Navigating HR1: Financial Implications and Strategic Response for North Carolina Health Centers

June 4–5, 2026 • Washington Duke Inn & Golf Club (Durham, NC)

Speakers

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Session:
Navigating HR1: Financial Implications and Strategic Response for North Carolina Health Centers
| 9:50-10:45 am | [room]

Key takeaways

- HR1 will reshape funding and compliance—plan ahead.
- NC-specific factors will drive local impact.
- Proactive planning is key to financial stability.

NORTH CAROLINA NCCHCA Serving Community & Migrant Health Centers Community Health Center Association

About Capital Link

Founded in 1995 | Nonprofit

- HRSA National Cooperative Partner
- Supporting health centers & nonprofits with capital, operational, and strategic planning
- National leader in facility, financial, and operational strategies

OUR VISION

We believe in a just future in which every individual is treated with dignity and respect and has access to quality healthcare, regardless of their ability to pay.

OUR MISSION

By fostering a culture of trust, collaboration, and respect, we support health centers to deliver high quality healthcare. We are dedicated to amplifying health center impact by providing comprehensive support for sustainability, growth, and resiliency through resources, technical assistance, and innovative solutions that help health centers leverage their assets, articulate their value, and deliver patient-centered care that meets the highest standards. We pursue excellence with humanity.

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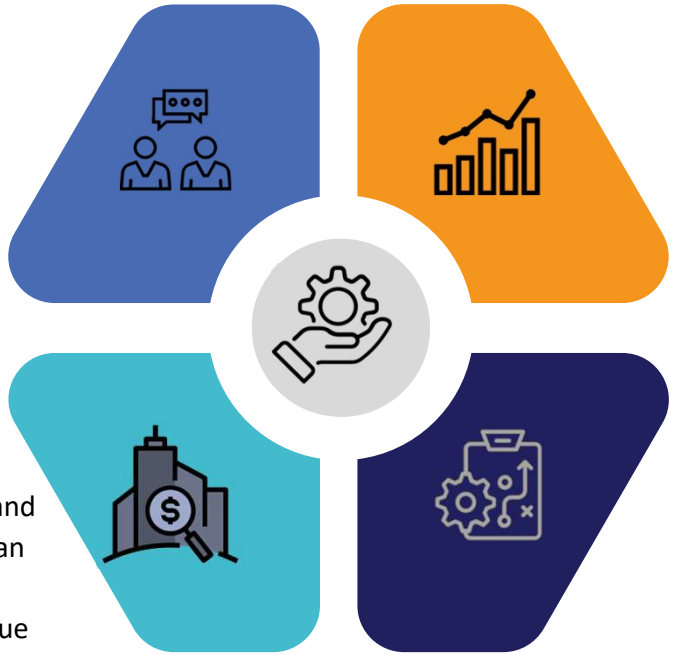
Capital Link Services

Advisory Services for Facilities Planning, Mobile Health Units & Operations

- EDAC-accredited evidence-based design for optimal **patient flow & efficiency**
- Consulting for **mobile health units** to support flexible, community-based care

Financial Advisory Services & Capital Project Financing

- Specialized in **New Markets Tax Credits** and federal loan guarantees (HRSA, USDA)Loan Guarantees (HRSA, UDSA)
- Business plans, financial forecasts, and due diligence support
- Helping organizations **secure funding** and make informed decisions.



Data-Driven Operational & Impact Analytics

- **Value and Impact Analysis** for stakeholders
- **Performance Enhancement Profile** benchmarking against peer health centers
- **Scenario modeling** to project revenue changes in dynamic environments
- Backed by a **database covering 80% of health center audits** and **100% of UDS data** from the past decade

Leverage Market Assessments & Strategic Planning

- Evaluate service areas and identify **growth opportunities**
- Facilitate strategic planning to set priorities, align resources, and ensure **sustainable growth**

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Objectives

Session Objectives

By the end of this session, participants will be able to:

- Review H.R. 1 policy changes
  - Summarize key provisions and timelines affecting Medicaid, funding, and compliance requirements for health centers
- Assess financial and market impacts in North Carolina
  - Evaluate how H.R. 1 will shift payer mix, patient access, and revenue dynamics across NC health centers
- Identify key financial and operational risks
  - Recognize potential impacts on margins, cash flow, uncompensated care, and administrative burden
- Develop actionable strategic responses
  - Prioritize short-, medium-, and long-term strategies to protect financial stability and sustain access to care

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Session Objectives and Why HR1 Matters Now

HR1 Policy Impact

HR1 introduces critical changes affecting funding, compliance, and financial oversight for health centers.

