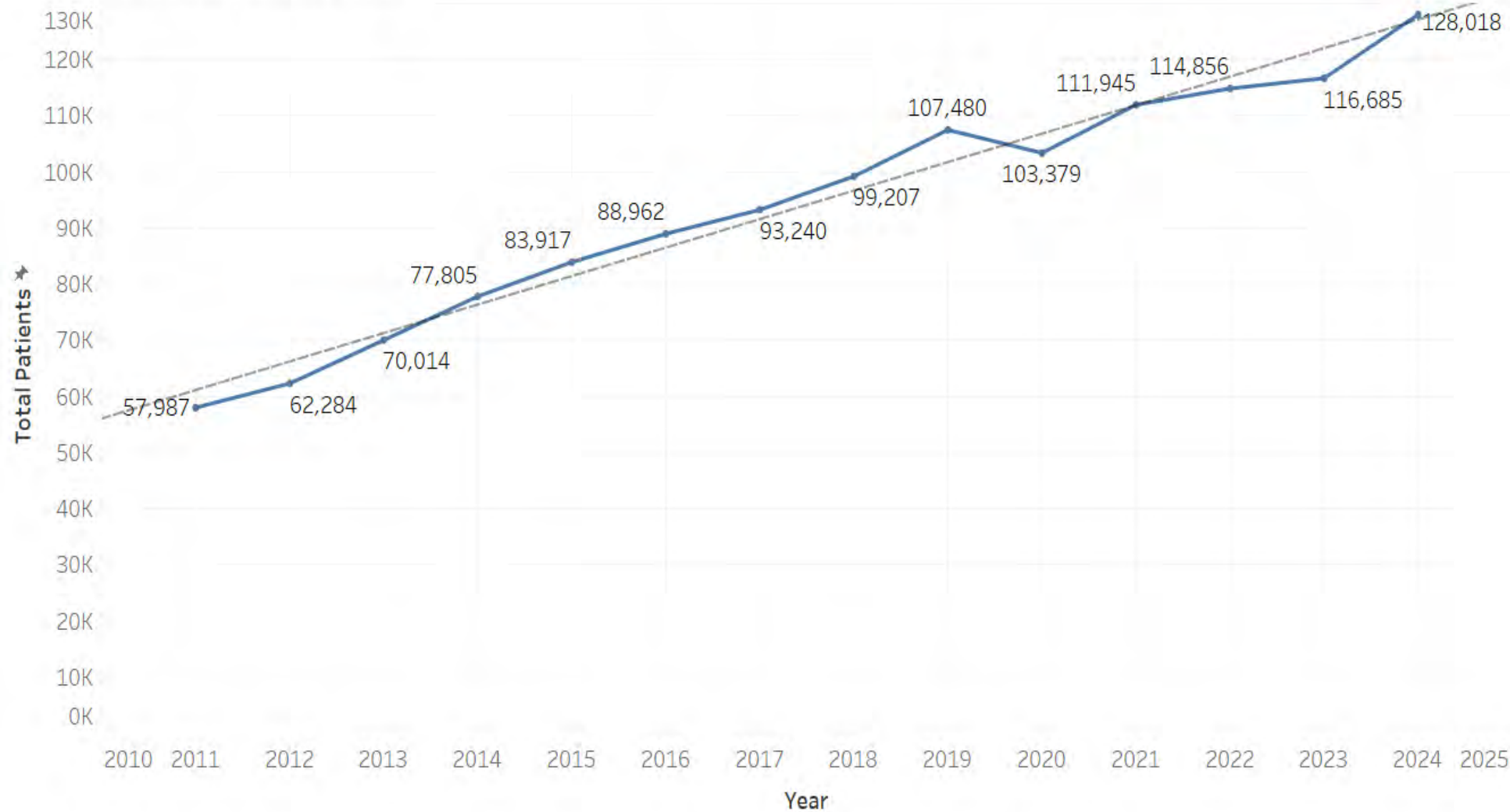
NVPCA 2024 UDS Update

September 9, 2025



Total Patients

Total Patients, Statewide



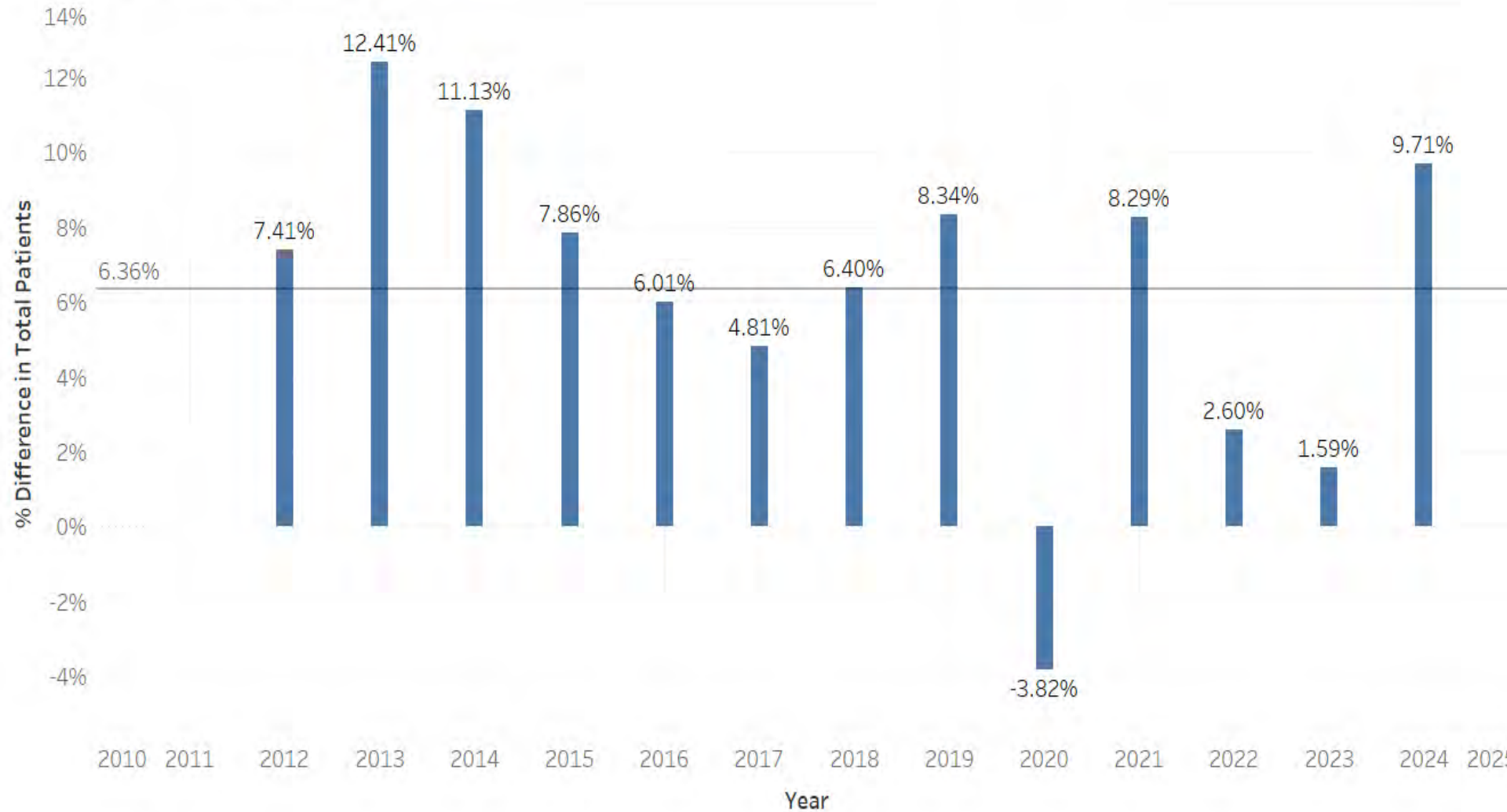
In 2023, total patients were 4,923 below trend

In 2024, they were 1,021 over trend



Total Patients

Total Patients, % change

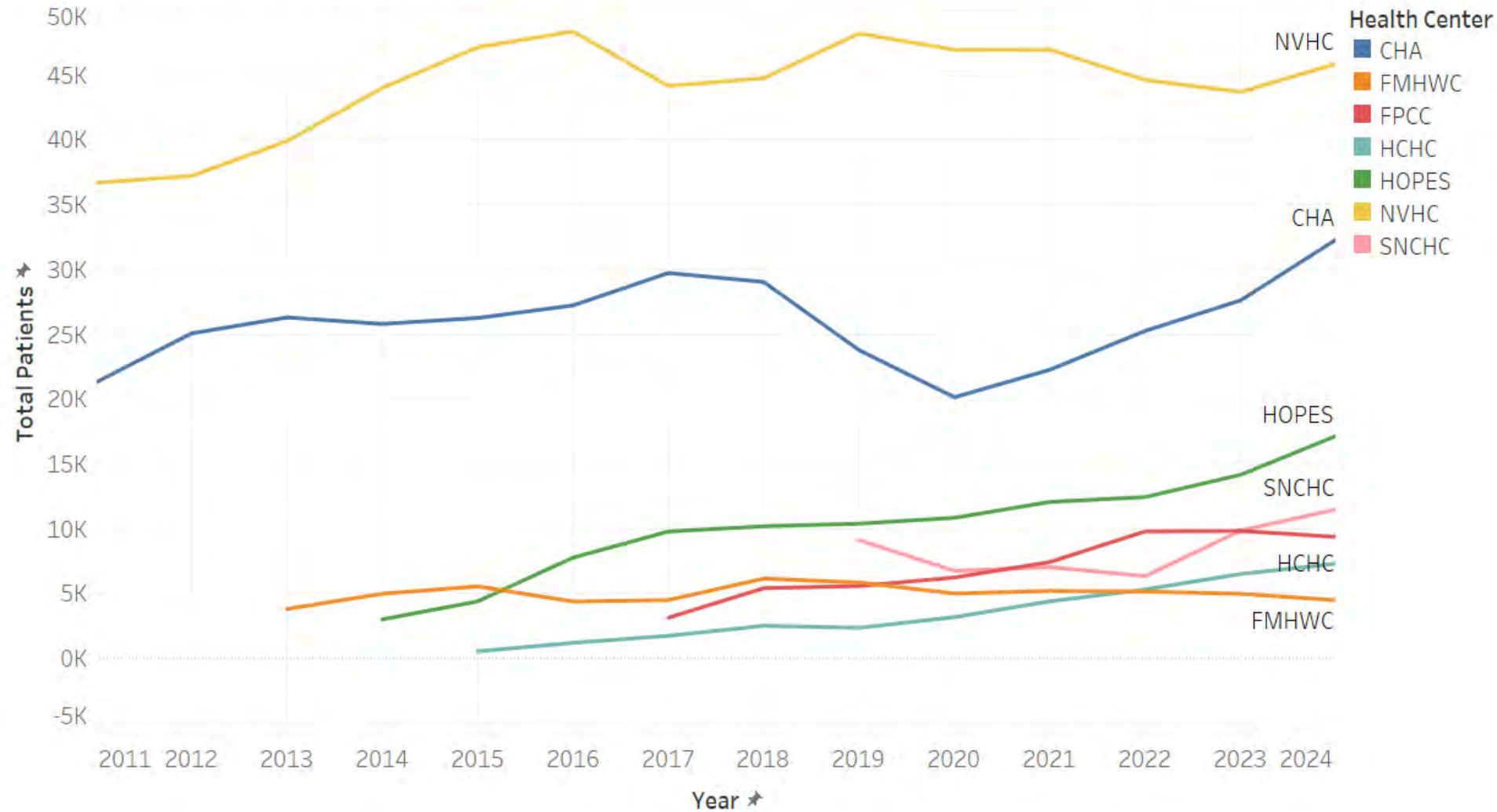


Best growth rate since 2014!



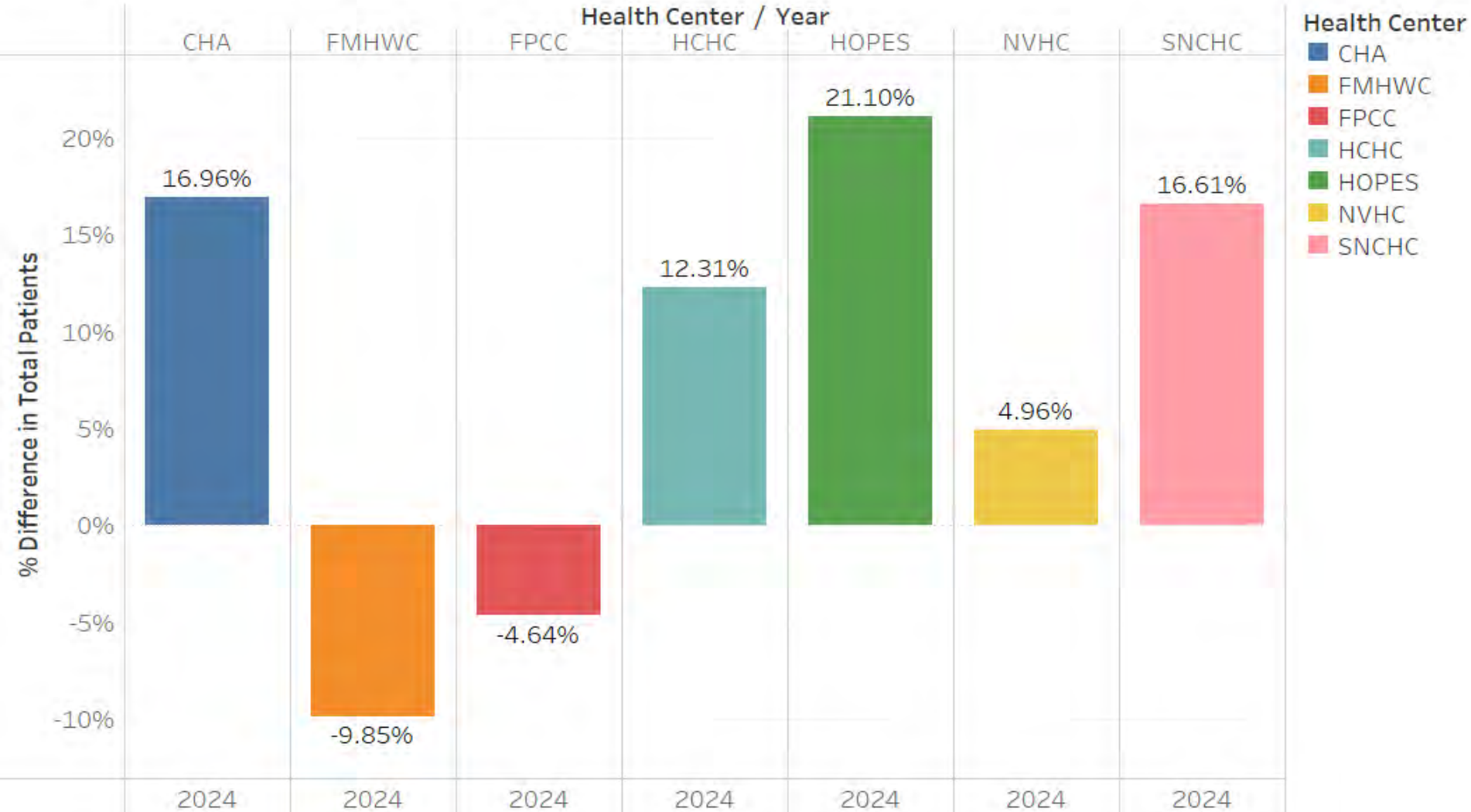
Total Patients by Health Center

Total Patients by Health Center



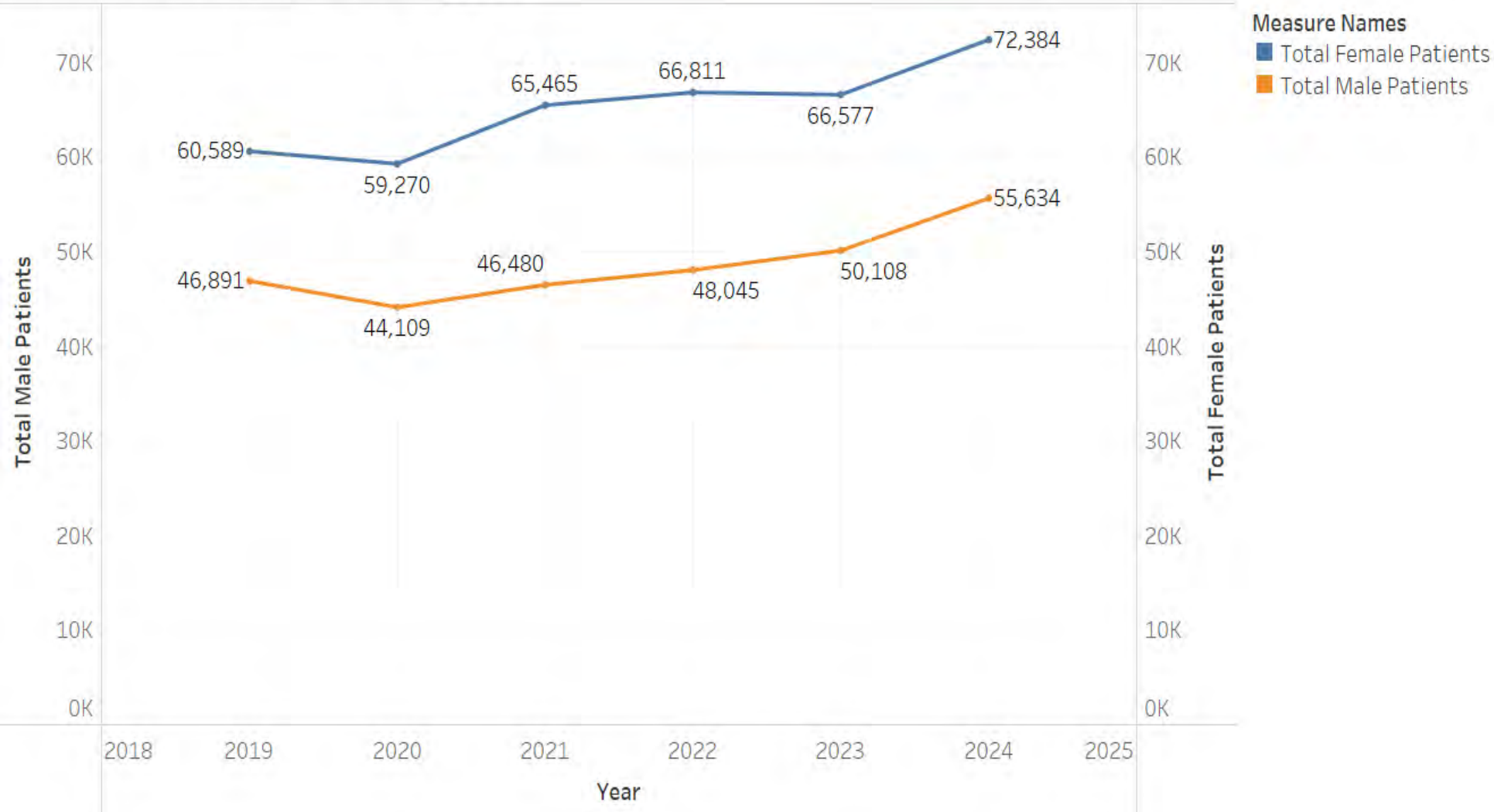
Total Patients by Health Center

Total Patients, % change 2023-2024



Patients by Sex

Total Patients, statewide by sex

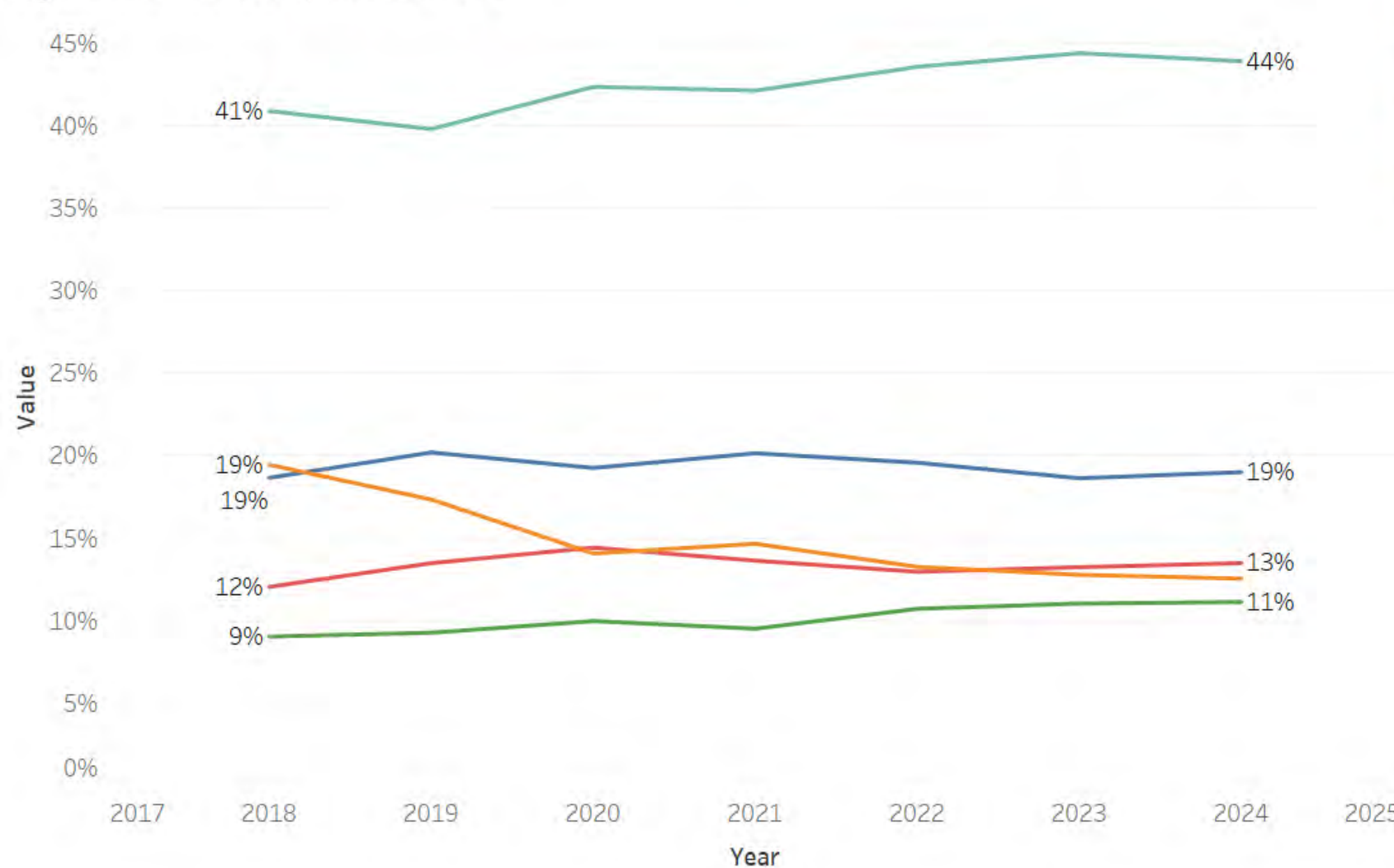


Growth among males and females after several years of stagnant growth in female patients



