Public Meeting

March 2024

community health center board

Multnomah County

Table of Contents

AGENDA

community health center board

Multnomah County

Public Meeting Agenda
March 11, 2024
6:00-8:00 PM (Via Zoom)

Health Center Mission: Bringing services to individuals, families, and communities that improve health and wellness while advancing health equity and eliminating health disparities.

CHCB Board Members Present:

Tamia Deary – Chair
Darrell Wade- Treasurer
Kerry Hoeschen – Secretary
Brandi Velasquez – Member-at-Large
Susana Mendoza- Member-at-Large
Alina Stircu – Board Member
Harold Odhiambo - Board Member

Darnell "DJ" Rhodes - Executive Director (Ex Officio)

- Meetings are open to the public
- Guests are welcome to observe/listen
- There is no public comment period
- All guests will be muted upon entering the Zoom

*Please email questions/comments to **the CHCB Liaison at CHCB.Liaison@multco.us**. Responses will be addressed within 48 hours after the meeting*

Time	Topic/Presenter	Process/Desired Outcome
6:00-6:10 (10 min)	**Call to Order / Welcome** Tamia Deary, CHCB Chair	
6:10-6:15 (5 min)	**Minutes Review - VOTE REQUIRED** February 12, 2024 Public Meeting Minutes	Board reviews and votes
6:15-6:30 (15 min)	**AGN.10.03 ICS Fee Policy - VOTE REQUIRED** Brieshon D'Agostini, Quality and Compliance Officer	Board reviews and votes
6:30-6:50 (20 min)	**Q4 Pt Experience Surveys** Linda Niksich, Program Specialist Senior, Quality Team	Board receives update
6:50-7:05 (15 min)	**Q4 Incidents & Complaints** Kimmy Hicks, Project Manager	Board receives update
7:05-7:15	**10 Minute Break**	
7:15-7:25 (10 min)	**FY25 Health Center/ICS Budget Approval - VOTE REQUIRED** Jeff Perry, Chief Financial Officer	Board reviews and votes
7:25-7:35 (10 min)	**Monthly Financial Reporting Package** Jeff Perry, Chief Financial Officer	Board receives update
7:35-7:45 (10 min)	**Committee Updates** Finance Committee: Darrell Wade, Finance Chair Quality Committee: Tamia Deary, Quality Chair Executive Committee: Tamia Deary, Board Chair	Board receives updates
7:45-7:50 (5 min)	**Executive Director's Strategic Updates** Darnell "DJ" Rhodes - Executive Director	Board receives updates

7:50-8:00 (10 min)	**Board Updates** ***(Closed Executive Session)*** Darnell "DJ" Rhodes - Executive Director	Board discusses confidential matters in an executive session
8:00	**Meeting Adjourns**	Thank you for your participation

PUBLIC MEETING MINUTES

community health center board

Multnomah County

CHCB Public Meeting Minutes
February 12, 2024
6:00-7:30 PM (Via Zoom)

Health Center Mission: Bringing services to individuals, families, and communities that improve health and wellness while advancing health equity and eliminating health disparities.

Board Members:

Tamia Deary – Chair
Darrell Wade- Treasurer
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Brandi Velasquez – Member-at-Large
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Alina Stircu – Board Member
Harold Odhiambo - Board Member

Darnell "DJ" Rhodes - Executive Director (Ex Officio)

Board Members Excused/Absent:

Topic/Presenter	Discussion / Recommendations	Action	Responsible Party	Follow-up Date
Call to Order / Welcome Tamia Deary, CHCB Chair	Meeting begins at 6:03PM We do have a quorum with 6 members present. Alina Stircu joined at 6:26pm Guest: Kallie Caito			
Review January 8th Public Meeting Minutes- **VOTE REQUIRED**	The board reviewed the January 8, 2024 minutes Question: ● Susana asked if January 8th is the correct date for review? ○ Yes, we are reviewing the minutes from the 1/8/24 public board meeting that took place in person in person at the McCoy building.	***Motion to approve Public meeting minutes: Susana Second: Kerry*** Yays: 6 Nays: 0 Abstain: 0 **Decision: Approved**		
Vacancy Report Erin Murphy - Human Resources Manager	Last month we did not have a vacancy report and Erin offered to present a robust report today and will be presenting the vacancy report quarterly moving forward	Suggestion to have Courtney attend a future	Erin Murphy	

	Provider Vacancy Trends ● Not seeing a positive trend in physician vacancy Frontline Medical Support Vacancy Trends ● Retention Bonuses for EFDAs, Medical Assistants and Pharmacy technicians were just approved ● Medical Assistants trend is looking positive Question: ● What is the difference between an EFDA and Dental Assistant? ○ EFDA is an expanded function dental assistant and can perform a wider range of duties FY24 Turnover Trends ● APC, MAs, and Pharmacy techs have a high turnover rate FY24 Financial Impact of Vacancies ● Direct correlation between our provider staff vacancy and revenue loss ICS Exit Interview Results & Trends ● Erin recommended to ask Courtney to provide an update. Courtney is closer to this work and the trends as the Employee Engagement Coordinator for the Health Department and if the board would like more info on these results, it would be good to invite her to a future meeting. Questions: ● Harold was concerned about the monthly loss due to vacancies. What is the hold up in filling these vacancies? ○ Partly due to getting enough candidates to apply and also through the recruitment process and	meeting to discuss exit survey results.		

	partly due to our compensation plans ○ We are competing with private competitors that can pay more ○ We are actively working on fellowship opportunities for APCs ● Susana asked - What is the reason for so many vacancies? Is there a survey that goes out to gauge why staff are leaving and find trends? ○ Compensation is generally top of mind for many of our employees ○ Right now, it is not an employer's market but an employee market. The bigger issue is getting employees on staff and not as much an issue with retention. Our vacancy rate is actually quite good at 6% comparatively			
ICS.01.44 Quality Improvement Policy **-VOTE REQUIRED** Brieshon D'Agostini Quality and Compliance Officer	Due for renewal in March and are making some minor changes to the policy prior to renewal Want to change the title and some content wording changes If not reviewed and approved by March renewal, at risk to be out of compliance with HRSA	***Motion to approve ICS.01.44 Quality Improvement Policy changes: Kerry*** ***Second: Darrell*** Yays: 7 Nays: 0 Abstain: 0 **Decision:** **Approved**		
Bi-Annual ED Evaluations - VOTE REQUIRED Tamia Deary, CHCB Chair	Proposing 6 months evaluations instead of annual Executive Director evaluations moving forward Questions posed by board members:			

	● Alina asked - What will the evaluation look like and what metrics are we using for the assessment? ○ Historically, the process has been getting the previous year's evaluation template and then we give feedback based on that. Tamia has put together some questions she would like written into the evaluation going forward but will have the board review ● Kerry asked -What is the incentive behind a more formal review rather than creating more regular feedback cycles? ○ Interested in both formal reviews and more regular feedback cycles ○ It is something we do with the county and it does not stop us from doing more informal feedback cycles ○ Opportunity for us to have at least 2 yearly evaluations rather than one to form a better framework and improve communication with the ED ○ Evaluation of the CHC executive director is part of the bylaws ● Bee asked - Are the end of year evaluations in December? ○ No, DJ's annual evaluation will be in May after he completes his first year at the county ● Bee asked - Is this going to cost the board as it pertains to changing the bylaws/is it cost effective? ○ We already pay county HR to do this work on our behalf and it should not cost us much to do the evaluation more than once a year. Cost benefit of having improved communication with our ED should outweigh the cost to make this change ○ Will cost more for translators and we need to have more conversations as a board on this			

	● Harold Asked - Should we hold on this for the moment instead of voting so that we can get it changed in the bylaws? ○ As we will see in the next agenda item, we have a few changes to bylaws coming up and Tamia thought it would be beneficial to add the ED evaluation to the change so that it is done at the same time ● Harold Asked - Did we already run this through our attorney? ○ Yes, Tamia has run this through him and he agreed that we need to make our bylaws more efficient ● Susana asked - How is it that Tamia got to the point of wanting to change the bylaws and were members of the board in agreement of these amendments and evaluate if these are important to make these changes? ○ As for the board member selection, requiring an interested person to attend 3 board meetings before being voted on the board requires a 3 month process which is quite a long duration. Since we are out of compliance with HRSA, it would be in best interest of the board and our clients to speed up the process to recruit board members and be in compliance with HRSA			
Notice of Intent To Amend CHCB Bylaws Tamia Deary, CHCB Chair	Recommended changes: ● Executive Director Evaluations ● Board Member Selection - nomination process We will not be voting on bylaws tonight This is just a notice of intent and we will be voting in March	***Motion to table changes to the bylaws until bylaws committee can meet and provide a***		

	These changes will need to go through our lawyer first. Bee motions to table this conversation and bring it back to the Executive Committee for further discussion as there seems to be many questions that still need to be answered	***recommendation to Exec Committee: Bee Second: Harold*** Yays: 6 Nays: 1 Abstain: 0 **Decision:** **Approved**		
10 min break	**7:15pm-7:25pm** Kerry left the board meeting at 7:26pm			
Monthly Financial Reporting Package Jeff Perry, Chief Financial Officer	The Health center is showing 15.6 million surplus Ran a loss in December of 1 million YTD Rundown: ● Dental has a $3.3 million loss ● Pharmacy $910,000 loss ● PC $5.2 million gain ● Student Health Centers $ 926,000 loss ● HIV Clinic $1.2 million loss ● Program income through December was $12.2 million bringing us to $79.9 million			
Committee Updates Finance Committee: Darrell Wade, Finance Chair Quality Committee: Tamia Deary, Quality Chair Executive Committee: Tamia Deary, Board Chair	Finance Committee met Friday 2/1 and will resume meeting in March Executive Committee met at the end of January and discussed some changes that we need to make in order to address our upcoming site visit and a workplan for this year, and committee appointments			

	Quality Committee met and reviewed the Quality Improvement Policy and Suzana attended for the first time. The committee did a deep dive into the vacancy report			
Executive Director's Strategic Updates Darnell "DJ" Rhodes Executive Director	DJ reviewed the Status Report on CHCB Priorities			
Meeting Adjourns	Meeting adjourns 7:38 PM			Next public meeting scheduled on 3/11/24

Signed:_____ Date:_____
Kerry Hoeschen, Secretary

Signed:_____ Date:_____
Tamia Deary, Board Chair

Scribe:
Name: Shawna Williams// Email: shawna.williams@multco.us

SUMMARIES

community health center board

Multnomah County

community health center board
Multnomah County

Policy Review Presentation Summary

Presentation Title	AGN.10.03 Community Health Center Services Fee Policy

Type of Presentation: Please add an "X" in the categories that apply.

Inform Only	Annual / Scheduled Process	New Proposal	Review & Input	Inform & Vote
				X

Date of Presentation:	3/11/24	**Program / Area:**	Health Center, all clinical services
Presenters:	Brieshon D'Agostini, Health Center Chief Quality and Compliance Officer		

Policy Title and Brief Description:

This policy requires the approval of the CHCB.

Policy purpose: Establish the sliding fee discount program for the Health Center and maintain HRSA compliance.

Describe the current situation:

Some inaccuracies were identified in the policy related to charges for pharmacy, enabling services, refugee services, and Ryan White language. Charges were being applied correctly, but the policy language needed to be updated.

Why is this project, process, system being implemented now?

This policy is not due for update until September 2024. However, several changes were identified as needing to be corrected or clarified:

- Approver names updated
- Updating language to align with other policies
- Updating Ryan White language for accuracy
- Fixing an inconsistency in language about enabling services and telehealth visits
- Pharmacy language being updated to current rate calculation practice

- Aligning COVID vaccine charges with flu vaccine charges

Briefly describe the history of the project so far *(Please indicate any actions taken to address needs and cultures of diverse clients or steps taken to ensure fair representation in review and planning):*

Thorough review of HRSA, Ryan White, and No Surprises Act guidance. Engagement with internal subject matter experts.

List any limits or parameters for the Board's scope of influence and decision-making:

The CHCB has oversight/approval authority of financial policies.

Briefly describe the outcome of a "YES" vote by the Board
(Please be sure to also note any financial outcomes):

Policy will be approved with proposed changes.

Briefly describe the outcome of a "NO" vote or inaction by the Board
(Please be sure to also note any financial outcomes):

Policy will not be changed. Outstanding questions will need to be analyzed and brought back to CHCB for future vote.

Which specific stakeholders or representative groups have been involved so far?

ICS Finance, including Rev Cycle, Eligibility, Contracting

Health Dept Finance and Business Management

ICS Clinical and Ops - Dental, Primary Care, Pharmacy, Lab, HHSC, SHC, Reproductive Health

ICS Quality program, including HRSA, Joint Comm

ICS Senior Leadership

Who are the area or subject matter experts for this project?
(Please provide a brief description of qualifications)

Brieshon D'Agostini, Chief Quality and Compliance Officer

Jeff Perry, Chief Financial Officer

What have been the recommendations so far?

Update the policy as proposed.
How was this material, project, process, or system selected from all the possible options?
This policy was compared against other internal policies and compliance standards including from Joint Commission, HRSA, and other resources.

Board Notes:

Q4 2023 Patient Surveys: Trends and Improvements

Prepared for CHCB Public Meeting
March 11, 2024

Linda Niksich, Patient Experience Program

Multnomah County
Health Department
Community Health Center

Update: Trends We Are Monitoring…

Common Trends Across the Health Center as a Whole (all service lines)

- Overall satisfaction (improving over time/close to hitting benchmark)
- Referral Intentions (improving over time and within 1% of benchmark)
- Cultural and Language Needs Being Met (seeing improvement)
- Disparities for Asian populations, Cantonese & Russian Languages, (continue over time)

Pharmacy

- Told When RX Would be Ready
- Spoke w/Personnel About RX

Primary Care

- Appt Wait Time
- Test results received quickly enough

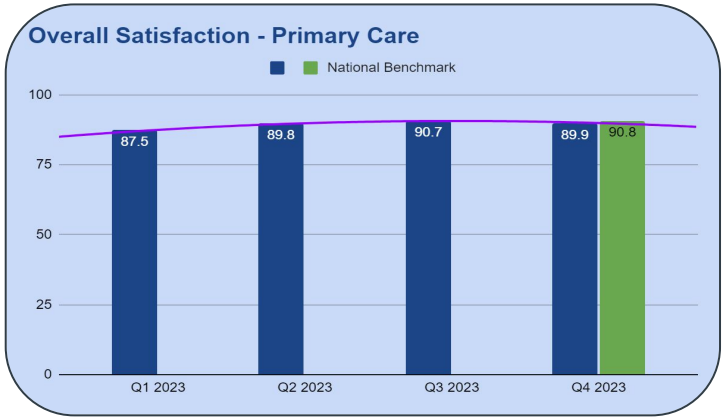
Dental

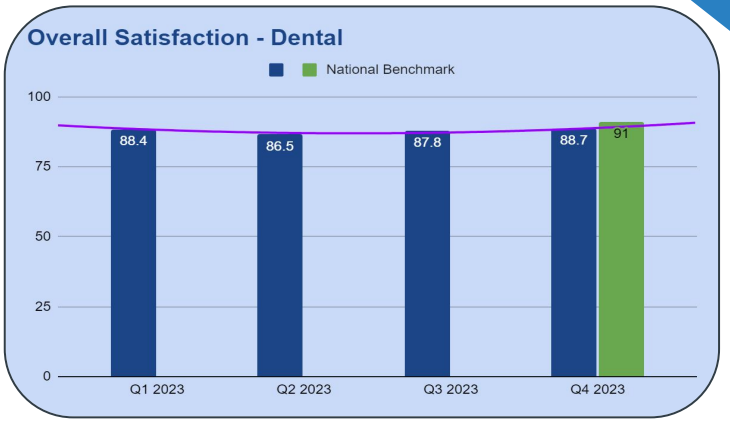
- Appointment Wait Time (starting to improve but will continue to watch)
- Provider Time Spent
- Quality of Care