Mission Sustainability

Understanding HR1 is essential for sustaining mission-driven access amid tight margins and increasing demand.

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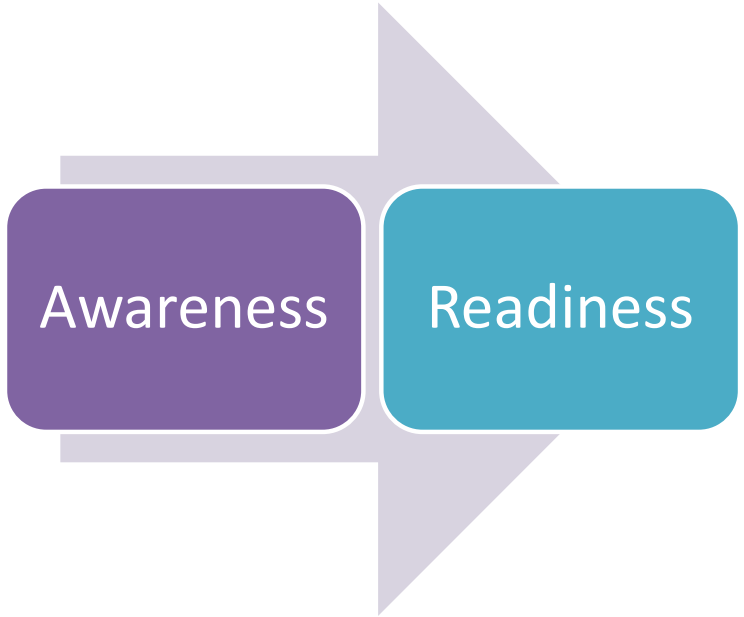
Session Objectives and Why HR1 Matters Now

Practical Readiness

Leaders should be empowered to move from awareness to readiness through clarity on HR1 and HRSA expectations.

Strategic Opportunity

HR1 offers a chance to improve financial discipline, transparency, and align strategy with outcomes.



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HR1 Overview: Key Provisions

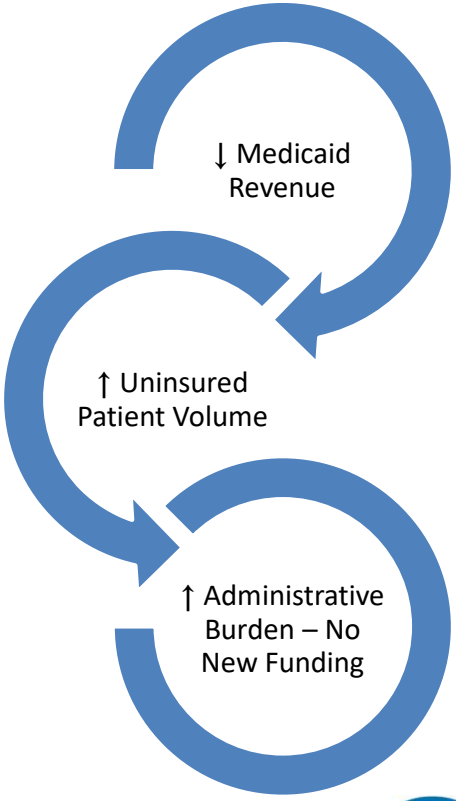
- Key Provisions Impact
  - HR1 focuses on federal funding oversight and measurable financial performance in health centers.
- Focus on Accountability
  - HR1 promotes accountability, sustainability, and data-driven oversight in community health centers.

