Council Members	AGENDA
Scott Jacobson, Chairman Eileen Sullivan, Vice Chairman Earl Arbuckle, Treasurer Nelly Clotter-Woods, Member Chris Hooper, Member Salina Imam, Member Norma Muñoz, Member William O'Neill, Member Essen Otu, Member Wayne Tormala, Member Jane Wilson, Member Mary Rose Garrido Wilcox, District Board, Non-Voting Member	**Valleywise Community Health Centers Governing Council** **Mission Statement** The Valleywise Health's mission is to provide exceptional care, without exception, every patient, every time.

▪ Virginia G. Piper Charitable Trust Pavilion ▪
▪ 2609 East Roosevelt Street ▪ Phoenix, Arizona 85008 ▪
▪ 2nd Floor ▪ Auditoriums 1 and 2 ▪

Wednesday, May 1, 2024
5:30 p.m.

Access to the meeting room will start at 5:20 p.m., 10 minutes prior to the start of the meeting.

One or more members of the Valleywise Community Health Centers Governing Council may be in attendance by technological means. Council members attending by technological means will be announced at the meeting.

Please silence cell phone, computer, etc., to minimize disruption of the meeting.

5:30 **Call to Order**

Roll Call

Call to the Public
This is the time for the public to comment. The Valleywise Community Health Centers Governing Council may not discuss items that are not specifically identified on the agenda. Therefore, pursuant to A.R.S. § 38-431.01(H), action taken as a result of public comment will be limited to directing staff to study the matter, responding to any criticism, or scheduling a matter for further consideration and decision at a later date.

ITEMS MAY BE DISCUSSED IN A DIFFERENT SEQUENCE

Agendas are available within 24 hours of each meeting at Valleywise Community Health Centers and at Valley Comprehensive Health Centers, and on the internet at https://valleywisehealth.org/about/governing-council/. Accommodations for individuals with disabilities, alternative format materials, sign language interpretation, and assistive listening devices are available upon 72 hours advance notice via the Clerk's Office, Virginia G. Piper Charitable Trust Pavilion, 2609 East Roosevelt Street, Phoenix, Arizona 85008, (602) 344-5177. To the extent possible, additional reasonable accommodations will be made available within the time constraints of the request.

4/25/2024 11:54 AM

General Session, Presentation, Discussion and Action:

5:35 1. Approval of Consent Agenda: 5 min

Any matter on the Consent Agenda will be removed from the Consent Agenda and discussed as a regular agenda item upon the request of any voting Governing Council member.

a. Minutes:

i. **Approve** Valleywise Community Health Centers Governing Council meeting minutes dated April 3, 2024

b. Contracts:

i. **Acknowledge** an intergovernmental agreement (90-24-286-1) between Arizona Department of Health Services and Maricopa County Special Health Care District dba Valleywise Health, for funding for HIV care and services to eligible clients, under Ryan White Part B

c. Governance:

i. **Approve** revisions to policy #23624 D - Federally Qualified Health Centers Sliding Fee Discount Program/Policy

d. Medical Staff:

i. **Acknowledge** the Federally Qualified Health Centers Medical Staff and Advanced Practice Clinician/Allied Health Professional Staff Credentials

End of Consent Agenda

5:40 2. Mission Moment – A Patient Story 5 min - No Handout
Misty Vo, Director, Pharmacy

5:45 3. Discuss and Review Federally Qualified Health Centers Uniform Data System (UDS) Quality Metrics for the First Quarter of Calendar Year 2024 10 min
Crystal Garcia, RN, MBA, Vice President, Specialty Services, Quality and Safety

5:55 4. Discuss and Review Federally Qualified Health Centers Patient Safety Report for the Third Quarter of Fiscal Year 2024 10 min
Crystal Garcia, RN, MBA, Vice President, Specialty Services, Quality and Safety

6:05 5. Discuss and Review Federally Qualified Health Centers National Research Corporation (NRC) RealTime Platform Patient Experience Data for the Third Quarter of Fiscal Year 2024 10 min
Crystal Garcia, RN, MBA, Vice President, Specialty Services, Quality and Safety

6:15 6. Discuss and Review Federally Qualified Health Centers Financials and Payor Mix for the Third Quarter of Fiscal Year 2024 10 min
Matthew Meier, MBA, Vice President, Financial Services

6:25 7. Discuss, Review and **Approve** Fiscal Year 2025 Patient Volumes; Discuss and Review Capital Target for the Federally Qualified Health Centers 15 min
Matthew Meier, MBA, Vice President, Financial Services

General Session, Presentation, Discussion and Action, cont.:

6:40 8. Discuss, Review and **Approve** the Maricopa County Special Health Care District dba Valleywise Health, Uniform Guidance audit for fiscal year ending June 30, 2023 and 2022, including information related to the Federally Qualified Health Centers 10 min
Claire Agnew, CPA, MBA, Executive Vice President, Chief Financial Officer

6:50 **Motion to Recess General Session and Convene in Executive Session**

Executive Session:

6:55 E-1 Legal Advice; Records Exempt by Law from Public Inspection; A.R.S. § 38-431.03(A)(3) and A.R.S. § 38-431.03(A)(2)[1]: Maricopa County Special Health Care District dba Valleywise Health, Marketing Strategy for Valleywise Health Federally Qualified Health Centers 20 min

[1] Exemptions based upon A.R.S. § 48-5541.01(M)(4) (c) including records or other matters, the disclosure of which would cause demonstrable and material harm and would place the district at a competitive disadvantage in the marketplace.

7:15 **Recess Executive Session and reconvene in General Session**

General Session, Presentation, Discussion and Action:

7:20 9. Federally Qualified Health Centers' Chief Executive Officer's Report including Ambulatory Operational Dashboards 10 min
Michelle Barker, DHSc, Chief Executive Officer, Federally Qualified Health Centers

7:30 10. Maricopa County Special Health Care District Board of Directors Report 5 min - No Handout
Mary Rose Garrido Wilcox, Director, Board of Directors

7:35 11. Valleywise Health's President and Chief Executive Officer's Report 5 min - No Handout
Steve A. Purves, FACHE, President and Chief Executive Officer, Valleywise Health

7:40 12. Concluding Items 10 min

a. Old Business: - No Handout

January 2024
Future presentation on behavioral health services offered at Valleywise Community Health Center-McDowell

Future presentation on effectiveness of depression interventions

December 6, 2023
Future presentation on Marketing/Communications – *(scheduled for April)*

b. Governing Council Member Closing Comments/Announcements - No Handout

7:50 **Adjourn**

1.a.i. Minutes - Meeting minutes dated April 3, 2024

Minutes

Valleywise Community Health Centers Governing Council Meeting
Virginia G. Piper Charitable Trust Pavilion
2609 East Roosevelt Street, Phoenix, AZ 85008
2nd Floor, Auditoriums 1 and 2
April 3, 2024, 4:45 p.m.

DRAFT

Members Present: Scott Jacobson, Chairman
Eileen Sullivan, Vice Chairman
Earl Arbuckle, Treasurer
Nelly Clotter-Woods, Member
Chris Hooper, Member
Norma Muñoz, Member
William O'Neill, Member
Essen Otu, Member
Wayne Tormala, Member – *participated remotely*
Jane Wilson, Member

Members Absent: Salina Iman, Member

Non-Voting Member Absent: Mary Rose Garrido Wilcox, District Board

Others/Guest Presenters: Michelle Barker, DHSc, Chief Executive Officer of the Federally Qualified Health Centers
Claire Agnew, CPA, MBA, Chief Financial Officer
Melanie Talbot, Chief Governance Officer
Ijana M. Harris, JD, General Counsel
Dennis Nochez, Patient Access Manager
Amanda De Los Reyes, MBA, CRCR, Vice President Revenue Cycle
Matthew Meier, MBA, Vice President, Financial Services
Crystal Garcia, RN, MBA, Vice President, Specialty Services, Quality and Safety

Recorded by: Denise Tapia, Deputy Clerk of the Board

Call to Order:

Chairman Jacobson called the meeting to order at 4:45 p.m.

Roll Call

Ms. Talbot called roll. Following roll call, she noted that eight of the eleven voting members of the Valleywise Community Health Centers Governing Council were present, which represented a quorum. Mr. Arbuckle and Ms. Muñoz arrived after roll call.

For the benefit of all participants, Ms. Talbot announced the Governing Council member participating remotely.

Call to the Public

Chairman Jacobson called for public comment.

Call to the Public, cont.

Dr. Barker announced that she would be absent from the May 1, 2024 Governing Council meeting. Ms. Christie Blanda, Director of Ambulatory Operations, would fill in for her absence. Dr. Barker stated she would be back for the June meeting.

Ms. Talbot introduced the new Deputy Clerk of the Board, Ms. Denise Tapia.

General Session, Presentation, Discussion and Action:

1. Approval of Consent Agenda:

   a. Minutes:

      i. Approve Valleywise Community Health Centers Governing Council meeting minutes dated March 6, 2024.

   b. Contracts:

      i. Acknowledge amendment #1 to the agreement (90-24-003-1-01) between Maricopa County Department of Public Health and Maricopa County Special Health Care District dba Valleywise Health, for services related to the Community Health Needs Assessment (2023-2026)

      ii. Acknowledge a new agreement (MCO-24-007-MSA) between Humana Dental Insurance Company and Maricopa County Special Health Care District dba Valleywise Health, to allow members to receive dental services through Valleywise Health dental providers

   c. Governance:

      i. Intentionally Left Blank

   d. Medical Staff:

i.

      i. Acknowledge the Federally Qualified Health Centers Medical Staff and Advanced Practice Clinician/Allied Health Professional Staff Credentials

MOTION: Ms. Wilson moved to approve the consent agenda. Mr. Otu seconded.

VOTE: 8 Ayes: Chairman Jacobson, Vice Chairman Sullivan, Dr. Clotter-Woods, Mr. Hooper, Mr. O'Neill, Mr. Otu, Mr. Tormala, Ms. Wilson
0 Nays:
3 Absent: Mr. Arbuckle Ms. Iman, Ms. Muñoz
Motion passed.

2. Mission Moment – A Patient Story

Mr. Nochez shared an outstanding customer service story about a new patient's interaction with a scheduler. The patient said the scheduler was patient, detailed and very helpful. As a result, the patient would come back to Valleywise Health because of the outstanding customer service received.

General Session, Presentation, Discussion and Action, cont.:

3. Discuss and Review the 2024 Federal Poverty Level Guidelines; Discuss and Review the Federally Qualified Health Centers Sliding Fee Discount Program/Policy, and Utilization of the Program; Approve Revisions to Appendix C, Federally Qualified Health Center Sliding Fee Discount Schedule, of Policy #23624 D - Federally Qualified Health Centers Sliding Fee Discount Program/Policy

Ms. De Los Reyes discussed the Federally Qualified Health Centers (FQHCs) Sliding Fee Discount Program/Policy (SFDP). Health Resources and Services Administration (HRSA) required all FQHCs to have one. She reviewed the updated federal poverty guidelines set forth by the U.S. Department of Health and Human Services (HHS), the policy, and revisions to the Sliding Fee Discount Schedule. There were minimal updates to the federal poverty guidelines, which were annually adjusted.

While there were no changes to the policy, Ms. De Los Reyes outlined the revisions to Appendix C, Sliding Fee Discount Schedule. Upon review of Chapter 9 of HRSA's Compliance Manual, FQHCs should not provide a discount to anyone over 200% of the federal poverty level (FPL) unless a grant or additional program covers it. Valleywise Health had not been following that guideline for a few services.

NOTE: Mr. Arbuckle arrived at 4:56 p.m.

Ms. De Los Reyes stated discounts were not available for individuals that were greater than 200% of the FPL, or within Category five of the Sliding Fee Discount Schedule, for specialty visits, ancillary services, and outpatient ancillary services. For dental services, there was a $30 fee, and the allowable rates changed, so there wouldn't be a discount provided for those patients that fell within Category Five.

Mr. Otu asked if patients would receive an estimate of the cost before services were provided.

Ms. De Los Reyes stated patients received an out-of-pocket estimate prior to receiving services.

Mr. Hooper asked if a patient was in the process of receiving treatment, would their rates change. If so, what were the solutions if the patient could no longer afford to continue with the treatment.

NOTE: Ms. Muñoz arrived at 4:58 p.m.

Ms. De Los Reyes stated if there were an overlap in the change of service, the patient would be charged by the date of service and the patient would be informed of that.

Mr. Hooper asked if there was any recourse if the patient couldn't pay.

Ms. De Los Reyes stated it would not be a Valleywise Health decision it would be based on the requirements from HRSA to stay in compliant.

Chairman Jacobson asked how services provided through the Ryan White grant were impacted.

Ms. De Los Reyes stated that Ryan White was a grant-funded program and, therefore, would not apply.

Chairman Jacobson asked if someone could receive discounts through the SFDP in addition to utilizing grant-funded services.

Ms. De Los Reyes stated that participating in a grant-funded program did not prohibit an individual from receiving discounts through the SFDP.

Mr. Otu asked how patients would be informed of the revisions to the sliding fee discount schedule.

Ms. De Los Reyes stated the patient would receive an estimate prior to services, usually when the appointment is scheduled.

General Session, Presentation, Discussion and Action, cont.:

3. Discuss and Review the 2024 Federal Poverty Level Guidelines; Discuss and Review the Federally Qualified Health Centers Sliding Fee Discount Program/Policy, and Utilization of the Program; Approve Revisions to Appendix C, Federally Qualified Health Center Sliding Fee Discount Schedule, of Policy #23624 D - Federally Qualified Health Centers Sliding Fee Discount Program/Policy, cont.

She provided an overview of the utilization of the SFDP for calendar year (CY) 2023, including but not limited to total visit count, total charges, total adjustments, and total payments received. The number of visits increased over CY 2022 while the number of unique patients decreased from the prior year.

Ms. Wilson pointed out that there were fewer patients but more visits.

Ms. De Los Reyes said there were various ways to analyze the data.

Mr. Otu asked if the increase in the average visits per year improved the overall health of the patient.

Ms. Barker stated that patients were receiving care, which was a positive perspective. However, given that the patients that needed a higher level of care utilized the SFDP, could be considered an unfortunate aspect of the current healthcare disparity in the community.

Chairman Jacobson asked how Valleywise Health could increase the number of unique patients.

Dr. Barker stated that discussion could be placed on a future meeting agenda.

Mr. Hooper asked if there were contributing factors for the decline in the number of patients visiting Valleywise Health.

Dr. Barker stated that staff would gather additional information to discuss with the Governing Council at a future meeting.

MOTION: Vice Chairman Sullivan moved to approve the revisions to Appendix C, Federally Qualified Health Center Sliding Fee Discount Schedule, of Policy #23624 D - Federally Qualified Health Centers Sliding Fee Discount Program/Policy. Mr. Hooper seconded.

VOTE: 10 Ayes: Chairman Jacobson, Vice Chairman Sullivan, Mr. Arbuckle, Dr. Clotter-Woods, Mr. Hooper, Ms. Muñoz, Mr. O'Neill, Mr. Otu, Mr. Tormala, Ms. Wilson
0 Nays
1 Absent: Ms. Iman
Motion passed.

4. Discuss and Review Quality of Care Audit for the Federally Qualified Health Centers for Calendar Year 2023

Ms. Garcia noted the quality measures included in the Uniform Data System (UDS) report were represented in the quality-of-care audit for CY 2023. A quality analyst dedicated to the FQHCs worked with physicians and leaders to ensure the quality metrics were met. In CY 2023, all but one quality metrics were met, with controlling high blood pressure not meeting the benchmark. Staff had implemented several action plans, which had improved the metric from the prior year. She noted that the NRC (National Research Corporation), Patient Experience Real Time Platform, which is the patient experience, was shared with the Governing Council on a quarterly basis.

General Session, Presentation, Discussion and Action, cont.:

5. Discuss and Review Fiscal Year 2025 Budget Calendar, Preliminary Patient Volume Assumptions and Capital Target for the Federally Qualified Health Centers

Mr. Meier reviewed the fiscal year (FY) 2025 budget calendar, noting the Governing Council would be presented with volume targets in May 2024. There would be two budget discussions in June 2024; the first meeting to review capital targets and operating expenses. The second meeting in June 2024, the Governing Council would be presented the final budget for the FQHCs, for consideration for approval.

Mr. Meier stated the overall volume assumptions were developed using the same methodology used in prior years. The most important part was that projected visits per session were reviewed and forecasted in collaboration with District Medical Group (DMG) and the operational leadership.

While reviewing the projected visits for the Valleywise Community Health Centers, he noted that visits were projected to increase by 6.6%, primarily due to additional staffing and the addition of the Mobile Health Unit services. Outpatient behavioral health visits were projected to increase by 8.1% due to the addition of five providers.

Visits within Valleywise Comprehensive Health Center-Peoria were projected to increase by 6.9% due to existing providers.

Visits within Valleywise Comprehensive Health Center-Phoenix were projected for a nominal 0.3% increase, which was provider-driven, based on the number of visits per session.

Dental visits were conservatively projected to increase by 2.2%, as the dental clinics were fully staffed and there were no anticipated vacancies.

Overall visits were projected to increase by 5%, or 15,585 more visits. As previously mentioned, many of the projected increases were due to additional providers. Mr. Meier reviewed the DMG provider staff by location, noting an overall increase of 5.55 full-time equivalents (FTEs).

The contingency capital was budgeted for $100,000 in case there were any equipment failures.

Mr. Hooper understood that provider staffing had been an ongoing concern and asked what the targeted number of providers was to have within the ambulatory setting.

Ms. Agnew stated the size of the clinic determined the number of providers at each location.

Dr. Barker acknowledged the improvements made in filling the provider vacancy rate, which was as high as 30% after the COVID-19 pandemic. She announced the vacancy rate was now less than ten percent.

Mr. Arbuckle asked if the contingency budget rolled over to the next fiscal year, if not used.

Ms. Agnew stated that the budget was set every year, and if the amount was not used, it would not roll over.

Dr. Barker stated there were grants that funded many of the capital needs the past year.

Adjourn

MOTION: Mr. Arbuckle moved to adjourn the April 3, 2024, Valleywise Community Health Centers Governing Council Meeting. Mr. Otu seconded.

VOTE: 10 Ayes: Chairman Jacobson, Vice Chairman Sullivan, Mr. Arbuckle, Dr. Clotter-Woods, Mr. Hooper, Ms. Muñoz, Mr. O'Neill, Mr. Otu, Mr. Tormala, Ms. Wilson
0 Nays
1 Absent: Ms. Iman
Motion passed.

Meeting adjourned at 5:26 p.m.

_____
Denise Tapia
Deputy Clerk of the Board

1.b.i. Contracts - 90-24-286-1

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Wednesday, April 10, 2024 3:34 PM
To: Melanie Talbot
Subject: Contract Approval Request: (IGA) Ryan White Part B HIV Care and Services (CTR068177) Arizona Department of Health Services (ADHS)

Message Information

From Purves, Stephen
To Talbot, Melanie;
Subject Contract Approval Request: (IGA) Ryan White Part B HIV Care and Services (CTR068177) Arizona Department of Health Services (ADHS)
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
RFBA		File	RFBA - ADHS.pdf
DHS Contract Review (2/29/24; signed 3/4/24)		File	CTR068177 AG Cover Sheet.pdf
OIG - Arizona Department of Health Services (ADHS)		File	OIG - Arizona Department of Health Services (ADHS) 2024.pdf
SAM - Arizona Department of Health Services (ADHS)		File	SAM - Arizona Department of Health Services (ADHS) 2024.pdf
ADHS IGA - pending Board signature		File	ADHS CTR068177.pdf

Contract Information

Division Contracts Division
Folder Contracts \ Grants
Status Pending Approval
Title (IGA) Ryan White Part B HIV Care and Services (CTR068177)
Contract Identifier Board - New Contract
Contract Number 90-24-286-1

Primary Responsible Party	Tymczyna, Katherine
Departments	Grants - ADHS HIV Rebate Funds
Product/Service Description	(IGA) Ryan White Part B HIV Care and Services (CTR068177)
Action/Background	Approve a new Intergovernmental Agreement (IGA) with Arizona Department of Health Services (ADHS) for the Ryan White Part B HIV Care and Services (CTR068177). This cost reimbursement agreement will provide services to eligible clients residing in Arizona. The current National HIV/AIDS strategy has four (4) goals which the Ryan White Part B program works to achieve, including: reducing new HIV infections; improving access to care and health outcomes; reducing HIV-related health disparities and achieving a more coordinated national response. The term of this IGA is April 4, 2023 through March 31, 2028. The State reserves the right to terminate the contract, in whole or in part at any time when in the best interest of the State, without penalty or recourse. This is a cost reimbursement with an anticipated annual reimbursement of $2,620,313.00 and has been budgeted for operational funding to the Grants department, which includes indirect costs of 28% ($606,103.00 annually). This IGA is sponsored by Dr. Michael White, EVP & Chief Clinical Officer.
Evaluation Process	The Contractor was determined to meet the requirements of the requesting department and Valleywise Health. Procurement has been satisfied pursuant to HS-102B(2) of the Procurement Code in that any Valleywise Health compliance with the terms and conditions of a grant, gift or bequest is exempt from the solicitation requirements of the Procurement Code.
Category	IGA
Effective Date	
Term End Date	3/31/2028
Annual Value	$2,620,313.00
Expense/Revenue	Revenue
Budgeted Travel Type	Yes
Procurement Number	
Primary Vendor	Arizona Department of Health Services (ADHS)

Responses

Member Name	Status	Comments
Pardo, Laela N.	Approved	Reviewed and approve. Will have final revision for clarity purposes on page 19 in red prior to official board date.
Melton, Christopher C.	Approved	
Joiner, Jennifer L.	Approved	
Hixson, Jeffrey B.	Approved	
Barker, Michelle J.	Approved	
White, Michael	Approved	
Harris, Ijana M.	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	
Talbot, Melanie L.	Current	

1.c.i. - Governance - Federally Qualified Health Centers Sliding Fee Discount Program/Policy

Valleywise Health Administrative Policy & Procedure

Effective Date: **05/15**

Reviewed Dates: **03/24**

Revision Dates: **01/18, 07/18, 09/18, 10/18, 02/20, 09/21, 08/22, 10/23 11/23, 5/24**

Policy #: 23624 D

Policy Title: FQHC Sliding Fee Discount Program

Scope:
[ ] District Governance (G)
[ ] System-Wide (S)
[X] Division (D)
[ ] Multi-Division (MD)
[ ] Department (T)
[ ] Multi-Department (MT)
[X] FQHC (F)

Purpose: In accordance with the Health Resources and Services Administration (HRSA) Health Center Program Compliance Manual, Chapter 9: Sliding Fee Discount Program, HRSA Valleywise Health's Federally Qualified Health Centers (FQHCs) established a sliding fee discount program that includes a schedule of fees for services, a schedule of discounts for services, or a sliding fee discount schedule, that minimizes financial barriers to care for patients who meet certain eligibility criteria.
This policy establishes the procedure for those patients who meet eligibility criteria to have access to necessary health care services at Valleywise Health's FQHC designated clinics at costs based on their ability to pay as determined by their gross annual household income and family size.

Definitions:
Advanced Practice Clinicians (APCs): Individuals other than Medical Staff members who are licensed healthcare professionals who are board certified and have at least a master's degree. APCs are trained to practice medicine and prescribe within the scope of their training as outlined by their specific scope of practice and are authorized by law and by the Hospital to provide patient care services.
~~Allied Health Professional: A health care practitioner, other than a Medical Staff member, who is authorized to provide patient care services to patients of Valleywise Health and been granted clinical privileges.~~

Deposit: Initial payment applied toward the total fees due.

FQHC Sliding Fee Discount Program: A program which ensures that Valleywise Health's FQHC Health Center patients have access to all services that are available at the health

center. The program seeks to provide its services to eligible patients and minimize financial barriers, all according to the following elements:

+ A schedule of fees for services.

+ A corresponding schedule of discounts for eligible patients that is adjusted based on the patient's family size and income.

+ Board of Director and Valleywise Community Health Centers Governing Council (VCHCGC) approved policies and Valleywise Health's supporting operating policies and procedures, including billing and collections.

Family Size / Household: Immediate family members including head of household, legal guardians, spouse, domestic partners, same gender marriage, and children under the age of 19 will be classified as part of the household. Individuals and family members temporarily living / sharing quarters or foreign visitors, where permanent residence will not be maintained, will not be considered as part of the household. Adults that are living in the household that are self-sufficient and are not included in the "household" are considered individually for eligibility.

Income / Annual Household Income: Gross annual income before deductions include the following: Earnings, unemployment compensation, worker's compensation, social security, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, estates and trusts, educational assistance, alimony and/or child support, financial assistance from outside of the household, and/or other sources of income.

Low Income: Annual income = less than or equal to 200% of the current Federal Poverty Level.

Medical Staff: All physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff by the Board of Directors of Valleywise Health. Medical Staff are also referred to as Attendings and for purposes of this policy is synonymous with Provider.

Nominal Fee / Nominal Charge: The amount charged for services to patients at or below 100% of the Federal Poverty Level (FPL). It is designed to help patients invest in their care and minimize the potential for inappropriate utilization of services. The nominal charge is a fixed fee that does not reflect the value of the service(s) provided and is considered nominal from the perspective of the patient. Nominal charges are not "minimum fees," "minimum charges," or "co-pays." The nominal fee must not impede the patient in accessing services due to their ability to pay.

Presumptive Eligibility Screening System: An automated software tool that predicts the likelihood of a patient to qualify for the Sliding Fee Program based on publicly available data sources. The tool provides estimates of the patient's household income and size.

Valleywise Health Clinic Manager: The Valleywise Heath clinic manager is responsible for the supervision, direction, and coordination of the day to day operations of the assigned Valleywise Health clinic.

Policy: A Sliding Fee Discount Schedule (SFDS) is used to determine the nominal fee and /or dollar amount of any given fee which the eligible patient is expected to pay. The SFDS is based on current FPL Guidelines and is adjusted annually based on gross annual household income and family size in the household. Under this policy, the patient is responsible for one hundred percent (100%) of the fees charged for the services rendered. However, the SFDS offers to the patient a method of satisfying the debt when the patient's resources are limited.

Valleywise Health recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Valleywise Health utilizes an automated, predictive scoring tool provided by our third-party vendor to assess patients for financial need. This screening process utilizes public record data and includes estimates for income and household size.

Procedure:

I. Eligibility

A. Valleywise Health will inform patients about the availability of the Sliding Fee Discount Program through signage, personal reminders and other methods of communication. As part of the preregistration or registration process, the Valleywise Health eligibility specialist or other front office staff will inform patients that are not informed of the SFDS.

B. Patients whose income exceeds 200% of the FPL Guidelines are not eligible for discounts on the Sliding Fee Discount Program. (Appendix A)

C. Valleywise Health uses two types of screening to determine eligibility for the Sliding Fee Discount Program: Presumptive and Traditional.
+ Presumptive screening is the initial process used to determine a patient's eligibility for the Sliding Fee Discount Program.
+ Traditional screening is completed for patients who disagree with the Sliding Fee level assigned by the Presumptive Eligibility Screening System.

D. Patients applying via the Traditional screening for the Sliding Fee Discount Program must provide written verification of monthly income (see Appendix A).
Examples include:
+ Previous year federal tax returns.
+ Paycheck stubs for each adult working in the household.
+ A signed statement from the patient's employer stating rate of pay, average number of hours worked weekly and hire date.
+ Quarterly tax statement for those self-employed.
+ Unemployment benefit letter.
+ Benefit letter from Social Security showing monthly payment received for each person in the household.
+ Documentation of child support and/or alimony (divorce paperwork, etc.)
+ Copy of pension / retirement benefits.
+ Copy of Veterans benefits.
+ Full time unemployed students: Provide proof of student status.

+ Federal or State support: Example: Food stamps, the packet received with approval is required, this includes start and stop dates and Food Stamp Summary page.

E. Valleywise Health will verify patient eligibility, at minimum, on an annual basis.

F. Patients unable or unwilling to provide verification may be eligible for self-declaration of income which will be used in special circumstances. Patients unable to provide written verification of income must provide a signed statement of income, and why he / she are unable to provide independent verification. This written statement is subject to management review and final determination as to the sliding fee category eligibility. Self–declaration applies to one visit only within a 12-month period and the patient must provide the required written verification of income of the items in Appendix A, within 30 days following the one time visit in order to remain eligible to participate in the Sliding Fee Discount Program. The assigned category will be retroactive for 30 days. (Appendix B)

G. Patients applying for the Sliding Fee Discount Program will be informed that they will need to contact Valleywise Health if their income or household status changes.

H. Situational waivers can be approved based on catastrophic situations or significant changes in guarantor income.

+ If during the process of discussing an outstanding balance with a patient or reviewing payment plan options a situation or change is brought up that would impact the ability to pay, a request will be forwarded to the Director of Patient Financial Services for review.
+ After review of a guarantor's significant change in ability to pay an approval may be granted for a waiver of all or some of the guarantor's outstanding balance.
+ Activities related to the review for waiver and approval, or declination will be documented in the patient accounting system.

II. Sliding Fee Discount Schedule

A. The Sliding Fee Discount Schedule and corresponding rates and policies for administration of the Sliding Fee Discount Program will be reviewed and updated annually.

B. The updated FPL income guidelines will be obtained from the Federal Register annually. The Poverty Guidelines document and corresponding systems will be updated promptly following the federal update.

C. Services covered by Sliding Fee Discount Program must be medically necessary, as determined by the health care provider. If additional services or tests are desired by the patient, including immunizations, they must be paid for in advance. Similarly, certain high cost procedures, elective procedures and lab tests with less expensive options are exempted from sliding fee discounts.

III. Billing and Collection Schedules

A. The patient will be advised that the applicable fee, including the nominal fee, is expected at the time of service. In the event the patient is unable to pay at the time of service, the patient will be informed that they will be billed. Patients are expected to make payment in full within 90 days or establish a payment plan,

including making payment(s) on their outstanding bill, with a Valleywise Health financial counselor.

B. An inability to pay will not impede access to care. Payment arrangements may be made through Patient Financial Services in accordance with policy #09003 S Revenue Cycle/Business Office: Payment Plans. This will be determined on an individual basis. Factors that may be considered in making this determination include large outstanding medical bills which place a client under extreme financial duress. Despite current income, staff are asked to apprise the clinic manager of the circumstances so that further discounts may be offered to the patient to facilitate his / her receipt of medically necessary services.
C. Refusal to pay will not impede access to care. Patients refusing to pay the nominal fee will not be denied care. Payment and/or payment arrangements may be made through Patient Financial Services in accordance with applicable policies.
D. Insured patients qualifying for Sliding Fee after insurance will be billed for the lessor of the copay/co-insurance assigned by their insurance company or the Sliding Fee Discount amount.

IV. Governing Body Oversight

A. Updates to the Sliding Fee Discount Program and proposed policy changes will be presented every ~~3~~3 years~~s~~ to the ~~to the VCHCGC Finance Committee, VCHCGC's Compliance and Quality Committee, and followed by approval of by the VCHCGC~~ Valleywise Community Health Centers Governing Council and~~and~~ the District~~'s~~ Board of Directors for approval.

B. The Sliding Fee Discount Schedule will be presented annually to the ~~VCHCGC Finance Committee, VCHCGC's Compliance and Quality Committee, and followed by approval of the VCHCGC~~ Valleywise Community Health Centers Governing Council and the District~~'s~~ Board of Directors for approval.

C. Sliding Fee Level Utilization information will be reviewed and discussed annually to ensure no barriers to care exist.

References: HRSA Health Center Program Compliance Manual, released August 2018
CHC & FHC Internal and External Referrals Policy # 20006 S

Valleywise Health Policy & Procedure - Approval Sheet
(**Before submitting, fill out COMPLETELY**.)