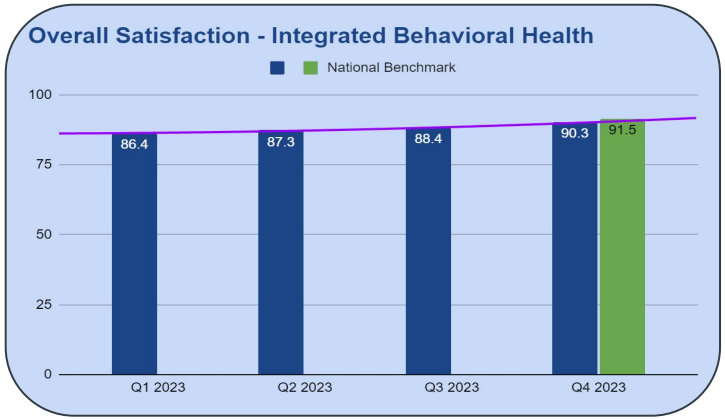
Behavioral Health

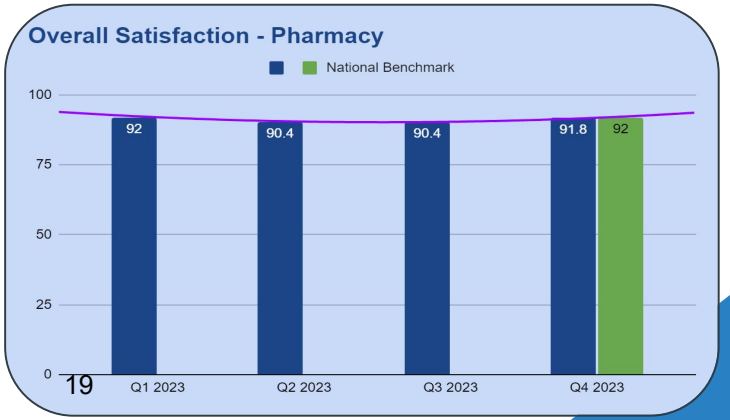
- Asked About Difficulties Caring for Health

Overall Satisfaction By Service Line - Q4 2023

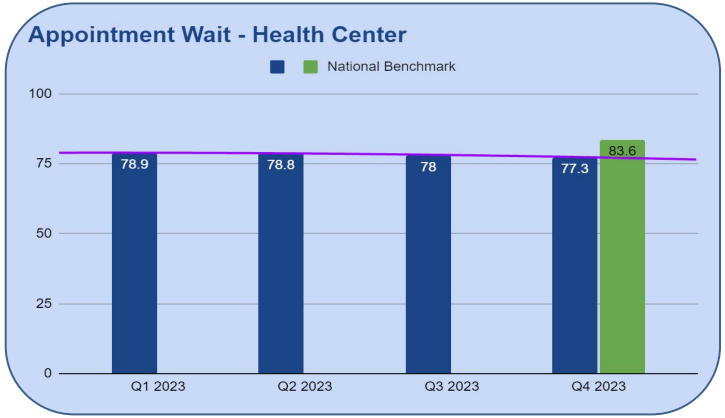


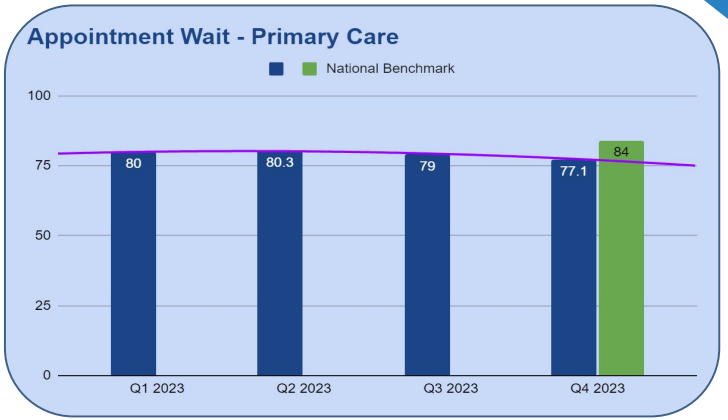


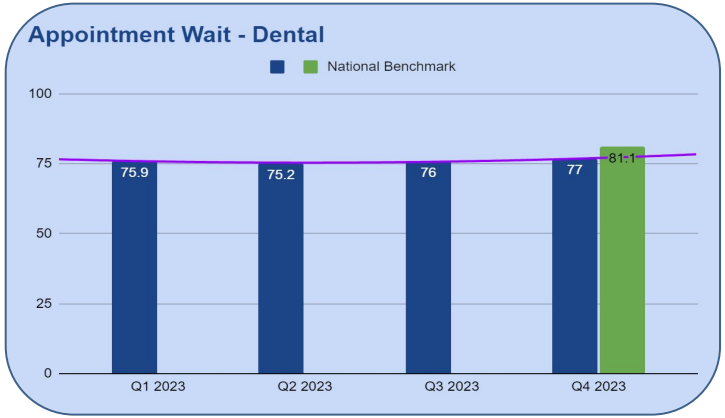


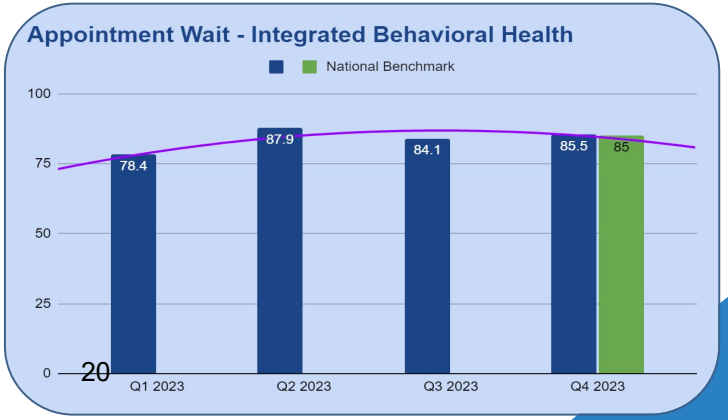


Appointment Wait By Service Line - Q4 2023









Improvements and Upward Trends (over time)…

Health Center as a Whole (all service lines)

- Provider Wait Exceeded BM by 3.3%
- Provider Rating Met BM
- Referral and Loyalty Intentions - Trending Up
- Asked About Difficulties Caring for Health - Trending Up
- Provider Involved you in Health Care Decisions - Trending Up
- Phone Attendant Courtesy and Helpfulness - Trending Up
- Portal Satisfaction (as more patients utilize) - Trending Up

Pharmacy

- Overall Satisfaction
- Staff Friendliness/Professionalism
- Explanation of RX
- Privacy of Health Info

Primary Care

- Cultural and Language Needs Being Met
- Asked About Difficulties Caring for Health

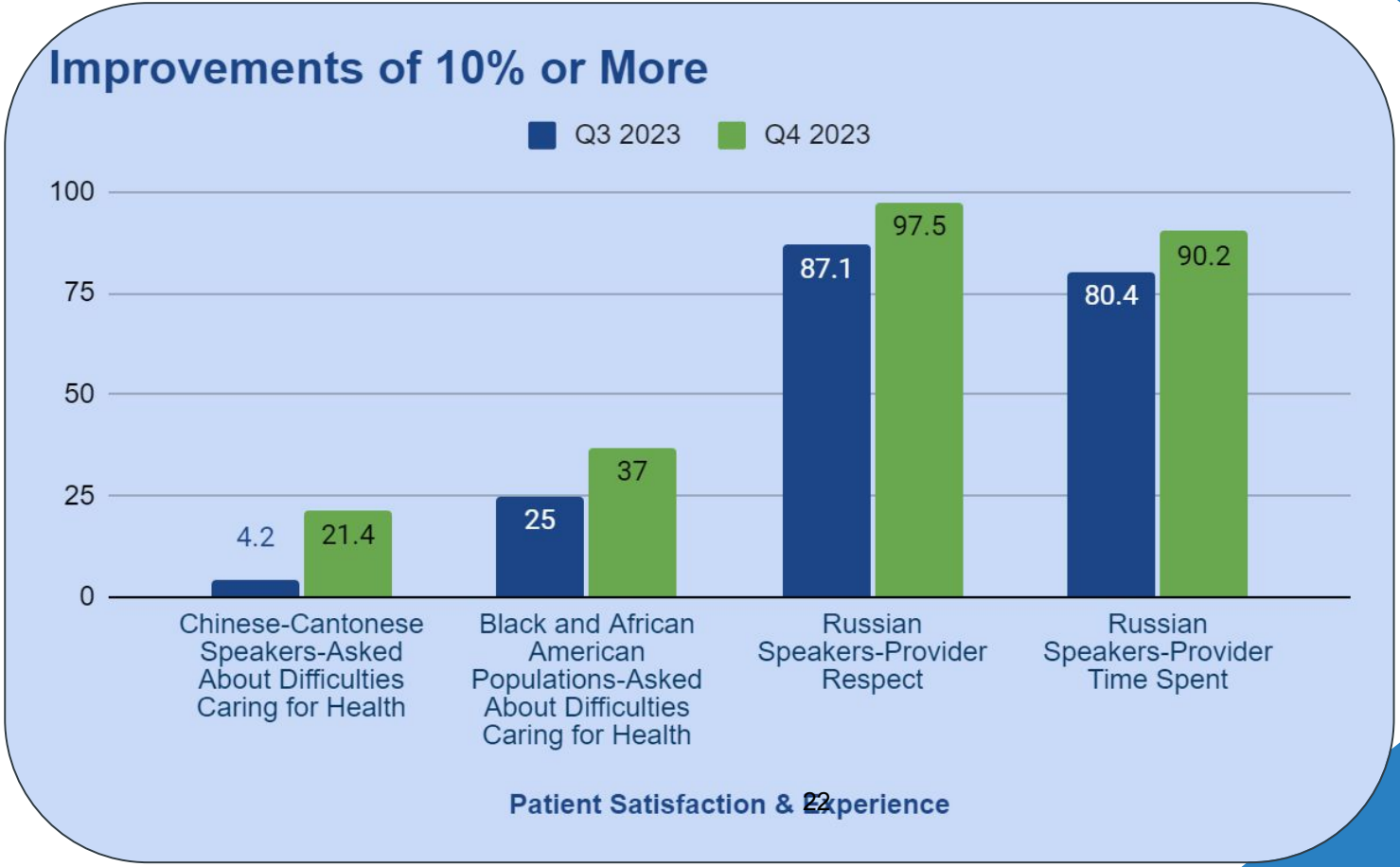
Dental

- Cultural and Language Needs Being Met
- Overall Satisfaction
- Provider Knowledge of Health History

Behavioral Health

- Overall Satisfaction
- Provider Respect
- Provider Time Spent

Improvements of 10% or More in Q4 2023 (Disparities)



Q4 2023 Incidents & Complaints

February 20, 2024

Multnomah County
Health Department
Community Health Center

Patient Incidents - Q4 2023

Incidents Report

Reported Incidents	Incident by Type	Reported Pharmacy Med Dispensing Errors	Med Dispensing Error by Type	Definitions

Multnomah County

Reported Incidents

This report displays all of the incidents reported to ICS.

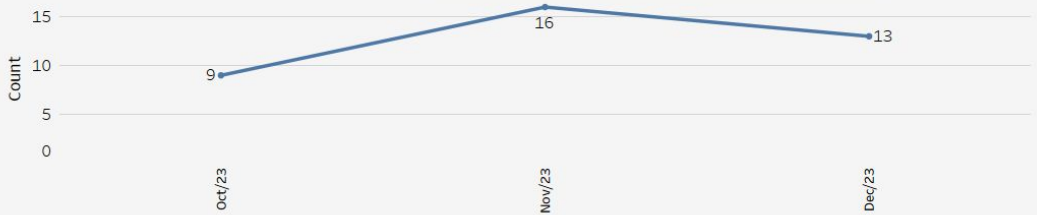
By Service Area
All

By Quarter:
2023 Q4

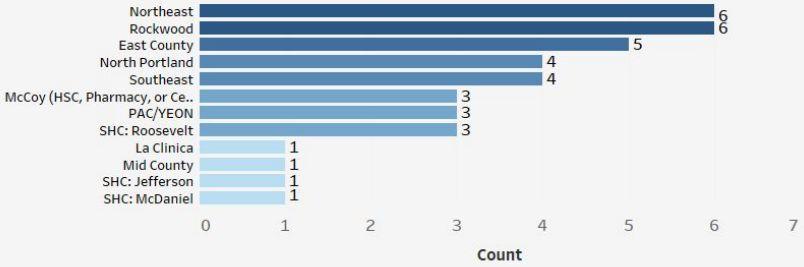
Subject Person Affected by Event:
Client

Point of Reference: From 09/01/2023 - 12/31/23: Primary Care completed 42,690 appts (includes Telehealth visits). Dental completed (aprox.) 20,461 appts.

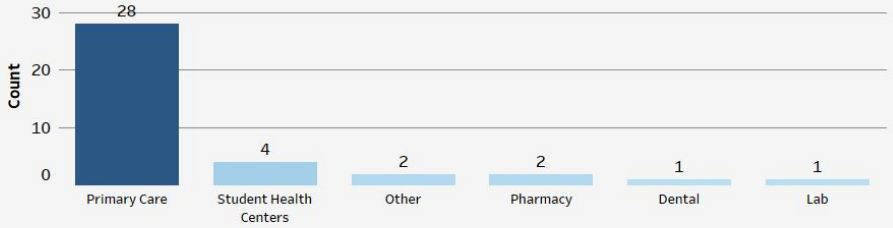
Incidents by Month



Incidents by Location



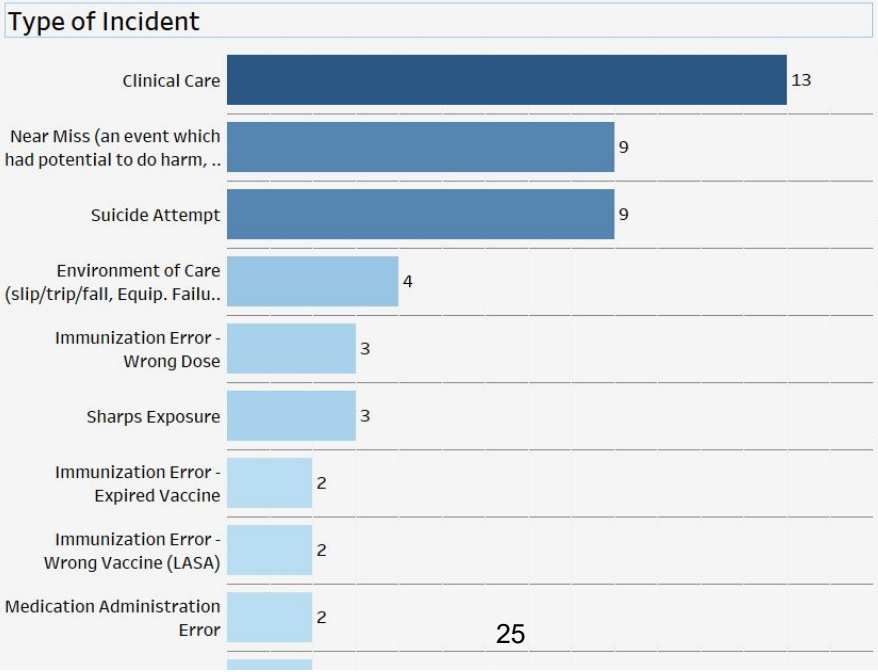
Incidents by Service Area



Patient Incidents by Type

Incidents Report

Reported Incidents | **Incident by Type** | Reported Pharmacy Med Dispensing Errors | Med Dispensing Error by Type | Definitions



Multnomah County

Use the filters below to further explore the data!