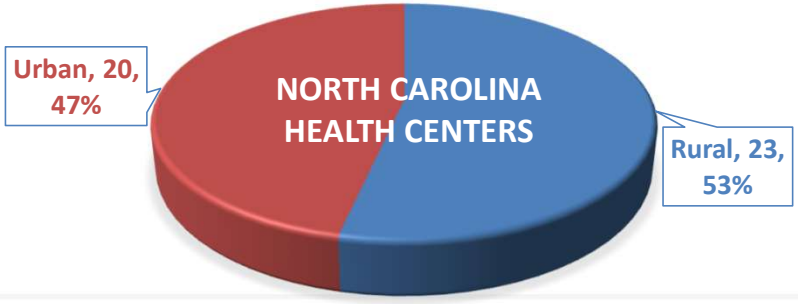
HR1 Overview: Timelines

- Implementation Timelines
  - The timeline shows phased elements already effective and those rolling out over months and years.
- Strategic Planning Importance
  - Understanding HR1 timing aids budgeting, board education, and operational readiness for health centers.

North Carolina-Specific Financial Impacts

- State Medicaid Environment
  - North Carolina's Medicaid policies shape financial outcomes for community health centers uniquely compared to other states.
- Rural and Urban Service Mix
  - The diverse rural and urban settings in North Carolina create distinct challenges for access and care delivery impacting finances.





North Carolina-Specific Financial Impacts

- Workforce and Staffing Constraints
  - Staffing shortages and workforce challenges affect productivity and cost structures within North Carolina health centers.
- Financial Planning and Collaboration
  - Scenario planning and cross-functional teamwork in finance, operations, and clinical leadership improve HR1 adaptation strategies.

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North Carolina-Specific Financial Impacts

UDS 2024 for 40/43 NC CHCs

North Carolina [2024]

May 22, 2025

Scenario Planning for Health Centers

Analyzing the Impact of Potential Policy Changes on Patient Volume and Health Center Revenues

Medicaid Coverage Losses Under a Federal Work Requirement

This analytic tool estimates the projected impact of a nationwide mandatory Medicaid work requirement covering the adult Medicaid patient population ages 18-64 who receive care at community health centers (CHCs). The analysis focuses on working-age adults who are CHC patients and who live in one of the 40 states and the District of Columbia that elected to implement the ACA Medicaid expansion to cover additional low-income adults. The CHCs included in this analysis are those that receive federal grants under Section 330 of the Public Health Service Act; the "look-alike" health centers are excluded.

Under H.R. 1, the House Budget Reconciliation bill as passed on May 22, 2025, Medicaid work requirements would take effect on January 1, 2027. The approach used to determine the total number of Medicaid adults in states that have implemented the ACA expansion, which is the focus of the work requirement, was developed by the Urban Institute and is based on an analysis of the impact of two state-level Medicaid work demonstration projects. The Urban Institute found that the percentage of people losing Medicaid coverage was approximately 36% where highly-automated data matching and enrollment processes were in place. However, under Arkansas's work demonstration, people who had to manually report information lost coverage at far greater rates; 72% of people, virtually all of whom remained eligible based on either work or an exemption, were disenrolled because they were unable to navigate the reporting process.

An additional consideration is what happens when, as under the House bill, people must report not only during eligibility periods but at the time of initial enrollment. In Georgia, where the Pathways to Coverage Medicaid demonstration requires work reporting at the time of enrollment, reporting complexity has caused enrollment to remain at less than 10 percent of the projected eligible population.

Increased Automated Eligibility Verification

Estimated percentage of Medicaid adults subject to reporting requirements who lose coverage under a more automated reporting system.

