Diversifying Funding: Planting the right seeds for growth

January 28, 2026

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Learning Objectives

- Understand potential opportunities for new funding streams
  - Large HRSA and non-HRSA grants
  - State and federal appropriations
  - Alternative services (i.e., not direct patient services)
  - Ongoing donors
  - Capital campaigns
- Learn tips to optimize existing funding streams
  - 340B Pharmacy
  - Medicaid Strategy
  - Value-based care
- Learn practical tips to improve grant and donor seeking success
- *Time Permitting: Review the role of health-center sponsored foundations*

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Agenda

Background on diversified funding (10 min)

Common grant funding challenges (10 min)

Best practices in grant seeking (20 min)

Optimizing existing funding streams (40 min)

Health Center-Led Foundations (10 min)

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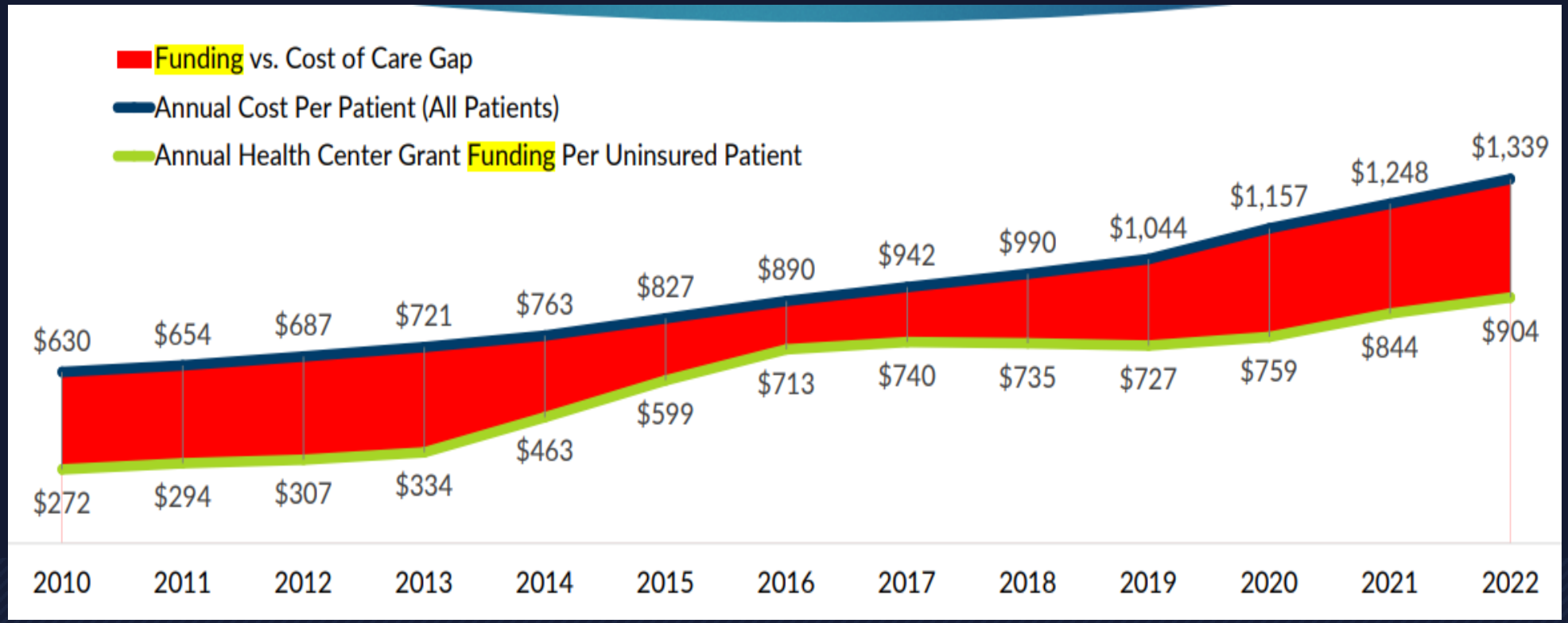
Why is this important?

