

CENTRAL HEALTH CARE ADVISORY REGION (HCAR)

Rural Health Transformation Program Meeting Minutes — Session 3

Date	Tuesday, September 15, 2026
Time	1:00–4:00 PM CT
Region & Location	Central Region — Central Community College, Grand Island, Nebraska
Presiding	Arlan Johnson, Chair
Facilitator / Prepared by	Charity Adams, Facilitate Co (contracted by NE DHHS)

Meeting Purpose

Session 3 continued the Central Region's six-meeting input process for the Nebraska Rural Health Transformation Program. The meeting included NE DHHS program updates, structured review of the Rural Workforce Incentive Program (Initiative 3.1), and a facilitated root cause analysis focused on barriers to achieving the region's vision. The HCAR is advisory; regional input is provided for consideration by NE DHHS and the Rural Health Advisory Commission.

1. Call to Order & Open Meetings Act

Chair Arlan Johnson called the meeting to order. The meeting was conducted as a public meeting under the Nebraska Open Meetings Act. No binding action was taken on the substance of regional input.

2. Attendance

Role	Seat	Member	Organization	Present?
Voting	ALF	Lisa Nielson	Ray Brown and Associates / Stone Hearth Estates	Yes
Voting	BH	Chase Franci (Vice Chair)	Mid-Plains Center	Yes
Voting	CAH/REH	Arlan Johnson (Chair)	Howard County Medical Center	Yes
Voting	CAH/REH	Justin Wolf	Memorial Community (Aurora)	Yes
Voting	Clinic	Dr. Todd Pankratz	Obstetrician & Gynecologists, PC	No
Voting	Clinic	Treg Vyzourek	Brodstone Family Medical Center	No
Voting	Dental	Dr. Sydney Grint	Radian Modern Dentistry	Yes
Voting	EMS/Comm	Haley Malone	Clay Center Ambulance	No
Voting	EMS/Hosp	Scott Rhinehart	Good Samaritan Hospital EMS	Yes
Voting	FQHC	Tami Smith	Heartland Health Center	Yes
Voting	HH	Alicia Beavers	Good Samaritan	Yes
Voting	NF/SNF	Mark Scroczyński	Emerald Health Care (Cozad)	No
Voting	PPS	Mike Hansen	Columbus Community	Yes
Non-voting	Ancillary	Vacant	—	—
Non-voting	CC	Marcie Kemnitz	Central Community College	Yes
Non-voting	CCBHC	Bob Shueey	South Central	No
Non-voting	LHD	Jeremy Eschliman	Two Rivers Public Health Department	No
Non-voting	Pharm	Heather Ockinga	Village Drug / Franklin Drug / Blue Hill Drug	Yes

Other attendees: Alex Zimmer and Kitra Monnier (NE DHHS); Charity Adams (Facilitator, Facilitate Co).

3. NE DHHS RHTP Update and Regional Discussion

NE DHHS reported that the Year 1 milestone report was submitted to CMS by the August 31 deadline. Year 2 funding will be based on Year 1 performance, with a CMS decision expected by November 1. Once Year 2 amounts are confirmed, additional funding opportunities are expected to move through the RFA process.

- Active work includes Department of Education workforce efforts, Workforce Pathways (3.3), Chronic Disease Navigation (4.4A), Remote Patient Monitoring (4.4B), Mobile Maternal (4.1), assisted-living initiatives, and the Invest Nebraska Catalyst Fund.
- The funding dashboard currently reflects the prime address of award recipients, which can make Douglas and Lancaster Counties appear to receive a disproportionate share. A later dashboard phase is intended to show where funds are actually deployed.

4. Initiative 3.1 Workforce Incentive Discussion

Participants reviewed the Rural Workforce Incentive Program in small groups using four questions: what stood out, what is stable and should be retained, what is concerning and should be reviewed, and what changes would make the program more effective. The full group records are included in Appendix A.

Participants generally supported the rural focus and five-year commitment, while raising concerns about implementation, targeting, sustainability, eligibility, employer burden, and the potential for a full five-year clawback.

- The five-year commitment was viewed as useful for retention, but participants favored a year-by-year or prorated repayment approach when commitments cannot be completed.
- Participants questioned whether awards are sufficiently targeted to recruitment and priority vacancies when some recipients are already established in rural communities.
- Eligibility and Medicaid-related requirements were described as unclear or difficult to apply consistently across different provider and facility types.
- Participants raised concern that publicly identifying awardees could make rural employees more visible to competing recruiters.
- Facilities need stronger employer-facing tracking tools and enough application time to identify and promote priority positions.
- Participants favored post-payment or retrospective approaches over pre-payment and recommended separating recruitment/relocation incentives from retention incentives.
- Local hospitals, clinics, health departments, and other employers should help identify actual workforce gaps before award priorities are set.

5. Root Cause Analysis Workshop

The workshop focused on identifying underlying root causes of barriers to achieving the Central Region's vision. The purpose was to move beyond surface-level problems so future program development can address the conditions creating the problem rather than only its visible symptoms.

- Staffing limitations and lost opportunity cost during training.
- Policy and insurance barriers affecting reimbursement.
- Sustainability and the lack of bridge programs connecting existing and new efforts.
- Disconnect between community needs and how funding is distributed.
- Funding not consistently flowing to proven or existing accountable programs.
- Training-program capacity and availability of qualified instructors.
- Technology adoption barriers.

6. EMT and Ground Ambulance Services

Participants discussed unmet training, equipment, reimbursement, and sustainability needs affecting rural EMT and ground ambulance services.

- Many rural services are volunteer-run, private, hospital-based, or use a combination of models.
- Participants described an approach using an equipped response vehicle for initial response, with an ambulance following when transport is needed.
- The model was discussed as a way to reduce mileage and wear on ambulance chassis, brakes, and engines while maintaining rural response capability.