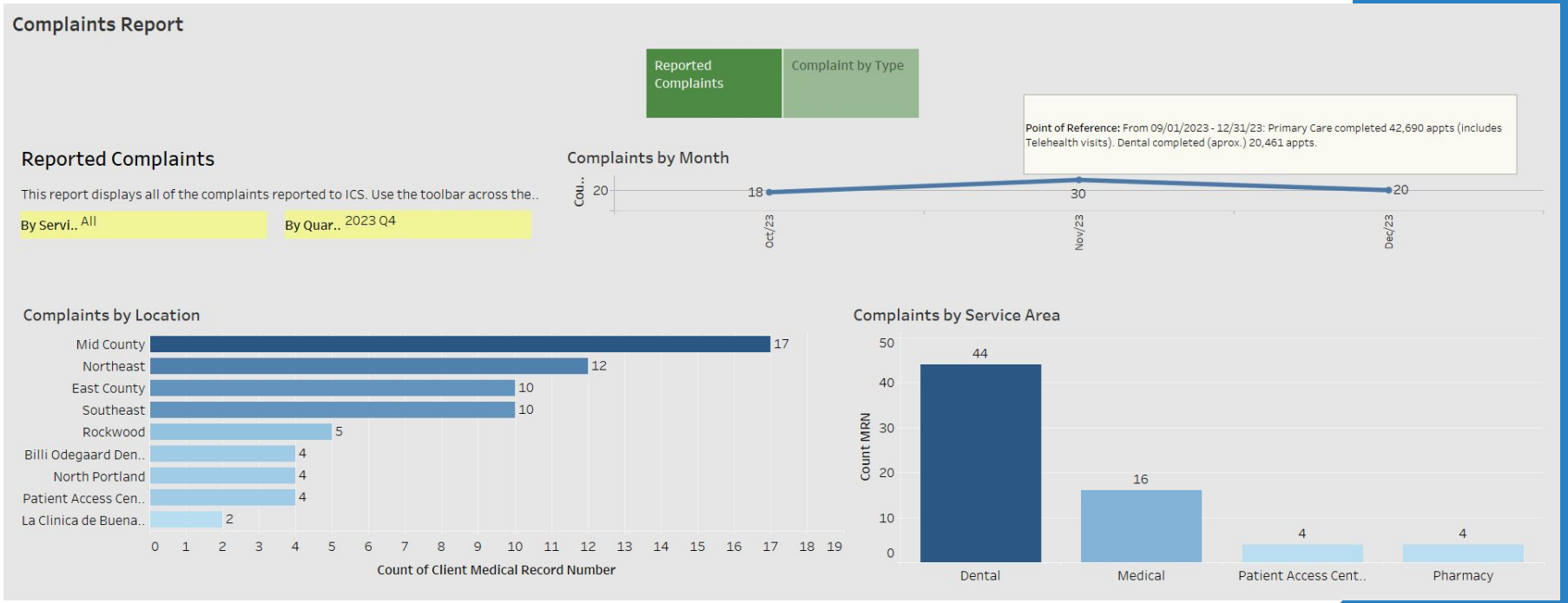
By Quarter:
2023 Q4

By Service Area
All

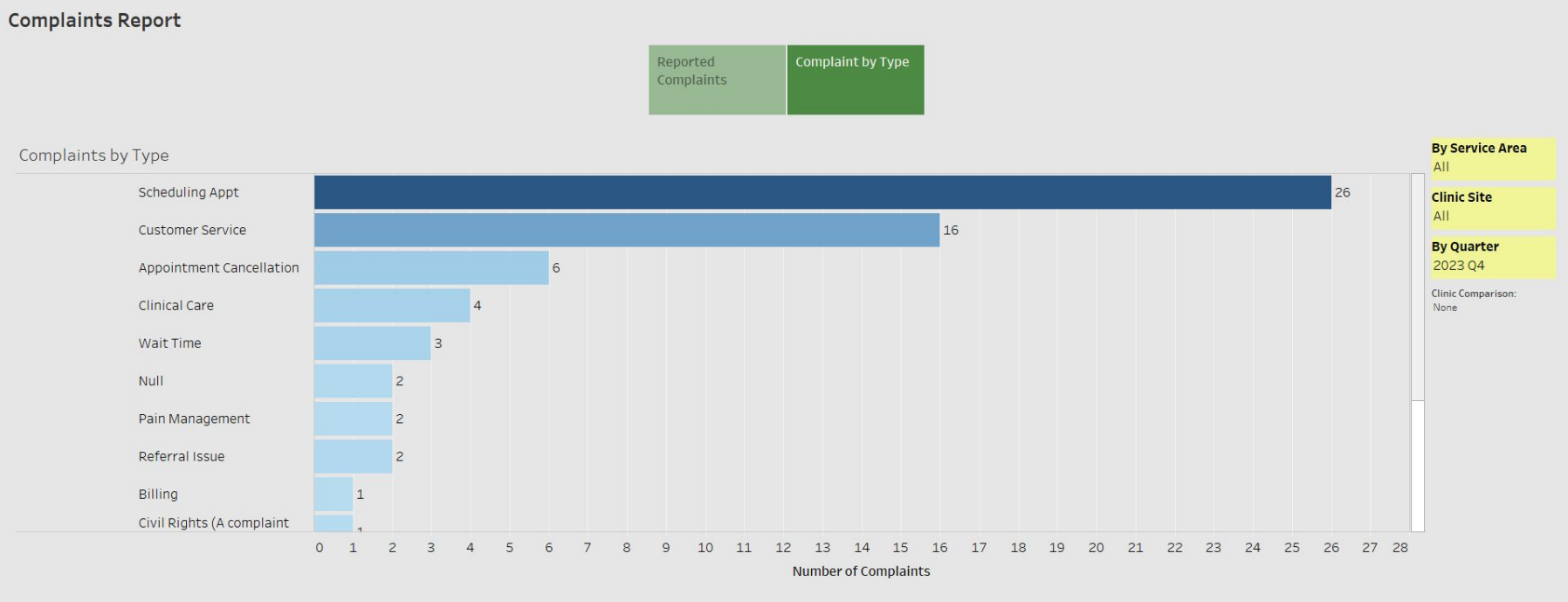
Clinic Site
All

Subject Person:
All

Patient Complaints Q4 2023



Patient Complaints Q4 2023



SUPPORTING DOCUMENTS

community health center board

Multnomah County

Title:	**Community Health Center Services Fee Policy**		
Policy #:	**AGN.10.03**		
Section:	Agency Wide Clinical	Chapter:	Fiscal
Approval Date:	09/13/2021~~03/11/2024~~	Approved by:	DJ Rhodes ~~Tasha Wheatt-Delancy, MSW~~/s/ Executive Director and CEO, Community Health Center Tamia Deary ~~Harold Odhiambo~~/s/ Chair, Community Health Center Board
Related Procedure(s):	Not applicable		
Related Standing Order(s):	Not applicable		
Applies to:	All services provided within the health center scope, including primary care, dental, behavioral health, pharmacy and specialty services.		

PURPOSE

The fee policy provides a consistent payment model approach to ensure access to health center services and fiscal sustainability. It offers clients an equitable, affordable and accessible means for receiving health care through services provided under the scope of the Multnomah County Community Health Center. Discounts are provided in accordance with federal guidelines and apply uniformly to all clients. Clients will be provided services regardless of ability to pay. This policy intends to educate staff and clients about payment and coverage options.

DEFINITIONS

Term	Definition
330 Grant	~~MCHD~~ The Multnomah County Community Health Center receives funding from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC). Health centers must meet all grant requirements to receive funding.

Deposit	Deposit for services is the amount asked for from clients determined to be in Tier 5 at check-in. The remaining balance will be collected or billed at the end of the appointment.
Family	Family is defined as a group of two or more persons related by birth, marriage, domestic partnership, or adoption who reside together. Components of the definition of family size include the client; spouse/other person having a child (or pregnancy) in common with the applicant; unmarried dependent children under age 19 (or needing to complete their senior year in high school) and living at home; and a child with disabilities, who is unmarried, living at home, and incapable of self-support. Clients under the age of 19 may be determined to be a family size of one if they are responsible for their own health care decisions, in a foster care program, emancipated or independently living from parents/guardians, or receiving confidential or grant-directed care services (such as Title X and Ryan White).
Flat Fee	The flat fee is the amount charged for a visit regardless of the amount of time and complexity of services provided during the visit.
Income	Different types of income are considered when evaluating a family's income and eligibility for the SFDS: ● money wages ● salaries before deductions ● self-employment income ● Social Security; Railroad Retirement ● Unemployment Compensation ● Workers Compensation ● strike benefits ● public assistance (i.e. Aid to Family with Dependent Children, General Assistance payment, SSI, etc.) ● training stipends ● students loans and grants ● alimony ● child support ● military family allotments ● private and government employee pensions ● regular insurance and annuity payments ● dividends ● interest

	• rent • loyalties or periodic receipts from trusts or estates • Veteran's Benefits • regular support from an absent family member or someone not living in the household. Income does not include food or rent received in lieu of wages; food stamps; savings withdrawn from a bank; gifts; tax refunds; WIC vouchers; lump-sum inheritance; one-time insurance payments; income from the sale of property, house or car; or imputed value of Medicaid or public housing.
~~MCHD~~ Health Center Formulary	A preferred list of over-the-counter and prescription drugs, that are available to clients at ~~MCHD~~ our Community H~~h~~ealth C~~c~~enter pharmacies. This formulary is reviewed and maintained in collaboration between Pharmacy, Primary Care, and Dental Services.
Nominal Fee	The nominal fee is the amount requested at check-in for clients who are at or below 100% of the Federal Poverty Level (FPL). The nominal fee must be nominal from the perspective of health center clients. Nominal charges are not “minimum fees,” “minimum charges,” or “co-pays.”
Reproductive Health Program	Reproductive Health Program is a state grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. The Reproductive Health Program is legally designed to prioritize the needs of low-income families or uninsured people (including those who are not eligible for Medicaid) who might otherwise not have access to these health care services.
Ryan White Program	The MCHD Health Services Center receives funding from the Health Resources and Services Administration’s (HRSA) Ryan White HIV/AIDS Program to provide a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV.
Sliding Fee Discount Schedule (SFDS)	Also known as a sliding fee scale, this schedule describes the range of discounts on fees for clients based on family income, size and federal poverty guidelines.
Telehealth or Telemedicine Visit	When used by payors, the terms “telehealth” and “telemedicine” includes both virtual (video) and telephone visits, even though charges are different for these two types of visits.

POLICY STATEMENT

Describe board strategies, define requirements and state exceptions/exclusions.

REFERENCES AND STANDARDS

Health and Human Services

- Reproductive Health Program Requirements

Health Resources and Service Administration

- HRSA Health Center Program Compliance Manual, "Sliding Fee Discount Program"
- HRSA HIV/AIDS Bureau Ryan White Programs Sliding Fee Scale Information

Federal Register

- Poverty Guidelines

PROCEDURES AND STANDING ORDERS

ELIGIBILITY FOR SLIDING FEE DISCOUNT PROGRAM

Clients who complete an eligibility screening and are determined to be at or below 200% of the Federal Poverty Level (FPL) are eligible for a sliding fee discount. The sliding fee discount schedule (SFDS) describes discounts by family income and size. Only family income and family size will be used in determining eligibility for the Sliding Fee Discount Program, once the patient completes the required registration process and provides required proof of income and family size, in accordance with this policy.

Clients are not required to apply for insurance in order to receive a discount; all clients will be offered an insurance eligibility screening. Should the client decide to apply for insurance, an Eligibility Specialist will assist in completing the application process. Clients are not eligible for a discount or services paid by 330 grant if their eligibility is not determined.

ELIGIBILITY SCREENING and DETERMINATION

Clients are screened annually. Their eligibility status is valid for one year unless the client's income or family size changes at which time the client is required to notify the registration staff and go through the screening process.

The process of providing documentation should not be overly burdensome to the client. If the client refuses to provide required ~~documentation~~ information, ~~that~~ the client ~~is~~ may not be

eligible for the SFDP. Sample documentation required to determine discount levels for uninsured clients may include:

Income Documentation

Current month and last 3 months paycheck stubs
Financial award letter from Social Security or Department of Veterans Affairs
State Employment Division – unemployment compensation statement
Proof of Workers Compensation monthly payments
Rental property agreement documenting monthly rent payment
Support Enforcement documentation of Child Support payment
Self-Employment form documenting proof of income
Statement of no income
Verbal or written s~~S~~elf-declaration of family size and income
Updated documentation can be submitted within 90 days of the first patient visit

SLIDING FEE DISCOUNT SCHEDULES (SFDS)

The SFDS apply to clients who have completed the eligibility screening process. All services listed in the HRSA Form 5A, whether required or additional, are provided on a SFDS. Only family income and family size will be used to determine eligibility. Individuals and families with annual incomes at or below 100% of the FPL will receive a full discount for services.

If a client is determined to be eligible for a Sliding Fee Discount, even if they have insurance, they will pay the lowest tier of SFDS and will not be charged more for any service than the clients, in a higher SFDS tier (table below) for the services provided. The SFDS will be applied to services not covered by insurance plans. If the total cost of the visit is lower than the flat fee, clients in tiers 2-4 will pay the total visit cost.

Service fees are based upon the usual and customary fees in the Multnomah County area as well as information provided by the Centers for Medicare and Medicaid. Service fees are evaluated and updated annually.

The federal poverty guidelines (FPL) are updated annually as prescribed by the Federal Registry for the purpose of updating increases in the Consumer Index and are presented to The Community Health Center Board. The Electronic Health Record updates the SFDS based on FPL after the updated FPL ~~are~~ is published. The Community Health Center Board must review and approve the SFDS Policy every 3 years.

Business Services, in collaboration with the health center, evaluates, at least once every three years, the sliding fee discount program. At a minimum, the health center:

- Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100% of the FPG, are accessing health center services;
- Utilizes this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
- Identifies and implements changes as needed.
- All services provided within the health center scope (required and additional health services) are provided on a sliding fee discount schedule including those provided through contract or formal written referral agreement.

Discounts and fees established through contract, by grant requirements, laws or local, state or federal requirements may augment, supplant or limit the applicability of the sliding fee discount program (e.g. Vaccines for Children program, School of Oral and Community Health, and Student Health Centers).

Sliding Fee Discount Schedules

Service* and Discount Tier	Tier 1 0 - 100% (Nominal Charge)	Tier 2 > 100 - 133%	Tier 3 > 133 - 167%	Tier 4 > 167 - 200%	Tier 5 > 200%
Medical Care (Includes in-house lab fees)	$35	$45	$55	$65	No Discount (Pay Full Fee, $75 deposit at Check-In)
Dental Care (Includes lab fees)	$45	$55	$65	$75	No Discount (Pay Full Fee, $85 deposit at Check-In)
Mental Health Care/ Behavioral Health Care**	$0	$0	$0	$0	No Discount (Pay Full Fee, $5 deposit at Check-In)
Clinical Pharmacy	$0	$0	$0	$0	No Discount (Pay Full Fee if applicable)

Telephone visits ~~Enabling & Other Services**~~	$0	$0	$0	$0	No Discount (Pay Full Fee if applicable)
Acupuncture	$5	$8	$10	$12	No Discount (Pay Full Fee, $15 deposit at Check-in)
In house LAB Only Visit	$0	$18	$19	$20	No Discount (Pay Full Fee, $25 deposit at Check-In)
Contracted lab services	$0	75% Discount	50% Discount	25% Discount	No Discount (pay full fee)

Service and Discount Tier	Tier 1 0 - 100%	Tier 2 > 100 - 150%	Tier 3 > 150 - 200%	Tier 4 > 200 - 250%	Tier 5 > 250%
Oregon Reproductive Health Program Service & Supply Discount Schedule (ONLY to be utilized when clients decline to enroll in Oregon RH Program but are seeking family planning services)	100% Discount	75% Discount	50% Discount	25% Discount	No Discount (Pay Full Fee)

*Virtual (video) visit charges align with in-person visits for the specific service
**Includes Substance Use Disorder services provided by the health center.
~~**Enabling services include (after insurance billing) case management (not performed by nurses), eligibility assistance, outreach, transportation, supportive and educational visits provided by Community Health Workers, and translation services. Other visits include telehealth visits, clinical pharmacist visits,, targeted case management in maternal, child and family health programs.~~

Service and Discount Tier	Tier 1 0 - 100% (Nominal Charge)	Tier 2 > 100 - 133%	Tier 3 > 133 - 150%	Tier 4 > 150 - 200%	Tier 5 > 200 - 300%	Tier 6 > 300%
Ryan White Services (per visit)	$0	$45	$55	$65	No Discount (Pay Full Fee, $75 deposit at Check-In)	No Discount (Pay Full Fee, $75 deposit at Check-In)
Ryan White Services (Cap on Charges)	$0	No More than 5% of Annual Income			No More than 7% of Annual Income	No More than 10% of Annual Income

FEES AND DISCOUNTS FOR RYAN WHITE SERVICES

In order to comply with Ryan White legislative requirements, the HIV Health Services Center (HHSC) offers a sliding fee scale to assist uninsured/underinsured patients who have difficulty paying for HIV primary care services. People ~~living~~ with HIV/AIDS (P~~L~~WHA) whose incomes are at or below 100% of the federal poverty level (FPL) will not be charged for HIV ~~primary care~~services, while P~~L~~WHA with incomes at 101% FPL or above who rely on Ryan White for access to HIV ~~primary~~ care will be charged for the services they receive, based on a sliding fee scale. No Ryan White patient shall be denied service due to an individual's inability to pay.

There is an annual cap on charges for Ryan White Part A, B, ~~and~~ C, and D clients which is based on annual gross income as a percentage of FPL. The cap on charges applies to all HRSA Ryan White Part A, B, ~~and~~ C, and D clients regardless of income or healthcare coverage. Ryan White clients who are charged for the services they receive will have their annual (calendar year)

charges capped at a percentage determined by their family size and income level. The cap on charges is re-evaluated every 12 months based on the client's Ryan White eligibility.

Patient char e is e ual to the art o me ical e ense care not covere by insurances.

A licable im ose not actual ee or service H -related charges during the calendar year include enrollment fees, premiums, deductibles, cost sharing , copayments, coinsurance, and other medical charges..

- To apply the Cap on Charges, the Ryan White Program will calculate each patient's annual cap based on their annual gross income, inform the patient of their cap and their responsibility to track and submit all other Ryan White imposed charges, track all applicable charges imposed by the HIV Health Services Center, and stop imposing charges on the Ryan White Part A, B, or C client once the cap is met each calendar year.