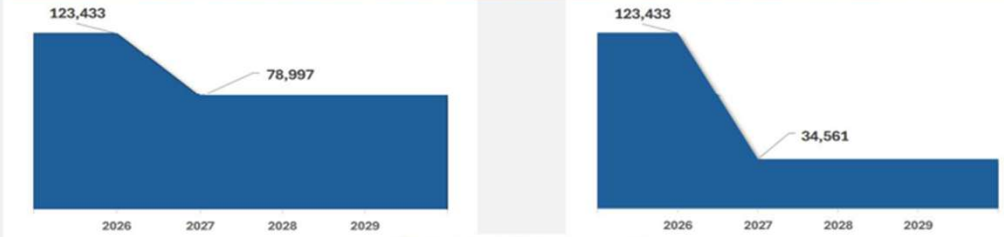
36%

Increased Manual Eligibility Verification

Estimated percentage of Medicaid adults subject to reporting requirements who lose coverage because they are unable to verify either compliance with a work requirement or an exemption.

72%

Estimated ACA Expansion State CHC Adult Patients Covered by Medicaid Under Each Verification Method



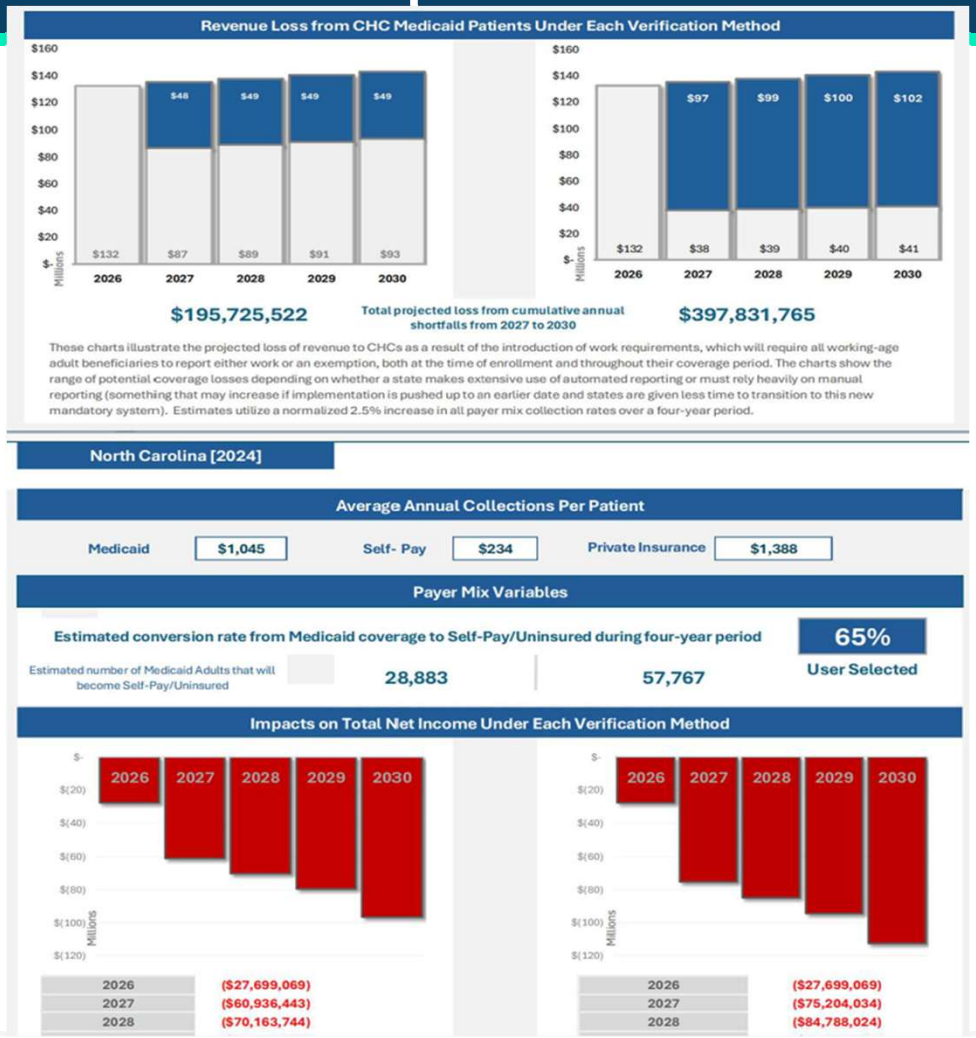
CHC Adult Patients Estimated to Lose Coverage Under Each Verification Method

44,436 | **88,872**

According to data from the 2023 Uniform Data System (UDS) to which all health centers report annually, in ACA expansion states (40 states and the District of Columbia) health centers serve approximately 7.7 million Medicaid-insured working-age adults. The data in this report will focus on losses in these states, and non-expansion states are excluded. UDS provides data for ages 18-64 (rather than 19-64), however this difference has a minimal impact on the analysis.