Patients by Age

Age Distribution, statewide



Measure Names

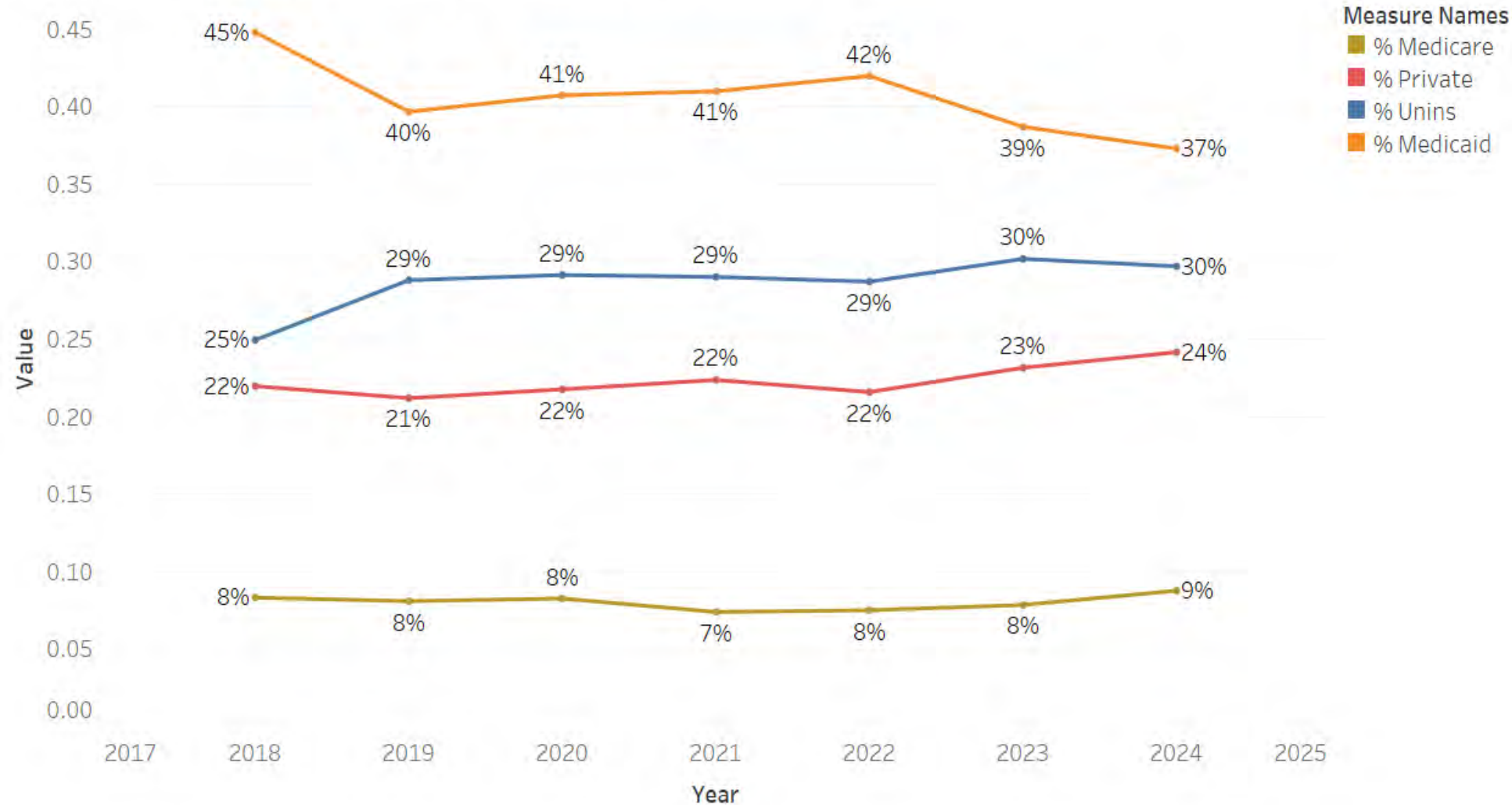
- % under 11
- % 11-24
- % 25-34
- % 35-64
- % 65+

Continued decline in young children while trend favors older adults and seniors



Patients by Insurance

Total Patients, by insurance, statewide

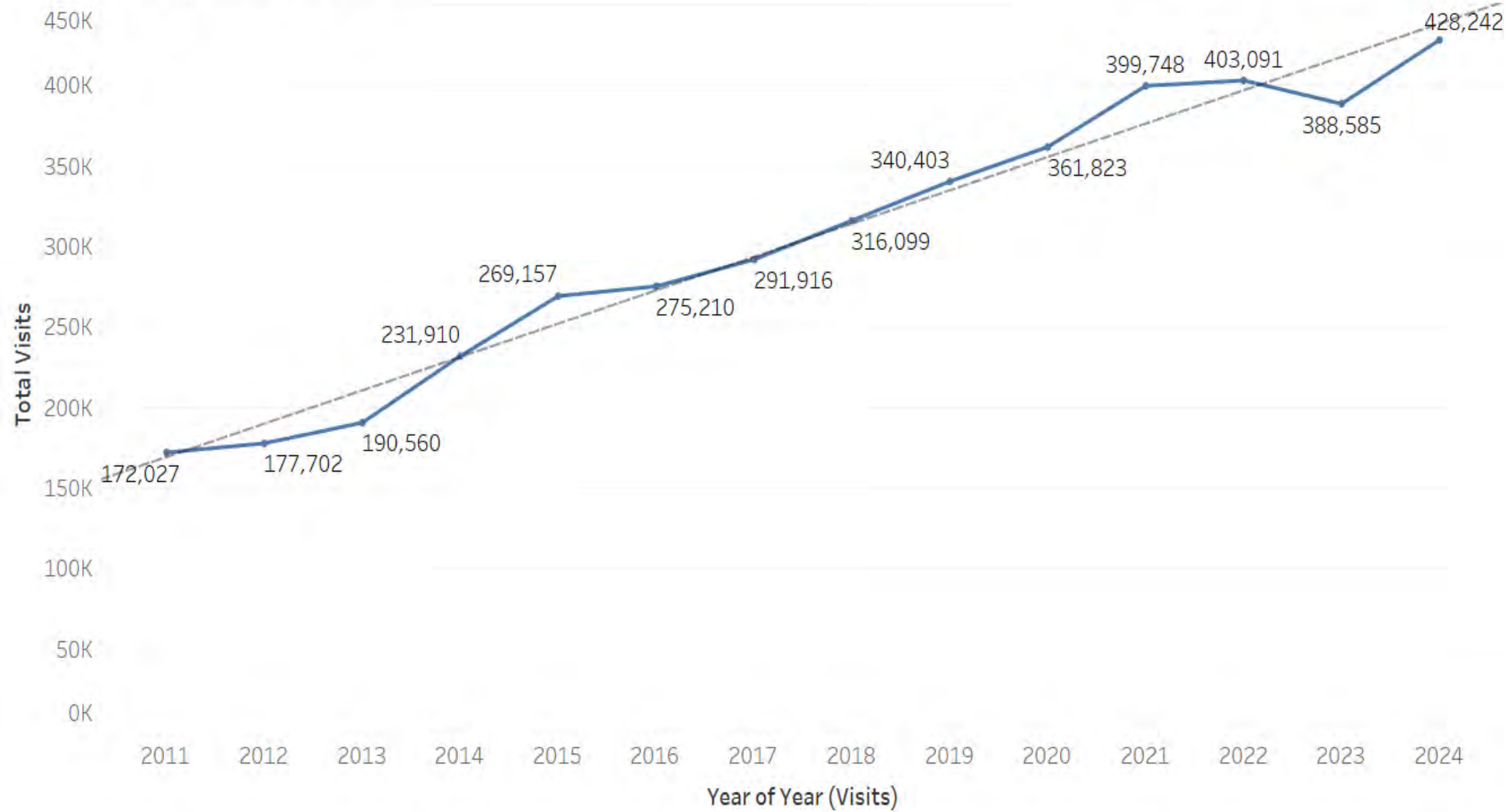


Medicaid share continuing to fall while Private and Medicare grow



Total Visits

Total Visits, statewide

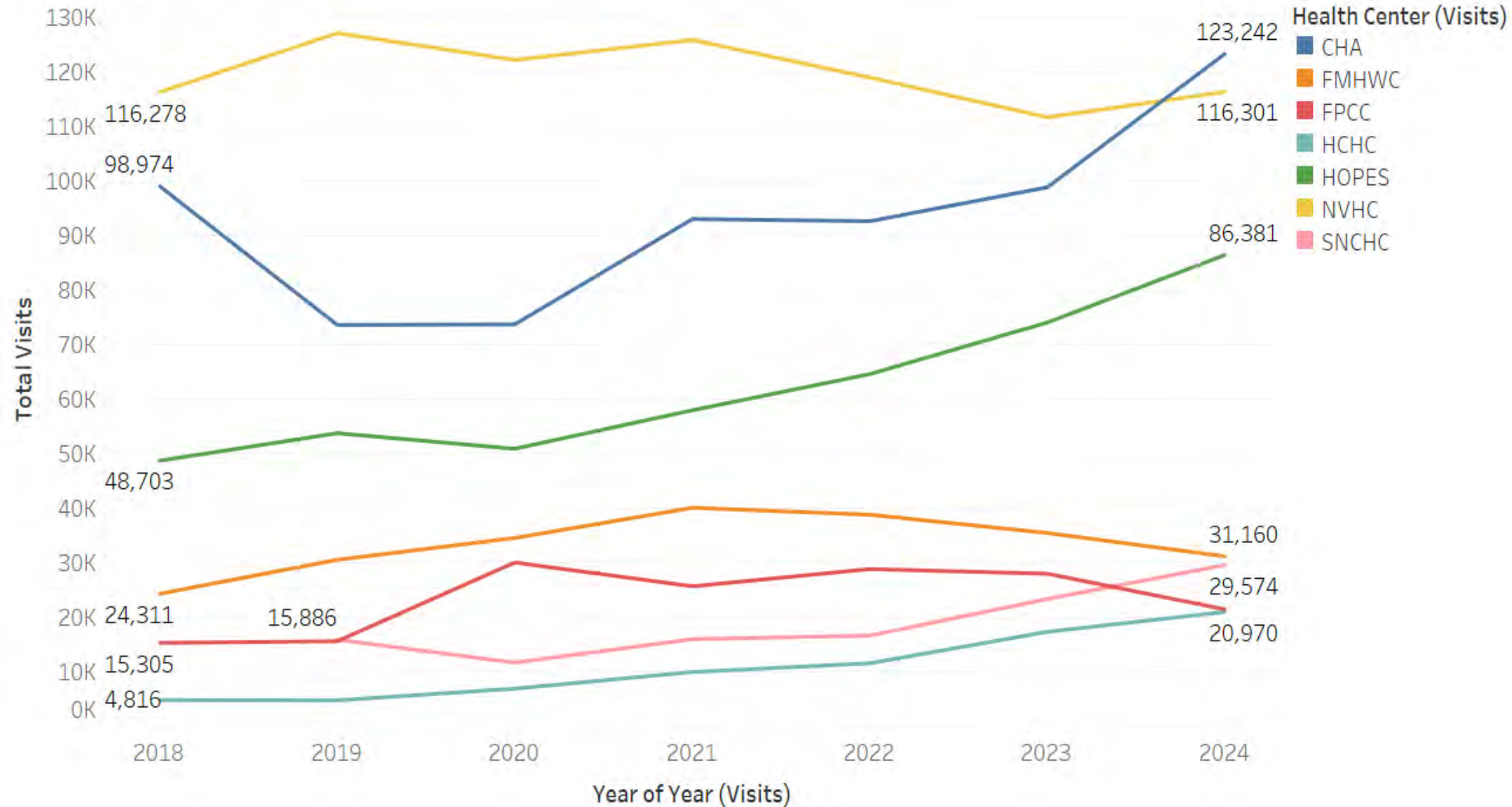


Near return to trend for visits



Visit Type

Total Visits, by CHC

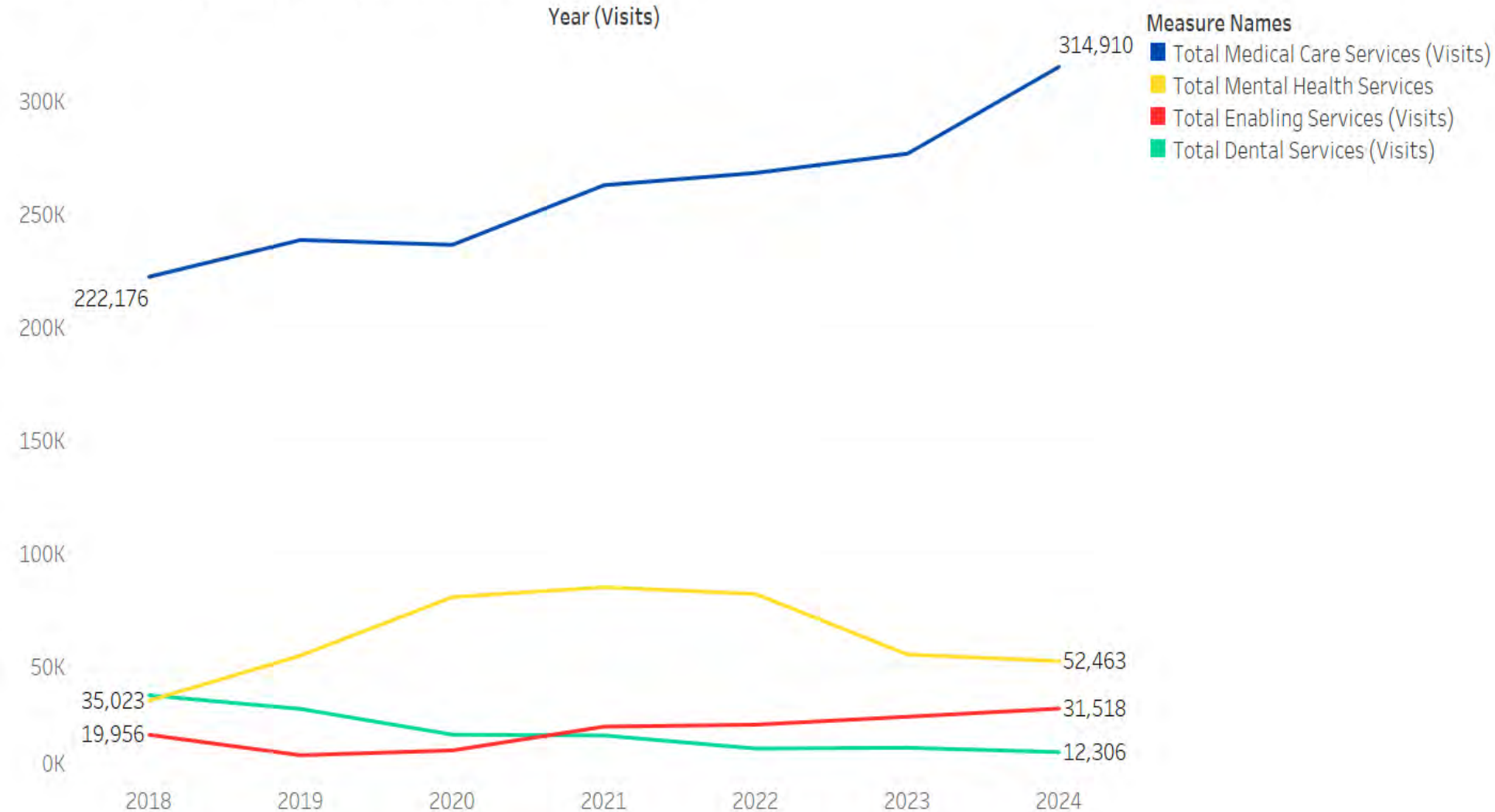


Most health centers reported fewer MH visits in 2023



Total Visits

Total Visits by service type, statewide



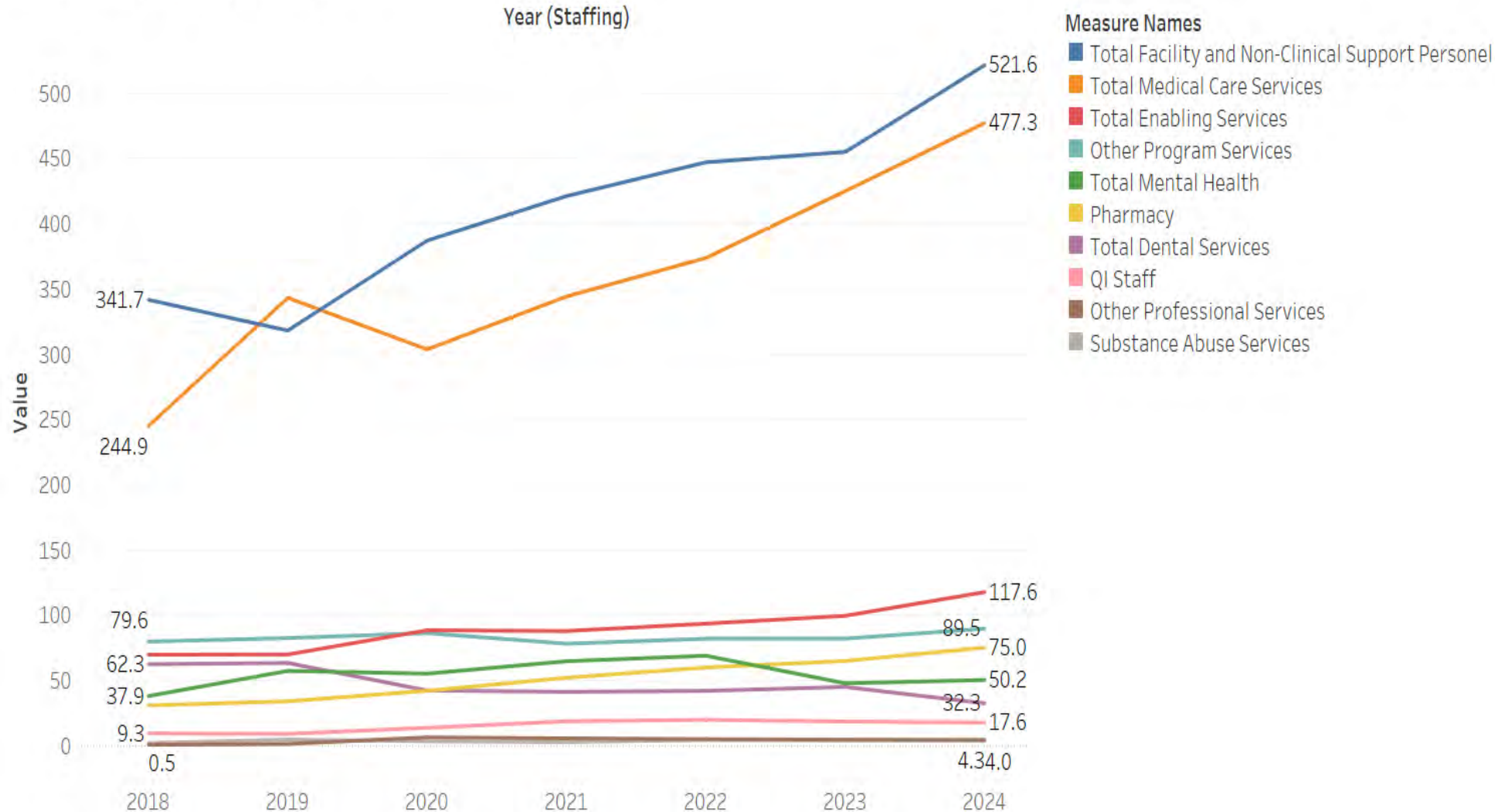
Continued decline in Dental and MH Services

