



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

NVPCA BOARD AGENDA

Tuesday, January 7, 2025

8:30 am – 10:00 am

Virtual Meeting – [Zoom Link](#)

2024-25 NVPCA Board Members:

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

8:30 am	1. Call to Order a) Approval of the Agenda (<i>vote</i>)	Steve Flores
8:35 am	2. Consent Agenda (<i>vote</i>) a) Board Minutes from Board Meeting on November 5, 2024 b) Chief Executive Officer’s Report & Organizational Dashboards	Steve Flores
8:40 am	3. Board Governance Moment a) Board Governance Moment b) Member Meeting Attendance Record	Steve Flores/ Nancy Bowen
8:45 am	4. Administrative and Financial Reports a) Budget to Actual YTD Financial Reports with Financial Dashboard and Balance Sheet (<i>vote</i>) b) CareSource Grant Funding and Application	Nancy Barklage/ Karen Ford Manza
9:05 am	5. Strategic Discussion a) Strategic Growth Ad Hoc Committee Requests b) Medicaid - Federal Level Concerns	Sharon Chamberlain/ Nancy Bowen
9:35 am	6. Policy Committee Update a) Federal Updates b) 2025 Legislative Priorities	Steve Flores/ Steve Messinger
9:50 am	7. Data Spotlight a) Hypertension	Kim Lambrecht/ Steve Messinger
10:00 am	8. Meeting Adjournment	Steve Flores

Zoom Meeting Link: <https://us02web.zoom.us/j/82320952786?pwd=NHAYs3VoaGxJajlpTFNEZWhMMG9MQT09>
Meeting ID: 823 2095 2786 Passcode: 767732

One tap mobile: +13462487799,,82320952786#,,,,*767732# US (Houston)
+166944449171,,82320952786#,,,,*767732# US



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

Land Acknowledgement

The Nevada Primary Care Association is dedicated to fostering a culture of inclusivity and health equity in all aspects of our work. We celebrate the diverse tribal communities that enrich the land where we work, play, and find community. We honor Nevada's 21 Indigenous Nations spanning 28 reservations, bands, colonies, and community councils, and over 62,000 Urban Indians.

Land acknowledgment is only one small part of supporting Indigenous communities, and it is an essential step towards honoring the history and people of Nevada. It is a way to show respect to those who have lived on this land for thousands of years and to recognize their enduring presence and contributions.

NVPCA remains steadfast in our commitment to health equity and inclusivity, particularly in relation to Indigenous populations. We are dedicated to fostering collaboration, advocating for underserved communities, and working towards a future where all individuals receive the care and support, they deserve.



NVPCA Board of Directors Board Meeting Minutes November 5, 2024

Board Members Present	Walter Davis, Teri Gilbert Eisenga, Sharon Chamberlain (left the meeting at 9:55), John Packham, Christopher (CJ) Hansen, Randy Smith (left the meeting at 9:40), Tina Alicea, David Robeck, Diego Martinez, Oscar Delgado (joined at 9:00) and Nancy Bowen (Ex Officio)
Board Members Absent	Steve Flores
Also Present	Olivia Howerton of Fester and Chapman, and NVPCA Staff Nancy Barklage, Karen Ford Manza, Steve Messinger, Kim Lambrecht, and Lisa Scurry (Note Taker)

1. Call to Order

Vice President Walter Davis called the meeting of the NVPCA Board of Directors to order at 8:35 am. The meeting was conducted electronically via Zoom. A quorum of members was established.

a) Approval of the Agenda

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

2. Consent Agenda

a) Approval of Minutes from Board Retreat on September 24, 2024

b) Chief Executive Officer's Report and Organizational Dashboards

The consent agenda, consisting of the minutes of the September 24, 2024, Board of Directors Retreat, the CEO report, and the organizational dashboard, was presented for approval. There were no comments or questions.

It was moved by Teri Gilbert Eisenga, and seconded by Sharon Chamberlain, to approve the consent agenda as presented. The motion passed unanimously.

3. Board Member Attendance at Meetings

At the request of the Board, the last year's attendance of members at regularly scheduled meetings was provided. This item was informational only.

4. Administrative and Financial Reports

a) Audit and Form 990

Olivia Howerton of Fester and Chapman, PLLC, presented the Fiscal Year 2024 Audit Report and the 2023 Form 990. She stated it was a clean audit, also known as an "unmodified opinion." Overall, cash flows for the association were positive. Ms. Howerton reviewed the Form 990 which was created based on the financial statements.

There were no questions from the Board.

It was moved by David Robeck, and seconded by Tina Alicea, to accept Form 990 for 2023 and the FY2024 Audit. The motion passed unanimously.

b) Budget to Actual YTD Financial Reports with Financial Dashboard

Nancy Barklage reviewed the Year-to-Date financial report through September 2024, including actual revenues and expenses. All expenses are on target and falling within the budgeted range. The financials included costs of the recent annual conference.

It was moved by Sharon Chamberlain, and seconded by Randy Smith, to accept the Budget-to-Actual Financial Report for Fiscal Year 2025, through September 2024. The motion passed unanimously.

c) Proposed Adoption of a Board Policy on “Policy Management”

At the July meeting, the Board recommended the CEO bring a Board policy documenting how policies are created and managed. The draft policy was written to define what a policy is; the process for review, revision, and adoption; and delegation of certain authority to the CEO.

There was discussion regarding HRSA requirements and if health centers should have such a document in place. Bowen responded that fiscal and human resources policies are recommended. There are guidelines for the PCA but they are different than what is recommended for health centers. She also described the difference between substantive and non-substantive changes, adding that only substantive changes will come back to the board. (Note – a substantive change is generally a typo or change to a title.)

It was moved by David Robeck, and seconded by Diego Martinez, to adopt a Board Policy on “Management of Board Policies” as presented. The motion passed unanimously.

d) Funding Opportunities

Nancy Bowen provided information about two potential funding opportunities. The first is a Fiscal Year 2025 Health Center Controlled Networks (HCCNs) cooperative agreement. The funding, which begins at \$705,000 per budget period, would support HCCNs in data management and analytics, Interoperability and Data Sharing, and UDS+ Implementation. She presented two options: apply for a Nevada HCCN or continue with Arizona’s HCCN. The challenge in apply for a Nevada HCCN would be getting 10 PHCs and maintaining them.

There was discussion about why Nevada wouldn’t seek collaboration with a larger conglomerate. Bowen explained that it was explored years ago but the concern was that Nevada’s members would be small fish in a large pond. She stated that further research would be done.

The second funding opportunity was a grant from CareSource in the amount of \$300,000. Grants awarded through the funding would support programs for members in rural service areas in all counties in Nevada, including the rural parts of Washoe and Clark Counties. NVPCA would develop a request for proposal (RFP) to which rural service area members would respond.

5. Strategic Discussion

a) Strategic Plan Pillars, Priorities, and Goals

Using the notes from the September Board Retreat discussion and in partnership with the Blueprint Collaborative, NVPCA staff has begun drafting changes to the Strategic Plan. The five Pillars of the Plan are Policy, Organizational Excellence, Strategic Growth, Members Services, and Outreach and Communication. Within each pillar, the strategic priorities and measurable goals were presented.

Board Leadership and NVPCA Leadership will develop a plan to improve trust, a focal point of the Board survey conducted in the summer.

6. Policy Committee Update

a) Federal & State Updates

Steve Messinger, Policy Director, presented an update on health center funding, protecting the right of health centers to contract pharmacies (340B), expanding PCP training opportunities in FQHCs, and 2025 legislative priorities.

b) NACHC Policy Fly-In – Washington DC, December 3, 2024

NACHC will host a fly-in to Washington DC on December 3rd. The purpose will be to advocate for funding for health centers.

7. Data Spotlight

a) Diabetes

b) Cardiovascular / Chronic Disease

Steve Messinger and Kimberly Lambrecht reviewed data regarding diabetes management, including how the data is reflected within Azara. Lambrecht showed how full reports can be accessed within the system for diabetes and cardiovascular / chronic disease.

8. Meeting Adjournment

There being no further business, Vice President Davis adjourned the meeting at 10:00 am.

NOTES

Next Meeting	The Board will conduct a virtual meeting on Tuesday, January 7, 2025, at 8:30 am.
Approved By	


ROLL CALL

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

The CEO report on the organization’s activities and meetings towards achieving the NVPCA mission:

November 1 – December 31, 2024

Policy -

- Ms. Bowen met with Stacie Weeks, DHCFP Administrator to discuss proposed 2025 legislation, the Managed Care Roundtable, and potential Alternative Payment Methodologies. Ms. Weeks, along with other Medicaid personnel, will participate in the next Managed Care Roundtable scheduled for Thursday, January 23 from 1-3 pm (PT). Register by clicking the following link. <https://us02web.zoom.us/meeting/register/tZwvdOivqDwrE9FZ0p-gkBmjzJ4mO5dyLkQU> . The format of this event will be all-virtual and limited to 2 hours. As before, we will have attendees from health centers and managed care organizations. There are currently over 50 participants registered.
- 
- As part of the ongoing Managed Care Round Tables, NVPCA hosted a Performance Measure Workgroup focused on diabetes on December 11. The workgroup will meet monthly, generally the third Thursday at 12:30 pm.
 - Ms. Bowen, CEO and Mr. Messinger, Policy Director presented on 340B Contract Pharmacy Protection to the Nevada Association of Counties (NACO). The association was concerned about the possible loss of contract pharmacies in the rural counties and agreed to support the upcoming legislation.
 - Ms. Bowen, CEO and Mr. Messinger, Policy Director along with 2 FQHC CEOs and 3 FQHC staff participated in the National Association of Community Health Centers (NACHC) Fly-in to Washington, DC Dec. 4, 2024. The team met with 4 Members of Congress, and two health staffers of Representatives Titus and Lee. Senator Cortez-Masto stepped out of a committee meeting at the Capital to meet with the Nevada group and NACHC CEO & policy staff. Cortez-Masto informed the group that health extenders were still on the table, and she was fighting for them in the Continuing Resolution (CR) discussions. Mr. Messinger also corresponded with Congressman Amodei’s health staffer after the visits specifically requesting Amodei to ask Speaker Johnson to include the Health Center Program reauthorization and funding in the CR.
 - The Continuing Resolution (CR) was approved late December 20th and includes only 3 months of reauthorization for the health center program through March 20, 2025. Ms. Bowen and Mr. Messinger will be back in Washington DC in early February 2025 to follow up on ensuring health center program, NHSC, and THCGME program are reauthorized in March and have increased funding.
 - CEO meet with other Primary Care Association (PCAs) CEOs while in Seattle, WA for NACHC Partner

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Conference to discuss concerns for health center program funding for both FQHCs and PCAs. Ms. Bowen agreed to support the contracting of consultants that have contacts in the incoming administration.

Organizational Excellence –

- NVPCA was awarded \$40,000 of the \$100,000 requested from SilverSummit HealthPlan to pilot the Azara Transition of Care (TOC) module at one health center. NVPCA submitted the same TOC proposal to Molina Healthcare and will learn if funded in mid-January 2025.
- The NVPCA Strategic Growth Ad Hoc Committee met on 12/19/24 for the first meeting. The committee had a very engaging discussion and agreed the next steps will be for health centers to share their growth plans for the next 18 months, and the NVPCA team to update the Strategic Growth Report from 2021. Ms. Chamberlain, the committee chair, will discuss this at the upcoming board meeting. NVPCA to create a SharePoint drive for members to submit their plans.
- NVPCA is administering up to \$175,000 of \$300,000 CareSource funds to improve (in priority) behavioral healthcare and primary care in rural Nevada. This opportunity is available to an NVPCA member that is an FQHC, FQHC Look-Alike, or Tribal Health Center headquartered in Nevada as of 10/1/2024. More than one project may be submitted per applicant. The funds are to be quickly spent and are very flexible. Projects are to commence February 1, 2025, and must be completed by July 31, 2025. One progress report and a final progress and fiscal report are required but brief. More details can be found in the attached document; submit applications by following this [link](#). Applications will be accepted until Friday, January 10, 2025, 5 PM Pacific

Community Engagement – National and State

- NVPCA CEO, Director of Health Center Informatics, and Policy Director attended NACHC Partners Conference in Seattle, WA. Primary Care Association (PCAs), Health Center Controlled Networks (HCCNs), and National Training and Technical Assistance Partners (NTTAPs) all participated in education sessions to support their work with the FQHCs.
- Ms. Bowen attended a full day of NACHC Board education and board meeting on November 17, 2024. This was the first meeting in Ms. Bowen’s 2-year term on the NACHC Board.
- While in Seattle, NVPCA CEO and Policy Director attended NACHC Strategy Meeting along with Mr. Davis, CEO Nevada Health Centers. Ms. Bowen introduced herself to the Eddie Chan, CEO of [North East Medical Services \(NEMS\)](#), a San Francisco FQHC that just opened a new clinic in Las Vegas. NEMS is a large FQHC in CA that has its own health plan and works with other FQHCs on value based contracting. Mr. Chan expressed his interest in similar work in Las Vegas.
- Ms. Bowen attended the Northern Nevada Public Health Community Health Improvement Project (CHIP) Access to Health Care meeting. Two MCO staff discussed how private practice groups limit the number of Medicaid patients they take which has created an access to health care problem. Both individuals spoke highly of the FQHCs in Northern Nevada.