North Carolina-Specific Financial Impacts

Estimated Revenue and Net Income Loss



Specific Financial Impacts

Enhanced Premium Tax Credit Impact

North Carolina

September 26, 2025

Scenario Planning for Health Centers

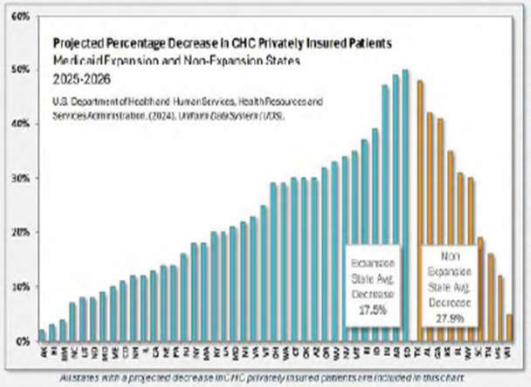
Analyzing the Impact of Potential Policy Changes on Patient Volume and Health Center Revenues

Projected CHC Patients With Private Insurance at Risk of Losing Coverage

Background: Beginning in 2014, the Affordable Care Act (ACA) health insurance exchanges ("Marketplaces") offered affordable coverage for millions of people. Bolstered by 2021 enhancements to premium tax credits (also known as subsidies) and simplified enrollment processes, Marketplace reforms expanded private insurance coverage for low-income people, dramatically reduced the number of uninsured community health center (CHC) patients, and, in turn, supported expansion of CHC capacity.

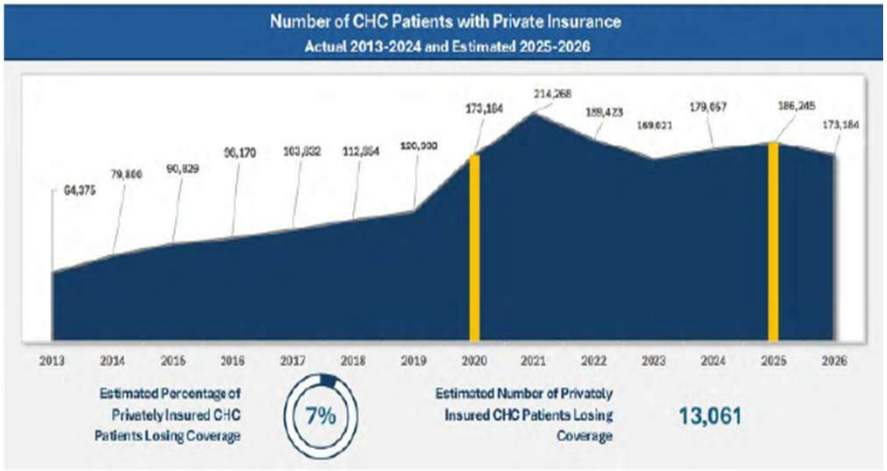
Last year CHCs served more than 32 million people nationwide in urban, rural and frontier communities across America. Subsidized Marketplace plans are an important source of coverage for low-income CHC patients, who typically work at jobs without affordable employer-based insurance. Federal data show that in 2024, in excess of 7 million CHC patients (22%) had private insurance, more than double the 3 million (14%) who had private coverage in 2013 before Marketplace plans became available. This growth in private insurance among CHC patients can be attributed to Marketplace coverage. There is no evidence that access to employer-based insurance has increased for low-income people since the implementation of the ACA. The Bureau of Labor Statistics reports that in 2022, just 26% of private industry workers in the lowest wage category were offered coverage and only 12% actually enrolled. Furthermore, the increase in private insurance coverage among health center patients parallels the surge in Marketplace enrollment among states following the adoption of enhanced tax credits and simplified enrollment policies enacted in 2021, particularly among people with incomes below 150%.