Sharp increase in Medical Services



Staffing by Department

Total FTE, by department



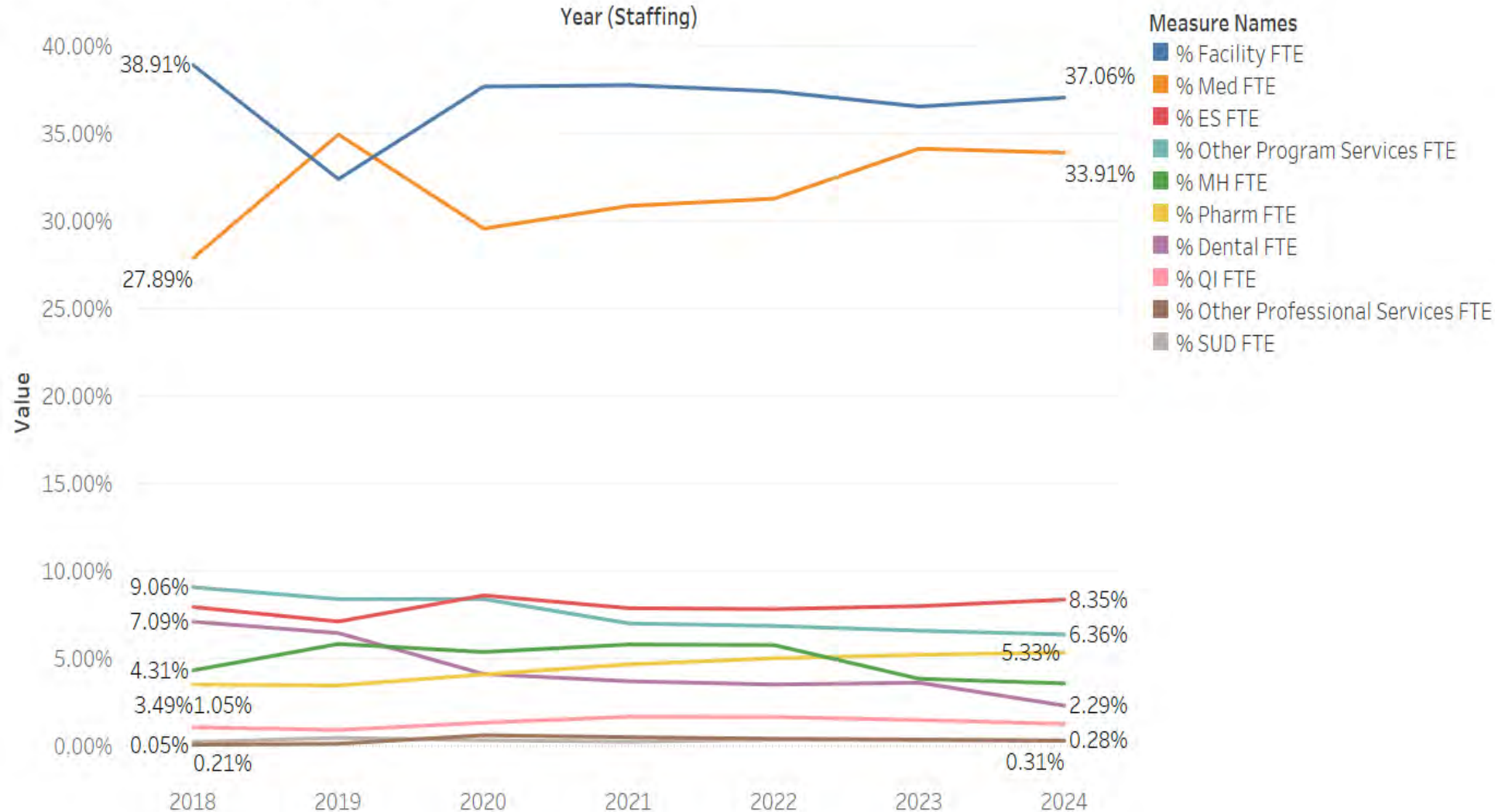
Admin growing faster than Medical Providers