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- NVPCA Leadership team with the DHCFP Nevada Oral Health staff to discuss the current status of oral health in Nevada and at Medicaid. group to discuss projects. NVPCA learned that the 1115 Waiver was scaled it back to patients that are served by the health center clinic that is providing the medical care based on feedback from Community Health Alliance. FQHC needs assistance with transportation issues - it should be accessible. DHCFP provided an update on NV SB385 (passed in 2023)- CMS kicked back the State Plan Amendment (SPA) saying that Medicaid has to also cover preventive services (i.e., cleanings, etc.) before it will approve for the crown reimbursement. Cleanings were not part of the bill.

Membership

- Ms. Bowen visited with 9 of 11 NVPCA Board members in December, thanking each for their service on the board and updating them on the CR that was being discussed in Washington DC that week.

Program Management and New Projects

- Staff continue to work on the (IT) Security Risk Assessment conducted by Medcurity in the Spring of 2024. The assessment identified 60 actionable recommendations to enhance our security measures. To date, two have been fully completed/implemented and all other recommendations have been drafted and/or implemented. We are awaiting Medcurity's final analysis and recommendations.
- NVPCA's new strategic plan began January 1, 2025. Updates will be given on the next CEO report. The following dashboards provide updates on the NVPCA Peer Networks, and the Title X Family Planning Program.

NVPCA Peer Workgroups / Networks Update

November & December 2024

1) Mobile Unit Peer Network (MUPN)

- a) Health Centers Participating: Nevada Health Centers, Community Health Alliance, First Person Care Clinic, Washoe Tribal HC, Hope Christian Health Center, Canyonlands Health Center, Northern Nevada HOPES, and All for Health, Health for All.
- b) Focus: The MUPN is learning and sharing best practices around mobile unit operations, sustainability, and mobile unit resources.
- c) November: Session 5 - Mission Mobile Medical shared how clinics have integrated and expanded behavioral health, harm reduction and mobile opioid treatment programs by using mobile medical units.
- d) December: Session 6 - Rural Mobile Health was the final session presented by Mission Mobile Medical. During this session, the MUPN learned about rural data best practices, targeting hotspots, community partnership best practices, and sustainability best practices.

2) Quality Improvement Peer Network (QIPN)

- a) Health Centers Participating: Nevada Health Centers, Community Health Alliance, First Person Care Clinic, Washoe Tribal HC, Hope Christian Health Center, Canyonlands Health Center, Southern Nevada Community Health Center, Northern Nevada HOPES, and All for Health, Health for All.
- b) Focus: The QIPN participants completed the Value Transformation Assessment. Based on the results of the assessment across the health centers, the QIPN has decided to focus on Social Determinants of Health (SDOH) as it crosses many of the domains impacting the health centers' readiness for value-based care and achieving the Quintuple AIM.
- c) November: No meeting. Participants were invited to the Performance Measure Workgroup focused on improving the UDS Diabetes Metric on December 11th.
- d) December: QIPN discussed SDOH data collection workflows. One Health Center is working on integrating PRAPARE. A review of the value transformation framework (VTF) was provided and the QIPN will be completing the VTF assessment to check in on progress made over the past year on SDOH collection.

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3) Clinician Leadership Peer Network

- a) Health Centers Participating: Nevada Health Centers, Community Health Alliance, Washoe Tribal HC, Hope Christian Health Center, Canyonlands Health Center, Northern Nevada HOPES, and All for Health, Health for All.
- b) Focus: Kickoff meeting was in March. Participants decided provider retention should be a primary focus. They also decided behavioral health and dental leaders should be included in the workgroup.
- c) November: November and December meetings were combined to accommodate a guest speaker that presented on December 4th.
- d) December: Colleen Camenisch from Nevada Physician Wellness Coalition (NPWC) presented on the impact of physician burnout and how NPWC can help physicians connect with one another and learn tools and strategies to support their wellbeing.

4) HR/Workforce Workgroup

- a) Health Centers Participating: Nevada Health Centers, Community Health Alliance, Washoe Tribal HC, Hope Christian Health Center, Canyonlands Health Center, Southern Nevada Health Centers, and Northern NV HOPES.
- b) Focus: Workforce retention, recruitment, and staff development.
- c) November: The Workforce Development and Human Resource Peer Network met in November to discuss health center impacts with HPSA modernization and to review the Compensation & Benefits Survey. Health centers shared that they have not seen the HPSA scores impact recruiting and retaining health center staff. Participants also found value in reviewing the Compensation & Benefits survey as a group to ask initial questions they may have with the survey.
- d) December: The Workforce Development & Human Resource Network convened on December 19th to address questions related to the compensation and benefits survey, as well as to brainstorm potential topics for the 2025 peer network. Key topics for 2025 include career ladders, employee engagement, and employer-of-choice badges.

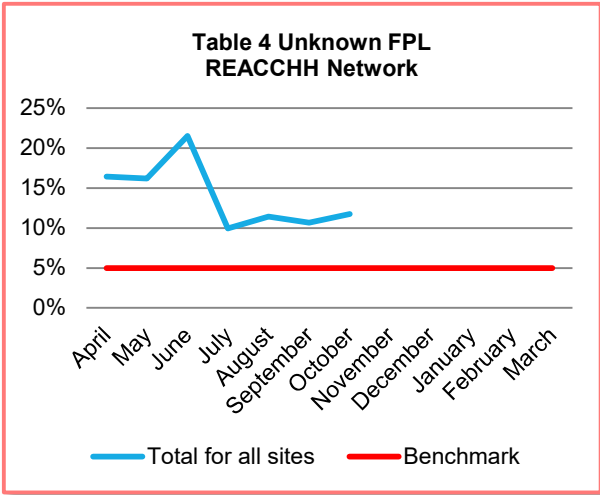
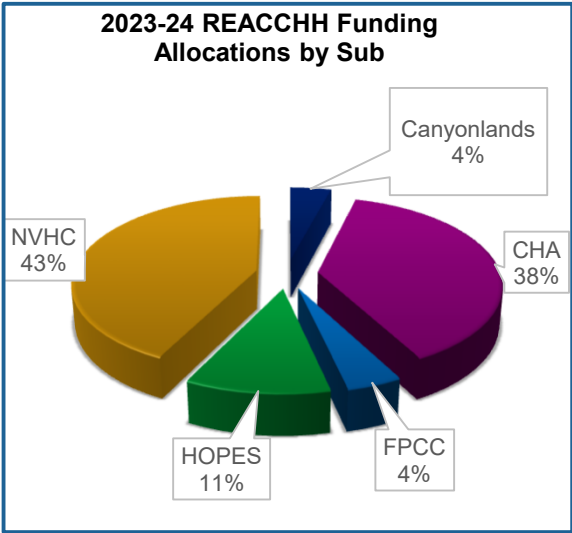
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NVPCA REACCHH Dashboard (YTD = 58%)

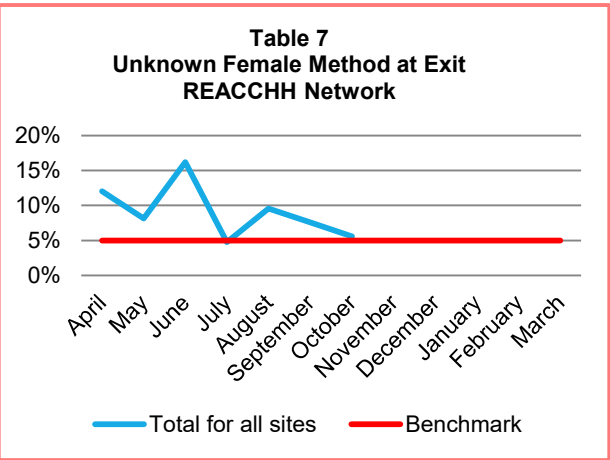
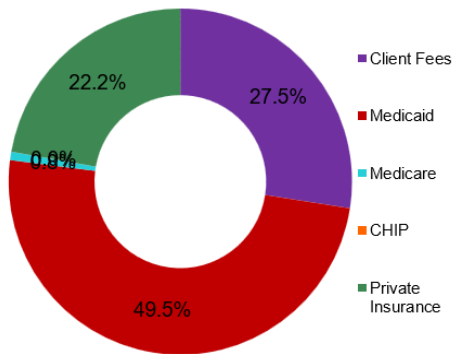
Contract Year: April 1 - March 31

2024-2025 Contracted Funds
 Canyonlands, CHA, FPCC, NN HOPES + NVHC

Data Quality - Unknown Rates*
 Quality Improvement Award Eligibility (4)



REACCHH Network Match Revenue Sources



At 58% into the contract year...

REACCHH Title X funds spent YTD = 57.4%

Unique Title X Patients Served by REACCHH = 86.1% of total contracted*

**note that two subrecipients are not reporting patient data due to EHR conversion and reporting issues, and one subrecipient is over-reporting due to EHR conversion issues*

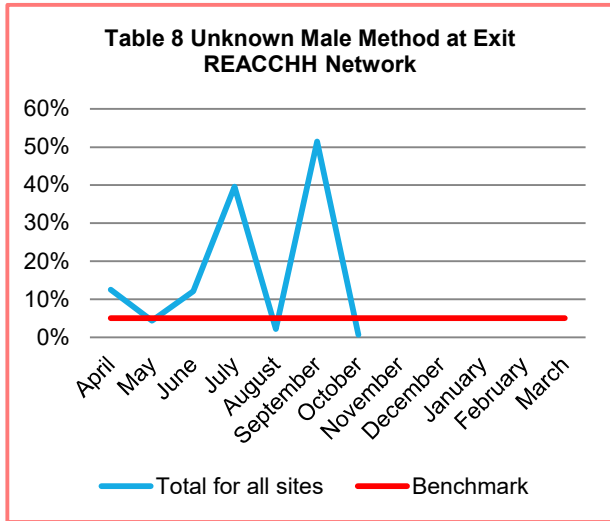
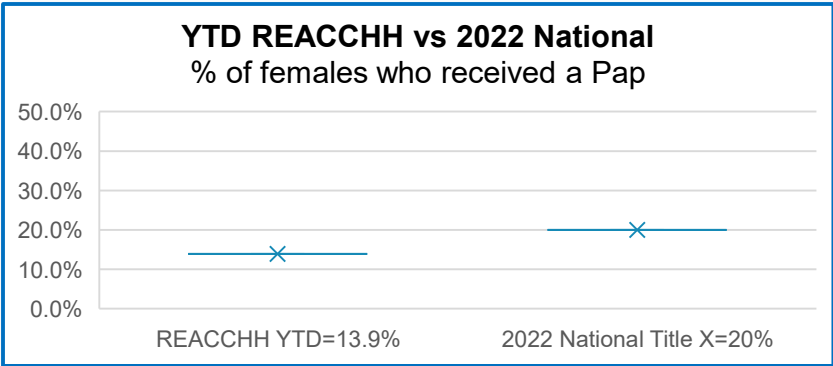
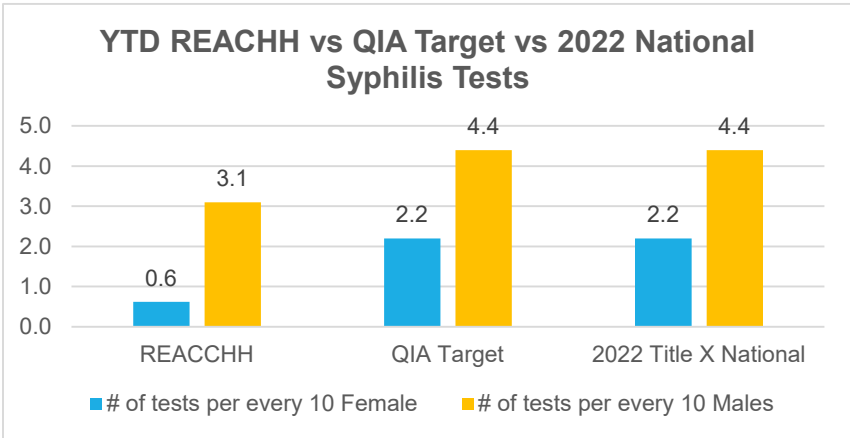
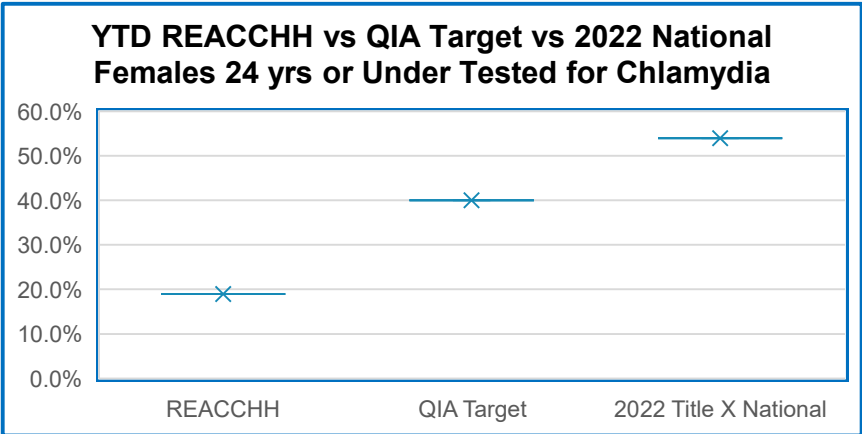