The Congressional Budget Office (CBO) estimates that, with the passage of the One Big Beautiful Bill Act (OBBBA) and the decision not to extend enhanced premium subsidies, Marketplace enrollment will fall by more than 8 million people by 2034. Losses in coverage will be especially high in states that have not adopted the ACA Medicaid expansion, since in these states eligibility for premium subsidies begins at 100% of the federal poverty level, rather than the higher 138% level used in Medicaid expansion states. CHC patients, 90% of whom have incomes at or below twice the federal poverty level, are likely to be disproportionately affected.



All states with a projected decrease in CHC privately insured patients are included in this chart

Analysis and Methods: This analytic tool estimates reductions in private insurance coverage among CHC patients when Marketplace policy changes go into effect in 2026, and the impact of those losses. Our analysis uses data on CHC grantee patient private coverage for 2013-2024 from HRSA's Uniform Data System (UDS), to which all health centers report annually. The analysis assumes, based on findings cited above, that the increase in private coverage among CHC patients through 2025 is attributable to the Marketplace. According to UDS, CHC grantees (excluding those in U.S. territories) served over 7 million patients with private insurance coverage in 2024 - which includes adults and children who would likely be covered under Marketplace plans as a family. Using Marketplace enrollment trends from 2021 to 2024 and growth estimates from KFF, we project 7.75 million CHC patients have private coverage in 2025. Subsequent coverage losses are projected from the 2025 estimate.



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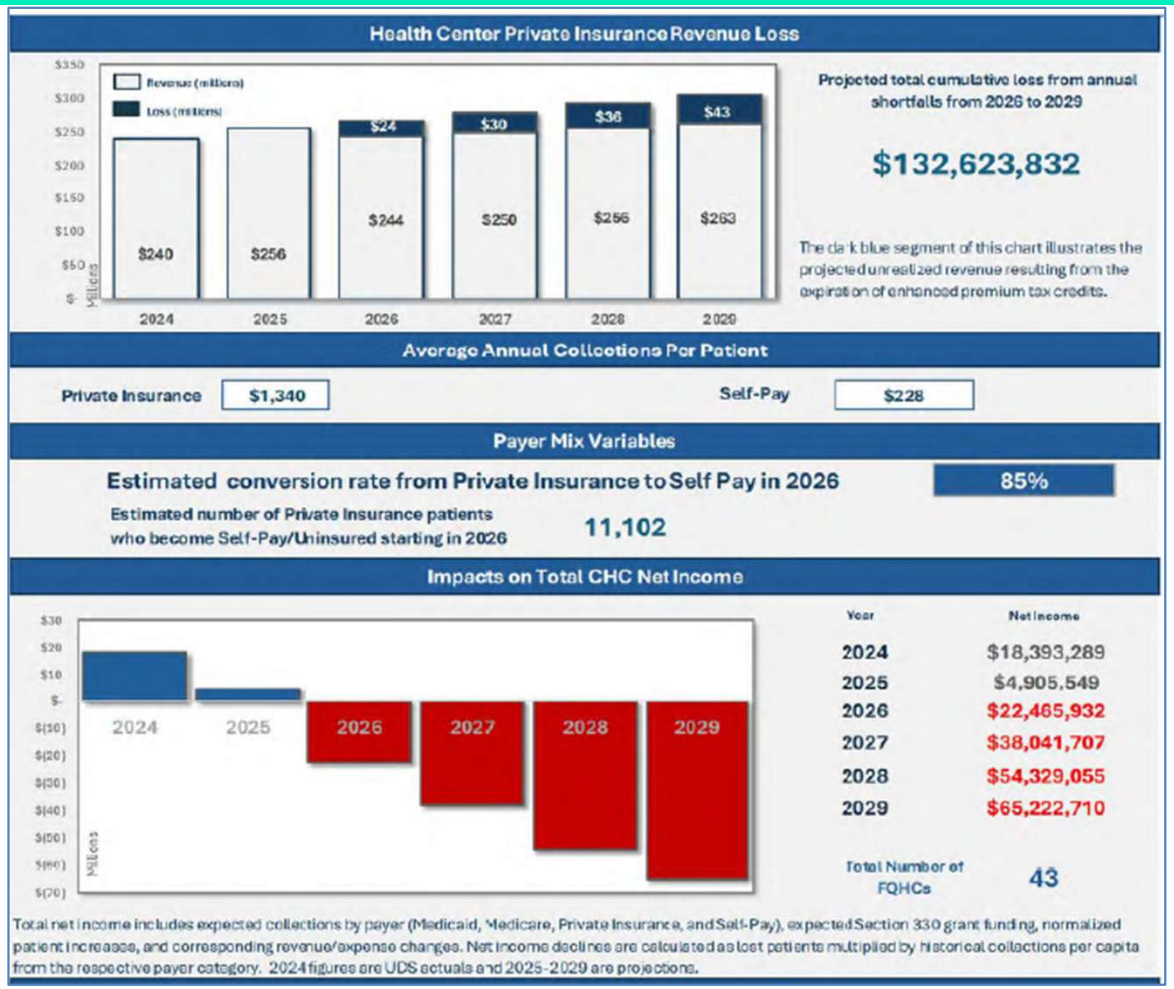
Specific Financial Impacts