Dental and MH staff are lower than in 2023



Staffing by Department

% Total FTE, by department

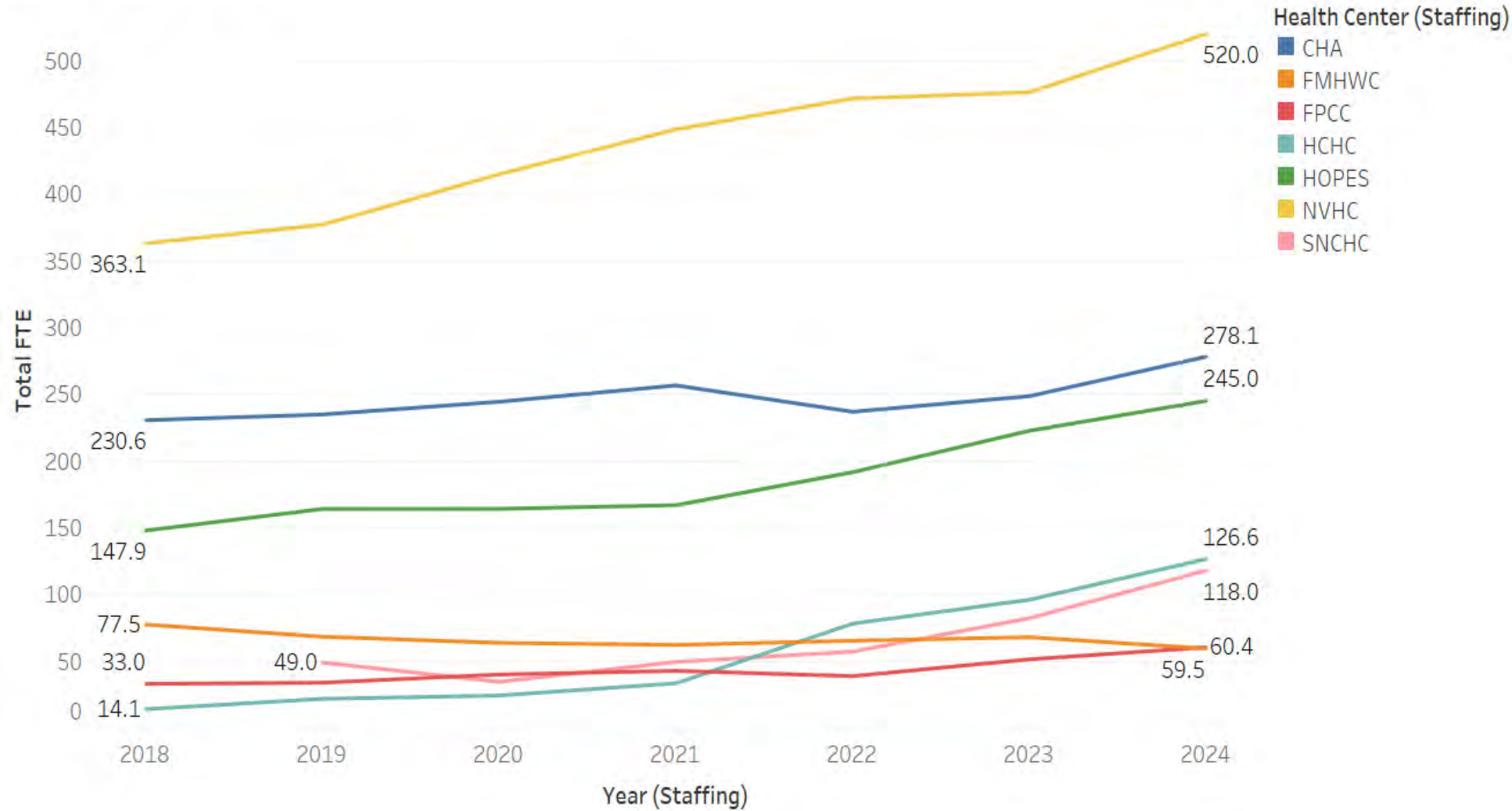


*Fairly stable
dept shares*



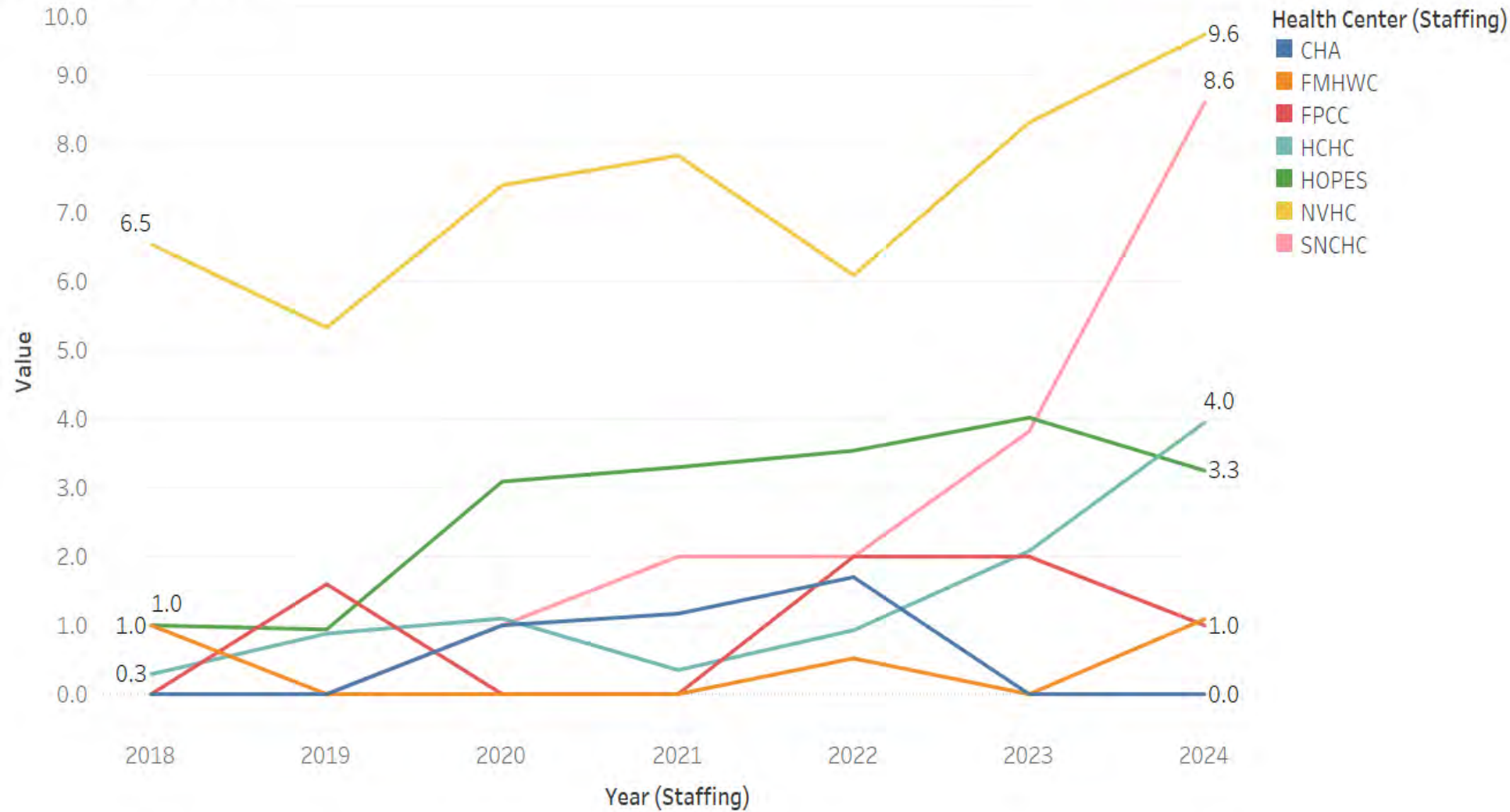
Total FTE by CHC

Total FTE, by CHC



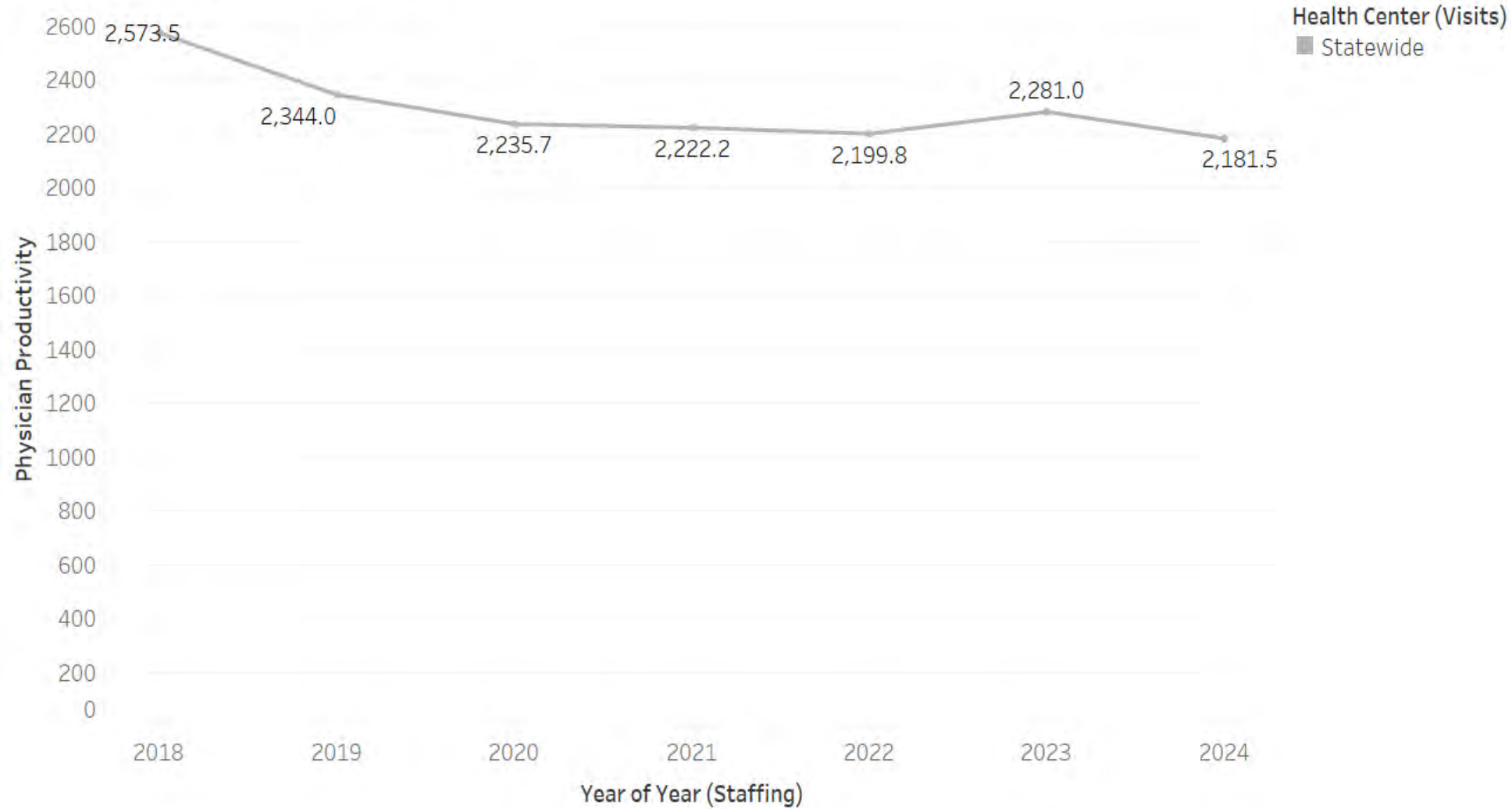
Community Health Workers

CHW FTE, by CHC



Physician Productivity

Visits per physician, total

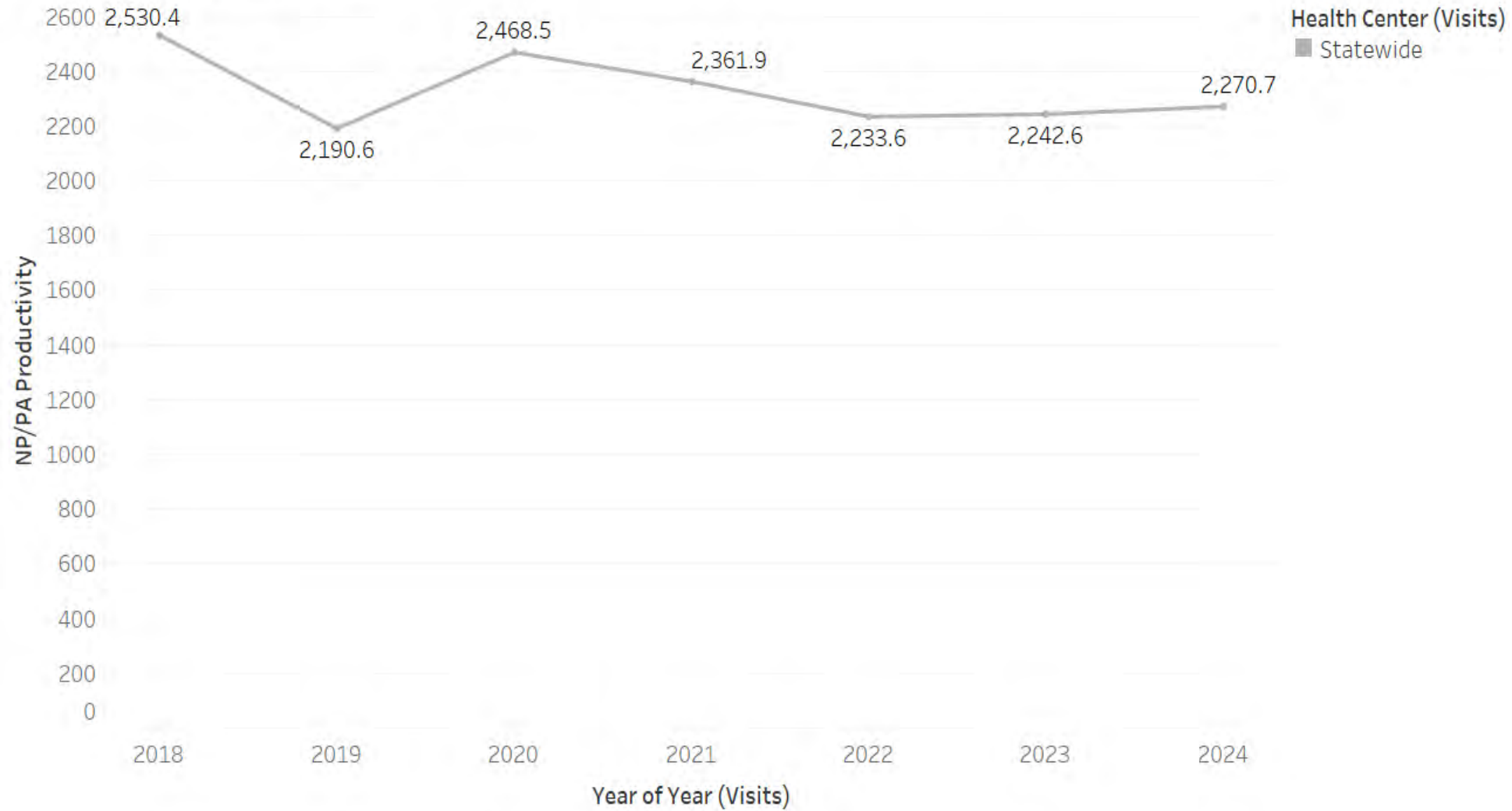


Continued trend of lower productivity



Mid Level Productivity

Visits per NP/PA, total

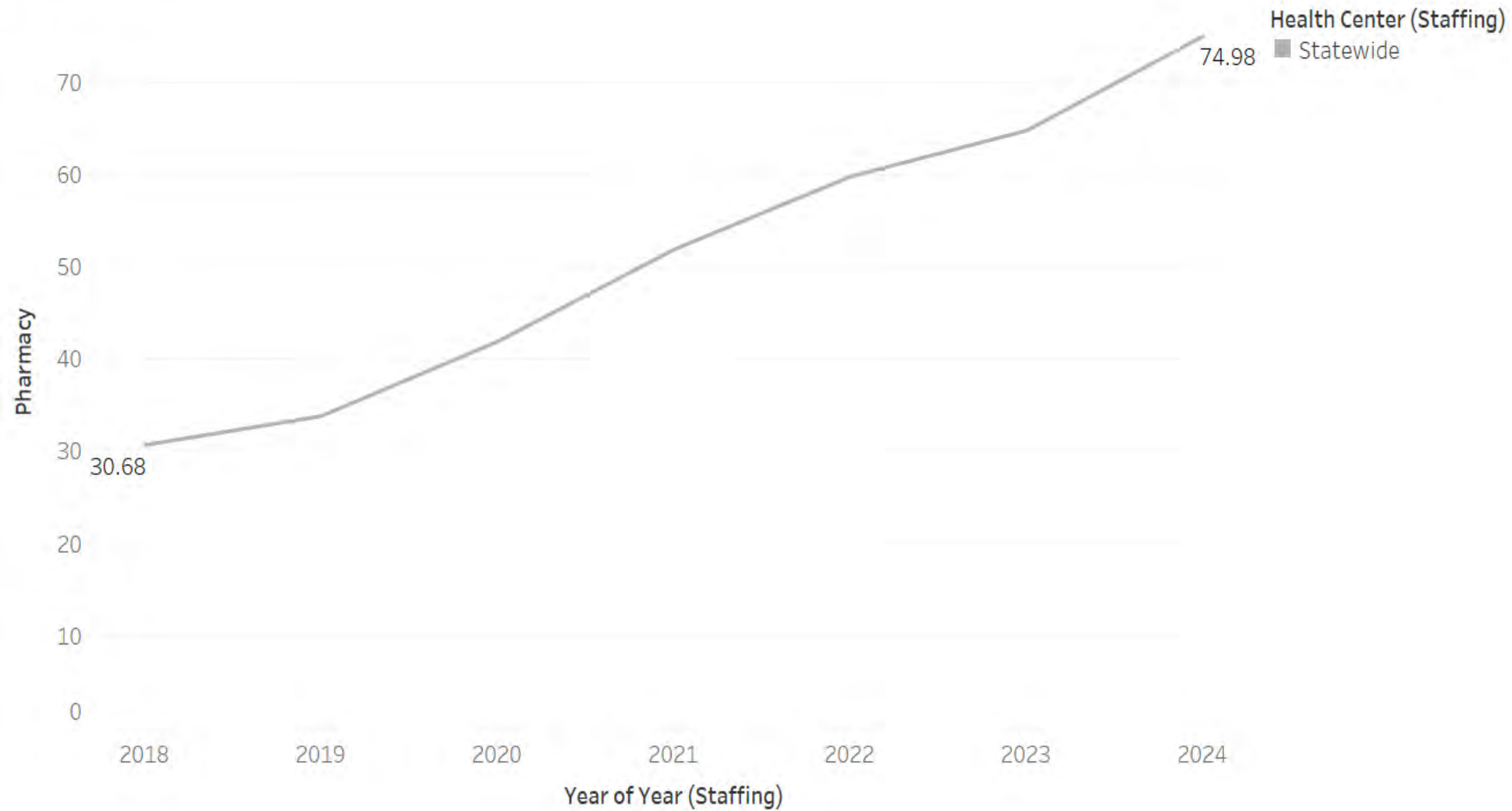


Flat mid level productivity



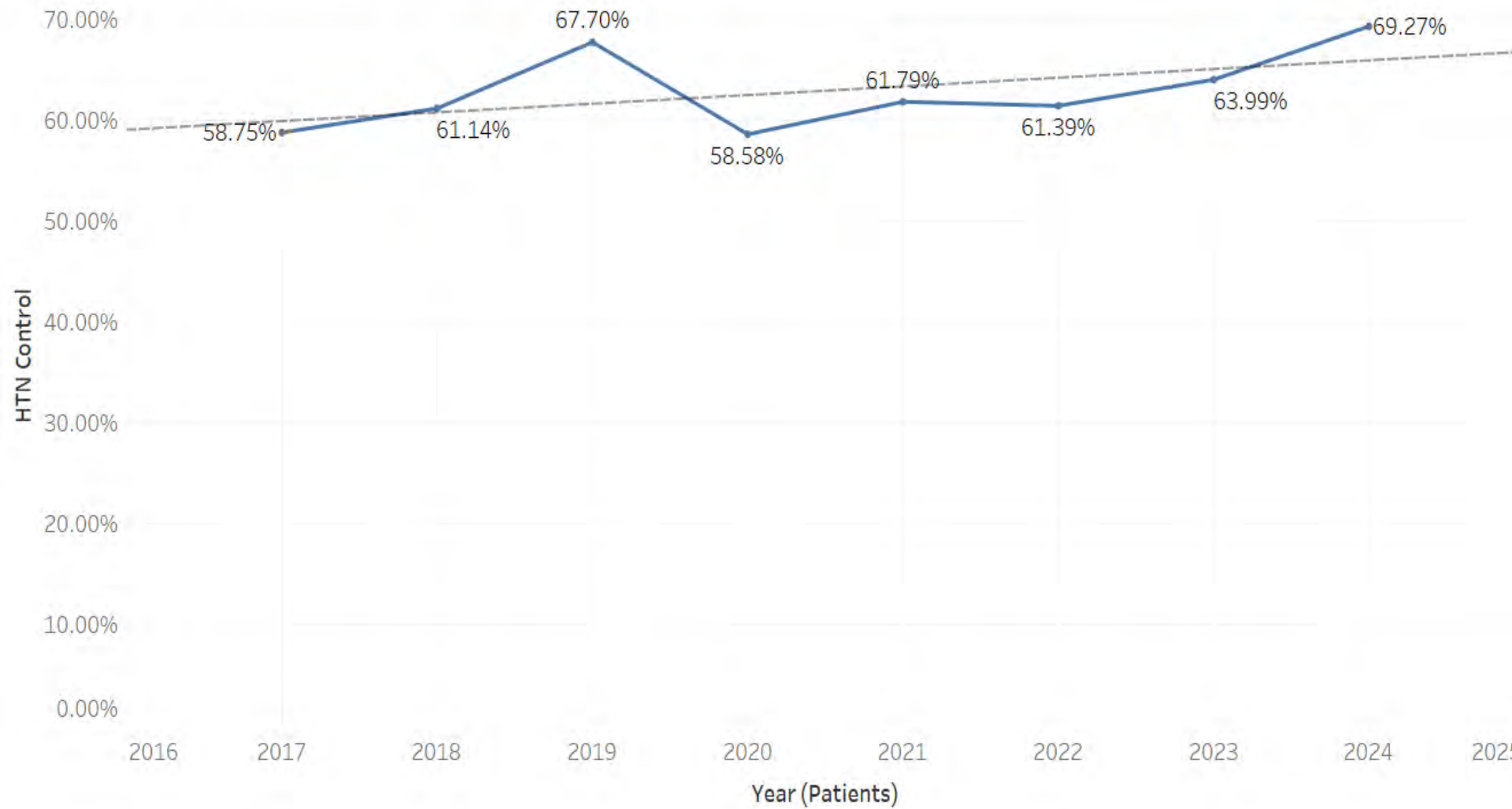
Pharmacy!

Pharm FTE



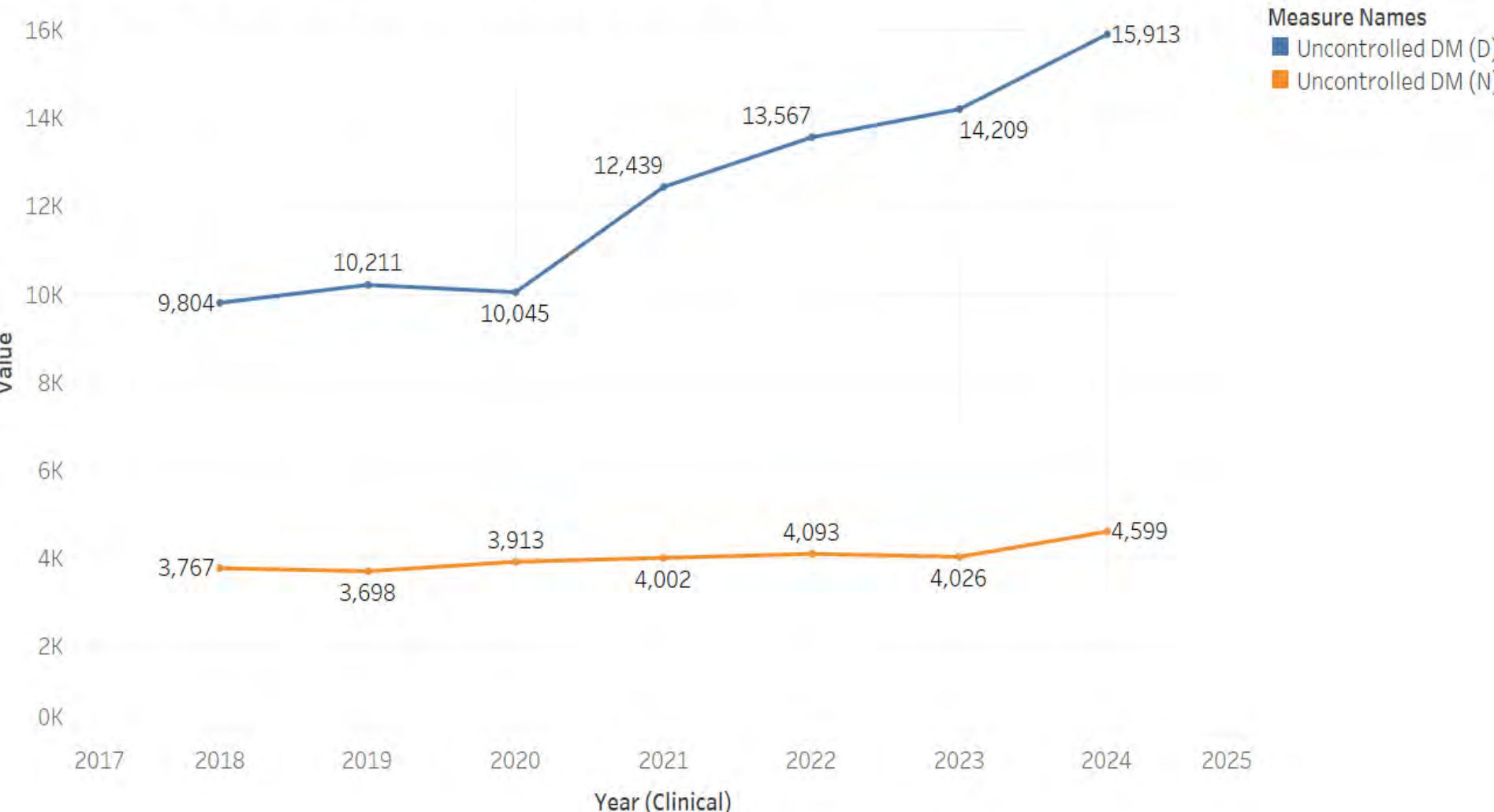
Hypertension

Controlled Hypertension, statewide



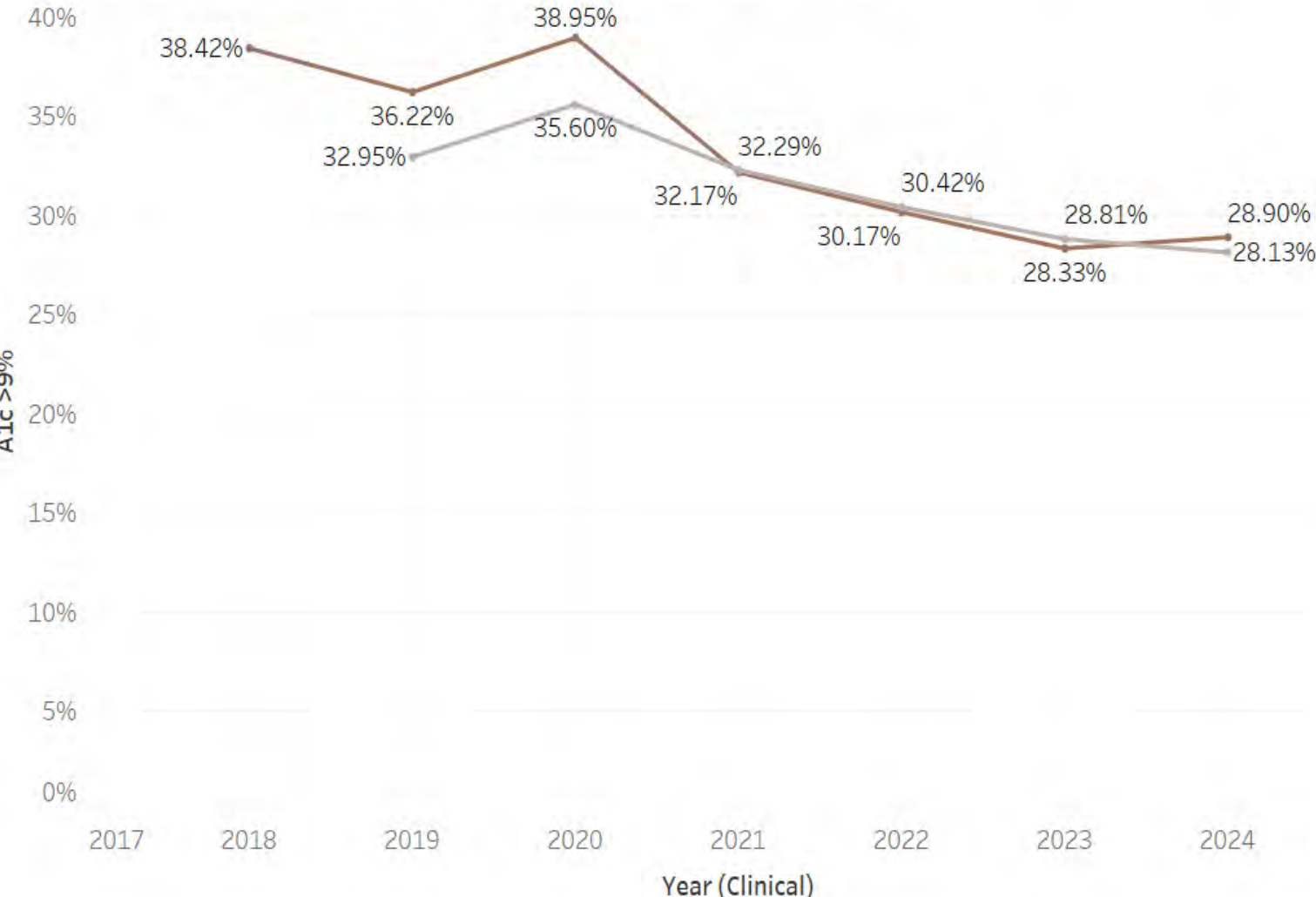
Diabetes

Total and Uncontrolled DM, statewide (A1c>9%)



Diabetes

Uncontrolled DM, statewide v. national (A1c >9%)

