The County of Santa Cruz
Integrated Community Health Center Commission
MEETING AGENDA

May 13, 2026 @ 1:00pm - 2:00pm

MEETING LOCATION: In-Person – 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060, 40 Eileen Street, Watsonville CA 95076, will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454-2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

ORAL COMMUNICATIONS - Any person may address the Commission during its Oral Communications period. Presentations must not exceed three (3) minutes in length, and individuals may speak only once during Oral Communications. All Oral Communications must be directed to an item not listed on today's Agenda and must be within the jurisdiction of the Commission. Commission members will not take actions or respond immediately to any Oral Communications presented but may choose to follow up at a later time, either individually, or on a subsequent Commission Agenda.

1. Welcome/Introductions
2. Oral Communications
3. April 8, 2026, Meeting Minutes – Action Required
4. HSA Billing FO Policy Procedure Policy 100.03 – Action Required
5. Policy 100.04 HSA Billing Sliding Fee Discount Program – Action Required
6. Quality Management Update
7. FY 26/27 Proposed Budget - Action Required
8. CEO Update

Action Items from Previous Meetings: Action Item	Person(s) Responsible	Date Completed	Comments

Next meeting: Wednesday, June 10, 2026, 1:00pm - 2:00pm **Meeting Location: In-Person -** 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454-2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held April 8, 2026

TELECOMMUNICATION MEETING: Microsoft Teams Meeting - or call-in number +1 916-318-9542 – PIN# 500021499#

Attendance	
Rahn Garcia	Member
Dinah Phillips	Member
Marco Martinez-Galarce	Member
Michelle Morton	Member
Maximus Grisso	Member
Amy Peeler	County of Santa Cruz, Chief of Clinics
Raquel Ruiz	County of Santa Cruz, Senior Health Services Manager
Julian Wren	County of Santa Cruz, Admin Services Manager
Jennifer Phan	County of Santa Cruz, Health Services Manager
Mary Olivares	County of Santa Cruz, Admin Aide
Meeting Commenced at 1:00 pm and concluded at 1:45 pm	

Excused/Absent:

Excused: Christina Berberich
Excused: Len Finocchio
Absent: Nicole Pfeil

1. Welcome/Introductions

Introductions were done at this time.

2. Oral Communications:

Marco reported on a 60 Minutes segment about an organization on the East Coast that provides weekend services to individuals who cannot afford healthcare. He will send Mary the link so she can share it with the commission.

3. March 4, 2026, Meeting Minutes – Action Required

The minutes from March 4, 2026, meeting were reviewed and recommended for approval. Rahn motioned to accept the minutes as presented. Marco seconded the motion. All members present voted in favor. Maximus abstained, as he was not present at the previous meeting.

4. Referral Process – Report Back

Jessica McElveny gave an in-depth report back on the referral process. Jessica reported the referral volume for fiscal year 2025/2026 is projected at 22,000 patients. Jessica reported on referral center tasks, referral processing, and referral closure process. Jessica reported some of the referral center challenges have been 5 medical leaves since January of 2025, 231 lost working days, 1 FTE Vacancy, 304 lost working days and Santa Cruz Health Information Exchange – An automatic process to send the provider the results changed to a multi-step manual process. Lastly jessica reported on strategies to reduce days to process

- Improve manual workflows and increase the use of technology whenever possible.
- •Re-assign direct referrals that are currently assigned to the referral center to the medical assistants.
- + Increase referrals per medical assistant per month by 8
- - Decrease referrals per referral center staff per month by 33

It was requested by commissioner to e-mail out presentation to commission staff, Mary to send out.

5. Central California Alliance for Health-Health Care Technology Grant Submission Approval - Action Item

Raquel presented that an application will be submitted to the Central California Alliance for Health for approval of a $50,000 Health Care Technology Grant, due May 5. The grant funds will be used for immunization and medication scanners and electronic enhancements. The anticipated award date for this grant is October 30th. Dinah motioned to accept the grant as presented, and Marco seconded the motion. All members present voted in favor.

6. X-Ray Expansion – Action Item

This is not an action item. Staff reported that they are working on a partnership with Community Health, which is in need of X-ray services. As part of being a strong community partner, no revenue will be generated from this arrangement. The collaboration is intended to strengthen relationships and support Community Health's service needs.

7. Rate Review – Action Item

Amy presented the rate review and reported on the sustainability plan. In collaboration with the organization's consultant, staff have determined that a rate study is needed. She explained that a triggering event is required in order to initiate this process and reviewed the steps with the commissioners. Staff requested that the commission authorize moving forward with pursuing a rate increase with

the state. Dinah motioned to approve the request as presented, and Marco seconded the motion. All members present voted in favor.
8. Quality Management Update
Raquel provided a Quality Management update. She reported on the Homeless Persons' Health Project (HPHP) colorectal cancer screening initiative, which aims to increase screening rates among HPHP primary care providers (PCPs) by 25% by May 1, 2026. Currently, screening completion is at 18% of 1,200 patients identified on a "screening due" report; however, only 400 of those patients are confirmed to be assigned to HPHP PCPs. Due to discrepancies in patient assignments, an additional quality improvement project has been initiated. This effort will focus on reviewing patient panels, assigning appropriate PCPs, and ensuring patients are properly routed through the screening process. Raquel also reported on the Ryan White Work Plan deliverables for HIV patients. Raquel also provided an update from the Peer Review and Risk Management Committee. She reported that 19 monthly peer review chart audits were conducted, and none raised concerns. Raquel further shared that the Watsonville Health Center presented a report on grievance and compliance review. Timely access to appointments had previously been identified as a concern; however, there has been significant improvement, with waiting times reduced from 60 days to 1 day for new patients and 6 days for follow-up appointments. Lastly, she reported that the committee finalized a report analyzing the types of medications prescribed, based on findings from chart audits.
9. Financial Update
At this time Rahn motioned to increase the meeting time by another 5 minutes. Dinah motioned to extend meeting time to another 5 minutes as requested, and Marco seconded the motion. All members present voted in favor. Amy reported in their adjusted budget, they expected to spend about $178K more than they brought in so they planned for a loss. Based on the latest estimated division actuals, that loss is now projected to be only about $19K. Amy reported they improved their financial position by roughly $159K compared to plan. Amy reported they are they improved negatively, but it does mean their operations performed significantly better than expected. Amy also reported on fiscal year July-March completed billable appointments comparison, fiscal year July-March unique patient comparison, and total uninsured completed appointments. Amy lastly reported overall, the key takeaway is that their financial position is improving compared to plan. However, they need to stay focused on sustaining revenue growth, managing uninsured exposure, and ensuring billing accuracy and efficiency.
10. CEO Update
Amy reported that we have a new commissioner coming on board in the next 1-2 months.

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- Minutes approved _____ ___/___/___
  (Signature of Board Chair or Co-Chair) (Date)

Health Centers Division

Health Centers FY 26/27 Proposed Budget

5-13-26

Policy and Coverage Changes Could Increase Demand While Making Revenue Less Predictable

Action Requested

Action

Approval of the Health Centers Division
FY 26-27 Proposed Budget

Budget Principles

Proposed Budget Principles

We are proposing a budget that uses the following as a foundation:

- **Access**: maintain staffing and revenue levels to support providing services to the patients that need it
- **Quality**: maintain staffing and increase revenue to the levels needed to continue to provide quality services
- **Cost**: continuing to implement strategies to reduce supply costs, eliminate/reduce costs that are less directly related to our core functions, increase revenue to cover expenditure budget
- **Workforce**: submitting budget with no change to current staffing FTEs to support us increasing our PPS Rate

Emerging Issues

Long-Term Sustainability Depends on Better Aligning Reimbursement With the Cost of Care

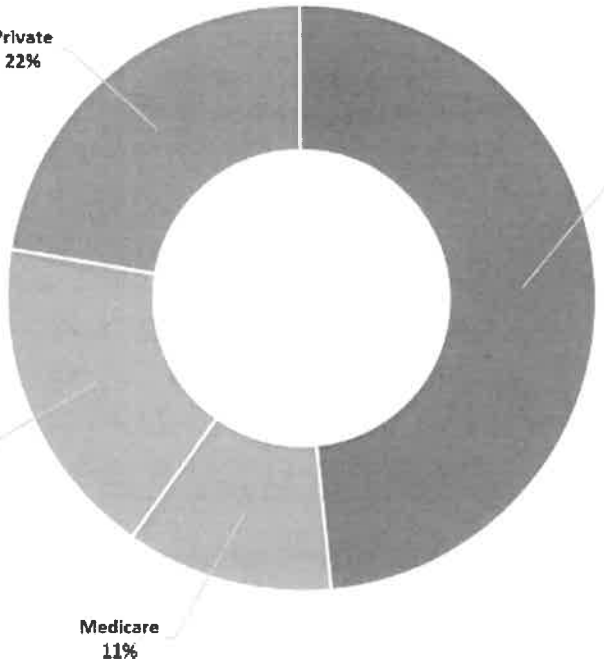
Key risk themes:

Emerging Issue	Budget Impact	Access Impact
More uninsured / underinsured residents	Higher uncompensated care costs	More patients need care without reliable coverage
Federal and State policy changes	Reimbursement uncertainty and administrative burden	Coverage interruptions may affect patients
Medicare telehealth uncertainty	Potential future revenue and access risk	Patients may lose flexible access options

Most CHC Patients are Insured But One in Five Lack Coverage.