Estimated cumulative loss from annual shortfalls 2026-2029



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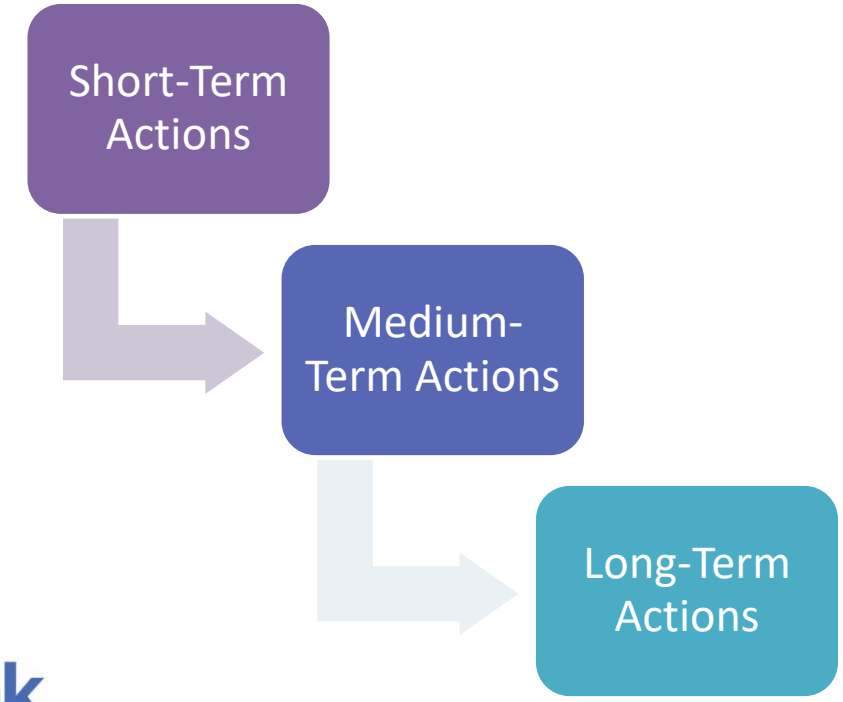
Strategic Response: Short-, Medium-, and Long-Term Actions

Strategy: Where do we start?



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Moving Health Forward

Strategic Response: Short-Term Actions

Short-Term Readiness

Focus on immediate readiness by reviewing financial metrics and aligning leadership on HR1 implications.

Strategic Response: Medium-Term Actions

Medium-Term Capacity Building

Strengthen financial reporting, enhance revenue oversight, and educate boards on key performance indicators.