Table 8 - all male data 'unknown' in Sept; recovery in progress

4) Data submitted using the FPAR 2.0 template

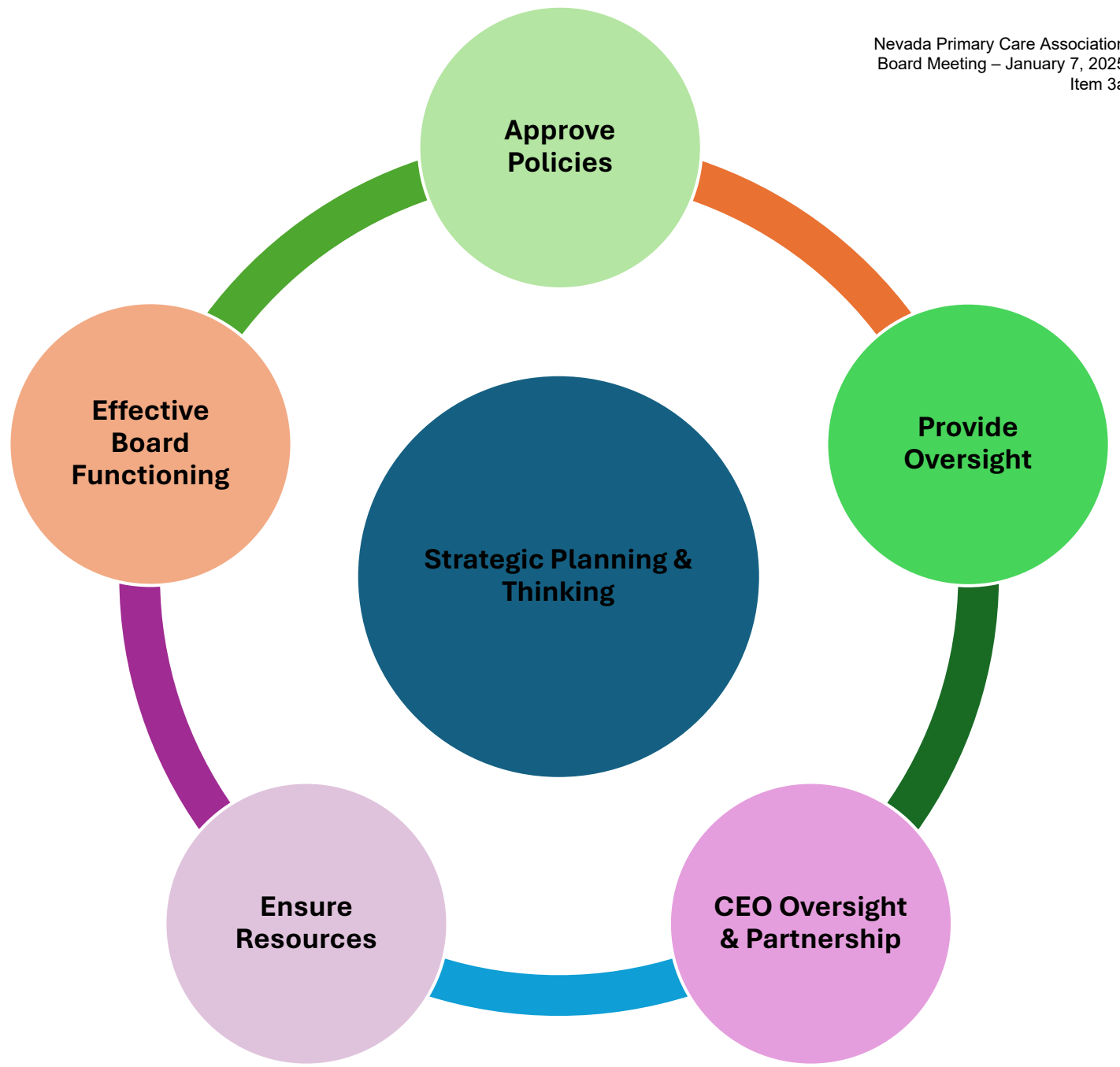
Clinical Quality Standards
Quality Improvement Award Criteria (4)



- *Notes & updates for data through October 2024:**
1. Quality Improvement Awards Period: 8/1-12/31/24
 2. Permanent sterilization (vasectomy) in northern NV by 3/31/25



Roles & Responsibilities of the Board



NVPCA Board of Directors Board

Governance Moment

January 7, 2025

1) Board Member Roles & Responsibilities Overview

- a) Collaborate with NVPCA leadership to create, adopt, and implement a strategic plan, and participate in ongoing strategic thinking.
- b) Participate in fiscal and operational oversight and policy development.
- c) Ensure the effective functioning of the board through productive board and committee meetings where members attend and participate
- d) Create and foster an atmosphere among board members of mutual trust and respect by:
 - i. Open Communication: Transparent and honest dialogue among board members. This helps in building trust and ensures that everyone feels heard and valued
 - ii. Mutual Respect: Foster an environment where all opinions are respected, even when there are disagreements. This can be achieved by setting clear expectations for respectful behavior and addressing any issues promptly
 - iii. Shared Vision: Align the board around a common mission and goals. When everyone is working towards the same objectives, it strengthens the sense of unity and purpose
 - iv. Effective Leadership: The board chair plays a crucial role in setting the tone for the board culture. They should model the desired behaviors, facilitate constructive discussions, and resolve conflicts before they escalate
 - v. Continuous Improvement: Regularly evaluate the board's dynamics and effectiveness. This can involve self-assessments, feedback sessions, and training to address any areas for improvement
 - vi. Inclusivity: Ensure that the board is diverse and inclusive. Different perspectives can lead to more robust discussions and better decision-making
- e) Ensures the association as enough and the correct resources to achieve the mission and vision
- f) CEO Oversight: Hires, establishes compensation, and evaluates the Chief Executive Officer. Ensures there is a succession plan in place.

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Board Member Attendance

Member Name	2024-11-05	2024-09-24	2024-07-17	2024-05-15	2024-03-20	1/17/2024, No Quorum	2023-11-16
Alicea, Tina	Present	n/a	n/a	n/a	n/a	n/a	n/a
Chamberlain, Sharon	Present	Present	Absent - Excused	Present	Present	Absent - Unexcused	Present
Davis, Walter	Present	Present	Present	Present	Present	Absent - Excused	Present
Delgado, Oscar	Present	Absent - Excused	Present	Absent - Unexcused	Present	Absent - Excused	Present
Flores, Steve	Absent - Excused	Present	Present	Present	Present	Present	Present
Gilbert Eisenga, Teri	Present	Present	Present	Present	Present	Present	Absent - Excused
Hansen, CJ	Present	Present	Present	Present	Absent - Excused	Present	Present
Martinez, Diego	Present	n/a	n/a	n/a	n/a	n/a	n/a
Packham, John	Present	Absent - Excused	Absent - Excused	Present	Present	Present	Present
Robeck, David	Present	Present	Present	Present	Absent - Excused	Present	Present
Smith, Randy	Present	Present	Present	Present	Present	n/a	n/a
Leguen, Fermin							Absent - Excused
Quinn, Angela		Absent - Unexcused	Absent - Unexcused	Absent - Unexcused	Absent - Unexcused	Absent - Unexcused	Absent - Unexcused
Valeton, Roxana				Absent - Excused	Absent - Excused	Absent - Excused	Present

Excused = notification was provided to CEO that the member would be absent

Unexcused = no notification was provided to the CEO that the member would be absent in advance of the specific meeting



NVPCA Financial Statement

YTD Target 41.7%

* Notes provided for variances + / - 25% of YTD target

17%

67%

NB= Not Budgeted

REVENUE

Federal Grants

BPHC Cooperative Agreement

821,802 345,012 42%

Reacch Title X

2,052,050 900,376 44%

Contracts

State- TPP PREP

92,758 47,624 51%

State- MACH

342,836 47,394 14%

HCCN

71,905 26,049 36%

Huntsman

NB 5,000

Other

Training & Events

24,750 30,795 124%

Sponsorship/Contributions

95,000 28,500 30%

Membership Dues

50,925 11,750 23%

NVCC

20,000 7,060 35%

Interest

7,500 7,930 106%

Total Revenue

3,579,526 1,457,490 41%

EXPENSES

Personnel/Salary & Fringe Benefits

1,394,774 549,591 39%

Travel

Airfare

18,230 8,064 44%

Hotel

20,778 8,711 42%

Ground transport/Car Rental

8,267 3,189 39%

Conference Registration

10,073 3,909 39%

Per diem

8,844 2,767 31%

Mileage/Gas

3,176 389 12%

Total Travel

69,368 27,029 39%

Supplies

Program Supplies- Direct Cost

1,752 919 52%

Computer/equipment

4,720 2,151 46%

Total Supplies

6,472 3,070 47%

Contractual

Computer & Web Support

5,180 1,750 34%

Consulting

56,589 32,719 58%

Reports and Projects

271,377 90,247 33%

Total Contractual

333,146 124,716 37%

Other Operating Expenses

Dues & Memberships

13,000 3,960 30%

Credit Card Processing Fees

1,100 1,947 177%

Legal

1,000 732 73%

Trainings/Events (6500)

128,156 115,847 90%

Meeting Staff/Board (6608)

2,900 107 4%

Printing/Outreach

500 112 22%

Staff/Board Development (6615)

2,760 1,050 38%

Recruitment Expenses

500 964 193%

Taxes & Licenses

75 51 68%

NVCC Operating Expenses

8,000 1,661 21%

Notes

MAs to start training program in March 25

AC24 registrations

AC24 sponsorships \$28,500; starting AC25 fundraising this month

AC24 cc processing fees

AC24

Recruitment for bookkeeper position; filled and employee started Oct 22



NVPCA Financial Statement

YTD Target 41.7%

* Notes provided for variances + / - 25% of YTD target
17%
67%
NB= Not Budgeted

Shared Costs
Audit
Auto Lease
Alarm
Bank Charges
General office supplies
IT Services
Janitorial
Insurances
Occupancy Costs
Software Subscriptions
Telephone & Internet
Total Other Operating & Shared

Pass Through
Pass through Contracts- Title X
Pass through Contracts- TPP PREP
Pass through Contracts- MACH
Total Pass Through
Total Expenses
INCOME OR LOSS

