C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

DISTRICT CLINIC HOLDINGS, INC.
d.b.a. C.L. BRUMBACK PRIMARY CARE CLINICS
BOARD OF DIRECTORS FINANCE COMMITTEE
MEETING MINUTES
July 31, 2019
1515 N. Flagler Drive
West Palm Beach, FL 33401

1. Call to Order

Mr. Elder called the meeting to order at 12:16 p.m.

A. Roll Call

Committee members present: James Elder, Michael Smith

Committee members excused: Joseph Morel

Staff present included: Dr. Belma Andric, VP & Executive Director of Clinic Services; Darcy Davis, CEO; Valerie Shahriari, General Counsel

Recording/transcribing Secretary: Jonathan Dominique

B. Affirmation of Mission: To provide compassionate, comprehensive health services to all Palm Beach County residents, through collaboration and partnership, in a culturally sensitive environment.

2. Agenda Approval

A. Additions/Deletions/Substitutions

None

B. Motion to Approve Agenda

CONCLUSION/ACTION: Mr. Smith made a motion to approve the agenda as presented/amended. The motion was duly seconded by Mr. Elder. A vote was called, and the motion passed unanimously.

3. Awards and Presentations

None.

4. Disclosure of Voting Conflict

None.

5. Public Comment

None.

6. Meeting Minutes

A. Staff Recommends a MOTION TO APPROVE:
C.L. Brumback Primary Care Clinics Finance Committee Minutes of May 28, 2019.

CONCLUSION/ACTION: Mr. Smith made a motion to approve the C.L. Brumback Primary Care Clinics Finance Committee minutes of June 26, 2019 as presented. The motion was duly seconded by Mr. Elder. A vote was called, and the motion passed unanimously.

7. Consent Agenda – Motion to Approve Consent Agenda Items

CONCLUSION/ACTION: Mr. Smith made a motion to approve the Consent Agenda items. The motion was duly seconded by Mr. Elder. A vote was called, and the motion passed unanimously.

A. ADMINISTRATION

7A-1 RECEIVE AND FILE:
July 2019 Internet Posting of District Public Meeting
http://www.hcdpbc.org-Resources-Public Meetings

7A-2 RECEIVE AND FILE:
Attendance Tracking

8. Regular Agenda

A. FINANCE

8A-1 **RECEIVE AND FILE:**
C.L. Brumback Primary Care Clinics Finance Report: June 2019

The June statements represent the financial performance for the first nine months of the 2019 fiscal year for C.L. Brumback. Total revenue is favorable to budget by $5.6M due to the grant recognition and the unbudgeted District Care subsidy and Low Income Pool (LIP) award. Effective May 1, 2019, the District Cares subsidy ended. Expenses before depreciation are better than budget by $380k or 2%.

Volumes for medical and dental are behind budget year to date. The volume variances are attributable to the ramp-up of the new strategy of integration with medical visits, which is slowing productivity. The District has subsidized a total of $2.6M to support their operations. Within the medical clinics, revenue is ahead of budget by $4.8M YTD primarily attribute to the Health Resources and Services Administration (HRSA) grant of $3.3M and other grants of $208k for the mobile van. Net patient revenue is favorable to budget by $1.2M. This positive variance was caused by unanticipated LIP revenue of $1.4M and unbudgeted District Cares subsidy payment of $923k for clinic visits. Expenses in the medical clinics are $168k better than budget. Significant savings are in salaries and benefits; these expenses are related to higher vacancy rates than budgeted. The positive variance in medical services of $206k is related to lower than anticipated laboratory services expenses due to the change of provider. However, there are unfavorable variances that offset the positive variance. Purchased services has a negative variance due to higher collection fees from Athena, and higher consulting fees related to grant writing and UDS report writing. Repairs and maintenance is unfavorable by $247k due to higher than anticipated software maintenance costs related to transitioning from Allscripts to Athena. The dental clinics revenue is ahead of budget by $749k YTD primarily attribute to the HRSA grant of $405k and other grants of $3k for Delta Dental. Net revenue is favorable to budget by $366k. This positive variance was caused by unanticipated LIP revenue of $653k, and unbudgeted District Cares subsidy payment of $226k for clinic visits. Total expenses of $3.4M are under budget by $213k, despite two budget categories with small variances. Other supplies are related to the increase in purchase of non-capital equipment for the new Belle Glade clinic. On the Balance Sheet, operating cash is negative, pending the drawdown of HRSA grant funding, which will occur in July. Further subsidies are budgeted but have not yet been needed.

Mr. Smith asked about the difference in contractual allowances between this last year (37% of gross patient revenue) and this current fiscal year (38% of gross patient revenue) and why contractual allowances were budgeted at only 23%.

Darcy Davis, CEO pointed out a change in policy which eliminates the $60 flat rate that was subsidized by the district.

Ms. Bayik continued that the budget did not anticipate that the clinics would continue to provide services at the subsidized rate ($60 Medical | $100 Dental) from the District Cares Initiative. The amount in the actual is included in the 'other Patient revenue' line (about $1.1 Million). Funds for LIP were approved after the budget was approved last September, leading to the absence of LIP revenue in the 'other patient revenue' line. So if you removed that line, the collection percentages should be closer.

Mr. Smith Asked about the charity care: Last year, it was about 19% of gross revenue, was budgeted at 38% this year, and has come in at 36% so far. What have been the changes year to year?