The majority of CHC patients are publicly-insured under Medicaid (49%) and Medicare (11%). Private coverage accounts for 22% of patients.

Payer Mix at Health Centers, 2024



4% Private

70% Medicaid

9% Uninsured

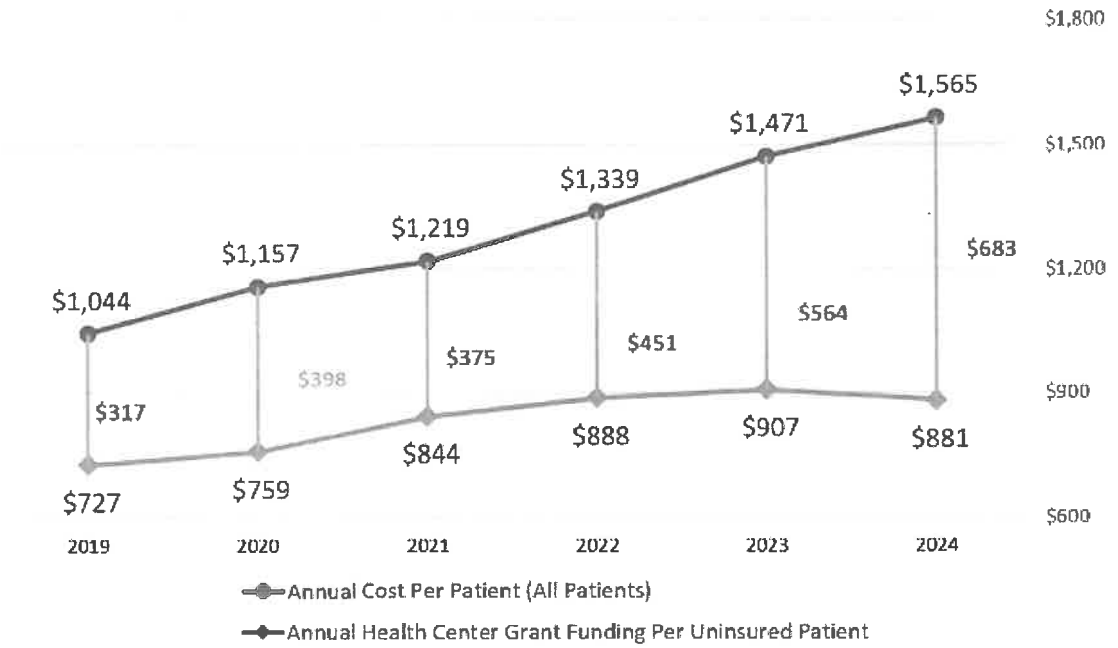
17% Medicaid

Source: 2024 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

Rising Uncompensated Care Costs

- In 2024, **the average cost per patient was $1,565—a 6.4% increase from 2023.**
- Despite this, **Section 330 grant funding fell to $881 per uninsured patient in 2024.**
- The gap between average per patient costs and federal support continues to widen—**a 21%** differential increase between 2023 and 2024 alone.

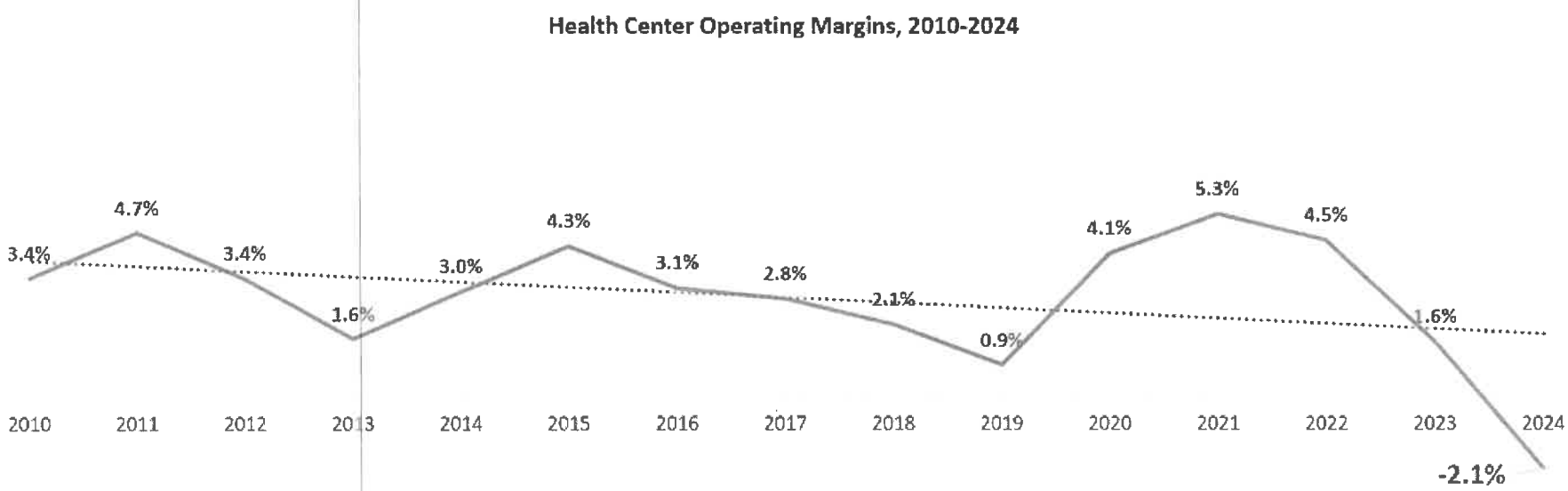
Per Patient Cost of Care Gap for Federally Funded Health Centers, 2019-2024



**Information on this slide includes data from federally funded (section 330) health centers only.

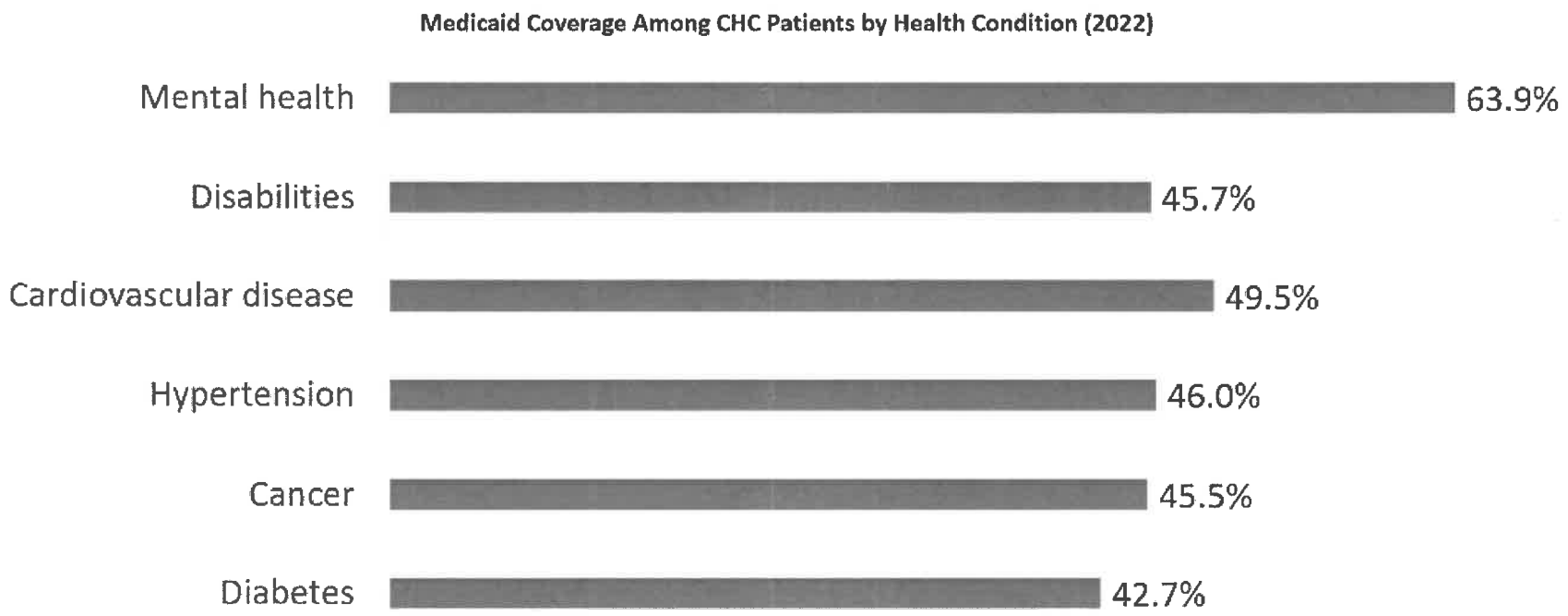
Source: 2019-2024 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