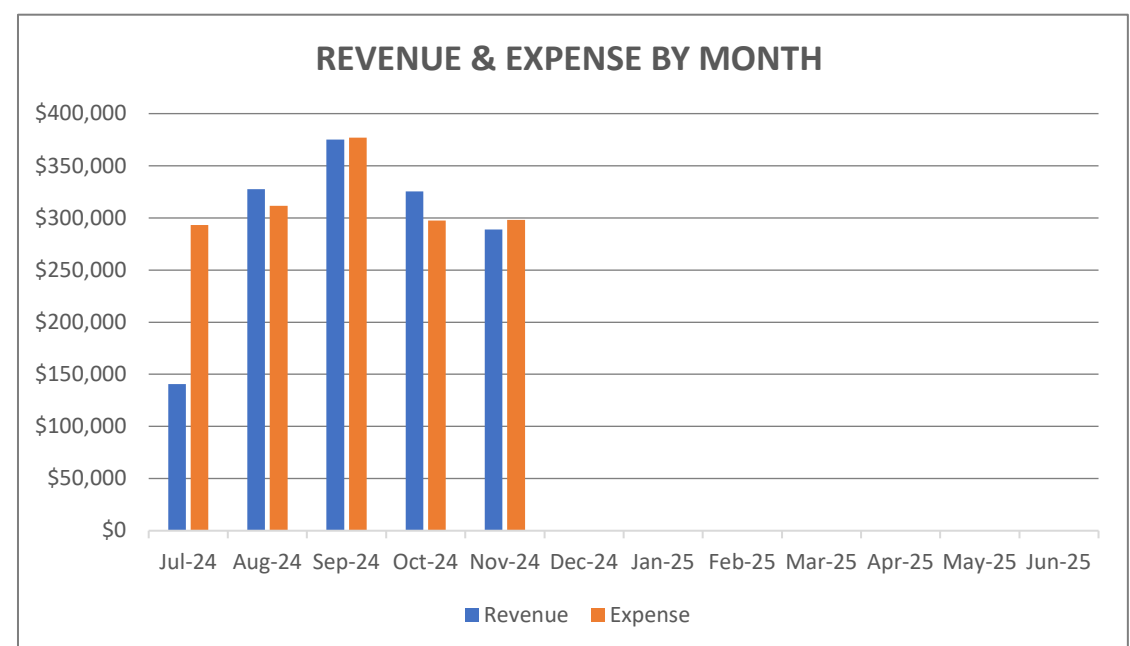
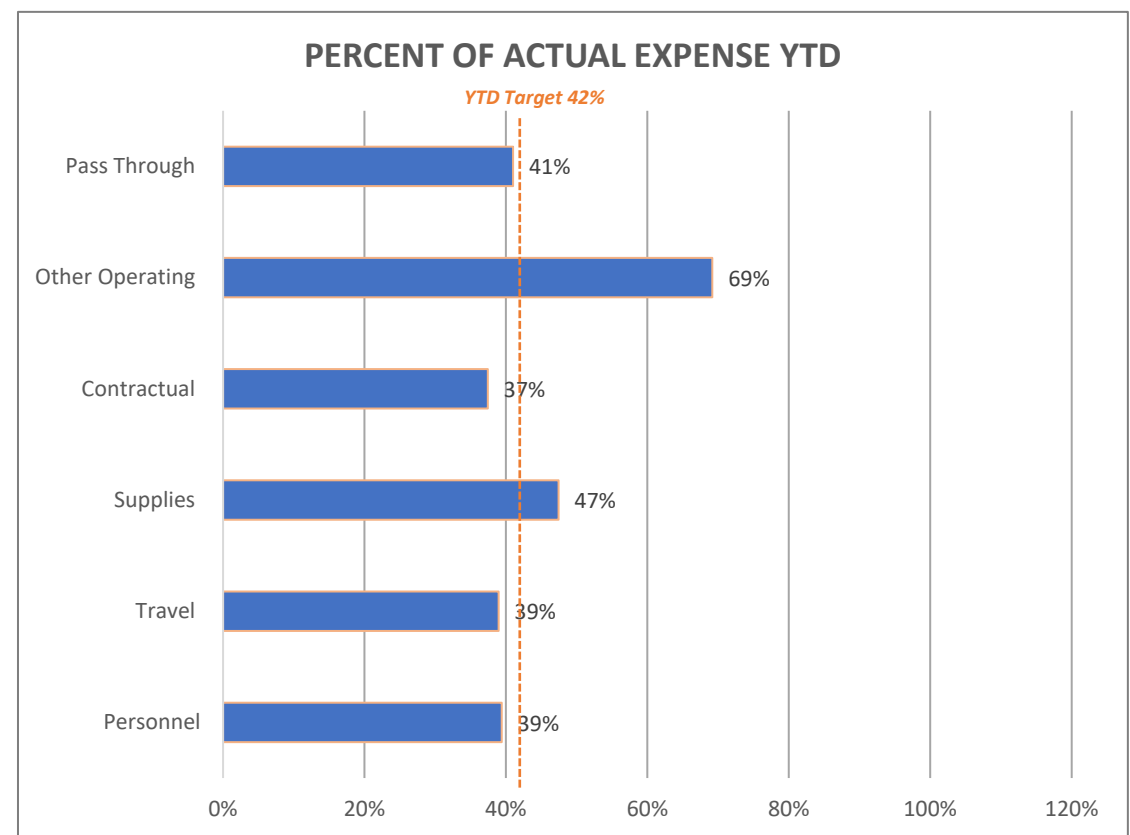
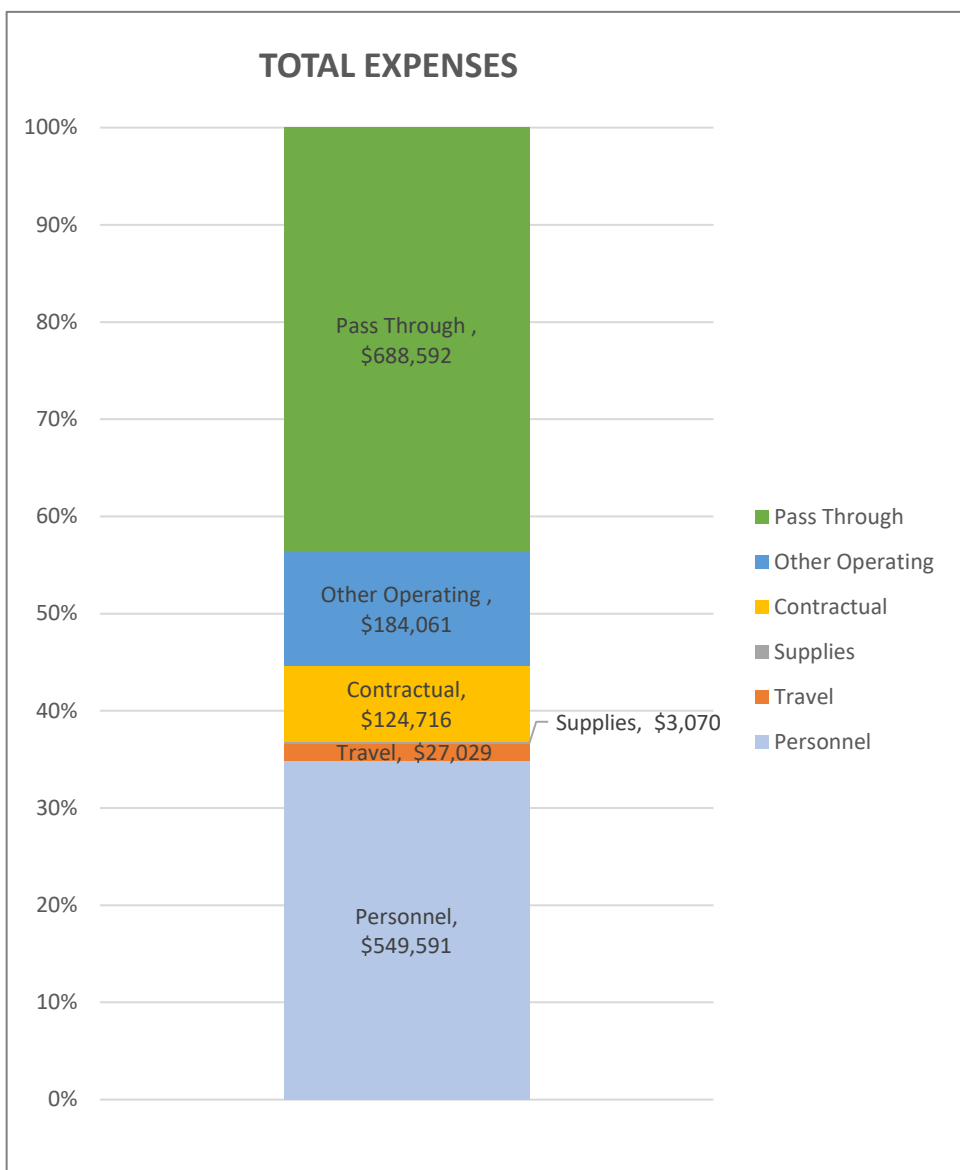
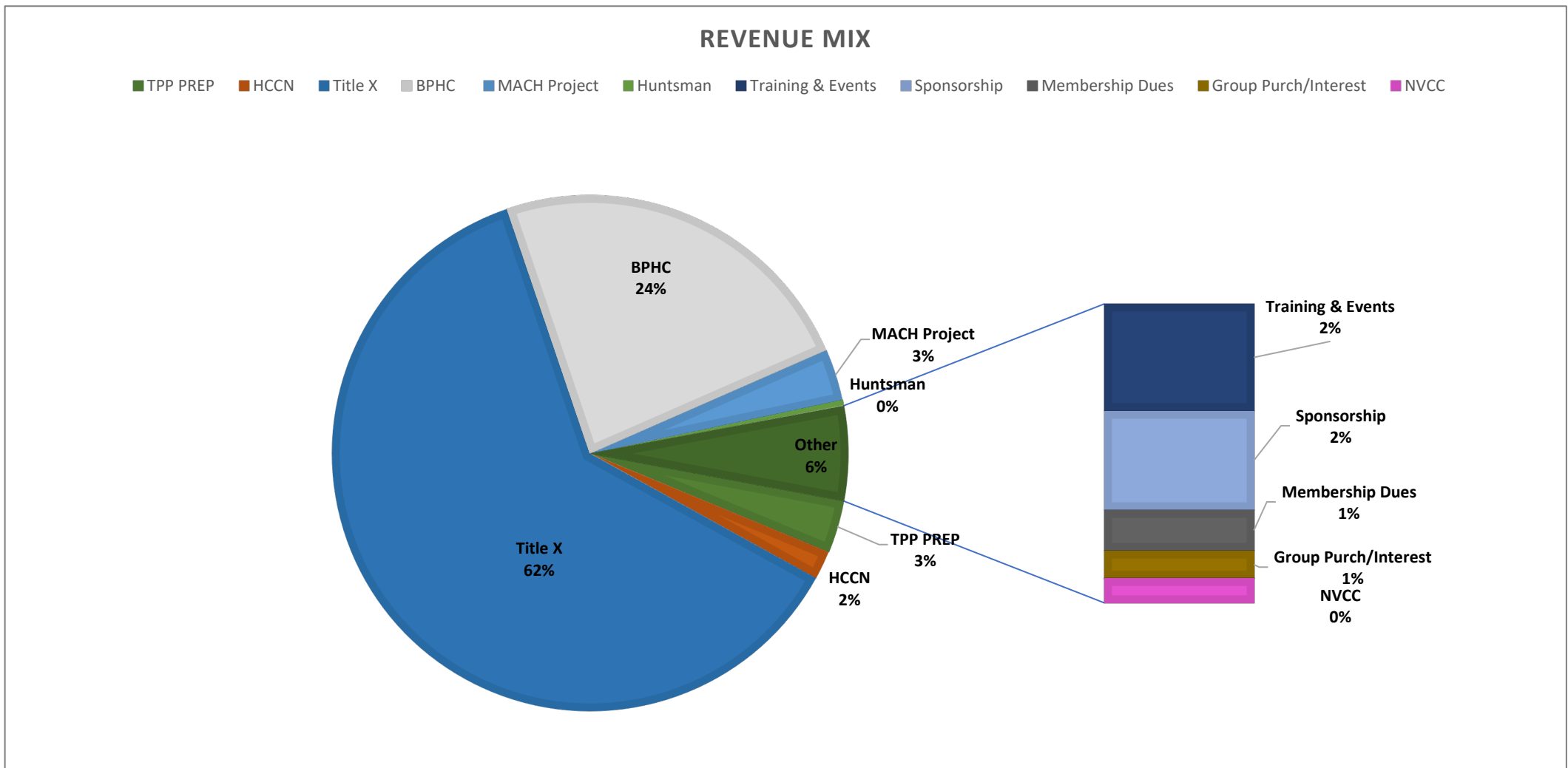
APPROVED			
BUDGET	YTD	% of	
Jul 2024-Jun 2025	Nov-24	Budget	Notes
19,000	18,700	98%	FY24 audit completed
7,453	3,001	40%	
678	282	42%	
144	53	37%	
3,000	688	23%	
NB	3,215		Outsourcing IT services; using staff salary & janitorial funds
3,000	0	0%	No longer using a service; funds will be used towards outsourced IT
11,000	5,477	50%	
32,256	13,184	41%	
23,000	10,000	43%	
8,543	3,029	35%	
266,065	184,061	69%	Audit and AC24 expenses recognized
1,455,166	657,434	45%	
64,404	31,158	48%	
140,000	-	0%	
1,679,170	688,592	41%	
3,748,995	1,577,059	42%	
(169,469)	(119,569)	71%	

Net assets released from purpose restrictions (Population Health Project, Intermountain Project, Molina, and SilverSummit Community Investment Project)
Adjusted Income or Loss

200,256	98,486	49%
30,787	(21,083)	

AC24 expenses recognized; AC25 sponsorship not in revenue yet

Financial Dashboard Report July 1, 2024 – November 30, 2024



	8-24	9-24	11-24	1-25	3-25	5-25	Avg
Days cash on hand* Goal = 60	63	59	60				61
Current ratio*	2.1	1.9	2.2				2.0

*Days cash on hand & current ratio are calculated without Pop Health, Molina Project, SSHP Project and CGM Project restricted funds.