- More than half of community health centers operate with margins below 5%,
- The gap between HRSA funding and the cost of care is growing
- The 3-year outlook for new federal investment in CHCs is pessimistic



2024 Estimate:
Cost: **$1,565**
Funding: **$996**
Gap: **$569**

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Where health centers get their money

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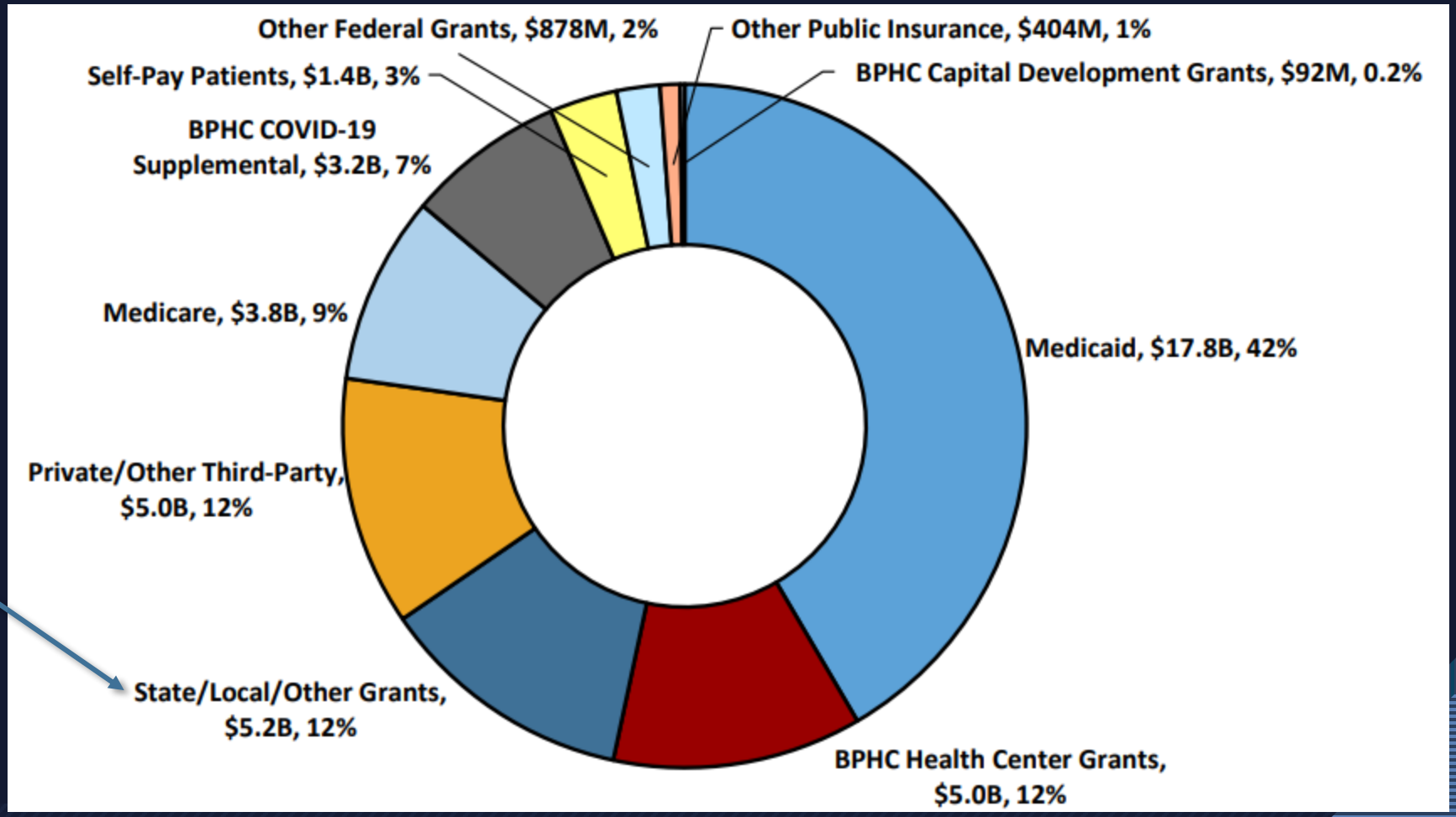
Health Center Revenue Sources