OREGON HEALTH AUTHORITY REPRODUCTIVE HEALTH PROGRAM

In addition to completing the eligibility form, the Reproductive Health Program requires that the client is asked to self-report income and family size. Clients who have been enrolled into the Reproductive Health Program will not be charged for reproductive services. Clients with greater than 250% FPL are not eligible for the program. All clients enrolled in the Reproductive Health Program regardless of FPL% will not be charged a nominal fee as this is a requirement of the program.

Reproductive Health Program discount may still be used for reproductive health qualifying services if a client refuses to share their income and family size. If a client refuses to apply for the RH program, or is not screened for it by clinic staff, the reproductive health program's sliding fee discount will be applied, according to income and family size.

Minors who request confidential Reproductive Health services, will have their sliding fee discount evaluated on their own income, and a family size of one, per Oregon Reproductive Health Program Requirements.

LAB FEES

All dental labs are covered by the nominal or flat fee. In-house labs within a primary care visit are covered by the nominal or flat fee. Lab Only Visits are charged in accordance with the SFDS. Labs provided by a third-party/ contracted provider will be discounted using the primary care SFDS (or a separate SFDS). This SFDS is in accordance with the Federal Poverty Level and can be viewed by contacting the vendor. Any uncollected client debt by the lab vendor will be billed to MCHD.

PHARMACY CHARGES

Self-pay clients

To ensure that health center clients lacking prescription benefits are able to obtain necessary prescribed medications, the health center ~~MCHD~~ formulary contains medications available through ~~MCHD's~~ the health center's in-house pharmacies offered at an FPL-based Sliding Fee Discount Schedule. The fee includes a dispensing fee. For uninsured clients who are prescribed medications that are not on the ~~MCHD~~health center formulary, if no formulary option is available, the prescriber may request a formulary exception (Tier 3). If upon clinical review, the exception is approved, ~~MCHD~~ health center Pharmacy Services may dispense up to 1 month supply of medication at a time for the duration of the approval.

Pharmacy Sliding Fee Discount Schedule

Medication and Discount Tier	**Maximum Days Supply**	**Tier 1 0 - 100%** (Nominal Fee)	**Tier 2 >100-133%**	**Tier 3 >133-167%**	**Tier 4 >167-200%**	**Tier 5 > 200% (No Discount)**
Level 1	30	$4	$6	$8	$10	$12
	90	$10	$12	$14	$16	$18
Level 2	30	$10	$12	$14	$16	$18
Level 3 (Non-Formulary)	30	$15	$20	$25	$30	$35

Insured Clients

For insured clients, pharmacy services follows the requirements outlined in the contract with the insurance plan or its third party processors (pharmacy benefits management or PBM company) regarding medication coverage and client copays according to the client's benefit plan. The pharmacy requests payment of copays as specified by their insurance. In the event a medication is not covered by the client's pharmacy benefit, the pharmacy will alert the prescriber of the need to request prior authorization or a formulary exception from the plan or advise the prescriber of covered alternatives. Clients seen in the clinic with prescription coverage under a plan that Pharmacy Services is not contracted with, will be encouraged to obtain services at an external pharmacy.

Collection of Payment

Clients will be asked to provide their insurance co-pay or the uninsured formulary drug price at the time of dispensing/pick-up. Clients who are unable to pay may have the charge applied to

their client account. Health center clients receive their medication regardless of their ability to pay.

SERVICES PROVIDED VIA A CONTRACT

For services provided via a contract, the health center ensures that fees for such services are discounted in a manner such that:

- A full discount is provided for individuals and families with annual incomes at or below 100% of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100% of the FPG.
- Partial discounts are provided for individuals and families with incomes above 100% of the current FPG and at or below 200% of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.
- No discounts are provided to individuals and families with annual incomes above 200% of the current FPG.

SERVICES PROVIDED VIA A FORMAL WRITTEN REFERRAL AGREEMENT

For services provided via a formal written referral agreement, the health center ensures that fees for such services are either discounted according to the health center's schedule or discounted in a manner such that:

- Individuals and families with incomes above 100% of the current FPG and at or below 200% of the FPG receive an equal or greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule; and
- Individuals and families at or below 100% of the FPG receive a full discount or a nominal charge for these services.

CLIENT PAYMENT SCHEDULE and NOMINAL CHARGE

All clients determined eligible in accordance with this policy are asked to pay at the time of check-in and will be charged for services according to the tier they qualify for based on family size and income. To determine if the nominal amount would be "nominal" from the perspective of the client one or more of the following will be used; board member input, patient surveys, review of collection % or bad debt or co-payment amounts.

Clients will be asked to pay any outstanding account balances. Clients who are unable to pay charges will not be denied services. Insured clients are asked to pay co-payments at the time of check-in, not to exceed the amount they would pay under the Sliding Fee Discount Schedule, whichever is lower, which may vary according to insurance coverage and services provided to the client. The nominal charge does not include any service or supply. The nominal charge will be applied the same day before applying to any outstanding balances the client owes prior to or future charges that are reflected on the client's account.

Prepayment For Service

All clients that do not qualify for a discount will be asked to pay an amount at check-in. Any remaining balance will be determined after services are rendered and collected/billed accordingly.

Write-offs ~~for Uncollectible client Accounts~~

The Multnomah County Community Health Center does not turn away clients for the inability to pay for services. Due to ~~Multnomah County's~~this policy ~~turn away clients for the inability to pay,~~ there may be charges~~costs~~ that go unpaid in which Multnomah County may write off from the client account. Criteria for write off are listed in MCHD policy FIS.01.06.

Services exempt from all client charges after any applicable insurance billing:

- Services covered by Medicaid
- Services covered by Medicare (client is responsible for copays/coinsurance)
- Services funded by Reproductive Health (RH) clients who completed the application for RH and whose FPL is below 250% only.
- ~~Maternal Child Family Health (MCFH)~~
- HIV Health Services Center visits after clients reach annual cap on charges (in accordance with F~~f~~ederal Ryan White rules)
- Enabling services ~~such as case management, eligibility assistance, transportation and translation~~ include case management (not performed by nurses), eligibility assistance, outreach, transportation, supportive and educational visits provided by Community Health Workers, and translation services.
- Family planning visits for enrolled clients
- Flu ~~price~~ and COVID vaccine administration fee
- Blood pressure checks
- ~~Add -~~ Plain X-Ray

Notification of Sliding Fee Discount Program

All clients are notified of the sliding fee discount program by one more of these methods: Notices in the waiting areas, by the registration staff, publications and web site. All communication is done at a literacy level that is appropriate for our patient population and in more than one language to reflect the patients served.

RELATED DOCUMENTS

Name	
Attachment A – Epic FPL Entry	

FIS.01.06: Write-offs for Uncollectible client Accounts
FIS.01.15: Medical Insurance Write Off Policy

POLICY REVIEW INFORMATION

Point of Contact:	Jeff Perry, Community Health Center Financial Officer Brieshon D'Agostini, Health Center Chief Quality and Compliance Officer
Supersedes:	Not applicable

Title:	**Community Health Center Services Fee Policy**		
Policy #:	**AGN.10.03**		
Section:	Agency Wide Clinical	Chapter:	Fiscal
Approval Date:	03/11/2024	Approved by:	DJ Rhodes /s/ Executive Director and CEO, Community Health Center Tamia Deary /s/ Chair, Community Health Center Board
Related Procedure(s):	Not applicable		
Related Standing Order(s):	Not applicable		
Applies to:	All services provided within the health center scope, including primary care, dental, behavioral health, pharmacy and specialty services.		

PURPOSE

The fee policy provides a consistent payment model approach to ensure access to health center services and fiscal sustainability. It offers clients an equitable, affordable and accessible means for receiving health care through services provided under the scope of the Multnomah County Community Health Center. Discounts are provided in accordance with federal guidelines and apply uniformly to all clients. Clients will be provided services regardless of ability to pay. This policy intends to educate staff and clients about payment and coverage options.

DEFINITIONS

Term	Definition
330 Grant	The Multnomah County Community Health Center receives funding from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC). Health centers must meet all grant requirements to receive funding.
Deposit	Deposit for services is the amount asked for from clients determined to be in Tier 5 at check-in. The remaining balance will be collected or billed at the end of the appointment.

Family	Family is defined as a group of two or more persons related by birth, marriage, domestic partnership, or adoption who reside together. Components of the definition of family size include the client; spouse/other person having a child (or pregnancy) in common with the applicant; unmarried dependent children under age 19 (or needing to complete their senior year in high school) and living at home; and a child with disabilities, who is unmarried, living at home, and incapable of self-support. Clients under the age of 19 may be determined to be a family size of one if they are responsible for their own health care decisions, in a foster care program, emancipated or independently living from parents/guardians, or receiving confidential or grant-directed care services (such as Title X and Ryan White).
Flat Fee	The flat fee is the amount charged for a visit regardless of the amount of time and complexity of services provided during the visit.
Income	Different types of income are considered when evaluating a family's income and eligibility for the SFDS: ● money wages ● salaries before deductions ● self-employment income ● Social Security; Railroad Retirement ● Unemployment Compensation ● Workers Compensation ● strike benefits ● public assistance (i.e. Aid to Family with Dependent Children, General Assistance payment, SSI, etc.) ● training stipends ● students loans and grants ● alimony ● child support ● military family allotments ● private and government employee pensions ● regular insurance and annuity payments ● dividends ● interest ● rent ● loyalties or periodic receipts from trusts or estates ● Veteran's Benefits

	• regular support from an absent family member or someone not living in the household. <u>Income does not include</u> food or rent received in lieu of wages; food stamps; savings withdrawn from a bank; gifts; tax refunds; WIC vouchers; lump-sum inheritance; one-time insurance payments; income from the sale of property, house or car; or imputed value of Medicaid or public housing.
Health Center Formulary	A preferred list of over-the-counter and prescription drugs, that are available to clients at our Community Health Center pharmacies. This formulary is reviewed and maintained in collaboration between Pharmacy, Primary Care, and Dental Services.
Nominal Fee	The nominal fee is the amount requested at check-in for clients who are at or below 100% of the Federal Poverty Level (FPL). The nominal fee must be nominal from the perspective of health center clients. Nominal charges are not “minimum fees,” “minimum charges,” or “co-pays.”
Reproductive Health Program	Reproductive Health Program is a state grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. The Reproductive Health Program is legally designed to prioritize the needs of low-income families or uninsured people (including those who are not eligible for Medicaid) who might otherwise not have access to these health care services.
Ryan White Program	The MCHD Health Services Center receives funding from the Health Resources and Services Administration’s (HRSA) Ryan White HIV/AIDS Program to provide a comprehensive system of HIV primary medical care, essential support services, and medications for low-income people with HIV.
Sliding Fee Discount Schedule (SFDS)	Also known as a sliding fee scale, this schedule describes the range of discounts on fees for clients based on family income, size and federal poverty guidelines.
Telehealth or Telemedicine Visit	When used by payors, the terms “telehealth” and “telemedicine” includes both virtual (video) and telephone visits, even though charges are different for these two types of visits.

POLICY STATEMENT

Describe board strategies, define requirements and state exceptions/exclusions.

REFERENCES AND STANDARDS

Health and Human Services

- Reproductive Health Program Requirements

Health Resources and Service Administration

- HRSA Health Center Program Compliance Manual, "Sliding Fee Discount Program"
- HRSA HIV/AIDS Bureau Ryan White Programs Sliding Fee Scale Information

Federal Register

- Poverty Guidelines

PROCEDURES AND STANDING ORDERS

ELIGIBILITY FOR SLIDING FEE DISCOUNT PROGRAM

Clients who complete an eligibility screening and are determined to be at or below 200% of the Federal Poverty Level (FPL) are eligible for a sliding fee discount. The sliding fee discount schedule (SFDS) describes discounts by family income and size. Only family income and family size will be used in determining eligibility for the Sliding Fee Discount Program, once the patient completes the required registration process and provides required proof of income and family size, in accordance with this policy.

Clients are not required to apply for insurance in order to receive a discount; all clients will be offered an insurance eligibility screening. Should the client decide to apply for insurance, an Eligibility Specialist will assist in completing the application process. Clients are not eligible for a discount or services paid by 330 grant if their eligibility is not determined.

ELIGIBILITY SCREENING and DETERMINATION

Clients are screened annually. Their eligibility status is valid for one year unless the client's income or family size changes at which time the client is required to notify the registration staff and go through the screening process.

The process of providing documentation should not be overly burdensome to the client. If the client refuses to provide required information,the client may not be eligible for the SFDP. Sample documentation required to determine discount levels for uninsured clients may include:

Income Documentation

- Current month and last 3 months paycheck stubs
- Financial award letter from Social Security or Department of Veterans Affairs
- State Employment Division – unemployment compensation statement
- Proof of Workers Compensation monthly payments
- Rental property agreement documenting monthly rent payment
- Support Enforcement documentation of Child Support payment
- Self-Employment form documenting proof of income
- Statement of no income
- Verbal or written self-declaration of family size and income
- Updated documentation can be submitted within 90 days of the first patient visit

SLIDING FEE DISCOUNT SCHEDULES (SFDS)

The SFDS apply to clients who have completed the eligibility screening process. All services listed in the HRSA Form 5A, whether required or additional, are provided on a SFDS. Only family income and family size will be used to determine eligibility. Individuals and families with annual incomes at or below 100% of the FPL will receive a full discount for services.

If a client is determined to be eligible for a Sliding Fee Discount, even if they have insurance, they will pay the lowest tier of SFDS and will not be charged more for any service than the clients, in a higher SFDS tier (table below) for the services provided. The SFDS will be applied to services not covered by insurance plans. If the total cost of the visit is lower than the flat fee, clients in tiers 2-4 will pay the total visit cost.

Service fees are based upon the usual and customary fees in the Multnomah County area as well as information provided by the Centers for Medicare and Medicaid. Service fees are evaluated and updated annually.

The federal poverty guidelines (FPL) are updated annually as prescribed by the Federal Registry for the purpose of updating increases in the Consumer Index and are presented to The Community Health Center Board. The Electronic Health Record updates the SFDS based on FPL after the updated FPL is published. The Community Health Center Board must review and approve the SFDS Policy every 3 years.

Business Services, in collaboration with the health center, evaluates, at least once every three years, the sliding fee discount program. At a minimum, the health center:

- Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100% of the FPG, are accessing health center services;
- Utilizes this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
- Identifies and implements changes as needed.
- All services provided within the health center scope (required and additional health services) are provided on a sliding fee discount schedule including those provided through contract or formal written referral agreement.

Discounts and fees established through contract, by grant requirements, laws or local, state or federal requirements may augment, supplant or limit the applicability of the sliding fee discount program (e.g. Vaccines for Children program, School of Oral and Community Health, and Student Health Centers).

Sliding Fee Discount Schedules

Service* and Discount Tier	Tier 1 0 - 100% (Nominal Charge)	Tier 2 > 100 - 133%	Tier 3 > 133 - 167%	Tier 4 > 167 - 200%	Tier 5 > 200%
Medical Care (Includes in-house lab fees)	$35	$45	$55	$65	No Discount (Pay Full Fee, $75 deposit at Check-In)
Dental Care (Includes lab fees)	$45	$55	$65	$75	No Discount (Pay Full Fee, $85 deposit at Check-In)
Mental Health Care/ Behavioral Health Care**	$0	$0	$0	$0	No Discount (Pay Full Fee, $5 deposit at Check-In)
Clinical Pharmacy	$0	$0	$0	$0	No Discount (Pay Full Fee if applicable)
Telephone visits	$0	$0	$0	$0	No Discount

					(Pay Full Fee if applicable)
Acupuncture	$5	$8	$10	$12	No Discount (Pay Full Fee, $15 deposit at Check-in)
In house LAB Only Visit	$0	$18	$19	$20	No Discount (Pay Full Fee, $25 deposit at Check-In)
Contracted lab services	$0	75% Discount	50% Discount	25% Discount	No Discount (pay full fee)

Service and Discount Tier	Tier 1 0 - 100%	Tier 2 > 100 - 150%	Tier 3 > 150 - 200%	Tier 4 > 200 - 250%	Tier 5 > 250%
Oregon Reproductive Health Program Service & Supply Discount Schedule (ONLY to be utilized when clients decline to enroll in Oregon RH Program but are seeking family planning services)	100% Discount	75% Discount	50% Discount	25% Discount	No Discount (Pay Full Fee)

*Virtual (video) visit charges align with in-person visits for the specific service
**Includes Substance Use Disorder services provided by the health center.