POLICY RESPONSIBLE PARTY: Valleywise Health Vice President of Revenue Cycle

DEVELOPMENT TEAM(S): Patient Financial Services, Valleywise Community Health Centers Administration, and Revenue Integrity Management

Policy #: 23624 D

Policy Title: FQHC Sliding Fee Discount Program

e-Signers: Amanda De Los Reyes, VP Revenue Cycle

Place an X on the right side of applicable description:

New -

Retire - **Reviewed -**

Revised with Minor Changes - X

Revised with Major Changes -

Please list revisions made below: (Other than grammatical changes or name and date changes)

Reviewed and Approved by in Addition to Responsible Party and E-Signer(s):

Required Approval: Valleywise Community Health Centers Governing Council	**054/24**
Required Approval: Maricopa County Special Health Care District Board of Directors	**054/24**
Required Approval: Michelle Barker, Sr VP Ambulatory Services and CEO FQHC Clinics	**03/24**
Required Approval: Vanessa Couch-Laguana, Director Patient Financial Services	**03/24**

Committee:

Other:

Appendix A

VALLEYWISE HEALTH FINANCIAL/DISCOUNTED POLICIES

Sliding Fee- Free Pregnancy Test- Prenatal Care-Maternity Agreements, Healthy (E)
AHCCCS Applications- Family Planning Program for Women
Thank you for your interest in Valleywise Health's medical programs. To assist you better please provide the following information at the time of your interview. Please provide documents from each of the following categories.

Proof of income for the past 30 days from interview date for EVERYONE in the household

- ✓ Current award letter from DES if receiving cash assistance or food stamps
- ✓ Paycheck stubs (4) if paid weekly, (2) if paid bi-weekly
- ✓ Employer statements on letterhead / business card or notarized.
- ✓ Unemployment income
- ✓ Social Security award letter or copy of check for all household members
- ✓ Veteran's Benefits
- ✓ Pensions
- ✓ Workman's Compensation
- ✓ Child support/Alimony
- ✓ Record of earnings from self-employment or odd jobs (Income calendar if paid in cash)
- ✓ Grants, scholarships or educational benefit letters
- ✓ Current bank statements, **checking and savings** for all household members
- ✓ Statement of support from person **providing** support

Self Employed Clients 30 days from interview date

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- ✓ Check stubs
- ✓ Income vouchers or receipts
- ✓ Income statement from person/company paying for the services rendered
- ✓ Income calendar or any other documentation
- ✓ Statements/calendars must display dates and total amount of payment and current tax returns
- ✓ All business expenses

Proof of Address/Monthly Household Monthly Expenses within 30 days from the interview date
(All that applies)

- ✓ Rent or lease agreement/mortgage payment
- ✓ Utility receipt electric, gas, water, phone, cable, internet, car insurance, bank statement
- ✓ Letter from Landlord or a neighbor if utility bills under someone else's name
- ✓ Current registration for school aged children

Proof of dependents/relationship

- ✓ Children's birth or baptismal certificates **(Even if child is already insured)**
- ✓ Marriage License
- ✓ Proof of Pregnancy (if applicable)
- ✓ Receipt from social security administration

Proof of Identity (Not required and inability to provide will not disqualify for Sliding Fee)

- ✓ Birth or Baptismal Certificate
- ✓ Naturalization/Citizenship Certificate
- ✓ Driver's license/Photo ID for everyone over 18 years of age
- ✓ Lawful Permanent Resident Card

- ✓ Employment Authorization Card
- ✓ Passport Visa
- ✓ Passport-INS-194

Appendix A

PÓLIZAS FINANCIERAS/DE DESCUENTOS DE VALLEYWISE HEALTH

Programa de Descuento - Pruebas de embarazo sin costo - Cuidado prenatal - Acuerdos de maternidad - Solicitudes para Healthy (E) AHCCCS - Programa de planificación familiar para mujeres

Gracias por su interes en los programas medicos de Valleywise Health. Para asistirle mejor, por favor traiga la siguiente información el día de su entrevista. Por favor proporcione documentos para cada una de las siguientes categorías.

Comprobante de ingresos de los últimos 30 días antes de la fecha de su entrevista de TODOS los que viven en la casa.

- ✓ Carta más reciente del Departamento de Servicios Económicos (DES) si recibe asistencia económica en efectivo, o estampillas de comida
- ✓ Talones de cheque (4) si el pago es semanal, (2) si el pago es cada dos semanas
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- ✓ Beneficios de veterano
- ✓ Pensiones
- ✓ Información de ingresos del seguro de compensación laboral
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- ✓ Registro de ingresos de trabajo por cuenta propia/o trabajos ocasionales
- ✓ Cartas de subsidios, becas u otros beneficios educacionales
- ✓ Estados actuales de cuenta bancaria, de ahorros y cheques para todos los que viven en su casa
- ✓ Carta de apoyo de la persona que lo mantiene

Clientes con Trabajo por Cuenta Propia Comprobante de los 30 días antes de la Entrevista

- ✓ Estados de cuenta bancaria
- ✓ Talones de cheque
- ✓ Vales o recibos de ingresos
- ✓ Declaración de ingresos de la persona/compañía que paga por los servicios proporcionados
- ✓ Calendario de ingresos o cualquier otro documento
- ✓ Las/los declaraciones/calendarios deben mostrar fechas y cantidad total del pago y devoluciones de impuestos actuales
- ✓ Todos los gastos del negocio

Comprobante de domicilio/gastos mensuales del hogar: Debe incluir los gastos dentro de los 30 días antes de la fecha de la entrevista (todo lo que corresponda).

- ✓ Recibo de pago o contrato de renta/hipoteca
- ✓ Recibos de luz, gas, agua, teléfono, cable, Internet, seguro del carro, cuenta de banco.
- ✓ Carta del arrendador o de un vecino si los recibos de servicios públicos están a nombre de alguien más
- ✓ Comprobante de la inscripción escolar actual de los niños

Comprobante de dependientes/parentesco

- ✓ Acta de nacimiento o certificado de bautismo de los niños (incluso si el menor ya tiene Seguro medico)
- ✓ Acta de matrimonio
- ✓ Prueba de embarazo (si corresponde)

Prueba de identidad (No es obligatorio y si no puede proporcionarlo, no será descalificado de los programas de descuento)

- ✓ Acta de nacimiento o certificado de bautismo
- ✓ Certificado de naturalización/ciudadanía
- ✓ Licencia para manejar o identificación con foto de todas las personas mayores de 18 años
- ✓ Tarjeta de residencia permanente legal
- ✓ Tarjeta de permiso para trabajar
- ✓ Pasaporte visado
- ✓ Pasaporte-INS-194

Si tiene alguna pregunta acerca de los documentos indicados anteriormente, por favor llame a 602-344-2550

Appendix B

MRN:
SELF-DECLARATION/DECLARACION: DATE/FECHA: _____

SIGNATURE/FIRMA: _____
Revised 02/2012

Appendix C

Valleywise Health
Federally Qualified Health Center Sliding Fee Discount Schedule
Effective 05/15 Reviewed/Revised ~~3/24~~ 5/24

Medical

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5
Federal Poverty Level Scale	**0-100%**	**101-138%**	**139-150%**	**151-200%**	**>201% FPL**
Primary Care	$20 Nominal Charge	$30 Flat Fee	$40 Flat Fee	$50 Flat Fee	No Discount
Family Planning Services - Maryvale Clinic Only	$0	$20	$30	$40	201-250% FPL $50
FQHC Specialty Visits (Example - Cardiology)	$50 Nominal Charge	$70 Flat Fee	$80 Flat Fee	$90 Flat Fee	No Discount
Outpatient Ancillary Services (Lab)	$10 Nominal Charge	25% of Medicare rate - 50% due prior to service ($20 minimum)	50% of Medicare rate - 50% due prior to service ($30 Minimum)	75% of Medicare rate - 50% due prior to service ($40 minimum)	No Discount
Outpatient Ancillary Services (Imaging)	$30 Nominal Charge	25% of Medicare rate - 50% due prior to service ($40 minimum)	50% of Medicare rate - 50% due prior to service ($50 Minimum)	75% of Medicare rate - 50% due prior to service ($60 minimum)	No Discount

Dental

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5
Federal Poverty Level Scale	**0-100%**	**101-138%**	**139-150%**	**151-200%**	**>201% FPL**
Diagnostic Dental Services	$10 Nominal Charge	$15 Flat Fee	$20 Flat Fee	$25 Flat Fee	No Discount
Restorative Dental Services ***See Grid Below**	$50 Nominal Charge + Cost of Supplies	75% of Delta Dental allowable rates	80% of Delta Dental allowable rates	85% of Delta Dental allowable rates	See Below
Dental Lab Services	$50 Nominal Charge + Cost of Supplies	85% of Delta Dental allowable rates	90% of Delta Dental allowable rates	95% of Delta Dental allowable rates	See Below

Restorative Grid	Category 1	Category 2	Category 3	Category 4	Category 5
Filling	$25.00	$35.00	$50.00	$75.00	No Discount
Crowns Simple	$75.00	$100.00	$125.00	$150.00	No Discount
Crowns	$250.00	$400.00	$450.00	$475.00	No Discount
Dentures - Temporary	$100.00	$200.00	$250.00	$300.00	No Discount
Dentures - partial	$300.00	$350.00	$400.00	$450.00	No Discount
Dentures - complete	$350.00	$795.00	$842.00	$865.00	No Discount
Bridges - Temporary	$50.00	$100.00	$150.00	$200.00	No Discount
Bridges	$200.00	$250.00	$300.00	$350.00	No Discount
Extractions - simple	$50.00	$62.00	$66.00	$70.00	No Discount
Extractions - complex	$100.00	$110.00	$125.00	$135.00	No Discount

Valleywise Health Administrative Policy & Procedure

Effective Date: **05/15**

Reviewed Dates: **03/24**

Revision Dates: **01/18, 07/18, 09/18, 10/18, 02/20, 09/21, 08/22, 10/23 11/23, 5/24**

Policy #: 23624 D

Policy Title: FQHC Sliding Fee Discount Program

Scope:
- **[ ] District Governance (G)**
- **[ ] System-Wide (S)**
- **[X] Division (D)**
- **[ ] Multi-Division (MD)**
- **[ ] Department (T)**
- **[ ] Multi-Department (MT)**
- **[X] FQHC (F)**

Purpose: In accordance with the Health Resources and Services Administration (HRSA) Health Center Program Compliance Manual, Chapter 9: Sliding Fee Discount Program, HRSA Valleywise Health's Federally Qualified Health Centers (FQHCs) established a sliding fee discount program that includes a schedule of fees for services, a schedule of discounts for services, or a sliding fee discount schedule, that minimizes financial barriers to care for patients who meet certain eligibility criteria.
This policy establishes the procedure for those patients who meet eligibility criteria to have access to necessary health care services at Valleywise Health's FQHC designated clinics at costs based on their ability to pay as determined by their gross annual household income and family size.

Definitions:
Allied Health Professionals (AHPs): Individuals other than Medical Staff members or APCs who are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital and are authorized by law and by the Hospital to provide patient care services.

Deposit: Initial payment applied toward the total fees due.

FQHC Sliding Fee Discount Program: A program which ensures that Valleywise Health's FQHC Health Center patients have access to all services that are available at the health center. The program seeks to provide its services to eligible patients and minimize financial barriers, all according to the following elements:

+ A schedule of fees for services.

+ A corresponding schedule of discounts for eligible patients that is adjusted based on the patient's family size and income.

+ Board of Director and Valleywise Community Health Centers Governing Council (VCHCGC) approved policies and Valleywise Health's supporting operating policies and procedures, including billing and collections.

Family Size / Household: Immediate family members including head of household, legal guardians, spouse, domestic partners, same gender marriage, and children under the age of 19 will be classified as part of the household. Individuals and family members temporarily living / sharing quarters or foreign visitors, where permanent residence will not be maintained, will not be considered as part of the household. Adults that are living in the household that are self-sufficient and are not included in the "household" are considered individually for eligibility.

Income / Annual Household Income: Gross annual income before deductions include the following: Earnings, unemployment compensation, worker's compensation, social security, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, estates and trusts, educational assistance, alimony and/or child support, financial assistance from outside of the household, and/or other sources of income.

Low Income: Annual income = less than or equal to 200% of the current Federal Poverty Level.

Medical Staff: All physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff by the Board of Directors of Valleywise Health. Medical Staff are also referred to as Attendings and for purposes of this policy is synonymous with Provider.

Nominal Fee / Nominal Charge: The amount charged for services to patients at or below 100% of the Federal Poverty Level (FPL). It is designed to help patients invest in their care and minimize the potential for inappropriate utilization of services. The nominal charge is a fixed fee that does not reflect the value of the service(s) provided and is considered nominal from the perspective of the patient. Nominal charges are not "minimum fees," "minimum charges," or "co-pays." The nominal fee must not impede the patient in accessing services due to their ability to pay.

Presumptive Eligibility Screening System: An automated software tool that predicts the likelihood of a patient to qualify for the Sliding Fee Program based on publicly available data sources. The tool provides estimates of the patient's household income and size.

Valleywise Health Clinic Manager: The Valleywise Heath clinic manager is responsible for the supervision, direction, and coordination of the day to day operations of the assigned Valleywise Health clinic.

Policy: A Sliding Fee Discount Schedule (SFDS) is used to determine the nominal fee and /or dollar amount of any given fee which the eligible patient is expected to pay. The SFDS is based on current FPL Guidelines and is adjusted annually based on gross annual household income and family size in the household. Under this policy, the

patient is responsible for one hundred percent (100%) of the fees charged for the services rendered. However, the SFDS offers to the patient a method of satisfying the debt when the patient's resources are limited.

Valleywise Health recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Valleywise Health utilizes an automated, predictive scoring tool provided by our third-party vendor to assess patients for financial need. This screening process utilizes public record data and includes estimates for income and household size.

Procedure:

I. Eligibility

A. Valleywise Health will inform patients about the availability of the Sliding Fee Discount Program through signage, personal reminders and other methods of communication. As part of the preregistration or registration process, the Valleywise Health eligibility specialist or other front office staff will inform patients that are not informed of the SFDS.

B. Patients whose income exceeds 200% of the FPL Guidelines are not eligible for discounts on the Sliding Fee Discount Program. (Appendix A)

C. Valleywise Health uses two types of screening to determine eligibility for the Sliding Fee Discount Program: Presumptive and Traditional.
+ Presumptive screening is the initial process used to determine a patient's eligibility for the Sliding Fee Discount Program.
+ Traditional screening is completed for patients who disagree with the Sliding Fee level assigned by the Presumptive Eligibility Screening System.

D. Patients applying via the Traditional screening for the Sliding Fee Discount Program must provide written verification of monthly income (see Appendix A).
Examples include:
+ Previous year federal tax returns.
+ Paycheck stubs for each adult working in the household.
+ A signed statement from the patient's employer stating rate of pay, average number of hours worked weekly and hire date.
+ Quarterly tax statement for those self-employed.
+ Unemployment benefit letter.
+ Benefit letter from Social Security showing monthly payment received for each person in the household.
+ Documentation of child support and/or alimony (divorce paperwork, etc.)
+ Copy of pension / retirement benefits.
+ Copy of Veterans benefits.
+ Full time unemployed students: Provide proof of student status.
+ Federal or State support: Example: Food stamps, the packet received with approval is required, this includes start and stop dates and Food Stamp Summary page.

E. Valleywise Health will verify patient eligibility, at minimum, on an annual basis.

F. Patients unable or unwilling to provide verification may be eligible for self-declaration of income which will be used in special circumstances. Patients

unable to provide written verification of income must provide a signed statement of income, and why he / she are unable to provide independent verification. This written statement is subject to management review and final determination as to the sliding fee category eligibility. Self–declaration applies to one visit only within a 12-month period and the patient must provide the required written verification of income of the items in Appendix A, within 30 days following the one time visit in order to remain eligible to participate in the Sliding Fee Discount Program. The assigned category will be retroactive for 30 days. (Appendix B)

G. Patients applying for the Sliding Fee Discount Program will be informed that they will need to contact Valleywise Health if their income or household status changes.

H. Situational waivers can be approved based on catastrophic situations or significant changes in guarantor income.
   + If during the process of discussing an outstanding balance with a patient or reviewing payment plan options a situation or change is brought up that would impact the ability to pay, a request will be forwarded to the Director of Patient Financial Services for review.
   + After review of a guarantor's significant change in ability to pay an approval may be granted for a waiver of all or some of the guarantor's outstanding balance.
   + Activities related to the review for waiver and approval, or declination will be documented in the patient accounting system.

II. Sliding Fee Discount Schedule

A. The Sliding Fee Discount Schedule and corresponding rates and policies for administration of the Sliding Fee Discount Program will be reviewed and updated annually.

B. The updated FPL income guidelines will be obtained from the Federal Register annually. The Poverty Guidelines document and corresponding systems will be updated promptly following the federal update.

C. Services covered by Sliding Fee Discount Program must be medically necessary, as determined by the health care provider. If additional services or tests are desired by the patient, including immunizations, they must be paid for in advance. Similarly, certain high cost procedures, elective procedures and lab tests with less expensive options are exempted from sliding fee discounts.

III. Billing and Collection Schedules

A. The patient will be advised that the applicable fee, including the nominal fee, is expected at the time of service. In the event the patient is unable to pay at the time of service, the patient will be informed that they will be billed. Patients are expected to make payment in full within 90 days or establish a payment plan, including making payment(s) on their outstanding bill, with a Valleywise Health financial counselor.

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B. The Sliding Fee Discount Schedule will be presented annually to the Valleywise Community Health Centers Governing Council and the District Board of Directors for approval.

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DEVELOPMENT TEAM(S): Patient Financial Services, Valleywise Community Health Centers Administration, and Revenue Integrity Management

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e-Signers: Amanda De Los Reyes, VP Revenue Cycle

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Revised with Major Changes -

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Required Approval: Michelle Barker, Sr VP Ambulatory Services and CEO FQHC Clinics	**03/24**
Required Approval: Vanessa Couch-Laguana, Director Patient Financial Services	**03/24**

Committee:

Other:

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VALLEYWISE HEALTH FINANCIAL/DISCOUNTED POLICIES

Sliding Fee- Free Pregnancy Test- Prenatal Care-Maternity Agreements, Healthy (E) AHCCCS Applications- Family Planning Program for Women

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Proof of dependents/relationship

- ✓ Children's birth or baptismal certificates **(Even if child is already insured)**
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- ✓ Proof of Pregnancy (if applicable)
- ✓ Receipt from social security administration

Proof of Identity (Not required and inability to provide will not disqualify for Sliding Fee)

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- ✓ Lawful Permanent Resident Card

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- ✓ Carta de apoyo de la persona que lo mantiene

Clientes con Trabajo por Cuenta Propia Comprobante de los 30 días antes de la Entrevista

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- ✓ Tarjeta de permiso para trabajar
- ✓ Pasaporte visado
- ✓ Pasaporte-INS-194

Si tiene alguna pregunta acerca de los documentos indicados anteriormente, por favor llame a 602-344-2550

Appendix B

MRN:
SELF-DECLARATION/DECLARACION: DATE/FECHA:

_____

SIGNATURE/FIRMA: _____
Revised 02/2012

Appendix C

Valleywise Health
Federally Qualified Health Center Sliding Fee Discount Schedule
Effective 05/15 Reviewed/Revised 5/24

Medical

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5
Federal Poverty Level Scale	**0-100%**	**101-138%**	**139-150%**	**151-200%**	**>201% FPL**
Primary Care	$20 Nominal Charge	$30 Flat Fee	$40 Flat Fee	$50 Flat Fee	No Discount
Family Planning Services - Maryvale Clinic Only	$0	$20	$30	$40	201-250% FPL $50
FQHC Specialty Visits (Example - Cardiology)	$50 Nominal Charge	$70 Flat Fee	$80 Flat Fee	$90 Flat Fee	No Discount
Outpatient Ancillary Services (Lab)	$10 Nominal Charge	25% of Medicare rate - 50% due prior to service ($20 minimum)	50% of Medicare rate - 50% due prior to service ($30 Minimum)	75% of Medicare rate - 50% due prior to service ($40 minimum)	No Discount
Outpatient Ancillary Services (Imaging)	$30 Nominal Charge	25% of Medicare rate - 50% due prior to service ($40 minimum)	50% of Medicare rate - 50% due prior to service ($50 Minimum)	75% of Medicare rate - 50% due prior to service ($60 minimum)	No Discount

Dental

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5
Federal Poverty Level Scale	**0-100%**	**101-138%**	**139-150%**	**151-200%**	**>201% FPL**
Diagnostic Dental Services	$10 Nominal Charge	$15 Flat Fee	$20 Flat Fee	$25 Flat Fee	No Discount
Restorative Dental Services ***See Grid Below**	$50 Nominal Charge + Cost of Supplies	75% of Delta Dental allowable rates	80% of Delta Dental allowable rates	85% of Delta Dental allowable rates	See Below
Dental Lab Services	$50 Nominal Charge + Cost of Supplies	85% of Delta Dental allowable rates	90% of Delta Dental allowable rates	95% of Delta Dental allowable rates	See Below

Restorative Grid	Category 1	Category 2	Category 3	Category 4	Category 5
Filling	$25.00	$35.00	$50.00	$75.00	No Discount
Crowns Simple	$75.00	$100.00	$125.00	$150.00	No Discount
Crowns	$250.00	$400.00	$450.00	$475.00	No Discount
Dentures - Temporary	$100.00	$200.00	$250.00	$300.00	No Discount
Dentures - partial	$300.00	$350.00	$400.00	$450.00	No Discount
Dentures - complete	$350.00	$795.00	$842.00	$865.00	No Discount
Bridges - Temporary	$50.00	$100.00	$150.00	$200.00	No Discount
Bridges	$200.00	$250.00	$300.00	$350.00	No Discount
Extractions - simple	$50.00	$62.00	$66.00	$70.00	No Discount
Extractions - complex	$100.00	$110.00	$125.00	$135.00	No Discount

1.d.i - Medical Staff - Medical Staff and Advanced Practice Clinician/Allied Health Professional Staff Credentials

Recommended by Credentials Committee: March 5, 2024
Recommended by Medical Executive Committee: March 12, 2024
Submitted to MSHCDB: March 27, 2024

VALLEYWISE HEALTH
CREDENTIALS AND ACTION ITEMS REPORT
MEDICAL STAFF

The credentials of the following individuals including, current licensure, relevant training and experience, malpractice insurance, current competence and the ability to perform the requested privileges have been verified.

INITIAL MEDICAL STAFF APPOINTMENT				
NAME	**CATEGORY**	**DEPARTMENT/SPECIALTY**	**APPOINTMENT DATES**	**COMMENTS**
NOTHING TO REPORT				

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**SPECIALTY/PRIVILEGES**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
NOTHING TO REPORT			

REAPPOINTMENTS/ONGOING PROFESSIONAL PRACTICE EVALUATION				
NAME	**CATEGORY**	**DEPARTMENT/SPECIALTY**	**APPOINTMENT DATES**	**COMMENTS**
R. Michael Brady, M.D.	Courtesy	Obstetrics & Gynecology	04/01/2024 to 03/31/2026	
Christopher S. Brendemuhl, D.M.D.	Active	Dentistry	04/01/2024 to 03/31/2026	
Robert L. Johnson, M.D.	Courtesy	Obstetrics & Gynecology	04/01/2024 to 03/31/2026	
Melissa F. Villamor Ballecer, D.D.S.	Active	Dentistry	04/01/2024 to 03/31/2026	

Recommended by Credentials Committee: March 5, 2024
Recommended by Medical Executive Committee: March 12, 2024
Submitted to MSHCDB: March 27, 2024

WAIVER REQUEST			
NAME	**SPECIALTY/PRIVILEGES**	**CATEGORY**	**COMMENTS**
Kassandra Jean Kosinski Romero, M.D.	Internal Medicine	Active	▪ Requesting a temporary waiver from the "Threshold Eligibility Criteria" requirements specific to Medical Staff Credentials Policy - Article 2.A.1.(m): Board Certification requirement ▪ Requesting a permanent waiver from the "Threshold Eligibility Criteria" requirements specific to Medical Staff Credentials Policy - Article 2.A.1.(a): having a current, unrestricted license to practice in Arizona and having never had a license to practice revoked or suspended by any state licensing agency. Chair of Internal Medicine is in support of the two above named waiver requests.

CHANGE IN PRIVILEGES			
NAME	**DEPARTMENT/SPECIALTY**	**ADDITION / REDUCTION / WITHDRAWAL**	**COMMENTS**
Tristan Leopold Pasek, M.D.	Internal Medicine	Withdrawal: Basic Critical Care Privileges	Dr. Pasek has Critical Care Core Privileges

RESIGNATIONS *Information Only*			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Roberta I. H. Matern, M.D.	Family & Community Medicine	Active to Inactive	Resigned effective March 31, 2024

Definitions:

Active	≥ 1,000 hours/year – Active members of the medical staff have voting rights and can serve on medical staff committees
Courtesy	< 1,000 hours/year – Courtesy members do not have voting rights and do not serve on medical staff committees
Reappointments	Renewal of appointment and privileges is for a period of two years unless otherwise specified for a shorter period of time.
FPPE	Focused professional practice evaluation is a process by which the organization validates current clinical competence. This process may also be used when a question arises in practice patterns.

Recommended by Credentials Committee: March 5, 2024
Recommended by Medical Executive Committee: March 12, 2024
Submitted to MSHCDB: March 27, 2024

VALLEYWISE HEALTH
CREDENTIALS AND ACTION ITEMS REPORT
ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL STAFF

The credentials of the following individuals including, current licensure, relevant training and experience, malpractice insurance, current competence and the ability to perform the requested privileges have been verified.

ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL – INITIAL APPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Spenser Kensington Dauwalder, A.G.A.C.N.P.	Internal Medicine	Practice Prerogatives on file	04/01/2024 to 03/31/2026	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**DEPARTMENT/SPECIALTY**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Jessica Lynn Curtisi, A.G.A.C.N.P.	Internal Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Nurse Practitioner Palliative Medicine Privileges.
Kelly Jo Plencner-Vega, C.N.M.	Obstetrics & Gynecology	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Certified Nurse Midwife Core Privileges.

ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL – REAPPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Kelly Jo Plencner-Vega, C.N.M.	Obstetrics & Gynecology	Practice Prerogatives on file	04/01/2024 to 03/31/2026	

General Definitions:

Advanced Practice Clinician	An Advanced Practice Clinicians (APC) means individuals other than Medical Staff members who are licensed healthcare professionals who are board certified and have at least a master's degree. APCs are trained to practice medicine and prescribe within the scope of their training as outlined by their specific scope of practice and are authorized by law and by the Hospital to provide patient care services.
Allied Health Professional	An Allied Health Professional (AHP) means individuals other than Medical Staff members or APCs who are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital and are authorized by law and by the Hospital to provide patient care services.
Practice Prerogatives	Scopes of practice summarizing qualifications for the respective category, developed with input from the physician director of the clinical service and the observer/sponsor/responsible party of the AHP, Department Chair, and other representatives of the Medical Staff, Hospital management, and other professionals.

Supervision Definitions:

(1) General Supervision	The procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure or provision of the services.
(2) Direct Supervision	The physician must be present in the office suite or on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
(3) Personal Supervision	A physician must be in the room during the performance of the procedure.