- *26% of CHC Funding is Grant Funded*
  - *12% BPHC/HRSA*
  - *12% State/Local/Other*
  - *2% Other Federal Grants*
- *"Other Grants"*
  - *Foundations*
  - *Private Donors*
  - *Non-patient Service Revenue not reported elsewhere*



Source: 2022 Health Center Program Highlights: Uniform Data System Trends

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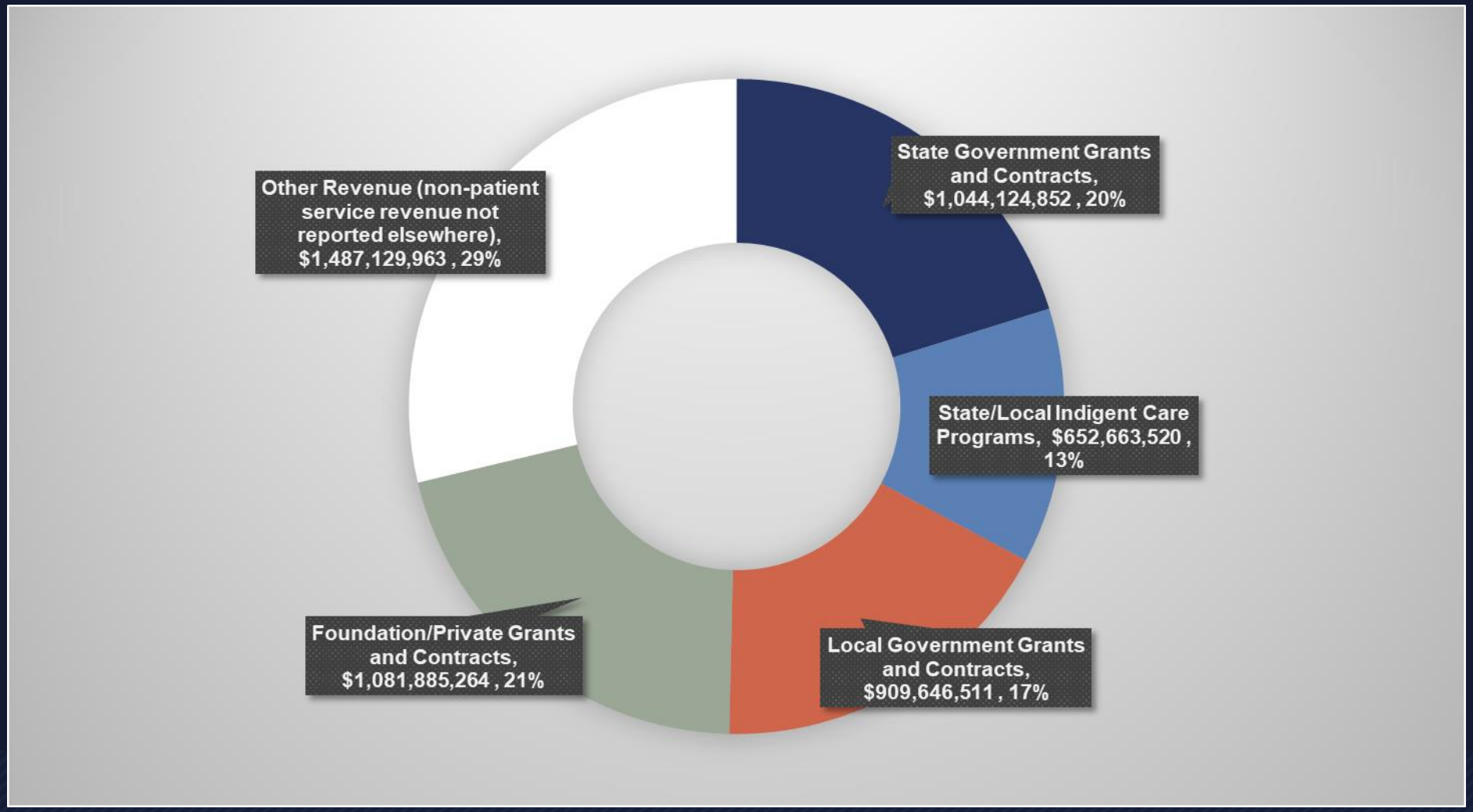
Breakdown of the $5.2B in state, local, and other grants