Nevada Primary Care Association

Nevada Primary Care Association
Board Meeting – January 7, 2025
Item 4a

Statement of Financial Position

As of November 30, 2024

	TOTAL	
	AS OF NOV 30, 2024	AS OF NOV 30, 2023 (PY)
ASSETS		
Current Assets		
Bank Accounts		
1020 NVPCA Bank of America Checking	70,662.65	37,236.81
1030 Live Oak Savings	405,440.84	431,463.23
Total Bank Accounts	\$476,103.49	\$468,700.04
Accounts Receivable		
1200 Accounts Receivable	259,663.87	167,589.13
Total Accounts Receivable	\$259,663.87	\$167,589.13
Other Current Assets		
1300 Undeposited Funds	0.00	0.00
1320 Prepaid Expense	0.00	0.00
1323 Insurance	12,863.00	12,361.51
1324 Prepaid Training Expense	0.00	0.00
1325 Prepaid Rent	0.00	0.00
1328 Software Subscriptions	2,656.04	2,158.00
1329 Auto Insurance	2,318.48	1,923.52
1330 Cyber Insurance	834.62	713.48
1331 D&O Insurance	2,164.62	2,026.50
1332 General Liability Insurance	886.59	600.89
1333 Workers Comp Insurance	2,340.68	2,335.76
Total 1320 Prepaid Expense	24,064.03	22,119.66
1340 Petty Cash	58.38	0.74
2120 Payroll Asset	0.00	0.00
2130 Payroll Corrections	0.00	
Total Other Current Assets	\$24,122.41	\$22,120.40
Total Current Assets	\$759,889.77	\$658,409.57
Fixed Assets		
Other Assets		
1500 Rent Deposits	2,498.00	3,100.00
1510 ROU Asset	108,941.95	
Total Other Assets	\$111,439.95	\$3,100.00
TOTAL ASSETS	\$871,329.72	\$661,509.57

Nevada Primary Care Association

Nevada Primary Care Association
Board Meeting – January 7, 2025
Item 4a

Statement of Financial Position

As of November 30, 2024

	TOTAL	
	AS OF NOV 30, 2024	AS OF NOV 30, 2023 (PY)
LIABILITIES AND EQUITY		
Liabilities		
Current Liabilities		
Accounts Payable		
2000 Accounts Payable	232,754.57	118,422.16
Total Accounts Payable	\$232,754.57	\$118,422.16
Credit Cards		
2100 BofA Credit Card VISA 6161	0.00	0.00
2105 B of A MASTER CARDS 1454	9,211.66	7,836.15
Total Credit Cards	\$9,211.66	\$7,836.15
Other Current Liabilities		
2115 Direct Deposit Payable	0.00	
2250 NVCC Reserve	10,000.00	10,000.00
2300 Goni Lease Liability	108,244.11	
2301 Lease Liabilities	1,956.04	
2500 Payroll Liabilities	15,544.81	288.06
2530 Accrued Retirement Benefit (IRA)	0.00	0.00
2540 Accrued Vacation	16,572.95	19,034.79
2700 Accrued Expense	0.00	0.00
2900 Deferred Income	0.00	3,165.39
Total Other Current Liabilities	\$152,317.91	\$32,488.24
Total Current Liabilities	\$394,284.14	\$158,746.55
Total Liabilities	\$394,284.14	\$158,746.55
Equity		
3000 Equity	9,942.41	9,942.41
3020 Accumulated Earnings	61,034.31	61,034.31
4000 Retained Earnings	525,638.23	523,700.53
Net Revenue	-119,569.37	-91,914.23
Total Equity	\$477,045.58	\$502,763.02
TOTAL LIABILITIES AND EQUITY	\$871,329.72	\$661,509.57

Call for Applications - 2025 CareSource Rural Nevada Investment

Applications accepted until **Friday, January 10, 2025, 5 PM Pacific**

NVPCA is administering up to \$175,000 of CareSource funds to improve (in priority) behavioral healthcare and primary care in rural Nevada. This opportunity is available to an NVPCA member that is an FQHC, FQHC Look-Alike, or Tribal Health Center headquartered in Nevada as of 10/1/2024. More than one project may be submitted per applicant.

❖ **Submit applications by following this [link](#).**

Upon receipt of each submission, NVPCA will verify the application with the organization's CEO or Executive Director, to confirm approval of the project's purpose, budget, and timeline. Upon approval confirmation, NVPCA will evaluate the application for funding.

-
1. This opportunity is available to an NVPCA member that is an FQHC, FQHC Look-Alike, or Tribal Health Center headquartered in Nevada as of 10/1/2024.
 2. Projects to commence February 1, 2025, and must be completed by July 31, 2025.
 3. The sum of all eligible and awarded projects will total at least \$175,000. More than one project may be submitted per applicant.
 4. Award recipient will submit a progress report and a final report to document and highlight the success of your project(s). Reports must be submitted by the following dates:
 - a) Progress Report – April 18, 2025, 5 PM Pacific; 2 page maximum.
 - b) Final Report – August 22, 2025, 5 PM Pacific, for project fully completed by July 31, 2025; 2 page maximum plus budget form.
 5. More than one project may be proposed; submit separate applications.
 - a) Expanding high-quality behavioral health services to rural Nevadans
 - b) Expanding access to comprehensive primary care for rural Nevadans
 6. Following is a sampling of requested information on the application:
 - a) Brief Overall or Strategic Project Description
 - b) Target Rural Audience
 - c) Program Evaluation (What the funding will support)
 - d) Brief Program Budget

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



NVPCA Board of Directors Strategic Growth Committee Meeting Minutes

December 19, 2024

Committee Members Present	Sharon Chamberlain, HOPES; Walter Davis, Nevada Health Centers; Teri Gilbert-Eisenga, Washoe Tribal Health Center; Ex Officio: Nancy Bowen; and NVPCA staff: Steve Messinger, Policy Director
Committee Members Absent	Tina Alicea, Safe Harbor Medical
Also Present	CJ Hansen, Diego Martinez, John Packham, Oscar Delgado, and Lisa Scurry (Note Taker)

1. Call to Order

Committee Chairperson Sharon Chamberlain called the meeting of the NVPCA Strategic Growth Committee to order at 12:02 pm. The meeting was conducted electronically via Teams. A quorum of members was established.

a) Approval of the Agenda

The agenda was reviewed with no questions or suggested changes. It was moved by Walter Davis, and seconded by Teri Gilbert-Eisenga, to approve the agenda as presented. The motion passed unanimously.

2. Discussion

- a) Purpose of the committee
- b) Review of last Capital Link reports from 2020 & 2022
- c) What is the goal of the updated strategic growth plan?
- d) Next steps

Chairperson Chamberlain stated the purpose of the committee was to create a model with a tactical plan for growth. She asked the other members for their thoughts and comments.

Davis asked what kind of growth they are discussion and what does the plan for access to care look like. He suggested they look at joining forces to address areas of need.

Hansen agreed and stated that there may be areas where the health centers can collaborate to close gaps for the underserved.

Bowen added that once a plan is developed, additional sources of funding can be sought.

Chamberlain stated that the health centers must all be transparent in their individual growth strategies.

After reviewing the data included in the Capital Link report:

Action Item: Data collection - add links to other sources of data under Appendices such as community needs assessments, the statewide health assessment from the Office of Statewide Initiatives, etc.

The timeline for the project was discussed. Davis suggested that it was vital to get started quickly and to have a one-year plan with the ability to extend out to a 2nd and 3rd year.

Gilbert-Eisenga asked about look-alikes and tribal health centers and suggested their data be added. She said there is a competitive impact to the work.

Hansen stated the committee needs to evaluate those areas where the most vulnerability exists to someone moving in (i.e. from California), and be more proactive about getting established in those areas.

Messinger made comment regarding penetration into zip codes in both the Reno and Las Vegas areas. He said the data indicates there is plenty of room to grow in those areas. As an example, he said that in Vermont there is a 97% penetration rate. In Nevada less than 10% of patients are being served.

After further discussion it was decided that there is not enough access because there are too few locations for patients. This led to a discussion about how much capacity each health center has and that they should each provide that information as well.

Gilbert-Eisenga added that Nevada is still more than 80% frontier or rural and asked how those patients can be reached.

It was decided that the individual growth plans need to be gathered. In alignment with that information, the data will be evaluated.

Action Item: A Sharepoint site will be started with a spreadsheet for each CEO to enter their health centers information related to growth plans. The sheet will go out 18 months. The information should be returned not later than January 15.

Action Item: Quarterly meetings are not frequent enough. A meeting will be scheduled for early February.

3. Meeting Adjournment

There being no further business, Chairperson Chamberlain adjourned the meeting at 12:50 pm

**PROTECTING MEDICAID FOR COMMUNITY HEALTH CENTERS AND THEIR PATIENTS:
A NATIONWIDE, PCA-LED, STATE-BASED STRATEGY**

December 9, 2024

Community health centers (CHCs) are a vital health care resource for their patients, and the communities they serve. Now in their 60th year, CHCs have provided high-quality, comprehensive, affordable primary and preventive care, dental, behavioral health, pharmacy, vision, and other essential health services nationwide; they work in thousands of urban and rural communities, serving over 31 million patients, about 1 in 10 people, at over 16,000 locations in rural, urban, suburban, frontier, and island communities, without regard to ability to pay. Seventy percent of all CHC patients live in poverty; 90 percent have family incomes below twice poverty. About 10 million rural residents (1 in 5 residents) rely on health centers, along with 1 in 8 U.S. children, about 4 million older adults, and about 400,000 veterans. In 2023, CHCs provided about 57 million distinct patient visits and serve as the patient-centered medical homes to almost 8 million patients undergoing chronic disease management.ⁱ

Medicaid is far and away the single most important source of insurance coverage for health center patients; it is also the lifeblood of CHCs, not only because of the operating revenue it provides but because, by insuring their patients, Medicaid enables health centers to provide or arrange for comprehensive care, including care typically not found in the health center itself. Examples include advanced treatment and management of life-threatening heart conditions and cancer treatment – services that simply would be out of reach without Medicaid. Medicaid, by far, is the dominant source of revenue on which CHCs depend as the principal financial means for serving the entire community with comprehensive care. (The deeply subsidized insurance available to near-poor health center patients through the ACA health insurance marketplace plays a major role as well, especially for CHCs operating in states that have not expanded Medicaid to all low-income working adults).

Medicaid, along with health insurance marketplace subsidies, now faces an existential threat, and therefore, so do health centers and the patients that depend on Medicaid. If fully enacted, the Medicaid reform proposals now on the table would cut the program by nearly 2 trillion dollars over a decade, fundamentally crippling not only states' ability to effectively and comprehensively insure their residents but also CHCs' operations. Plainly put, CHCs would, if they survive, become a shadow of their former selves. Health care for approximately 80 million children and adults – 1 in 5 of them CHC patients – is under fundamental threat.

To meet the challenge of preserving Medicaid from such a fundamental threat, the nation's 52 state and regional Primary Care Associations (PCAs), which represent and work on behalf of CHCs in their states and regions, propose to join forces to mount a state-based effort to help stop these cuts. Because of where CHCs are, whom they serve, and the deep regard in which they are held, bringing a strong, nationwide, health center voice to every Congressional district and state is simply essential at this critical time in the life of the Medicaid program. Similarly, CHCs can add enormously to the effort to avert deeply damaging reductions in the ACA insurance subsidies on which their patients depend.