7. Public Comment

The public comment period was opened and closed. No members of the public spoke.

8. Follow-up and Next Meeting

- NE DHHS will take the root-cause themes back to leadership and identify connections to existing initiatives and areas where federal flexibility may be available.
- Participants requested clarification about which program elements are fixed by federal requirements before investing additional time in recommendations that cannot be changed.
- Future work will continue to examine provider incentives and retention and opportunities to scale effective existing programs rather than replace them.

The region set its next meeting for November 17, 2026, at the same location. Tami Smith moved to confirm the date and location; Mike Hansen seconded. The motion passed.

9. Closing

The meeting concluded following closing comments and confirmation of the next meeting.

Appendix A — Initiative 3.1 Workforce Incentive Workshop Record

Central HCAR — Session 3 | September 15, 2026

Participants reviewed Initiative 3.1 in small groups using the same four questions. The entries below preserve the substance and wording of the group records, with light spelling and punctuation correction for readability.

Group 1

1. What key points stood out?	Exception request for extenuating circumstances (re: payback); payback of full award is too punitive (year-by-year).
2. What is stable?	Ease of applying; FAQ was helpful; quick obligation of funds.
3. What is concerning?	Claims data not a good tracking modality for many; payback threats due to uncontrollable circumstances; certain professions were de-prioritized; DHHS needs more staff/tools to manage applications.
4. What suggestions would make this program more effective?	Need for additional enrollment/new workforce entrants; better employer tracking tools and ability to fix previously submitted applications; post-funding sustainability/employer expectations; longer window to apply and promote; avoid disincentivizing essential supervisory positions; post-payment rather than pre-payment.

Group 2

1. What key points stood out?	Rural focus/recruitment, but not retention; great recognition of need.
2. What is stable?	Recruitment guidelines; retention to a location; clarify year-by-year commitment rather than treating the five years only as initially stated.
3. What is concerning?	Different needs and priorities across communities; number applying versus receiving awards; retention to a business.
4. What suggestions would make this program more effective?	Timeframe of applicants and clearer recruitment/retention guidance.

Group 3

1. What key points stood out?	Rural/recruitment; Medicaid percentage and workforce requirements; self-pay considerations.
2. What is stable?	Encouraging rural participation.
3. What is concerning?	Dashboard issues.
4. What suggestions would make this program more effective?	No clawback; loan payback.

Group 4

1. What key points stood out?	Five-year commitment; childcare; housing; tuition reimbursement.
2. What is stable?	RFAs; transparency.
3. What is concerning?	Sustainability; dollars to person; decisions made by DHHS.
4. What suggestions would make this program more effective?	Consistency; streamlining; rural hospital funding.

Group 5

1. What key points stood out?	Freight-train pace of RFA; concern regarding award amount relative to industry.
2. What is stable?	Right general idea; good practices.
3. What is concerning?	Large applicant pool with relatively few awards; some staff excluded; process may reward people already relocated rather than create new recruitment.
4. What suggestions would make this program more effective?	Partner with local entities to determine needs more effectively; use local health departments, health systems, clinics, and hospitals to identify priorities; use funding to support current loan repayment where appropriate.

Appendix B — Root Cause Analysis Workshop Record

Central HCAR — Session 3 | September 15, 2026

Root cause blocks and barriers identified by participants. Wording is preserved with spelling corrections only.

Insurance & legislation prevents adequate reimbursement	Disconnect between people needing dollars vs distributing	People not enough — upskilling + providing limits care	Sustainability — no bridge programs to connect to old and no training	Fund serve proven programs	Qualified instructors	G.
• Policy loopholes • Providers not in-network (barrier to reimbursement) • Insurance loopholes	• State support for actionable items on community needs surveys • State support for community needs survey items • Actual needs not identified	• Lost opportunity cost during training • Lost opportunity cost	• Grant programs to support solar power greenhouse set up • Facilities to cook	• RHTP funding not flowing to effective areas • RHTP funding not flowing/partnering w/ existing accountable programs	• Training program class sizes • Not incentivizing providers to stay in NE	• Technology adoption (thru non-covered entities)

Appendix – NE DHHS Report to the Health Care Advisory Regions

Session 3 – Program Update and Initiative 3.1 (Workforce Incentive Program) Feedback Session

Presented by:	Nebraska Department of Health and Human Services (NE DHHS), Alex Zimmer (Central) & Treasa Hunt (Mid-Plains & Western)
Presented at:	Session 3 meetings of the Western half of the Health Care Advisory Regions (Central, Mid-Plains, & Western), Sept 15-17 th , 2026
Filed as:	An appendix to the Session 3 meeting minutes of each Health Care Advisory Region

This appendix records the substance of the report delivered by the NE DHHS representative at each region's Session 3 meeting. The same report was given in the Western half of the HCAR regions; Central, Mid-Plains, and Western. It is reproduced here so that the information is available to members and to the public in identical form across all six regions.

DHHS Session 3 Agenda –

1. Current Status & Updates
2. Upcoming Year 2 Programming
3. Regional Consensus Workshop Themes
4. Request for Regional Input
5. Open Q&A Session (if needed/time permits)

1. Current Status & Updates

New RHTP Staff

- Kitra Monnier – HCAR RHTP Program Coordinator
- Can be reached at Kitra.monnier@nebraska.gov
- Will attend future HCAR meetings for all regions.

Year 1 — awards, budgets, compliance

- NE had reporting due to CMS on Aug. 31.
 - Year 2 award will be scored and distributed based on state's performance reported.
- On the ground, several vehicles are already live.
 - Initiatives that have gone live:
 - Initiative 1 - NDE (NE Dept. of Education) is working on roll out;
 - 3.3 workforce pathways;

- 4.4a chronic-disease navigation/education;
- 4.4b Remote Patient Monitoring/tele;
- 4.1 mobile maternal;
- Initiative 6 – ALFs, and
- Initiative 7 – Invest Nebraska partnership.