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Going even deeper into other revenue

- Most frequently cited in the detailed UDS tables:
  - **General donations** are most cited by health centers with 501 notations
    - Up to $2.5M+ for a single health center
    - United Way most commonly noted (163 notations) and often $100k to $500k
    - Others often noted: Blue Cross/Shield Foundations, Delta Dental/Arcora, United Health
    - A multitude of hospital systems, PCA, and local foundations and businesses are also common
  - **Fundraising** (89 notations)
    - Up to $670k for a CHC
  - **Rental income** up to $365k (209 notations)
  - **Investment income** up to $130k
  - **Interest income** up to $712k (699 notations)
  - **Medical records** fees are very commonly noted, but small amounts
- Some interesting wins:
  - Hospital support up to $407k
  - Retail pharmacy income of $10M for one CHC
  - ACO distribution of $734k (66 notations)

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Some “big” ideas and examples of diversification (not including clinical services)

- **Long-term sponsors and donors**
  - Organizations like United Way and credit unions often provide long-term funding
  - High net worth individual and foundations do the same
- **Non-HRSA government support**
  - Local health departments/districts or hospital systems often provide direct, ongoing financial support and/or significant in-kind donations
- **Training Programs and Services for other CHCs**
  - Fee-based training and educational workshops (clinical training, team-based care, community health worker, 340B optimization, cultural competency)
  - Off back-off services (billing, accounting, IT)
- **Facilities**
  - Rent out facilities during off-hours, lease clinic space, get in-kind space
- **Residencies**
  - Independent or partnership approaches to physician, NP, or dental residencies
- **Deep Partnerships:**
  - Collaboration with sectors such as Housing, Workforce Development, Education, and Technology.

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Discussion: What are some successes at your health center related to diverse funding?

Common Grant Funding Challenges

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- Applying without Success
- Unpredictable Funding
- Sustaining Grant-Funded Programs
- Administrative Workload
- Relationship Building

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Applying Without Success

Key Challenges:

- #1: Grant Applications are highly competitive
  - HRSA Typically awards only 10-25% of applications.
  - Foundations award about 18-30% of grant applications.
- #2: Funding Catch-22 *(needing grants to get grants)*
- #3: Lack of grant writing expertise
- #4: Short application timelines and technical challenges
- #5: Sustainability and match fund requirements
- #6: Identifying measurable outcomes
- #7: Complex requirements and compliance
- #8: Collaboration and partnerships are required to apply

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Unpredictable Funding

- Causes of Unpredictable Funding Streams
  - Changes in political, economic, and social landscapes
    - Shifts in government leadership and policy priorities
    - Economic downturns and recessions
    - Social changes *(immigration, aging populations)*
    - Health crises *(COVID-19)*

- Health Center Challenges:
  - Struggle to commit to long-term community health initiatives
    - Most grants want to fund new programs and interventions
  - New funding opportunity is not aligned to your existing plans but too good to ignore
    - This can lead to mission drift
  - Hard to find grants that align with your strategic priorities

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Sustainability can be hard

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Administrative Workload

- The administrative workload tied to grant funding can create a significant strain on health center staff.
  - #1: Intensive Application Processes
  - #2: Complex Compliance and Reporting
  - #3: Resource Constraints for Data Management
  - #4: Tracking and Evaluating Multiple Grants
  - #5: Building Community Partnerships and Collaborations
- Requires a substantial investment in time, personnel and health center infrastructure to build sustainable and diverse grant-funding.
  - Grants
  - Development
  - Communications
  - Program Management
  - Compliance and Reporting
  - QA/QI Programs

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Relationship Building

- Challenge #1: Dedicating Development Staff with Expertise in Relationship Building.
  - Development staff support strategic networking, targeted outreach, and effective communication with foundations, community leaders, and potential corporate partners.
  - Highly competitive service areas, rural service areas, and newly establish health centers or look-alikes can have difficulty engaging new partners and establishing new relationships without dedicated development and outreach staff.
- Challenge #2: Funder Hesitation - Trust Takes Time
  - Health centers with limited history or a lack of presence in the community have to prove their worthiness for funding and partnership opportunities.
  - Even for well established health centers, new partnerships and community collaborations take time to build.
- Challenge #3: Communication Strategy and Stewardship
  - Many health centers lack the resources to execute comprehensive communication strategies with clear messaging, regular updates, and visible outcomes that are essential to keeping funders and partners engaged.