CHC's Slim Margins on the Decline



Source: 2010-2024 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

CHCs Provide Essential Care for Medicaid Patients with High Chronic Disease Burdens



Note: Disabilities reflect difficulty with self care; mental health based on patient or doctor considered seeing a mental health professional in past 12 months; pregnant women included if ever pregnant.

Source: 2022 Health Center Patient Survey, Bureau of Primary Health Care, HRSA, DHHS.

Major Budget Changes

Major Budget Changes

MAJOR CHANGES	NET FTE CHANGES	2026-27 ONGOING BUDGET INCREASE / (DECREASE)	2026-27 ONE-TIME BUDGET INCREASE / (DECREASE)
> Clinic Services			
Intergovernmental Revenues	0.00	$790,928	$0
Charges for Services	0.00	$7,647,990	$0
Miscellaneous Revenues	0.00	$26,290	$0
Salaries & Benefits	0.00	$4,784,038	$0
Staffing Reduction	-5.60	($161,931)	$0
Staffing realignment	0.00	$0	$0
Juvenile Hall Staffing	-0.10	($25,233)	$0
Mental Health Staffing	-0.50	($155,611)	$0
Services & Supplies	0.00	$4,257,260	$0
OSD Services & Charges	0.00	($312)	$0
ISD Services & Charges	0.00	$393,767	$0
Other Charges	0.00	($6,107)	$0
Fixed Assets	0.00	$248,000	$0
Intrafund Transfers	0.00	($815,054)	$0

Major Budget Changes

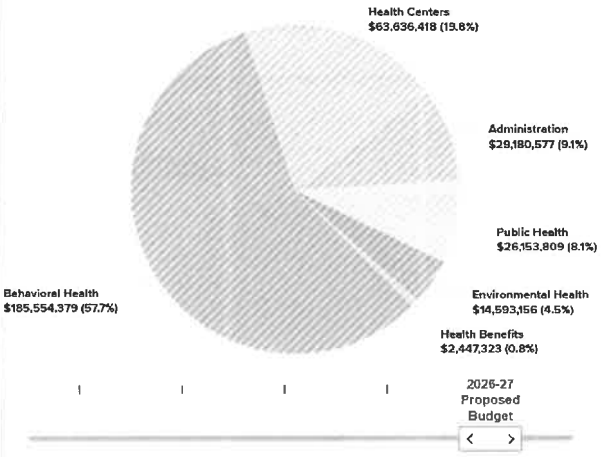
DivName	2025-26 Adopted Staffing	Mid Year Changes	2025-26 Adjusted Staffing	2026-27 Proposed Staffing	2026-27 Changes from Adjusted
⊟ Health Centers	204.45	-5.60	198.85	198.25	-0.60
⊞ Emeline Health Center	69.60	-4.80	64.80	68.10	3.30
⊞ Health Center Administration	35.00	3.00	38.00	39.00	1.00
⊞ Homeless Persons Health Project	29.45	-2.00	27.45	26.80	-0.65
⊞ Juvenile Hall Medical	3.80	0.00	3.80	3.70	-0.10
⊞ Watsonville Health Center	66.60	-1.80	64.80	60.65	-4.15
Total	204.45	-5.60	198.85	198.25	-0.60

Budget Charts and Data

Health Services Agency FY 26-27 Proposed Budget

FY 2026-27 Proposed Budget

Visualization



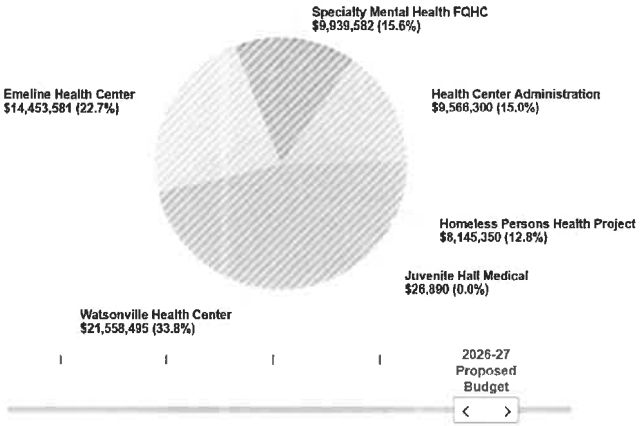
Expand All	2023-24 Actuals	2024-25 Actuals	2025-26 Adopted Budget	2025-26 Estimated Actuals	2026-27 Proposed Budget
▸ Behavioral Health	$ 133,178,189	$ 146,988,786	$ 180,747,239	$ 180,294,979	$ 185,554,379
▸ Health Centers	43,772,081	53,902,941	55,117,600	58,425,059	63,636,418
▸ Administration	31,782,718	36,078,066	29,480,382	29,480,380	29,180,577
▸ Public Health	25,705,752	23,507,174	23,928,878	25,087,014	26,153,809
▸ Environmental Health	10,948,780	12,036,588	14,103,785	14,195,085	14,593,156
▸ Health Benefits	1,739,932	1,831,750	6,801,287	6,672,182	2,447,323
Total	$ 247,127,452	$ 274,345,305	$ 310,180,171	$ 314,154,699	$ 321,565,662

Data filtered by Health Services Agency. Expenses are exported on May 1, 2026. Created with OpenGov

Health Centers FY 26-27 Proposed Budget

FY 2026-27 Proposed Budget

Visualization



Sort Large to Small

- Watsonville Health Center
- Emeline Health Center
- Specialty Mental Health FQHC
- Health Center Administration
- Homeless Persons Health Project
- Juvenile Hall Medical

Expand All	2023-24 Actuals	2024-25 Actuals	2025-26 Adopted Budget	2025-26 Estimated Actuals	2026-27 Proposed Budget
▸ Watsonville Health Center	$ 14,685,772	$ 16,442,170	$ 16,026,318	$ 19,385,988	$ 21,558,495
▸ Emeline Health Center	13,424,108	13,796,184	13,195,219	12,182,905	14,453,581
▸ Specialty Mental Health FQHC	6,524,376	7,820,589	10,031,125	10,381,230	9,939,582
▸ Health Center Administration	2,087,566	8,559,410	8,867,026	9,574,114	9,566,300
▸ Homeless Persons Health Project	6,987,282	7,284,589	7,097,391	6,920,822	8,145,350
▸ Juvenile Hall Medical	82,977	0	-99,479	0	-26,890
Total	$ 43,772,081	$ 53,902,941	$ 55,117,600	$ 58,425,059	$ 63,636,418

Data owned by Health Centers. Expenses and exported on May 7, 2026. Created with OpenGov

FY 26-27 Proposed Budget Summary

Optional Subtitle Goes Here

The Proposed Budget Is Balanced, but Relies on $4.0M in One-Time Support

We are proposing a budget that uses the following as a foundation:

- $63.6M proposed appropriations
- $63.6M total revenues/funding, including...
- **$4.0M** one-time trust funds
- **Revenues increase** $8.5M, driven by clinic and Medi-Cal Administrative Activities revenue
- **Expenses increase** $8.5M, driven by labor, dental, pharmacy, supplies, and internal costs

Long-Term Sustainability Depends on Better Aligning Reimbursement With the Cost of Care

We are proposing a budget that uses the following as a foundation:

- Current budget uses IGT revenue to help address funding gaps
- Long-term strategy depends on PPS rate adjustment
- Focus areas: visit efficiency, scheduling, contract oversight, cost containment
- We are looking into expanding access and revenue opportunities through Acupuncture, MAT, and other services.