Service and Discount Tier	**Tier 1** **0 - 100%**	**Tier 2** **> 100 - 133%**	**Tier 3** **> 133 - 150%**	**Tier 4** **> 150 - 200%**	**Tier 5** **> 200 - 300%**	**Tier 6** **> 300%**

	(Nominal Charge)					
Ryan White Services (per visit)	$0	$45	$55	$65	No Discount (Pay Full Fee, $75 deposit at Check-In)	No Discount (Pay Full Fee, $75 deposit at Check-In)
Ryan White Services (Cap on Charges)	$0	No More than 5% of Annual Income			No More than 7% of Annual Income	No More than 10% of Annual Income

FEES AND DISCOUNTS FOR RYAN WHITE SERVICES

In order to comply with Ryan White legislative requirements, the HIV Health Services Center (HHSC) offers a sliding fee scale to assist uninsured/underinsured patients who have difficulty paying for HIV primary care services. People with HIV/AIDS (PWHA) whose incomes are at or below 100% of the federal poverty level (FPL) will not be charged for HIV services, while PWHA with incomes at 101% FPL or above who rely on Ryan White for access to HIV care will be charged for the services they receive, based on a sliding fee scale. No Ryan White patient shall be denied service due to an individual's inability to pay.

There is an annual cap on charges for Ryan White Part A, B, C, and D clients which is based on annual gross income as a percentage of FPL. The cap on charges applies to all HRSA Ryan White Part A, B, C, and D clients regardless of income or healthcare coverage. Ryan White clients who are charged for the services they receive will have their annual (calendar year) charges capped at a percentage determined by their family size and income level. The cap on charges is re-evaluated every 12 months based on the client's Ryan White eligibility.

- Patient charge is equal to the part of medical expense care not covered by insurances.
- Applicable imposed (not actual fee for service) HIV-related charges during the calendar year include enrollment fees, premiums, deductibles, cost sharing , copayments, coinsurance, and other medical charges..
    - To apply the Cap on Charges, the Ryan White Program will calculate each patient's annual cap based on their annual gross income, inform the patient of their cap and their responsibility to track and submit all other Ryan White imposed charges, track all applicable charges imposed by the HIV Health Services

Center, and stop imposing charges on the Ryan White Part A, B, or C client once the cap is met each calendar year.

OREGON HEALTH AUTHORITY REPRODUCTIVE HEALTH PROGRAM

In addition to completing the eligibility form, the Reproductive Health Program requires that the client is asked to self-report income and family size. Clients who have been enrolled into the Reproductive Health Program will not be charged for reproductive services. Clients with greater than 250% FPL are not eligible for the program. All clients enrolled in the Reproductive Health Program regardless of FPL% will not be charged a nominal fee as this is a requirement of the program.

Reproductive Health Program discount may still be used for reproductive health qualifying services if a client refuses to share their income and family size. If a client refuses to apply for the RH program, or is not screened for it by clinic staff, the reproductive health program's sliding fee discount will be applied, according to income and family size.

Minors who request confidential Reproductive Health services, will have their sliding fee discount evaluated on their own income, and a family size of one, per Oregon Reproductive Health Program Requirements.

LAB FEES

All dental labs are covered by the nominal or flat fee. In-house labs within a primary care visit are covered by the nominal or flat fee. Lab Only Visits are charged in accordance with the SFDS. Labs provided by a third-party/ contracted provider will be discounted using the primary care SFDS (or a separate SFDS). This SFDS is in accordance with the Federal Poverty Level and can be viewed by contacting the vendor. Any uncollected client debt by the lab vendor will be billed to MCHD.

PHARMACY CHARGES

Self-pay clients

To ensure that health center clients lacking prescription benefits are able to obtain necessary prescribed medications, the health center formulary contains medications available through the health center's in-house pharmacies offered at an FPL-based Sliding Fee Discount Schedule. The fee includes a dispensing fee. For uninsured clients who are prescribed medications that are not on the health center formulary, if no formulary option is available, the prescriber may request a formulary exception (Tier 3). If upon clinical review, the exception is approved, health center Pharmacy Services may dispense up to 1 month supply of medication at a time for the duration of the approval.

Pharmacy Sliding Fee Discount Schedule

Medication and Discount Tier	Maximum Days Supply	Tier 1 0 - 100% (Nominal Fee)	Tier 2 >100-133%	Tier 3 >133-167%	Tier 4 >167-200%	Tier 5 > 200% (No Discount)
Level 1	30	$4	$6	$8	$10	$12
	90	$10	$12	$14	$16	$18
Level 2	30	$10	$12	$14	$16	$18
Level 3 (Non-Formulary)	30	$15	$20	$25	$30	$35

Insured Clients

For insured clients, pharmacy services follows the requirements outlined in the contract with the insurance plan or its third party processors (pharmacy benefits management or PBM company) regarding medication coverage and client copays according to the client's benefit plan. The pharmacy requests payment of copays as specified by their insurance. In the event a medication is not covered by the client's pharmacy benefit, the pharmacy will alert the prescriber of the need to request prior authorization or a formulary exception from the plan or advise the prescriber of covered alternatives. Clients seen in the clinic with prescription coverage under a plan that Pharmacy Services is not contracted with, will be encouraged to obtain services at an external pharmacy.

Collection of Payment

Clients will be asked to provide their insurance co-pay or the uninsured formulary drug price at the time of dispensing/pick-up. Clients who are unable to pay may have the charge applied to their client account. Health center clients receive their medication regardless of their ability to pay.

SERVICES PROVIDED VIA A CONTRACT

For services provided via a contract, the health center ensures that fees for such services are discounted in a manner such that:

- A full discount is provided for individuals and families with annual incomes at or below 100% of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100% of the FPG.

- Partial discounts are provided for individuals and families with incomes above 100% of the current FPG and at or below 200% of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.
- No discounts are provided to individuals and families with annual incomes above 200% of the current FPG.

SERVICES PROVIDED VIA A FORMAL WRITTEN REFERRAL AGREEMENT

For services provided via a formal written referral agreement, the health center ensures that fees for such services are either discounted according to the health center's schedule or discounted in a manner such that:

- Individuals and families with incomes above 100% of the current FPG and at or below 200% of the FPG receive an equal or greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule; and
- Individuals and families at or below 100% of the FPG receive a full discount or a nominal charge for these services.

CLIENT PAYMENT SCHEDULE and NOMINAL CHARGE

All clients determined eligible in accordance with this policy are asked to pay at the time of check-in and will be charged for services according to the tier they qualify for based on family size and income. To determine if the nominal amount would be "nominal" from the perspective of the client one or more of the following will be used; board member input, patient surveys, review of collection % or bad debt or co-payment amounts.

Clients will be asked to pay any outstanding account balances. Clients who are unable to pay charges will not be denied services. Insured clients are asked to pay co-payments at the time of check-in, not to exceed the amount they would pay under the Sliding Fee Discount Schedule, whichever is lower, which may vary according to insurance coverage and services provided to the client. The nominal charge does not include any service or supply. The nominal charge will be applied the same day before applying to any outstanding balances the client owes prior to or future charges that are reflected on the client's account.

Prepayment For Service

All clients that do not qualify for a discount will be asked to pay an amount at check-in. Any remaining balance will be determined after services are rendered and collected/billed accordingly.

Write-offs

The Multnomah County Community Health Center does not turn away clients for the inability to pay for services. Due to this policy, there may be charges that go unpaid in which Multnomah County may write off from the client account. Criteria for write off are listed in MCHD policy FIS.01.06.

Services exempt from all client charges after any applicable insurance billing:

- Services covered by Medicaid
- Services covered by Medicare (client is responsible for copays/coinsurance)
- Services funded by Reproductive Health (RH) clients who completed the application for RH and whose FPL is below 250% only.
- HIV Health Services Center visits after clients reach annual cap on charges (in accordance with Federal Ryan White rules)
- Enabling services include case management (not performed by nurses), eligibility assistance, outreach, transportation, supportive and educational visits provided by Community Health Workers, and translation services.Family planning visits for enrolled clients
- Flu and COVID vaccine administration fee
- Blood pressure checks
- Plain X-Ray

Notification of Sliding Fee Discount Program

All clients are notified of the sliding fee discount program by one more of these methods: Notices in the waiting areas, by the registration staff, publications and web site. All communication is done at a literacy level that is appropriate for our patient population and in more than one language to reflect the patients served.

RELATED DOCUMENTS

Name	
Attachment A – Epic FPL Entry	
FIS.01.06: Write-offs for Uncollectible client Accounts	
FIS.01.15: Medical Insurance Write Off Policy	

POLICY REVIEW INFORMATION

Point of Contact:	Jeff Perry, Community Health Center Financial Officer Brieshon D'Agostini, Health Center Chief Quality and Compliance Officer
Supersedes:	Not applicable

FISCAL YEAR 2025 BUDGET

The only way to do great work is to love what you do

- Steve Jobs

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Today's Agenda

- Budget process/timeline overview
- FQHC Total Budget
- Budgets by Program
- Q & A

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BUDGET OVERVIEW

Community Health Center // Health Center Board's Role in Budgeting

Role: Governing role is to approve the health center budget. The budget cannot be changed without the approval of the Health Center Board.

Goal: Assure that the Community Health Center has appropriately designed the financial resources to carry out its scope of project - also known as: What did we promise to patients?

All board members:

- Provide input, share priorities, give feedback on budget needs
- Participate in budget trainings
- Vote on the final budget proposal

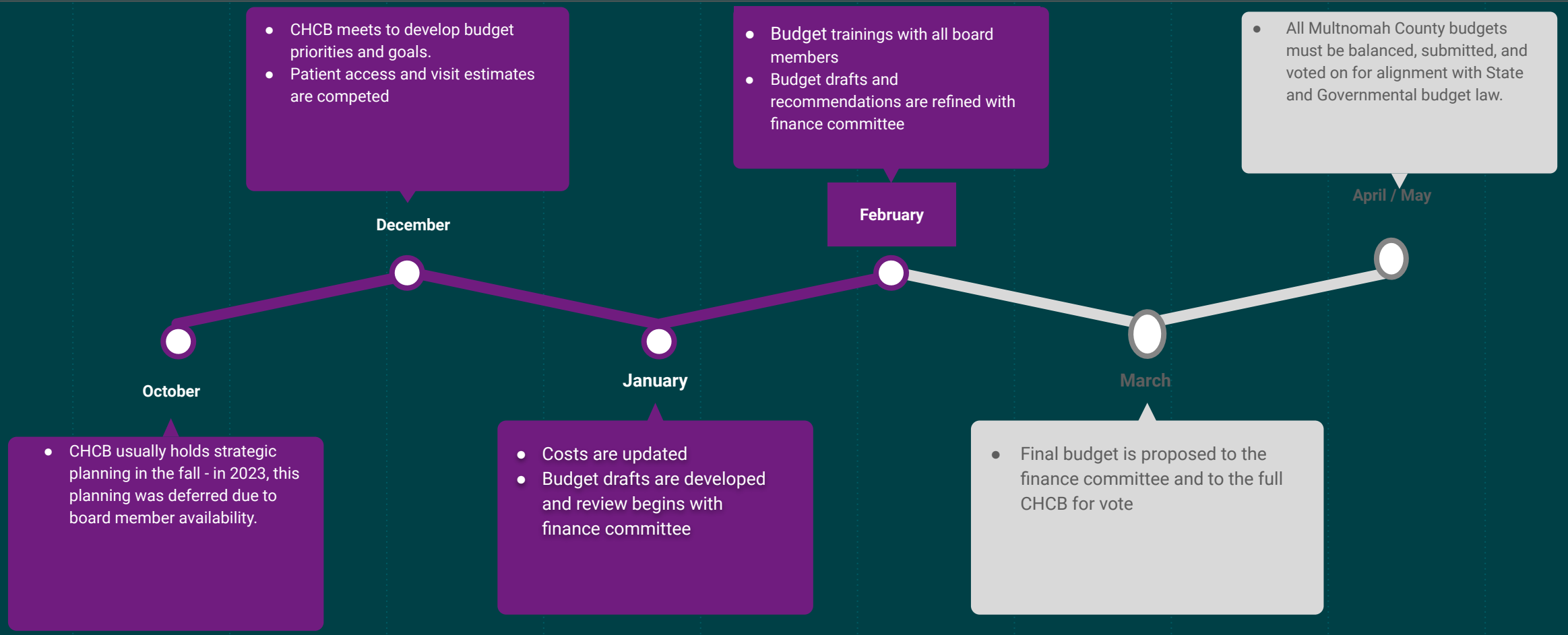
Finance committee members:

- Develop and partner with health center staff on budget drafts
- Assist with final budget refinements and share recommendations with full board

Board members do not:

- Make specific decisions on individual staff changes (except for the Executive Director role)

Community Health Center // Budget Timeline



Community Health Center // Strategy to Budget

The current 2022-2025 strategic plan include outlines the following guiding strategic goals. The budget should reflect services and resources sufficient to carry out these goals.

- Operational Excellence: Build One Health Center that delivers high touch, high quality care driven by the needs of our community
- Advance health equity: Nurture thriving healthy communities by centering race in order to advance health equity
- Our People: Our people are our greatest asset: success is reliant on a strong workforce that can drive goals for decades to come.
- Health Center of Choice: Be the first place that people want to get their healthcare.
- Financial Stewardship: Design financial systems and performance so that the health center is here for the next five decades

Community Health Center // Changes from FY24

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FY25 Budget Financial Summary

- **Total draft budget is $200M**
- **Used $8M BWC**
- **Used $65M APM**
- **Used $7M Incentives**
- Clinical Services recovery continues for FY25 as predicted:
  - Dental no change/projected to be conservative for FY25
  - Primary Care growth projected to be conservative for FY25
  - Pharmacy growth projected to be conservative for FY25
  - Student health growth to be at maintenance/no change for FY25
  - Funding for new PCC clinic included
  - Expansion of behavioral health and CHNs built in for value based pay emphasis

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FQHC BUDGET

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How it all begins

Revenue

- County General Funds
- Grants
- Medicaid Quality Incentives
- Health Center Fees
- Miscellaneous Revenue
  - APM
  - Wraparound
  - Beginning Working Capital

Expense

- Personnel
- Contractual Services
- Internal Services
- Materials and Services
- Capital Outlay

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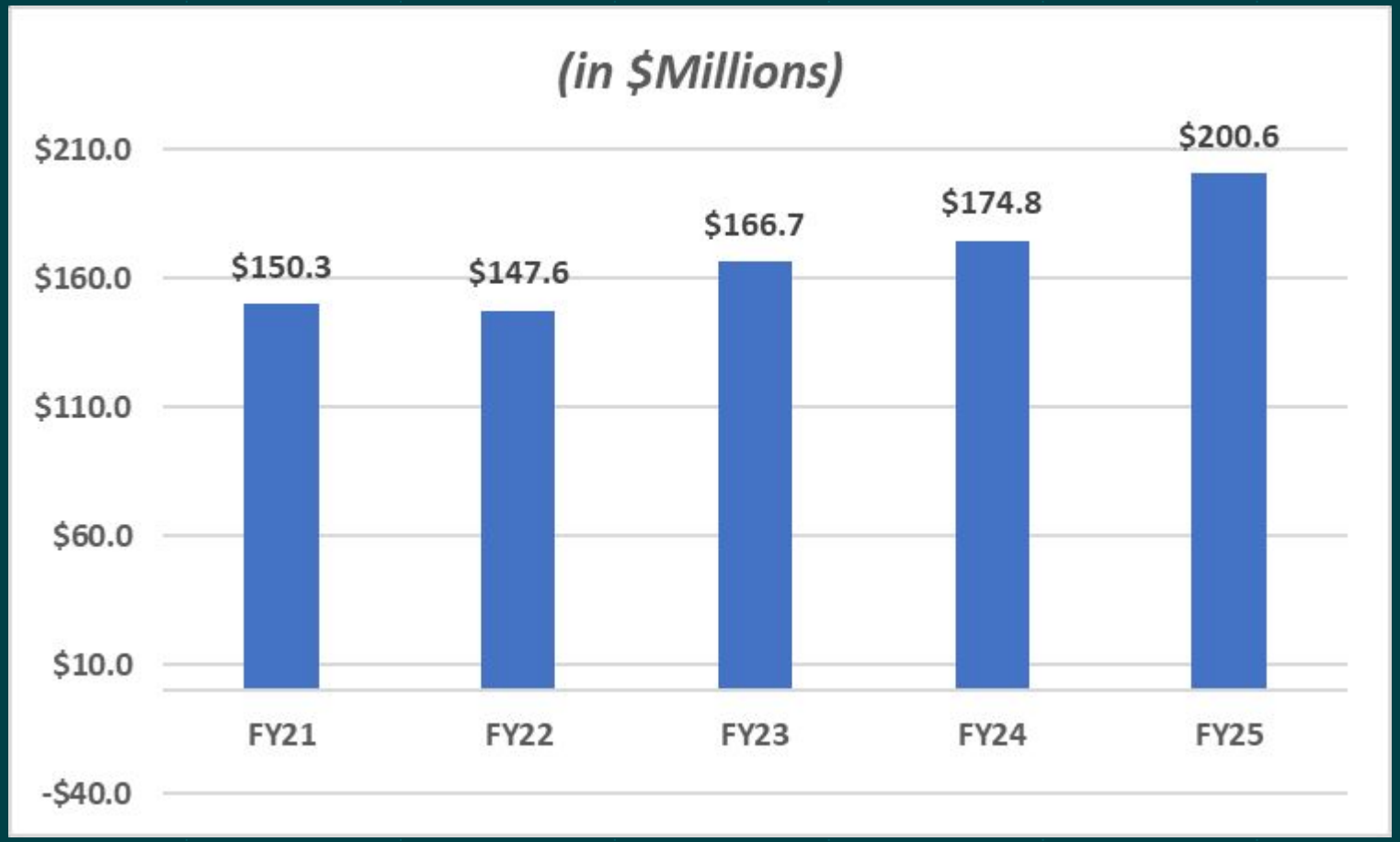
Health Center Budget Trend