- **Dashboard – Phase 1**

- Obligated funds are shown according to the address of where the organization is located, not where services are offered. Because of this, there appears to be a bulk of funding in Douglas and Lancaster counties. As an example, funds to Creighton School of Dentistry appear in Douglas county, when in reality the project rotates dental students across rural areas in Nebraska as part of their training.
- Phase 2 roll-out of the dashboard will include data on how funds are being spent.
- For questions/concerns, please contact dhhs.gis@nebraska.gov

2. RHTP Program - Upcoming Year

Year 2 — RFAs and applications

- We expect CMS to award Year 2 funds by November 1. Once those amounts are known, we can start the RFA process.
- Year 2 RFAs and funding applications are coming soon.

3. Regional Consensus Workshop Themes

Major Themes from All 3 Regions (Central, Mid-Plains, & Western)

- The Workforce Incentive Program (RHTP Initiative 3.1) is the loudest, most consistent theme from all three regions

4. Request for Regional Input

RHTP Initiative 3.1 – Rural Health Workforce Incentive Program, Cohort 2 Planning

Intent: provide monetary incentives to health care providers in exchange for a service commitment to work in a rural county for a 5-year period.

Background Basics:

- Clinical providers receiving an individual benefit must complete a 5-year rural service commitment
 - Providers must report and verify rural service
 - Tracking individuals to accommodate this reporting must occur for 5 years, regardless of which rural facility the provider works for.
- Providers licensed/credentialed, work full-time, and live in Nebraska
- Employers must meet the Medicaid/target population service and match thresholds
- Agreements must be executed no later than August 2027 to allow for September payments

DHHS Request for Regional Input:

- *Reviewing “Defining Category E” from CMS - any updated/changed methodology to issue awards should ensure fair distribution across state, provider types, and facilities (no one system should receive a disproportionate share).*
- **DHHS request:** We would like feedback on edits that can be made to Cohort 2 RFA process, eligibility, requirements, etc. to improve the next rollout.

Charity will facilitate small group discussions, answering the following four questions:

1. What key points stood out to you?
2. What is stable?
3. What is concerning?
4. What suggestion would make this program more effective?

5. Open Q&A Session (if needed/time permits)

WESTERN HEALTH CARE ADVISORY REGION (HCAR)

Rural Health Transformation Program Meeting Minutes — Session 3

Date	Wednesday, September 16, 2026
Time	1:00–4:00 PM CT (12:00–3:00 PM MT)
Region & Location	Western Region — Prairie Winds Community Center, 428 N Main St, Bridgeport, NE 69336
Presiding	Diana Lecher, Chair
Facilitator / Prepared by	Charity Adams, Facilitate Co (contracted by NE DHHS)

Meeting Purpose

Session 3 continued the Western Region's six-meeting input process for the Nebraska Rural Health Transformation Program. The meeting included a NE DHHS program update, structured review of Category E workforce guidance, and a facilitated root cause analysis focused on barriers to achieving the region's vision. The HCAR is advisory and no formal votes were taken during this session.

1. Call to Order & Open Meetings Act

Chair Diana Lecher called the meeting to order. The meeting was conducted as a public meeting under the Nebraska Open Meetings Act.

2. Attendance

Role	Seat	Member	Organization	Present?
Voting	ALF	Alice Smith	Highland Park Assisted Living — Vetter Senior Living	No
Voting	BH	Kristen Rose	Sidney Regional Medical Center	Yes
Voting	CAH/REH	John Reiners	Chadron Hospital	Yes
Voting	CAH/REH	Sam Pennington	Garden County Health Services	No
Voting	Clinic	Dr. Brian Shelmadine	Box Butte General Hospital	Yes
Voting	Clinic	Jason Petik	Sidney Regional Medical Clinic / Walk-in Clinic	No
Voting	Dental	Dr. Sami Webb	Webb Orthodontics	No
Voting	EMS/Comm	Cody William Rohrig	Gordon Volunteer Rescue Squad	No
Voting	EMS/Hosp	Shannon Odiet	SRMC EMS	No
Voting	FQHC	Betsy Vidlak	Community Action Health Center	No
Voting	HH	Diana Lecher (Chair)	Chadron Hospital Home Health Agency	Yes
Voting	NF/SNF	Judy Frerichs (Vice Chair)	Pole Creek Estates — Sidney Regional Medical Center	No
Voting	PPS	Ned Resch	Regional West	No
Non-voting	Ancillary	Creston M. Myers, OD	Family Vision Clinic of Alliance	Yes
Non-voting	CC	Allisha Weeden	Weitzel	No
Non-voting	CCBHC	Jennifer "Nickie" Kroon	Lutheran Family Services	Yes
Non-voting	LHD	Jessica Davies	Panhandle Public Health District	Yes
Non-voting	Pharm	Jason Reed	Stockmen's Drug	Yes

Other attendees: Treasa Hunt (NE DHHS); Charity Adams (Facilitator, Facilitate Co). Kitra Monnier was introduced as a new DHHS contact who was unable to attend this session and is expected to attend future HCAR meetings.

3. NE DHHS RHTP Update and Regional Discussion

Treasa Hunt reported that Year 1 reporting was submitted to CMS by the August 31 deadline. Year 2 funding will be scored and distributed based on CMS feedback, expected around November 1.

- Initiative 1: Nebraska Department of Education workforce pathways.
- Initiative 4: chronic disease navigation, remote patient monitoring, and mobile maternal care.
- Initiative 6: assisted living facilities.
- Initiative 7: partnership with Invest Nebraska to support rural health-care startups.
- Dashboard development continues. Phase 1 displays funding sources by county; Phase 2 is intended to show how funds were distributed and spent. A video walkthrough may be available for a future meeting.