Action

Approval of the Health Centers Division
FY 26-27 Proposed Budget

Is there anything I can Clear up for you?

Thank You

SANTA CRUZ COUNTY HEALTH SERVICES AGENCY

SANTA CRUZ COUNTY HEALTH CENTERS

SUBJECT:	POLICY NO.:	
Billing Department and Front Office Operations Policies and Procedures	**100.03**	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
SERIES: 100 Administration	**PAGE:** 1 **OF** 14	**Clinics and Ancillary Services**
APPROVED BY: Amy Peeler, Chief of Clinic Services	**EFFECTIVE DATE:** August 2014	
	REVISED: August 2017 August 2018 February 2020 June 2021 January 2024 February 2024 December 2024 May 2026	

POLICY STATEMENT:

The Health Services Agency (HSA) Clinic Services Division operates Santa Cruz County-run community health centers. The purpose of this policy is to describe all billing policies and procedures currently in use for ensuring assets are safeguarded, guidelines of grantors are complied with, and finances are managed with accuracy, efficiency, and transparency.

The Health Services Agency (HSA) will ensure access to health care services by families and individuals regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay, as described in the Sliding Fee Scale Discount Program policy #100.04.

HSA staff with a role in the management of billing operations are expected to comply with the policies and procedures in this manual.

These policies will be reviewed annually and revised as needed by the staff and approved by the Chief of Clinic Services.

The Health Services Agency (HSA) maintains a fee schedule for all services that are based on locally prevailing rates and designed to cover the reasonable costs of operation. The Sliding Fee Discount Program (SFDP), as described in Policy 100.04, is applied to this fee schedule to determine patient charges based on ability to pay. Billing and collections practices are applied uniformly to all patients and are structured to ensure that no patient is denied access to care due to inability to pay.

PROCEDURE:

A. Billing Overview: Clinic Services Division will provide methods for appropriate and sensitive evaluation of each patient's ability to pay for services rendered.

1. Financial screening of each patient shall not impact health care delivery.

2. The ability to pay (Sliding Fee Discount Program) is available for all patients to apply.

3. The screening will include exploration of the patient's possible qualification for specialized payer programs and is based only on income and family size. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.

4. All financial screening and billing determinations shall be applied consistently and uniformly across all patients regardless of insurance status, income level, or demographic characteristics. Determinations related to ability to pay shall be based solely on income and family size in accordance with Policy 100.04.

5. Patients who are unable to pay for services due to special circumstances may request for fees to be waived. All fee waivers must be reviewed and approved by the Business Office Manager and/or Health Center Managers. The Business Office staff, or the registration desk staff will request the waiver from the Health Center Manager or the Business Office Manager prior to waiving of any fees either through email, in person, or by telephone.

6. Payment Plan Policy: The Clinic Services Division offers payment plans to eligible patients to ensure access to care while maximizing reimbursement for self-pay patients.

   a. Eligibility:
   i. Patients with income up to 200% of Federal Poverty Level **OR**
   ii. Express an inability to pay **AND**
   iii. Self-Pay

   b. Terms:
   i. Minimum monthly payment: $20
   ii. Maximum repayment period: 24 months
   iii. Patient may choose monthly payment amount above minimum.

   c. Process:
   i. Offer payment plans to all eligible patients
   ii. Explain terms clearly before setup of payment plan

   d. Limitations:
   i. No interest charges
   ii. No late fees
   iii. Cancel plan after 90 days of non-payment.

   e. Staff Guidelines:
   i. Verify patient eligibility
   ii. Work with patient to determine affordable amount
   iii. Document payment plan in Epic chart (amount and time frame)

f. Monitoring:
i. Review payment plan performance quarterly
ii. Adjust policy as needed to improve collection rate

Payment plans shall be structured in a manner that reflects the patient's ability to pay and shall not create a barrier to access. For patients at or below 100% of the current Federal Poverty Level (FPL), collection efforts will be limited and will not include aggressive collection practices that could impede access to care.

B. General Payers

1. Medi-Cal: Most Medi-Cal patients are insured through Santa Cruz County's local managed care provider, Central California Alliance for Health (CCAH). CCAH members must be:

   a. Assigned to HSA for their primary care; or

   b. Within their first 30 days of CCAH membership and therefore not yet formally assigned to a care provider (administrative member); or

   c. Pre-authorized to be seen by an HSA provider.

2. Patients who have State Medi-Cal are generally patients with restricted benefits or transitioning to the managed care program.

3. Medicare: (non-managed care type) Recipients may qualify due to age and/or disability or may be dependent of an aged and/or disabled person.

4. Third-Party Insurance (Private Insurance): Contracted with Blue Shield PPO. Courtesy billing for other PPO insurance is available, however, the patient is responsible for any costs not covered by non-contracted insurance providers.

C. Specialized Payers

1. The following payer types are government-funded program and require application screening to determine eligibility:

   a. Family Planning, Access, Care and Treatment (Family PACT) program: State program for family planning services. Covers annual exams, sexually transmitted infection (STI) checks, birth control methods and emergency contraception.

   b. Every Woman Counts (EWC): Breast and cervical cancer screening and diagnostic services. Covers clinical breast exam, screening and diagnostic mammogram, pelvic exam and pap.

c. Child Health and Disability Prevention (CHDP) Program: Well care visits, including immunizations, for children. The age limit is 18 years and 11 months. Grants 60 days of full Medi-Cal benefits while the family formally applies for on- going insurance.

d. MediCruz: Locally funded program that provides specialty care to patients who fall at or below 100% of the Federal Poverty Level and are not eligible for Medi-Cal. Patients fill out an application and provide verification documents.

D. Self-Pay Payers

1. The Ability to Pay (Sliding Fee Discount Program) is available for all patients to apply. Patients with non-contracted insurance types, are responsible to pay for visit costs, including ancillary services. Patients are encouraged to apply for the Ability to Pay (Sliding Fee Discount Program), if eligible. Refer to the Ability to Pay (Sliding Fee Scale Discount Program) policy and procedure, #100.04.

2. The Sliding Fee Discount Program is applied to all eligible patient charges prior to billing. Patients who qualify for the SFDP will not be charged more than the amount determined under the applicable discount tier.

E. Verification of Eligibility and Benefits Determination by Payer

1. Medi-Cal

a. Eligibility Verification: Verification of coverage, restrictions, and cost-share must be obtained through the Medi-Cal website. Patients who may be eligible for Medi-
Cal, but are not enrolled, will be encouraged to apply

b. Benefits Determination: Once the eligibility is verified, the benefit type must be reviewed. There are several types of Medi-Cal benefits, ranging from full scope to restricted services. For additional information, the Medi-Cal provider manual can be referenced for benefit rulings. If coverage indicates that the patient is a member of CCAH, then eligibility and assignment must be verified via the CCAH website.

2. Central California Alliance for Health (CCAH)

a. Eligibility Verification: Information regarding the eligibility of coverage must be obtained through the CCAH provider web portal.

b. Benefits Determination: All Medi-Cal benefit rulings apply to CCAH

patients assigned to HSA; however, CCAH may offer more benefits than State Medi-Cal (see CCAH provider manual). If the patient is assigned to another provider, they may only be seen by our office for a sensitive service or under the authorization from their assigned primary care provider. A list of sensitive services can be found on the CCAH website.

3. Medicare

    a. Eligibility Verification: Medicare eligibility may be verified on-line through the Trizetto Gateway EDI website or by phone. Some Medicare patients have supplemental insurance coverage that may include commercial insurance or Medi- Cal coverage.

    b. Benefits Determination: Co-pay is due on the date of service. Normally Medicare requires an annual deductible that must be met prior to accessing benefits, however, HSA's Federally Qualified Health Center status allows waiver of the deductible.