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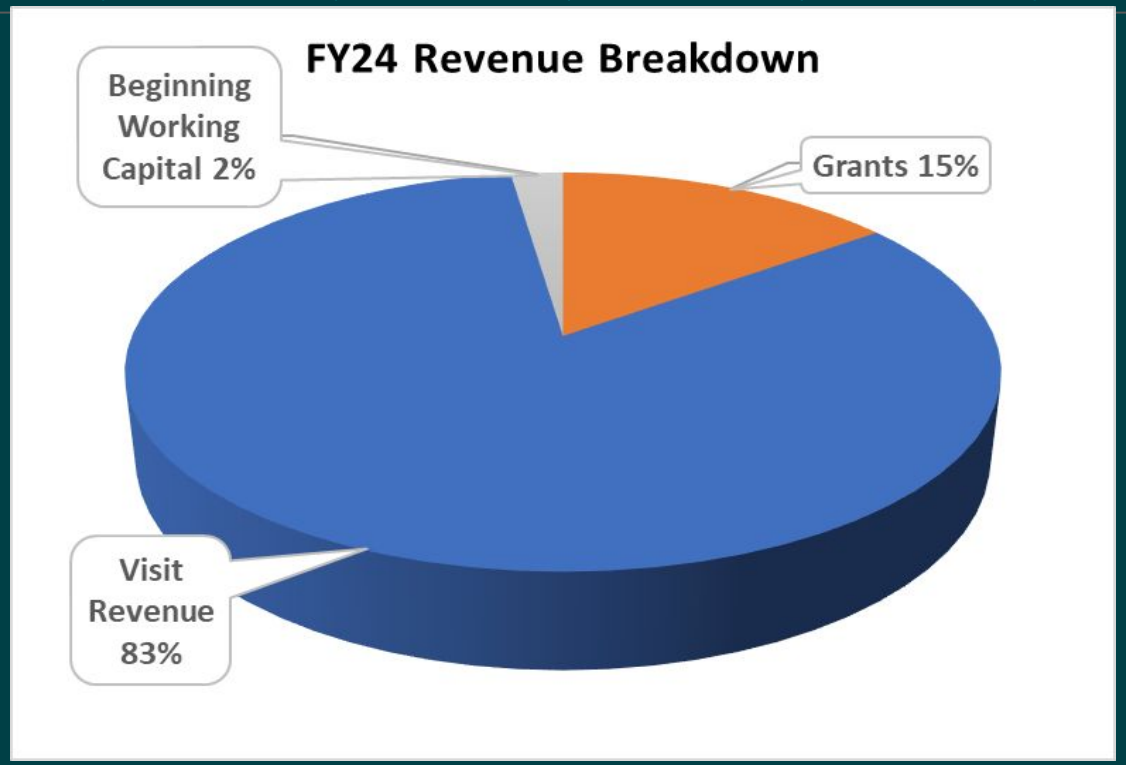
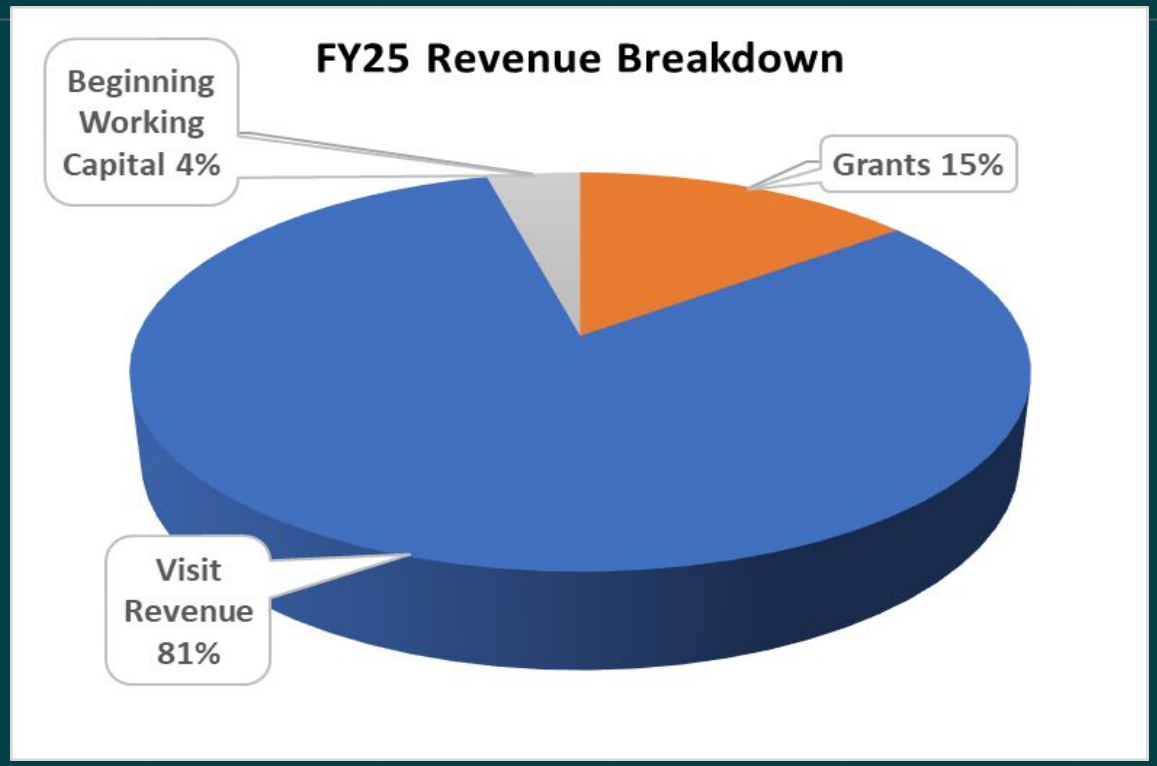
How it all begins

Revenue

- County General Funds
- Grants
- Medicaid Quality Incentives
- Health Center Fees
- Miscellaneous Revenue
  - APM
  - Wraparound
  - Beginning Working Capital

Revenue Breakdown





* Visit Revenue = Medicaid Quality Incentives, Health Center Fees, Self Pay Fees, APM & Wraparound

How it all begins

Expense

- Contract Services
  - Professional Services
- Internal Services
  - Indirect Expense
  - Data
  - Distribution
  - Building Services
  - Facilities Management
  - Telecommunications
- Personnel
- Materials & Supplies
  - Pharmaceuticals
  - Medical & Dental Supplies
  - Admin Supplies
  - Training

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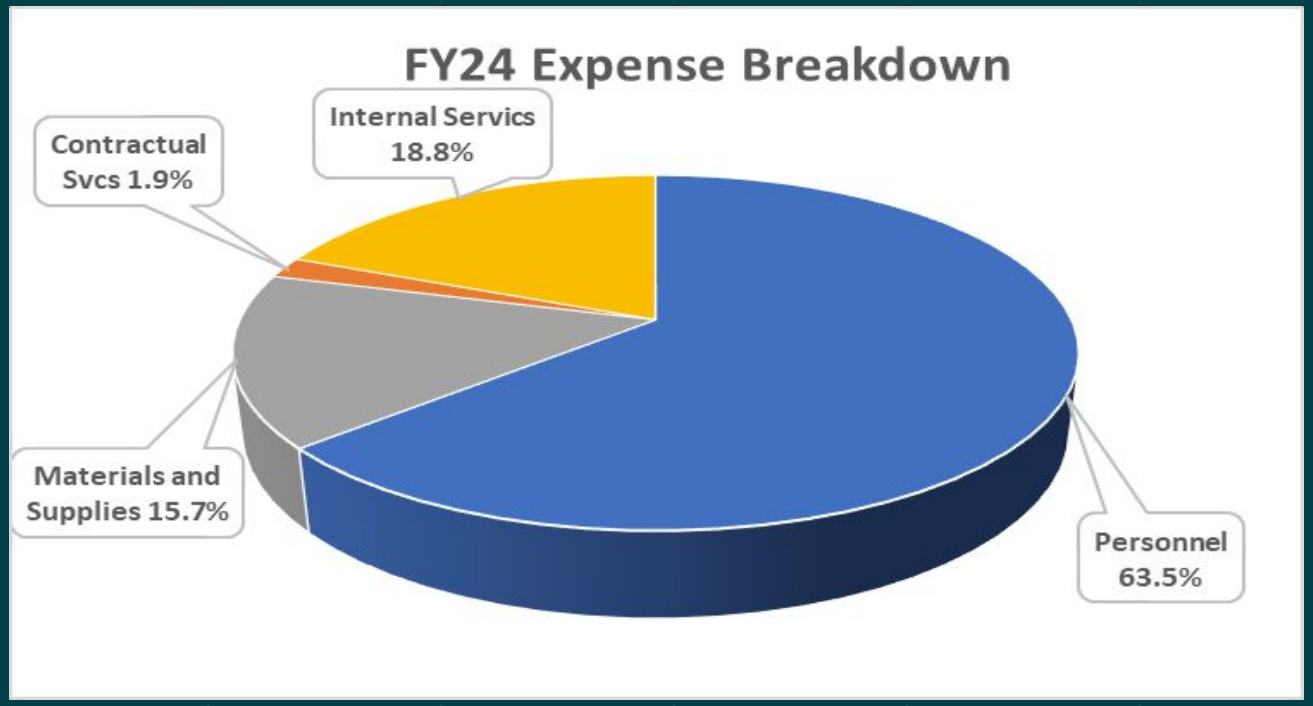
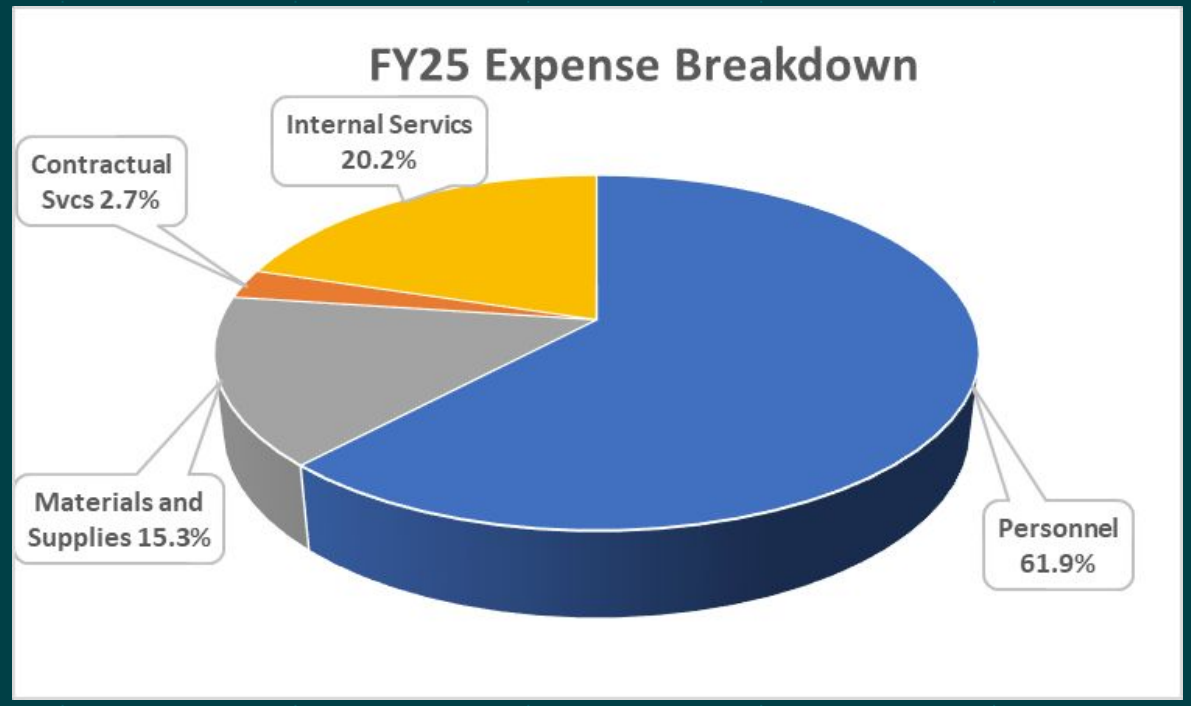
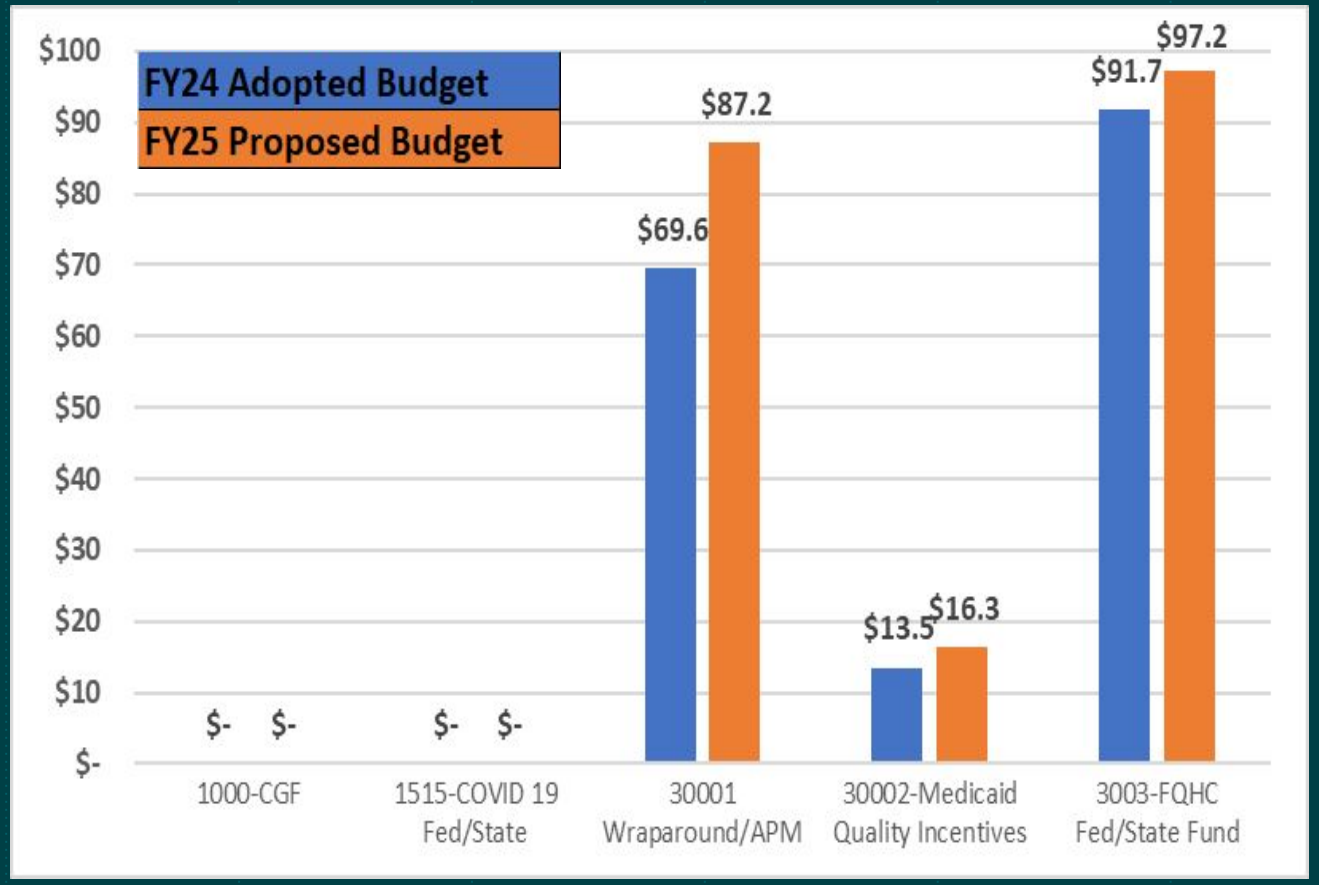
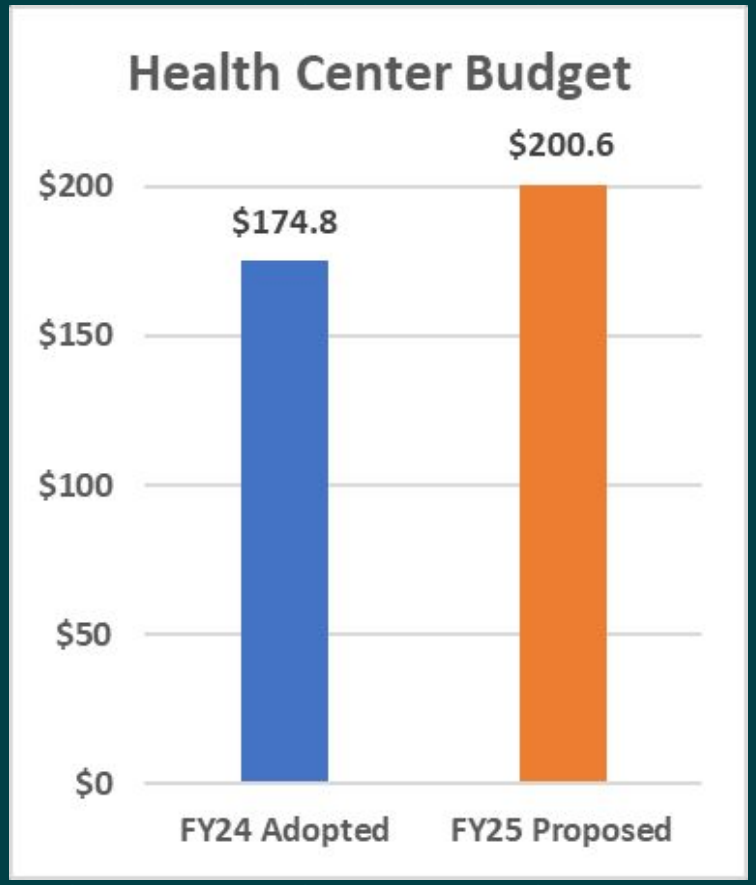
Expense Breakdown