4. Initiative 3.1 Workforce Incentive Discussion

Participants reviewed the Category E workforce guidance in small groups using four questions: what stood out, what is stable and should be retained, what is concerning and should be reviewed, and what changes would make the program more effective. The group records are included in Appendix A.

- Tuition and training reimbursement, childcare, housing, and other community supports were identified as important workforce considerations.
- Participants noted the program's clinical-provider focus and raised concern that lab, surgical, administrative, and other support roles are also necessary to sustain rural health services.
- The five-year commitment and continued rural focus were generally viewed as stable concepts.
- Participants raised questions about sustainability after Year 5, the scale of the initial cohort, and whether a broader systems approach is needed.

5. Initiative 3.1 Workforce Incentive — Concerns and Recommendations

- Participants requested consistent communication of eligibility, employer obligations, Medicaid requirements, and contract terms before program rollout.
- Participants reported concern that Medicaid percentage requirements and other expectations changed or became clearer only after the application or award process.
- The full-award clawback was viewed as a deterrent to participation and potentially to career advancement when a worker's circumstances or role changes.
- Participants questioned how role changes, advanced training, travel requirements, tracking, and accountability will be handled during the five-year period.
- Participants raised concern about public disclosure of award recipients and the potential effect on recruitment by competing employers.
- Participants emphasized the need for a sustainability plan for Year 6 and beyond.
- Participants recommended a broader 'grow your own' strategy using local recruitment, rural rotations, education pipelines, and post-education employment incentives.
- An open question remained regarding how many award recipients ultimately decline to sign contracts.

6. Root Cause Analysis Workshop

The workshop focused on identifying underlying root causes of barriers to achieving the Western Region's vision. The purpose was to move beyond surface-level problems so future program development can address the conditions creating the problem rather than only its visible symptoms.

- Disruptive payer and regulatory requirements affecting provider sustainability and access to care.
- Misaligned leaders failing to recognize community needs narratives, limiting progress, growth, adaptation, and improvement.
- Siloed EMR systems and unaffordable interfaces hindering seamless communication and quality patient care.
- Rules, regulations, and arbitrary policy limiting the ability to use food as medicine.
- Rural resource availability restricting care, including equipment, training, housing, childcare, schools, and facility access.

Participants identified disruptive payer and regulatory requirements as a particularly catalytic barrier because changes in this area could affect several other issues. Appendix B preserves the participant-created block titles and supporting data points.

7. Upcoming Events and Announcements

- Safety and Wellness Conference — September 17 at the Civic Center; Dr. Brian Shelmadine and Cody Rohrig presenting on lifestyle medicine; Travis Beck receiving the Governor's Wellness Award.
- Early Childhood Health Event — October 8 at the Hearing Services Center; no charge. Announced topics included maternal mental health, nutrition for child development, a policy panel, a parent panel, and data presentation.

8. Follow-up / Future Topics

- Connect with Kitra Monnier regarding the sub-initiative 1.2/1.3 white paper and farm-to-school requirements.
- Continue discussion of sub-initiative 3.1 requirements and whether a white paper could support changes to criteria.
- Provide the root-cause analysis outputs to NE DHHS.
- Prepare a future discussion regarding placement of a single regional Da Vinci surgical system with attention to equitable patient access.
- Share the October 8 Early Childhood Health Event information with attendees.

9. Closing

The meeting concluded following closing comments and discussion of future topics.

Appendix A — Initiative 3.1 Workforce Incentive Workshop Record

Western HCAR — Session 3 | September 16, 2026

The entries below preserve the substance and wording of the small-group records, with spelling corrections only where clear.

Group 1

1. What key points stood out?	Retention/recruitment; childcare.
2. What is stable?	5-year commitment.
3. What is concerning?	Dissemination of information; Medicaid — changing rules/lack of clarity; what happens in Year 6; community — childcare, housing, economic development.
4. What suggestions would make this program more effective?	Clear communication; include childcare; housing stipend.

Group 2

1. What key points stood out?	Tuition/training reimbursement; childcare needs; focus on providers or clinical staff.
2. What is stable?	Funding stable for 5 years for 250 people; the stable thing in healthcare is change.
3. What is concerning?	Continued funding after 5 years; stipend is contingent on multiple factors; disappointed applicants.
4. What suggestions would make this program more effective?	Continue funding after 5 years/financial sustainability; distribute funds equitably — few rural awardees; feedback about awards and/or scoring criteria; focus on systems in place rather than individuals.

Group 3

1. What key points stood out?	Many competing workforce categories (not clear in original RFA); few definitions and expectations; 5-year commitment — defined circumstances only, death and disability.
2. What is stable?	Rural is consistent (not expanded to inner city, for example); broad coverage for who is covered versus defined clinicians/roles.
3. What is concerning?	Can provider move rural communities and not lose funding? Lack of clarity around long-term obligations and expectations about payback if no longer qualifying; information on who got funded/who didn't.
4. What suggestions would make this program more effective?	Make it easier for hospitals to understand details and expectations; receive high-level information from state organizations with simultaneous communication to providers and administration; better understanding of award determinations — why or why not awarded.

Group 4

1. What key points stood out?	Creative with funds — childcare example.
2. What is stable?	5 years; defined clearly.
3. What is concerning?	Existing expansion/training; tracking.
4. What suggestions would make this program more effective?	Legislation changes in role definitions; pharmacy included; what are community resources people coming to the community can use?

Appendix B — Root Cause Analysis Workshop Record

Western HCAR — Session 3 | September 16, 2026

Participant-created block titles and supporting data points. Wording is preserved with spelling corrections only.