3. Uniform Data System (UDS) Quality Metrics

UDS Reporting for March 2024 CYTD

Report prepared by: Amanda Jacobs, Quality Analyst

Report presented by: Crystal Garcia, VP of Specialty Srvs, Quality and Patient Safety

May 1, 2024

Valleywise Health FQHC UDS Quality Measure Report Results: March 2024 CYTD

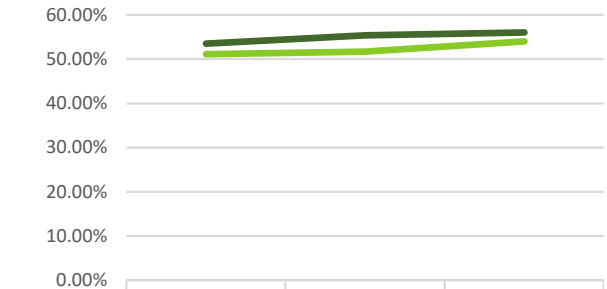
UDS Clinical Quality Measure	CY 2022	Adjusted Quartile Ranking 2022**	CY 2023	Adjusted Quartile Ranking 2023**	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	HP 2030 Goal	*Target Goal* (2022 UDS National Average)	Variance from Current Target	Intended Direction	Monthly Status (2022 UDS average)
Body Mass Index (BMI) Screening and Follow-Up Plan	66.13%	2	92.31%	***	88.52%	90.00%	91.00%										N/A*	61.04%	28.96%	↑	
Cervical Cancer Screening	53.62%	2	57.20%	***	56.60%	55.73%	56.07%										84.3%	53.99%	1.74%	↑	
Childhood Immunization Status (CIS)	9.40%	4	37.62%	***	15.90%	16.88%	17.35%										N/A*	33.23%	-16.35%	↑	
Colorectal Cancer Screening	51.39%	1	46.18%	***	33.81%	36.12%	37.84%										74.4%	42.82%	-6.70%	↑	
Controlling High Blood Pressure	53.68%	4	58.07%	***	55.02%	57.13%	58.04%										N/A*	63.40%	-6.27%	↑	
Diabetes: Hemoglobin A1c Poor Control	30.28%	3	29.87%	***	60.66%	52.48%	45.20%										11.6%	30.42%	22.06%	↓	
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	75.07%	3	76.08%	***	76.52%	76.76%	76.31%										N/A*	76.83%	-0.07%	↑	
Screening for Clinical Depression and Follow-Up Plan if positive screen	54.67%	4	73.77%	***	67.02%	69.50%	71.00%										13.5%	70.02%	-0.52%	↑	
Tobacco Use: Screening and Cessation Intervention	88.88%	2	90.12%	***	81.84%	84.96%	86.85%										N/A*	84.60%	0.36%	↑	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	78.55%	2	78.14%	***	46.99%	50.71%	54.42%										N/A*	69.81%	-19.10%	↑	
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	71.68%	4	75.29%	***	76.40%	76.88%	76.90%										N/A*	76.07%	0.81%	↑	
Breast Cancer Screening	59.89%	1	61.32%	***	53.51%	55.39%	56.07%										80.5%	50.28%	5.11%	↑	
HIV Screening	63.40%	1	67.50%	***	71.15%	70.15%	70.15%										N/A*	43.82%	26.33%	↑	

Monthly Status Key	
Target Met or Exceeded	Indicator has met or is exceeding the target goal
Approaching Target	Indicator is within 10% of the target goal
Not in Target	Indicator is > 10% outside target goal
Improving	Indicator is NOT meeting the target goal but has shown consistent improvement (3 months or longer) *Consistent improvement identified as ≥ 5% over a 3 month lookback period

*HP 2030 Objective definition not equivalent to UDS Quality of Care

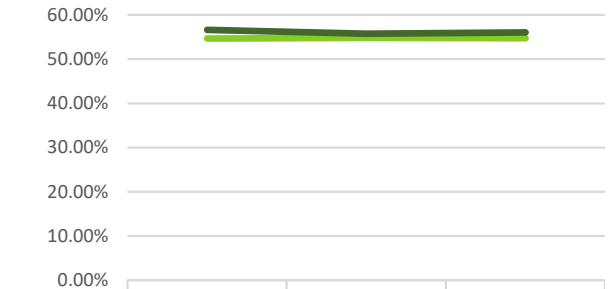
Year Start Comparison Overview

Breast Cancer Screening



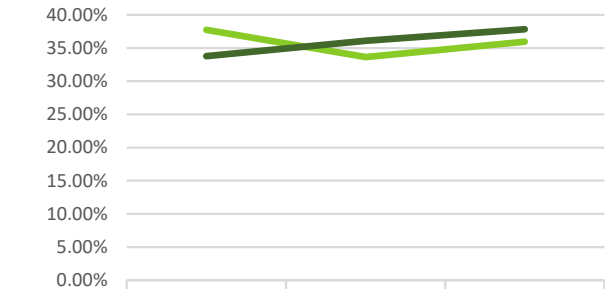
	January	February	March
2023	51.10%	51.68%	54.03%
2024	53.51%	55.39%	56.07%

Cervical Cancer Screening



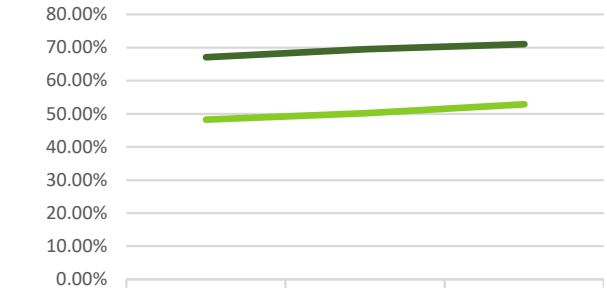
	January	February	March
2023	54.68%	54.81%	54.76%
2024	56.60%	55.73%	56.07%

Colorectal Cancer Screening



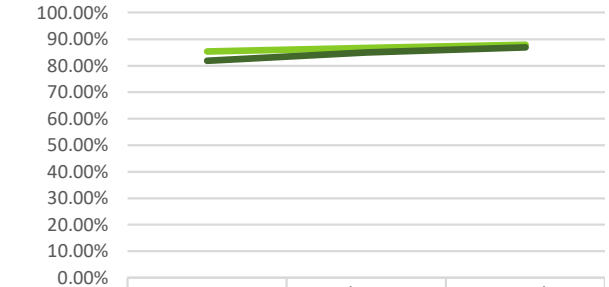
	January	February	March
2023	37.75%	33.64%	35.97%
2024	33.81%	36.12%	37.84%

Depression Screening



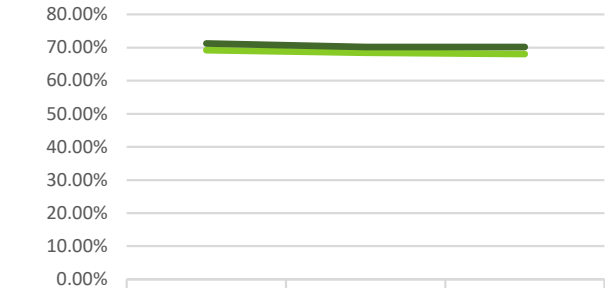
	January	February	March
2023	48.25%	50.16%	52.84%
2024	67.02%	69.50%	71.00%

Tobacco Screening



	January	February	March
2023	85.29%	86.69%	87.81%
2024	81.84%	84.96%	86.85%

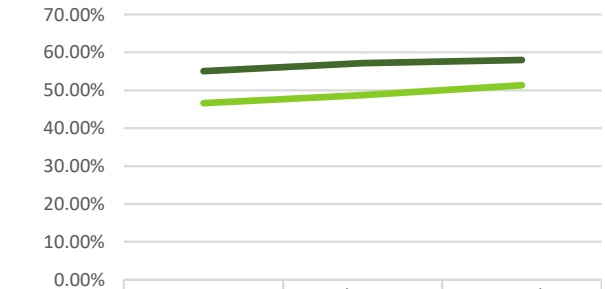
HIV Screening



	January	February	March
2023	69.14%	68.38%	68.00%
2024	71.15%	70.15%	70.15%

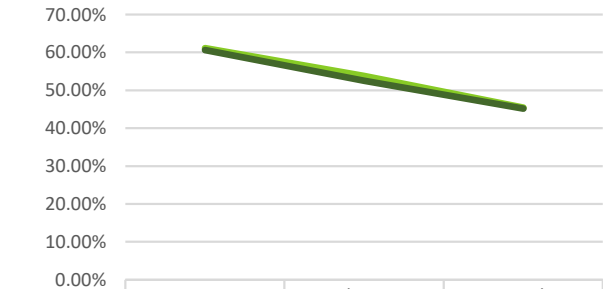
Year Start Comparison Overview

Controlling High BP



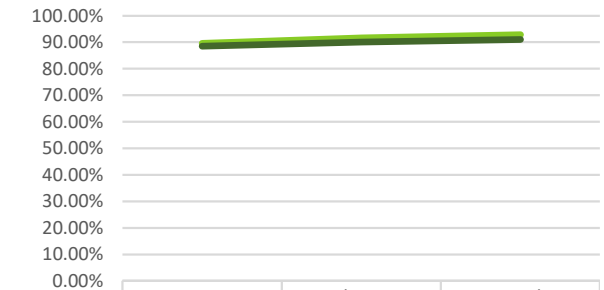
	January	February	March
2023	46.59%	48.74%	51.35%
2024	55.02%	57.13%	58.04%

Diabetes Poor Control



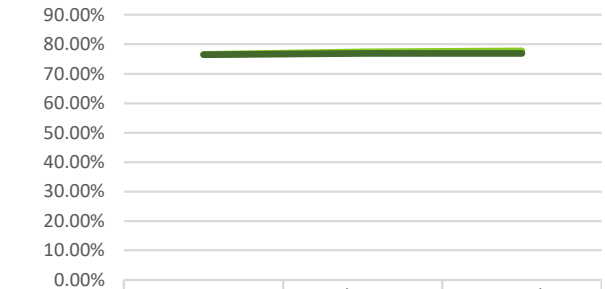
	January	February	March
2023	61.15%	53.74%	45.41%
2024	60.66%	52.48%	45.20%

BMI Screening



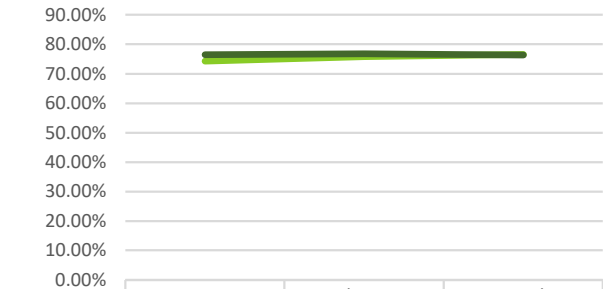
	January	February	March
2023	89.54%	91.66%	92.88%
2024	88.52%	90.00%	91.00%

Statin Therapy



	January	February	March
2023	76.56%	77.44%	77.70%
2024	76.40%	76.88%	76.90%

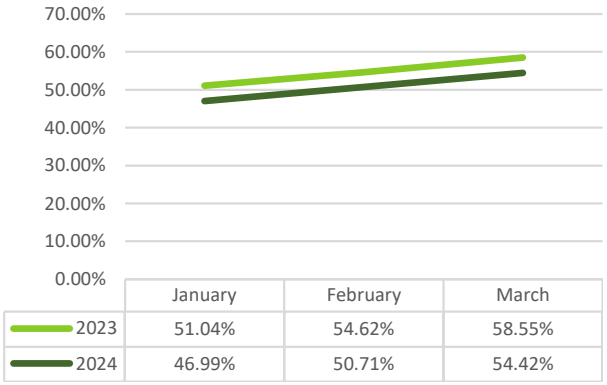
IVD



	January	February	March
2023	74.29%	75.78%	76.58%
2024	76.52%	76.76%	76.31%

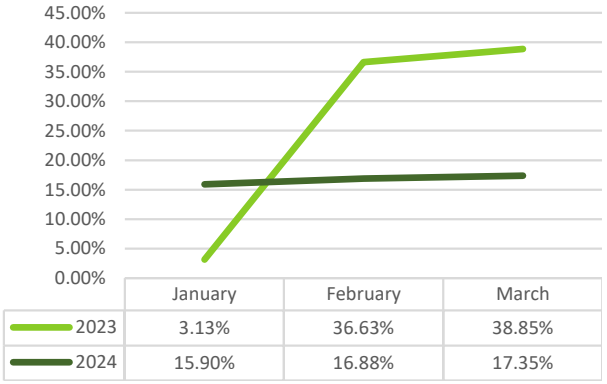
Year Start Comparison Overview

Childhood Weight Assessment and Nutrition & Physical Activity Counseling



	January	February	March
2023	51.04%	54.62%	58.55%
2024	46.99%	50.71%	54.42%

Childhood Immunization Status



	January	February	March
2023	3.13%	36.63%	38.85%
2024	15.90%	16.88%	17.35%

Childhood Immunization Status

eCQM Known Issues / EKI-27

CMS117v11 and CMS117v12

Details

Type:	EP/EC	Resolution:	Unresolved
Priority:	Moderate		
Labels:	None		
Resolution:	Implementers can map the use of 20-valent pneumococcal conjugate vaccine (PCV20) (CVX code 216) to the 'pneumococcal vaccine, unspecified formulation' code (CVX code 109) or the 'Pneumococcal Conjugate, unspecified formulation' code (CVX code 152) in the 'Pneumococcal Conjugate Vaccine' (OID: 2.16.840.1.113883.3.464.1003.196.12.1221) value set.		
Year:	2023; 2024		

People

Assignee:	Unassigned
Reporter:	Mathematica EC eCQM Team
Votes:	1 Vote for this issue
Watchers:	6 Start watching this issue

Dates

Created:	02/14/24 11:00 AM
Updated:	02/14/24 11:01 AM

Description

eCQMs Impacted – CMS117v11 and CMS117v12: Childhood Immunization Status

Issue – Due to publication timeline, the measures do not include the recently updated Advisory Committee on Immunization Practices guidelines to include code for specific formulation, PCV20 pneumococcal vaccine formulation, to meet numerator requirements.

Vaccines and Preventable Diseases

PCV15 and PCV20

The Food and Drug Administration (FDA) licensed PCV15 and PCV20 in 2021 for use in adults. Studies showed they induced antibody levels comparable to those induced by PCV13. The studies also showed PCV15 and PCV20 were safe compared with PCV13.

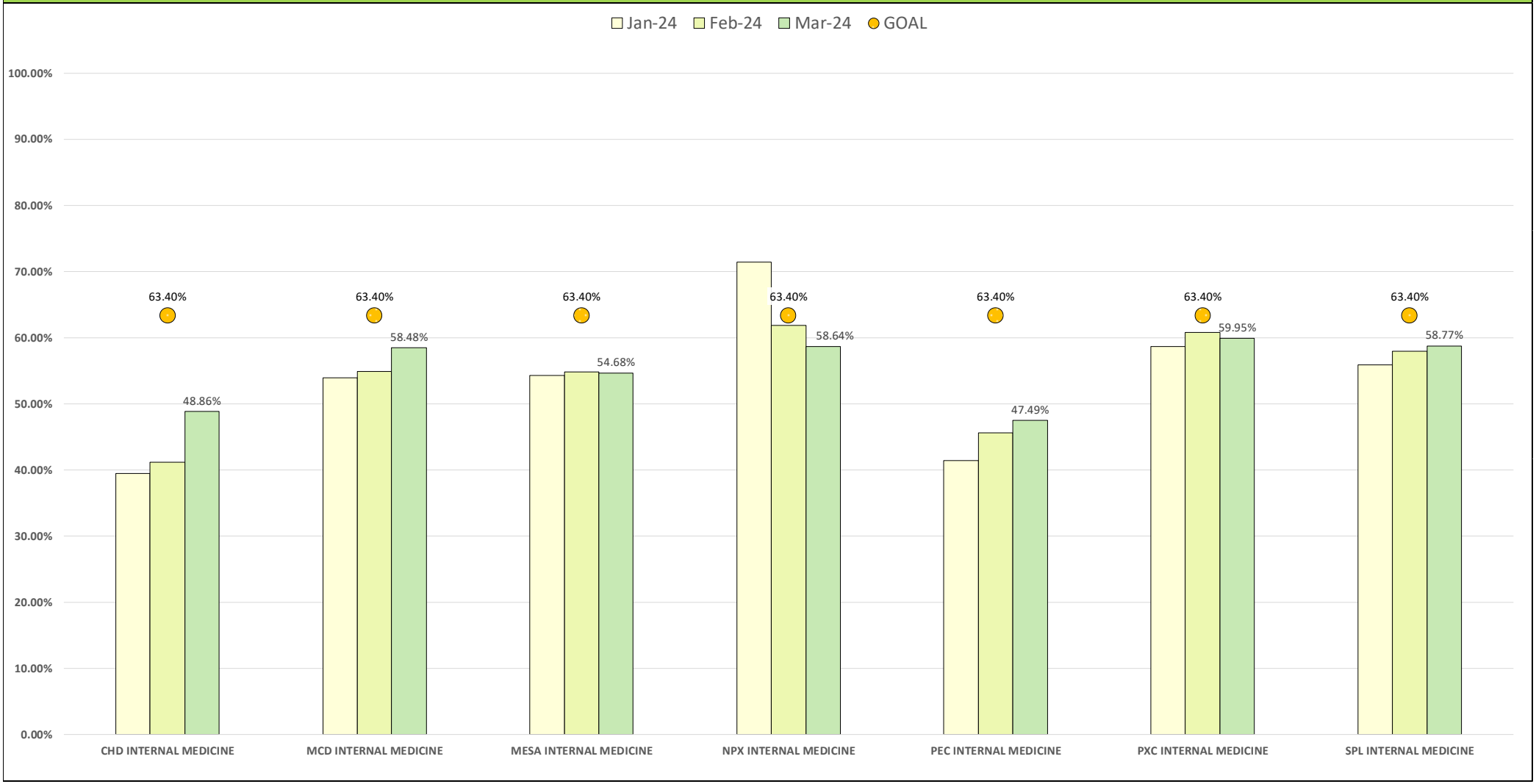
FDA approved PCV15 in 2022 and PCV20 in 2023 for use in children 6 weeks through 17 years of age. This was based on clinical trial data showing they induced antibody levels comparable to those induced by PCV13. The studies also showed and that PCV15 and PCV20 were safe.

CVX Code	CVX Short Description	VaccineStatus	update_date
109	pneumococcal, unspecified formulation	Inactive	30-Sep-10
133	Pneumococcal conjugate PCV 13	Active	28-May-10
152	Pneumococcal Conjugate, unspecified formulation	Inactive	28-Jan-13
215	Pneumococcal conjugate PCV15, polysaccharide CRM197 conjugate, adjuvant, PF	Active	18-Aug-21
216	Pneumococcal conjugate PCV20, polysaccharide CRM197 conjugate, adjuvant, PF	Active	9-Mar-23

CDC

Drilldown: Controlling High BP
Valleywise Health UDS Quality of Care by *PCP Department Location* : Family Medicine
Reporting Year 2024

Drilldown: Controlling High BP
Valleywise Health UDS Quality of Care by *PCP Department Location* : Internal Medicine
Reporting Year 2024



Data Sharing 2024 – Clinic Reports

BPA Report: Blood Pressure Rechecks

February 2024 Blood Pressure Re-Check Leaders

ACTION_NAME: Acknowledge/Override Warning
RSN_NAME: Will Retake BP

🏆 awarded when > 80% and n-size of at least 5 instances when the BPA was triggered

Department Name	1st Systolic Count	2nd Systolic Count	% 2nd BP Taken	Quantity	% 2nd BP NOT Taken	Quantity
AVD FAMILY PRACTICE 🏆	364	323	88.7%	323	11.3%	41
CHD FAMILY PRACTICE 🏆	198	174	87.9%	174	12.1%	24
CHD INTERNAL MEDICINE 🏆	137	117	85.4%	117	14.6%	20
GDL FAMILY PRACTICE 🏆	106	92	86.8%	92	13.2%	14
MCD FAMILY PRACTICE	48	38	79.2%	38	20.8%	10
MCD INTERNAL MEDICINE	51	35	68.6%	35	31.4%	16
MESA FAMILY PRACTICE 🏆	163	152	93.3%	152	6.7%	11
MESA INTERNAL MEDICINE	142	86	60.6%	86	39.4%	56
NPX FAMILY PRACTICE 🏆	203	186	91.6%	186	8.4%	17
NPX INTERNAL MEDICINE 🏆	28	26	92.9%	26	7.1%	2
PEC FAMILY PRACTICE 🏆	310	262	84.5%	262	15.5%	48
PEC INTERNAL MEDICINE	129	59	45.7%	59	54.3%	70
PXC ADOLESCENT	1	1	100.0%	1	0.0%	0
PXC INTERNAL MEDICINE 🏆	427	354	82.9%	354	17.1%	73
SPL FAMILY PRACTICE 🏆	115	92	80.0%	92	20.0%	23
SPL INTERNAL MEDICINE 🏆	117	103	88.0%	103	12.0%	14
SPX FAMILY PRACTICE	340	271	79.7%	271	20.3%	69
Grand Total	**2879**	**2371**	**82.4%**	**2371**	**17.6%**	**508**

Data Sharing 2024 – Clinic Reports

BPA Report: Blood Pressure Rechecks

March 2024 Blood Pressure Re-Check Leaders

ACTION_NAME: Acknowledge/Override Warning
RSN_NAME: Will Retake BP

🏆 awarded when > 80% and n-size of at least 5 instances when the BPA was triggered

Department Name	1st Systolic Count	2nd Systolic Count	% 2nd BP Taken	Quantity	% 2nd BP NOT Taken	Quantity
AVD FAMILY PRACTICE 🏆	254	224	88.2%	224	11.8%	30
CHD FAMILY PRACTICE 🏆	220	188	85.5%	188	14.5%	32
CHD INTERNAL MEDICINE	144	112	77.8%	112	22.2%	32
GDL FAMILY PRACTICE 🏆	92	78	84.8%	78	15.2%	14
MCD FAMILY PRACTICE 🏆	61	54	88.5%	54	11.5%	7
MCD INTERNAL MEDICINE	209	147	70.3%	147	29.7%	62
MESA FAMILY PRACTICE 🏆	220	208	94.5%	208	5.5%	12
MESA INTERNAL MEDICINE	152	103	67.8%	103	32.2%	49
NPX FAMILY PRACTICE 🏆	245	221	90.2%	221	9.8%	24
NPX INTERNAL MEDICINE 🏆	41	33	80.5%	33	19.5%	8
PEC FAMILY PRACTICE 🏆	351	313	89.2%	313	10.8%	38
PEC INTERNAL MEDICINE	78	41	52.6%	41	47.4%	37
PXC INTERNAL MEDICINE 🏆	441	353	80.0%	353	20.0%	88
SPL FAMILY PRACTICE 🏆	135	124	91.9%	124	8.1%	11
SPL INTERNAL MEDICINE 🏆	99	89	89.9%	89	10.1%	10
SPX FAMILY PRACTICE	339	276	81.4%	276	18.6%	63
Grand Total	**3081**	**2564**	**83.2%**	**2564**	**16.8%**	**517**

Data Sharing 2024 – Clinic Reports

BPA Report: Blood Pressure Rechecks – User Shout Out

ACTION_NAME	Acknowledge/Override Warning
RSN_NAME	Will Retake BP

User Name	1st Systolic Count	2nd Systolic Count	% 2nd BP Taken	Quantity	% 2nd BP NOT Taken	Quantity
CORTEZ, LOURDES	103	103	100.0%	103	0.0%	103
RIOS GUEVARA, MARIA L	83	82	98.8%	83	1.2%	82
RIVAS SALAZAR, RICARDO	72	71	98.6%	72	1.4%	71
OLIVOS-GOMEZ, NINFA E	65	60	92.3%	65	7.7%	60
ARMENDARIZ, PATRICIA	64	61	95.3%	64	4.7%	61
BUCKEY, MICHELLE J	63	62	98.4%	63	1.6%	62
MARTINEZ, MARIA T	63	60	95.2%	63	4.8%	60
PEREZ, CYNTHIA	59	57	96.6%	59	3.4%	57
PINO, LAURA M	56	54	96.4%	56	3.6%	54
BECKER STARK, IRIA	55	51	92.7%	55	7.3%	51
RIVAS, JUANA A	52	52	100.0%	52	0.0%	52
GARCIA, ERICA	51	50	98.0%	51	2.0%	50
RAMOS, ELISA	45	45	100.0%	45	0.0%	45
GARCIA, VERONICA J	45	43	95.6%	45	4.4%	43
PINA, MARIA G	44	44	100.0%	44	0.0%	44
VALENCIA, TANIA	42	42	100.0%	42	0.0%	42
AGUILAR MARCIAL, MAYRA S	42	41	97.6%	42	2.4%	41
AHNERT, ROBERT J	42	38	90.5%	42	9.5%	38
ORONA, KIMBERLY Y	42	38	90.5%	42	9.5%	38
BELETZUY OROXOM, LESLEY M	34	32	94.1%	34	5.9%	32
GOODSON, DELISICA	34	32	94.1%	34	5.9%	32
BARBOSA, NORMA A	33	32	97.0%	33	3.0%	32
MORALES, VERONICA A	33	32	97.0%	33	3.0%	32
QUINTERO, DELLA R	31	29	93.5%	31	6.5%	29
RAWSON, LAURA J	30	29	96.7%	30	3.3%	29

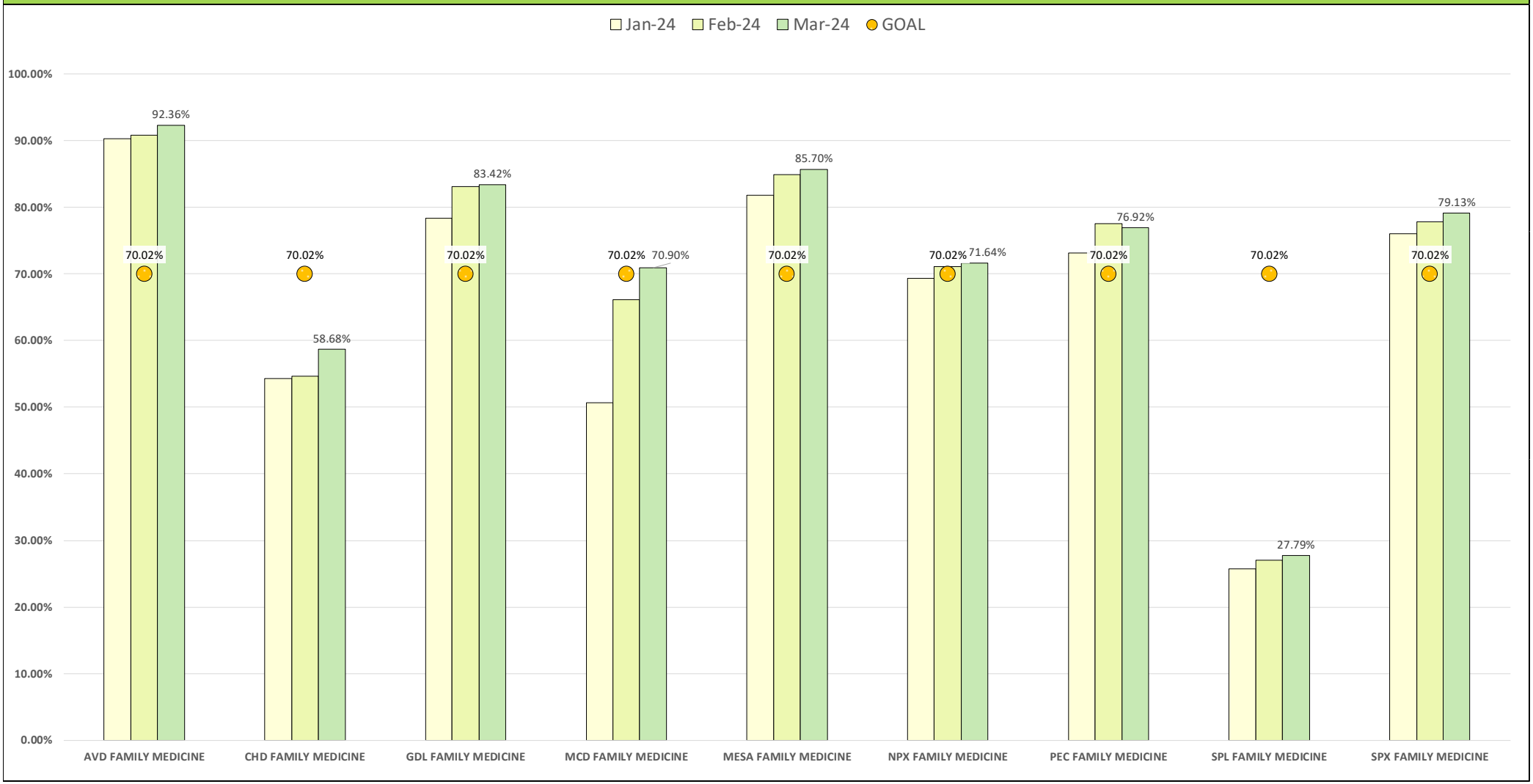
Data Sharing 2024 – Clinic Reports

BPA Report: Blood Pressure Rechecks – New Addition

BPA Canceled > 10x during March (by Department & User)		
Department	**User**	**# Cancels**
MCD FAMILY PRACTICE	[redacted]	**24**
MCD INTERNAL MEDICINE		**16**
NPX INTERNAL MEDICINE		**13**
SPL INTERNAL MEDICINE		**37**
SPX FAMILY PRACTICE		**43**
		39

- To provide details into repeated canceled BPAs

Drilldown: Screening for Depression & Follow-Up Plan if Positive Screen
Valleywise Health UDS Quality of Care by *PCP Department Location* : Family Medicine
Reporting Year 2024



Drilldown: Screening for Depression & Follow-Up Plan if Positive Screen
Valleywise Health UDS Quality of Care by *PCP Department Location* : Internal Medicine
Reporting Year 2024

Depression Scoring and Screening Analysis –
Feb 2024 Data

Family Medicine

Count of PHQ2	Column Labels								
Department	0	1	2	3	4	5	6	blank	Grand Total
AVD FAMILY PRACTICE	1352	44	31	13	15	6	13	3	1477
CHD FAMILY PRACTICE	386	8	21	12	16	13	7		463
GDL FAMILY PRACTICE	355	10	17	7	3	3	4		399
MCD FAMILY PRACTICE	267	1	3					1	272
MESA FAMILY PRACTICE	463	5	45	3	4		8	3	531
NPX FAMILY PRACTICE	486	2	25	8	10	1	3		535
PEC FAMILY PRACTICE	768	22	34	20	7	2	12		865
SPL FAMILY PRACTICE	88	1	3	1	1	4	2	1	101
SPX FAMILY PRACTICE	1120	5	39	17	12	4	12		1209
WMV FAMILY PRACTICE	18	1			1				20
Grand Total	5303	99	218	81	69	33	61	8	5872
	90.3%	1.7%	3.7%	1.4%	1.2%	0.6%	1.0%	0.1%	
	95.7%			4.2%					

Internal Medicine

Count of PHQ2	Column Labels								
Department	0	1	2	3	4	5	6	blank	Grand Total
CHD INTERNAL MEDICINE	83	3	5	1	4	5	5		106
MCD INTERNAL MEDICINE	368	6	14	1	3	1	1	2	396
MESA INTERNAL MEDICINE	294	1	9	3	3		9		319
NPX INTERNAL MEDICINE	134		1	1	1				137
PEC INTERNAL MEDICINE	73	2	1	4	2		1		83
PXC INTERNAL MEDICINE	1379	12	107	5	13	1	24	1	1542
SPL INTERNAL MEDICINE	67	5	2	2	2		2		80
Grand Total	2398	29	139	17	28	7	42	3	2663
	90.0%	1.1%	5.2%	0.6%	1.1%	0.3%	1.6%	0.1%	
	96.4%			3.5%					

- Analysis is not limited to UDS patients.
- Allows us to view total depression screenings that occur by department visit area and the scoring of those screenings.

Note: Red Arrow

Areas on UDS charts trending lower than others have reduced/lower total screenings

Depression Scoring and Screening Analysis –
Feb 2024 Data

Peds

Count of PHQ2 Score	Column Labels								
Department	0	1	2	3	4	5	6	blank	Grand Total
MESA PEDIATRICS	8	1	1						10
NPX PEDIATRICS	12						1		13
PEC PEDIATRICS	12	3	1	3	2			1	22
PXC ADOLESCENT	27		1	1		1			30
PXC PEDS	34	2	4		2		1		43
SPL PEDIATRICS	11	1							12
WMV PEDIATRICS	70		1					1	72
Grand Total	174	7	8	4	4	1	2	2	202
	86.1%	3.5%	4.0%	2.0%	2.0%	0.5%	1.0%	1.0%	
	93.6%			5.4%					

OB/GYN

Count of PHQ2	Column Labels								
Department	0	1	2	3	4	5	6	blank	Grand Total
CHD OB/GYN	4								4
GDL OB/GYN	69								69
MESA OB/GYN	12		4						16
NPX OB/GYN	75	1			4		2		82
PEC OB/GYN	211	4	4		2				221
PXC ANTEPARTUM TEST	310		1	1					312
PXC COLPOSCOPY	30	1			1				32
PXC GYN TUMOR	25								25
PXC OB/GYN	1262	15	22	2	2	2	5		1310
PXC OB/GYN INFER (REI)	24								24
PXC OBSTETRICS COMP	86	1	1	1			1		90
PXC UROGYNECOLOGY	30								30
SPL OB/GYN	4								4
WMV OB/GYN	385				2			1	388
Grand Total	2527	22	32	4	11	2	8	1	2607
	96.9%	0.8%	1.2%	0.2%	0.4%	0.1%	0.3%	0.0%	100.0%
	99.0%			1.0%					

- Added insight to OB/GYN and Women's Departments

Note: Red Arrow

Minimal screening quantities – huge fluctuations across sites

Drilldown: UDS Measure Summary (Progress CYTD)
Valleywise Health UDS Quality of Care by *PCP Department Location* : Family Medicine & Internal Medicine
Reporting Year 2024

March 2024 - Family Medicine Summary - UDS Progress

UDS Measure	AVD Fam Med	CHD Fam Med	GDL Fam Med	MCD Fam Med	Mesa Fam Med	NPX Fam Med	PEC Fam Med	SPL Fam Med	SPX Fam Med
BMI Screening and F/U Plan	YES	YES	YES	YES	YES	YES	YES	YES	YES
Breast Cancer Screening	YES	NO	NO	YES	YES	YES	YES	YES	YES
Cervical Cancer Screening	YES	NO	NO	YES	YES	NO	NO	NO	YES
Childhood Imm Status	NO	NO	NO	N/A	N/A	NO	NO	YES	NO
Colorectal Cancer Screening	NO	NO	NO	YES	NO	NO	NO	YES	NO
Controlling High BP	NO	NO	NO	NO	NO	NO	NO	NO	NO
Depression Screening and F/U Plan if Positive Screen	YES	NO	YES	YES	YES	YES	YES	NO	YES
Diabetes Poor Control	NO	NO	NO	NO	NO	NO	NO	NO	NO
HIV Screening	YES	YES	YES	YES	YES	YES	YES	YES	YES
IVD	NO	NO	NO	NO	YES	NO	YES	NO	NO
Statin Therapy	YES	NO	YES	NO	YES	NO	YES	NO	YES
Tobacco Use Screening and Cessation	YES	NO	YES	NO	YES	YES	YES	NO	YES
Weight Assessment and Counseling Children	NO	NO	NO	N/A	NO	NO	YES	NO	NO

March 2024 - Internal Medicine Summary - UDS Progress

UDS Measure	CHD IM	MCD IM	Mesa IM	NPX IM	PEC IM	PXC IM	SPL IM
BMI Screening and F/U Plan	YES	YES	YES	YES	YES	YES	YES
Breast Cancer Screening	NO	NO	YES	NO	NO	YES	YES
Cervical Cancer Screening	NO	YES	YES	NO	NO	YES	NO
Childhood Imm Status	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Colorectal Cancer Screening	NO	NO	YES	NO	NO	NO	NO
Controlling High BP	NO	NO	NO	NO	NO	NO	NO
Depression Screening and F/U Plan if Positive Screen	NO	NO	NO	YES	NO	YES	NO
Diabetes Poor Control	NO	YES	NO	NO	NO	NO	NO
HIV Screening	YES	YES	YES	YES	YES	YES	YES
IVD	YES	NO	YES	YES	NO	YES	YES
Statin Therapy	YES	YES	YES	YES	NO	NO	YES
Tobacco Use Screening and Cessation	YES	YES	NO	YES	YES	YES	NO
Weight Assessment and Counseling Children	N/A	N/A	N/A	N/A	N/A	N/A	N/A

*** This summary table provides a quick Yes/No overview of each UDS measure and its progress towards the current year benchmark - based upon the PCP Department Summary charts***

N/A = no data

Yes = currently at or above benchmark No = currently below benchmark

Note : ALL DATA is attributed by PCP department location and is intended to be a guide for assessing locational trends; patients who are not assigned a PCP in Epic cannot be attributed to a location, therefore some variability in this information is anticipated.