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Discussion:
What are some of your center's challenges with grant funding?

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Best Practices in Grant Seeking

- Continual research
- Keep a “shovel-ready” list of ideas
- Engage stakeholders and partners early
- Develop grant decision making rubric
- Create tailored proposals
- Leverage data and use AI judiciously
- Establish and cultivate relationships
- Evaluate and learn

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Best Practices for Grant Applications

UNDERSTAND COMMUNITY NEED TO IDENTIFY AREA AND POTENTIAL SERVICES

CONNECT WITH STAKEHOLDERS AND POTENTIAL PARTNERS

IDENTIFY APPROPRIATE SITE WITH ABILITY TO CONTROL

ALIGN STRATEGIC DIRECTION

DECIDE TO APPLY

KICKOFF APPLICATION TEAM

What it takes to do well in the most time-consuming pieces of federal grant applications

Needs assessment

Existing health centers with a recent assessment that covers the same service area will be well positioned.

Others must do significant research to understand and summarize unique health factors, unmet needs, social determinants, existing access to care.

A+ work? *Survey potential patients and collaborating organizations.*

Narrative

Fully answering each and every question is critical and can take 50 to 90 pages of text and graphics.

Most points come from the narrative response, so a strong narrative is critical.

A+ work? *The narrative is written clearly and concisely to allow the reviewers to easily see how each scoring criteria has been met.*

Patient Projections & Operational Plan

Balancing how quickly the new clinic can be operational and serve a meaningful number of patients with what can realistically be accomplished is key.

HRSA will hold you accountable to meeting the projections.

A+ work? *An operational plan that clearly addresses each major health need and disparity identified in the needs assessment.*

Letters of Support

Letters need to reflect meaningful conversations that will result in real-world collaboration.

If you are not able to meet all required primary care services yourself, contacting future partners now will enable success by the 120 day mark.

A+ work? *You start early and have well written, customized letters from all key current and future collaborators.*

Facilities overview

You must have verified site control and floor plans.

If you don't already own the building, you need to demonstrate that you will have control of the site through lease and/or future purchase with a floor plan that reflects the services and staffing proposed.

A+ work? *Your site plans leave no doubt to reviewers that plans are concrete and realistic.*

Other Attachments

These include a variety of staff bios, job descriptions, contracts summary, bylaws, and more.

None of it is particularly hard, but if you are not yet a health center, each attachment could be significant effort.

A+ work? *All requirement attachments are present, properly labeled, and don't put you over the page count.*

Financials

A budget for two years that meets federal standards (using Standard Form 424). Includes projected income from all revenue sources, a staffing plan, and a budget narrative that describes each expense.

A+ work? *The budget aligns with patient projections and shows a competitive cost per patient with a mix of payers and grant revenue.*

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How to fail at grants

- Limited feedback-seeking from funders, colleagues, and community stakeholders to improve applications.
- Over-reliance on single funding streams.
- Minimal collaboration with other organizations or community projects to show shared impact.
- Weak QA/QI monitoring, and evaluation programs resulting in insufficient data and outcomes.
- Low engagement with program staff in planning and implementing grant applications.
- Bypassing NOFO questions without suitable responses.
- Inconsistent narrative, budget, staffing, and project plans due to lack of coordination.
- Last-minute upload of documents to electronic systems.