Disruptive Payer and Reg Rights Prevent Access to Care & Provider Sustainability	Rural Resource Availability Restricts Care	Rules, Regs and Arbitrary Policy Limits the Ability to Use Food as Medicine	Siloed EMR and Unaffordable Interface Hinders Seamless Communication & Quality Patient Care	Misaligned Leaders Failing to Recognize Community Needs Narrative Stifling Progress, Growth and Adaptation and the Ability to Improve
• Time & complexity of authorizations hinders patient/client suffering • Reimbursements unsustainable for providers • No sustainable support for providing remote care, especially rural & frontier remote areas • Inconsistent rules/requirements • Over regulation • Only help a few individuals • ROI for community resource navigators isn't self funded by department • Put limits on miles can be traveled or require unrealistic miles • Willing transport providers and people don't qualify for reimbursement — too much red tape/cost to become transport	• Limited training options/areas/rural • Inadequate equipment prevents EMS response • Make a moratorium on opening new facilities • Access to school/access & housing • Close rural hospitals/clinics • Infrastructure for growing yourself locally is lacking (schools, demand for level of clinicians having childcare needs)	• Only allow Nebraska home-grown food — no access • No incentive for local growers to donate/distribute food to pantries, schools, etc. • Food lobby for USDA • Poor food distribution access	• Technology/vendors are still financially incentivized to not be their own & integrated to become interoperable • Siloed EMR • Prohibitive cost of integration	• Town limits of city/community growth • Refusing to explore other options • Community leaders keep it rural

Appendix – NE DHHS Report to the Health Care Advisory Regions

Session 3 – Program Update and Initiative 3.1 (Workforce Incentive Program) Feedback Session

Presented by:	Nebraska Department of Health and Human Services (NE DHHS), Alex Zimmer (Central) & Treasa Hunt (Mid-Plains & Western)
Presented at:	Session 3 meetings of the Western half of the Health Care Advisory Regions (Central, Mid-Plains, & Western), Sept 15-17 th , 2026
Filed as:	An appendix to the Session 3 meeting minutes of each Health Care Advisory Region

This appendix records the substance of the report delivered by the NE DHHS representative at each region's Session 3 meeting. The same report was given in the Western half of the HCAR regions; Central, Mid-Plains, and Western. It is reproduced here so that the information is available to members and to the public in identical form across all six regions.

DHHS Session 3 Agenda –

1. Current Status & Updates
2. Upcoming Year 2 Programming
3. Regional Consensus Workshop Themes
4. Request for Regional Input
5. Open Q&A Session (if needed/time permits)

1. Current Status & Updates

New RHTP Staff

- Kitra Monnier – HCAR RHTP Program Coordinator
- Can be reached at Kitra.monnier@nebraska.gov
- Will attend future HCAR meetings for all regions.

Year 1 — awards, budgets, compliance

- NE had reporting due to CMS on Aug. 31.
 - Year 2 award will be scored and distributed based on state's performance reported.
- On the ground, several vehicles are already live.
 - Initiatives that have gone live:
 - Initiative 1 - NDE (NE Dept. of Education) is working on roll out;
 - 3.3 workforce pathways;

- 4.4a chronic-disease navigation/education;
- 4.4b Remote Patient Monitoring/tele;
- 4.1 mobile maternal;
- Initiative 6 – ALFs, and
- Initiative 7 – Invest Nebraska partnership.

- **Dashboard – Phase 1**

- Obligated funds are shown according to the address of where the organization is located, not where services are offered. Because of this, there appears to be a bulk of funding in Douglas and Lancaster counties. As an example, funds to Creighton School of Dentistry appear in Douglas county, when in reality the project rotates dental students across rural areas in Nebraska as part of their training.
- Phase 2 roll-out of the dashboard will include data on how funds are being spent.
- For questions/concerns, please contact dhhs.gis@nebraska.gov

2. RHTP Program - Upcoming Year

Year 2 — RFAs and applications

- We expect CMS to award Year 2 funds by November 1. Once those amounts are known, we can start the RFA process.
- Year 2 RFAs and funding applications are coming soon.

3. Regional Consensus Workshop Themes

Major Themes from All 3 Regions (Central, Mid-Plains, & Western)

- The Workforce Incentive Program (RHTP Initiative 3.1) is the loudest, most consistent theme from all three regions

4. Request for Regional Input

RHTP Initiative 3.1 – Rural Health Workforce Incentive Program, Cohort 2 Planning

Intent: provide monetary incentives to health care providers in exchange for a service commitment to work in a rural county for a 5-year period.

Background Basics:

- Clinical providers receiving an individual benefit must complete a 5-year rural service commitment
 - Providers must report and verify rural service
 - Tracking individuals to accommodate this reporting must occur for 5 years, regardless of which rural facility the provider works for.
- Providers licensed/credentialed, work full-time, and live in Nebraska
- Employers must meet the Medicaid/target population service and match thresholds
- Agreements must be executed no later than August 2027 to allow for September payments

DHHS Request for Regional Input:

- *Reviewing “Defining Category E” from CMS - any updated/changed methodology to issue awards should ensure fair distribution across state, provider types, and facilities (no one system should receive a disproportionate share).*
- **DHHS request:** We would like feedback on edits that can be made to Cohort 2 RFA process, eligibility, requirements, etc. to improve the next rollout.

Charity will facilitate small group discussions, answering the following four questions:

1. What key points stood out to you?
2. What is stable?
3. What is concerning?
4. What suggestion would make this program more effective?