Some UDS measures will not be met immediately in the CY and that is to be expected based on the nature of the measure definition and eligible UDS visit criteria.

Announcements

Hypertension Task Force:

- BP Audit Kickoff

Pediatrics Task Force:

- Group merged with VBP to align/collaborate on initiatives for quality improvement

Valleywise Health Community Health Center
Blood Pressure Technique Audit Tool – Adult Patients

Observer: _____ **Clinic:** _____ **Date:** ____/____/_____ **Time:** __:__	**Name:**			**Name:**		
Preparation:	Yes	No	NA	Yes	No	NA
1. Perform hand hygiene						
2. Ensure proper cuff size						
3. Position patient correctly (all elements must be included for credit) • Patient is to remain calm. • Avoid any conversation during procedure. • Patient legs are uncrossed with feet flat on the floor. • Arm should be resting comfortably at heart level.						
Procedure:	Yes	No	NA	Yes	No	NA
1. Apply fully deflated cuff snugly, ensuring the artery indicator arrow on the cuff is correctly placed over the artery.						
2. Start machine to obtain reading						
3. Document in Epic • If reading is less than 140/90, process is complete.						
4. If reading is 140/90 or greater, recheck blood pressure (B/P) 3-5 min after initial reading was obtained (re-check can be performed at rooming area or exam room).						
5. If B/P re-check is to be done at examen room, place re-check reminder sign outside the door.						
6. Report B/P second reading to provider.						
7. Document in Epic.						
8. Second B/P reading is completed before patient discharge.						

Corrective Action taken for any "No" answer:

_____

_____

_____

2024

Quality Task Force Focus Teams

	Physician	Accountable Leader
BMI & Diabetes A1C Management	Dr. Sandra Yuh	Kelly Nightengale
Hypertension High Blood Pressure	Dr. Baharak Tabarsi	Monica Winbush
Cervical & Breast Cancer Screening	Dr. Christina Smarik-Snyder Dr. Patricia Habak	Georgette Lindner

	Physician	Accountable Leader
Colorectal Cancer Screening	Dr. Sunitha Bandlamuri	Fernando Reyes
Childhood Immunization & Weight Assessment Screening	Dr. Jodi Carter	Jeffrey Spacht
Depression Screening	Dr. Lenore Encinas	Vicki Staples

Upcoming Meetings:

- *Quality Focus Teams:*

  - Diabetes & A1C Management – monthly meeting 5/7
  - Hypertension High Blood Pressure – 2x monthly Friday meetings; upcoming 4/19
  - Cervical & Breast Cancer Screening – monthly meeting; upcoming 5/13
  - Colorectal Cancer Screening – no formal meeting scheduled; as needed
  - Depression Screening & Follow Up Plan– monthly meeting; upcoming 5/28
  - Childhood Immunization & Weight Assessment Screening - monthly; upcoming 5/1

4. Patient Safety Report

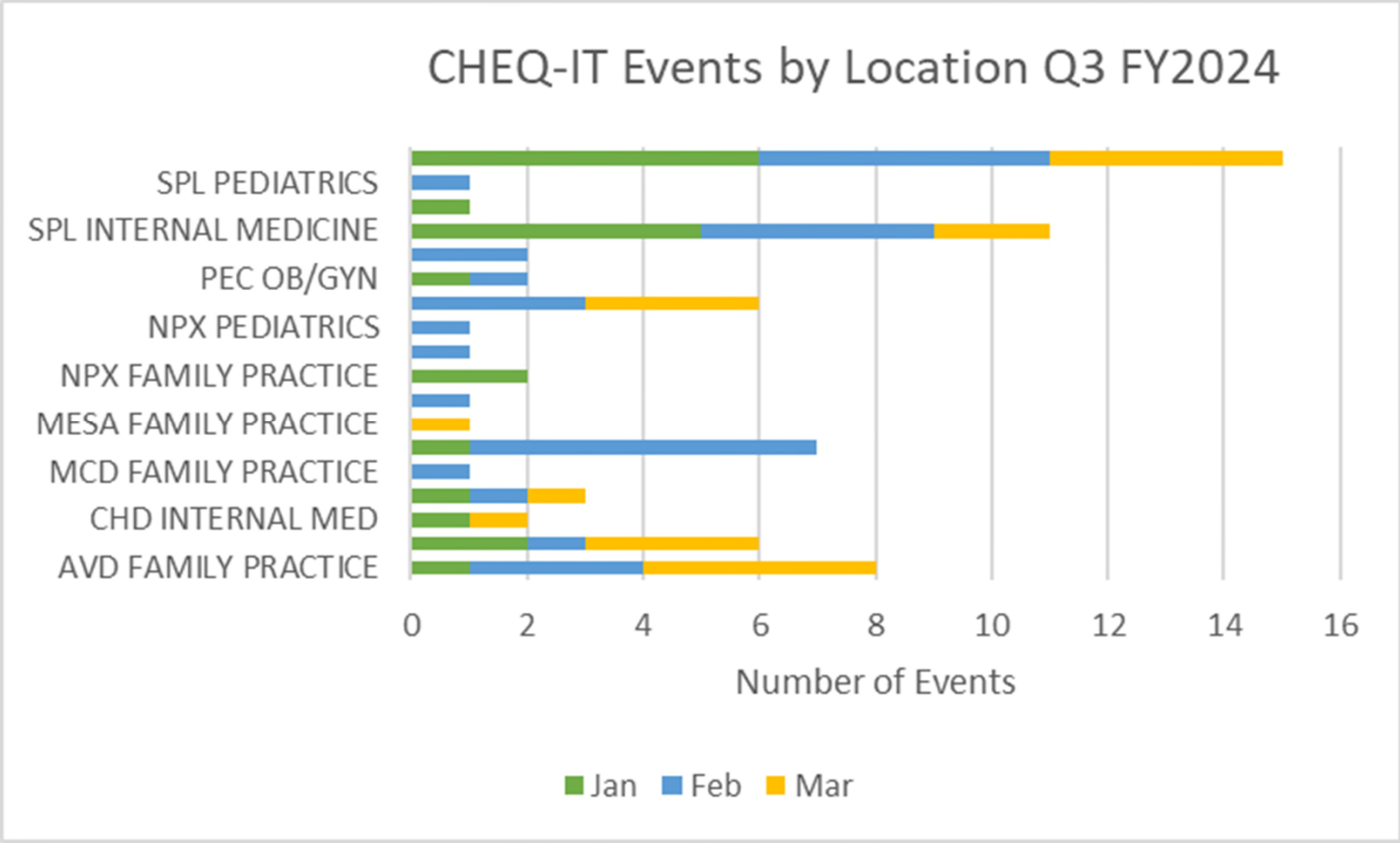
Federally Qualified Health Center (FQHC)

Patient Safety FY 24 Qtr 3

Report prepared by Jo Anna Hernandez, Quality Analyst

Report Presented by Crystal Garcia, VP of Specialty Srvs, Quality and Patient Safety

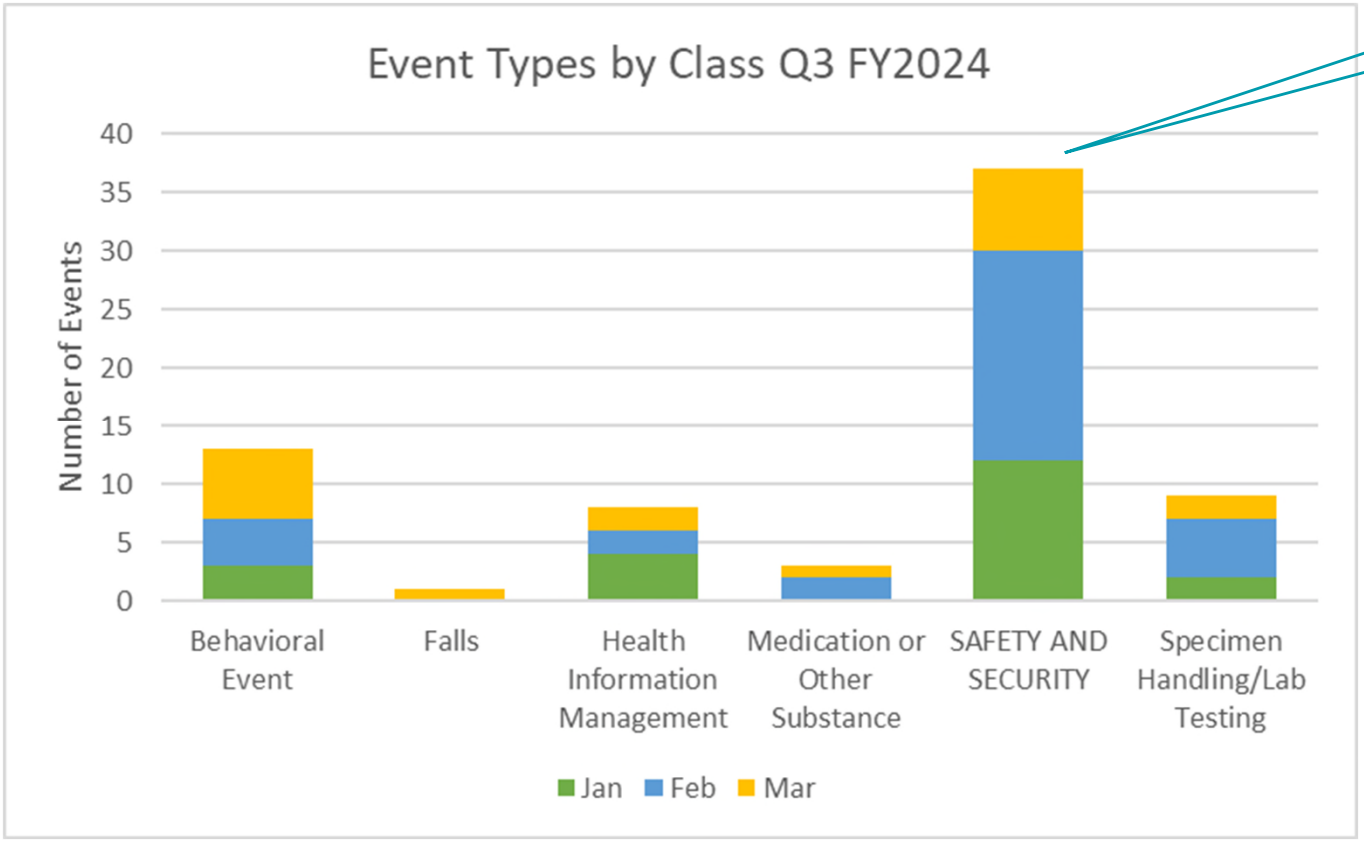
CHEQ-IT Events by Location



The highest number of occurrences reported are SPL Peds and Internal Medicine. Thank you for reporting!

Number of FQHC visits (including nurse visits): Qtr 3 – 81,473
Total number of CHEQ-IT Events Qtr 3 - 71

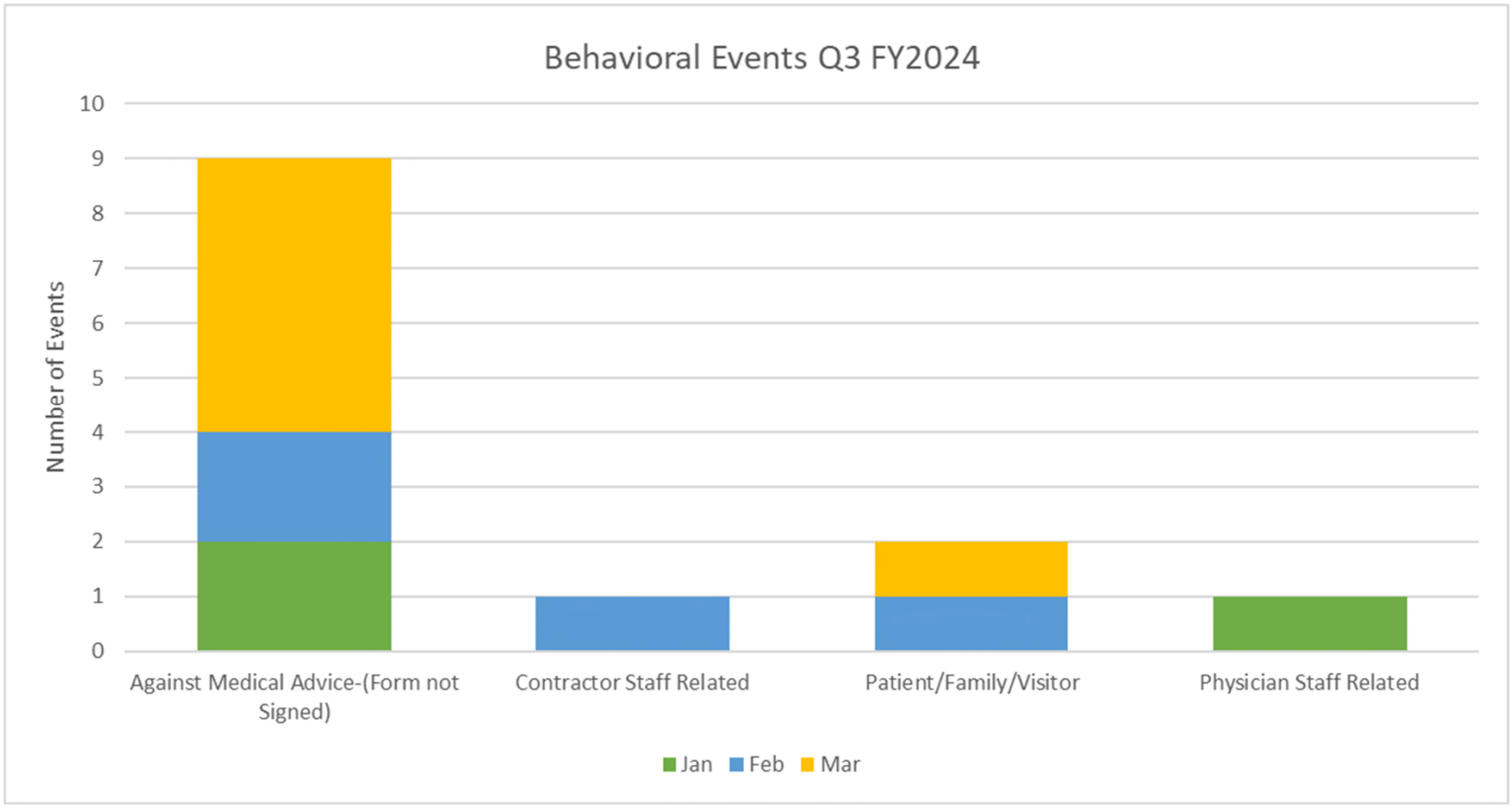
CHEQ-IT Events by Class



Code White Events

The most frequently reported class of events are Safety and Security, followed by Behavioral.

Behavioral Events



Behavioral Events

Pt/Family/Visitor

- Pt. leaning on computer desk using wall phone, computer desk came unhinged from wall.
- Disruptive pt. in lobby. Security and PD responded.

Physician Staff Related

- Transportation issue with pt. needing transport to VHMC.

AMA/Triage Line

- 5 events SOB or chest pain, refused to go to the ED.
- Pt. took 2x dose of Lasix and Aldactone due urine retention, refused to go to ED.

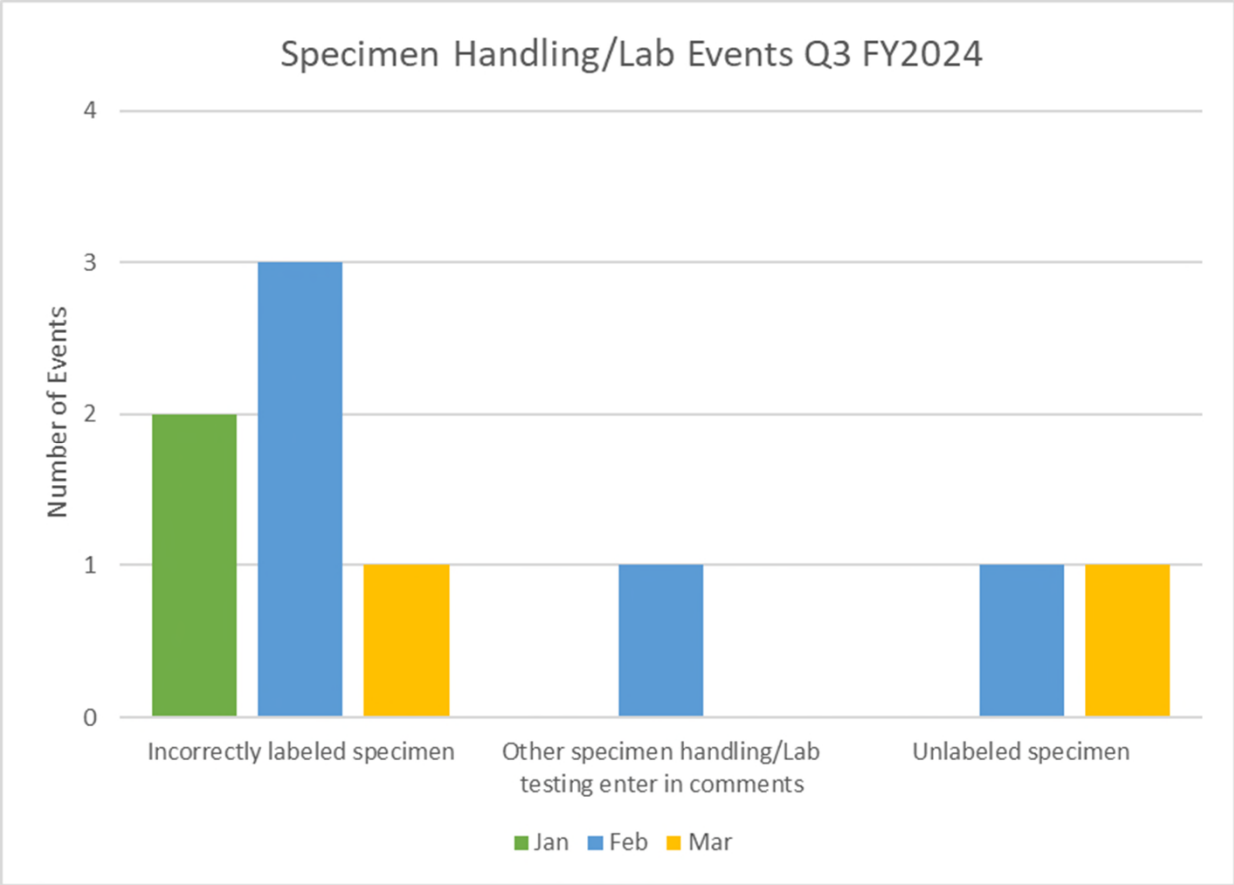
Contractor Staff Related

- Interpreter not available

Physician Staff Related

- Transportation issue with pt. needing transport to VHMC.

Specimen Handling/Lab Events



Other specimen handling- wrong source

- Urine received >48 hrs. after collection.

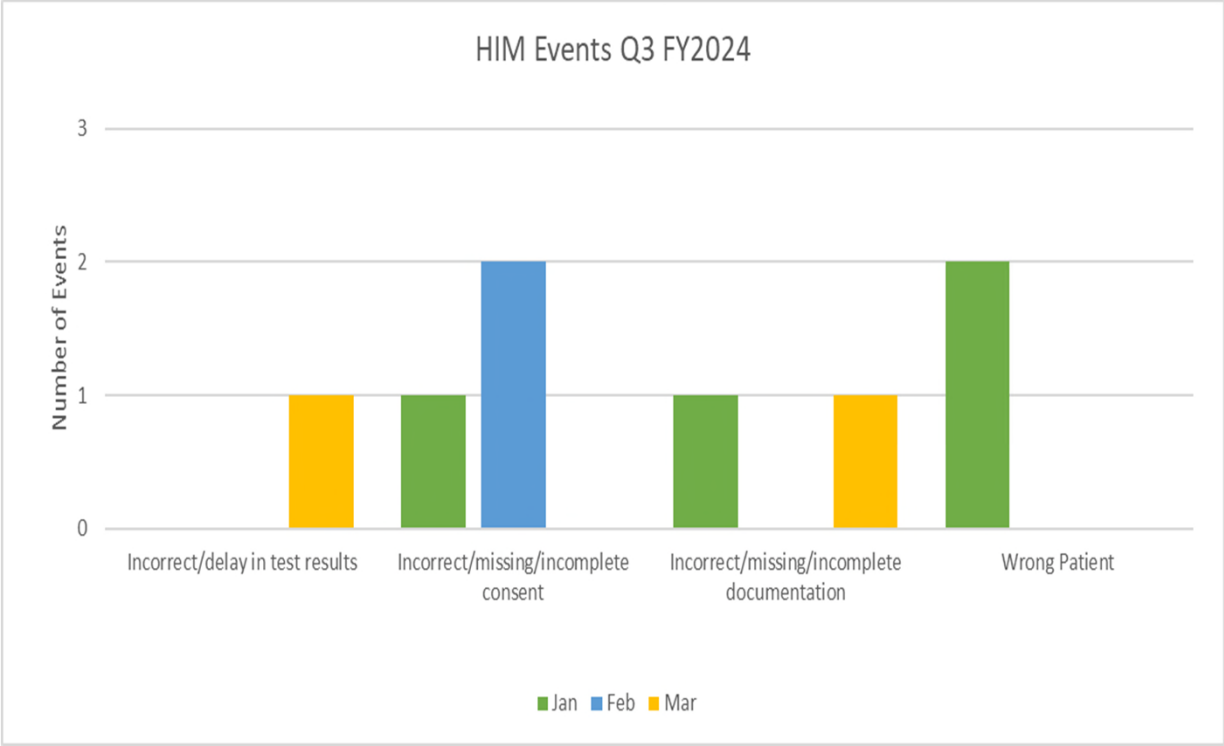
Incorrectly labeled specimen

- Skin for source, not specific source.
- Mislabeled specimens
  - Urine
  - GC/Chlamydia (2)
  - PAP (4)

Unlabeled specimen

- Unlabeled urine cup found next to pregnancy test.
- PAP specimen leaked erasing demographics from vial.

HIM Events



Consent related

- 3 Missing Consents (down from 11 in Q2)

Incorrect/delay in test results

- Urine pregnancy test entered as POS, actually NEG.

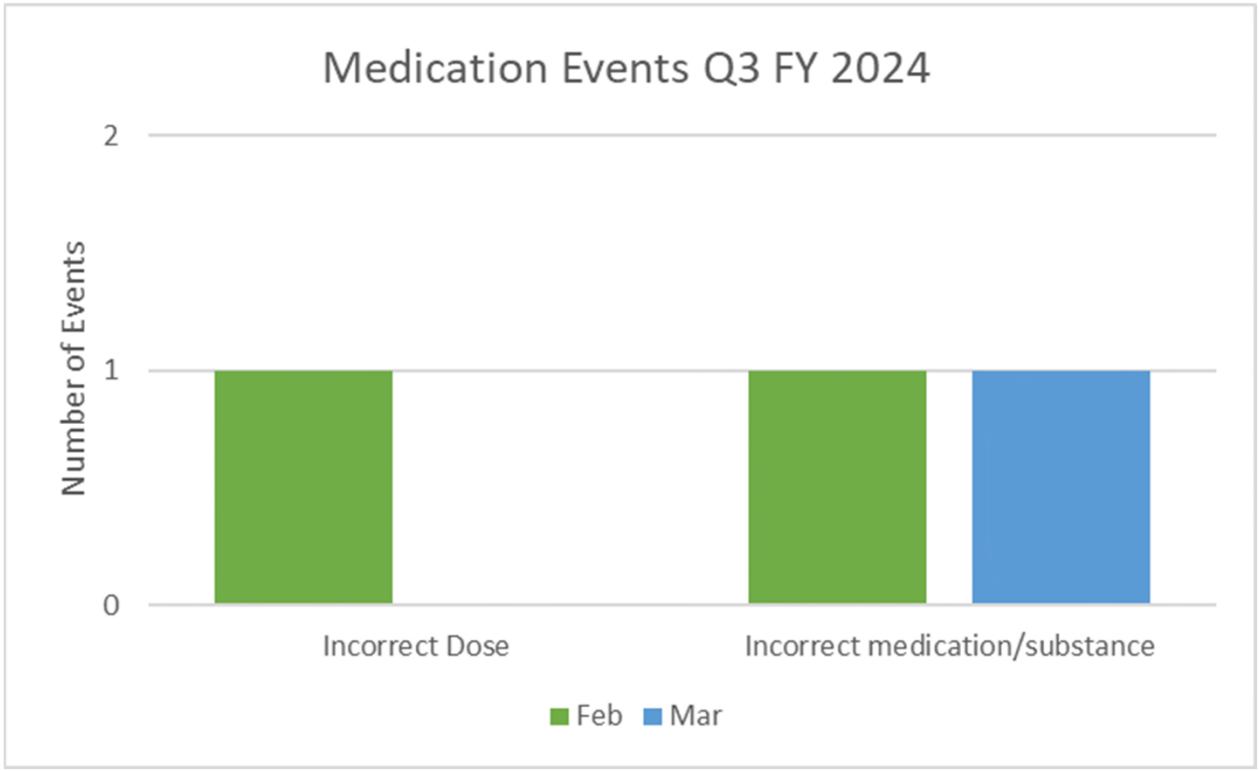
Registration/Scheduling related

- Pregnancy test upload under incorrect encounter.

Wrong Patient

- 1 Barcode scanning issues (down from 5 in Q2)
- EKG scanned into incorrect chart.

Medication Events



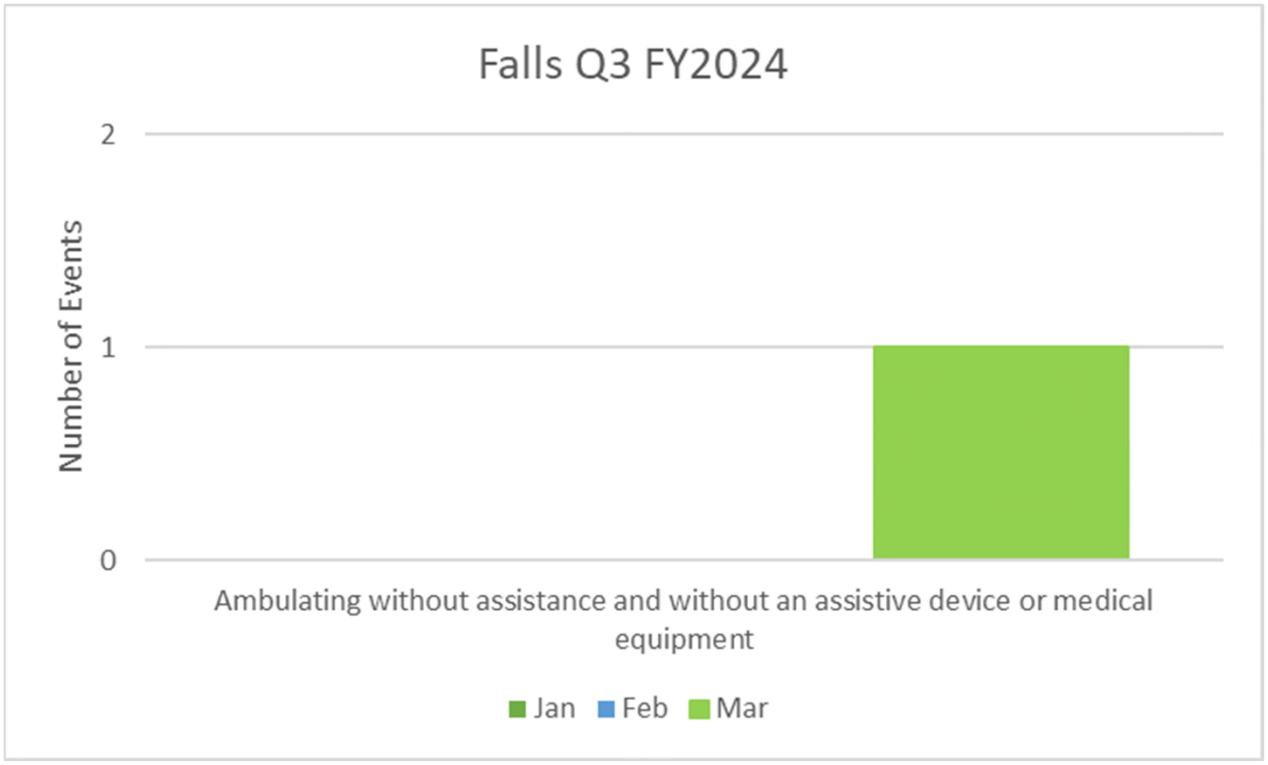
Incorrect medication/substance

- Pentacel and Pediarix vaccines administered at the same time.
- HPV vaccine administered instead of Shingrix.

Incorrect Dose

- Incorrect dose (underdose) COVID vaccine.

Fall Events



One fall while entering clinic, no injuries.

FQHC's: What's Happening?

- Incorrectly labeled specimens continue to trend up with irretrievable specimens having to be recollected.
- Noticeable improvements in missing consents
- Decrease in barcode scanning events.
- Continue to track and trend and develop action plans as necessary.
- Report all deviations from patient care and safety.

QUESTIONS?