Health Center Trend





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PROGRAM BUDGETS

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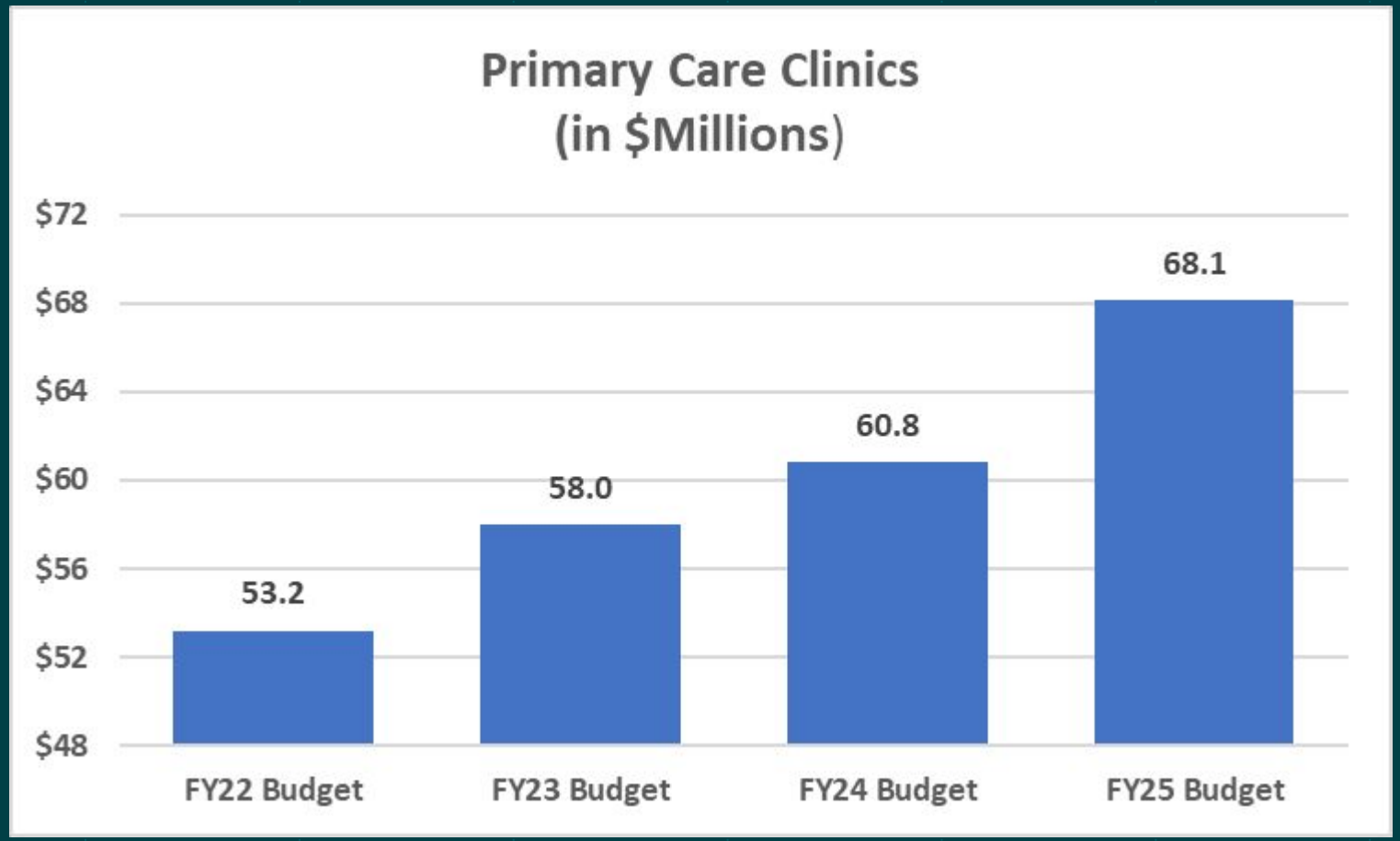
Primary Care



Primary Care KPIs

	FY22	FY23	FY24	FY25
FTE	287.7	281.3	300.7	307.9
Visits	179,792	187,751	192,730	161,587
Visit/Day	17	17	17	15

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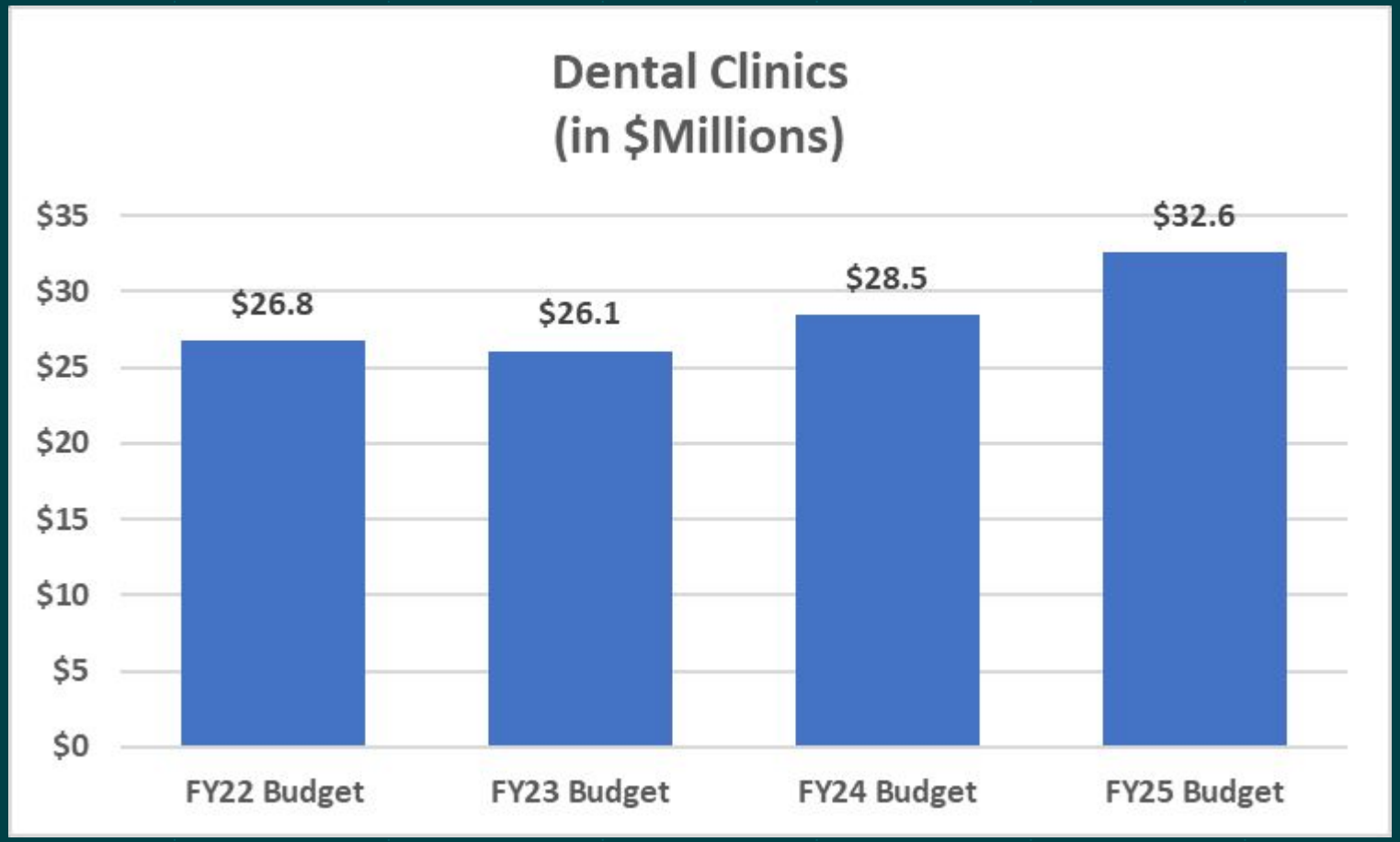
Dental



Dental KPIs

	FY22	FY23	FY24	FY25
FTE	145.1	144.1	120.5	120.1
Visits	94,738	80,497	73,777	75,059
Dentists	25.3	19.2	19.0	19.0
Hygienist	15.6	14.5	13.9	12.8

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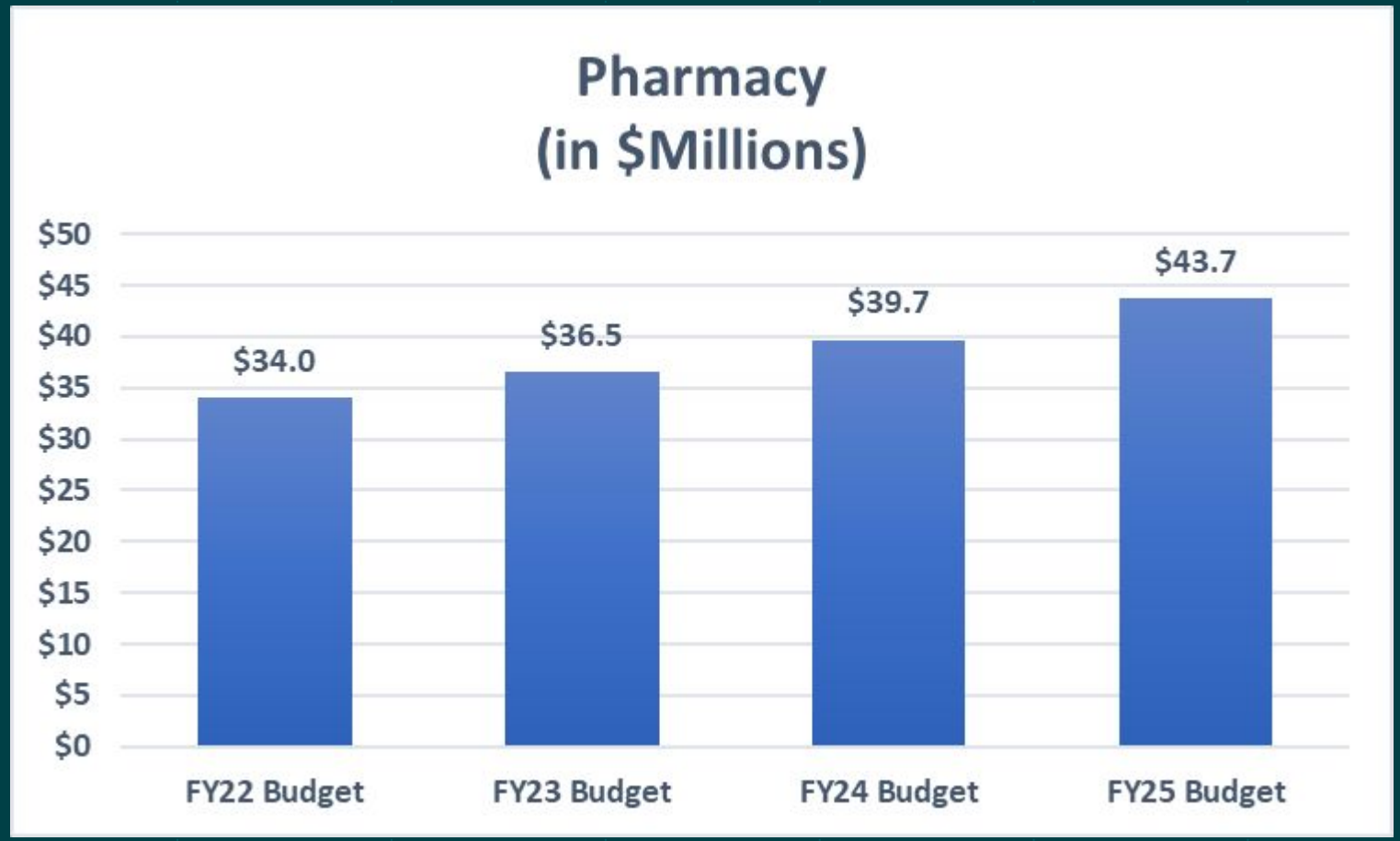
Pharmacy



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Pharmacy KPIs

	FY22	FY23	FY24	FY25
FTE	55.3	63.5	61.6	62.7
Rx	372,000	373,500	390,000	410,000
Capture Rate	63%	60%	56%	58%

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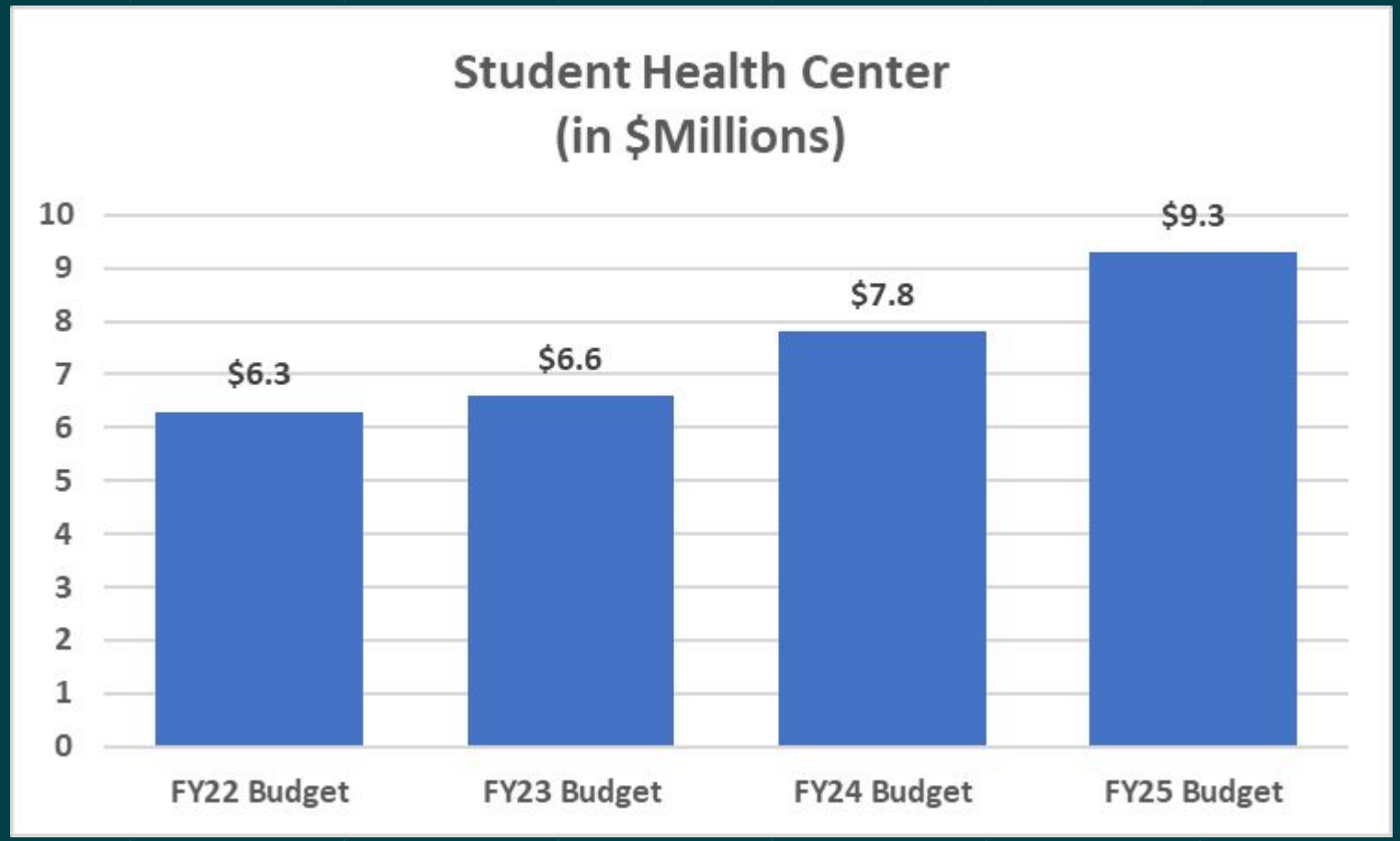
Student Health Centers