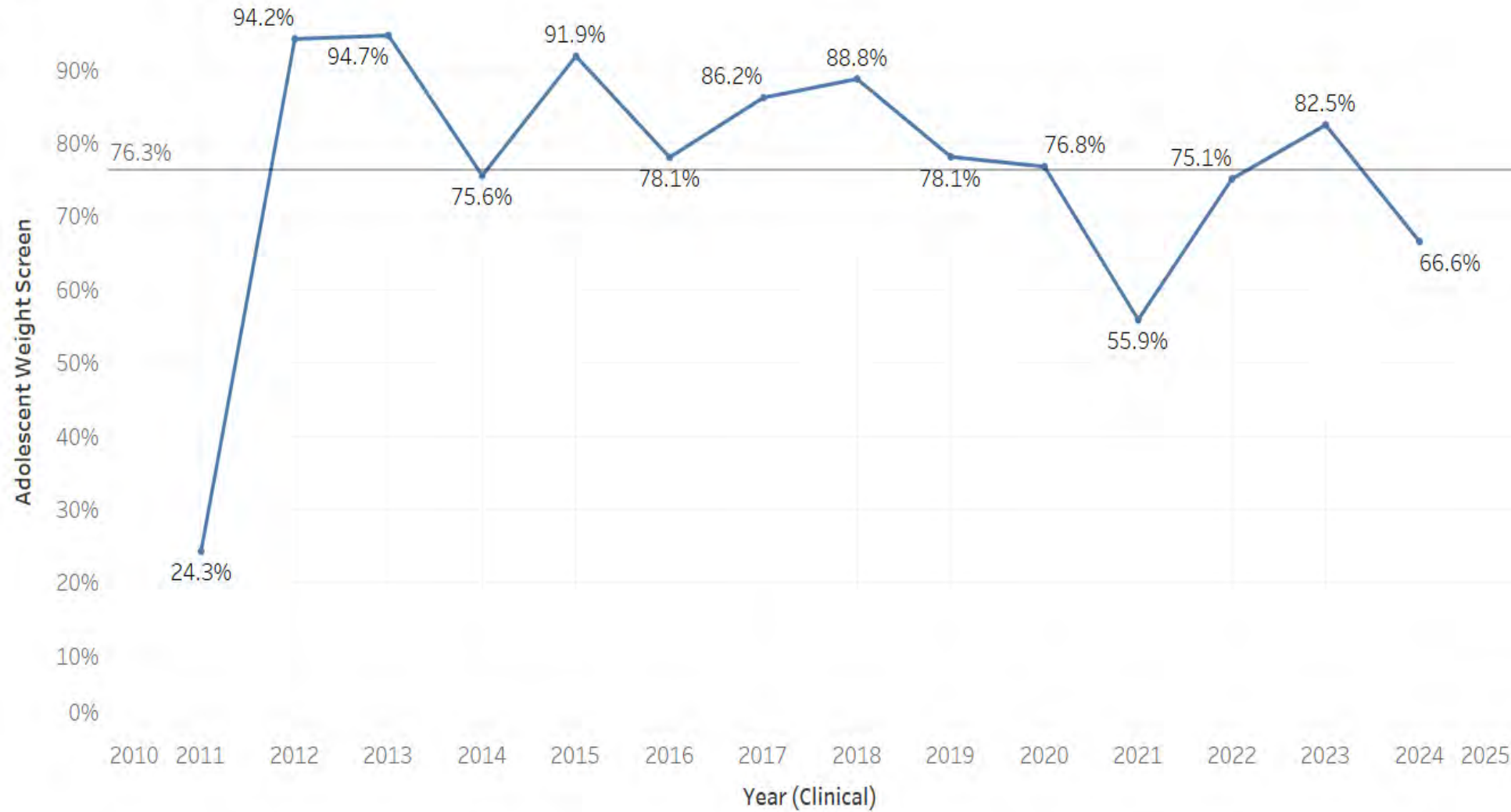


Health Center (Clinical)
■ National HCP
■ Statewide



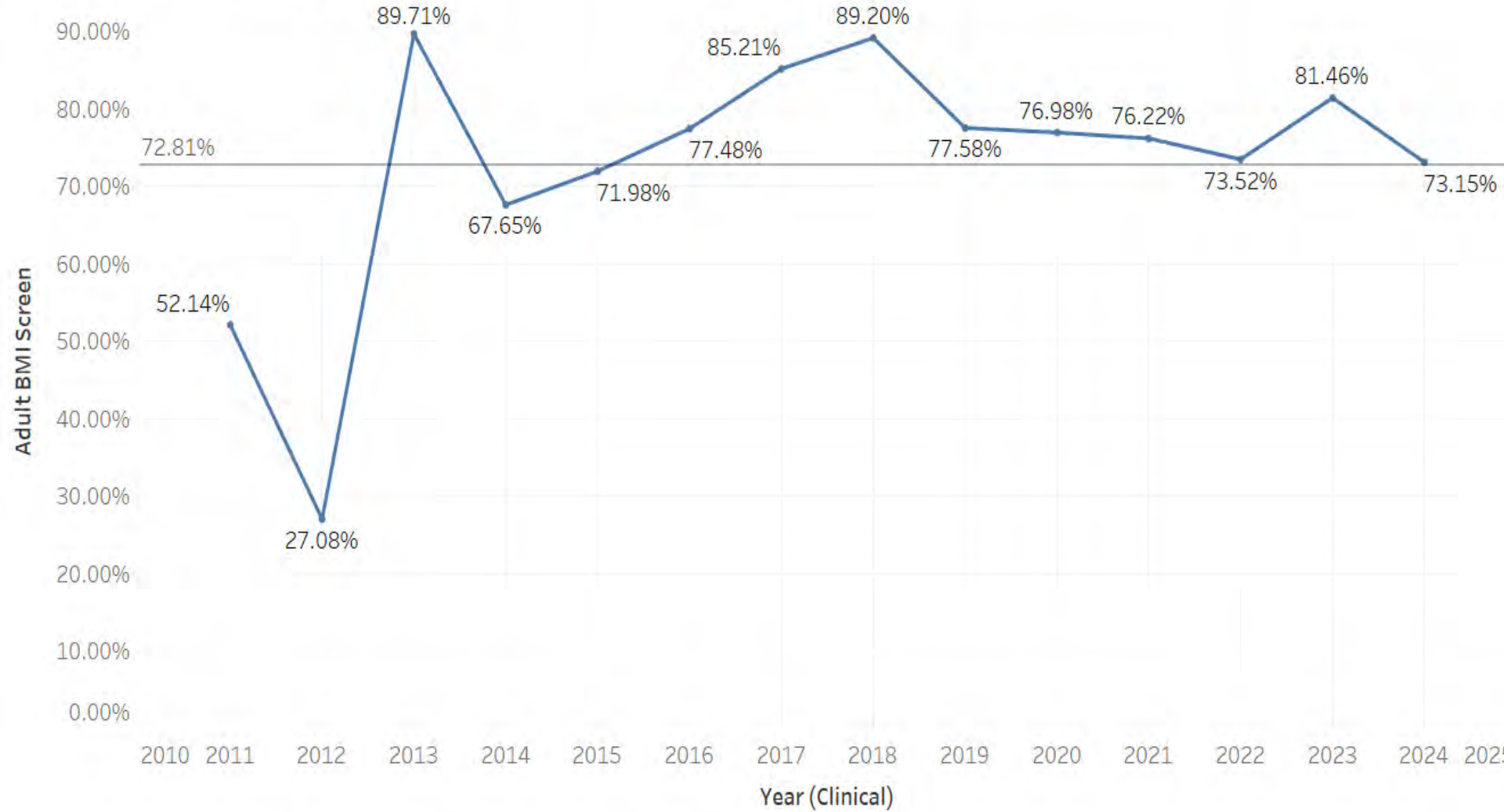
Adolescent Weight Screen

Adolescent Weight Screen



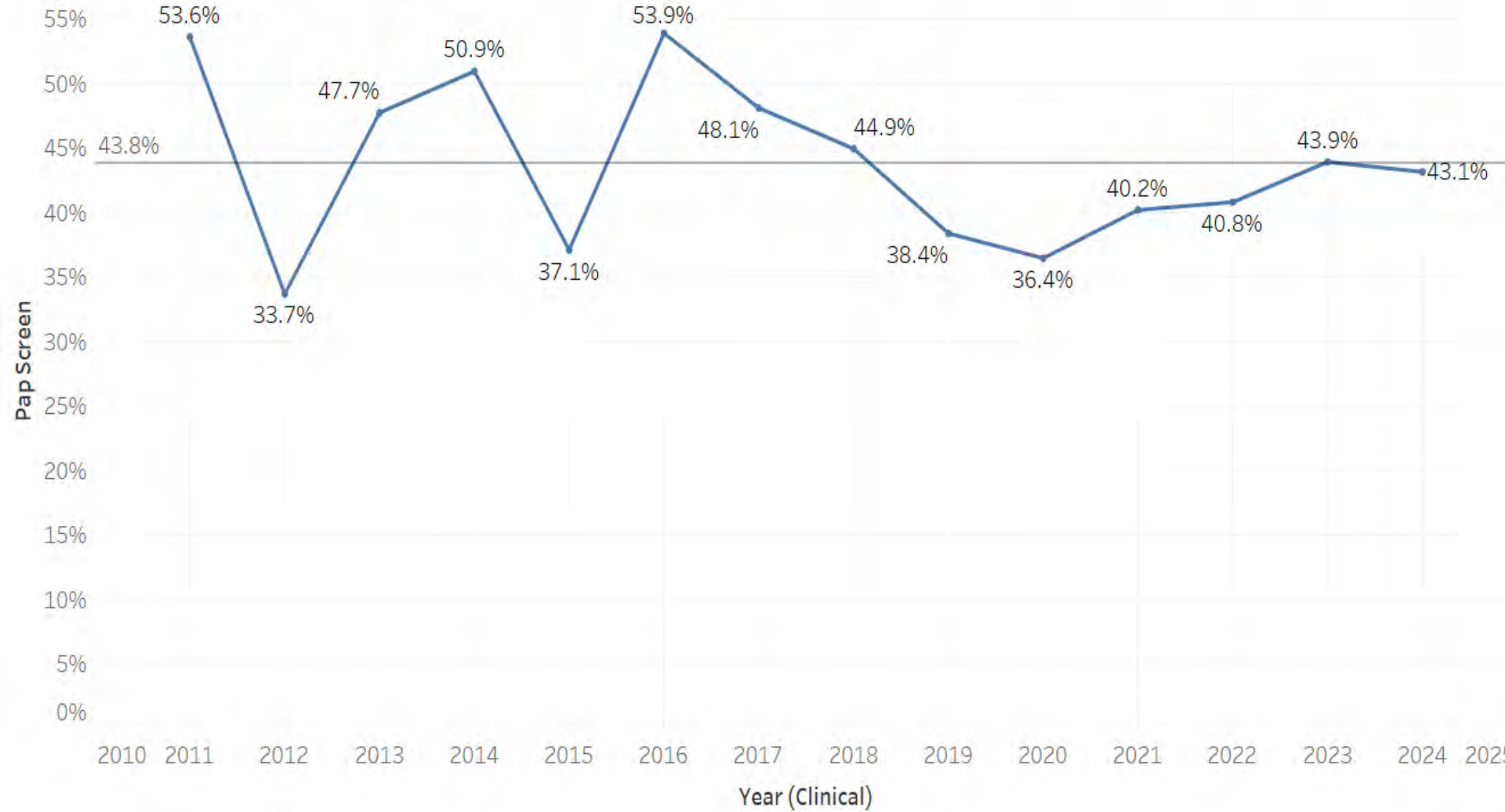
Adult Weight Screen

Adult BMI Screening



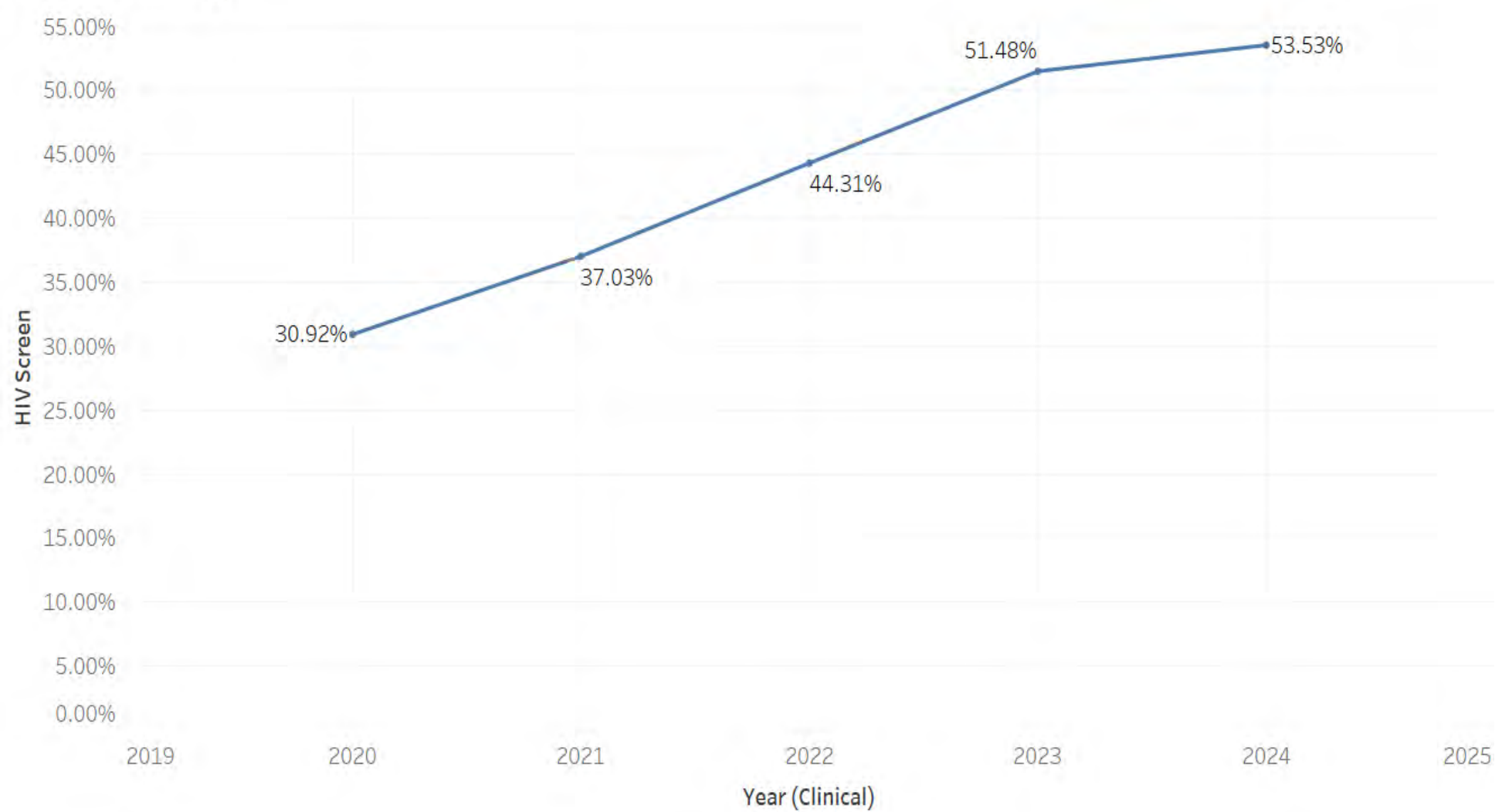
Cervical Cancer Screen

Cervical Cancer Screening



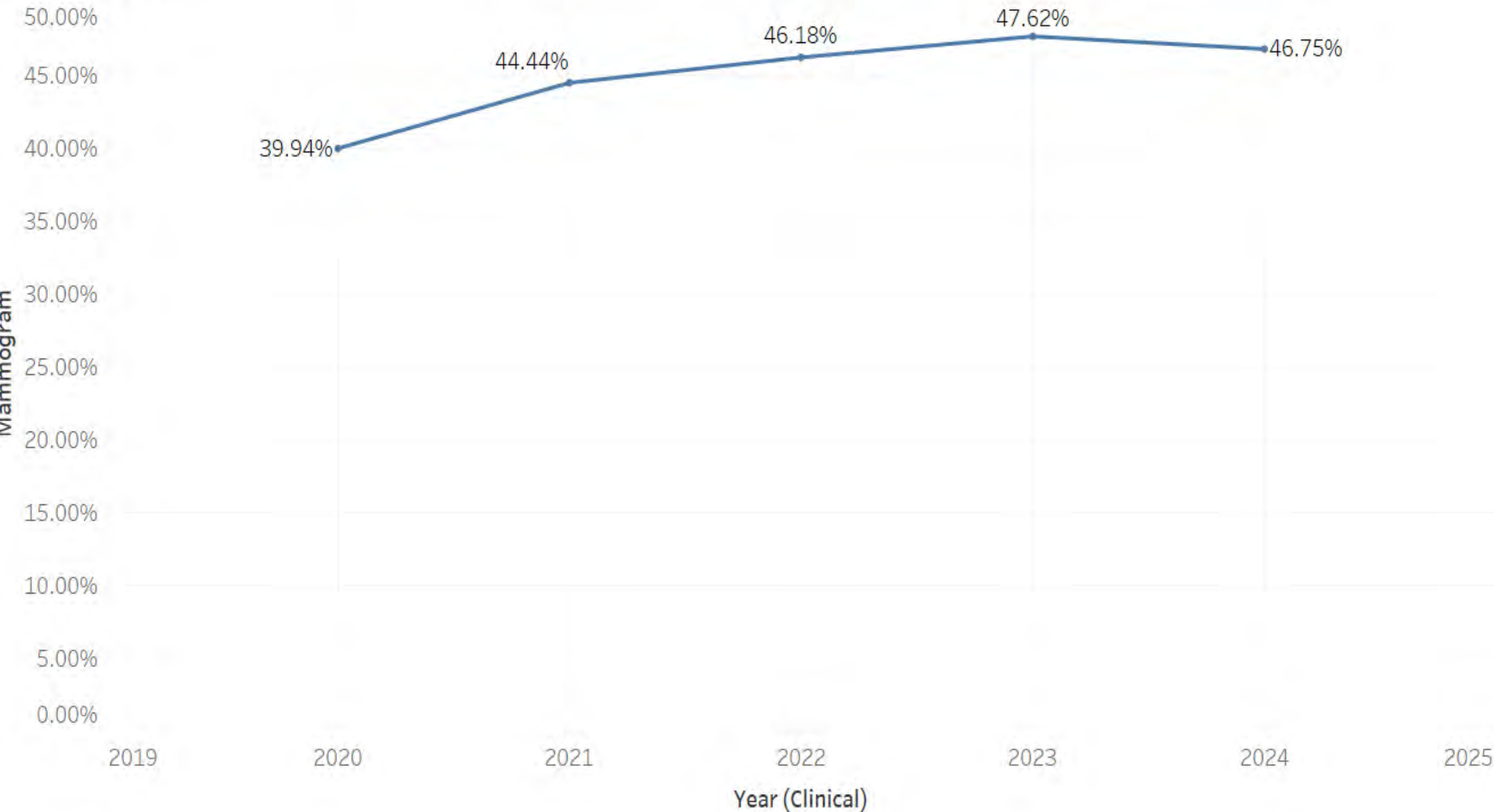
HIV Screen

HIV Screening



Breast Cancer Screen

Mammogram



Questions



Steven Messinger
smessinger@nvzca.org



NVPCA Policy Plan - draft for Board of Directors Discussion

Level	Priority 1-5	Policy Area	Goal/Objective
State		Lobbying	secure lobbyist contract for Jan 2026-Dec 2027
State Legislature		340B	Protection for FQHC's contract pharmacies
Federal		340B	Carve out FQHCs from rebate program
State Legislature		Primary Care GME/Training Programs	Funding for training programs at FQHCs
Local Government		State Legislature	No Property Tax for FQHCs
Medicaid Medicaid		Unbundle Prenatal Care Adult Dental	Unbundle Prenatal Care
Federal		330 Program Funding	Increase funding for 330 program Advocate for no changes to base funding even if the FQHC patient # decreases
Medicaid		Rural Health Transformation Fund	
Medicaid		Credentialing	
Medicaid		Work Requirements	
		Mental Health Maternal Health	concern over decline in mental health services
		Food as Medicine	



AUGUST 2025

Implementing High-Quality Primary Care

A Policy Menu for States

With passage of [One Big Beautiful Bill Act \(H.R. 1\)](#), [states are moving forward with implementing health-related provisions of the law](#) and responding to its far-reaching implications for state budgets, health care delivery systems, and residents. Decreases in federal Medicaid expenditures will increase pressure on constrained state budgets, and [projected losses](#) in coverage within Medicaid and state-based health insurance marketplaces will pose new barriers to health care access and [increase financial pressures on providers](#). As legislators and state leaders make decisions about how to account for funding reductions, prioritizing high-value investments with demonstrated impacts on health outcomes will be critical to sustain the health of our communities.

Decades of research have established that primary care is the foundation of a well-performing health system that [improves health for all communities](#). Access to high-quality care is associated with [increased life expectancy, reduced chronic disease burden, higher patient satisfaction, fewer hospitalizations, and lower health care costs](#). Despite these benefits, the [U.S. continues to invest just 5 to 7 cents of every health care dollar on primary care](#) — significantly less than other high-income countries. This underinvestment has contributed to [declining numbers of clinicians](#) serving in primary care fields and a [growing primary care access crisis](#). Without further action, states will grapple with [worsening wait times for appointments](#) and [declining numbers of individuals with a usual source of care](#), resulting in missed opportunities for preventing and managing costly chronic diseases and hospitalizations.

Ensuring access to robust primary care is a pillar of a comprehensive approach for improving health outcomes while curbing the growth of overall health care costs. Over the last decade, many states have worked to rebalance health spending; advance payment and delivery models that incentivize high-quality, team-based care; attract and retain primary care clinicians; and address patient barriers to care. State executive and legislative leaders can explore these policy levers and successes as they seek to implement cost-effective strategies to strengthen primary care systems within their own states.

A Primary Care Policy Menu for States

Health policy leaders need a comprehensive approach to strengthening primary care. *Implementing High-Quality Primary Care: A Policy Menu for States* builds on the National Academy of Science and Medicine's 2021 [Implementing High-Quality Primary Care](#) report by providing state leaders with a range of policy options states can use to strengthen primary care across geopolitically diverse contexts. Strategies in this menu are organized in five critical and complementary priority areas, with additional resources for each area in an appendix. These priority areas include:

1. [Make and Keep Primary Care a Top Policy Priority](#)
2. [Pay Primary Care More and Differently](#)
3. [Make it Easier for People to Access Their Primary Care Clinician](#)
4. [Expand and Support the Current and Future Primary Care Workforce](#)
5. [Build Provider Capacity to Provide Patient-Centered, Whole-Person Care](#)

Priority Area 1: Make and Keep Primary Care a Top Policy Priority

Develop a statewide vision, convene key stakeholders, incorporate community voices, set goals, establish priorities and accountability, and measure progress.

Policy Actions	State Spotlights
<p>Establish a multistakeholder statewide primary care council, commission, task force, or practice level transformation group to assess and report on health of primary care and catalyze action.</p>	<p>States that have launched primary care commissions through legislation, executive orders, and public-private partnerships include California, Colorado, Massachusetts, Maryland, Virginia, and Vermont.</p>
<p>Define specific roles, scope, duties, deliverables, and a sustainability plan for the primary care commission through legislation or other means. Sample deliverables include:</p> <ul style="list-style-type: none"> Identifying definitions and measurement approaches for primary care investment, workforce, and other key metrics Developing recommendations, goals, or strategies for primary care spending and other key priorities Creating workgroups or forums for collaboration across partners 	<ul style="list-style-type: none"> Established by 2025 legislation, Arkansas’ Primary Care Payment Working Group will bring together state officials, primary care providers (PCPs), and payers to define, measure, and report primary care spending and recommend payment targets. Supported by investments from the Virginia Department of Health, the Virginia Center for Health Innovation (VCHI) launched the Virginia Task Force on Primary Care to promote the sustainability of primary care. Current recommendations from the task force include supporting integrated behavioral health models, setting a primary care spend target, and establishing a learning collaborative for incorporating technology and AI into primary care.
<p>Through the commission or other mechanism, publish a yearly primary care scorecard, report, or data dashboard to document ongoing progress toward spending targets, as well as other key indicators related to primary care workforce, access, and other priorities.</p>	<p>States with primary care scorecards or data dashboards include Massachusetts, New York, and Virginia.</p>

→ To read more about this topic, see [“Additional Resources”](#)

Priority Area 2: Pay Primary Care More and Differently

Increase the portion of health care spending going toward primary care and promote non fee-for-service reimbursement approaches that incentivize high-quality, team-based, whole-person care across all communities.

Policy Actions	State Spotlights
<p>Establish primary care spending targets through legislation or executive orders that promote greater and sustainable financing of primary care. States can increase accountability for achieving spending targets through a range of options, including:</p> <ul style="list-style-type: none"> • Requiring commissions, payer collaboratives, Medicaid agencies, insurance regulators, or departments of health to issue annual public reports on primary care spending by payer that track progress toward spending targets • Setting absolute and relative spending goals for primary care spending that include both fee-for-service (FFS) and non-FFS spending • Requiring Medicaid and state insurance regulators to measure and increase the portion of health care dollars going into primary care across all payers, with penalties for noncompliance 	<ul style="list-style-type: none"> • California’s Office of Health Care Affordability set a goal of increasing primary care investment to 15% of overall medical spending by 2034, with an increase of .5-1% percentage points per year of overall spending for each payer. • Oklahoma requires its Medicaid managed care organization contractors to report on primary care spending and implementation plans for increasing spending. • Rhode Island and Oregon have processes in place to report on and enforce spending target goals across payers.
<p>Update existing Medicaid reimbursement models for primary care to promote financial sustainability and high-quality care. Specific approaches include:</p> <ul style="list-style-type: none"> • Increase Medicaid reimbursement rates to reflect true cost of team-based care delivery • Reimburse at 100% of the Medicare physician fee schedule (PFS) wherever possible (see here) • Leverage contractual requirements for Medicaid managed care organizations (MCOs) to offer additional payments to primary care or offer incentives to meet quality benchmarks 	<ul style="list-style-type: none"> • Effective January 1 2025, New Mexico raised Medicaid provider reimbursement rates for primary care services, with some increasing to 150% of the Medicare 2024 benchmarks. • In 2024, Medicaid physician fee schedules in Montana, Alaska, New Mexico, North Dakota, Wyoming, Maryland, Indiana, and Vermont reimbursed primary care at or above 100% of Medicare rates. • Arizona uses state directed payments to increase primary care spend rates by 15% through MCO contracts. • Tennessee’s Patient Centered Medical Home model, supported by the state’s Health Care Innovation Initiative, serves approximately 40% of the Tennessee Medicaid population. Providers are eligible for a yearly payment based on performance, including outcomes, quality, and efficiency.

Continued

Policy Actions	State Spotlights
<p>In Medicaid and/or public employee plans, reduce use of fee-for-service payments and encourage, incentivize, or require adoption of innovative value-based payment models that encourage high-quality team-based care. Methods include:</p> <ul style="list-style-type: none"> • Leverage Medicaid authorities (e.g., through Medicaid 1115 waivers, health homes, state plan amendments, or other authority) to incentivize primary care models that improve outcomes for patients • Develop advanced payment models (APMs) aligned with the HCP-LAN Framework to move toward value-based payment approaches • Incentivize team-based care by providing per capita bonuses for medical home certification by the National Committee for Quality Assurance (NCQA) or a state medical home certification 	<ul style="list-style-type: none"> • Maine’s Primary Care Plus program is a tiered payment model, with the highest tier providing population-based payments tied to cost- and quality-related outcomes, emphasizing whole-person focused primary care • North Carolina’s Advanced Medical Home program is a tiered medical home model with hybrid payment requirements established through Medicaid managed care contracts. • Massachusetts’ Primary Care Sub-Capitation program has three tiers of payments to providers based on increasing levels of comprehensiveness with supplemental fee for service payments, implemented through its Accountable Care Organization.