BOARD OF DIRECTORS

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Strategic Response: Long-Term Actions

Long-Term Sustainability

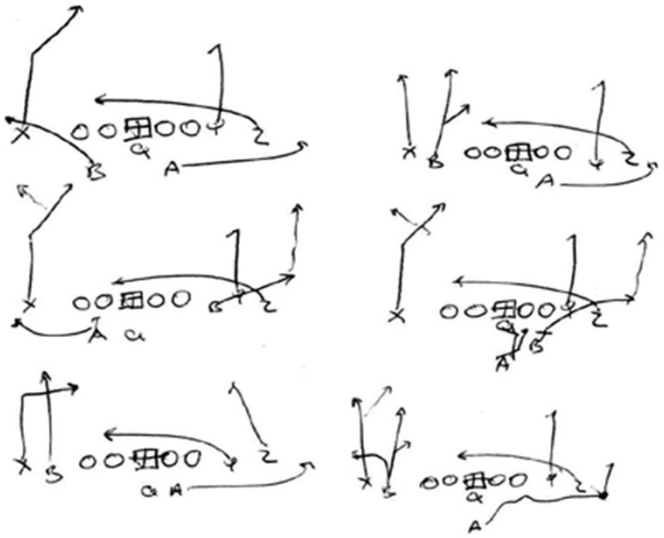
Align strategic plans with funding realities, build reserves, and invest in data systems for ongoing monitoring.

Strategic Response: Coordinated Phased Efforts

Coordinated Phased Efforts

Success depends on phased, coordinated actions prioritized by risk, capacity, and impact across the organization.

Capital Link's Playbook



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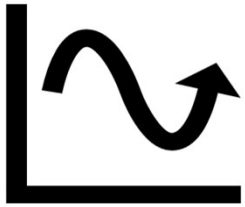
Scenario Planning

Assess Risk

- Medicaid Changes
- Value Based Care Contracting
- HRSA Changes
- Competition
- Reimbursements

Scenario Planning



- Monitoring
- Early Risk Response
- Cost Containment
- Critical Interventions
- Emergency Operations

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Scenario Planning

Summary of Scenario Modelings	Budgeted	Scenario	Variance	% Change
Total Patients	14,150	13,910	(240)	-2%
Total Visits	52,355	51,467	(888)	-2%
Uninsured Patients	1,500	2,860	1,360	91%
Uninsured Visits	5,550	10,582	5,032	91%
Patient Revenue	$14,702,875	$12,263,835	-$2,439,040	-17%
Operating Revenue	$24,252,875	$21,813,835	-$2,439,040	-10%
Operating Expenses	$23,700,000	$23,700,000	$0	0%
Net Operating Income	$552,875	-$1,886,165	-$2,439,040	-441%
Operating Margin	2%	-9%	-11%	
Days Cash on Hand			(39)	
330 Grant per Uninsured Patient	$658	($480)	($1,138)	-173%
Financial Scenario Summary				
	Level 1	Level 2	Level 3	Level 4	Level 5
Patient Revenue Decline Parameters	0-5%	5%-10%	10-17%	18-25%	>25%
Net Income	Breakeven or above	5%-10%	10-17%	18-25%	>25%
Operating Margin	>0%	<-5%	<-10%	<-20%	>-20%
Days Cash In Hand	>60 days	>30 Days	<30 Days	<30 Days	<30 Days

Revenue Loss 0-5%

- Data Collection
- Supply Ordering
- Productivity Benchmarks

Revenue Loss 10-20%

- Expand Hours/Increase Volume
- Evaluate Vendor Contracts

Revenue Loss 25+%

- Consolidate Operations
- Adjust Service Delivery Models

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Moving Health Forward

Key Take Aways

HR1 Overview

- This matters now for health centers

North Carolina Specific Data

- Rural environment impacts
- Payer mix changes

Three Phased Approach

- Short-Term Actions
- Medium-Term Actions
- Long-Term Actions

Playbook

- Develop a strategy that is focused on risks, capacity of the organization to make change and staff.

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Contact Us

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Thank You!

Thanks for joining us.

We’re glad you’re here—let’s keep moving health forward.