5. National Research Corporation (NRC) RealTime Platform Patient Experience Data

Service Excellence Committee Report: FQHCs

Date: May 1, 2024
Report Prepared by: Steven Elliott, RN Quality Analyst
Report Presented by : Crystal Garcia, VP of Specialty Srvs, Quality and Patient Safety

FQHC's Combined: Survey Participation Details FYTD 2024

FQHC Participation

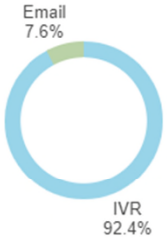
Favorite | Subscribe | Export | Jul 01, 2023 - Mar 31, 2024

RESPONSE RATE: 29.7%

# of Responses	# of People Attempted
33,013	111,214

MODE PERFORMANCE

% OF TOTAL RESPONSES



AGE GROUP BREAKDOWN

Age	Response Rate	Email	IVR
< 1	24.9%	1.6%	9.6%
1 - 2	19.9%	1.9%	7.9%
3 - 5	20.8%	2.3%	8.5%
6 - 12	23.0%	2.5%	9.5%
13 - 17	27.2%	3.1%	11.8%
18 - 26	22.5%	1.8%	10.9%
27 - 34	24.2%	2.5%	11.9%
35 - 44	29.1%	3.3%	14.4%
45 - 54	34.5%	4.2%	17.4%
55 - 64	37.3%	6.3%	18.0%
65 - 74	39.4%	7.7%	18.8%
75 - 84	31.9%	4.4%	15.0%
85+	30.6%	4.6%	13.7%

% of Attempts | % of Attempts

FQHC Priority Matrix

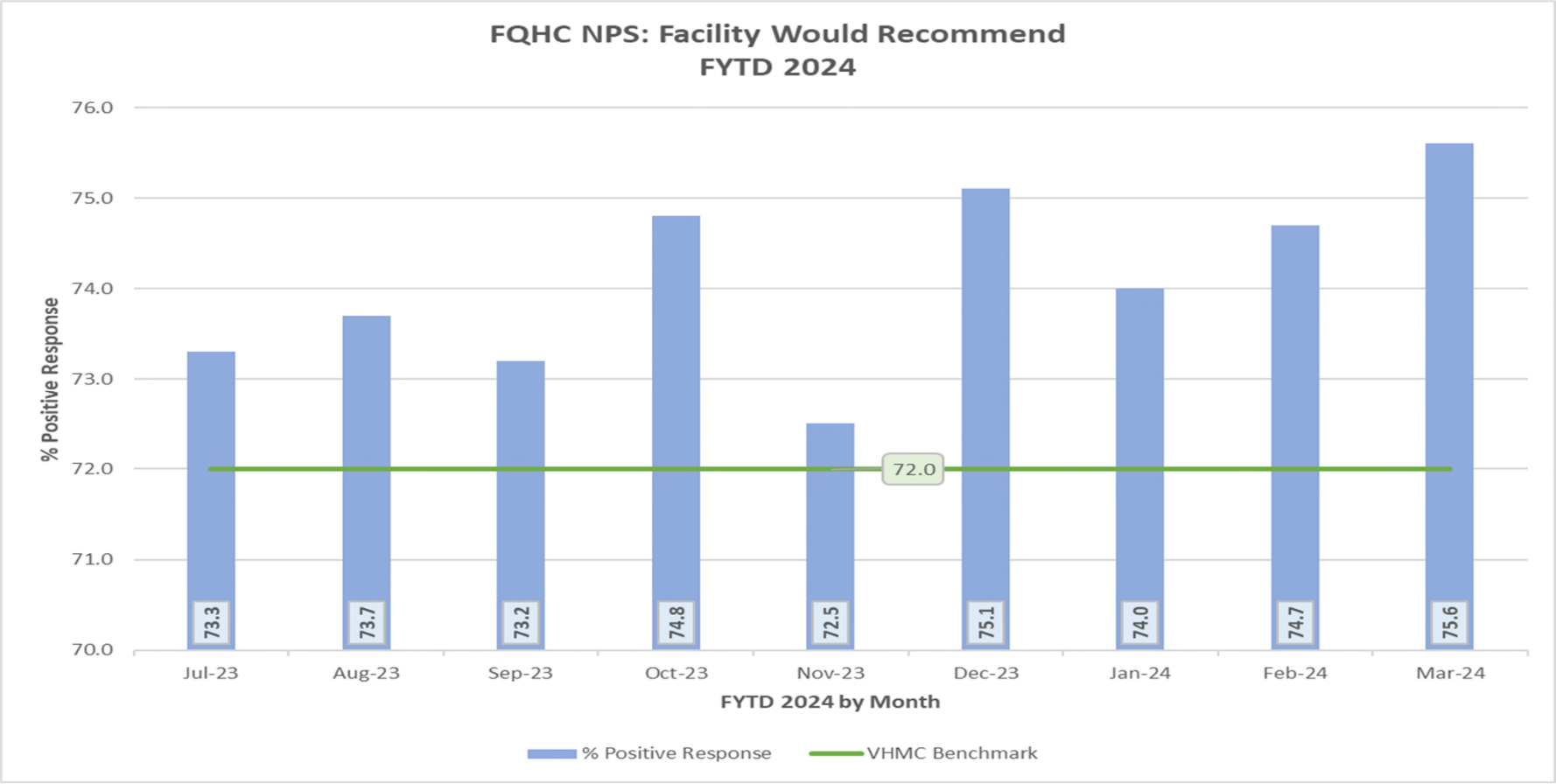
Facility Locations by Question Pods:

Medical Practice		Outpatient Behavioral Health	Outpatient Testing
AVD FAMILY PRACTICE	PEC INTERNAL MEDICINE	AVD INTEGRATED BH	PXC ANTEPARTUM TEST
CHD FAMILY PRACTICE	PEC OB/GYN	CHD INTEGRATED BH	PXC COLPOSCOPY
CHD INTERNAL MEDICINE	PEC PEDIATRICS	GDL INTEGRATED BH	PXC PEDS PROCEDURE
CHD OB/GYN	PXC ADOLESCENT	MESA INTEGRATED BH	
GDL FAMILY PRACTICE	PXC GYN TUMOR	MESA PREVENTION PSYCH	
GDL OB/GYN	PXC INTERNAL MEDICINE	MESA SPECIALTY BH	
MCD FAMILY PRACTICE	PXC OB/GYN	MSA INTEGRATED BH	
MCD INTERNAL MEDICINE	PXC OB/GYN INFER (REI)	NPX INTEGRATED BH	
MESA FAMILY PRACTICE	PXC OBSTETRICS COMP	PEC INTEGRATED BH	
MESA IMM CLINIC	PXC PEDS	SPL INTEGRATED BH	
MESA INTERNAL MEDICINE	PXC UROGYNECOLOGY	SPX INTEGRATED BH	
MESA OB/GYN	SPL FAMILY PRACTICE	PXC Peds Integrated BH	
MESA PEDIATRICS	SPL INTERNAL MEDICINE		
MESA PREVENTION	SPL OB/GYN		
NPX FAMILY PRACTICE	SPL PEDIATRICS		
NPX INTERNAL MEDICINE	SPX FAMILY PRACTICE		
NPX OB/GYN	WMV Family Practice		
NPX PEDIATRICS	WMV OB/GYN		
PEC FAMILY PRACTICE	WMV PEDIATRICS		

* Locations as last edited and reviewed on 07/14/23

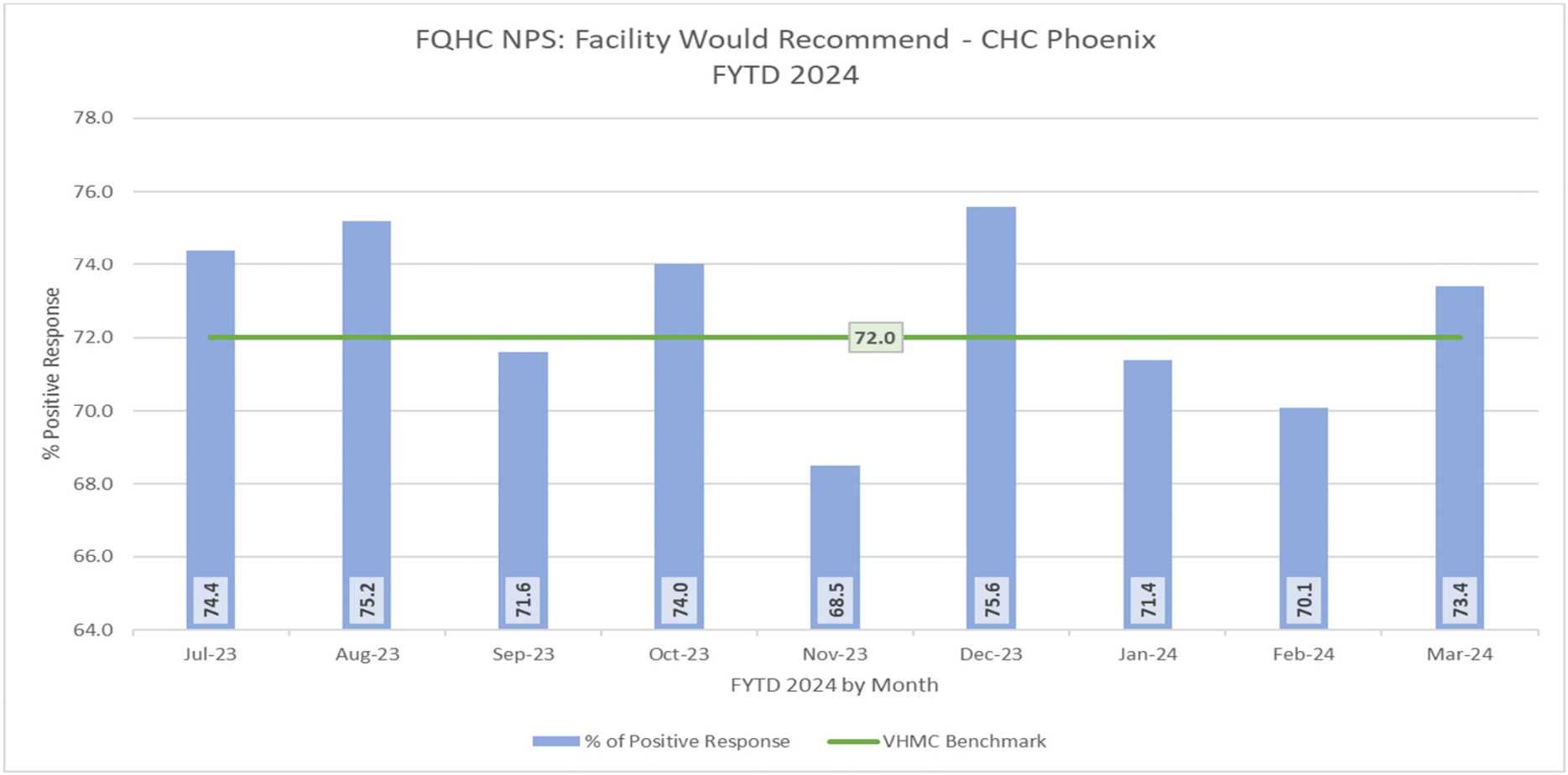
Overview of Combined Score – CHC Phoenix, CHC Peoria, and FQHC

March n-size – 3232



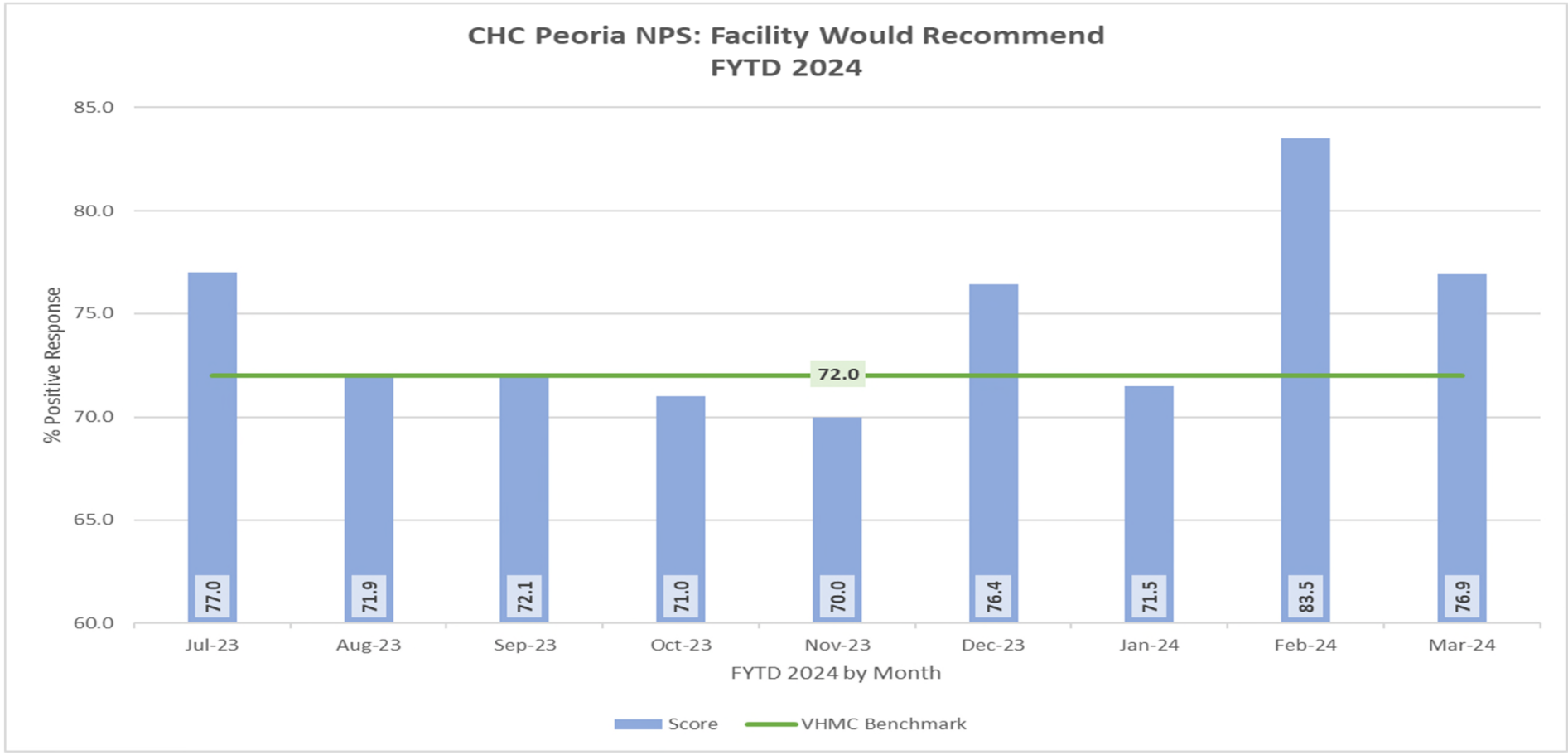
FQHC: CHC-Phoenix – FYTD 2024

Mar n-size - 834



FQHC: CHC Peoria – FYTD 2024

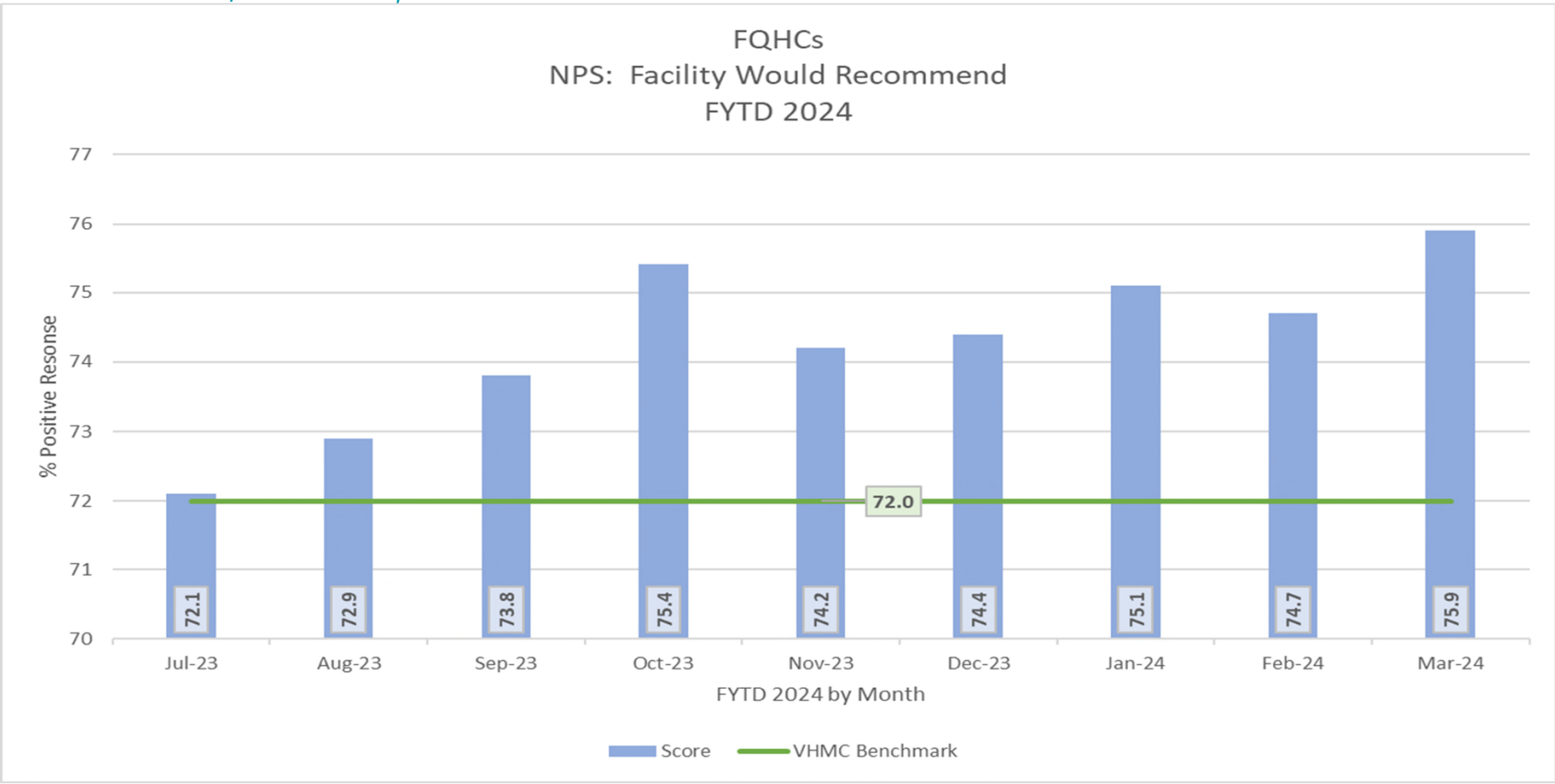
Mar n-size – 338



FQHCs: NPS – Facility Would Recommend – FYTD24

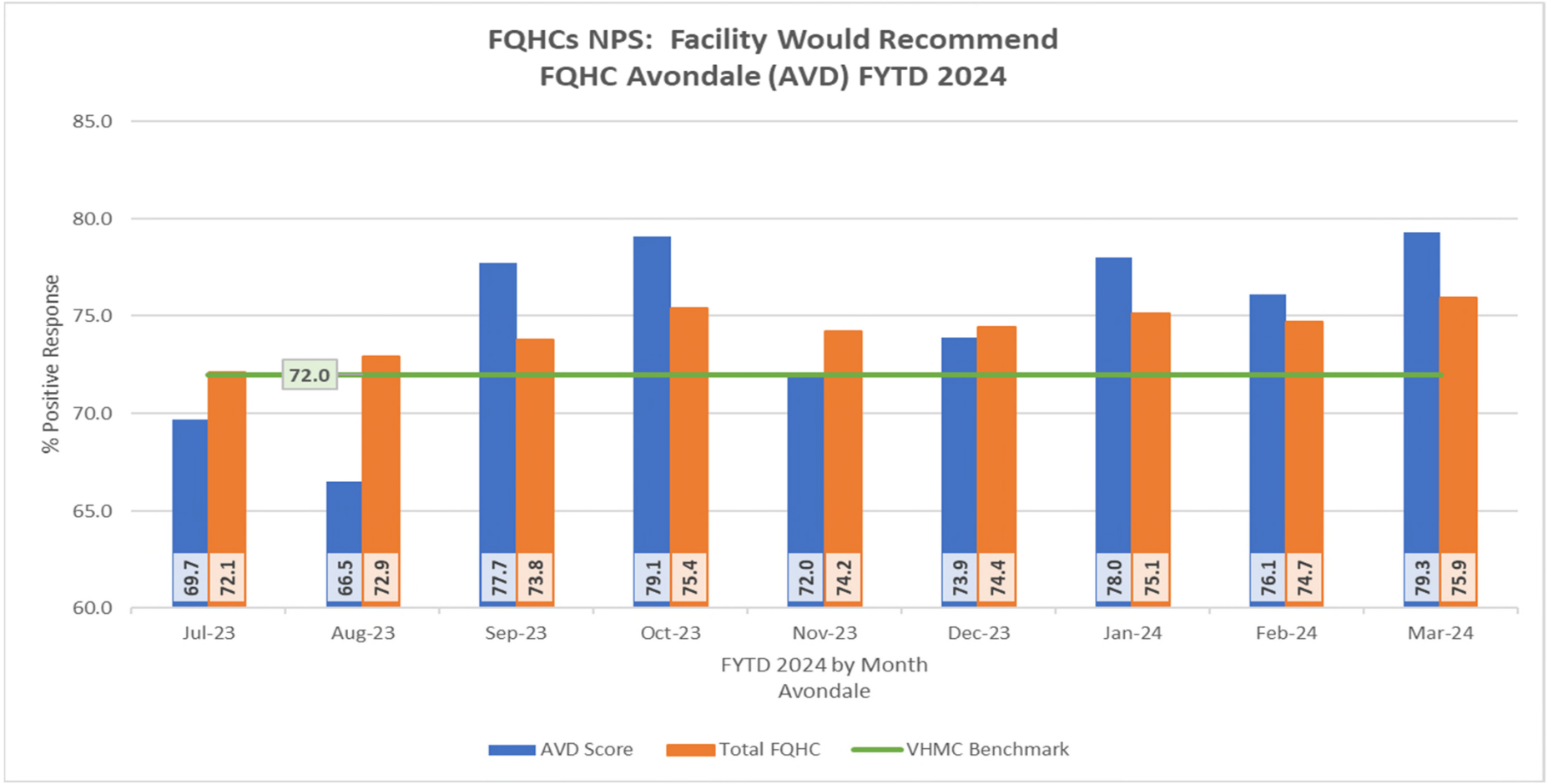
Avondale, Chandler, Guadalupe, McDowell, Mesa, North Phoenix, South Central Phoenix S. Phoenix/Laveen, West Maryvale.