4. Other Government Funded Programs

    a. Eligibility Verification: Government Funded Programs have eligibility period limitations, ranging from one day to one year. Eligibility periods for Family PACT, EWC, and CHDP Medi-Cal can be obtained through the Medi-Cal eligibility portal. MediCruz eligibility may be determined via the County's MediCruz Office.

    b. Benefits Determination

        i. Family PACT: covers all birth control methods offered at the HSA clinics, STI screenings, and treatments as part of the primary benefits. For secondary benefits, review the Family PACT Benefits Grid located on the Medi-Cal website.

        ii. EWC: covers annual cervical and breast cancer screenings as part of the primary benefits. For secondary benefits, review the covered procedure list located on the Medi-Cal website.

        iii. ~~CHDP: grants full-scope Medi-Cal benefits on a temporary basis~~ to allow application processing for Medi-Cal.

5. MediCruz covers specialty care on a temporary and episodic basis.

    a. Eligibility Verification: Eligibility will be verified with contracted insurances using the insurance company's website or via the telephone number provided on the patient's insurance card.

    b. Benefits Determination: As insurance plan benefits vary significantly, it is the patient's responsibility to understand their insurance benefits

prior to obtaining services. Since understanding health insurance benefits can be challenging, as a courtesy, HSA staff may assist patients with obtaining coverage information.

F. Enrollment: Other State Funded Programs

HSA is a Qualified Provider allowed to screen, verify, and enroll patients in State Funded Programs using the guidelines set forth by each of the following programs:

1. CHDP

    a. The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

    In accordance with current CHDP guidelines, HSA staff will pre-screen patients for program eligibility and provide a program application to eligible patients. Staff enters the completed application via the CHDP Gateway and prints two paper cards, with one card signed by the participant's parent and retained at HSA. The other card is provided to the participant's parent, along with a verbal explanation from HSA staff that the child is fully covered by Medi-Cal until the expiration date printed on the card. It is the parent's responsibility to follow-up with County Human Services regarding further application requirements for ongoing Medi-Cal eligibility.

2. Family PACT

    a. Family PACT clients are residents of California that demonstrate a need for family planning services, but have no other source of family planning coverage, and qualify for the program based on family income. Medi-Cal clients with an unmet cost-share may also be eligible. In accordance with Family PACT guidelines, eligibility determination and enrollment are conducted by HSA staff (patient completes an application) with the point of service activation, granting the applicant up to one year of benefits for family planning and reproductive health services. Qualified applicants are given a membership card and informed about program benefits, state-wide access, as well as the renewal process.

3. Every Woman Counts (EWC)

    a. EWC provides free clinical breast exams, mammograms, pelvic exams,

and Pap tests to California's underserved women. The mission of the EWC is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and treatment, and integrated preventive services, with special emphasis on the underserved. Income qualification and age-related service information are available at the EWC website.

b. HSA Clinics staff will screen patients for eligibility in accordance with program guidelines. The EWC application packet is completed by the patient, and the completed application is processed by HSA staff via the online portal. Patients are issued a paper membership card granting up to one year of benefits for breast and/or cervical services and given information regarding program benefits and the program renewal process. They are also instructed to present their membership card when obtaining services outside of HSA, such as a mammogram.

4. Ryan White HIV/AIDS Program (RWHAP)

a. For patients receiving Ryan White HIV/AIDS Program funded services the following process on charges related to HIV care will be followed: Patients receiving Ryan White HIV/AIDS Program funded services will not be charged fees related to care. The office visit fees will be waived (see section A, #4).

G. Patient Information Policy

1. Exchange of Information

a. Registration forms are maintained by Registration staff. Patients are either offered forms or questions are asked verbally, depending on patient preference. Information is collected on all new patients and updated at least every 12 months. All information on the registration form must be collected. The patient address/phone number must be confirmed at each visit. The registration form is also used to collect demographic information necessary for program and agency- wide reporting purposes.

2. Patient Scheduling

a. Appointment requests may be made in person or over the phone. At the time of an appointment request, staff will confirm the patient's name, date of birth, and phone number. The patient's reason for the appointment should be requested to determine appointment type and duration.

3. No Show and Late Cancels Defined

a. No Show Appointment: The patient does not arrive for a scheduled appointment.

b. Late Cancel Appointment: The patient cancels appointment less than 24 hours prior.

4. Follow-up

    a. If deemed necessary by the medical provider, HSA staff will follow up with patients unable to attend a previously scheduled appointment in order to schedule another appointment or determine if the health issue has been resolved.

H. Financial Policies

1. Accepted Forms of Payment:

    a. Cash: Cash is counted in front of the patient, payments are posted on the patient account (via Epic), and a receipt is printed for the patient.

    b. Credit/Debit Card: Charge information is submitted via the credit card merchant services portal. Payment is then posted on the patient account (via Epic), and a receipt is printed for the patient.

    c. Personal Checks: Checks are verified with the patient's name; the back of the check is stamped with the Santa Cruz County Bank account information for deposit. Payments are posted on the patient account (via Epic), and a receipt is printed for the patient.

    d. Money Orders: Money order backside is stamped with HSA Bank account information for deposit. Payments are posted on the patient account (via Epic), and a receipt is printed for the patient.

2. Payment Agreements: Payment agreements may be negotiated between the patient and BO staff, providing up to three payment installments for past due charges (over 30 days).

3. Refunds: Patient refunds are requested by BO staff using the appropriate County form and require BO Manager approval. Once approved, the request for a refund check is submitted to HSA Finance. Once prepared, the check is forwarded to the BO for delivery coordination with the patient. BO staff documents the refund in the patient account.

4. Non-sufficient Funds (NSF) Returned Checks: NSF Returned Checks are received by mail, email, or identified via bank account review by HSA Finance. The payment is reversed on the patient's account; a new billing claim is created and the County's NSF fee charge of $40 is posted and billed to the patient.

5. Insurance Payments: HSA receives insurance payments in two forms: electronic funds transfer and paper checks. All payments are reconciled to the Explanation of Benefits (EOB), Remittance Advice (RA), or Electronic Remittance Advice (ERA). EOB, RA, and ERA all provide detailed information about the payment.

6. Payments Received by Mail: BO staff are responsible for opening and sorting business office mail. Insurance checks received by mail will be distributed to appropriate BO staff members for processing and deposit preparation, following established County procedures. Payment detail may be posted manually using the correlated EOB via upload to the practice management system through an ERA. The final daily deposit should be completed by a different BO staff member.

7. Direct Deposits: Most direct deposits from third party insurances are accompanied by an ERA uploaded to the practice management system. The biller will reconcile the bank account direct deposits with the ERAs received.

I. Billing Procedures

1. Encounter Development and Management

   a. ICD, CPT, and HCPCS Code Upgrades: ICD and CPT codes are updated as needed by HSA's practice management system vendor. Periodic manual updates are made by BO staff as necessary, and at the request of the medical team. Fees are updated at the beginning of each fiscal year, as applicable, following the Board of Supervisors approval of the Unified Fee Schedule.

2. Encounter to Claim Process

   a. HSA Medical Providers consists of physicians, nurse practitioners, physician assistants, and registered nurses. Providers select CPT and ICD codes for every outpatient face-to-face encounter. CPT codes include but are not limited to: evaluation and management (E&M) codes, preventative care codes, and/or procedure codes depending on the type of service provided. Additional information regarding coding, including program/payer specifications, can be found in HSA's BO Operations Manual. Once providers complete documentation of an encounter, a claim is generated.

   b. Claims that do not automatically transmit are retained in a billing work queue for review by the BO. Following review, the claim is either corrected by a biller or coder as appropriate or returned to the provider for consideration of chart level correction. Following these reviews and possible changes, the claim is then submitted for processing.

c. Claims are submitted through the payment clearinghouse in batches grouped by payer type. The clearinghouse then forwards claims to the prospective payers. Claim batches are tracked weekly for transmission and payer acceptance.

3. Collections: HSA makes every reasonable effort to collect reimbursement for services provided to patients. This includes collection at time of service, as well as follow-up collection methods including statement dispatch and account notes. Collection practices shall be reasonable and uniformly applied and shall not create barriers to care. Patients eligible for the Sliding Fee Discount Program shall be afforded protections consistent with their ability to pay including limitation of collection actions for those at or below 100% of the current FPL.