Ms. Bayik explained that in the past, district care members were considered as being covered for primary care (a change that took place this year). We see a flip in the budget but when comparing contractual allowances actual to prior the year, the numbers are actually pretty close. The change to which the patients were to be considered uninsured was supposed to take place on October 1st of 2018, but wasn't implemented until May 1st of 2019. This led to the charity care that was budgeted to being higher than what we are seeing year to date. However, going forward the patients are considered uninsured, and therefore we should be seeing these numbers move as expected.

Mr. Smith asked about what we charge for services in the clinics, and how by not having prices comparable to private clinics or Medicare fee schedules, we end up significantly understating the amount of services that are provided (especially the charity care provided by the district). We have our fee schedules perhaps set much lower…

Ms. Davis, explained to Mr. Smith that we are not significantly lower than any clinic or FQHC because we do have payers

Mr. Smith continues: If we have a Doctor's office charges $200.00 for an initial visit how much do we charge comparably

Ms. Davis states that the price is within market in comparison with other Clinics / FQHCs for similar services. This is because we also receive payments from insurance companies, Medicare/Medicaid, and we have to price ourselves competitively as to not lose the opportunity on those who have funding. Failing to do this would mean that we lose the opportunity for revenue.

Mr. Smith asks of we are competitive with the private Market

Ms. Davis clarified that we are competitive with our industry, and we have to make sure that our gross charge moves with the line of the FQHC fee schedule or else we lose the opportunity with private pay patients. Ms. Davis also pointed out that there is a concerted effort to keep the fee schedule updated as to not lose any opportunities. Ms. Davis will bring in the Clinic Charge master to explain the process during the next finance committee meeting.

Mr. Smith asked about Fee schedules that the district uses when we send a patient for a service that the district cannot provide. What fee schedule the health care district pays.

Ms. Davis explains that those are individually negotiated contracts with providers through district cares. The benefit to the patients after they go to the primary care world is covered by the Health Care District (specialist benefits, hospital benefits, etc.). It's not formal insurance, but it functions as a lookalike benefit. We have negotiated with specialists, so if any need arises we have them in our "network" and we have negotiated a rate with them. The rate is usually at a percentage of other payers i.e. 80% of Medicare or something of the sort to recognize the payer mix.

Mr. Smith asks of we pay them out periodically.

Ms. Davis indicated that since she has come in, we have reduced the size of our network and of the number of contracts we have maintained with hospitals and specialists. It was once a big free for all, but we are refining the network, finding more value, and determining what our network should look like. We are also looking to reducing our hospital network (based off of where our physicians practice) next year.

Dr. Andric pointed out that this all falls under District cares and is not directly related with the clinics.

Mr. Smith Asks about drug testing in the clinics, the overcharging of testing companies for tests. He also wondered where the value was in testing patients with every visit when some patients may have recently used, and some drugs stay in the systems of patients for long periods of time.

Valerie Shahriari, Legal Counsel informed Mr. Smith that it is within the medical standard of care when providing Suboxone or in drug treatment, it is important to know whether or not a patient is using because that changes the therapy that you provide. If they are using and you are unaware, then the medications that you are prescribing can be adverse to them; and the counseling/ group counseling you are providing them can be impacted. It is important for their standard of care and therapy that they know that. The problem with the testing companies was with confirmatory labs. Based on the structure that they had, they were sending 100% of their Labs out for Confirmatory testing which is a much higher reimbursement. There are legal restrictions on who can own the labs, as there were sometimes referral relationships between the substance abuse facilities and the Labs. It was a legal piece on how they were structured, and the fact that they were sending out 100% for confirmatory testing (which is not medically necessary).

Mr. Smith went on to further specify he means the benefit of drug screening a patient that tests positive and who is an admitted drug user because you are not conducting a Quantitative test you are going to get a positive result.

Dr. Andric pointed out that some drugs stay longer in the system and some do not. The purpose of the clinics conducting frequent drug screens is to confirm that the patient is, in fact, taking Suboxone. Since we are providing Suboxone as a prescription pill, the primary purpose of the screening is to make sure that the patients are taking Suboxone as part of their treatment plan. If they show up as negative for Suboxone use, that means that they are diverting the drug. If they appear as positive for non-prescribed drug use that is okay, the urine will indicate that but the program is not punitive in that sense. Positive drug screens mean an increase in treatment, but what we're really looking for is the presence of Suboxone in the patient's system to make sure that they're taking the prescribed medication. Approximately 90% of our substance abuse patients are on Suboxone.

Dr. Andric also pointed out that much had not changed with our labs, and yet our labs cost less. This is because Quest provides us with more advanced tests that allow for review of each individual test ordered, and therefore if needed, more economical options can be selected and this has reduced our costs.

CONCLUSION/ACTION: Receive & File. No further action necessary.

9. VP and Executive Director of Clinic Services Comments

None.

10. Board Member Comments

None.

11. Establishment of Upcoming Meetings

August 28, 2019 (HCD Board Room)
12:15pm Finance Committee

September 25, 2019 (HCD Board Room)
12:15pm Finance Committee

October 30, 2019 (HCD Board Room)
12:15pm Finance Committee

November 27, 2019 (HCD Board Room)
12:15pm Finance Committee

December 18, 2019 (HCD Board Room)
12:15pm Finance Committee

12. Motion to Adjourn

Mr. Smith made a motion to adjourn. The motion was duly seconded by Mr. Elder. A vote was called, and the motion passed unanimously.

There being no further business, the meeting was adjourned at 12:41 p.m.

DCHI Finance Committee Chair **Date** 9/28/2019