Mar n-size – 2,161



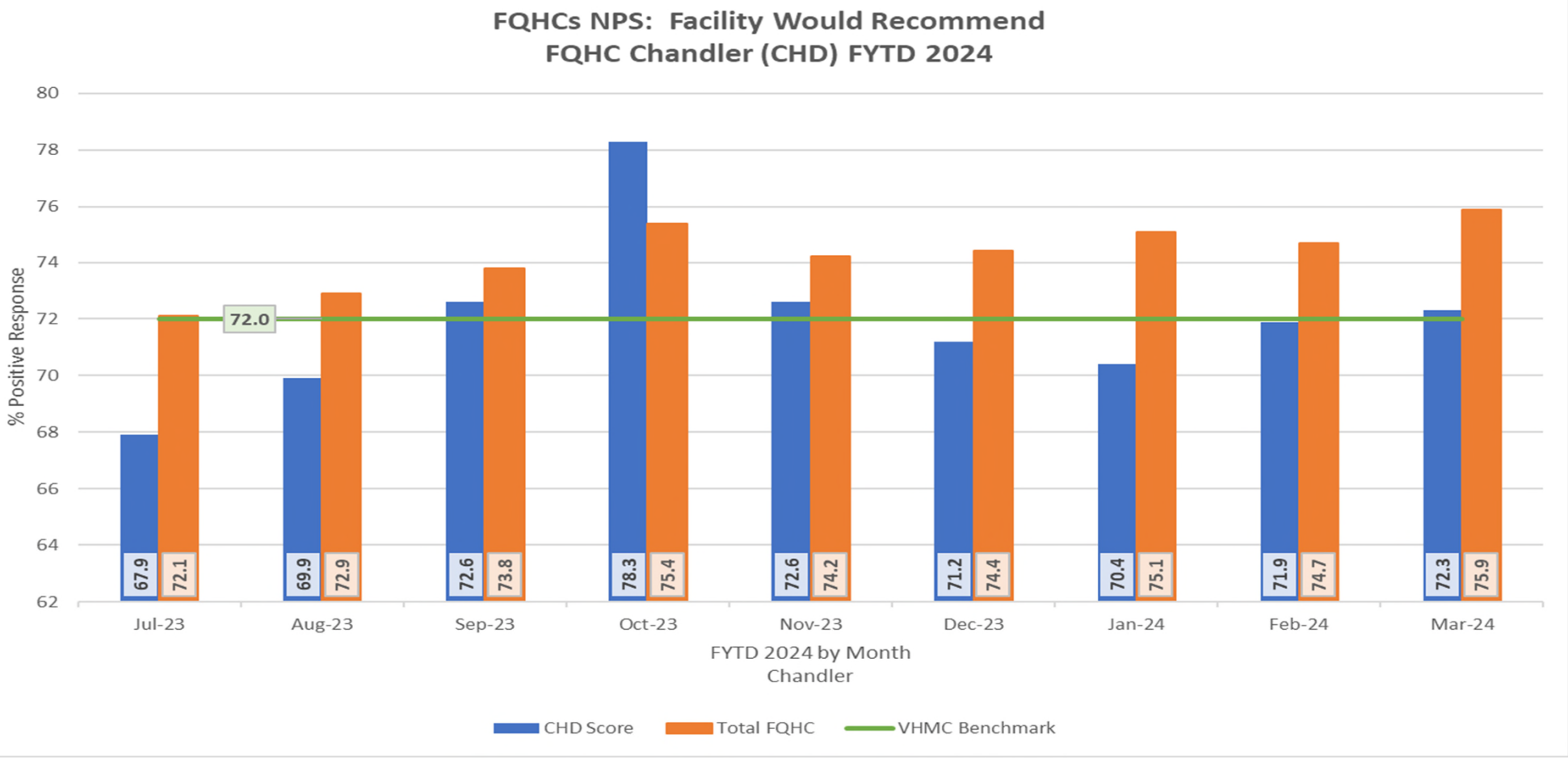
FQHC: Avondale – FYTD 2024

Mar n-size – 208



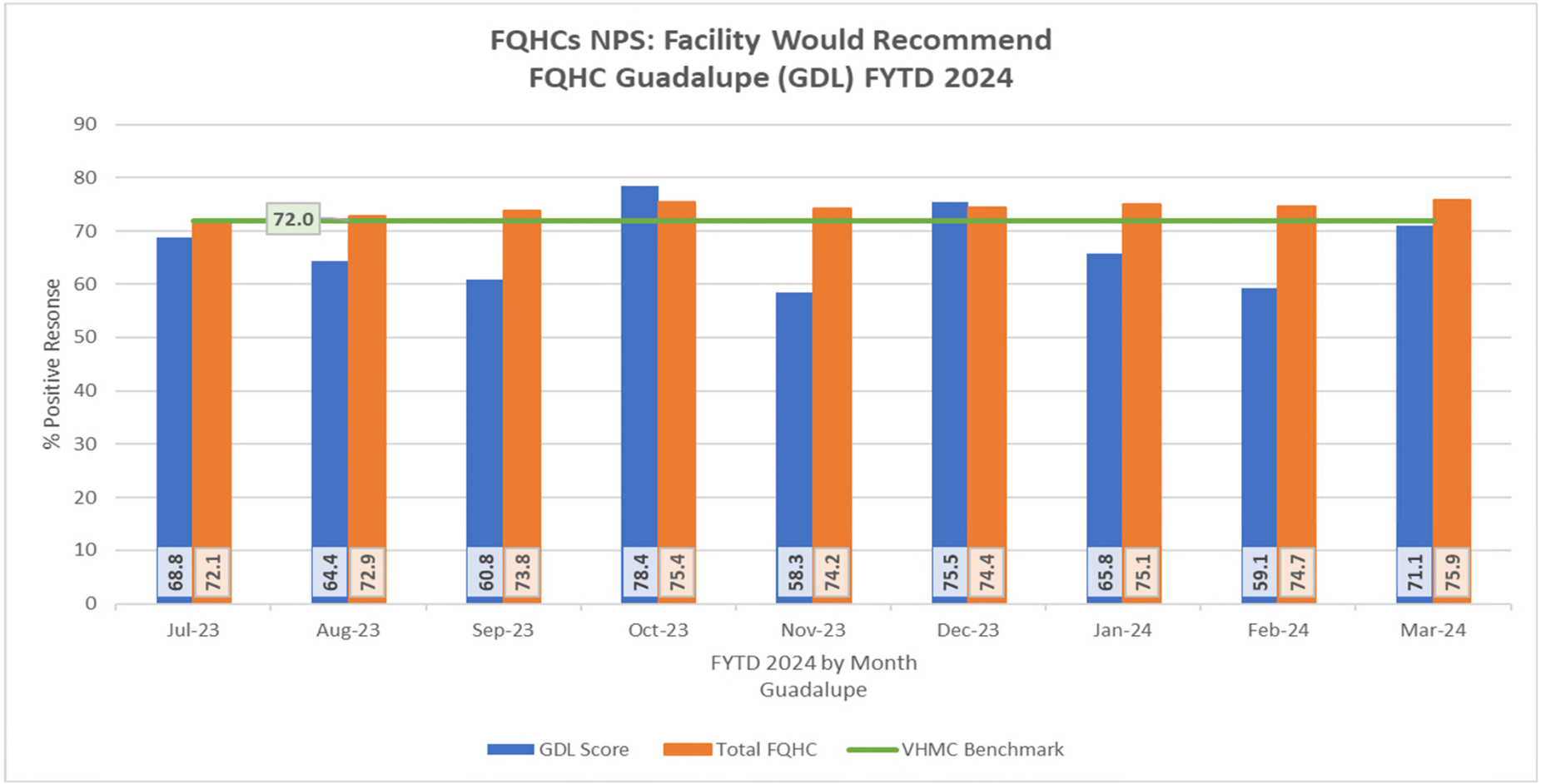
FQHC: Chandler – FYTD 2024

March n-size – 278



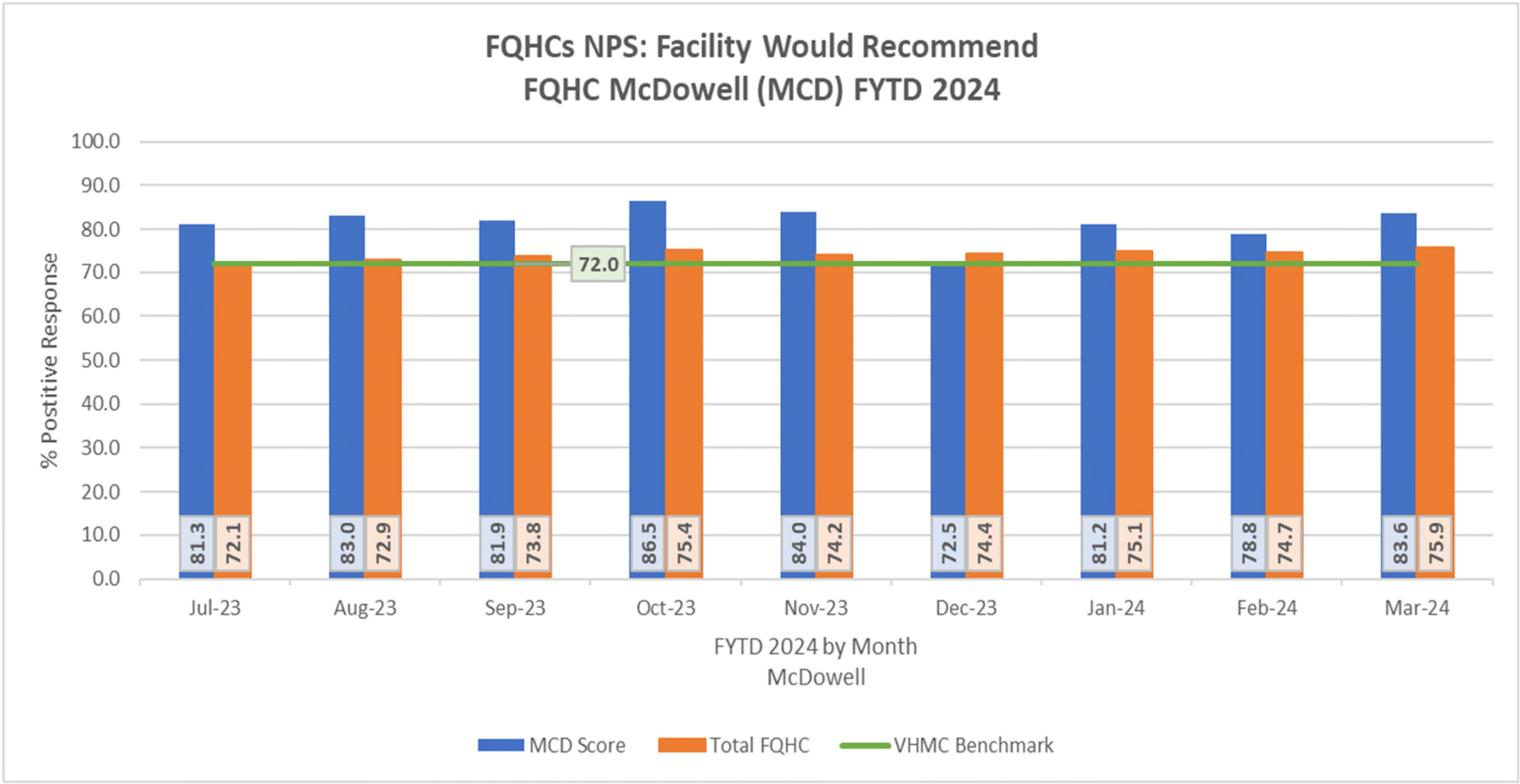
FQHC: Guadalupe – FYTD 2024

Mar n-size – 90



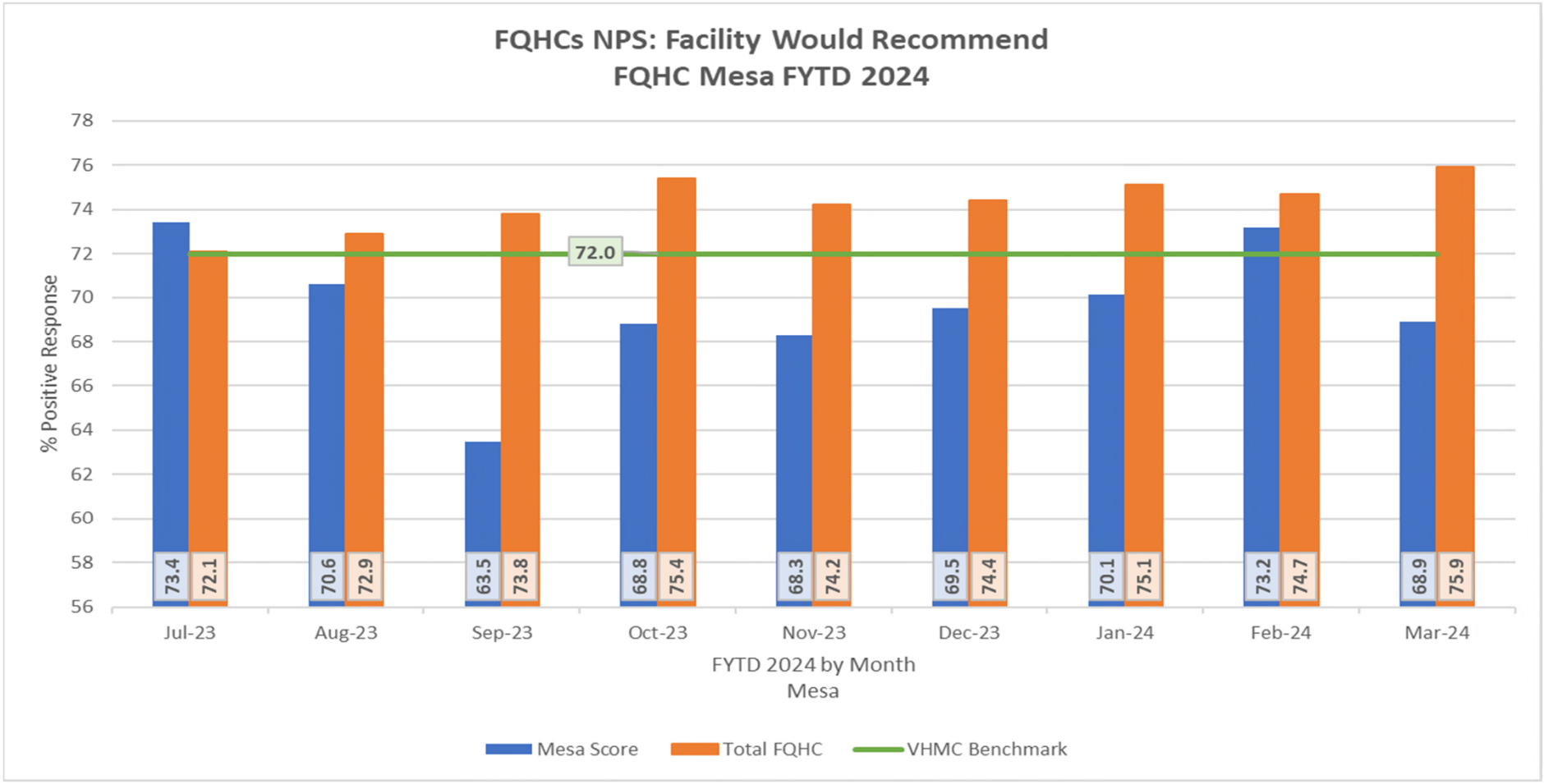
FQHC: McDowell – FYTD 2024

Mar n-size – 226



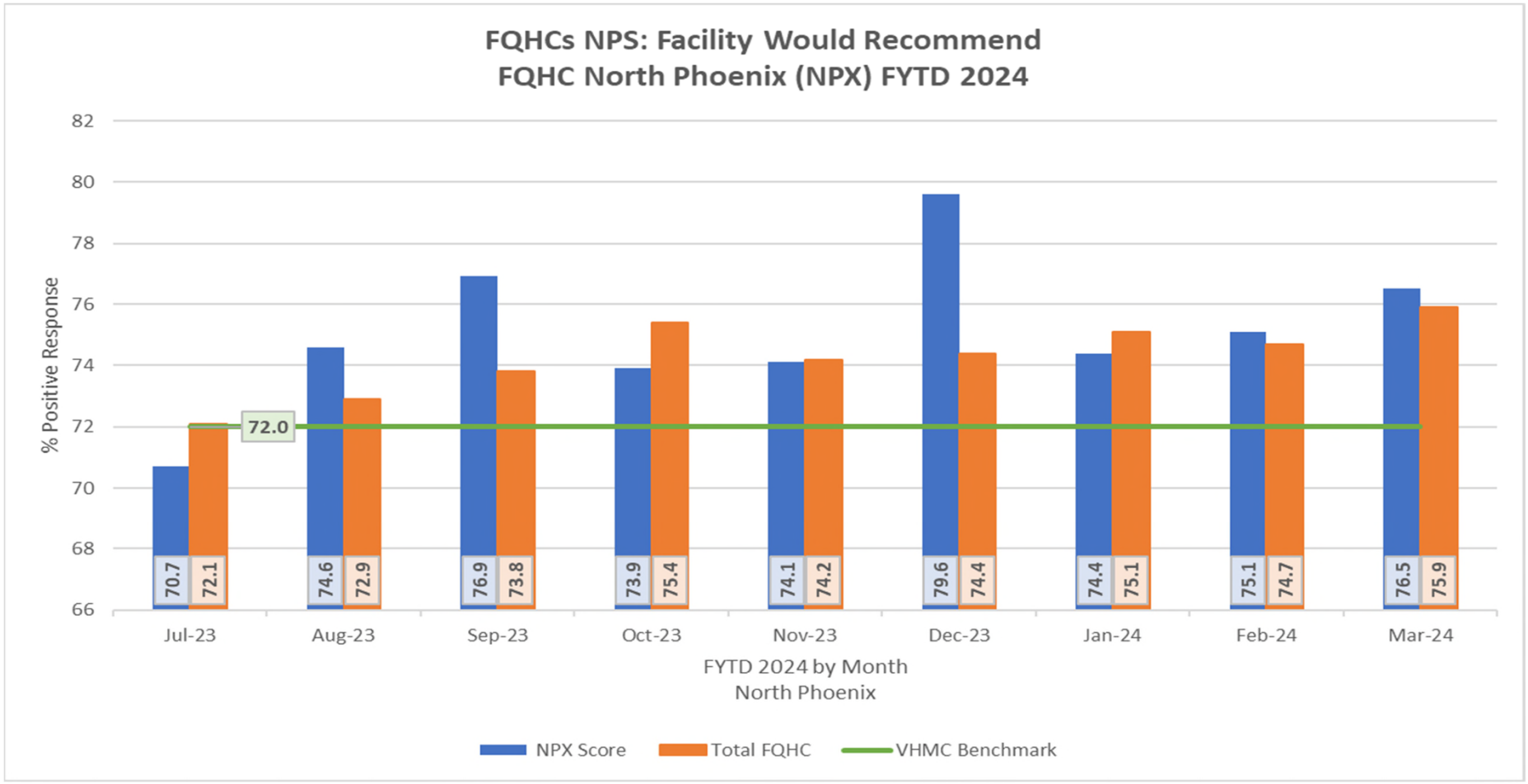
FQHC: Mesa – FYTD 2024

Mar n-size – 328



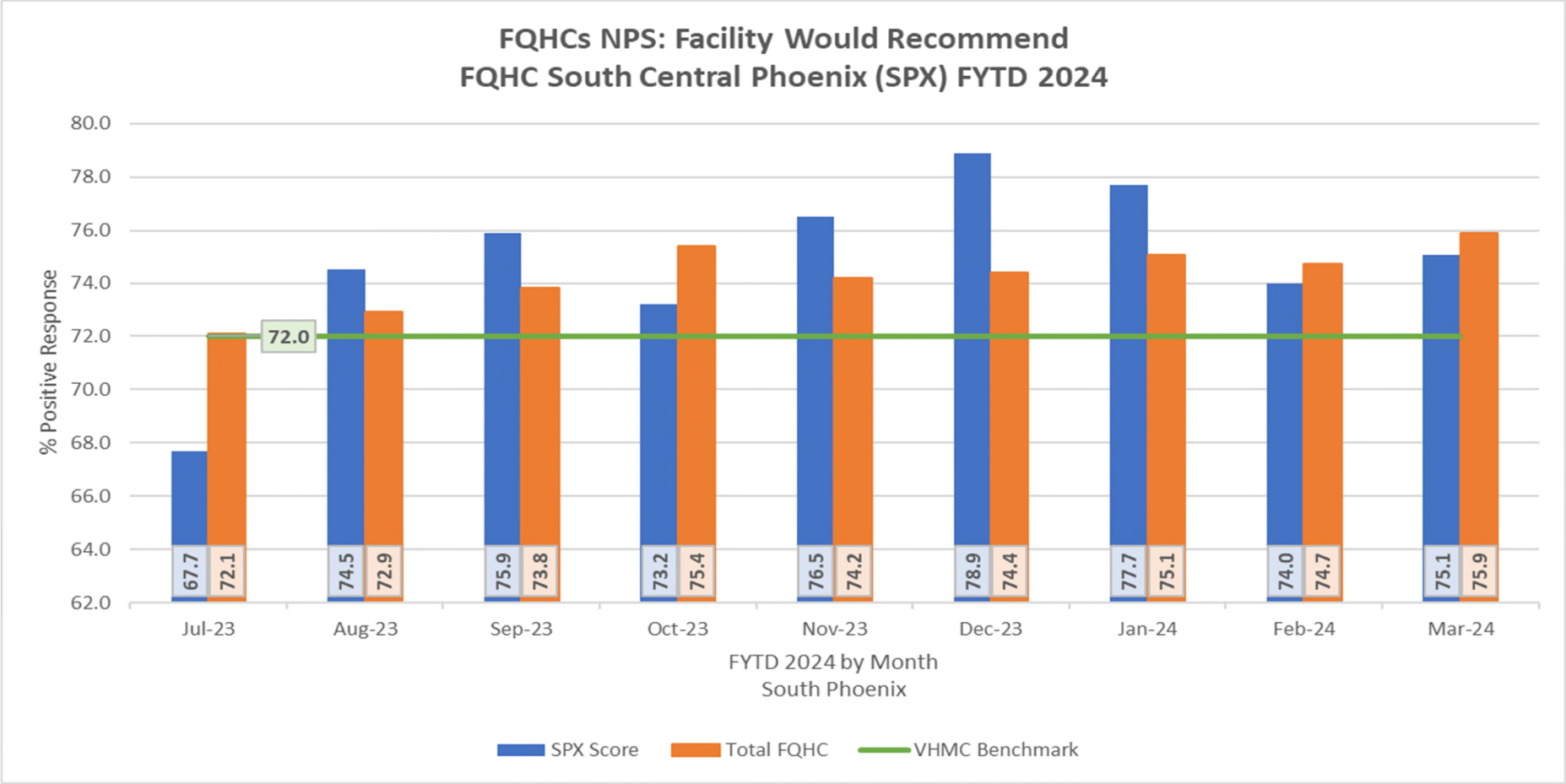
FQHC: North Phoenix – FYTD 2024

Mar n-size – 357



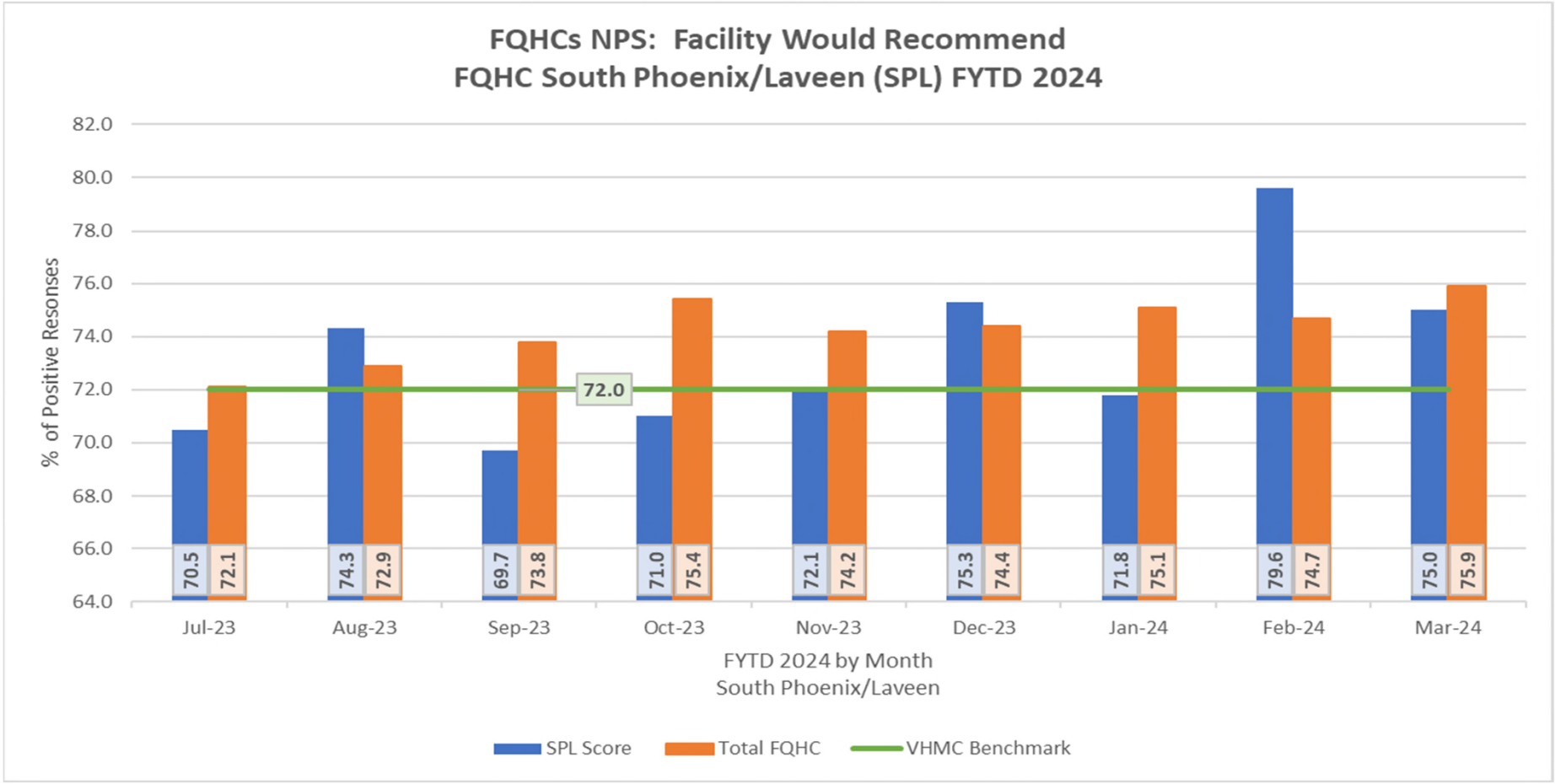
FQHC: South Central – FYTD 2024

Mar n-size – 269



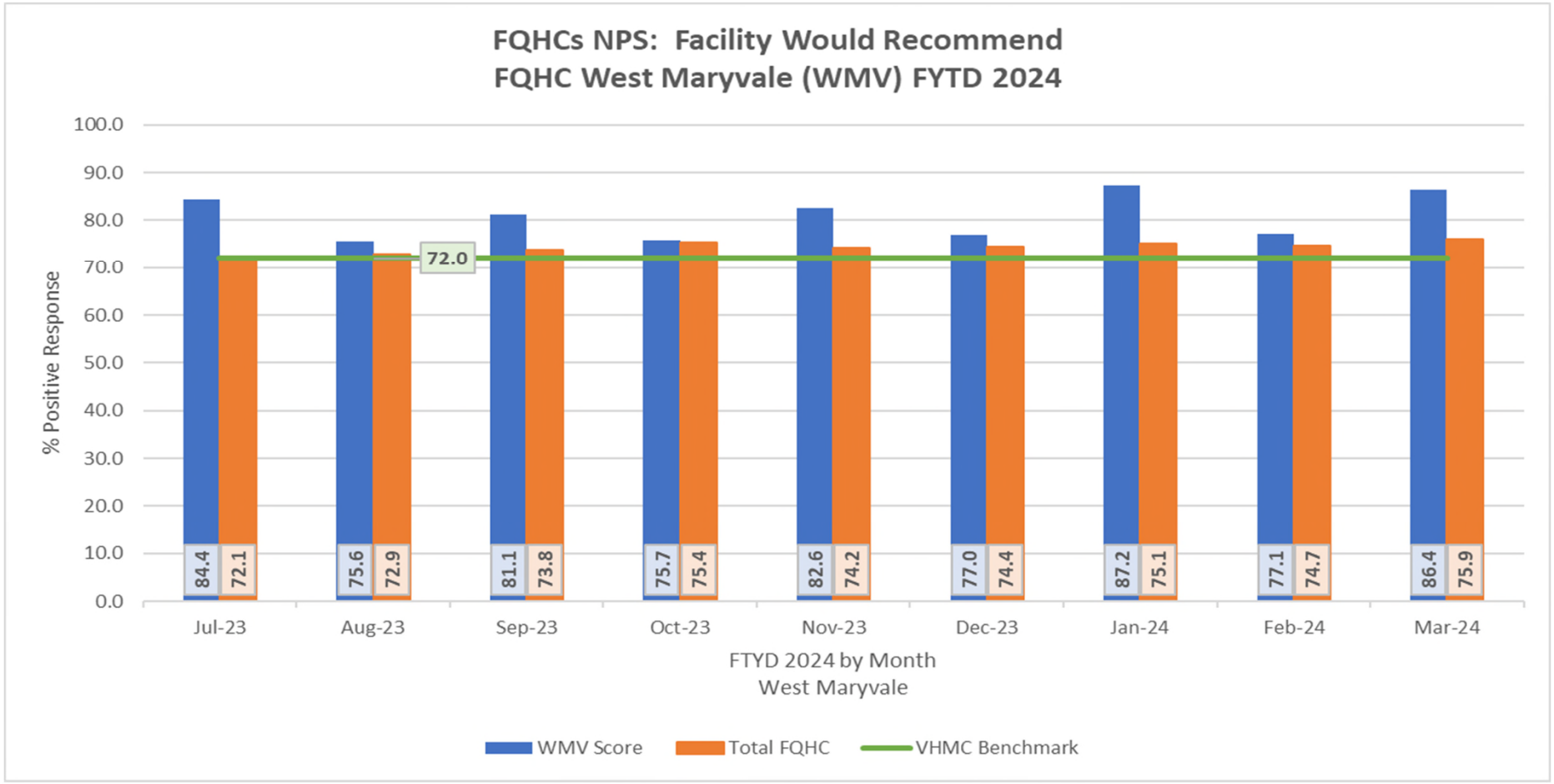
FQHC: South Phoenix/ Laveen – FYTD 2024

Mar n-size – 260



FQHC: West Maryvale – FYTD 2024

Mar n-size - 140



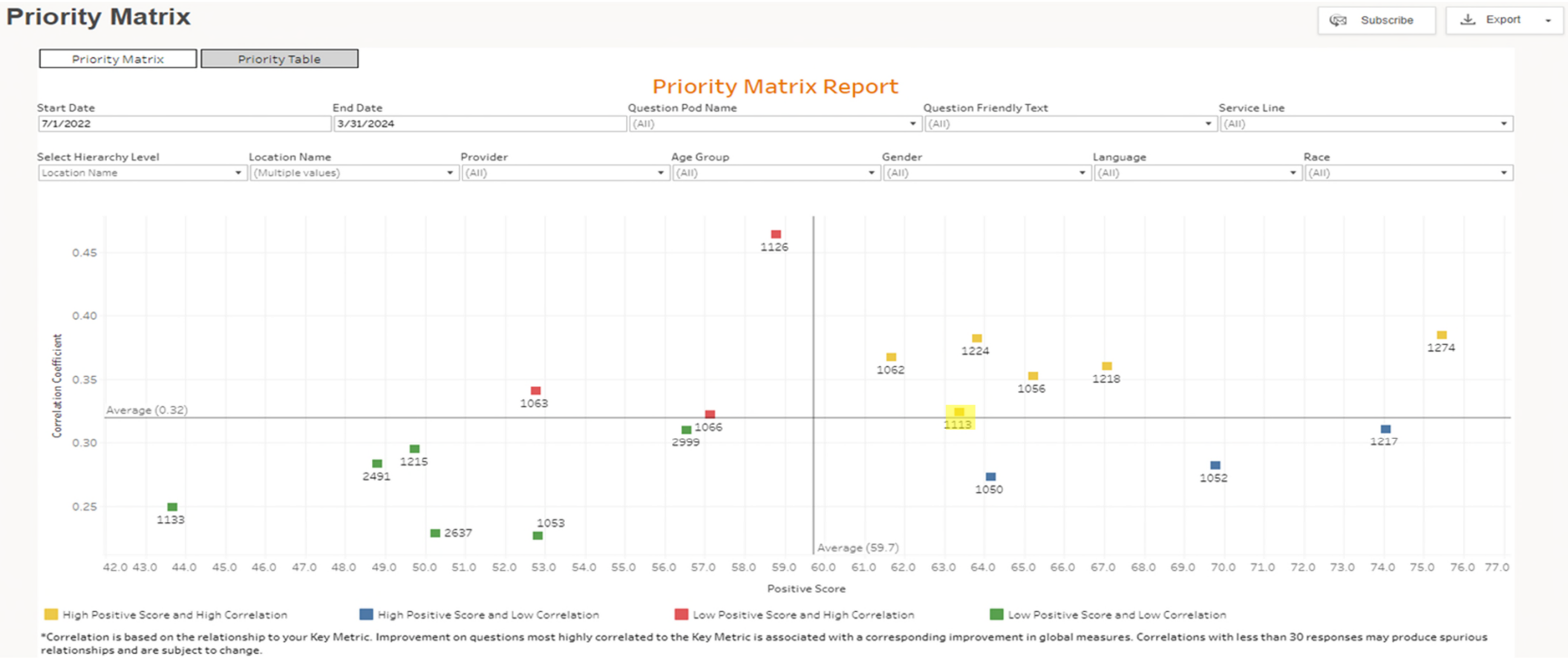
FQHC Priority Matrix

Facility Locations by Question Pods:

Medical Practice		Outpatient Behavioral Health	Outpatient Testing
AVD FAMILY PRACTICE	PEC INTERNAL MEDICINE	AVD INTEGRATED BH	PXC ANTEPARTUM TEST
CHD FAMILY PRACTICE	PEC OB/GYN	CHD INTEGRATED BH	PXC COLPOSCOPY
CHD INTERNAL MEDICINE	PEC PEDIATRICS	GDL INTEGRATED BH	PXC PEDS PROCEDURE
CHD OB/GYN	PXC ADOLESCENT	MESA INTEGRATED BH	
GDL FAMILY PRACTICE	PXC GYN TUMOR	MESA PREVENTION PSYCH	
GDL OB/GYN	PXC INTERNAL MEDICINE	MESA SPECIALTY BH	
MCD FAMILY PRACTICE	PXC OB/GYN	MSA INTEGRATED BH	
MCD INTERNAL MEDICINE	PXC OB/GYN INFER (REI)	NPX INTEGRATED BH	
MESA FAMILY PRACTICE	PXC OBSTETRICS COMP	PEC INTEGRATED BH	
MESA IMM CLINIC	PXC PEDS	SPL INTEGRATED BH	
MESA INTERNAL MEDICINE	PXC UROGYNECOLOGY	SPX INTEGRATED BH	
MESA OB/GYN	SPL FAMILY PRACTICE	PXC Peds Integrated BH	
MESA PEDIATRICS	SPL INTERNAL MEDICINE		
MESA PREVENTION	SPL OB/GYN		
NPX FAMILY PRACTICE	SPL PEDIATRICS		
NPX INTERNAL MEDICINE	SPX FAMILY PRACTICE		
NPX OB/GYN	WMV Family Practice		
NPX PEDIATRICS	WMV OB/GYN		
PEC FAMILY PRACTICE	WMV PEDIATRICS		

* Locations as last edited and reviewed on 07/14/23

FQHC Priority Matrix FY23-FY24TD

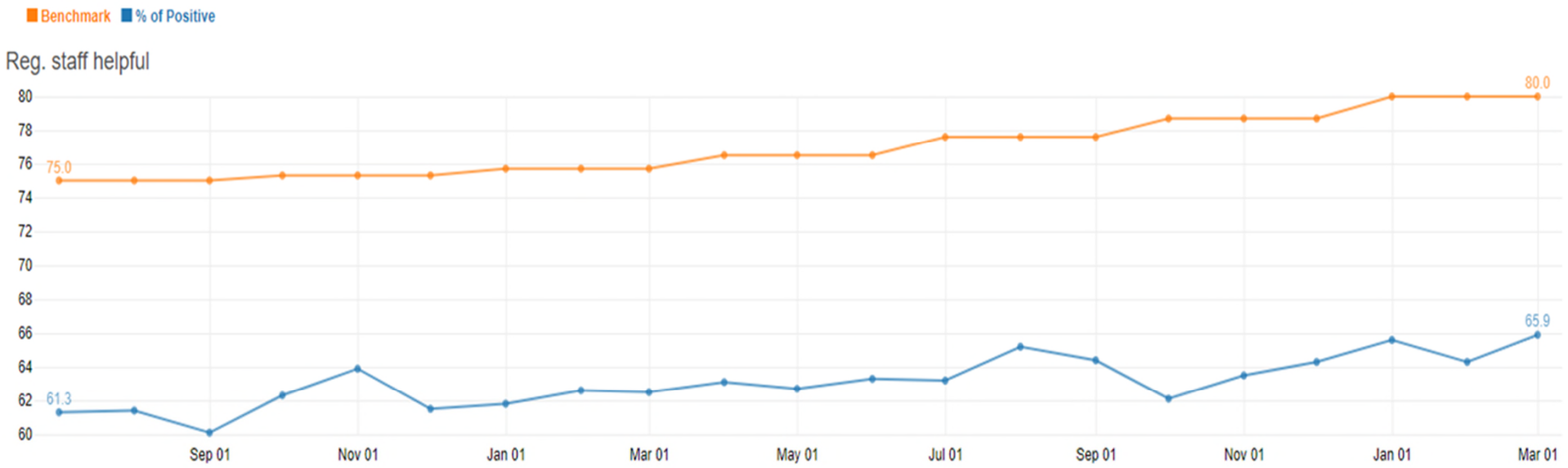


FQHC Positive Responses – Reg Staff Helpful

Trend

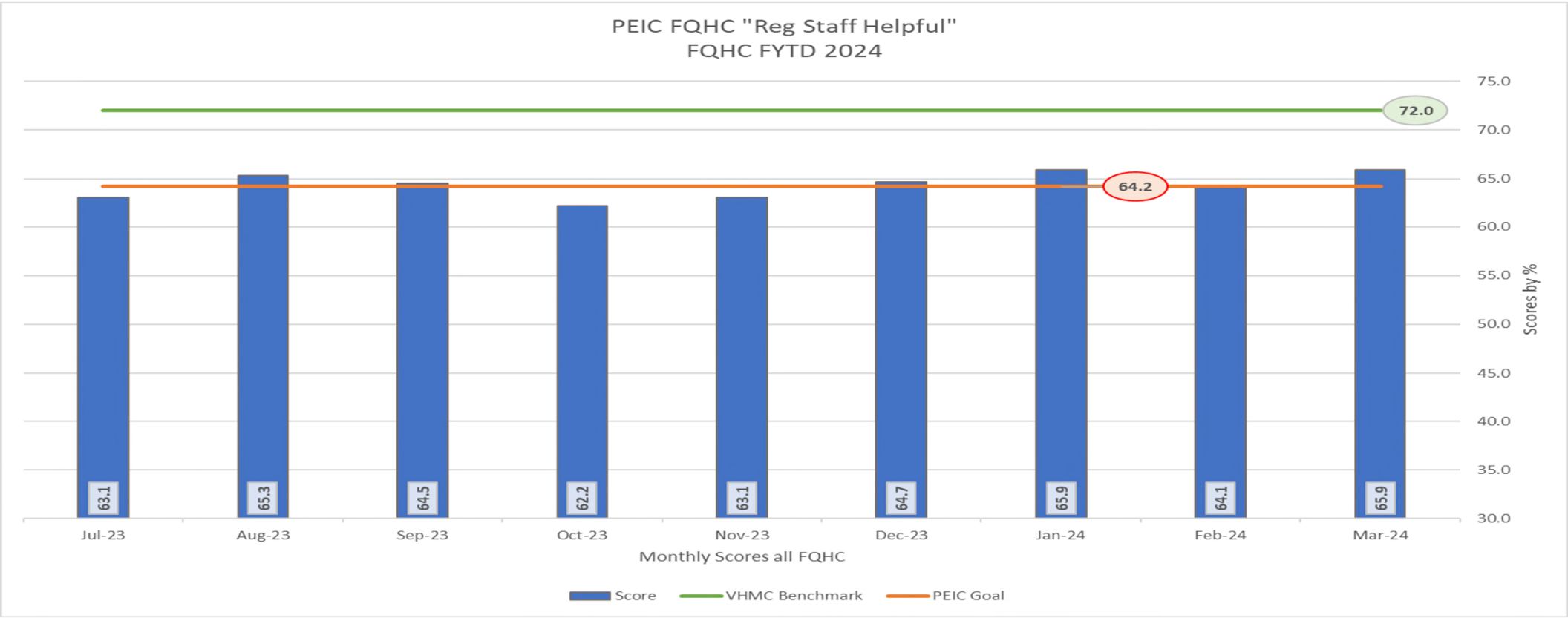
Favorite | Subscribe | Export | Jul 01, 2022 - Mar 31, 2024

Respondents 45,190

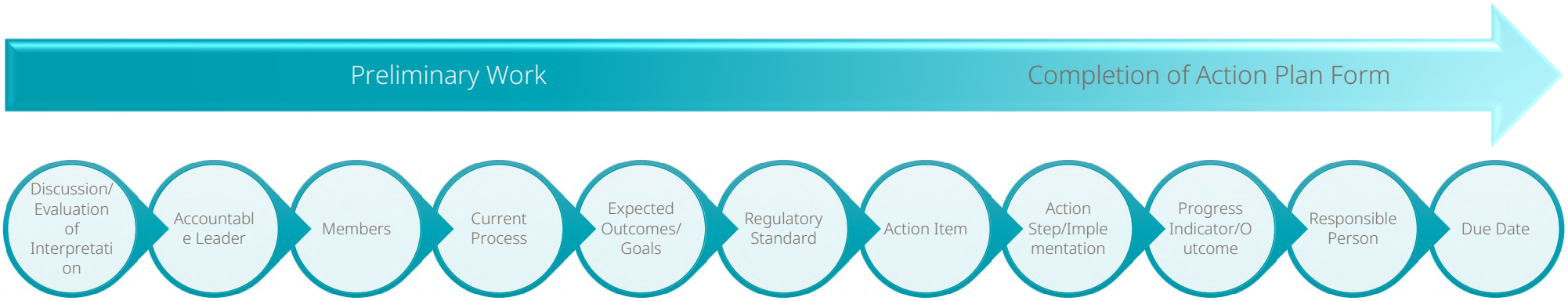


	Jul 01	Aug 01	Sep 01	Oct 01	Nov 01	Dec 01	Jan 01	Feb 01	Mar 01	Apr 01	May 01	Jun 01	Jul 01	Aug 01	Sep 01	Oct 01	Nov 01	Dec 01	Jan 01	Feb 01	Mar 01
% of Positive	61.3 n = 1,566	61.4 n = 1,822	60.1 n = 1,734	62.3 n = 1,695	63.9 n = 1,661	61.5 n = 1,451	61.8 n = 1,720	62.6 n = 1,560	62.5 n = 1,967	63.1 n = 1,839	62.7 n = 1,774	63.3 n = 1,953	63.2 n = 2,269	65.2 n = 2,647	64.4 n = 2,317	62.1 n = 2,688	63.5 n = 2,405	64.3 n = 2,439	65.6 n = 3,201	64.3 n = 3,128	65.9 n = 3,354

FQHC Positive Responses – Reg Staff Helpful with PEIC Goal Line



Committing to Action Planning



- Interpret Reports
- Who is the individual that can assist the Members to understand the purpose of action plan and required steps to achieve?
- Who are the individuals that can influence how this process is achieved
- In general, describe what the current process
- What is the ROI?
- "Specifically, what can we expect as an outcome, resultantly, from addressing this question?"
- Why, according to Regulation, is action necessitated?
- "What must be considered in order to position our teams to successfully implement?"
- How will we accomplish the action needed to position the team for successful implementation?
- How do we know when we can check off achieving the needed Action Item?
- Who holds those accountable to make this happen or not?
- When we expect this project to be implemented fully?
- "Can we clearly articulate what the desired end state will look like? If yes, then how long do we expect this to take?"