5. Open Q&A Session (if needed/time permits)

HCAR Meeting Minutes

Mid-Plains Health Care Advisory Region — Session 3

Public meeting held under the Nebraska Open Meetings Act, Neb. Rev. Stat. §§ 84-1407 to 84-1414

Project Name:	HCAR
Date of Meeting:	09/17/2026 (Thursday)
Time:	1:00–4:00 p.m. Central
Region & Location:	Mid-Plains — Mid-Plains Community College, North Platte North Campus, 1101 Halligan Dr, North Platte, NE 69101 — Room 202
Chair:	Dr. Benjamin Lashley
Facilitator:	Charity Adams, Facilitate Co (contracted by NE DHHS)
Prepared by:	Charity Adams, Facilitate Co

Meeting Purpose

Session 3 continued the Mid-Plains Region's input to the Rural Health Transformation Program (RHTP). The meeting included a NE DHHS program update and discussion, a focused review of the Category E workforce initiative, and a facilitated root-cause analysis of barriers that could prevent the region from achieving the vision elements developed in Session 2. The HCAR is an advisory, non-decision-making body; the workshop records capture regional input for consideration by NE DHHS and the Rural Health Advisory Commission.

1. Call to Order & Welcome

Dr. Benjamin Lashley, Chair, presided. The Chair welcomed participants.

2. Open Meetings Act

A current copy of the Nebraska Open Meetings Act was available for public review at the meeting location, and the agenda had been made publicly available in advance of the meeting.

3. Roll Call & Attendance

Attendance was recorded for the meeting. The HCAR is an advisory body, and no votes or other formal actions were taken during this session.

Role	Seat	Member	Organization	Present?
Voting	ALF	Judy McCune	Kinship Pointe McCook	No
Voting	BH	Jessica Vickers	Livewell	Yes
Voting	CAH/REH	Brett Eggleston	Callaway District Hospital	No
Voting	CAH/REH	Kyle Kellum	Melham Medical Center	No
Voting	Clinic	Dr. Jason Blomstedt	McCook Family Medicine	Yes
Voting	Clinic	Jim Bargaen	Cherry County Medical Clinic	No
Voting	Dental	Dr. Benjamin Lashley (Chair)	Maple Park Dental Associates	Yes
Voting	EMS/Comm	Marc Harpham	McCook City and Volunteer Fire Department	Yes
Voting	FQHC	Tami Smith	Heartland Health Center	No
Voting	HH	Tyson Gould	Brookstone Home Health & Hospice	No
Voting	NF/SNF	Kristin Arrowsmith	Accura Health Care — North Platte Facility	Yes
Voting	PPS	Ivan Mitchell	Great Plains Health	Yes
Non-voting	Ancillary	Cassie Penn	Callaway District Hospital	No
Non-voting	CC	Clint Reading	Mid-Plains Community College	Yes
Non-voting	CCBHC	Shirley Terry (Vice Chair)	Lutheran Family Services	No

The Rural Health Transformation Program is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (US HHS) as part of a financial assistance award totaling \$218,529,075.01 with 100 percent funded by CMS/US HHS. The contents are those of the Nebraska Department of Health and Human Services (DHHS) and do not necessarily represent the official views of, nor an endorsement by, CMS/US HHS, or the U.S. Government.

Non-voting	LHD	Meghan Trevino	West Central District Public Health Department	Yes
Non-voting	Pharm	Brian Wilson	U-Save Pharmacy Ogallala	No

Other attendees: Treasa Hunt (NE DHHS); Charity Adams (Facilitator, Facilitate Co).

4. Review of the Agenda

The agenda was reviewed as posted. The source notes provided for preparation of these minutes do not identify a motion or vote on the agenda.

5. NE DHHS RHTP Update and Regional Discussion

Treasa Hunt, Deputy Director for Medicaid, provided an RHTP update. She reported that Year 1 milestone reporting had been submitted to CMS by the August 31 deadline, with a CMS response expected on or before November 1. The resulting score will affect Year 2 funding levels. She also reported that RHTP leadership had received a positive early signal from CMS regarding the application.

Active work discussed included:

- Initiative 1 / Nebraska Department of Education workforce pathways (3.3) rolling out.
- Initiative 4 chronic-disease navigation and remote patient monitoring going live.
- Initiative 7 / Medicaid Catalyst Fund work with Invest Nebraska to support rural health technology startups.

Dashboard Feedback

Participants discussed the RHTP dashboard and noted that displayed funding amounts appeared significantly lower than awards organizations had received. The group requested clearer definitions of whether dashboard figures represent allocated, obligated, invoiced, or received funds. Participants also asked that the dashboard show which organizations in a community received funding and allow filtering by initiative. A current display issue was described in which funding appears at an organization's headquarters rather than at the locations where funds are being used. NE DHHS indicated that a county-level view is planned and that a video walkthrough will be shared when available.

6. Initiative 3.1 Workforce Incentive Discussion

Participants reviewed Category E workforce documentation independently and then worked in four small groups to identify key points, stable elements to retain, concerns requiring review, and suggestions for improving the program. The group responses are documented in Appendix A — Initiative 3.1 Workforce Incentive Workshop Record.

Discussion reflected support for a five-year rural-service commitment as a reasonable balance between stability and feasibility. Participants cautioned, however, that a workforce strategy focused primarily on financial incentives may not create long-term retention and that clinical services depend on non-clinical staff and infrastructure. Participants called for a more holistic approach to rural workforce sustainability and stronger recognition of the different conditions affecting communities across the state.

Participants raised concerns about strategic targeting and the application process. They described the application as too limited to distinguish community need or provider fit and recommended that facility-level needs help drive awards. Suggested measures included counties served, length of time in the area, years in practice compared with years practicing in the specific area, and a facility-ranked recruitment-need score. Participants also noted that point-on-map data can understate the service areas of regional hubs and recommended supplementing map data with information from hospitals and providers.

The group discussed Medicaid participation requirements, noting that providers do not control payer mix and expressing concern that escalating percentage requirements may create unintended incentives. Dental reimbursement was specifically cited as a sustainability concern. Participants also raised the administrative cost to sponsoring facilities for award compliance and the need for outcome measures that distinguish true recruitment into rural areas from awards to providers already practicing there.