4. Denial Management Procedure

    a. Information regarding denied claims are uploaded into the practice management system electronically or entered manually. BO staff are responsible for researching, correcting, and resubmitting (or appealing) clean claims within a 30-day period upon receipt of denial information. Researching may involve contact with the payer, patient, or clearinghouse. A review of the payer-provider manual may also serve as a resource for denied claims.

    b. Discoveries may include: patient responsibility for all or part of the charges; incorrect or incomplete information originally submitted to the payer; claim and EOB information must be forwarded to another insurance through a crossover claim process. Correcting the claim may require provider review, CPT or ICD code update within the practice management system, and/or submission to a secondary or tertiary insurance. As soon as the claim is corrected it may be resubmitted with the next batch of claims. If a crossover claim, then required documentation is submitted to the secondary payer.

5. Patient Account Balances: Patient's with account balances of $15 or more are sent a monthly statement. Patients with unpaid balances are flagged during the appointment registration process and directed to the Business Office. Prior to initiating collection activities, HSA will ensure that eligibility for the Sliding Fee Discount Program has been assessed and applied where appropriate.
6. Uncollectable and Bad Debt Adjustments

    a. Under the direction of the Business Office Manager, staff will adhere to the following write-off guidelines. The Business Office Manager has the authority to approve write-offs. Write-offs will be measured by HSA Fiscal Department after the month-end close and accounts will be audited as part of standard fiscal year-end practice.

7. Write-off Adjustments

a. All balances surpassing the Timely Filing Deadline, regardless of payor, will be written off. A chart outlining the specific write-off timelines and adjustment codes for each payor is provided at the end of this section. Refer to the Write-Off Chart for detailed instructions on write-off timing and adjustment codes for each payor.

b. The timely Filing Deadline will be based on the posted Date of Service.

c. Exception: In the event the patient has a secondary insurance, and the primary insurance has provided a denial prior to the timely filling date, and the correction is timely, then there is no need for a write-off.

a. Write-Off Chart for Business Office (See addendum)

8. Other Adjustments

a. Billing Error (BE) – For duplicate claims, when a non-payable charge is billed to an insurance, or a split claim is erroneously created.

b. Professional Courtesy (PC) – For charges disputed by patients or hardship waiver (see section A, #4).

9. Month End Closing Procedure: The month-end closing is performed at the end of each month and involves the reconciliation of payments and charges for that period.

a. Reconciliation: For every insurance payment received, BO staff will log the payment on a spreadsheet titled Record of Receipt (ROR) and E-remit tracking prior to posting the payment in the practice management system. At the end of the month, assigned staff will reconcile the payments deposited into HSA's bank account with the ROR entered onto the spreadsheet, and the payments posted in the practice management system. Discrepancies will be reported to HSA Fiscal staff assigned to HSA.

b. All patient payments will be collected by BO staff and reconciled on a daily basis in the practice management prior to deposit. Any discrepancies will be reported to the Business Office Manager and HSA Fiscal.

c. Claim dates will be reconciled by date of service. All charges to third party insurances must be submitted prior to the month-end closing.

10. Vaccines for Children (VFC) Billing Policy

a. Introduction

This policy outlines the billing practices for the Vaccines for Children (VFC) Program at HSA Health Centers. We are committed to complying with all VFC program regulations and ensuring all eligible children receive VFC vaccines at no cost.

b. VFC Vaccine Cost

- VFC vaccines are provided **free of charge** to all eligible children.
- **No charges** for the vaccine itself can be billed to the patient, their insurance, or any other payer.

c. Vaccine Administration Fees

- Medicaid-eligible children: We will bill Medicaid for the vaccine administration fee according to their guidelines.
- Non-Medicaid VFC-eligible children:
    - We may choose to charge the **patient** for the vaccine administration fee on the day of the vaccination only.
    - The fee must be within the **state/territory cap** established by the Centers for Medicare and Medicaid Services (CMS).
    - Patients cannot be:
        - Denied vaccination due to inability to pay the administration fee.
        - Reported to collections for non-payment of the administration fee.

d. Billing Procedures

- Medicaid claims: Billing for Medicaid-eligible children will follow the standard Medicaid billing procedures.
- Non-Medicaid claims:
    - To ensure compliance with California's VFC program regulations, any VFC administration fee not paid on the day of vaccination will be written off by the business office.

e. Recordkeeping

We will maintain accurate records for all VFC vaccinations administered, including:

- Patient information
- VFC eligibility documentation
- Vaccine administered
- Administration fee (if applicable)
- Documentation of any communication with the patient regarding billing

ADDENDUM 1

PAYOR	DESCRIPTION	TIMELY FILING DEADLINE (days)	CODE	REASON CODE
Self Pay	No Payor; in addition, write-off any balance for patient not assigned to HSA following Referral Authorization Form (RAF) denial or denial for out of county managed care	365 from 1st statement date	BAD DEBT WRITE-OFF (CR ACC) [1002]	N/A
Carelon	Behavioral Health Visits	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
Medicare	Straight Medicare Visits	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
FAMPACT	Family Planning Visits	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
O/P Medi-Cal	Straight Med-Cal	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
Alliance Medi-Cal	Managed Medi-Cal	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
Commercial	Commercial	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
ALT Medi-Cal	Wrap Visits	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
EWC	Every Women Counts	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
CHDP	Child Health and Disability Prevention	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29

SUBJECT: Billing Department Ability to Pay (Sliding Fee Scale Program) Policies and Procedures **SERIES: 100** Administration **APPROVED BY:** Amy Peeler, Chief of Clinic Services	**POLICY NO.:** **100.04** **PAGE:** 1 **OF** 7 **EFFECTIVE DATE:** March 2020 **REVISED:** February 2022 May 2024 June 2024 May 2026	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY **Clinics and Ancillary Services**

PURPOSE:

The purpose of this policy is to reduce or eliminate financial barriers to patients who qualify for the Ability to Pay (ATP) (Sliding Fee Discount Program) to ensure access to services regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay.

The ATP applies to the full scope services provided by Health Services Agency's (HSA) Clinic Services Division, which includes Primary Care, Integrated Behavioral Health, Acupuncture, and Dental Services.

The Sliding Fee Discount Program (SFDP) is applied uniformly to all patients and to all required and additional services within the HRSA-approved scope of project for which distinct fees are established.

POLICY STATEMENT:

The Health Services Agency (HSA) Clinic Services Division operates county-run community health centers. The purpose of this policy is to describe all billing policies and procedures currently in use for ensuring assets are safeguarded, guidelines of grantors are complied with, and finances are managed with accuracy, efficiency, and transparency.

It is the policy of County of Santa Cruz Health Services Agency (HSA) to comply with government regulations. HSA is a Federally Qualified Health Center (FQHC) and received federal funding under the Health Center Program authorized by Section 330 of the Public Health Services (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330C and (h)). The program is administered by the federal Health Resources and Services Administration (HRSA)

HSA staff with a role in the management of billing operations are expected to comply with the policies and procedures in this manual.

These policies will be reviewed annually and revised as needed by the staff and approved by the Integrated Community Health Center Commission, the Chief of Clinic Services, and HSA Director.

PATIENT NOTIFICATION:

HSA will ensure that patients are informed of the availability of the Sliding Fee Discount Program through multiple methods, including but not limited to:

1. Posted signage at all clinic locations
2. Information provided during the registration and intake process
3. Availability of information on the HSA website
4. Materials provided in languages and formats appropriate to the patient population

PROCEDURE:

A. Billing Overview: Clinic Services Division will provide methods for appropriate and sensitive evaluation of each patient's ability to pay for services rendered.

1. Financial screening of each patient shall not impact health care delivery.
2. The screening will include exploration of the patient's possible qualification for specialized payer programs. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.

    a. The Business Office Manager and Health Center Managers are authorized to waive patient fees due to expressed financial hardship or disputes, as described in the HSA Billing FO Policy and Procedures 100.3 (Section A, #4).

3. The Health Services Agency (HSA) will ensure access to health care services by families and individuals regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay.

B. Sliding Fee Discount Program (Ability To Pay: ATP)

The Sliding Fee Discount Program is applied to the HSA fee schedule and adjusts patient charges based on ability to pay in accordance with Federal requirements.

1. Definition of Income: Income is defined as earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, alimony, child support, or any other sources that typically become available. Noncash benefits, such as food stamps and housing subsidies, do not count.

2. A family is a group of individuals who share a common residence, are related by blood, marriage, adoption, or otherwise present themselves as related, and share the costs and responsibility of the support and livelihood of the group. Children of said individuals under the age of 19 or if the child is a full-time student, under the age of 21 who do not share a common residence with said individuals but are supported financially and are the responsibility of said individuals will be counted as part of the family.