Continued

Policy Actions	State Spotlights
<p>Encourage multi-payer alignment across Medicaid, Medicare, and commercial markets on primary care spending thresholds, quality measures, and payment approaches. Strategies include:</p> <ul style="list-style-type: none"> • Convene interagency or multi-payer collaborative groups to align on quality measures, payment approaches, and multi-payer targets • Participate in multi-payer Center for Medicare and Medicaid Innovation (CMMI) demonstration projects, such as the All-Payer Health Equity Approaches and Development (AHEAD) Model • Support the development of common sets of quality metrics across payers to ease reporting burdens on providers and encourage adoption of APMs • Encourage common care delivery and billing requirements and processes among payers (e.g., comparative coding tables) 	<ul style="list-style-type: none"> • Colorado HB 22-1325 gives the Colorado Division of Insurance the authority to develop aligned alternative payment model parameters for primary care services in partnership with state agencies, insurers, providers, and consumers. The aligned APM parameters address quality measures, core competencies for the delivery of advanced primary care, risk adjustment, and patient attribution, and are reviewed annually through a stakeholder process. • Maryland's primary care program assists practices in transforming health care delivery to put more of an emphasis on preventive care and chronic disease management • California's Medicaid program (Medi-Cal), health insurance marketplace (Covered California), and public employee and retiree program (CalPERS) developed nearly identical contract provisions to require health plans to report on primary care spend, primary care payment models, and increase adoption of value-based purchasing (VBP) models for primary care. • Maryland, Connecticut, Hawaii, Vermont, Rhode Island, and five counties in New York are participating in CMMI's model. AHEAD is a state total cost of care model that seeks to reduce cost growth while improving population health. Increasing investment in primary care across all payers and aligning primary care transformation with innovations in Medicaid are core components of the model.

→ To read more about this topic, see [“Additional Resources”](#)

Priority Area 3: Make it Easier for People to Access Their Primary Care Clinician

Implement targeted approaches to address individual, community, and market-level barriers to primary care access.

Policy Actions	State Spotlights
<p>Incentivize primary care providers operating in shortage areas or serving underserved patient populations to expand services through capital grants or loans.</p>	<ul style="list-style-type: none"> • Colorado’s Primary Care Fund, supported by state tobacco taxes, provides funding for community health centers and safety net clinics based on the number of medically indigent patients served. • Rhode Island’s Executive Office of Health and Human Services announced \$5 million in grant funding to support recruitment and retention of PCPs. Practices can receive up to \$375,000 for expanding patient panels, accepting Medicaid patients, and recruiting new clinicians or mid-level clinicians. • New York’s Community Health Care Revolving Capital Fund is a public-private financing partnership that provides affordable loan capital for eligible community-based primary care and behavioral health providers.
<p>Update Community Health Center (CHC) and Rural Health Center (RHC) reimbursement models to support sustainability for medically underserved areas. Strategies may include:</p> <ul style="list-style-type: none"> • Adopt CHC and RHC APMs that reflect the cost of care • Align CHC change-in-scope requirements with federal standards • Allow CHCs to bill for multiple encounters in the same day visit 	<ul style="list-style-type: none"> • Through a state plan amendment, Louisiana provides additional reimbursement through APMs to federally qualified health centers (FQHCs) to assist with costs incurred from operating in underserved areas. • Effective 2023, North Carolina adopted an APM that allows for FQHC Medicaid reimbursement rate to be rebased triennially based on Medicaid cost reports. Between rebasing years, FQHCs can request an adjustment to their encounter rate for a change in scope of services such as adding a new service or service delivery site or adding a new target population. • Oklahoma allows billing for multiple visits at a FQHC within the same category of service on the same day if each visit addresses a distinct and unrelated diagnosis. Florida’s same-day billing policies allows for Medicaid reimbursement of services provided through the fee-for-service delivery system at an encounter rate. Providers may be reimbursed for up to one medical, one dental, and one behavioral health visit provided to a recipient on the same day.

Continued

Policy Actions	State Spotlights
<p>Expand access to primary care services provided via telehealth and ensure payment supports all modes of patient interaction. Approaches include:</p> <ul style="list-style-type: none"> • Partner with state economic development and broadband agencies to expand access to, ensure payment support of, and increase adoption of broadband, especially in rural and other underserved areas. • Require all payers to pay for telehealth at parity with in-person visits (as long as additional facility fees are not charged) 	<ul style="list-style-type: none"> • Forty-one states and the District of Columbia require private insurers to cover telehealth visits at parity with in-person visits. • Arkansas’ Center for Telehealth works toward statewide broadband adoption by providing technology training and infrastructure support.
<p>Study and address the impact of provider consolidation on access to primary care, particularly in rural areas.</p>	<ul style="list-style-type: none"> • Many states are taking steps to assess and address the impact of vertical consolidation on healthcare costs and access, including access to primary care. • Oregon’s Health Care Market oversight program reviews proposed health care mergers, acquisitions, and other deals to ensure that they support state goals related to equity, access, cost, and quality. Additional legislation enacted in 2025 expands Oregon’s corporate practice of medicine doctrine requiring that medical practices are owned and controlled by state-licensed clinicians.
<p>Within state employee and retiree health plans, implement insurance benefit designs that reduce financial barriers to using designated primary care clinician.</p>	<ul style="list-style-type: none"> • The California Public Employees’ Retirement System (CalPERS) offers deductible credits for enrollees who complete preventive care activities. • Connecticut’s Health Enhancement Program, operated by the state health employee health plan, rewards participants that complete certain preventive screenings and exams, as well as educational modules for chronic diseases, with decreased premiums and deductibles.

→ To read more about this topic, see [“Additional Resources”](#)

Priority Area 4: Expand and Support the Current and Future Primary Care Workforce

Expand the primary care pipeline, reduce barriers to joining the primary care workforce, and strengthen recruitment, training, and retention.

Policy Actions	State Spotlights
<p>Measure and assess data on state’s primary care workforce needs and shortage areas. Approaches include:</p> <ul style="list-style-type: none"> • Use licensure or survey data to create workforce reports • Create a registry to identify clinicians and employers • Utilize an All-Payer Claims Database (APCD) or other data infrastructure to assess state workforce composition and distribution • Leverage partnerships with universities and primary care Centers of Excellence to understand primary care workforce data and inform strategies 	<ul style="list-style-type: none"> • States such as Utah, Virginia, and Arkansas have used data from all-payer claims databases to conduct analysis of the primary care workforces. • Vermont’s Health Care Workforce Census analyzes health care clinicians, including their distribution by geography and specialty, statewide. Vermont’s Office of Health Care Reform is creating a Health Care Workforce Data Center that will support analysis of primary care workforce shortages. • The Behavioral Health Education Center of Nebraska helps support behavioral health workforce development in the state by leveraging data to inform recruitment strategies and training programs.

Continued

Policy Actions	State Spotlights
<p>Expand the primary care workforce pipeline through programs, partnerships, and policy. Examples include:</p> <ul style="list-style-type: none"> • Partner with medical and professional schools to promote community-based training and pathway programs • Initiate/expand loan forgiveness and scholarship programs, including for pre-med programs and other non-medical school programs • Incentivize clinicians, including advanced practitioners, to specialize in primary care through salary supplements for primary care clinicians who opt to work in CHCs, public hospitals, and/or rural areas • Improve monitoring of Medicaid graduate medical education (GME) accountability to ensure it supports primary care trainees • Offer state tax credits for preceptors to provide supervision of primary care trainees • Support existing and proposed teaching health center residency programs, particularly in rural areas 	<ul style="list-style-type: none"> • Minnesota’s State Primary Care Office offers grants to support CHCs and other primary care practices operating in workforce shortage areas. The Rural Primary Care Residency Training Grant Program awards grants to eligible programs to plan, implement, and sustain rural primary care residency training programs. The Primary Care office also offers a range of resources and technical assistance on topics such as workforce retention and loan repayment. • Through a partnership with the California Health Care Foundation, California has several initiatives to support statewide planning and coordination on the primary care workforce, including the California Health Workforce and Education Training Council, the Workforce for a Healthy California Initiative, and the California Future Health Workforce Commission. • The Ohio Department of Health collaborates with the Ohio Association of Community Health Centers (OACHC) to support the Primary Care Workforce Initiative, which provides funding for medical, dental, behavioral health, advanced practice nursing, and PA students to have rotations in FQHCs recognized as patient-centered medical homes (PCMHs_). • Michigan’s MIDOCs is a state- and federally funded program expanding graduate medical education residency positions in select specialties to recruit and retain physicians in underserved areas of the state.

Continued

Policy Actions	State Spotlights
<p>Reduce barriers clinicians face in joining the primary care workforce, including:</p> <ul style="list-style-type: none"> • Joining interstate licensing compacts • Facilitating international medical graduates’ ability to practice • Expanding scope of practice for advanced practitioners consistent with team-based care, training, capabilities, and workforce needs 	<ul style="list-style-type: none"> • Oregon’s Senate Bill 476 and Massachusetts’ Physician Pathway Act allows the states’ medical boards to issue a provisional license to qualified internationally trained clinicians. • The model law for Full Practice Authority for Advanced Nurse Practitioners has been adopted in some form in 27 states.
<p>Provide ongoing training and support for primary care retention and wellness.</p>	<ul style="list-style-type: none"> • Washington, DC’s Department of Health conducted listening sessions with PCPs and published a request for stakeholder input on opportunities to reduce clinician burnout and increase retention. DC’s workforce wellness report identifies promising strategies and recommendations for improving workforce wellness • Virginia maintains a Primary Care Innovation Hub where stakeholders can access information about innovative workforce and payment pilots and policies, learning networks for best practices in technology, AI, integrated health, updated Medicaid policy guidance, and research on primary care policy.
<p>Reduce common administrative challenges that lead to inefficiency and burnout:</p> <ul style="list-style-type: none"> • Limit use of prior authorization by commercial insurers and MCOs • Encourage adoption of advanced primary care management (APCM) codes to reduce documentation burden 	<ul style="list-style-type: none"> • Regulations issued by Rhode Island’s Office of the Health Insurance Commissioner required insurers to reduce prior authorization requirements by 20%.
<p>Study use of AI in primary care settings to reduce provider documentation time and burnout.</p>	<ul style="list-style-type: none"> • Virginia operates a learning collaborative on primary care and AI.

→ To read more about this topic, see “[Additional Resources](#)”

Priority Area 5: Build Provider Capacity to Provide Patient-Centered, Whole-Person Care

Support practice transformation and facilitate the development of resources, tools, and technology to strengthen the ability of primary care clinicians to provide whole-person care, including behavioral and social supports.

Policy Actions	State Spotlights
<p>Provide resources, grants, and technical assistance to support PCPs with practice transformation standards and resources that foster high-quality, team-based care (“Advance Primary Care”) and can be the basis for alternate payment mechanisms (see above):</p> <ul style="list-style-type: none"> • Create a medical home certification program that includes necessary supports and technical assistance to help practices meet requirements for patient-centered, team-based, accessible, and coordinated care • Partner with universities, health systems, and provider associations to support Primary Care Centers of Excellence 	<ul style="list-style-type: none"> • The North Carolina Area Health Education Center assists practices in evolving care delivery and adopting new payment models. • Washington’s Primary Care Practice Recognition program scores practices on how well they are meeting ten practice accountabilities, including whole-person care and behavioral health integration, among others. • Vermont’s Blueprint for Health and Maryland’s Primary Care Program provide technical assistance, opportunities for learning and innovation, and/or shared services to expand the capacity of primary care practices in areas such as chronic care management and care coordination. • California’s Equity and Practice Transformation Payments Program is providing \$140 million over three years on a one-time basis to support primary care practices engaged in delivery system transformation. Alongside the funding, the California Department of Health Care Services is offering a statewide practice transformation technical assistance center.

Continued

Policy Actions	State Spotlights
<p>Enhance the ability of primary care practices to implement, consult, and coordinate care for patients with behavioral health needs.</p> <p>Approaches include:</p> <ul style="list-style-type: none"> • Support increased uptake of the Collaborative Care Model (CoCM), an evidence-based primary care-based behavioral health integration model. • Increase funding and support for community health centers to improve integration of primary care and behavioral health, and/or foster partnerships among CHCs and community based behavioral health clinics (CCBHCs), which deliver both crisis and an array of evidence-based behavioral health services and supports. • Encourage teleconsultation models to bring specialty services into primary care settings • Allow Medicaid billing for asynchronous provider to provider “e-consults” to enhance coordination between specialists and PCPs 	<ul style="list-style-type: none"> • Two-thirds of states provide coverage for CoCM under Medicaid • North Carolina offered an enhanced reimbursement rate for primary practices implementing the collaborative care model and leveraged state funds to provide capacity building grants to support provider adoption • In 2023, MassHealth of Massachusetts added current procedural terminology (CPT) codes and issued guidance for billing of Provider-to-Provider E-Consults. • At least 30 states, including Missouri and Illinois, provide Medicaid coverage for interprofessional consultation. • The Colorado Pediatric Psychiatry Consultation & Access Program (CoPPCAP) supports Colorado pediatric primary care providers to assess and provide treatment for pediatric behavioral and mental health conditions presenting in the primary care setting, via peer, e-consultation, and linkages to specialty services. • In Vermont, the Department of Health and the Blueprint provide funding for mental health and substance use disorder (MH and SUD) services for people receiving medication for opioid use disorder, including those receiving treatment in primary care practices, through the Hub and Spoke program. The Blueprint’s Mental Health Integration pilot provides primary care practices with resources for standardized MH, SUD, and social needs screenings and for staffing to provide interventions and/or connect people to social service or other community service providers.

Continued

Policy Actions	State Spotlights
<p>Enhance the ability of primary care practices to coordinate patient physical health, oral health, and social needs. Approaches include:</p> <ul style="list-style-type: none"> • Strengthen partnerships with community care hubs (CCHs) and other community backbone organizations that can assist patients with social support needs and barriers to care • Improve tools and partnerships to help connect patients with resources to address social needs through Community Information Exchange (CIE) referral systems for social needs • Adopt APMs, reimbursement models, and implementation support for PCPs to provide coordination and linkage to services for patients’ physical, behavioral and social needs, including dental services and social supports 	<ul style="list-style-type: none"> • FQHCs participating in Ohio Medicaid’s APM receive additional fixed amounts over the regular PPS rate for services that include dental, behavioral health, physical or occupational therapy, and transportation. • Under Washington’s Medicaid waiver, the state’s nine Accountable Communities of Health (ACHs) manage Community Care Hubs (CCHs) that organize and support a network of organizations providing community-based care coordination services to individuals with both health and social needs. • The Iowa Community HUB is a statewide nonprofit CCH that connects communities with health promotion programs and connects individuals with CBOs providing social services and supports. Primary care providers can refer patients to the hub for a variety of service and supports, including housing stability, transportation access, nutrition, chronic disease self-management, childhood obesity, cancer survivorship, and diabetes prevention. • Connect Oregon, one of two main statewide CIE efforts, connects Coordinated Care Organizations (CCOs), health care providers, community-based organizations, HRSN service providers, and public agencies. These partners use the Unite Us platform to identify, deliver, and pay for services that address community needs.
<p>Encourage improved interoperability and bi-directional payer information sharing that enables Advanced Primary Care. Approaches include:</p> <ul style="list-style-type: none"> • Strengthen state-based interoperability through investments in APCDs and Health Information Exchanges (HIEs), and CIEs • Leverage federal Medicaid matching funds, state revenues, fee assessments, or other funding sources to support APCD systems • Provide grants or resources to support primary care practices with EHR and technology upgrades 	<ul style="list-style-type: none"> • HIEs in states like Arkansas, Maryland, and Oklahoma can improve patient care coordination and reduce fragmentation of care by facilitating the secure sharing of patient information across health care providers.

→ To read more about this topic, see [“Additional Resources”](#)

Additional Resources:

Make and Keep Primary Care a Top Policy Priority

- [Increasing Investment in Primary Care —Lessons from States](#) (The Commonwealth Fund)
- [2025 Primary Care Scorecard Data Dashboard](#) (Milbank Memorial Fund)
- [It Takes Two to Tango: Creating an Effective State-Federal Partnerships for Primary Care Reform](#) (Milbank Memorial Fund)
- [State Initiatives Database](#) (Primary Care Collaborative)
- [Does Higher Spending on Primary Care Lead to Lower Total Health Care Spending?](#) (Health Affairs)
- [Quantifying the Value of Primary Care in a Health Setting](#) (Manatt)
- [State Trends Primary Care Investment Update: A Look Back at 2024](#) (Primary Care Development Corporation)

Pay Primary Care More and Differently

- [Optimizing State Policies for Primary Care Payment Reform](#) (Milbank Memorial Fund)
- [How Massachusetts Medicaid is Paying for Primary Care Teams to Take Care of People, Not Doctors to Deliver Services](#) (Milbank Memorial Fund)
- [Five States Leading Efforts to Increase Primary Care Spending](#) (Milbank Memorial Fund)
- [Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health-Supported Advanced Primary Care Paradigm](#) (Milbank Memorial Fund)
- [Advancing Primary Care Innovations in Medicaid Managed Care: Using State Levers to Drive Uptake and Spread](#) (Center for Health Care Strategies)
- [Developing Primary Care Population-Based Payment Models in Medicaid: A Primer for States](#) (Center for Health Care Strategies)
- [Implementing Primary Care Population-Based Payment in Medicaid: State Case Studies](#) (Center for Health Care Strategies)
- [Investing in Primary Care: Lessons from State-Based Efforts](#) (California Health Care Foundation)
- [State Policies to Advance Primary Care](#) (Eugene Farley Health Policy Center)

Make it Easier for People to Access Their Primary Care Clinician

- [Where Everybody Knows Your Name: Why Having a Usual Source of Care is Important](#) (Milbank Memorial Fund)
- [State Obligations for Payments to Community Health Centers in Medicaid Programs](#) (Medicaid and CHIP Payment and Access Commission)
- [Private Equity in Key Healthcare Sectors](#) (Private Equity Stakeholder Project)
- [How Primary Care Physicians Experience Telehealth: An International Comparison](#) (The Commonwealth Fund)
- [Effective Implementation of Integrated Care in a Community Health Center Setting](#) (Primary Care Development Corporation)

Expand and Support the Current and Future Primary Care Workforce

- The [All-Payer Claims Database Council site](#) offers a map of state efforts toward implementation of an APCD
- The California Health Care Foundation has a [comprehensive set of resources](#) for expanding the state's primary care workforce
- [Developing Sustainable Community Health Worker Career Paths](#) (Milbank Memorial Fund)
- [Training the Primary Care Workforce to Deliver Team-Based Care in Underserved Areas: The Teaching Health Center Program](#) (Milbank Memorial Fund)
- [AI and the Future Primary Care Workforce](#) (California Health Care Foundation)
- [Current Programs and Incentives to Overcome Rural Physician Shortages in the United States: A Narrative Review](#) (PubMed)
- [State of the Primary Care Workforce, 2024](#) (Health Resources and Services Administration)

Build Provider Capacity to Provide Patient-Centered, Whole-Person Care

- [Considerations for Statewide Advanced Primary Care Programs](#) (Milbank Memorial Fund)
- [Integrated Behavioral Health Works and Saves Money – Why Aren't We Doing It?](#) (Milbank Memorial Fund)
- [States Enhance Medicaid Payment for Interprofessional Consultation: Opportunities for Maternal and Child Behavioral Health](#) (National Academy for State Health Policy)
- [Promoting Integration of Primary and Behavioral Health Care](#) (Substance Abuse and Mental Health Services Administration)
- [Pediatric Mental Health Care Access Program: Improving Behavioral Health Services](#) (Health Resources and Services Administration)
- [Aligning Systems, Advancing Care: State Behavioral Health Integration Approaches](#) (National Academy for State Health Policy)
- [Community Health Centers' Progress and Challenges in Meeting Patients' Essential Primary Care Needs](#) (The Commonwealth Fund)

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About the Milbank Memorial Fund

The Milbank Memorial Fund works to improve population health and health equity by collaborating with leaders and decision makers and connecting them with experience and sound evidence. Founded in 1905, the Milbank Memorial Fund fulfills its mission by identifying, informing, and inspiring current and future state health policy leaders to enhance their effectiveness; convening and supporting state health policy decision makers to advance strong primary care and sustainable health care costs; and publishing evidence-based publications and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy. For more information, visit www.milbank.org.

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Rural Health Transformation Program

What We Know as of August 11, 2025

[H.R. 1 Section 71401](#) of the One Big Beautiful Bill Act (OBBBA), enacted into law on July 4, 2025, establishes the Rural Health Transformation Program (Program). As a direct appropriation to states (i.e., no state match required), the Program is designed to mitigate some of the effects of reduced Medicaid financing for rural providers resulting from the legislation.

The Program provides \$10 billion per year for federal fiscal years 2026 through 2030 for a total of \$50 billion. All 50 states are eligible to apply for this funding.