Award communication was another concern. Participants reported that many applicants had not received a decision or status update. Treasa Hunt agreed to follow up with the workforce initiative lead regarding award-notification status.

7. Root Cause Analysis Workshop

The region conducted a facilitated root-cause analysis focused on barriers to achieving the region's vision. The aim was to move beyond surface-level descriptions of challenges and identify the underlying causes creating or sustaining those barriers. Defining root causes provides more useful regional input for future program development by helping programs address the source of an issue rather than only its visible symptoms.

The root-cause clusters and supporting participant data points are documented in Appendix B — Root Cause Analysis Workshop Record.

The barriers discussed included difficult credentialing and licensure processes; increasing training and compliance requirements; reimbursement structures that do not align with EMS and other rural service costs; failure to use community subject-matter expertise in program design; administrative burden and inequitable reimbursement affecting behavioral health and other services; and unaffordable nutrition as a barrier to food-as-medicine approaches.

Credentialing was described as a direct patient-access barrier. Participants reported separate credentialing with Medicaid and three managed-care organizations, inconsistent systems and syncing problems, delays extending well beyond expected timeframes, and providers stepping away from Medicaid participation when they cannot be reimbursed while credentialing remains unresolved. Participants also described aggressive audits as adding to the administrative burden.

Training and compliance requirements were described as constraining the labor supply. Examples included the time and travel burden required for volunteer EMT training and frequently changing continuing-education requirements. EMS participants also described a reimbursement gap when emergency or community-paramedicine services do not result in transport, leaving municipalities and local taxpayers to absorb costs.

A recurring theme was frustration that several issues — including credentialing, reimbursement, and dual-eligibility concerns — have been raised repeatedly at the state level without participants seeing meaningful change. Participants emphasized the importance of decision-makers using the expertise of providers and community subject-matter experts when programs are designed and implemented.

8. Public Comment

No members of the public were present. No public comment was received.

9. Closing Comments, Follow-up, and Session 4

Follow-up items identified during the meeting were:

- Treasa Hunt will follow up on the status of workforce initiative award notifications for applicants who had not received a decision or update.
- Treasa Hunt will clarify the funding methodology used in the RHTP dashboard, including whether figures reflect obligated/allocated, invoiced, or received funds, and share the clarification with the group.
- The Fire Chief will bring a working proposal or outline regarding regionalization of rural EMS for discussion at the next meeting. Participants expressed interest in the topic.

Participants were encouraged to submit topics they would like addressed between sessions. The meeting notes indicate that the next Mid-Plains meeting will occur at the same 1:00 p.m. Central start time on the region's every-other-month schedule; the exact date and location were not included in the source notes provided for this .

10. Adjournment

The source notes provided for preparation of these minutes do not identify the adjournment motion, second, vote, or exact adjournment time. These details should be confirmed before the minutes are finalized.

Prepared by Charity Adams, Facilitate Co (contracted by NE DHHS). These minutes are presented to the Mid-Plains Health Care Advisory Region for review and approval at a subsequent session.

Mid-Plains HCAR — Session 3

Region:	Mid-Plains
Session:	Session 3
Date:	09/17/2026 (Thursday)
Location:	Mid-Plains Community College — North Platte North Campus, Room 202
Facilitator:	Charity Adams, Facilitate Co (contracted by NE DHHS)

A.1 Method

Participants were given time to review the Category E documentation independently. The group then divided into four teams. Each team received a flip chart and responded to four questions. Spelling has been corrected where clear; participant wording is otherwise retained.

Team 1

1. What key points stood out to you?	• “Sustainable” — need for a clear path for [illegible/unfinished] • “Clinical” • “Direct Care”
2. What is stable and should be held on to?	Distinction between clinical/non-clinical
3. What is concerning and should be reviewed?	• Can't have clinical work w/o non-clinical • Too separated (undermines the work that happens behind the scenes) • Not enough (or any) focus on retention and sustainability • Not enough focus on supporting the system as a whole.
4. What suggestions would make this program more effective?	• Incentives can't be the only focus. • Retention needs are different across the state. • Sidenote: There should be some kind of an effort to promote the unique opportunities in rural areas.

Team 2

1. What key points stood out to you?	CHILDCARE
2. What is stable and should be held on to?	RURAL
3. What is concerning and should be reviewed?	MOVING AN ISSUE DOESN'T SOLVE PROBLEM
4. What suggestions would make this program more effective?	MARKETING — SPREAD THE WORD!

Team 3

1. What key points stood out to you?	Providers paid on committing to rural NE
2. What is stable and should be held on to?	5 year commit adds to stability

The Rural Health Transformation Program is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (US HHS) as part of a financial assistance award totaling \$218,529,075.01 with 100 percent funded by CMS/US HHS. The contents are those of the Nebraska Department of Health and Human Services (DHHS) and do not necessarily represent the official views of, nor an endorsement by, CMS/US HHS, or the U.S. Government.

3. What is concerning and should be reviewed?	• Defines what FT service looks like • What is the employer incentive for tracking compliance
4. What suggestions would make this program more effective?	• Possibly change framework for how funds are distributed — perhaps direct reimbursement for student loans. • Possible tax deductions for existing docs.

Team 4

1. What key points stood out to you?	Doesn't address supply, good band-aid to incentivize retention
2. What is stable and should be held on to?	5 yr commitments
3. What is concerning and should be reviewed?	• Selection process • Not needs focused • Money is just thrown, not thought through or effective • Medicaid requirements
4. What suggestions would make this program more effective?	• Let facilities dictate their need • Open college opportunities — more med school & nursing training opportunities; slots.