3. The Sliding Fee Discount Program incorporates the most recent Federal Poverty Level Guidelines published by the Federal Health and Human Services.

4. Eligibility is based on income and family size only.

5. All patients are eligible to apply for the program.

6. All patients are assessed for eligibility for the Sliding Fee Discount Program at intake and re-assessed at least every 12 months or when there is a change in income or family size.

7. Eligibility will be honored for 12 months

8. Ability to Pay (ATP) is a sliding fee program available to all patients who qualify according to family size and income (individuals/families living at or below 200% of the Federal Poverty Level (FPL). Partial discounts or a nominal fee are provided for individuals and families with incomes above 100% of the current FPL and at or below 200% of the current FPG (see attachment 1).

9. The Sliding Fee Discount Program is structured as follows:

    a. Individuals and families at or below 100% of the current Federal Poverty Level receive a full discount or are charged a nominal fee, which is set at a level that does not create a barrier to care and does not reflect the actual cost of services.
    b. Individuals and families with incomes above 100% and at or below 200% of the current Federal Poverty Level receive partial discounts based on a minimum of three (3) graduated discount tiers, with discounts increasing as income decreases.
    c. Individuals and families with incomes above 200% of the current Federal Poverty Level are not eligible for discounts.

10. Patients will self-report income and family size on the ATP self-declaration/provisional application if the individual or family does not have the proof of income at the time of the visit. However, reasonable efforts will

be made to obtain verification within a defined timeframe. The self-declaration/provisional application period expires after 30 calendar days. Patients applying for the ATP program are re-assessed if income or family size changes, as self-reported or the ATP eligibility period expires, and a new application is received.

11. Patients must first be screened for third-party insurance. Nominal fee charges apply to individuals and families with annual incomes at or below 100% of the Federal Poverty Guidelines. The Business Office Manager and Health Center Managers are authorized to waive patient fees due to expressed financial hardship or disputes. An example of a financial hardship is, but is not limited to, (temporary earnings reduction, loss of employment, natural disaster like flood or fire, or experiencing homelessness).

    A) The Business Office staff, or the registration desk staff will request the waiver from the Health Center Manager or the Business Office Manager prior to waiving of any fees either through email, in person, or by telephone. Patients who are covered by a third-party Insurance with "out of pocket" costs (i.e. co-insurance, co-pays, share of cost) may apply for the ATP program, if it is not prohibited by the third-party insurance.

    B) Staff will screen patient for eligibility for the ATP program by asking the patient to complete the application and provide proof of income.

    C) Once the sliding fee level for the patient is assessed, the patient may pay the lesser of the charge discounted to the patient's sliding fee level OR the patient's out of pocket costs. Patients with third-party coverage who qualify for the Sliding Fee Discount Program will not be charged more than the amount they would pay under the applicable sliding fee discount tier.

12. No discounts are provided to individuals and families with annual incomes above 200% of the current FPL. Sliding Fee Discount Scale Program (ATP) levels are described in Attachment 1 for Clinic, Integrated Behavioral Health, and Acupuncture services. Ability to Pay scale levels are described in Attachment 2 for Dental Services.

13. Patients interested in applying for this program are required to complete an application and provide proof of household income. Registration staff collects preliminary income and family size documentation for each applicant then enters the information into the appropriate EPIC module for payment range determination in accordance with FPL. Self- declaration of income and household information will be accepted.

14. For full program qualification, patients must provide income verification documents to support their application, such as:

a. Most recent Federal tax return

b. IRS form W-2 or 1099

c. Two (2) most recent consecutive paystubs

d. Social Security, disability or pension benefit statements

e. Documentation of other governmental assistance

f. Verification of Student status and FAFSA form

g. Unemployment Benefits / Worker's Compensation

h. Self-declaration form may be accepted if formal documentation is not available.

15. The ATP shall apply to all required and additional health services within the HRSA- Approved scope of project for which there are distinct fees. This includes services provided directly by HSA, as well as services provided through formal written contracts and referral arrangements. HSA ensures that discounts for such services are consistent with or greater than those provided under the Sliding Fee Discount Program.

16. All documentation received from the patient related to the ATP application are filed and kept on site until the HSA Fiscal retention date has expired.

17. HSA will annually assess the ATP activity and present findings to the Integrated Community Health Center Commission that ensure the ATP does not create a barrier for patient access to care. HSA will:

a. Collect utilization data that allows it to assess the rate at which patients within each of discount pay classes, as well as those at or below 100% of the FPG, are accessing health center services:

b. Utilize this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys patients at various income levels to evaluate the effectiveness of its sliding fee scale discount program in reducing financial barriers to care; and

UNIFORM APPLICATION:

The Sliding Fee Discount Program is applied consistently and uniformly across all patients, sites, and services without discrimination.

C. Sliding Fee Discount Program (SFDP) Evaluation

Authority

This policy adheres to Section 330(k)(3)(G) of the Public Health Service (PHS) Act and the following regulations: 42 CFR 51c.303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR 56.303(g), and 42 CFR 56.303(u).

Purpose

This section outlines the procedures for evaluating HSA Health Center Division's Sliding Fee Discount Program (SFDP) to ensure compliance with Section 330 of the PHS Act. The evaluation will be conducted at least once every three years.

Evaluation Process

The evaluation will involve a multi-faceted analysis aimed at assessing the effectiveness of the SFDP in reducing financial barriers to care.

1) On a quarterly basis, the Health Centers will conduct a patient experience survey and analyze the results to identify any financial barriers and areas for improvement.
2) Health Centers will also gather financial data to calculate the base fee for each tier in the SFDP scale.

Below is the equation that represents the calculation used to ascertain the new fee for each sliding fee scale tier:

New Tier Fee = (AT / TV) * Tier Collections (2 FY) / 2 + Base Tier Fee

where:

- **New Tier Fee** = The new fee amount for a specific sliding fee tier.
- **AT** = Total number of E&M visits across all tiers (2 FY).
- **TV** = Total amount collected from all other payments (excluding E&M) across all tiers (2 FY).
- **Tier Collections (2 FY)** = Sum of collections from E&M payments for the specific tier over a two-year fiscal period.
- **Base Tier Fee** = Existing fee amount for the specific sliding fee tier (before adjustment).

Explanation:

1. **(AT / TV):** This term calculates the average amount collected per E&M visit by dividing

the total number of E&M visits (AT) by the total amount collected from all other payments (TV). This represents the additional flat fee needed to cover the average cost per visit.

2. **Tier Collections (2 FY) / 2:** This term calculates the average E&M revenue collected from a specific tier over a year. We sum the E&M collections for the tier over two fiscal years (2 FY) and then divide by 2 to get the yearly average.
3. **(AT / TV) * Tier Collections (2 FY) / 2:** This multiplies the average collected per visit by the average E&M revenue from the specific tier, essentially calculating the additional flat fee required for that tier.
4. **+ Base Tier Fee:** Finally, we add this additional flat fee to the existing base fee for the specific tier to arrive at the new sliding fee amount.

This equation considers both the overall cost per visit and the existing revenue collected from each tier to determine the adjusted fee schedule.

Outcomes and Action

Following the evaluation, a comprehensive report will be generated summarizing the findings and recommendations for improvement. Based on the results, HSA Health Center Division will identify and implement necessary changes to optimize the effectiveness of the SFDP in promoting access to affordable healthcare services.