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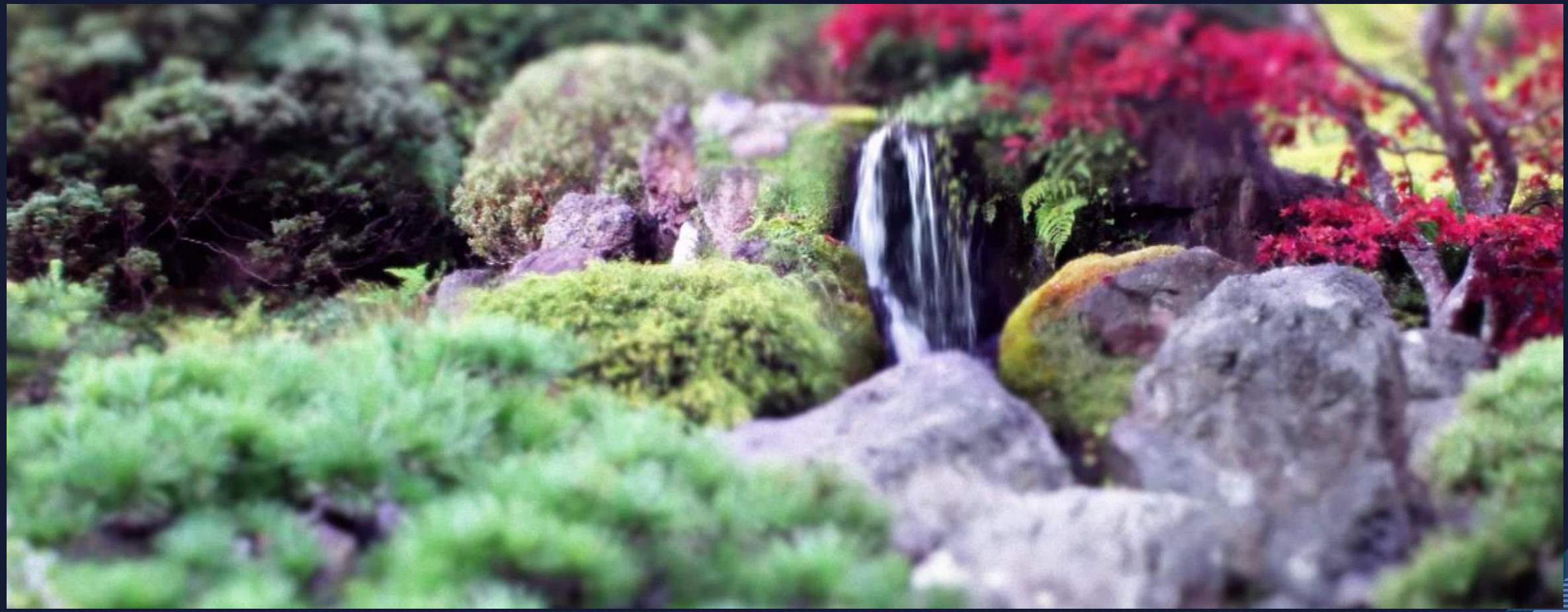
Optimizing Existing Funding Streams

~340B Pharmacy ~ Medicaid Strategy ~ Value Based Care



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340B Pharmacy

- Assess your current program
  - Not Participating
  - Contract Pharmacy
  - In House Pharmacy
- Assess current performance
  - Metrics Dashboard
- Identify opportunities to expand
- Identify opportunities to reduce cost
- Identify opportunities to preserve

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Metrics Dashboard

- Using TPA data reports
- Multiple stores per each chain
- Shows Data Trend
- Calculated ratios to compare performance

BigBox Pharmacy	June	July	August	Total	YTD Average
Net Script Count	77.07	61.72	60.15	513.44	64.18
Sales	66,299.14	56,878.70	47,556.42	401,383.76	50,172.97
Dispense Fee	8,879.73	5,491.78	4,225.76	58,677.49	7,334.69
Admin Fees	4,126.38	4,444.18	4,032.66	32,195.84	4,024.48
Drug Cost	20,752.97	11,004.82	6,208.77	64,204.00	8,025.50
Net Income	$32,540.06	$35,937.92	$33,089.23	$246,306.43	$30,788.30
Net/Script	$422.21	$582.27	$550.11	$479.72	$479.72
Profit Margin %	49.08%	63.18%	69.58%	61.36%	61.36%
Dispense fee/script	$115.22	$88.98	$70.25	$114.28	$114.28
Admin Fee/script	$53.54	$72.01	$67.04	$62.71	$62.71
Admin Fee/Sale %	6.22%	7.81%	8.48%	8.02%	8.02%
Total Fees/script	$168.76	$160.98	$137.30	$176.99	$176.99
Total Fees/Sale %	19.62%	17.47%	17.37%	22.64%	22.64%
Drug Cost / Script	$269.27	$178.30	$103.22	$125.05	$125.05

