PSA/IHPF Strategic Brief — September 10, 2026

Revised week-to-date edition: September 7–10

TLDR — What this means for PSA

- **Make navigation measurable.** New federal reporting requirements recognize coverage assistance, transportation and language support—but PSA must still demonstrate completed care.
- **Separate immediate AI experiments from future clinical capabilities.** Narrow retrieval deserves testing now; autonomous cardiovascular care is entering a multiyear development program, not becoming an available service.
- **Build the operating model alongside the technology.** This week's funding and payment developments make staffing, local access, documentation and financial sustainability central to implementation.

These are strategic interpretations of the evidence below, not demonstrated results from an IHPF pilot.

1. Navigation is becoming recognized infrastructure—not an optional extra

What changed: HRSA's **September 8** reporting changes add counts of patients receiving case management, eligibility assistance, transportation and language assistance. Health centers report the 2026 data in February 2027. Official changes

Why it matters: These are core IHPF capabilities, particularly for Medicaid-heavy, rural and bilingual communities.

Scale/evidence: National health-center reporting requirements—not new reimbursement or proof that navigation improves outcomes. These are patient counts, not necessarily individual-level submissions.

PSA implication — now: Align a partner pilot with recognized service categories, while adding coverage retained, referrals completed and unresolved barriers.

Action: Ask one southern New Mexico FQHC to jointly design a minimal navigator record: barrier, responsible person, next step, deadline and verified result.

2. Clinical AI's direction is consequential; its readiness remains task-specific

What changed: On **September 9**, ARPA-H announced a **four-year, $62.7 million cardiovascular AI program**, including clinical agents, supervisory systems and independent evaluation. Separately, a September 9 hospital study found six small local

models performed much better on simple retrieval than complex clinical tasks. ARPA-H awards · Hospital evaluation

Why it matters: Future clinical automation could change PSA's cardiac-care partnerships. It does not remove today's need for accountable clinicians and navigators.

Scale/evidence: ARPA-H's multisystem deployments are planned; FDA authorization and savings are goals, not achieved outcomes. The local-model study used French data from one Swiss hospital.

PSA implication — now versus 2–3 years: Test narrow retrieval now; monitor clinical-agent validation. Do not extrapolate one study to all AI systems.

Action: Compare human-only and AI-assisted retrieval of approved navigation information, measuring errors, correction time and English–Spanish performance.

3. Payment and documentation are immediate access risks

What changed: CMS's **September 10** bulletin says rural health clinics and FQHCs must change Medicare distant-site telehealth coding beginning **October 1**. HRSA's September 340B update also introduces October 1 registration and documentation changes without changing statutory eligibility. CMS guidance · 340B update

Why it matters: Available technology does not sustain access if claims fail or supporting records are incomplete.

Scale/evidence: Operational federal guidance, not evidence of improved care. Medicare billing changes should not be assumed to apply to New Mexico Medicaid.

PSA implication — now: A useful cockpit needs payer-specific checklists and human-reviewed exceptions.

Action: Ask partner billing leads to verify readiness and identify where a simple checklist could prevent rework before considering AI.

4. Rural funding favors concrete service capacity

What changed: CMS announced **$4.8 million for West Virginia on September 9**, including recruitment and worksite care, and **$11.7 million for Vermont on September 10**, including workforce development, ventilators and local dialysis capacity. West Virginia · Vermont

Why it matters: These offer models for bringing services closer to rural residents.

Scale/evidence: Funded state projects—not demonstrated outcomes or funding available to PSA.

PSA implication — planning now: Neighborhood diagnostics proposals should specify staffing, clinical oversight, referral destinations, operating costs and travel avoided.

Action: Develop one costed local-service concept with a provider partner; identify who receives and acts on every abnormal result.

5. A practical evaluation resource can strengthen both healthcare and education pilots

What changed: The Education Department released its **Learning Agenda Playbook on September 9**, developed with eight states. It supplies planning templates, facilitator materials and capacity-assessment tools. Announcement and toolkit access

Why it matters: PSA needs a repeatable way to decide whether a pilot merits expansion—not just collect encouraging anecdotes.

Scale/evidence: A state-tested planning resource, not proof of improved student or patient outcomes.

PSA implication — now: Adapt the process for bilingual school-family navigation and IHPF follow-through.

Action: Before launch, specify the outcome, comparison, accountable owner, cost ceiling and findings that would trigger revision or stopping.

Scope correction: This covers verified, priority releases across September 7–10, not every announcement. The earlier vaccine release was dated September 1, and the NM school-support memo September 3. I also omitted the earlier diagnostic-report review because I could not reverify its source.