Audrey De Alva, 07/19/2022
Modified: 08/02/2022

The Voice of the Patient:

Peoria CHC	10 – Being on time and the service that I received was absolutely fantastic with tender loving care. I did appreciate it.
	6 - My only complaints are the appointment scheduling process and lack of availability (appointments being too far out) But once I've actually gotten a hold of someone, they have made me feel heard and like they really care. For example, Lynn Meadows, Lillian S & Diana A. That's very important to me and I really appreciate their help, our brief interactions have helped calm my anxieties. Thank you.
	10 -My provider (A. Rush) had excellent bedside manner. I hope saying no, that she didn't know my medical hx isn't marked negatively . I'm a new patient so I feel that question was irrelevant. However, we went over that in the room. My MA Lilly , was very helpful and inviting . The entire staff from beginning to end was friendly and gave me a very positive experience.
Phoenix CHC	10 - I was very grateful to be seen right away, especially with a weekend coming up. With severe sudden onset COPD since February, I felt the need to be cautious when what appeared to be early symptoms of bronchitis appeared. Although symptoms were mild and lungs sounded clear, I felt sick and was concerned by darkening phlegm. I really appreciated Dr. Murthy's trust in me as a patient and my sense that I was indeed sick. She prescribed a short course of Amoxicillin, and I began to improve within 24 hrs.
	10 -I tell you, Valleywise, I really like them a lot. They tell me, they explain everything to me. I mean, everything, it's really good. I enjoy going there and they explain to me, like I said, everything is clean there. I get my appointments right away. They get me in. I mean and I'm in and out of there. They just take good care of me and I would recommend them to anybody. Thank you. Bye.
	5 -Always good

McDowell	10 -I would like to say the nurse Michelle was very kind and very welcoming. At first I was nervous to see a new RN assisting me but her calm and bright spirit immediately gave me a sense of ease. She was amazing
	10 – Dr. Khalsa and the staff are exceptional care givers in every way.
	0 – This is the most uncomfortable experience I've ever had in any of my years since I've been positive since 2008. The doctor was extremely rude and condescending. He refused to treat a STI that I was showing symptoms was and exposed to. This was my first time ever walking out of a provider's office. I will not be returning back to this clinic. Thank you.
Mesa	0 – The doctors need to listen to their patients more and allow them to explain things and not talk over them.
	10 –My doctor was very good and he was explaining everything to me and very knowledgeable and I was really appreciated that doctor and he's the best doctor in my opinion I can say. I like him and it was a good experience with him. Thank you.
	5 -It was getting easier to be myself.
North Phoenix	10 - I love this facility. They are always pleasant and professional.
	10 - I love it! Its fast and providers are attentive
	1 - My Dr ordered a holster monitor. Never heard from anyone about it. Now my Dr has left Valleywise. I have no Dr now. No Holster monitor. And no one to refill my prescriptions. We ask who would be taking over my Dr's patients, we got a shrug and we're told "everybody else?".

South Central	10 – Good location & all is helpful. Very good care. Thank you.
	10 - Tomorrow I'm going home. But I don't know how to say thank you, thank you for everything and I recommend this center to someone I know because I don't have family here. Thank you all.
	8 - The doctors should inform us better about how to take care of a possible chronic disease. They should help us and give us follow-up care to know what to do.
South Phoenix / Laveen	10 - The doctor, Dr. Heather was very accurate. She answered all my questions without me feeling rushed. She was very in-depth and she knows what she's talking about and he basically tells you everything how it is instead of lying to you. She's just amazing. I would definitely recommend her for whoever I can get to go see her. She's such an amazing doctor and I can't wait until my health goes back to how it was and I'm excited for what she can help me with and accomplish. So I'm just obsessed that I found somebody that actually wants to help me.
	10 - The doctor who attended me was very professional, very nice, very caring, very thorough. I just want to appreciate her, her care and I would highly recommend her and the facility also. I've been with Valley wise for a very long time and I highly recommend it to anybody.
	1 - Yes, I went to the appointment. Come to find out I was canceled and I did not get no information as well as I got a text the night before that the appointment was initially for me to go. Got there, come to find out there was canceled without me knowing and a schedule for another time date
West Maryvale	10 -Hello, everything went well during my delivery and my postpartum care. I loved all the nurses and the doctors and everyone who was just there to help me and baby. And I love all the support that was given.
	0 -I'd like to say that I'm extremely dissatisfied with the service at ValleyWise. Whenever I visit, I don't get enough information about my health. I have to either inquire or call back again, and I'm asked to come and I don't get information about my health even in those visits.

6. Financials and Payor Mix

Valleywise Health
FQHC

With Ancillary Services
MAR FY 2024

MTD Actual vs Budget

		VCHC				OP Behavioral Health				VCHC - Phoenix			
		MAR Month to Date				MAR Month to Date				MAR Month to Date			
		FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%	FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%	FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%
(a)	**Visits**	**13,265**	**15,315**	**(2,050)**	**(13%)**	**2,874**	**2,554**	**320**	**13%**	**5,893**	**5,755**	**138**	**2%**
	Operating Revenues												
(b)	Net patient service revenue	**$ 3,145,029**	**$ 3,468,067**	**$ (323,038)**	**(9%)**	**$ 640,885**	**$ 643,501**	**$ (2,616)**	**(0%)**	**$ 1,012,460**	**$ 1,031,375**	**$ (18,915)**	**(2%)**
(c)	Other Operating Revenue	193,631	180,152	13,479	**7%**	130,991	108,092	22,899	**21%**	36,017	22,546	13,471	**60%**
(e)	**Total operating revenues**	**$ 3,338,660**	**$ 3,648,219**	**$ (309,559)**	**(8%)**	**$ 771,876**	**$ 751,593**	**$ 20,283**	**3%**	**$ 1,048,477**	**$ 1,053,921**	**$ (5,444)**	**(1%)**
	Operating Expenses												
(f)	Salaries and wages	1,195,305	1,271,208	75,903	6%	343,634	295,959	(47,676)	(16%)	569,188	528,055	(41,133)	(8%)
(g)	Contract labor	-	-	-		-	-	-		-	-	-	
(h)	Employee benefits	371,343	413,392	42,049	10%	110,106	86,289	(23,816)	(28%)	174,685	164,804	(9,881)	(6%)
(i)	Medical service fees	1,345,179	1,372,918	27,739	2%	106,875	54,141	(52,734)	(97%)	560,364	555,957	(4,407)	(1%)
(j)	Supplies	180,456	176,459	(3,998)	(2%)	3,038	956	(2,082)	(218%)	38,007	48,300	10,293	21%
(k)	Purchased services	9,120	9,579	459	5%	1,972	1,568	(404)	(26%)	5,229	5,978	749	13%
(l)	Other expenses	66,770	70,044	3,274	5%	4,070	2,034	(2,037)	(100%)	3,331	2,173	(1,159)	(53%)
(n)	Allocated ancillary expense	1,268,189	895,992	(372,196)	(42%)	-	-	-		164,146	90,723	(73,423)	(81%)
(o)	**Total operating expenses**	**$ 4,436,361**	**$ 4,209,591**	**(226,770)**	**(5%)**	**$ 569,695**	**$ 440,946**	**(128,749)**	**(29%)**	**$ 1,514,951**	**$ 1,395,991**	**(118,959)**	**(9%)**
(p)	**Margin (before overhead allocation)**	**$ (1,097,702)**	**$ (561,372)**	**$ (536,330)**		**$ 202,181**	**$ 310,647**	**$ (108,466)**		**$ (466,474)**	**$ (342,071)**	**$ (124,403)**	
(q)	Percent Margin	(33%)	(15%)			26%	41%			(44%)	(32%)		
(u)	*Overhead Allocation*	*1,153,401*	*1,091,874*	*(61,527)*		*120,653*	*97,886*	*(22,767)*		*348,236*	*322,084*	*(26,152)*	
(v)	**Margin (after overhead allocation)**	**$ (2,251,102)**	**$ (1,653,246)**	**$ (597,856)**		**$ 81,528**	**$ 212,761**	**$ (131,233)**		**$ (814,710)**	**$ (664,155)**	**$ (150,555)**	
(w)	Percent Margin	(67%)	(45%)			11%	28%			(78%)	(63%)		
	Per Visit Analysis ($/Visit)												
(x)	Net patient service revenue	$ 237.09	$ 226.45	$ 10.64		$ 222.99	$ 251.96	$ (28.96)		$ 171.81	$ 179.21	$ (7.41)	
(y)	Other Operating Revenue	14.60	11.76	2.83		45.58	42.32	3.26		6.11	3.92	2.19	
(aa)	**Total operating revenues**	**$ 251.69**	**$ 238.21**	**$ 13.48**	**5%**	**$ 268.57**	**$ 294.28**	**$ (25.71)**	**(10%)**	**$ 177.92**	**$ 183.13**	**$ (5.21)**	**(3%)**
(ab)	**Total operating expenses**	**334.44**	**274.87**	**(59.57)**	**(22%)**	**198.22**	**172.65**	**(25.57)**	**(15%)**	**257.08**	**242.57**	**(14.51)**	**(6%)**
(ac)	**Margin (before overhead allocation)**	**$ (82.75)**	**$ (36.66)**	**$ (46.10)**	**(126%)**	**$ 70.35**	**$ 121.63**	**$ (51.28)**	**(42%)**	**$ (79.16)**	**$ (59.44)**	**$ (19.72)**	**(33%)**
(af)	*Overhead Allocation*	86.95	71.29	(15.66)	(22%)	41.98	38.33	(3.65)	(10%)	59.09	55.97	(3.13)	(6%)
(ag)	**Margin (after overhead allocation)**	**$ (169.70)**	**$ (107.95)**	**$ (61.75)**	**(57%)**	**$ 28.37**	**$ 83.31**	**$ (54.94)**	**(66%)**	**$ (138.25)**	**$ (115.40)**	**$ (22.85)**	**(20%)**

Valleywise Health
FQHC

With Ancillary Services
MAR FY 2024

MTD Actual vs Budget

		VCHC - Peoria				Dental				Mobile Health Unit			
		MAR Month to Date				MAR Month to Date				MAR Month to Date			
		FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%	FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%	FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%
(a)	**Visits**	**2,096**	**2,503**	**(407)**	**(16%)**	**2,173**	**2,028**	**145**	**7%**	**-**	**148**	**(148)**	**(100%)**
	Operating Revenues												
(b)	Net patient service revenue	**$ 386,501**	**$ 486,688**	**$ (100,187)**	**(21%)**	**$ 252,887**	**$ 275,516**	**$ (22,629)**	**(8%)**	**$ -**	**$ 17,909**	**$ (17,909)**	**(100%)**
(c)	Other Operating Revenue	12,898	9,702	3,196	**33%**	45,440	40,910	4,531	**11%**	11,847	76	11,771	**15,411%**
(e)	**Total operating revenues**	**$ 399,400**	**$ 496,390**	**$ (96,990)**	**(20%)**	**$ 298,327**	**$ 316,426**	**$ (18,099)**	**(6%)**	**$ 11,847**	**$ 17,985**	**$ (6,138)**	**(34%)**
	Operating Expenses												
(f)	Salaries and wages	195,809	205,520	9,711	5%	393,217	374,406	(18,811)	(5%)	19,097	12,761	(6,335)	(50%)
(g)	Contract labor	-	-	-		-	-	-		-	-	-	
(h)	Employee benefits	62,068	65,299	3,231	5%	122,799	109,835	(12,963)	(12%)	4,296	4,448	152	3%
(i)	Medical service fees	226,218	193,514	(32,704)	(17%)	-	-	-		-	13,220	13,220	100%
(j)	Supplies	9,874	14,899	5,025	34%	28,361	30,441	2,080	7%	2	1,534	1,532	100%
(k)	Purchased services	1,419	1,493	75	5%	3,196	17,324	14,128	82%	-	4	4	100%
(l)	Other expenses	1,116	718	(397)	(55%)	4,979	4,621	(358)	(8%)	-	1,288	1,288	100%
(n)	Allocated ancillary expense	73,427	49,320	(24,108)	(49%)	-	-	-		-	4,138	4,138	100%
(o)	**Total operating expenses**	**$ 569,932**	**$ 530,764**	**(39,168)**	**(7%)**	**$ 552,551**	**$ 536,627**	**(15,925)**	**(3%)**	**$ 23,395**	**$ 37,393**	**13,998**	**37%**
(p)	**Margin (before overhead allocation)**	**$ (170,532)**	**$ (34,374)**	**$ (136,158)**		**$ (254,224)**	**$ (220,201)**	**$ (34,024)**		**$ (11,547)**	**$ (19,407)**	**$ 7,860**	
(q)	Percent Margin	(43%)	(7%)			(85%)	(70%)			(97%)	(108%)		
(u)	*Overhead Allocation*	*143,593*	*140,333*	*(3,261)*		*160,222*	*155,101*	*(5,121)*		*4,679*	*7,479*	*2,800*	
(v)	**Margin (after overhead allocation)**	**$ (314,126)**	**$ (174,706)**	**$ (139,419)**		**$ (414,446)**	**$ (375,302)**	**$ (39,144)**		**$ (16,226)**	**$ (26,886)**	**$ 10,660**	
(w)	Percent Margin	(79%)	(35%)			(139%)	(119%)			(137%)	(149%)		
	Per Visit Analysis ($/Visit)												
(x)	Net patient service revenue	$ 184.40	$ 194.44	$ (10.04)		$ 116.38	$ 135.86	$ (19.48)		$ -	$ 121.01	$ (121.01)	
(y)	Other Operating Revenue	6.15	3.88	2.28		20.91	20.17	0.74		-	-	-	
(aa)	**Total operating revenues**	**$ 190.55**	**$ 198.32**	**$ (7.76)**	**(4%)**	**$ 137.29**	**$ 156.03**	**$ (18.74)**	**(14%)**	**$ -**	**$ 121.52**	**$ (121.52)**	**100%**
(ab)	**Total operating expenses**	**271.91**	**212.05**	**(59.86)**	**(22%)**	**254.28**	**264.61**	**10.33**	**4%**	**-**	**252.65**	**252.65**	**100%**
(ac)	**Margin (before overhead allocation)**	**$ (81.36)**	**$ (13.73)**	**$ (67.63)**	**(492%)**	**$ (116.99)**	**$ (108.58)**	**$ (8.41)**	**(8%)**	**$ -**	**$ (131.13)**	**$ 131.13**	**100%**
(af)	*Overhead Allocation*	68.51	56.07	(12.44)	(22%)	73.73	76.48	2.75	4%	-	50.53	50.53	100%
(ag)	**Margin (after overhead allocation)**	**$ (149.87)**	**$ (69.80)**	**$ (80.07)**	**(115%)**	**$ (190.73)**	**$ (185.06)**	**$ (5.67)**	**(3%)**	**$ -**	**$ (181.66)**	**$ 181.66**	**100%**

Valleywise Health
FQHC

With Ancillary Services
MAR FY 2024

MTD Actual vs Budget

All Clinics Combined

		MAR Month to Date			
		FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%
(a)	**Visits**	**26,301**	**28,303**	**(2,002)**	**(7%)**
	Operating Revenues				
(b)	Net patient service revenue	**$ 5,437,761**	**$ 5,923,056**	**$ (485,295)**	**(8%)**
(c)	Other Operating Revenue	430,825	361,478	69,347	**19%**
(e)	**Total operating revenues**	**$ 5,868,586**	**$ 6,284,534**	**$ (415,948)**	**(7%)**
	Operating Expenses				
(f)	Salaries and wages	2,716,250	2,687,909	(28,341)	(1%)
(g)	Contract labor	-	-	-	
(h)	Employee benefits	845,297	844,068	(1,229)	(0%)
(i)	Medical service fees	2,238,636	2,189,750	(48,887)	(2%)
(j)	Supplies	259,739	272,589	12,850	5%
(k)	Purchased services	20,936	35,947	15,011	42%
(l)	Other expenses	80,266	80,877	612	1%
(n)	Allocated ancillary expense	1,505,762	1,040,173	(465,589)	(45%)
(o)	**Total operating expenses**	**$ 7,666,885**	**$ 7,151,312**	**(515,573)**	**(7%)**
(p)	**Margin (before overhead allocation)**	**$ (1,798,298)**	**$ (866,778)**	**$ (931,521)**	**(107%)**
(q)	Percent Margin	(31%)	(14%)		
(u)	*Overhead Allocation*	*1,930,783*	*1,814,756*	*(116,028)*	*(6%)*
(v)	**Margin (after overhead allocation)**	**$ (3,729,082)**	**$ (2,681,534)**	**$ (1,047,548)**	**(39%)**
(w)	Percent Margin	(64%)	(43%)		
	Per Visit Analysis ($/Visit)				
(x)	Net patient service revenue	$ 206.75	$ 209.27	$ (2.52)	
(y)	Other Operating Revenue	16.38	12.77	3.61	
(aa)	**Total operating revenues**	**$ 223.13**	**$ 222.04**	**$ 1.09**	**0%**
(ab)	**Total operating expenses**	**291.51**	**252.67**	**(38.84)**	**(15%)**
(ac)	**Margin (before overhead allocation)**	**$ (68.37)**	**$ (30.62)**	**$ (37.75)**	**(123%)**
(af)	*Overhead Allocation*	73.41	64.12	(9.29)	(14%)
(ag)	**Margin (after overhead allocation)**	**$ (141.78)**	**$ (94.74)**	**$ (47.04)**	**(50%)**

Valleywise Health
FQHC

With Ancillary Services
MAR FY 2024

YTD Actual vs Budget

		VCHC				OP Behavioral Health				VCHC - Phoenix			
		MAR Year to Date				MAR Year to Date				MAR Year to Date			
		FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%	FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%	FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%
(a)	**Visits**	**120,482**	**125,474**	**(4,992)**	**(4%)**	**23,019**	**20,482**	**2,537**	**12%**	**51,865**	**51,212**	**653**	**1%**
	Operating Revenues												
(b)	Net patient service revenue	**$ 28,054,039**	**$ 28,396,503**	**$ (342,464)**	**(1%)**	**$ 5,358,054**	**$ 5,137,396**	**$ 220,658**	**4%**	**$ 8,930,700**	**$ 9,195,145**	**$ (264,445)**	**(3%)**
(c)	Other Operating Revenue	1,844,420	1,651,619	192,800	**12%**	1,644,800	978,835	665,965	**68%**	345,291	217,055	128,237	**59%**
(e)	**Total operating revenues**	**$ 29,898,458**	**$ 30,048,122**	**$ (149,664)**	**(0%)**	**$ 7,002,854**	**$ 6,116,231**	**$ 886,623**	**14%**	**$ 9,275,991**	**$ 9,412,200**	**$ (136,209)**	**(1%)**
	Operating Expenses												
(f)	Salaries and wages	10,471,513	10,627,271	155,758	1%	2,934,703	2,346,342	(588,360)	(25%)	4,900,487	4,723,595	(176,892)	(4%)
(g)	Contract labor	59	-	(59)	(100%)	-	-	-		(994)	-	994	(100%)
(h)	Employee benefits	3,267,144	3,459,396	192,252	6%	904,497	688,127	(216,370)	(31%)	1,515,555	1,478,570	(36,985)	(3%)
(i)	Medical service fees	10,185,073	11,267,716	1,082,643	10%	713,239	486,564	(226,675)	(47%)	4,791,376	4,990,175	198,799	4%
(j)	Supplies	1,917,321	1,671,451	(245,869)	(15%)	13,411	8,268	(5,144)	(62%)	395,527	431,708	36,180	8%
(k)	Purchased services	189,686	96,662	(93,023)	(96%)	232,982	14,386	(218,595)	(1,519%)	95,722	57,784	(37,938)	(66%)
(l)	Other expenses	660,914	656,518	(4,395)	(1%)	28,690	20,573	(8,117)	(39%)	34,596	26,651	(7,945)	(30%)
(n)	Allocated ancillary expense	7,591,418	7,403,209	(188,210)	(3%)	-	-	-		997,498	798,848	(198,649)	(25%)
(o)	**Total operating expenses**	**$ 34,283,128**	**$ 35,182,224**	**899,096**	**3%**	**$ 4,827,521**	**$ 3,564,260**	**(1,263,261)**	**(35%)**	**$ 12,729,766**	**$ 12,507,331**	**(222,435)**	**(2%)**
(p)	**Margin (before overhead allocation)**	**$ (4,384,669)**	**$ (5,134,102)**	**$ 749,433**		**$ 2,175,333**	**$ 2,551,971**	**$ (376,639)**		**$ (3,453,775)**	**$ (3,095,131)**	**$ (358,644)**	
(q)	Percent Margin	(15%)	(17%)			31%	42%			(37%)	(33%)		
(u)	*Overhead Allocation*	*8,874,451*	*9,104,375*	*229,923*		*1,043,216*	*786,570*	*(256,646)*		*2,965,137*	*2,885,001*	*(80,136)*	
(v)	**Margin (after overhead allocation)**	**$ (13,259,121)**	**$ (14,238,477)**	**$ 979,356**		**$ 1,132,116**	**$ 1,765,401**	**$ (633,285)**		**$ (6,418,912)**	**$ (5,980,132)**	**$ (438,780)**	
(w)	Percent Margin	(44%)	(47%)			16%	29%			(69%)	(64%)		
	Per Visit Analysis ($/Visit)												
(x)	Net patient service revenue	$ 232.85	$ 226.31	$ 6.53		$ 232.77	$ 250.82	$ (18.06)		$ 172.19	$ 179.55	$ (7.36)	
(y)	Other Operating Revenue	15.31	13.16	2.15		71.45	47.79	23.66		6.66	4.24	2.42	
(aa)	**Total operating revenues**	**$ 248.16**	**$ 239.48**	**$ 8.68**	**3%**	**$ 304.22**	**$ 298.61**	**$ 5.61**	**2%**	**$ 178.85**	**$ 183.79**	**$ (4.94)**	**(3%)**
(ab)	**Total operating expenses**	**284.55**	**280.39**	**(4.16)**	**(1%)**	**209.72**	**174.02**	**(35.70)**	**(21%)**	**245.44**	**244.23**	**(1.21)**	**(0%)**
(ac)	**Margin (before overhead allocation)**	**$ (36.39)**	**$ (40.92)**	**$ 4.52**	**11%**	**$ 94.50**	**$ 124.60**	**$ (30.09)**	**(24%)**	**$ (66.59)**	**$ (60.44)**	**$ (6.15)**	**(10%)**
(af)	*Overhead Allocation*	73.66	72.56	(1.10)	(2%)	45.32	38.40	(6.92)	(18%)	57.17	56.33	(0.84)	(1%)
(ag)	**Margin (after overhead allocation)**	**$ (110.05)**	**$ (113.48)**	**$ 3.43**	**3%**	**$ 49.18**	**$ 86.19**	**$ (37.01)**	**(43%)**	**$ (123.76)**	**$ (116.77)**	**$ (6.99)**	**(6%)**

Valleywise Health
FQHC

With Ancillary Services
MAR FY 2024

YTD Actual vs Budget

		VCHC - Peoria				Dental				Mobile Health Unit			
		MAR Year to Date				MAR Year to Date				MAR Year to Date			
		FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%	FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%	FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%
(a)	**Visits**	**19,822**	**21,672**	**(1,850)**	**(9%)**	**18,068**	**17,660**	**408**	**2%**	**-**	**493**	**(493)**	**(100%)**
	Operating Revenues												
(b)	Net patient service revenue	**$ 3,699,050**	**$ 4,204,615**	**$ (505,565)**	**(12%)**	**$ 2,052,418**	**$ 2,408,039**	**$ (355,621)**	**(15%)**	**$ -**	**$ 59,517**	**$ (59,517)**	**(100%)**
(c)	Other Operating Revenue	137,499	91,056	46,443	**51%**	399,807	368,725	31,081	**8%**	98,021	265	97,756	**36,855%**
(e)	**Total operating revenues**	**$ 3,836,549**	**$ 4,295,672**	**$ (459,123)**	**(11%)**	**$ 2,452,225**	**$ 2,776,765**	**$ (324,540)**	**(12%)**	**$ 98,021**	**$ 59,782**	**$ 38,239**	**64%**
	Operating Expenses												
(f)	Salaries and wages	1,758,353	1,806,887	48,534	3%	3,312,259	3,253,039	(59,220)	(2%)	96,998	73,409	(23,589)	(32%)
(g)	Contract labor	-	-	-		-	-	-		-	-	-	
(h)	Employee benefits	561,490	575,784	14,295	2%	960,941	930,346	(30,595)	(3%)	22,218	25,800	3,582	14%
(i)	Medical service fees	1,851,220	1,700,175	(151,046)	(9%)	-	-	-		-	59,402	59,402	100%
(j)	Supplies	138,414	143,786	5,372	4%	266,722	265,654	(1,069)	(0%)	(7)	5,109	5,116	100%
(k)	Purchased services	26,967	14,800	(12,167)	(82%)	117,347	152,650	35,304	23%	-	15	15	100%
(l)	Other expenses	10,642	9,156	(1,487)	(16%)	45,344	44,582	(762)	(2%)	386	7,549	7,163	95%
(n)	Allocated ancillary expense	506,200	423,258	(82,942)	(20%)	-	-	-		-	13,759	13,759	100%
(o)	**Total operating expenses**	**$ 4,853,286**	**$ 4,673,845**	**(179,441)**	**(4%)**	**$ 4,702,613**	**$ 4,646,271**	**(56,342)**	**(1%)**	**$ 119,596**	**$ 185,044**	**65,448**	**35%**
(p)	**Margin (before overhead allocation)**	**$ (1,016,737)**	**$ (378,174)**	**$ (638,564)**		**$ (2,250,388)**	**$ (1,869,507)**	**$ (380,881)**		**$ (21,575)**	**$ (125,262)**	**$ 103,687**	
(q)	Percent Margin	(27%)	(9%)			(92%)	(67%)			(22%)	(210%)		
(u)	*Overhead Allocation*	*1,222,778*	*1,235,752*	*12,975*		*1,365,518*	*1,340,980*	*(24,538)*		*23,919*	*37,009*	*13,090*	
(v)	**Margin (after overhead allocation)**	**$ (2,239,515)**	**$ (1,613,926)**	**$ 651,538**		**$ (3,615,906)**	**$ (3,210,487)**	**$ (405,419)**		**$ (45,494)**	**$ (162,271)**	**$ 116,777**	
(w)	Percent Margin	(58%)	(38%)			(147%)	(116%)			(46%)	(271%)		
	Per Visit Analysis ($/Visit)												
(x)	Net patient service revenue	$ 186.61	$ 194.01	$ 7.40		$ 113.59	$ 136.36	$ (22.76)		$ -	$ 120.72	$ (120.72)	
(y)	Other Operating Revenue	6.94	4.20	(2.74)		22.13	20.88	1.25		-	-	-	
(aa)	**Total operating revenues**	**$ 193.55**	**$ 198.21**	**$ 4.66**	**(2%)**	**$ 135.72**	**$ 157.23**	**$ (21.51)**	**(16%)**	**$ -**	**$ 121.26**	**$ (121.26)**	**100%**
(ab)	**Total operating expenses**	**244.84**	**215.66**	**29.18**	**(14%)**	**260.27**	**263.10**	**2.82**	**1%**	**-**	**375.34**	**375.34**	**100%**
(ac)	**Margin (before overhead allocation)**	**$ (51.29)**	**$ (17.45)**	**$ 33.84**	**(194%)**	**$ (124.55)**	**$ (105.86)**	**$ (18.69)**	**(18%)**	**$ -**	**$ (254.08)**	**$ 254.08**	**100%**
(af)	*Overhead Allocation*	61.69	57.02	4.67	(8%)	75.58	75.93	0.36	0%	-	75.07	75.07	100%
(ag)	**Margin (after overhead allocation)**	**$ (112.98)**	**$ (74.47)**	**$ 38.51**	**(52%)**	**$ (200.13)**	**$ (181.79)**	**$ (18.33)**	**(10%)**	**$ -**	**$ (329.15)**	**$ 329.15**	**100%**