To this end, a national PCA network, working in collaboration with Advocates for Community Health (ACH-a national CHC' membership organization with broad reach), propose to build a multi-faceted, state-based initiative that can: build public awareness about Medicaid's vital role for 80 million people and every U.S. community and the importance of averting any diminution of its mission; educate policymakers about the importance of preserving Medicaid's ability to fulfill its many missions; and

ensure that CHCs, which are so vital to Medicaid’s health care mission and to a healthy nation, are equipped and supported to fully engage in the effort. Bi-State Primary Care Association, which serves Vermont and New Hampshire, will serve as one of the leads and the coordinating home for this effort.

To carry out this mission, the initiative will rely on evidence-based impact analyses conducted by George Washington University’s Geiger Gibson Program in Community Health.

This nationwide, state-based, PCA-led initiative to protect Medicaid effort will be led by Bi-State PCA, the Missouri PCA, with support from Advocates for Community Health, PCA Leadership Council (a leadership body of PCA’ CEOs across the nation representing each of the 10 regions) and work disseminated reaching each PCA through the “PCA Hub” (a 52 State and Regional Primary Care Association Hub representing the PCAs’ nationally). To note, PCAs have had enormous success working together for years, and we have built strong trusting relationships amongst each other across the nation.

**Workplan to demonstrate the value of Medicaid and analysis of Medicaid Reform;
National and Statewide strategy for PCAs on behalf of CHCs and their patients**

Goal 1: Create a coordinated national and state public awareness campaign

- Create a coordinated multifaceted effort to build public awareness, influence lawmakers and mobilize key stakeholders. Data driven strategy, targeted communication, grassroots mobilization, and coalition building with clear compelling narrative on the impacts of Medicaid Reform. The campaign will focus on financial, economic, and human impact.
- Thought leaders and stakeholders:
 - Team lead-Orchestrate and coordinate (Bi-State PCA and Missouri PCA)
 - Communication and Distribution of Messaging Lead (PCA Leadership Council, PCA Hub, ACH)
 - Research, policy and legal analysis (GWU)
 - Political liaison (ACH, Potomac Strategic, PCAs)
 - Grassroots mobilizer leads (ACH, and PCA Hub)

Goal2: Gather Data and Impact; Create data and impact statements at the national, state and Congressional District level on Medicaid Reform

- GWU will create data and impact statements
- Socialize the data and impact regarding Total Medicaid beneficiaries and total state and federal financing including traditional and CHIP FMAP, Enhanced Medicaid Expansion, Provider Taxes and IGT transfers
- Analyze and create impact statements of Medicaid reform by state and Congressional District: number of people affected, services at risk, impact on the health care provider community eco system
- Create impact statement for PCAs on behalf of each CHCs- CHC’ Boards and their patients for public dissemination

Goal3: Grassroots Mobilizing and Building Allies: Work with PCA towards a statewide grassroots mobilization plan on the impact statements of Medicaid with a central aim to work with Members of Congress in Leadership, Key Committees, Influencers, and other value-added reasons.

- PCAs and ACH to create a targeted state by state grassroots Congressional mobilization plan
 - Coaching and training support from peer PCAs, ACH and other experienced leaders

- Concentrate the work in states with high value Members of Congress
- Identify key allies and joint efforts:
 - Health Care providers (CHCs, Hospitals, Long Term Care, Mental and Behavioral Health Centers, Medical Society, Home Health etc.)
 - Advocacy Groups (AARP)
 - Congressional Champions (Current and Past Members of Congress, Governors, State Legislative leaders)
 - Past Medicaid Expansion allies
 - Chamber of Commerce (labor/workers would be impacted)
 - Data allies including local Chapters of Center on Budget and Policy Priorities (CBPP), AARP, Disability Rights, etc.
- Work with state allies on impact to Mental and Behavioral Health providers, urban and rural Hospitals, Long term care and disability community, Medical Society provider community, Home Health partners
- Work with Governors and State Medicaid Directors on financial, economic and human impact
- Create Engagement Plan
 - CHCs and their Board of Directors, Local business community
- Create Digital strategy
- Public engagement plan
 - Create public relations and media strategy
- Create thoughtful and strategic Congressional Legislative Strategy:
 - Identify key lawmakers,
 - Identify allies and thought leaders,

Goal4: Messaging and narrative development

- Develop clear and compelling messages on Medicaid Reform effects on states, CHCs and their patients
 - State budget
 - Local and municipality budgets
 - Cost shifting to states, healthcare providers, individuals
- Develop patient stories-Key to the work is to elevate the patient and their story
 - Include low-income families, elderly individuals and those w/ chronic illness and disabilities.
 - Assure impact statements focus on access, state budget pressures, economic impact, workforce, health disparities, necessity of broad health care coverage for Medicaid vulnerable populations.
 - Create statements by Members of Congress District
- Messaging distribution
 - Create diversified action plan
 - Consider Media outlets, lobbying, public figures, influencers

ⁱ Health Resources and Services Administration (HRSA). “National Health Center Program Uniform Data System (UDS) Awardee Data.” <https://data.hrsa.gov/tools/data-reporting/program-data/national>

Medicaid proposals December 5

Sara Rosenbaum, J.D.
Emerita Professor,
Health Law and Policy



Current and past savings proposals

- Reduce FMAP for ACA expansion population (20m people, \$50b in 2025 alone, 14b state costs to 64b state costs in 2025)
- Reduce expansion eligibility to 100% FPL
- Reduce overall FMAP- eliminate 50% floor (10b/year alone to NY and CA; 2.3/year in MA)
- Per capita caps – ~1 trillion/10 years
- Eliminate provider taxes (~1 trillion/10 years)
- Eliminate IGTs and CPEs – 100s of billions/10 years
- Mandate state work requirements or face total funding loss for affected populations – AR (97% people losing coverage were working; GA (5000 out of estimated 240,000 eligible enrolled
- End enrollment and renewal streamlining (and restore asset test) – multiple eligibility checks/year

New state flexibilities to address funding loss

- Eliminate eligibility groups
- Eliminate benefits
- Reinstate cost sharing and premiums
- Cap enrollment
- Eliminate provider payment rules (e.g., DSH, PPS)

Timing and Impact

- First reconciliation bill, effectively as tax package offset
- Second reconciliation bill just because
- House – 1 vote margin now; perhaps 3 later this year
- Impact: state health systems; state economic stability

<https://www.cbpp.org/research/health/medicaid-threats-in-the-upcoming-congress>

THE GEORGE
WASHINGTON
UNIVERSITY

WASHINGTON, DC

**National Health Care Policy Think Tank (HCP-TT) - Meeting on Medicaid with Dr. Sara Rosenbaum
December 5, 2024
Summary and Resources**

Agenda:

Dr. Rosenbaum asked that attendees review the following documents as they will be instructive to the conversation:

1. The Paragon Health Institute's Medicaid financing reform paper from July 2024
<https://paragoninstitute.org/medicaid/medicaid-financing-reform-stopping-discrimination-against-the-most-vulnerable-and-reducing-bias-favoring-wealthy-states/>
2. The KFF Medicaid expansion state report
<https://www.kff.org/medicaid/issue-brief/medicaid-expansion-is-a-red-and-blue-state-issue/>
3. The Center on Budget and Policy Priorities report on Medicaid threats in the upcoming Congress
<https://www.cbpp.org/research/health/medicaid-threats-in-the-upcoming-congress>

Key Takeaways:

- There are changes expected to Medicaid, administratively and legislatively, under a new Administration and Congress.
 - See Dr. Rosenbaum's slides for a list of these specific proposals (attached).
 - A recent Center on Budget and Policy Priorities report outlines the various Medicaid proposals being discussed by Republicans (see link at end of page).
- Dr. Rosenbaum expects to see the budget reconciliation process used to enact most of these changes – The Republican party is expected to put together two reconciliation packages in 2025.
 - The budget reconciliation process only requires a simple majority and is filibuster-proof in the Senate. Reconciliation allows for expedited consideration of certain tax, spending, and debt limit legislation. This process has real advantages for enacting budget and tax measures for the majority party.
- The proposals are designed to alter federal funds to Medicaid. Either by cutting federal funding by reducing the Federal Medical Assistance Percentage (FMAP) or to thwart states to generate their own expenditures.
- Some of these proposals are projected by the CBO to save the federal government \$2 trillion over 10 years. This number aligns with the Department of Government Efficiency's (DOGE) stated goals.
- Reducing the FMAP for the Medicaid Expansion (MedEx) population – over 20 million people nationally – will result in the elimination of millions of dollars from state budgets.
- 40 states and the District of Columbia have expanded Medicaid. There are 12 states with trigger laws.
- Other proposals include dropping MedEx eligibility to 100% of FPL, reducing the regular FMAP to below 50%, instituting per capita caps (could generate \$1T over 10 years), eliminating states' ability to use provider taxes (could generate \$1T over 10 years; see CRS report on provider taxes at end of document), instituting Medicaid work requirements, and rolling back enrollment and renewal streamlining measures, restoring asset tests, and instituting multiple eligibility checks.
 - About 70% of the 18-64 Medicaid population works – and if not typically because of a disability.

- States would likely get new flexibilities to address funding losses stemming from these proposals, including the flexibility to eliminate eligibility groups and benefits, reinstate cost sharing and premiums, cap enrollment, and eliminate provider payment rules including DSH and PPS.
 - Republicans may make these cuts but also provide states new flexibilities
- The timing is uncertain. We should expect to see changes included in one or both anticipated budget reconciliation packages next year, as soon as spring/summer 2025 and as late as fall 2025.
 - The House will have a one-vote margin next year until special elections in the spring – then they will only have a three-vote margin.
- Collectively we will need to demonstrate the impact of these changes including the effect on state health systems and state economies.
- Geiger Gibson will be leading the impact and legal analyses of these proposals, including analysis of each state’s trigger laws for MedEx.
- PCAs will lead education and advocacy efforts.
 - Tess is organizing opportunities for PCAs to work collectively on the grassroots strategy/mobilizing.
- We should also engage other organizations/coalitions like the Partnership on Medicaid, the Center on Budget and Policy Priorities, and Protect Our Care and coordinate efforts and resources.

Attendees:

Sara Rosenbaum
Feygele Jacobs
Alan Pruhs
Amy Behnke
Elena Nicolella
Marc Wetherhorn
Darcy Shargo
Jessica Yanow
Shannon Attanasio
Chuck O’Neal
Cindy Stergar
Bruce Gray
Gerrelda Davis
Molly Lewis
Libby Thurman
Sara Barry
Shannon Bacon
Robert Gomez
John Su
Dr. James Hellinger
Dan Hawkins
Colleen Meiman
Peter Epp
Joe Dunn
Tess Kuenning
Rebecca Rocheleau

Resources from meeting:

Center on Budget and Policy Priorities

Medicaid Threats in the Upcoming Congress, December 2024

<https://www.cbpp.org/research/health/medicaid-threats-in-the-upcoming-congress>

KFF Health News

9 States Poised To End Coverage for Millions if Trump Cuts Medicaid Funding, December 2024

<https://kffhealthnews.org/news/article/medicaid-expansion-funding-trigger-laws-9-states-trump-administration/>

Kaiser Family Foundation

Medicaid Expansion is a Red and Blue State Issue, November 2024

<https://www.kff.org/medicaid/issue-brief/medicaid-expansion-is-a-red-and-blue-state-issue/>

(Arizona, Arkansas, Illinois, Indiana, Montana, New Hampshire, North Carolina, Utah and Virginia)

Paragon Health Institute

Medicaid Financing Reform, July 2024

<https://paragoninstitute.org/medicaid/medicaid-financing-reform-stopping-discrimination-against-the-most-vulnerable-and-reducing-bias-favoring-wealthy-states/>