Smiths Drug Stores	June	July	August	Total	YTD Average
Net Script Count	1511.11	1445.27	1492.50	12023.34	1502.92
Sales	111,572.27	106,773.02	126,841.87	960,617.22	120,077.15
Dispense Fee	29,844.06	28,716.26	30,110.45	243,373.05	30,421.63
Admin Fees	25,321.18	18,789.32	19,189.02	186,591.97	23,324.00
Drug Cost	22,098.71	18,324.82	24,595.94	175,090.29	21,886.29
Net Income	$34,308.32	$40,942.62	$52,946.46	$355,561.91	$44,445.24
Net/Script	$22.70	$28.33	$35.48	$29.57	$29.57
Profit Margin %	30.75%	38.35%	41.74%	37.01%	37.01%
Dispense fee/script	$19.75	$19.87	$20.17	$20.24	$20.24
Admin Fee/script	$16.76	$13.00	$12.86	$15.52	$15.52
Admin Fee/Sale %	22.69%	17.60%	15.13%	19.42%	19.42%
Total Fees/script	$36.51	$32.87	$33.03	$35.76	$35.76
Total Fees/Sale %	49.44%	44.49%	38.87%	44.76%	44.76%
Drug Cost / Script	$14.62	$12.68	$16.48	$14.56	$14.56

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Cost Reduction in 340B Program

- TPA- Third Party Administrator
  - Assess fees: Reasonable? Time to shop around?
  - Consolidate, if advantageous
  - Value provided (monitor eScript patterns, advise on MF issues,etc)
- Contract Pharmacy PSA
  - Dispensing Fees reasonable
  - Offer choice of brand-only, or include generics
  - Offer Winners-only model
- 340B Management Vendor
  - Not always necessary
  - Is vendor providing value, or just siphoning revenue away?

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Preservation of 340B Program

- Know your program- monitor performance and compliance
- Navigate manufacturer restrictions
  - Leverage TPAs to support reporting or carve-outs
  - Jump through hoops to submit claims data to restore pricing
- Advocate for legislation

"I'm not jumping through hoops for you. It's *my* Hula-Hoop. I'm doing this for *me*."

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Current Threats to 340B

- Manufacturers began restricting access to 340B pricing for contract pharmacy arrangements
  - Started with one in August 2020, then 25+ others jumped on the bandwagon
  - Originally more focused on Hospitals, now expanded to Health Center/Grantees
  - NEW- last week, Novartis announced first such restrictions for IN HOUSE PHARMACY
- Some Manufacturers allowed conditions to restore pricing discount
  - 340B ESP- share your claims data- ALL your claims
  - Designate ONE contract pharmacy
- Health Centers, Hospitals, other CEs have lost many millions of dollars in savings

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Core Issues

Manufacturers claim system is fraught with problems

- Duplicate discounts- state Medicaid programs & CEs
- Third Parties profiting from system, not intended to benefit

HRSA does not have codified authority to enforce compliance

- 340B statute written as guidance, not law
- Allowance of "unlimited contract pharmacies" is unclear, subject to interpretation & challenge

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Prepare to Tell Your 340B Story NOW

CHCs do an excellent job using the savings to expand patient services, but don't often tell the story.

Several bills introduced to congress, most contain language requiring some type of reporting and transparency.

Create an Impact Summary showing programs you support with 340B savings, direct relationship to serving patients

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Who Needs to Know?