The Centers for Medicare & Medicaid Services CMS will establish an application process and due date, which cannot occur later than December 31, 2025. Additionally, CMS must approve or deny applications no later than December 31, 2025, so it is anticipated that the CMS application due date will be in advance of the mandatory award date.

CMS will only award Program funds to states with an approved application. The legislation does not specify if the application and required spending plan will need to be submitted at the same time.

The application process is a one-time event. If CMS denies an application, states are not eligible to receive any funding under the Program.

The legislation prescribes that allotment amounts, withheld payments, payment reductions, and recovery of payments received under the Program are not subject to administrative or judicial review under Social Security Act (SSA) Section 1116 “or otherwise.”

Disbursement of Funds

The funds are divided into two pools:

1. CMS must distribute 50 percent of Program funds to all states with an approved application.
2. CMS will allot the remaining 50 percent to at least a quarter of eligible states using a methodology that considers:
 - The percentage of a state’s population that is located in a rural census tract of a metropolitan statistical area (using the latest Goldsmith Modification methodology, which designates some outlying metropolitan counties as qualifying for rural designation).
 - The proportion of rural health facilities in the state, relative to the number nationwide.
 - The situation of disproportionate share hospitals in the state.
 - “Any other factors that the Administrator [of CMS] determines appropriate.”

States will have until the end of the fiscal year following the fiscal year in which funds are allotted to spend their awarded funds. The only exception is that funds redistributed from CMS in 2032 must be spent by September 30, 2032.

CMS retains the ability to withhold or reduce payments to states if it deems a state is not using the funds in line with its spending plan (described further below). In other words, states should give

special consideration to the categories of uses (listed below) they include in their spending plan, as they will be limited to these uses.

Rural Health Providers Defined

As part of the methodology CMS is to develop to determine 50 percent of available funding, H.R. 1 directs CMS to consider the following categories of providers defined by the legislation as a “rural health facility”:

- Rural hospitals (including those identified using the latest Goldsmith Modification)
- Critical access hospital
- Sole community hospitals
- Medicare-dependent small rural hospitals (defined in SSA 1886(d)(5)(G)(iv))
- Low-volume hospitals (as defined in SSA 1886(d)(12)(C))
- Rural emergency hospitals (as defined in SSA 1861(kkk)(2))
- Federally qualified health centers
- Rural health clinics
- Any health center receiving a grant under Section 330 of the Public Health Service Act
- Community mental health centers
 - Opioid treatment programs and certified community behavioral health clinics located in rural census tracts.

Other Key Provisions

- A state’s administrative expenses are capped at 10% of allotted funds.
- Only states — not District of Columbia or territories — are eligible for the Program.
- Annual reports on the use of funds will be required.

State Application Must Contain

Rural Health Transformation Plan and Certification

H.R. 1 requires states to include in their application a detailed rural health transformation plan describing strategies to:

- Improve access to hospitals, other healthcare providers, and healthcare items and services furnished to rural residents of the state.
- Improve healthcare outcomes of rural residents of the state.
- Prioritize the use of new and emerging technologies that emphasize prevention and chronic disease management.
- Initiate, foster, and strengthen local and regional strategic partnerships between rural providers and other healthcare providers in order to promote measurable quality improvement, increased financial stability, maximize economies of scale, and share best practices and care delivery.
- Enhance economic opportunity for, and the supply of, healthcare clinicians through enhanced recruitment and training.
- Prioritize data and technology driven solutions that help rural hospitals and other rural healthcare providers furnish high quality healthcare services as close to a patient's home as is possible.
- Outline strategies to manage long-term financial solvency and operating models of rural hospitals in the state.
- Identify the specific causes driving the accelerating rate of standalone rural hospitals becoming at risk of closure, conversion, or service reduction.

States must also certify that none of the funds to be used under this Program will be “attributable to an intergovernmental transfer, certified public expenditure, or any other expenditure to finance the non-federal share.” As with other federal grants, awarded funds do not qualify as the non-federal share of Medicaid payments. The legislation permits CMS to request additional information through the application as well.

Spending Plan

States will submit to CMS “at a time, and in a form and manner specified by [CMS]” details on 3 or more of the following activities for which the state elects to use allotted funds if awarded:

- Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.
- Providing payments to healthcare providers for the provision of healthcare items as specified by CMS.
- Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.
- Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.
- Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of five years.

Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.

- Assisting rural communities to right-size their healthcare delivery systems by identifying needed preventive, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
- Supporting access to opioid use disorder treatment services (as defined in SSA Section 1861(jjj)(1)), other substance use disorder treatment services, and mental health services.
- Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.
- Additional uses designed to promote sustainable access to high quality rural healthcare services, as determined by CMS.

CMS will need to provide further details on how the application process and submission of the spending plan will align.

Priority Areas of Focus

Application decisions will be prioritized considering the following:

- OBBBA funding is time-limited for 5 years and will end in federal fiscal year 2030. To ensure that projects initiated or augmented with OBBBA funding will not be negatively impacted after the funding ceases, the Nevada Health Authority will prioritize concepts for the use of funds for projects or initiatives that are one-time costs or projects that clearly identify how it will be sustained without additional state or federal funding.
- Priority will be given for concepts that support rural health workforce development and workforce retention especially in the areas of maternal health, behavioral health and primary care.

How to get involved

- 1.) Be sure to sign up to receive Nevada Health Authority Listserv updates: [Listserv Sign Up](#)
- 2.) Complete the survey before September 15th.
- 3.) Attend the public workshop scheduled for September 30, 2025, to be held virtually. Public Workshop notice will be sent out on the Listserv (**new update**) and meeting information will be posted here: (insert link)

Listserv

Survey

Public Workshop info

Examples of FQHC Inclusion in Rural Health Transformation Program Plans

The Mid-Atlantic Association of Community Health Centers, on behalf of Delaware's three Federally Qualified Health Centers, is offering ideas to help the state meet the goals of the Rural Health Transformation Program (RHTP), as established in the 2025 One Big Beautiful Bill (OBBB). FQHCs are part of the solution to strengthen and modernize healthcare delivery consistent with this federal initiative. RHTP funding will be critical to mitigate the impact of sweeping Medicaid cuts affecting all providers, and strategic investments in FQHCs will help maintain access to care while easing the burden on hospitals.

Delaware's three federally qualified health centers (FQHCs)—Henrietta Johnson Medical Center, La Red Health Center, and Westside Family Healthcare—are uniquely positioned to help the state achieve Rural Health Transformation Program goals. Together, the centers serve more than 41,000 people each year and play an essential role in supporting patients and local hospitals. As community-based providers governed by patient-majority boards, FQHCs deliver comprehensive primary care services in designated Medically Underserved Areas (MUAs) or to Medically Underserved Populations (MUPs), regardless of patients' ability to pay.

Given that 40 percent of Delaware's health center patients are covered by Medicaid, the cuts included in the OBBB will likely result in service reductions and potential site closures. With no increase in federal grant funding expected, and Delaware's FQHCs already operating on razor-thin margins, these reductions pose a serious threat to healthcare access for communities most in need. Allocating a portion of RHTP funds to FQHCs would enable centers to innovate while strengthening operations and long-term sustainability. The RHTP provides an opportunity to ensure continued access to primary care in Delaware. Strategic investments—such as health IT upgrades, workforce training, and expanded behavioral health services—will equip FQHCs to continue prioritizing prevention, care coordination, and workforce development supports.

When patients have consistent access to FQHCs, chronic conditions are better managed, emergency department use declines, and overall healthcare costs are reduced—outcomes that directly support the Administration's access and cost-containment priorities.

We stand ready to support the state with its application to CMS and recommend that FQHCs be a part of Delaware's strategy to implement its Rural Health Transformation Plan.

This memo contains examples of how funding from the Rural Health Transformation Program could support federally qualified health centers (FQHCs). This list is not comprehensive and is intended to support discussions with state leaders for inclusion in applications to CMS. Each of the ten categories is one of the listed allowable uses of funds as outlined in the One Big Beautiful Bill.

1. Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.

Health centers are well-aligned with chronic disease management initiatives. Technology and workforce investments would support and expand capabilities.

- a. Point-of-care testing: Software like Relaymed, an A1C point-of-care tool that integrates Affinion A1C machines with many EHRs, allows medical assistants to test patients and receive results within minutes. Providers can then address the results with patients in real time.
- b. E-consult platforms: For example, PicassoMD provides virtual, real-time specialty consultations for primary care providers. Such services reduce the need for follow-up appointments and long wait times for specialty referrals that are common in rural areas.
- c. Diabetes Educator Training for Clinical Pharmacists: Education opportunities allow clinical pharmacists to provide more tailored, patient-centered care that can engage patients in care decisions and lifestyle changes.
- d. Cancer screening programs: Tools and patient education resources can help health centers work with patients to access appropriate cancer screening and understand the importance of testing.
- e. Food as Medicine Programs: Resources and equipment, like weather-safe refrigerators, would increase access to fresh food for health center patients.
- f. Nutrition Programs: Supplies and training for new and existing nutritionists and dieticians can help patients identify health habits and improve chronic disease outcomes.

2. Providing payments to health care providers for the provision of health care items or services, as specified by the Administrator.

- a. Mobile health units: Support for and development of mobile health programs will help FQHCs continue to deliver comprehensive health services directly to rural communities.

3. Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.

Health centers would benefit from investments in technology and training and technical assistance to implement innovations.

- a. Tablets or iPads: These tools help streamline patient intake processes and access virtual translation services. Tablets can also help with patient education to help explain provider instructions.
 - b. Patient Portals: Education opportunities for clinical teams to implement and optimize workflows with patient portals will improve patient access to health information, support education, and streamline communication.
 - c. AI Tools: Software like AI scribe services eases provider burden, saving time and accurately tracking next steps for patients. Some AI scribe services interface directly with the EHR, further supporting efficiency in billing and coding with more accurate claims.
- 4. Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.**

Not applicable.

5. Recruiting and retaining clinical workforce talent in rural areas, with commitments to serve rural communities for a minimum of 5 years.

FQHCs are a critical part of the healthcare infrastructure and often contribute to training the next generation of healthcare professionals.

- a. New or expanded FQHC clinical education training programs: Opportunities such as nurse practitioner or physician assistant fellowships, or medical and dental residency programs in FQHCs, will help healthcare professionals gain experience in a community-focused, primary care setting.
- 6. Providing technical assistance, software, and hardware for significant information technology advances designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.**

Despite being low-cost providers, FQHCs are known clinical innovators. Funding to support innovation will help health centers stay current with the changing healthcare landscape.

- a. Self-paced training programs: Programs like ThriveAP, a year-long didactic learning course, can help support top-of-license work for advanced practitioners and clinical support teams.
- b. EHR upgrades and applicable training: Upgrading FQHCs' EHRs and integrations improves clinical care, safety, efficiency, compliance, and financial performance. For example, EHR vendors often charge fees to activate single sign-on with state health information exchanges. Supporting an upgrade and associated clinical staff education would ensure that the health center can submit and receive timely data with minimal workflow interruption.
- c. Patient communication software: tools like Phreesia, a patient intake platform, allow healthcare providers to message patients and improve efficiency by reducing the burden of filling out forms in person.

- d. Telemedicine solutions: Telehealth has been shown to increase access to care, especially for people who live in rural areas or need specific care, such as behavioral health services. Telemedicine also helps maintain continuity of care for recently discharged patients, reducing the likelihood of unnecessary readmission.
- e. Automated medication dispensing systems: Medication dispensing systems reduce the demand on staff and lower the risk of medication or dosage errors. The systems also improve patient safety, supply tracking, and operational efficiencies.
- f. Cybersecurity software, hardware, and technical assistance: Investment in FQHCs' cybersecurity will improve patient health information protection, support continuity of operations, and ensure cybersecurity measures are up to federal standards.

7. Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.

As trusted community providers, FQHCs have direct insight into localized health needs, as evaluated in regular community needs assessments.

- a. Access to primary, behavioral, pharmacy, and dental health services to support treatment in the lowest cost care settings. Such investments could also target renovations for aging sites.

8. Supporting access to opioid use disorder treatment services, other substance use disorder treatment services, and mental health services.

The health center model supports behavioral health access, as many health centers offer comprehensive primary, behavioral, dental, and maternal health all in one location.

- a. Training and technical assistance: Opportunities that allow FQHCs to maintain their unique integrated care model, including training for medication-assisted treatment and SBIRT (Screening, Brief Intervention, and Referral to Treatment).

9. Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models, as appropriate.

As integrated primary care providers, FQHCs often have innovative care models that align with value-based care arrangements. Most recently, programs that enable patients to take ownership of their care have shown promise.

- a. Remote patient monitoring programs: Programs that utilize tools like self-measured blood pressure cuffs or other wearable self-monitoring tools help patients build independence while actively tracking chronic diseases. The improved health outcomes with chronic disease management, medication adherence, and hospital readmission prevention align directly with value-based care arrangements.

10. Additional uses designed to promote sustainable access to high quality rural health care services, as defined by the Administrator.

To be determined.

Introduction

The Washington Association for Community Health represents the state’s network of 28 Community Health Centers, which provide primary care, behavioral health, dental, and pharmacy services to more than 1.27 million patients annually in Washington. Collectively, our CHCs serve as the backbone of Washington’s primary care safety net by providing access to care for underserved communities, regardless of individuals’ insurance status or ability to pay.

CHCs are a critical lifeline to health care services for individuals in underserved urban and rural communities. Of the 28 CHCs, more than half have clinics in rural counties. Our network of health centers has a broad geographic reach, serving communities on the Olympic peninsula, throughout central Washington, and across the frontier of northeastern Washington. Our membership also includes two Urban Indian Organizations and one Tribal Health Center.

Approximately 38% of patients live at or below 100% Federal Poverty Guidelines (FPG), and 58% live at or below 200 percent of FPG. Nearly 830,000 patients are publicly insured through Medicaid, CHIP, or Medicare. Over one third of the state’s Medicaid population is served by CHCs. In addition, CHCs serve more than 117,000 migratory and seasonal agriculture workers or their families annually, demonstrating a strong commitment to the vital agricultural regions of our state.

The Association and the state’s CHCs believe that high-quality primary health care is essential to creating healthy communities and preventing chronic conditions. Strong preventive care helps reduce the strain on hospitals and emergency rooms. We welcome the opportunity to invest additional resources provided by the Rural Health Transformation Program (RHTP) to meet the critical needs of rural communities.

Below, we describe areas of investment that are highest priority for CHCs. We urge the state to create a plan that allocates this funding prudently, swiftly, and fairly to strengthen the full rural health care system, which includes primary care, hospitals, and behavioral health care. We would like to see the State’s Rural Health Transformation Plan prioritize direct support to providers in rural communities.

This document was developed with input from Washington’s rural community health centers and reflects shared priorities. If you have any questions, please contact Edwin

Chen at echen@wacommunityhealth.org and Dave Pearson at dpearson@wacommunityhealth.org.

1. Improving Value-Based Care with Digital Health Technologies

Advancing value-based care offers the potential to improve quality of care and reduce health care costs across the health care system. With the support of digital health technologies, rural health providers and primary care providers can engage patients in managing health conditions, deliver patient-centered care more effectively, and avoid costly, acute care. These enhancements would be a lasting investment in the rural delivery system and future value-based payment initiatives.

Primary care providers and patients located in rural areas may significantly benefit from expanding the use of digital health tools to track symptoms and conditions associated with common chronic conditions such as heart disease, hypertension, diabetes, obesity, and lung diseases. Digital health tools may include sensors that are used intermittently, such as spirometers, or continuously, such as wearable glucose monitors. These tools can collect certain clinical health data, which can inform strategies for both the patient and care provider to manage chronic health conditions and detect more severe health risks. This can be particularly helpful for patients located in rural areas, who may not have as many opportunities to access care in-person.

To promote uptake and effectiveness of digital health tools, patients may need additional support to adopt and use new digital devices. For example, although many health centers have expanded telehealth services in recent years, many patients, including those in rural areas, may continue to face barriers in utilizing telehealth. Digital navigators are critical assets for connecting community members to internet services, improving digital literacy, and using digital devices. Digital navigation services can help patients overcome challenges with using digital health tools by building trust and confidence in health technologies and improving patient engagement.

The Community Health Network of Washington (CHNW) has supported 7 CHCs to grow digital navigator capacity through the Link to Care WA program. This program has provided technical assistance to build new workflows, training and peer support networks, and toolkits to help rural CHCs support their patients in integrating new technologies. Programs such as Link to Care WA should be leveraged to provide resources to rural providers with expanding digital navigation services.

Furthermore, utilizing digital health technologies can lead to new strategies for value-based payment models by increasing the ability to track health and quality outcomes over time, which is a frequent challenge for models based on quality improvement. As the state moves forward with primary care transformation and value-based payment initiatives, the state should consider the new possibilities afforded by the expansion of patient-facing digital health technologies.

Aligns with the following allowed uses of funds:

- Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.
- Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.
- Developing projects that support innovative models of care that include value-based care arrangements and alternative payment models.

Key Partners:

The Health Care Authority will be a key partner in supporting CHCs and other providers in distributing and implementing digital health technologies. To support digital navigation, the Community Health Network of Washington is a key partner through their Link to Care WA program.

Potential Risks:

The expansion of digital health technologies creates additional risks for data privacy and security. While digital navigators can help educate patients about the digital privacy risks associated with health technologies, HCA and providers must develop appropriate safeguards on patient health data to prevent inappropriate uses or disclosures of health data. HCA should provide guidance and support to rural providers to adhere to national standards and federal law governing patient data, such as the Health Information Portability and Accountability Act (HIPAA).

2. Recruiting and Retaining Rural Health Workforce

Description: Rural health care providers continue to experience a severe shortage of health care workers. Additional funding is needed to support strategies to recruit and retain health care workers which will support access to care in rural areas. In total, WA's CHCs provide nearly 13,500 jobs and are vital contributors to their local economies. However, staffing gaps result in longer wait times for appointments, reduced services, and inability

to accept new patients. Investments in rural health workforce generate significant positive economic impact for rural communities and have a net return on investment to create even further growth in access and services in the long term.

As identified in the Health Workforce Council 2024 Report, rural health workforce needs remain severe, and challenges persist for rural communities to access traditional postsecondary education pathways. Like many other rural health care entities, Community Health Centers commonly experience long vacancies for registered nurses, medical assistants, and dental assistants. According to projections of the nursing workforce conducted by the Health Resources and Services Administration (HRSA), nonmetro areas are projected to have a higher shortage of RNs than metro areas. In addition, Washington is projected to be among the ten states with largest RN shortages in 2037. Investing in education pathways to strengthen and develop the state’s health care workforce is as important as ever.

CHCs and other rural providers have turned towards “grow-your-own” workforce development programs to help fill these gaps. These programs may include no-cost training opportunities and academic partnerships with local, more accessible education institutions. For example, NEW Health, a CHC located in northeastern Washington, has demonstrated the significant impact of grow-your-own programs in rural communities. In 2021, NEW Health launched NEW Health University in partnership with local high schools, universities, and school board. This community-based program provides on-the-job training that is highly accessible to low-income and rural students, including a Medical Assistant Apprenticeship, Pre-Apprenticeship, and Dental Assistant Training Program, and dedicated monthly education time for all employees. A strong advantage of apprenticeships and other grow-your-own programs is that the training provided is community-based and tailored to the clinic or healthcare facility, which also increases the likelihood of the trainee staying in those settings.

Although these programs can be successful, they can be prohibitively resource-intensive for rural health care providers to stand up, recruit, and operate. To recruit new talent, Community Health Centers support the following strategies:

- Invest in “grow-your-own” programs, including apprenticeship programs for medical assistants and dental assistants.
- Expand programs that provide exposure to medical professions for students from rural communities.

Another persistent workforce challenge is retaining clinical staff, particularly in rural settings. Health facilities are demanding work environments, and workers must be supported with ongoing training to expand their skills to meet specific challenges in their roles. While external factors such as childcare, housing, and transportation contribute towards turnover, resources must be invested in retention efforts. To retain clinical staff, Community Health Centers support the following strategies:

- Invest in additional resources to create new upskilling opportunities. This can include rural-focused mentorship programs, training for entry-level staff to support digital navigation and telehealth services, or other technology-focused learning aimed at future-proofing the rural healthcare workforce.
- Expand state-based investments in loan repayment programs with specific incentives for providers in rural areas.

Aligns with the following allowed uses of funds:

- Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of five years.
- Assisting rural communities to right-size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.

Key Partners:

Although most CHCs have developed relationships with institutions of higher education, community and technical colleges, and high schools, these relationships and workforce programs can be strengthened and further supported by the Washington Area Health Education Centers, the Washington Student Achievement Council, and other health care workforce partners.

Potential Risks:

Education and training pathways in healthcare are complex, often requiring multiple credentials, hands-on clinical hours, and licensure steps that create barriers for students and job seekers. Alignment between education providers and health care providers is needed to ensure graduates are job-ready and meet credentialing requirements. Additionally, evaluation is needed to determine whether strategies are meeting employer demands as shortages and needs change over time.