Congressional Research Service

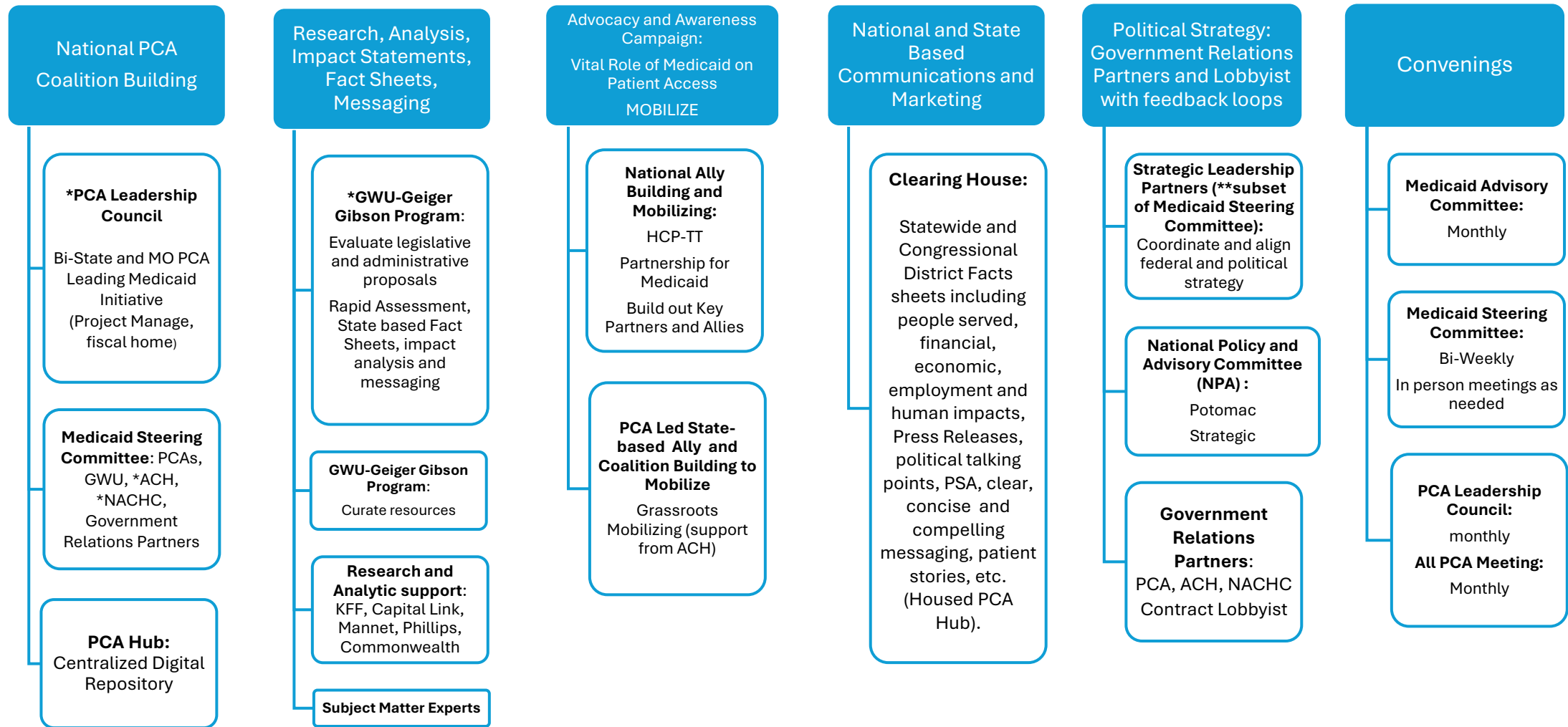
Medicaid Provider Taxes, August 2016

<https://crsreports.congress.gov/product/pdf/RS/RS22843>

(see helpful diagram on page 7)

Medicaid Initiative To Preserve Patient Access

Coalition with Common Agenda to Protect Medicaid for Community Health Centers serving 32 million Americans A Nationwide, PCA-Led State-Based Strategy*



*Strategic Partnership among Advocates for Health (ACH); NACHC, Primary Care Associations (PCAs-Bi-State and MO PCA leads), and The GWU Geiger Gibson Program
Governance:

Medicaid Advisory Committee: Strategic Direction and fund raising

Medicaid Steering Committee: Support Strategic Direction, align federal and political strategy**, advise, input, and support execution

Grassroots Advocacy Relationship Inventory

Overview:

One of the most important tools within any grassroots advocacy campaign is its network of relationships. Strong connections with legislators, community partners, and allies help create a unified voice, amplify efforts, expand influence and reach. A relationship inventory allows you to track and understand your team’s current connections.

Who to Track in this Inventory:

- Elected Officials - local, state, and national
- Partners – nonprofit and for-profit (i.e.: business partners; banking institution, local restaurants, local insurance agency, vendors, etc.)
- Other Leaders & Influencers (Faith based leaders, Community Elders, Athletes, Local Celebrities, etc.)

Tips for Identifying Contacts:

- Remember that you might not be the person with the direct relationship – if you are connected by up to three degrees of separation (i.e.: your neighbor is the cousin of Congressman Smith) it is worth listing that connection.
- All different types of people hold influence – think about those in the community that are respected and influential. It could be the pastor at your church, a social media influencer in the community, a business leader, or someone everyone in the community knows and respects.
- Remember that decisionmakers exist at all levels of government – local, county, state and federal. If you have a relationship with your City Councilor but you have never asked them to support your advocacy efforts with your state or federal policymaker, there is an opportunity to expand your reach and influence.

Name	Relationship	Contact	Notes

NVPCA Board of Directors Policy Update

January 7, 2025

1) Federal Update

- a) Health Center funding expires March 14
- b) P&I call / fly-in February 5

2) 2025 Legislative Priorities

- a) Establish Medicaid GME in health centers
 - i. [SB40](#) establishes the Medicaid Health Care Workforce Account, which allows Medicaid to receive state GME dollars to be matched with federal dollars
- b) Additional 340B protections
 - ii. BDR 54-511 *Prohibits certain activities related to the 340B Drug Pricing Program*

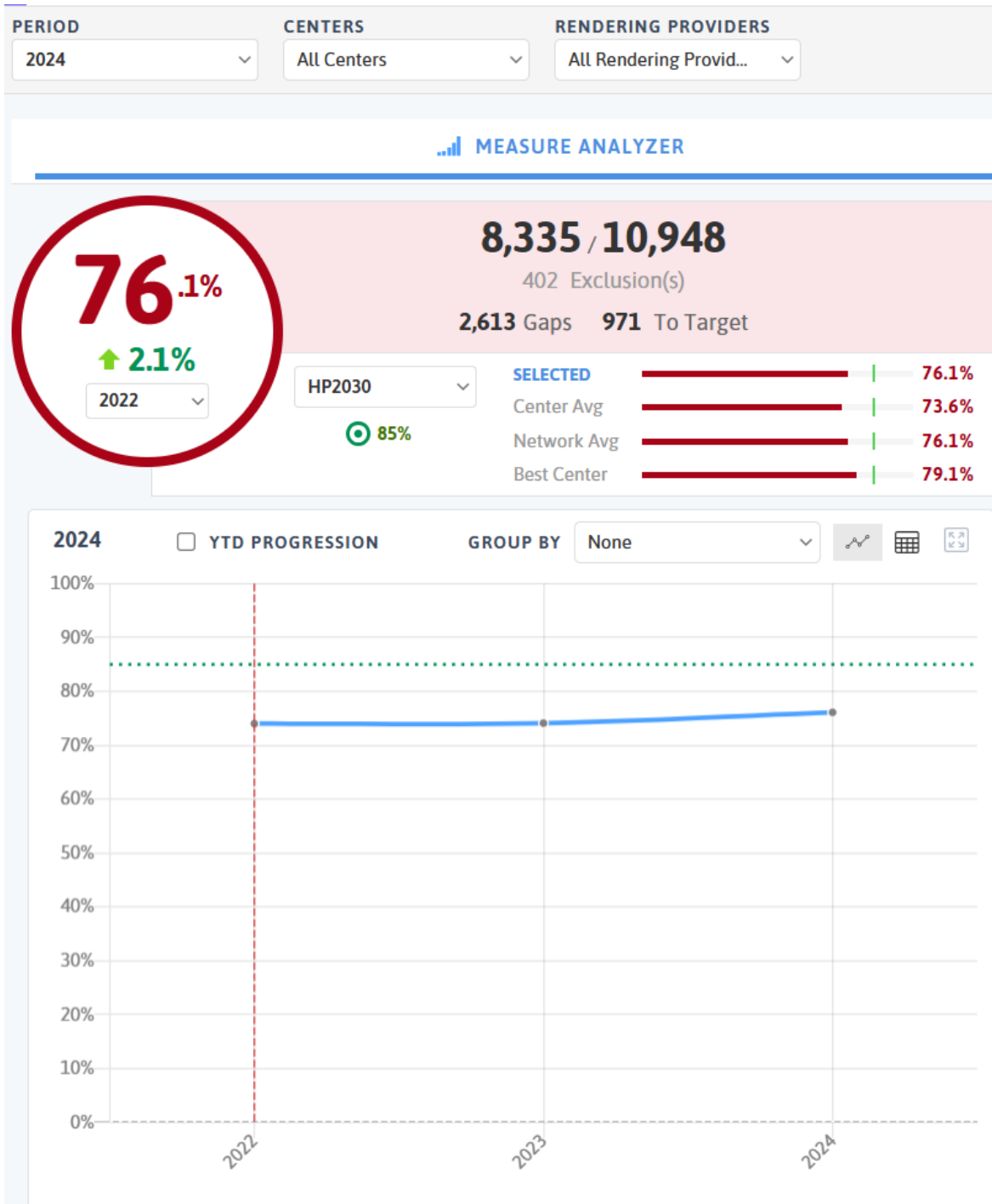
3) 2025 Policy Plan

- a) Drafted by February 2025
- b) Are there any additional legislative priorities health centers are focused on?

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

Azara DRVS Report
December 30, 2024

1) 2024 Year-to-Date UDS Hypertension % for the 3 Health Centers on the NVPCA Network:



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

2) The chart below shows the % of patients with controlled hypertension by social drivers of health. This information can be helpful in deciding where to focus funding resources into SDOH supportive services to improve the % of patients with controlled hypertension.

Comparison		GROUP BY SDOH				
SDOH	RESULT	CHANGE	NUM	DENOM	EXCL	
MIGRANT	100%	0%	2	2	0	
UTILITY	81%	+ 21.2% ▲	56	69	3	
STRESS	80%	0%	169	212	17	
EDU	80%	- 15.5% ▼	196	246	24	
ISOLATION	79%	0%	207	262	17	
LANGUAGE	78%	- 2.2% ▼	3,345	4,307	156	
MED/CARE	78%	0%	189	244	30	
VIOLENCE	77%	- 22.6% ▼	24	31	6	
FPL<200	77%	0%	6,096	7,899	319	
EMPLOYMENT	76%	- 4.4% ▼	155	203	10	
FOOD	76%	+ 4.3% ▲	164	215	22	
TRANSPORT-NONM...	76%	0%	153	202	21	
VETERAN	74%	- 0.5% ▼	155	210	5	
PHONE	73%	0%	22	30	3	
HISP/LAT	73%	- 6.1% ▼	1,545	2,119	53	
RACE	72%	- 2.3% ▼	1,436	1,987	58	
TRANSPORT-MED	72%	- 8.5% ▼	113	158	15	
INCARC	71%	0%	10	14	0	
HOMELESS	71%	- 4.7% ▼	312	442	12	
SAFETY	70%	- 29.6% ▼	50	71	3	
HOUSING	70%	- 7.2% ▼	252	359	19	
CLOTHING	69%	0%	63	91	6	
REFUGEE	67%	- 13.3% ▼	6	9	0	
CHILDCARE	60%	0%	3	5	0	

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

3) 2024 UDS Definition

Hypertension Controlling High Blood Pressure (CMS165v12)

Endorser: None
Steward: NCQA

Patients 18-85 years of age who had an active diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period and whose most recent blood pressure during the measurement period was adequately controlled (<140/90mmHg).

Numerator:

Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period*

- Most recent systolic blood pressure in measurement period < 140 mmHg
- Most recent diastolic blood pressure in measurement period < 90 mmHg

*If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." If multiple readings are taken on the same day, measure will look for the lowest diastolic and lowest systolic values from all readings. The Detail List includes a "Multiple BP" column that shows the lowest systolic and lowest diastolic readings. This means the final reported diastolic and systolic numbers may be a composite of values from different readings. For example, on reading of 150/95 and another of 135/100 would result in a reported value of 135/95.