Transcription note: One phrase in Team 1, Question 1 could not be read clearly and is marked as unfinished/illegible rather than inferred.

Appendix B — Root Cause Analysis Workshop Record

Purpose. The workshop focused on barriers to achieving the region's vision and was designed to move beyond surface-level descriptions of challenges to identify underlying root causes. Defining root causes can inform future program development by helping interventions address the source of an issue rather than only its visible symptoms.

Increased Training & Compliance Requirements, plus inaccessible training, stifles the labor supply.	Administrative Burden & Inequitable reimbursement of mental health service... ties up other medical/social services	Unaligned Community Cost-based reimbursement increases taxes & staffing requirements, delays response & eliminates services	Impossible Credentialing & Licensure Systems prevents patient service & prevents providers from wanting to provide services.	Not utilizing Community Subject matter experts creates a duplication of efforts & inefficient processes, diminishing resources.	Unaffordable nutrition prevents food as medicine
• Child care is not accessible to everyone. • Recruitment/retention of people • Not enough spots for nurses, doctors, dentists & hygienists — none in our area • Training location • Lack of EMT's and EMS response	• Mental health for those in crisis • Behavioral Health loses money — staff are consistently assaulted • Telehealth for older adults • Mental Health Resources are not the proper needs • No Tele-Health Reimbursement for Primary Care	• Ambulance reimbursement for no transport • Reimbursement doesn't align w/ costs • EMS not cost based reimbursed • Billing services	• Aggressive audits • Credentialing of new providers long, administratively labor intensive and must do it with 3 separate payors • Delayed credentialing process	• Give funding to District health centers then ask them to request providers to volunteer to provide care. The wrong people are at the table • Additional hurdles to partnering w/ community	• Make junk food less \$ than fresh

Participant wording is retained, with spelling corrected where clear.

Appendix – NE DHHS Report to the Health Care Advisory Regions

Session 3 – Program Update and Initiative 3.1 (Workforce Incentive Program) Feedback Session

Presented by:	Nebraska Department of Health and Human Services (NE DHHS), Alex Zimmer (Central) & Treasa Hunt (Mid-Plains & Western)
Presented at:	Session 3 meetings of the Western half of the Health Care Advisory Regions (Central, Mid-Plains, & Western), Sept 15-17 th , 2026
Filed as:	An appendix to the Session 3 meeting minutes of each Health Care Advisory Region

This appendix records the substance of the report delivered by the NE DHHS representative at each region's Session 3 meeting. The same report was given in the Western half of the HCAR regions; Central, Mid-Plains, and Western. It is reproduced here so that the information is available to members and to the public in identical form across all six regions.

DHHS Session 3 Agenda –

1. Current Status & Updates
2. Upcoming Year 2 Programming
3. Regional Consensus Workshop Themes
4. Request for Regional Input
5. Open Q&A Session (if needed/time permits)

1. Current Status & Updates

New RHTP Staff

- Kitra Monnier – HCAR RHTP Program Coordinator
- Can be reached at Kitra.monnier@nebraska.gov
- Will attend future HCAR meetings for all regions.

Year 1 — awards, budgets, compliance

- NE had reporting due to CMS on Aug. 31.
 - Year 2 award will be scored and distributed based on state's performance reported.
- On the ground, several vehicles are already live.
 - Initiatives that have gone live:
 - Initiative 1 - NDE (NE Dept. of Education) is working on roll out;
 - 3.3 workforce pathways;

- 4.4a chronic-disease navigation/education;
- 4.4b Remote Patient Monitoring/tele;
- 4.1 mobile maternal;
- Initiative 6 – ALFs, and
- Initiative 7 – Invest Nebraska partnership.

- **Dashboard – Phase 1**

- Obligated funds are shown according to the address of where the organization is located, not where services are offered. Because of this, there appears to be a bulk of funding in Douglas and Lancaster counties. As an example, funds to Creighton School of Dentistry appear in Douglas county, when in reality the project rotates dental students across rural areas in Nebraska as part of their training.
- Phase 2 roll-out of the dashboard will include data on how funds are being spent.
- For questions/concerns, please contact dhhs.gis@nebraska.gov

2. RHTP Program - Upcoming Year

Year 2 — RFAs and applications

- We expect CMS to award Year 2 funds by November 1. Once those amounts are known, we can start the RFA process.
- Year 2 RFAs and funding applications are coming soon.

3. Regional Consensus Workshop Themes

Major Themes from All 3 Regions (Central, Mid-Plains, & Western)

- The Workforce Incentive Program (RHTP Initiative 3.1) is the loudest, most consistent theme from all three regions

4. Request for Regional Input

RHTP Initiative 3.1 – Rural Health Workforce Incentive Program, Cohort 2 Planning

Intent: provide monetary incentives to health care providers in exchange for a service commitment to work in a rural county for a 5-year period.

Background Basics:

- Clinical providers receiving an individual benefit must complete a 5-year rural service commitment
 - Providers must report and verify rural service
 - Tracking individuals to accommodate this reporting must occur for 5 years, regardless of which rural facility the provider works for.
- Providers licensed/credentialed, work full-time, and live in Nebraska
- Employers must meet the Medicaid/target population service and match thresholds
- Agreements must be executed no later than August 2027 to allow for September payments

DHHS Request for Regional Input:

- *Reviewing “Defining Category E” from CMS - any updated/changed methodology to issue awards should ensure fair distribution across state, provider types, and facilities (no one system should receive a disproportionate share).*
- **DHHS request:** We would like feedback on edits that can be made to Cohort 2 RFA process, eligibility, requirements, etc. to improve the next rollout.

Charity will facilitate small group discussions, answering the following four questions:

1. What key points stood out to you?
2. What is stable?
3. What is concerning?
4. What suggestion would make this program more effective?

5. Open Q&A Session (if needed/time permits)