Internal

- Executive Team
- Governing Board
- Program Managers

External

- Community/Patients
- HRSA/NACHC/PCA
- Federal & State Lawmakers

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Medicaid Strategy- Rate Planning

- Identify strategic initiatives that may create CIS opportunities
- Align with strategic planning process
- Create proactive plan to manage PPS rate changes
- Track each Change in Scope application
  - Maintain record of rate changes
  - Document specifics for the next generation
  - Document reasons, if not approved

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Change in Scope Triggering Events

- State plan is required to provide process to rebase rate when a triggering event occurs
- Triggering event is change in service of at least one of following:
  - Type
  - Intensity
  - Duration
  - Amount
- Identify planned changes in each fiscal period
- Evaluate unplanned changes for opportunity
- Be prepared to file, know your opportunity each year

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Medicaid Strategy- CIS Process

- Understand Medicaid Rate Setting and Change in Scope process
- What is included/excluded
  - Pharmacy, Lab, Out of Scope Programs
- Rate Calculation Basis
  - Incremental: costs and visits tied to specific event
  - Full: all eligible costs and all visits included in calculation
- Change in Scope Filing Period:
  - Retrospective: Actual costs of recent closed fiscal period
  - Prospective: Budgetary data for planned CIS event (occurring within limited timeframe)
  - Incremental Blend: both actual and prospective (Oregon)
- Filing Deadlines and Finalization
  - What is deadline (ex. 150 days after FYE)
  - State reconciliation process/look back (e.g. Idaho 2 years)

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Value Based Care

- What is this?
- What opportunities are available?
- Is it a fit for your organization?
- Is it beneficial to participate?

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VALUE-BASED REIMBURSEMENT

- Providers are reimbursed on a basis of quality rather than quantity
- Aimed at lowering cost and improving quality
- Potentially involves more risk sharing
- The basis of the calculation can take various forms
- Can be ALL or PART of a reimbursement model

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Value-Based Payment Models

- Pay for Performance
  - Rewarded for meeting performance metrics
- Bundled Payments
  - Flat rate for specified procedures, provider assumes risk
- Shared Savings
  - Incentivizes providers to reduce health care spending for the patient population
  - Offers a percentage of savings as a result
- Capitation
  - Per member per month flat payment
  - Visit volume does not generate revenue
- ACO- Accountable Care Organization
  - Provider groups (FQHCs, RHCs, Hospitals, etc) form ACO to manage care of population
  - Examples: Medicare Shared Savings Program, ACO Reach

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What VBMs are available?

- What is the Medicaid landscape in your state?
  - Managed Care Organizations
  - APM- Alternative Payment Method
- Medicare ACOs
- Medicare Advantage Plans
- Commercial Insurance Contracts

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Evaluate Fit and Benefit

- Provider team, leadership, staff must all have buy-in
- Resources- would this require additional investment in technology, other?
- How achievable are the deliverables?
- Know your numbers:
  - Current quality metrics
  - Patient population
  - Payor mix
  - Chart coding & documentation accuracy
- Downside risk if deliverables are not met

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Health Center-Led Foundations

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What are health center-led foundations?

Nonprofit organizations established by FQHCs to support their mission and work

Typically setup as separate 501(c)(3) entities

The foundation board can be unique or overlap with the health center's existing board, but the foundation has distinct meetings, bylaws, tax return, etc.

Staff of the foundation, if any, can also be employees of the CHC or solely work for the foundation

Foundations typically focus on fundraising, though the primary donor is often the CHC itself, as well as community engagement

Foundation resources can support CHC programs, provide patient support, CHC employees in need, or fund partners who serve the same population

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Considerations in establishing your own foundation

Why

- Allows for spending that might otherwise be unallowable (like patient support for copays, insurance, or equipment)
- Clarifies to donors that they are supporting a charitable cause
- Encourages employee donations
- Shifts cash balances when times are good
- Enables involvement of a different type of board member more into fundraising
- Creates conversations with other foundations

Why Not

- Administrative complexity
- Board governance complexity
- Legal complexities
- Can create the appearance of obfuscation
- Donations can already be made direct to your 501c3 CHC
- Fundraising expenses can be high relative to income

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Questions and Conclusions