3. Modernizing Health IT Infrastructure and Enhancing Cybersecurity

Description: Adoption of modern Electronic Health Records (EHRs) and other provider-facing, advancing technologies can improve clinical care, support health information exchange, and patient experience. However, significant disparities in health IT adoption and interoperability exist between rural and urban health care providers. Many rural health providers face financial barriers to adopt EHR systems, which consequently impacts patient care and safety.

Although all health centers in WA currently have an EHR system installed, approximately half of health centers use multiple EHRs or data systems that are specific to certain service types (e.g., dental, behavioral health, care coordination). In addition to direct investments in CHCs' EHR systems and IT infrastructure, CHCs can significantly benefit from other providers in their areas adopting EHRs and related systems to enable information exchange and clinical linkages.

While health centers are dedicated to enhancing patient care through advanced technologies, they can also be susceptible to cybersecurity threats. Like all health care providers, CHCs must contend with increasingly dangerous cybersecurity threats and can be frequent targets of bad actors. When cyberattacks occur, they can significantly harm CHCs' operations and their patients. For example, as a result of the Change Healthcare Security Breach, 62% of health centers nationwide had patients who were affected by a delay in access to care due to inability to obtain prior authorization, service interruption, or went without needed medications. Only two-thirds of health centers reported having a cybersecurity committee or leader, and 78.9% reported having 1-10 full-time equivalents (FTEs) supporting health IT. Under limited resources, health centers are already working around the clock to adhere to the necessary cybersecurity standards. Additional funding and support for cybersecurity enhancements are needed to protect health IT resources from external threats and ensure safeguarding of patient data.

Additional funding should be utilized to promote the following strategies:

- Incentivize rural health care providers to adopt or upgrade EHR systems.
- Develop a pilot program to test the use of AI to increase efficiency in clinical workflows, such as managing more burdensome administrative tasks.
- Provide additional resources for providers to strengthen cybersecurity by improving data governance, risk assessment, threat mitigation, and compliance with federal data security standards.

- Improve health information exchange between different provider types in rural areas, such as between Community Health Centers, Indian Health Centers, and rural acute care hospitals.
- Increase patient access to health information and the portability of protected health information.

Aligns with the following allowed uses of funds:

- Providing technical assistance, software, and hardware for significant information technology advances that are designed to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes.
- Designing/implementing other programs that support sustainable access to high-quality rural health care services.

Key Partners:

HCA, the Department of Health, Department of Social & Health Services, and Office of the Chief Information Officer are critical leaders in guiding statewide investments in health and human service IT systems. Although different health care providers may have individual health IT needs, alignment with a statewide health IT framework can help to promote interoperability across systems and promote data sharing when appropriate.

Potential Risks:

CHCs typically rely on a variety of vendors for health IT and cybersecurity services, as may be the case for many other rural health care providers. The state could support CHCs and other health care entities in identifying appropriate third-party vendors that can provide these services, with consideration for interoperability and cybersecurity needs.

September 3, 2025

To: Secretary Johnson, Department of Health Services

From: Wisconsin Primary Health Care Association

Re: RHTP and Encouraging Investments in Primary Care

Secretary Johnson,

On behalf of Wisconsin's 19 Community Health Centers, thank you for your leadership during a period of complexity and transition for the healthcare ecosystem. As the membership organization for the state's 19 Federally Qualified Health Centers (Community Health Centers or CHCs), the Wisconsin Primary Health Care Association (WPHCA) has a deep understanding of the opportunities and barriers to improving access to high quality, cost-effective primary care and is excited to provide a proposal for the Rural Health Transformation Program (RHTP).

In 2024, Wisconsin CHCs served 298,192 unique patients through 1,159,674 visits including medical, dental, behavioral health, SUD, and enabling services.ⁱ 66% of CHC patients earn at or below 100% of the Federal Poverty Level, and 58% are Medicaid-insured. 127 of 259 CHC sites have a rural service area population (see site map in Appendix A).ⁱⁱ

CHCs are the backbone of the safety net, expanding to address local priorities by reducing care gaps and evolving delivery models to meet complex patient needs. The RHTP offers a timely opportunity to reinvest in the long-term sustainability and transformation for CHCs in Wisconsin by reinvesting in comprehensive primary and integrated care and focusing on the most complex patients. Prioritizing funding for CHCs is essential to stabilize the safety net, especially given recent investments in hospital-based care and Medicaid rate increases for other provider types, which exclude CHCs due to their unique Prospective Payment System (PPS). CHCs are ready to be the solution but need system-level transformation to address community care gaps and financial constraints.

Abstract

Recommendations include strategies to improve access to primary care, dental care, and behavioral health care, leverage technology to create efficiencies, and invest in critical workforce resources essential to rural healthcare. Proposals are informed by conversations with CHC leaders and a survey facilitated in August 2025 specifically in response to the RHTP opportunity. This memo provides six transformational proposals to address workforce and reimbursement challenges.

Organizational Background and Experience

WPHCA provides training and technical assistance for CHCs related to Health Information Technology (HIT), quality improvement, practice transformation, population health management, and manages a clinically integrated network, WisconsinHealth+. WPHCA also serves as a Health Center Controlled Network through which CHCs collaborate to strengthen and leverage HIT to improve operational and clinical practices. WPHCA has a long-established partnership with DHS including providing contractual services for HPSA

designations. WPHCA engages directly with all 19 CHCs in Wisconsin and facilitates multiple Peer Learning Networks that could assist to gather feedback, convene stakeholders, and develop implementation strategies related to the proposals in this memo. The lead contact person for this RFI response is Richelle Andrae, Associate Director of Government Relations, randrae@wphca.org.

Detailed Response

Proposal #1	RHTP Activities (see Appendix B)
Develop a CHC-based Primary Care Management Pilot	2, 3, 4, 5, and 6

Based on WPHCA’s review of Medicaid members assigned to a primary care provider at a CHC through their enrollment in managed care, 20 to 30% of members are not receiving any medical services annually. For example, for one BadgerCare Plus HMO, CHC-attributed patients have roughly 750 ER visits per 1,000 members and 130 inpatient admissions per 1,000 members. Nearly 50% of these ER visits and 25% of the inpatient admissions are considered *potentially avoidable*. Many of these Medicaid-enrolled patients repeatedly present at hospitals with unmanaged behavioral health needs. CHCs are uniquely positioned to address these issues, provided there is a financial mechanism to support the team-based care management model that CHCs currently use with the most complex patients.

WPHCA is seeking funding to establish a Primary Care Management Pilot which would support CHC efforts to build staffing and workflows needed to facilitate care transitions and improve access to care management and care coordination for complex patients. Examples of programs could include:

- Conducting outreach to patients that have not received primary care services;
- Improving connections to primary care health homes after release from an inpatient stay or emergency room visit; and
- Integrating services across medical, dental, and behavioral health to wrap care around patients more effectively.

CHCs have expressed interest in expanding care management and coordination for patients with complex needs through a prospective per member per month (PMPM) payment. In 2025, Medicare introduced the Advanced Primary Care Management model in which providers can bill for care management and coordination services monthly. This model could be replicated with a new pilot for Medicaid and CHCs. This fund would move CHCs and the state to explore transformational payment mechanisms outside of the current PPS infrastructure, ensuring sustainability while testing an innovative approach.

WPHCA recommends structuring the pilot as a two-year development phase, then two years of implementation, demonstration, and evaluation, with a final year transitioning to long-term sustainability after demonstration of value to Medicaid and its beneficiaries. WPHCA recommends that a portion of funds be used for administration, including DMS staff support, to establish and implement the program. WPHCA is committed to working closely with DMS staff on all steps of implementation, including development, financial modeling, convening participants, and other collaboration as appropriate.

Proposal #2	RHTP Activities
Invest in dental and behavioral health pipeline development, recruitment, and retention	1, 4, 5, 6, and 10

Workforce limitations are the primary challenge facing CHCs in their efforts to provide more services. According to 2022 data, only 28% of Medicaid members received preventive dental services. CHCs report it takes an average of three months to hire a Hygienist and nearly six months to hire a Dentist.ⁱⁱⁱ An improper distribution of clinicians also contributes to workforce challenges as 53% of zip codes in Wisconsin have no licensed Dentists.^{iv} CHCs report similar challenges for behavioral health staffing. WPHCA recommends that DHS provide funding directly to CHCs to implement their own recruitment and retention strategies and fund grant programs to support long-term transformational systems change. Without investing in workforce pipelines, all other efforts will be limited in impact. Recommendations for statewide work include:

- **Behavioral Health Training Consortia:** WPHCA recommends adding a new grant program that creates Behavioral Health provider training consortia and leverages the success of the Advanced Practice Clinician Training Grants and Allied Health Professional Education and Training Grants. Funds would create consortia of health care organizations and local educational partners to build capacity to train within their communities and retain clinicians in under-resourced areas.
- **Loan Assistance Program for Behavioral Health providers:** The [Health Professions Loan Assistance Program](#), administered by the Wisconsin Office of Rural Health, makes awards to providers for education loan repayment, in return for practicing in an underserved area. WPHCA recommends creating a similar program for behavioral health and SUD professionals. Evidence from a 2018 study indicates that loan assistance is a powerful recruitment tool with 33% of survey respondents that received loan assistance reporting that the program was “critical” or “important” to their site selection, and 81% of awardees staying at the site after their service obligation, highlighting the value as a retention strategy, too.^v This proposal is also supported by the NAMI Mental Health Action Partnership.
- **WTCS and Clinical Training Support:** CHCs rely on technical college partners to educate dental assistants and hygienists and collaborate to provide clinical training experiences and preceptors. Recent state investments allowed the Wisconsin Technical College System (WTCS) to expand training for the oral health care workforce. Funds are estimated to generate 250 new program slots annually and improve access to dental care for 263,000 Wisconsin residents. WPHCA proposes exploring new incentives for the WTCS to offer and expand dental programs, as well as identifying opportunities outside of the system to train the next generation of oral health professionals (e.g., creating a rural health hygiene training consortium for on-site training in CHCs).
- **Dental Teaching Health Center:** Provide seed funding to establish a new [Teaching Health Center Graduate Medical Education \(THCGME\)](#) program focused on dentists that would allow for expanded community-based dentistry exposure. Funding is

available at the federal level for the THCGME program and could provide long-term sustainability. WPHCA would collaborate with the Wisconsin Council on Rural GME to develop the program.

Proposal #3	RHTP Activities
Implement a centralized managed care credentialing system	1 and 8

WPHCA recommends leveraging the RHTP to create efficiencies through development and implementation of a centralized MCO provider credentialing platform. This solution would improve access to care by ensuring that Medicaid providers are able to practice and bill insurance quickly. CHCs often cite credentialing delays and inefficiencies as a source of frustration and barrier to delivering timely patient care. This proposal is ideally suited to meet shared goals of increasing government efficiency by reducing red tape and administrative burdens.

BadgerCare Plus HMOs are required by contract to complete the insurance credentialing process within 90 days, however, the process frequently takes up to 120 days or occasionally up to a year. Further, many current processes are duplicative and burdensome. In 2023 WPHCA conducted a high-level analysis regarding credentialing delays which estimated lost revenue of \$1.8m across just the 19 CHCs in Wisconsin.

A centralized system would leverage the data already on file for Medicaid enrolled providers and apply that information to MCO plans, streamlining the credentialing process. Multiple states have recognized the administrative efficiencies of a centralized credentialing system.^{vi} This proposal is truly transformational; a one-time investment could have significant meaningful outcomes to expand access to care for patients (measured by reduced credentialing timelines) and create system efficiencies. WPHCA suggests providing staffing at DHS to assemble stakeholders, including Medicaid MCOs, and then subsequently implement system upgrades.

Proposal #4	RHTP Activities
Establish a CHC School Health Expansion Fund	2, 4, 5, 6, and 10

In 2024, Wisconsin CHCs served 8,127 students via school-based services, including behavioral health therapy, sealants through Seal-A-Smile, restorative dental care, etc., an 8% since 2023. However, start-up barriers include non-billable planning and implementation activities such as staff to project manage, coordinate details with schools, process paperwork, and problem-solve technology and space restrictions.

WPHCA proposes establishing a CHC School Health Expansion Fund to provide financial support for program coordination, recruitment incentives, coverage for initial start-up salaries for providers, improved data functionality and information exchange with schools, and/or

purchasing equipment to telehealth service delivery. Similar grant programs exist in states across the country, including [Michigan’s CAHC Program](#), which has improved outcomes for students. CHCs can currently bill Medicaid for services rendered in schools for Medicaid-enrolled children and families, which provides ongoing and long-term financial sustainability.

Proposal #5 Summary	RHTP Activities
Enhance CHC HIT, cybersecurity, and interoperability capacity	7, 8, 9, and 10

WPHCA proposes investments in HIT and data security tools for safety net providers that, unlike regional or national systems, lack the scale or capital to adopt cutting edge tools. RHTP funds should be granted directly to safety net entities or associations for both systems-wide and individualized projects. Priorities include:

- Expand Adoption of Clinical Documentation Tools to Increase Efficiency:** The use of AI-powered clinical documentation solutions will increase provider productivity and serve as a recruitment and retention tool for CHCs. These tools capture real-time conversations between providers and patients as clinical notes directly within the EHR. One Wisconsin CHC that recently piloted an AI-powered tool showed improvements in the percentage of charts closed within two days and decreased time spent outside of scheduled work hours.
- Remote Patient Monitoring (RPM):** The use of RPM devices results in increased patient engagement, higher medication adherence rates, and overall improvements with the patient’s health through lifestyle changes. CHCs have successfully launched RPM devices to manage and assess health conditions, such as controlled blood pressure. However, limited funding restricts CHCs from fully implementing a sustainable model. Funding could be used to purchase devices and increase Medicaid reimbursement for digitally enabled RPM tools that automatically transfer patient data to EHRs.
- Autonomous Diabetic Retinopathy Cameras:** CHCs are interested in offering diabetic retinopathy screening during primary care visits to overcome rural access barriers to ophthalmology and reduce delays in preventive care. RHTP support would cover device acquisition, EHR integration, staff training, and workflow redesign, allowing CHCs to increase screening rates, close care gaps for patients with diabetes, and reduce vision loss risk. Reimbursement of remote E&M codes at the PPS rate could support sustainability of such technologies after initial purchases.
- Expand Data Reporting and Interoperability Opportunities:** Several Wisconsin CHCs currently share their clinical EHR data in a nationally recognized data analytics and visualization tool called Azara DRVS to drive clinical quality performance and advance value-based care. In some situations, advanced investment and functionality of the tool integrates health plan enrollment and care gap data into Azara, exchanged at the state, regional, and national level to support CHC and health plan quality performance and population health strategies. Continued investment in this platform will lead to enhanced statewide reporting capabilities, improved data analytics, and connection with payors for enrollment data and data exchanges such as WISHIN.

Funding would be used to increase capabilities of the platform across the CHC network.

Proposal #6 Summary	RHTP Activities
Address current barriers with the PPS Change in Scope process for CHCs to expand services via the creation of a start-up funding program	2, 5, and 6

As CHCs have adapted to PPS reimbursement, they have worked with Medicaid to implement Wisconsin’s first Changes in Scope (CIS). The 3% threshold is difficult to meet in practice and intensifies as a CHC expands services and sites. This makes growth difficult and can discourage innovation and pilot testing that may not hit the threshold. Further, CHCs face cash flow challenges as they make upfront investments in the provision of services prior to making a CIS request.

WPHCA recommends the creation of a zero-interest loan program where CHCs could proactively plan for future CISs and utilize these funds to support the upfront investments needed to implement new services prior to achieving the 3% threshold. Upfront funding for early investments can help establish or grow programs that are sustainable over time through existing Medicaid reimbursement channels as evidenced by early adoption of HOPE grants for SUD expansions at CHCs.

We look forward to discussing these proposals and appreciate your thoughtful engagement to ensure that RHTP is optimized to benefit Wisconsinites.



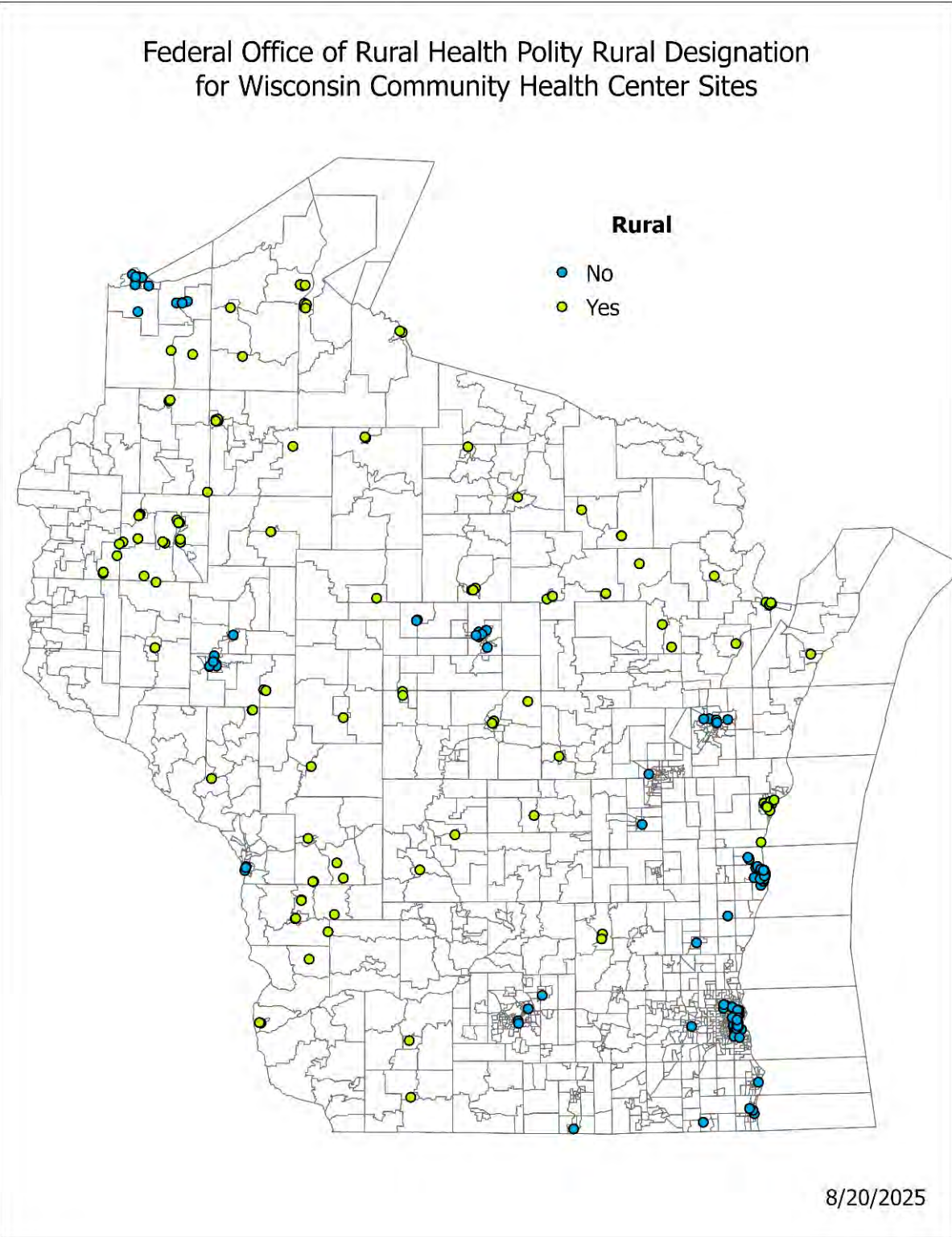
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RFI submitted with support from the following Wisconsin CHCs:

- Partnership Community Health Center
- Kenosha Community Health Center/Pillar Health
- Community Health Systems, Inc.

- Scenic Bluffs Community Health Centers
- Access Community Health Centers
- Lakeshore Community Health Care
- NorthLakes Community Clinic
- Family Health Center
- Bridge Community Health Clinic
- N.E.W. Community Clinic

Appendix A: Wisconsin CHC Sites by Rural and Urban Designation (2025)



Appendix B: Allowable Uses of RHTP Funds

1. Recruit and retain clinical workforce talent to rural areas, with a 5-year commitment
2. Provide payments to providers for health care items or services
3. Develop projects that support innovative models of care (value-based care, alternative payments)
4. Promote sustainable access to high quality rural health care services
5. Assist rural communities to right size their health care delivery systems (preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care services)
6. Support access to opioid use disorder treatment, substance use treatment, and mental health services
7. Provide training and technical assistance to develop and adopt technology-enabled solutions to improve care delivery in rural hospitals (remote monitoring, robotics, AI)
8. Provide technical assistance, software, and hardware for IT advances to improve efficiency, enhance cybersecurity capacity, and improve health outcomes
9. Promote consumer-facing, technology-driven solutions for the prevention and management of chronic diseases
10. Promote evidence-based, measurable intervention to improve prevention and chronic disease management

ⁱ 2024 Uniform Data Set (UDS).

ⁱⁱ Federal Office of Rural Health census tracts data and 2024 UDS.

ⁱⁱⁱ 2021 CHC workforce survey. WPHCA.

^{iv} 2023 DSPS Dentist license analysis. WPHCA.

^v Wisconsin Office of Rural Health Analysis, HPLAP. 2018.

^{vi} See [Mississippi launched their centralized credentialing system and full implementation complete in October 2022.](#)