Health Centers Division

Quality Management Report

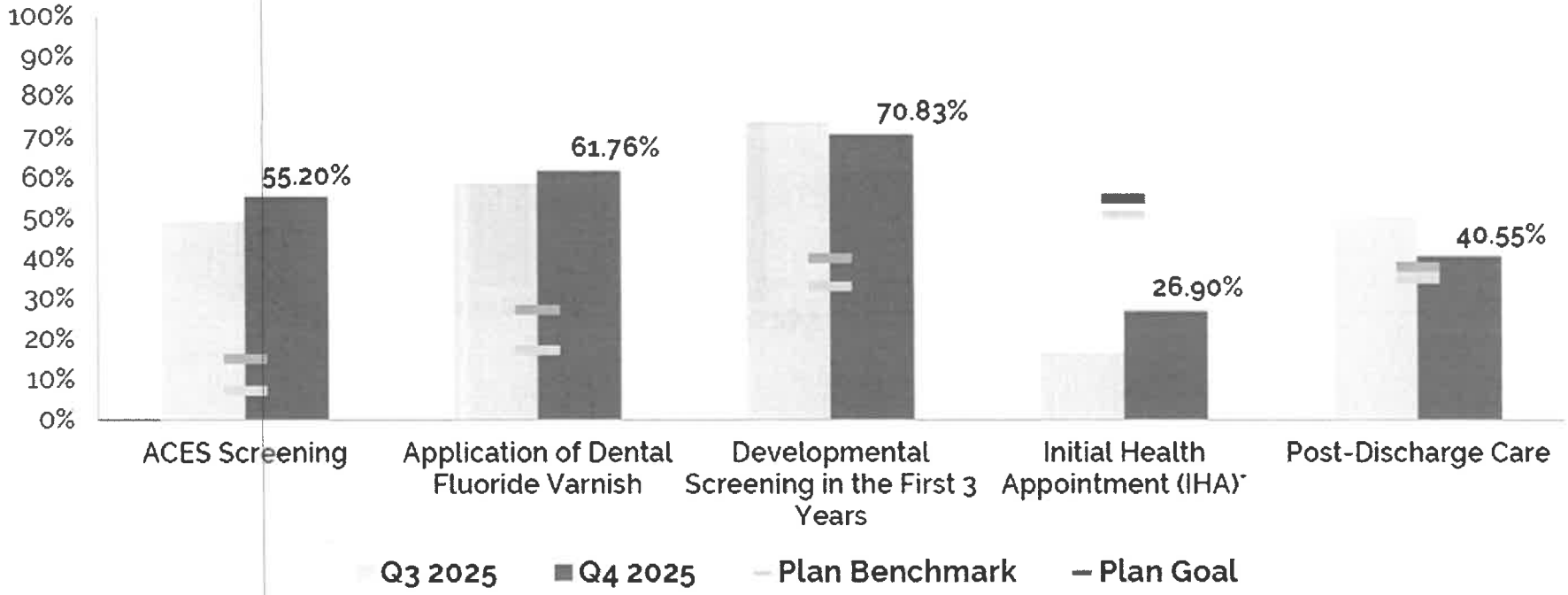
May 13, 2026

Quality Management Committee

- Central California Alliance for Health- Care Based Incentive Calendar year 2025 Review
- Programmatic measures
  - Total Potential: 100 Points
  - Peer Average: 69.4 Points
  - **Our Health Centers: 93.0 Points**
  - Total amount earned: **$524,529.31**

Care Based Incentive Data

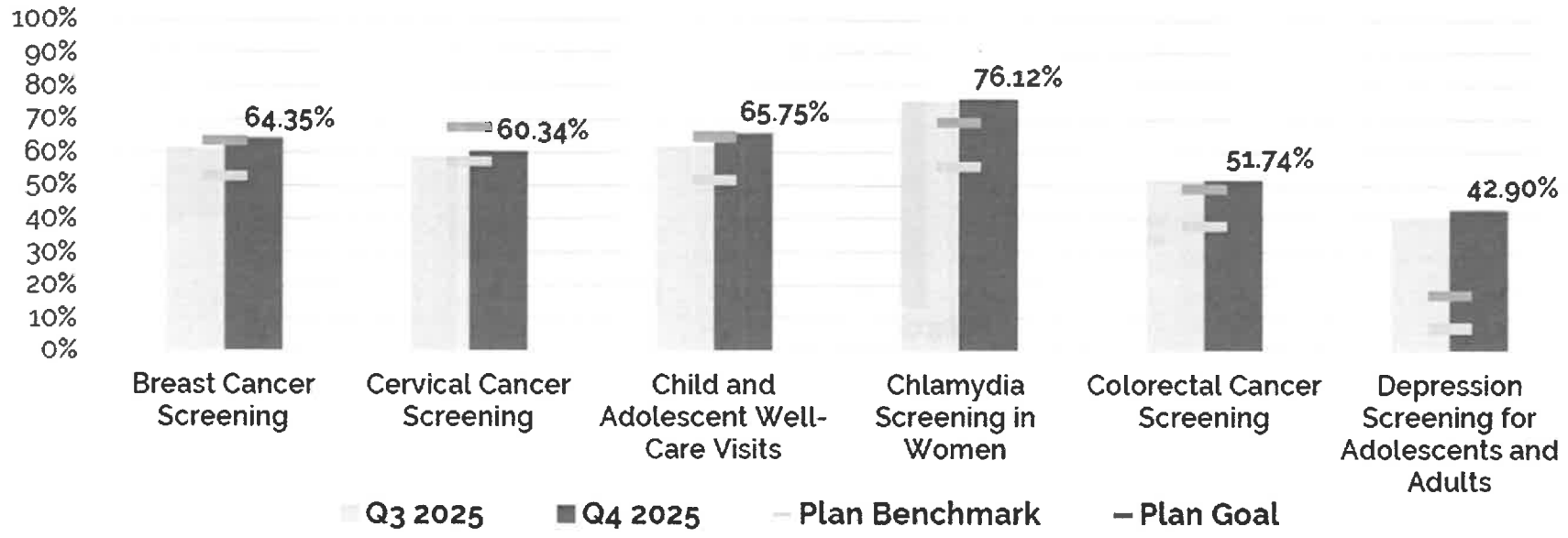
CARE COORDINATION – ACCESS MEASURES



*Receiving full points due to 2.5% or more improvement rate

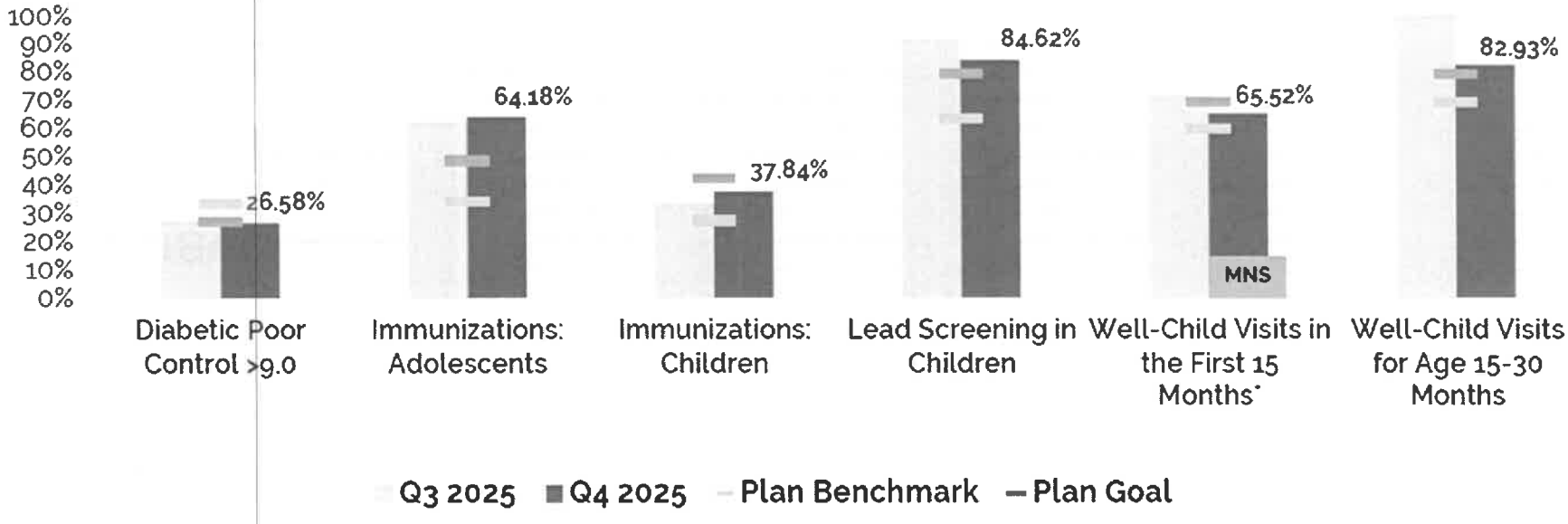
Care Based Incentive Data

QUALITY OF CARE MEASURES



Care Based Incentive Data

QUALITY OF CARE MEASURES



MNS – Membership not sufficient
(Not enough members to qualify)

*Q4 - Only 1 member away from qualifying for measure

Peer Review and Risk Management Committee

- Reviewed 14 Monthly Peer Review Chart Audits
- Creating a new data base for complaints and grievances.

Questions?

Thank You