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Student Health Centers KPIs

	FY22	FY23	FY24	FY25
FTE	32.3	28.2	34.0	32.8
Visits	16,474	16,796	16,897	16,339

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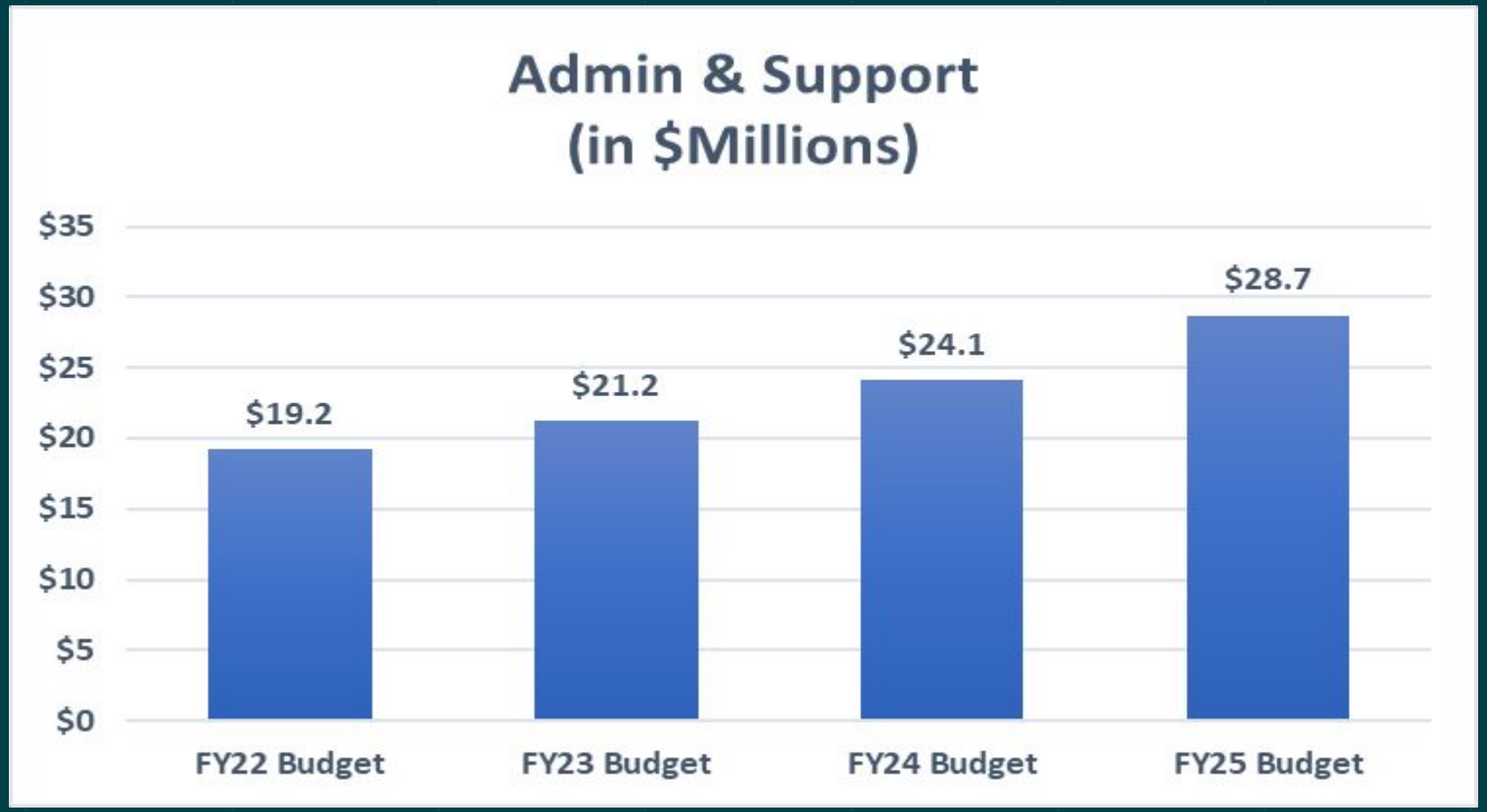
Administrative & Support



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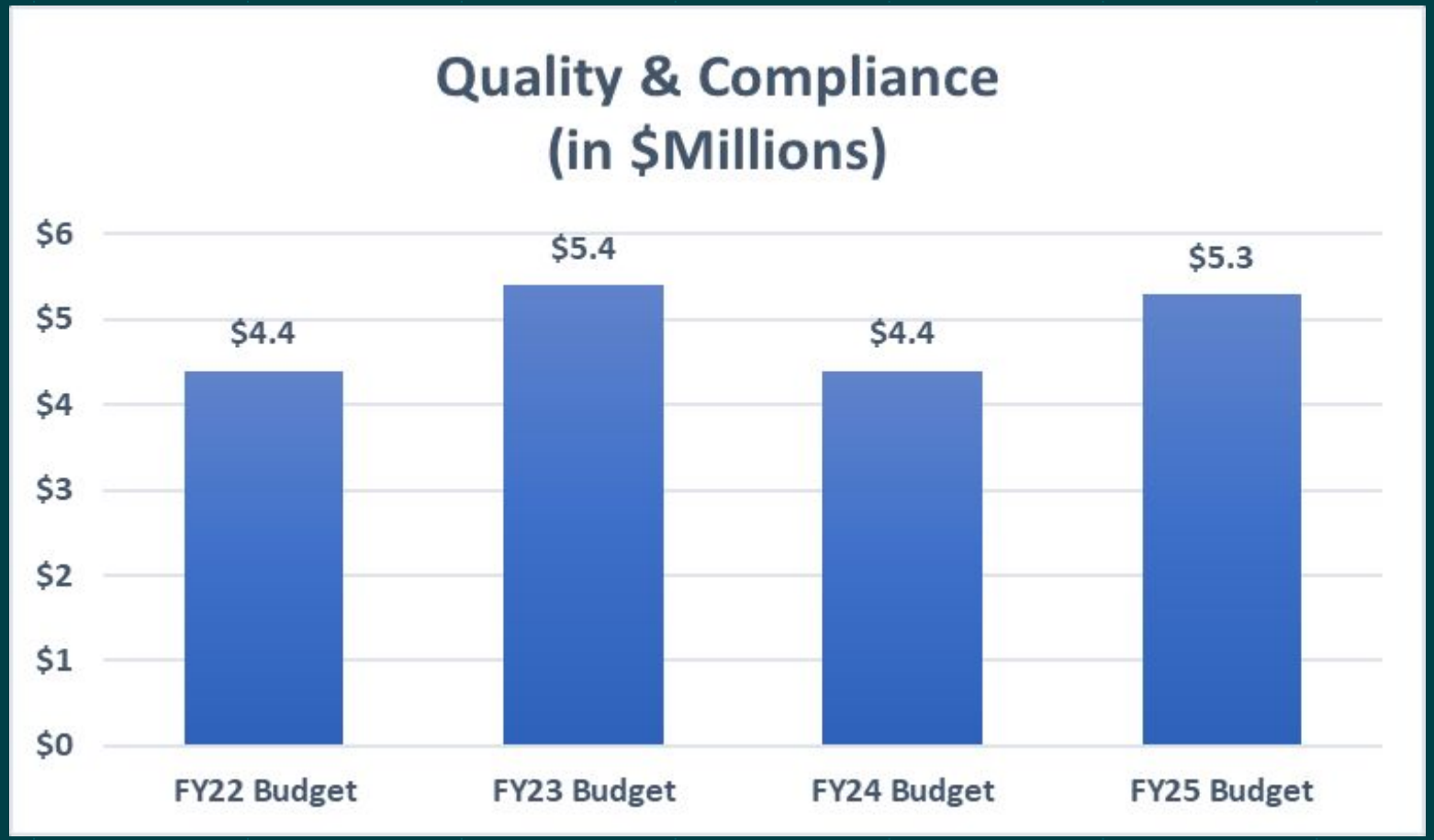
Quality & Compliance



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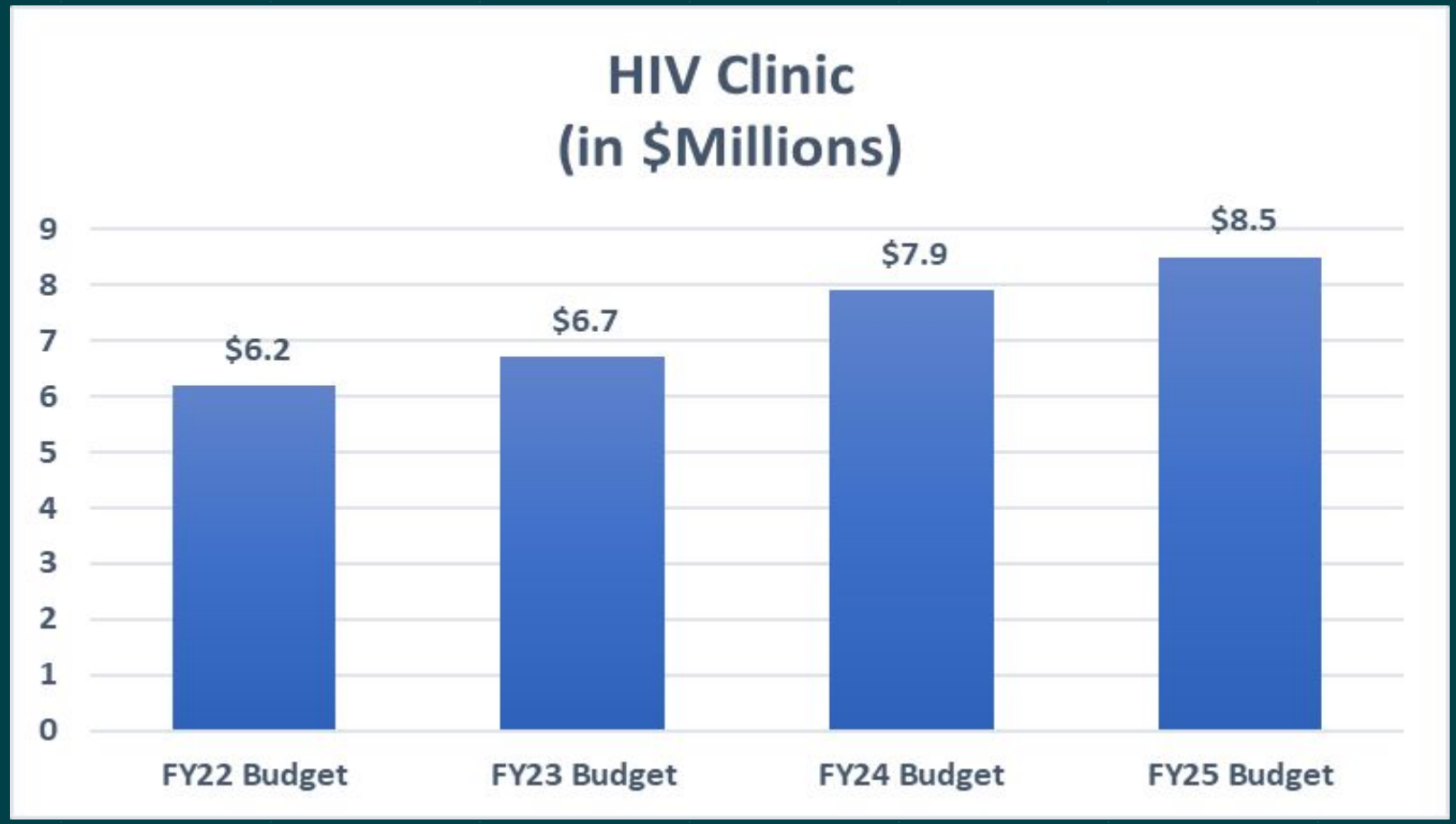
HIV Clinic



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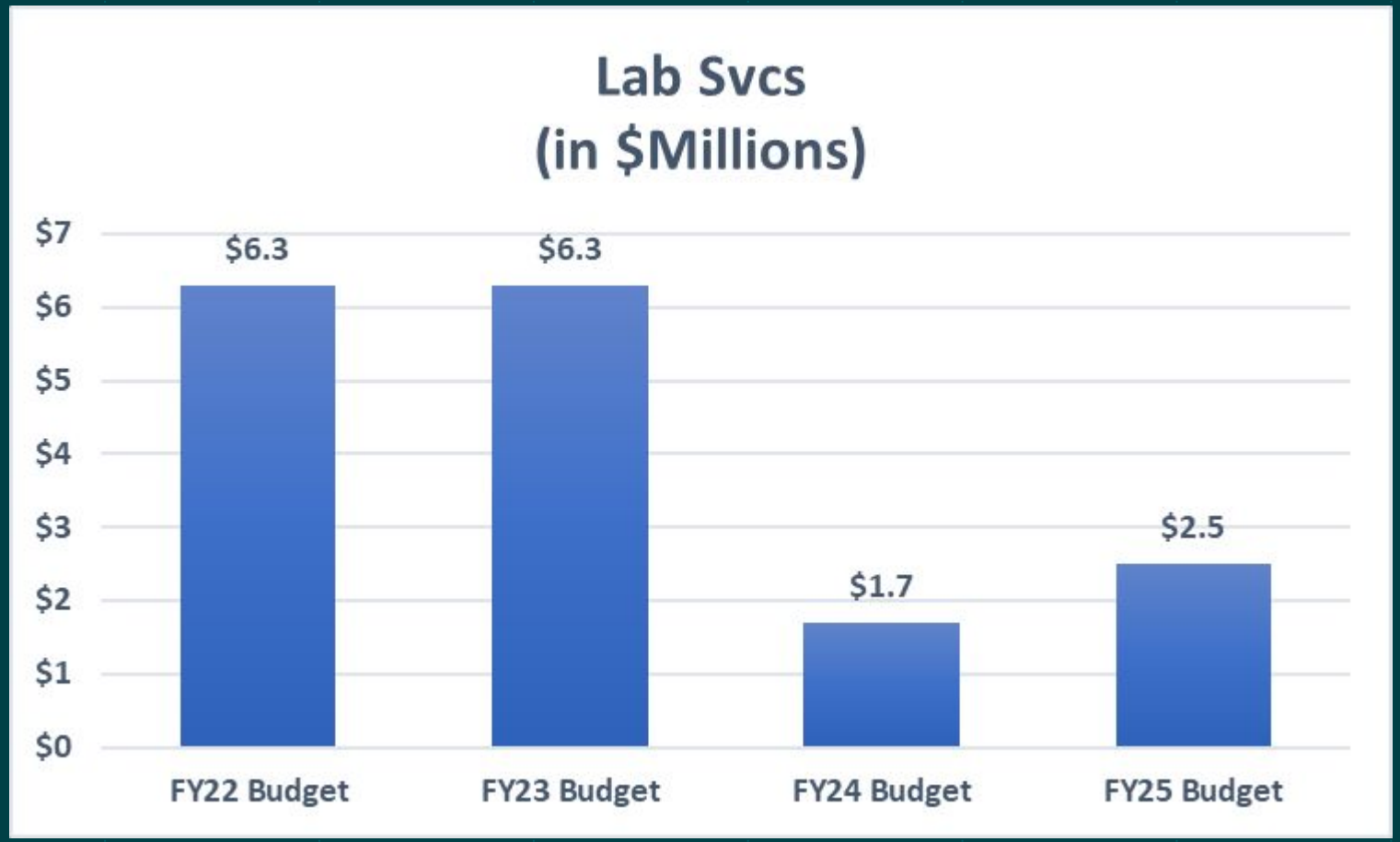
Lab



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Thanks!

Any questions?