Denominator:

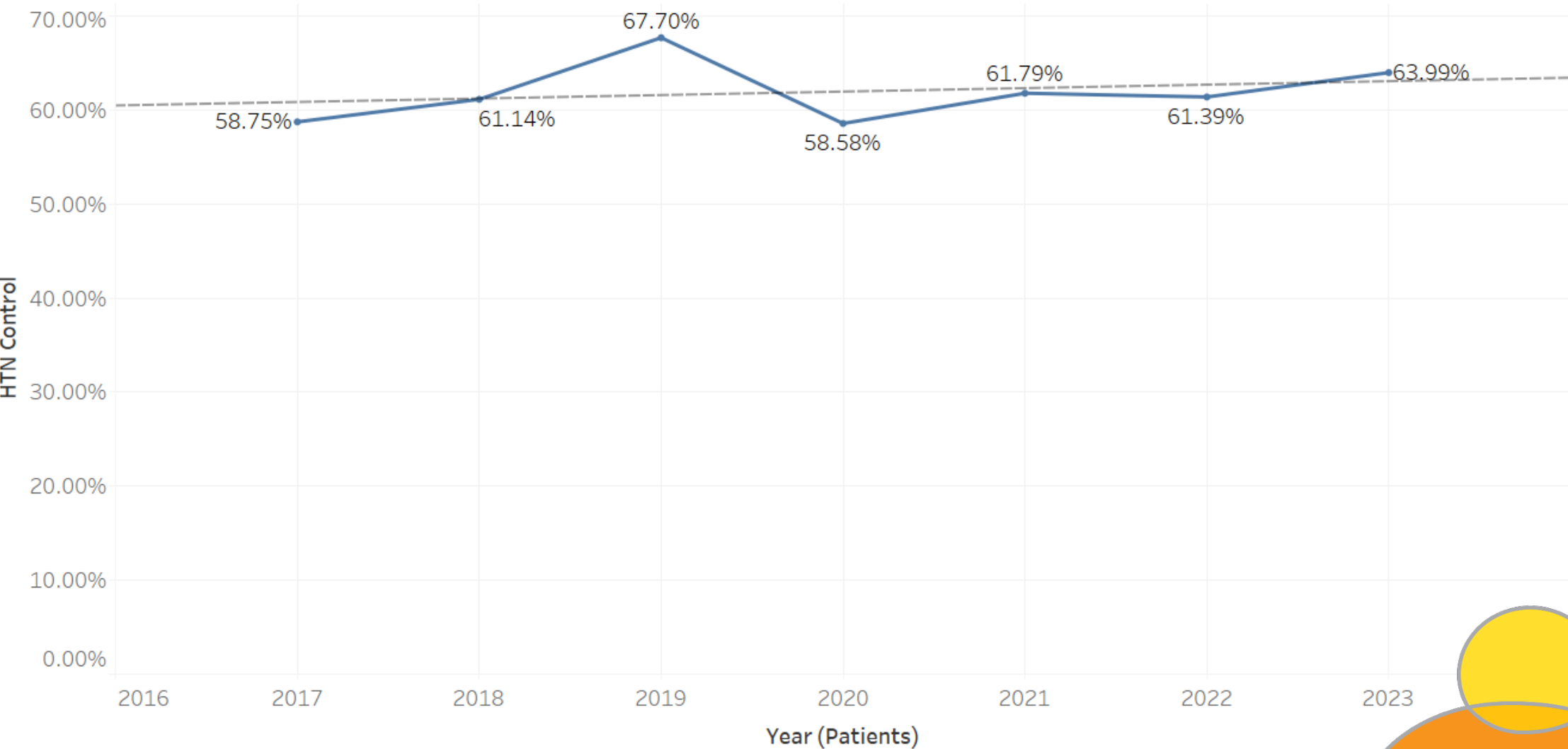
Patients 18-85 years of age by the end of the measurement period who had a visit during the measurement period and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period.

- Age ≥ 18 and < 86 by the end of the measurement period
- Active diagnosis of Essential Hypertension starting before and continuing into, or starting during the first six months of the measurement period.
- Qualifying visit in the last 12 months (see Technical Specifications)

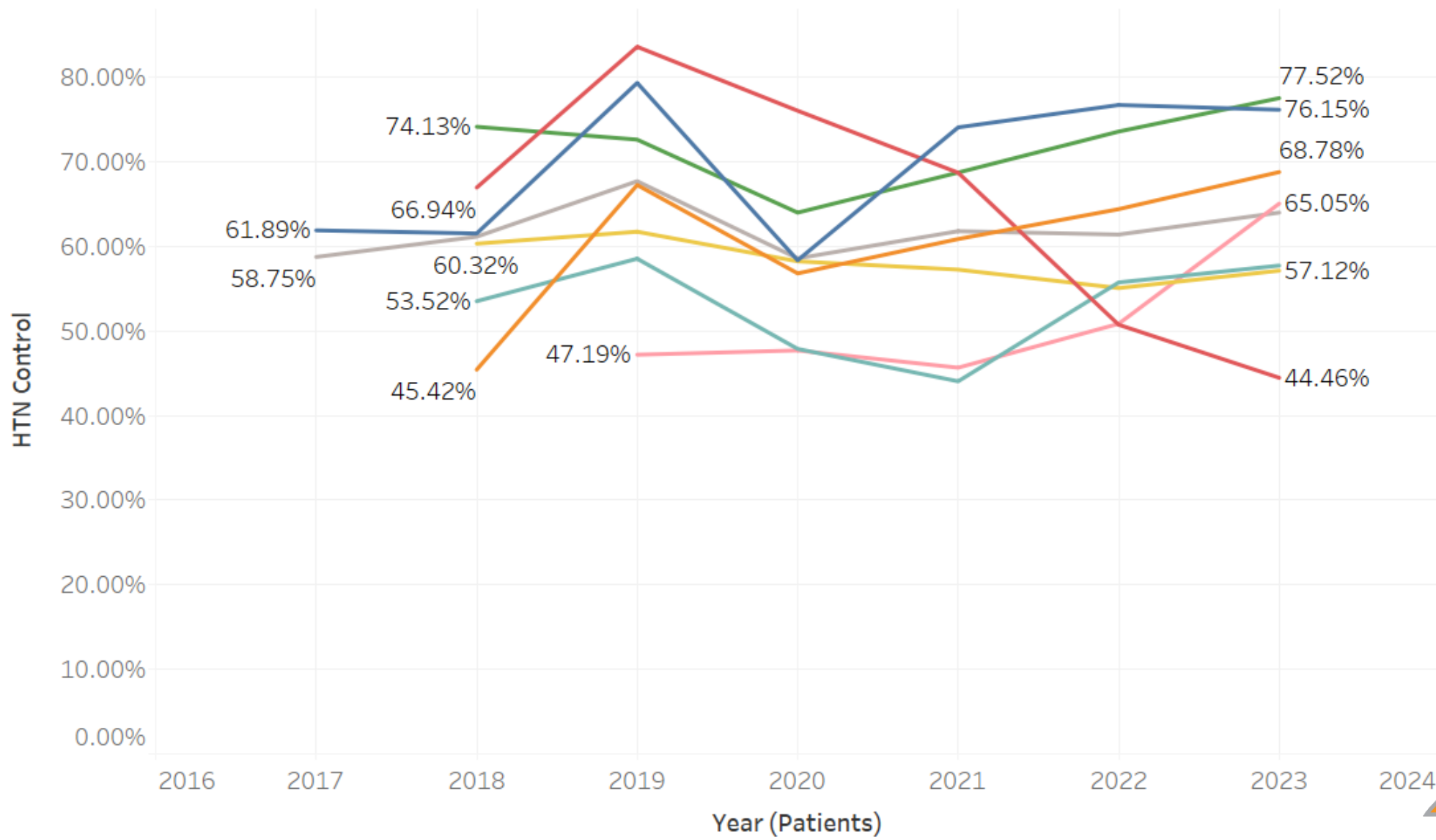
Exclusions:

- Active Pregnancy during the measurement period
- End Stage Renal Disease before or during the measurement period
- Chronic Kidney Disease, Stage 5 before or during the measurement period
- Dialysis, Kidney Transplant recipient before or during the measurement period
- Hospice Care for any part of the measurement period
- Palliative Care for any part of the measurement period
- Age ≥ 66 and older by the end of the measurement period living long-term in a nursing home any time on or before the end of the measurement period
- Age ≥ 66 and < 81 by the end of the measurement period, AND the following
 - Evidence of frailty overlapping the measurement period, AND the following in the two years before the end of the measurement period:
 - > 1 outpatient visit with a diagnosis of Advanced Illness

Controlled Hypertension, statewide



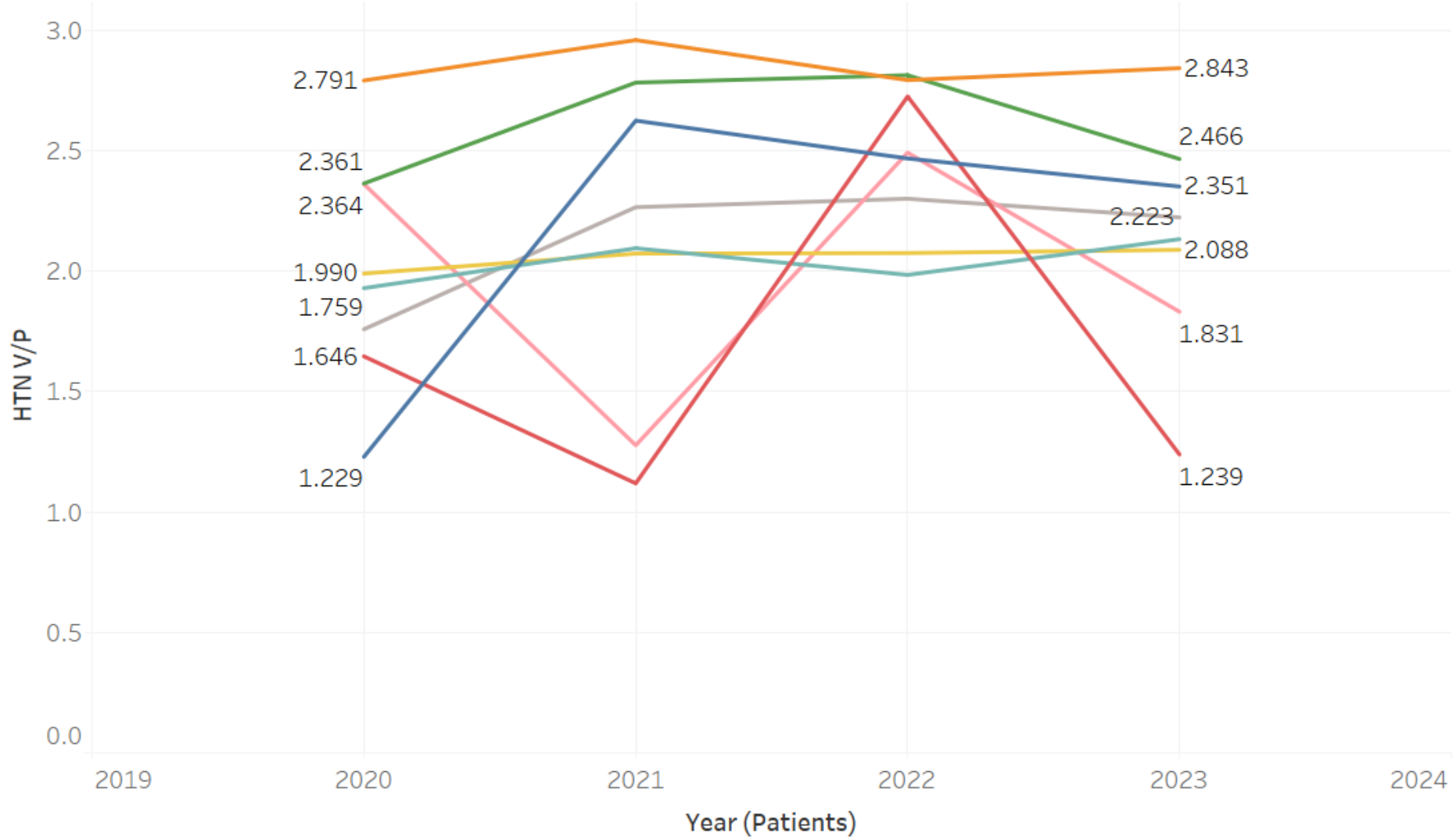
Controlled Hypertension



- Health Center**
- CHA
 - FMHWC
 - FPCC
 - HCHC
 - HOPES
 - NVHC
 - SNCHC
 - Statewide

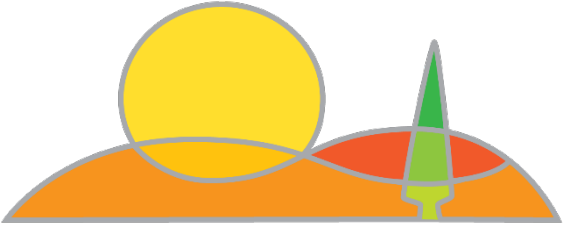


HTN V/P



Health Center (Patients)

- CHA
- FMHWC
- FPCC
- HCHC
- HOPES
- NVHC
- SNCHC
- Statewide



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PRIMARY CARE ASSOCIATION