Valleywise Health
FQHC

With Ancillary Services
MAR FY 2024

YTD Actual vs Budget

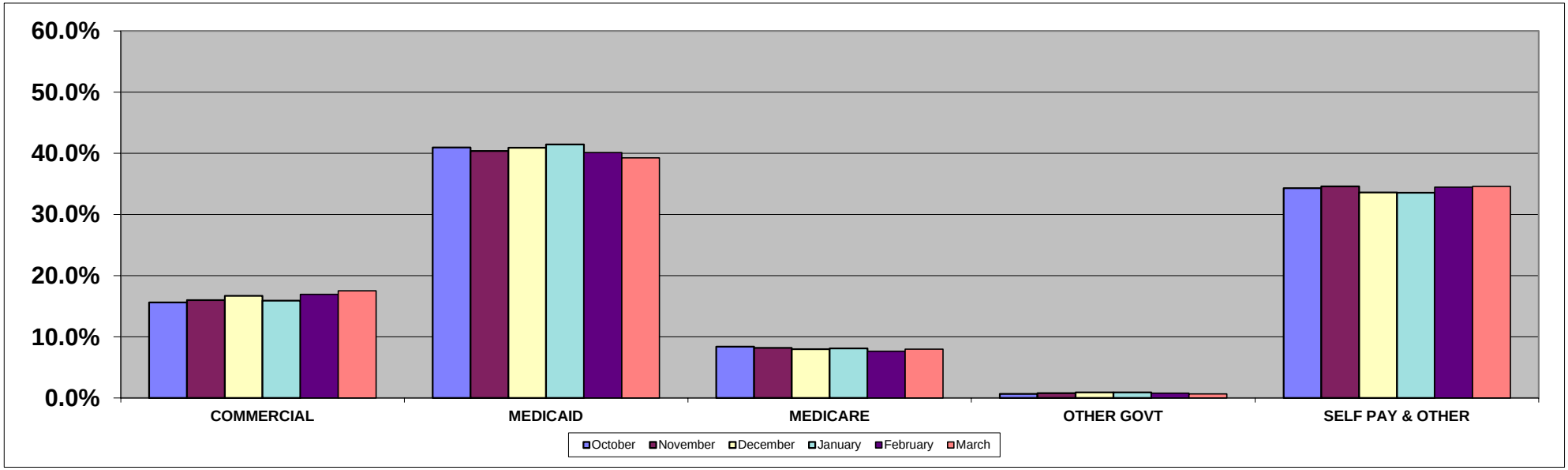
All Clinics Combined

		MAR Year to Date			
		FY24 Actual	FY24 Budget	Variance Favorable (Unfavorable)	%
(a)	**Visits**	**233,256**	**236,993**	**(3,737)**	**(2%)**
	Operating Revenues				
(b)	Net patient service revenue	**$ 48,094,260**	**$ 49,401,215**	**$ (1,306,954)**	**(3%)**
(c)	Other Operating Revenue	$ 4,469,837	$ 3,307,556	1,162,281	**35%**
(e)	**Total operating revenues**	**$ 52,564,098**	**$ 52,708,771**	**$ (144,673)**	**(0%)**
	Operating Expenses				
(f)	Salaries and wages	23,474,313	22,830,544	(643,769)	(3%)
(g)	Contract labor	(936)	-	936	100%
(h)	Employee benefits	7,231,846	7,158,023	(73,822)	(1%)
(i)	Medical service fees	17,540,908	18,504,031	963,123	5%
(j)	Supplies	2,731,389	2,525,975	(205,414)	(8%)
(k)	Purchased services	662,703	336,298	(326,405)	(97%)
(l)	Other expenses	780,572	765,029	(15,543)	(2%)
(n)	Allocated ancillary expense	9,095,116	8,639,075	(456,041)	(5%)
(o)	**Total operating expenses**	**$ 61,515,910**	**$ 60,758,976**	**(756,934)**	**(1%)**
(p)	**Margin (before overhead allocation)**	**$ (8,951,812)**	**$ (8,050,204)**	**$ (901,608)**	**(11%)**
(q)	Percent Margin	(17%)	(15%)		
(u)	*Overhead Allocation*	*15,495,019*	*15,389,687*	*(105,332)*	*(1%)*
(v)	**Margin (after overhead allocation)**	**$ (24,446,831)**	**$ (23,439,892)**	**$ (1,006,940)**	**(4%)**
(w)	Percent Margin	(47%)	(44%)		
	Per Visit Analysis ($/Visit)				
(x)	Net patient service revenue	$ 206.19	$ 208.45	$ (2.26)	
(y)	Other Operating Revenue	19.16	13.96	5.21	
(aa)	**Total operating revenues**	**$ 225.35**	**$ 222.41**	**$ 2.94**	**1%**
(ab)	**Total operating expenses**	**263.73**	**256.37**	**(7.35)**	**(3%)**
(ac)	**Margin (before overhead allocation)**	**$ (38.38)**	**$ (33.97)**	**$ (4.41)**	**(13%)**
(af)	*Overhead Allocation*	66.43	64.94	(1.49)	(2%)
(ag)	**Margin (after overhead allocation)**	**$ (104.81)**	**$ (98.91)**	**$ (5.90)**	**(6%)**

Valleywise Health - Federally Qualified Health Centers
Comparison ALL FQHC Visits by Payor - 6 Month Trend

Payer	October	November	December	January	February	March
COMMERCIAL	4,328	4,073	3,852	4,477	4,588	4,612
MEDICAID	11,328	10,297	9,435	11,644	10,869	10,324
MEDICARE	2,327	2,084	1,839	2,281	2,075	2,098
OTHER GOVT	187	207	208	254	210	173
SELF PAY & OTHER	9,496	8,811	7,761	9,432	9,342	9,094
Total	**27,666**	**25,472**	**23,095**	**28,088**	**27,084**	**26,301**

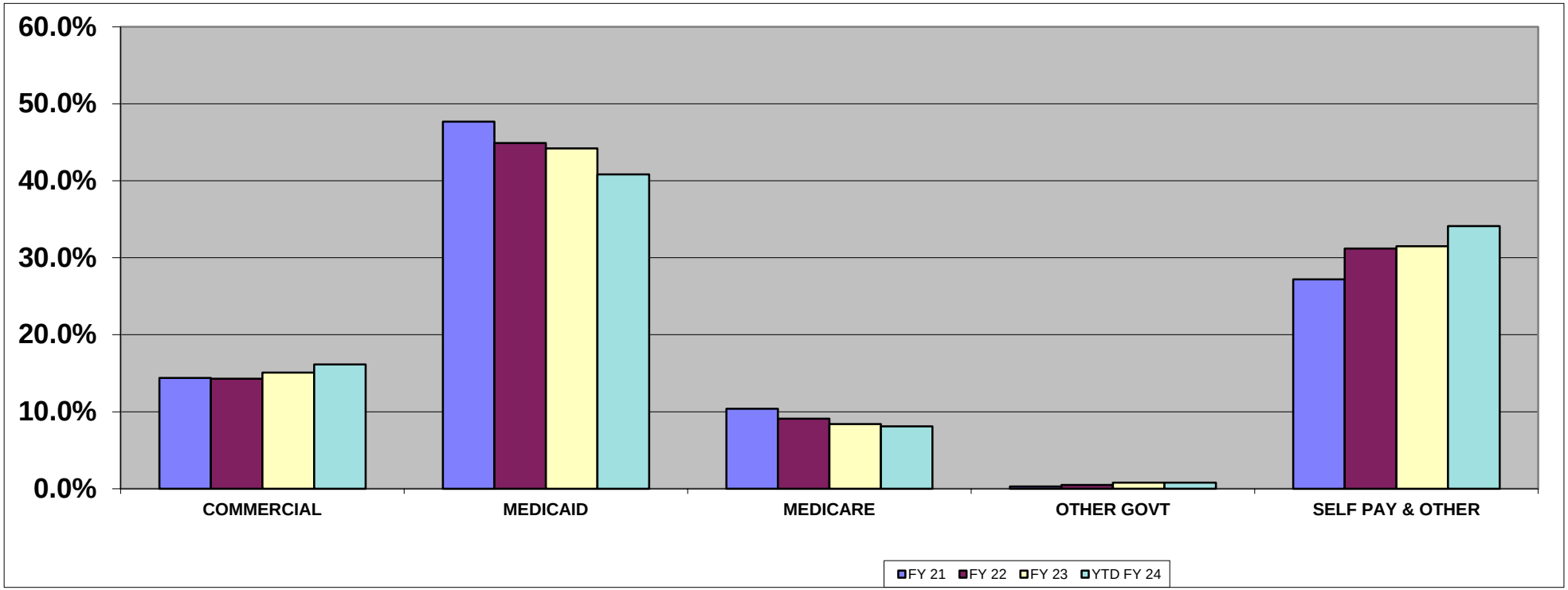
Payer	October	November	December	January	February	March
COMMERCIAL	15.6%	16.0%	16.7%	15.9%	16.9%	17.5%
MEDICAID	41.0%	40.4%	40.9%	41.5%	40.1%	39.3%
MEDICARE	8.4%	8.2%	8.0%	8.1%	7.7%	8.0%
OTHER GOVT	0.7%	0.8%	0.9%	0.9%	0.8%	0.7%
SELF PAY & OTHER	34.3%	34.6%	33.6%	33.6%	34.5%	34.6%
Total	**100.0%**	**100.0%**	**100.1%**	**100.0%**	**100.0%**	**100.0%**



Valleywise Health - Federally Qualified Health Centers
Comparison ALL FQHC Visits by Payor - 4 Year Trend

Payer	FY 21	FY 22	FY 23	YTD FY 24
COMMERCIAL	42,914	45,520	47,527	37,658
MEDICAID	142,338	142,824	139,480	95,261
MEDICARE	31,086	28,805	26,566	18,910
OTHER GOVT	939	1,737	2,422	1,858
SELF PAY & OTHER	80,977	99,276	99,230	79,569
Total	**298,254**	**318,162**	**315,225**	**233,256**

Payer	FY 21	FY 22	FY 23	YTD FY 24
COMMERCIAL	14.4%	14.3%	15.1%	16.1%
MEDICAID	47.7%	44.9%	44.2%	40.8%
MEDICARE	10.4%	9.1%	8.4%	8.1%
OTHER GOVT	0.3%	0.5%	0.8%	0.8%
SELF PAY & OTHER	27.2%	31.2%	31.5%	34.1%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**



7. Fiscal Year 2025 Patient Volumes; Discuss and Review Capital Target

Valleywise Community Health Centers Governing Council
Fiscal Year 2025 Operating Budget
Preliminary Volumes Assumptions, Provider Staffing, and Capital

Volume Assumptions

Overall

- For Fiscal Year 2025, the same methodology for forecasting volumes was utilized as FY 2024 volume forecasts.
- The visits per sessions were reviewed and forecasted in collaboration with physician and operational leadership, generally maintaining actual visits per session experienced in FY 2024 year-to-date by provider, provider type and specialty.
- As appropriate openings existed due to turnover or growth, the provider model was reviewed with regards to the Advanced Practice Providers (APPs) to Physician ratio. The APPs include Nurse Practitioners (NPs), Physician Assistants (PAs), and Certified Nurse Midwives (CNMs). Changes in the provider model were based on a collaboration with physician leadership.

Valleywise Community Health Centers (VCHCs)

- The changes in individual clinics are due to provider movements, overall increase from Projection is 6.6%
- The budget assumes the South Phoenix Laveen and Avondale clinics will have an increase of 2.30 and 1.50 FTE's, respectively.
- The budget assumes the Mobile Health Unit will be in operation by start of July 2024 with Family Practice services.

Valleywise Comprehensive Healthcare Center (VCHC) – Phoenix Clinic

- Womens has a small increase, while Peds is decreasing slightly. Overall, the increase is 0.3% over the projection.
- The assumed changes in patient and staff scheduling in Antepartum Testing causing a decrease of 12.6%.

Valleywise Comprehensive Healthcare Center (VCHC) – Peoria Clinic

- The budget assumes that assigned provider staff at Peoria will have an increase in sessions or the equivalent of 0.40 FTE's.

Dental Clinics

- Dental volumes were projected using planned providers.
- Dental offices are expected to be fully staffed for the upcoming year.
- There will be a small increase to volumes this year because of less staffing transitions due to unplanned leave that was experienced during the last year, 5.7% overall.

Integrated Behavioral Health

- In a similar manner to other Federally Qualified Health Center (FQHC) clinics, Behavioral Health departments were budgeted based on the number of providers at each location.
- Behavioral Health services are expanding and currently have providers ramping up, causing an 8.1% increase.
- 5 new provider FTE's to start in FY25.

FEDERALLY QUALIFIED HEALTH CENTERS
BUDGET FY 2025
Preliminary VISITS SUMMARY

	FY 2023	FY 2024	FY 2024 Budget		Budget Information FY 2025				
	Actual	Projection	Budget	Variance from Budget (Projection)	Proposed Budget	Variance from Projection	Variance %	Variance from FY2024 Budget	Variance %
VCHC Clinics									
FQHC CLINIC - SOUTH CENTRAL PHOENIX	25,704	21,758	21,628	0.6%	21,978	220	1.0%	350	1.6%
FQHC CLINIC - SOUTH PHOENIX LAVEEN	16,558	14,856	18,055	(17.7%)	18,273	3,417	23.0%	218	1.2%
FQHC CLINIC - AVONDALE	20,528	19,037	20,491	(7.1%)	22,416	3,379	17.7%	1,925	9.4%
FQHC CLINIC - CHANDLER	20,561	19,889	23,172	(14.2%)	19,041	(848)	(4.3%)	(4,131)	(17.8%)
FQHC CLINIC - GUADALUPE	7,912	7,317	8,805	(16.9%)	7,503	186	2.5%	(1,302)	(14.8%)
FQHC CLINIC - NORTH PHOENIX	21,331	20,145	22,336	(9.8%)	22,008	1,863	9.2%	(328)	(1.5%)
FQHC CLINIC - MCDOWELL	19,891	19,298	17,533	10.1%	18,406	(892)	(4.6%)	873	5.0%
FQHC CLINIC - WEST MARYVALE	18,106	18,275	20,126	(9.2%)	20,145	1,870	10.2%	19	0.1%
FQHC CLINIC - MESA	17,996	19,110	20,837	(8.3%)	19,448	338	1.8%	(1,389)	(6.7%)
FQHC CLINIC - MOBILE HEALTH UNIT	-	-	1,000	(100.0%)	1,000	1,000	100.0%	-	0.0%
FQHC MCDOWELL SERVICES - MESA	1,165	1,143	1,040	9.9%	1,157	14	1.2%	117	11.3%
Total	**169,752**	**160,828**	**175,023**	**(8.1%)**	**171,375**	**10,547**	**6.6%**	**(3,648)**	**(2.1%)**
% Change compared to Prior Year		-5.3%							
OP BH Clinics									
BH FQHC - SOUTH CENTRAL PHOENIX	3,855	2,783	4,310	(35.4%)	3,216	433	15.6%	(1,094)	(25.4%)
BH FQHC - SOUTH PHOENIX LAVEEN	1,157	1,832	1,925	(4.8%)	2,468	636	34.7%	543	28.2%
BH FQHC - AVONDALE	2,858	3,288	3,267	0.6%	3,791	503	15.3%	524	16.0%
BH FQHC - CHANDLER	1,431	2,196	1,852	18.6%	2,170	(26)	(1.2%)	318	17.2%
BH FQHC - GUADALUPE	1,746	1,847	1,794	3.0%	1,357	(490)	(26.5%)	(437)	(24.4%)
BH FQHC - NORTH PHOENIX	1,223	2,121	1,557	36.2%	2,179	58	2.7%	622	40.0%
BH FQHC - PEORIA	4,343	4,271	4,382	(2.5%)	3,327	(944)	(22.1%)	(1,055)	(24.1%)
BH FQHC - MESA	3,471	4,560	3,966	15.0%	3,772	(788)	(17.3%)	(194)	(4.9%)
BH FQHC - WEST MARYVALE	1,762	1,848	1,691	9.3%	2,780	932	50.4%	1,089	64.4%
BH FQHC - PSYCHIATRY	3,217	4,323	2,889	49.6%	4,612	289	6.7%	1,723	59.6%
BH FQHC - PHOENIX	36	1,151	611	88.4%	2,998	1,847	160.5%	2,387	390.7%
Total	**25,099**	**30,220**	**28,244**	**7.0%**	**32,671**	**2,451**	**8.1%**	**4,427**	**15.7%**
% Change compared to Prior Year		20.4%							
Comprehensive Health Center-Peoria									
FQHC PRIMARY CARE - PEORIA	27,328	26,589	29,451	(9.7%)	28,416	1,827	6.9%	(1,035)	(3.5%)
Total	**27,328**	**26,589**	**29,451**	**(9.7%)**	**28,416**	**1,827**	**6.9%**	**(1,035)**	**(3.5%)**
% Change compared to Prior Year		-2.7%							
VCHC - Phoenix Clinics									
FQHC WOMENS CARE - PHOENIX	20,716	20,543	20,227	1.6%	22,468	1,925	9.4%	2,241	11.1%
FQHC ANTEPARTUM TESTING - PHOENIX	9,452	10,868	9,538	13.9%	9,502	(1,366)	(12.6%)	(36)	(0.4%)
FQHC DIABETES CARE - PHOENIX	1,581	1,386	1,438	(3.6%)	1,505	119	8.6%	67	4.7%
FQHC PEDIATRIC CLINIC - PHOENIX	18,381	17,384	17,950	(3.2%)	16,650	(734)	(4.2%)	(1,300)	(7.2%)
FQHC MEDICINE CLINIC - PHOENIX	18,960	18,779	20,104	(6.6%)	19,074	295	1.6%	(1,030)	(5.1%)
Total	**69,090**	**68,960**	**69,257**	**(0.4%)**	**69,199**	**239**	**0.3%**	**(58)**	**(0.1%)**
% Change compared to Prior Year		-0.2%							
Dental Clinics									
FQHC DENTAL - PHOENIX	9,932	9,632	9,727	(1.0%)	9,727	95	1.0%	-	0.0%
FQHC DENTAL - CHANDLER	2,520	3,009	2,582	16.5%	3,063	54	1.8%	481	18.6%
FQHC DENTAL - AVONDALE	2,681	2,828	2,601	8.7%	2,875	47	1.7%	274	10.5%
FQHC DENTAL - MCDOWELL	3,804	3,240	3,771	(14.1%)	3,500	260	8.0%	(271)	(7.2%)
FQHC DENTAL - PEORIA	5,019	5,135	5,039	1.9%	5,200	65	1.3%	161	3.2%
Total	**23,956**	**23,844**	**23,720**	**0.5%**	**24,365**	**521**	**2.2%**	**645**	**2.7%**
% Change compared to Prior Year		-0.5%							
Grand Totals	**315,225**	**310,441**	**325,695**	**(4.7%)**	**326,026**	**15,585**	**5.0%**	**331**	**0.1%**
% Change compared to Prior Year		-1.5%							

DMG Provider Staffing

The schedule below is the preliminary planned District Medical Group provider staffing by location.

	COST CENTER and DESCRIPTION		FYE 2022	FYE 2023	FYE 2024	FYE 2025
Total Providers FTEs	416601	FQHC CLINIC - SOUTH CENTRAL PHOENIX	6.42	6.10	5.18	5.45
	416603	FQHC CLINIC - AVONDALE	6.51	5.92	7.14	8.61
	416608	FQHC CLINIC - CHANDLER	6.05	5.91	6.03	5.61
	416609	FQHC CLINIC - GUADALUPE	2.78	2.57	2.52	2.56
	416613	FQHC CLINIC - MCDOWELL	9.44	8.72	8.90	8.30
	416701	FQHC CLINIC - SOUTH PHOENIX LAVEEN	5.42	5.62	4.60	6.88
	416704	FQHC CLINIC - WEST MARYVALE	3.43	5.39	5.44	6.26
	416707	FQHC CLINIC - MESA	2.50	5.92	6.55	6.35
	416711	FQHC CLINIC - NORTH PHOENIX	6.53	6.79	7.26	7.67
	476707	FQHC MCDOWELL SERVICES - MESA	0.14	0.45	0.44	0.44
	576130	FQHC MCDOWELL SERVICES - PEORIA	0.37	0.00	0.00	0.00
	476101	FQHC WOMENS CARE - PHOENIX	6.23	6.77	7.12	7.49
	476105	FQHC PEDIATRIC CLINIC - PHOENIX	5.52	4.82	4.98	5.09
	476106	FQHC MEDICINE CLINIC - PHOENIX	6.04	5.99	5.76	5.87
	576101	FQHC PRIMARY CARE - PEORIA	9.62	9.19	10.17	10.56
	416750	FQHC CLINIC - MOBILE HEALTH UNIT	0.00	0.00	0.00	0.50
		TOTAL	**77.00**	**80.16**	**82.09**	**87.64**

Capital

- Currently, Contingency Capital is preliminarily planned at $100K, which is in line with prior year.

8. Uniform Guidance audit for fiscal year ending June 30, 2023 and 2022

Maricopa County
Special Health Care District

Hospital Administration & Finance
2601 E. Roosevelt
Phoenix, AZ 85008
Phone: (602) 344-8428

DATE: April 24, 2024

TO: Valleywise Community Health Centers Governing Council

FROM: Claire Agnew, EVP, Chief Financial Officer

SUBJECT: Audited Financial Statements, Reports, Supplementary Information and Schedule Required by the Uniform Guidance, FYE June 30, 2023 and 2022

Accountability and transparency of federal award spending is necessary for effective stewardship of these federal funds, and the audit and reporting under the Office of Management and Budget's (OMB) *Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards* (commonly called "Uniform Guidance") is to fulfill this requirement.

The *Audited Financial Statements, Reports, Supplementary Information and Schedule Required by the Uniform Guidance for the years ended June 30, 2023 and 2022* is attached for acceptance by the Valleywise Health Centers Governing Council (the Council). This report will be shared with the Valleywise Health's Finance, Audit and Compliance Committee on April 17th, 2024.

The annual audit for fiscal year ending June 30, 2023, was received by the Council previously. Like in most recent years, the audit report did not include the results of the Uniform Guidance audit for the same time period as this audit has a different due date; nine months after the fiscal period end date as set by the Office of Management and Budget for fiscal year 2023.

The added section regarding the Uniform Guidance audit begins on **page 56**. The Schedule of Findings and Questionable Costs on **page 65** indicates that there were no material weaknesses nor significant deficiencies identified in the audit.

Also attached are presentation slides from auditors EY on the results of the FY2023 Uniform Guidance results.

Maricopa County Special Health Care District (Valleywise Health)

2023 Uniform Guidance audit results

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Uniform Guidance audit results

A summary of the results of the Office of Management and Budget Uniform Guidance audit is presented below:

Summary of audit results	2023
Financial statement section	
Type of auditor's report issued (unmodified, qualified, adverse, or disclaimer)	Unmodified
Internal control over financial reporting:	
• Material weakness(es) identified	No
• Significant deficiency(ies) identified	No
• Noncompliance material to financial statements noted	No
Federal awards section	
Internal control over major programs:	
• Material weakness(es) identified	No
• Significant deficiency(ies) identified	No
Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)	No
Major programs and type of auditor's report on compliance for major programs (unmodified, qualified, adverse, or disclaimer)	
• WIOA Cluster	Unmodified
• Assistance Listing Number 21.027 — COVID-19 — Coronavirus State and Local Fiscal Recovery Funds	Unmodified
• Health Center Program Cluster	Unmodified
• Assistance Listing Number 93.498 — COVID-19 — Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution	Unmodified
• Assistance Listing Number 93.917 — HIV Care Formula Grants	Unmodified
• Assistance Listing Number 93.918 — Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	Unmodified
Federal award expenditures section	
WIOA Cluster	$5,000,000
Assistance Listing Number 21.027 — COVID-19 — Coronavirus State and Local Fiscal Recovery Funds	$12,086,006
Health Center Program Cluster	$9,499,937
Assistance Listing Number 93.498 — COVID-19 — Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution	$12,784,970
Assistance Listing Number 93.917 — HIV Care Formula Grants	$2,160,898
Assistance Listing Number 93.918 — Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	$785,270
Total Expenditures of Federal Awards	$49,653,305

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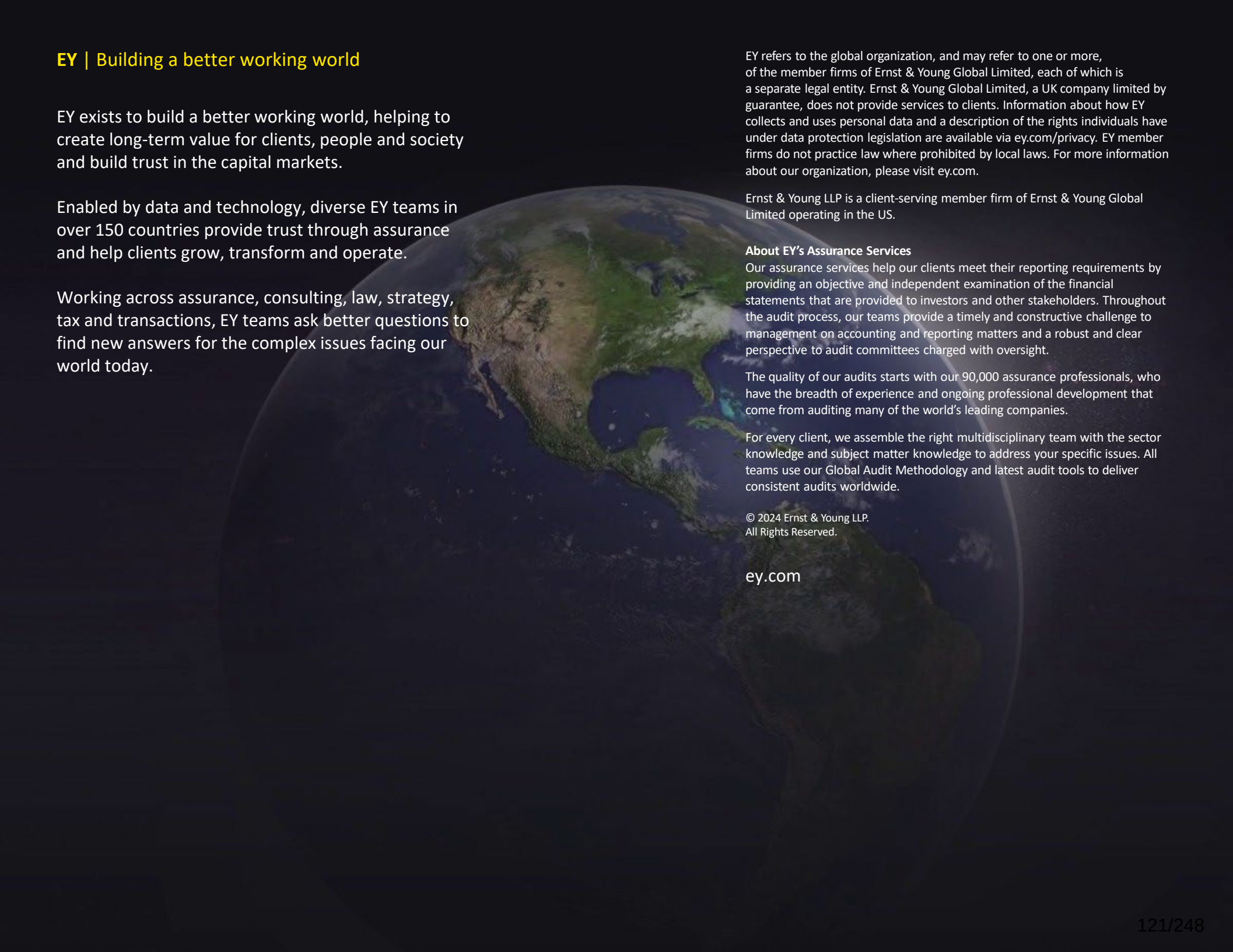

About EY's Assurance Services

Our assurance services help our clients meet their reporting requirements by providing an objective and independent examination of the financial statements that are provided to investors and other stakeholders. Throughout the audit process, our teams provide a timely and constructive challenge to management on accounting and reporting matters and a robust and clear perspective to audit committees charged with oversight.

The quality of our audits starts with our 90,000 assurance professionals, who have the breadth of experience and ongoing professional development that come from auditing many of the world's leading companies.

For every client, we assemble the right multidisciplinary team with the sector knowledge and subject matter knowledge to address your specific issues. All teams use our Global Audit Methodology and latest audit tools to deliver consistent audits worldwide.

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Financial Statements, Required Supplementary Information, Reports, Supplementary Information, and Schedule Required By The Uniform Guidance

Maricopa County Special Health Care District
d/b/a Valleywise Health
Years Ended June 30, 2023 and 2022
With Reports of Independent Auditors

Ernst & Young LLP

Maricopa County Special Health Care District
d/b/a Valleywise Health

Financial Statements, Required Supplementary Information, Reports, Supplementary Information, and Schedule Required by the Uniform Guidance

Years Ended June 30, 2023 and 2022

Contents

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Report of Independent Auditors

Management and the Board of Directors
Maricopa County Special Health Care District
d/b/a Valleywise Health

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of the Maricopa County Special Health Care District d/b/a Valleywise Health (the District), as of and for the years ended June 30, 2023 and 2022, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of the District at June 30, 2023 and 2022, and the respective changes in financial position, and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States *(Government Auditing Standards)*. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the District and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

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Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis, the Schedule of District's Proportionate Share of the Net Pension Liability, the Schedule of District's Proportionate Share of the Net OPEB Liability (Asset), the Schedule of Contributions – Pension Plan, and the Schedule of Contributions – OPEB be presented to supplement the financial statements. Such information is the responsibility of management and, although not a part of the financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

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Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise the District's financial statements. We have not performed any procedures with respect to the audited financial statements that collectively comprise the financial statements subsequent to November 21, 2023. The Schedule of Expenditures of Federal Awards, as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards,* is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the Schedule of Expenditures of Federal Awards is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Information

Management is responsible for the other information included in the annual report. The other information comprises the Management's Discussion and Analysis but does not include the financial statements and our auditor's report thereon. Our opinion on the financial statements do not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 21, 2023 on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

Ernst & Young LLP

November 21, 2023, except for our report on the Schedule of Expenditures of Federal Awards, for which the date is March 22, 2024.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Management's Discussion and Analysis

Years Ended June 30, 2023 and 2022

The following discussion and analysis of the operational and financial performance of Maricopa County Special Health Care District d/b/a Valleywise Health (the District) provides an overview of the financial position and activities for the years ended June 30, 2023 and 2022. This discussion has been prepared by management and should be read in conjunction with the accompanying financial statements, as well as the notes to the financial statements, which follow this section. The financial statements discussed in this section offer short-term and long-term financial information about the District's activities, including:

Statements of Net Position: This statement includes all of the District's assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position and provides information about the nature and amounts of investments in resources (assets) and the obligations of the District to creditors (liabilities). It also provides the basis for evaluating the capital structure, and assessing the liquidity and financial flexibility of the District.

Statements of Revenues, Expenses and Changes in Net Position: This statement accounts for all of the current year's revenues and expenses, measures changes in operations over the past two years, and can be used to determine whether the District has been able to recover all of its costs through several revenue sources.

Statements of Cash Flows: The primary purpose of this statement is to answer questions such as where cash came from, what cash was used for, and what was the change in the cash balance during the reporting period.

Organizational Overview

Founded in 1877, the District has served as Maricopa County's public teaching hospital and safety net system, filling critical gaps in care for underserved populations. In partnership with District Medical Group, an unrelated not-for-profit entity, the District provides care throughout Maricopa County.

The District is an academic training center, a regional provider of primary and specialized medical services, and a leading provider of mental health services. It provides clinical rotations each year for allopathic and osteopathic medical students, nursing students, and allied health professionals.

Licensed for 758 beds, the District provides a full range of inpatient acute and intensive care, inpatient and outpatient behavioral health, and a full complement of ancillary, support, and ambulatory services. The facilities that are housed on the District's main campus include:

- Valleywise Health Medical Center
- Valleywise Health – Arizona Burn Center
- Valleywise Comprehensive Health Center – Phoenix
- Valleywise Behavioral Health Center – Phoenix

The facilities that are located external to the main campus include:

- Valleywise Behavioral Health Center – Maryvale
- Valleywise Behavioral Health Center – Mesa
- Valleywise Comprehensive Health Center – Peoria

Ambulatory care is also provided at nine Community Health Centers located throughout Maricopa County. In addition to ambulatory services, many of these locations offer outpatient behavioral health and dental services.

Care Reimagined

On November 4, 2014, the voters of Maricopa County approved Proposition 480. Proposition 480 allows the District to issue up to $935,000,000 in general obligation bonds to be repaid in 30 years to fund outpatient health facilities, including improvement or replacement of existing outpatient health centers, a behavioral health hospital, and the construction of a new acute medical center

In 2017, the District Board set a roadmap for our organization's future by receiving the final report resulting from the Proposition 480 implementation planning initiative. This plan, known as Care Reimagined, will ensure our organization continues to be recognized for high-quality care, innovation, and service. It creates a better model of patient care and medical education that improves access, quality, cost, and outcomes for patients and increases the supply of future health care professionals.

The implementation of this capital plan is well underway; through June 30, 2023, $817,790,916 of the bond proceeds have been expended. During fiscal year 2023, the majority of project funds

were expended on the main campus for the construction of the new hospital scheduled to be complete in April 2024. The Comprehensive Health Center-Peoria (Peoria) project has been completed and opened in January 2021. Peoria includes an outpatient surgery center, endoscopy suites, dialysis services, primary and specialty clinics, and a family learning center. Two new Community Health Centers, in Mesa and West Maryvale, opened during fiscal year 2022, replacing old clinics at Mesa and Maryvale locations.

The District was authorized to issue $935,000,000, in aggregate, principal amount toward the Care Reimagined project. Through June 30, 2023, all of the District's authorized amount has been issued.

Financial Highlights

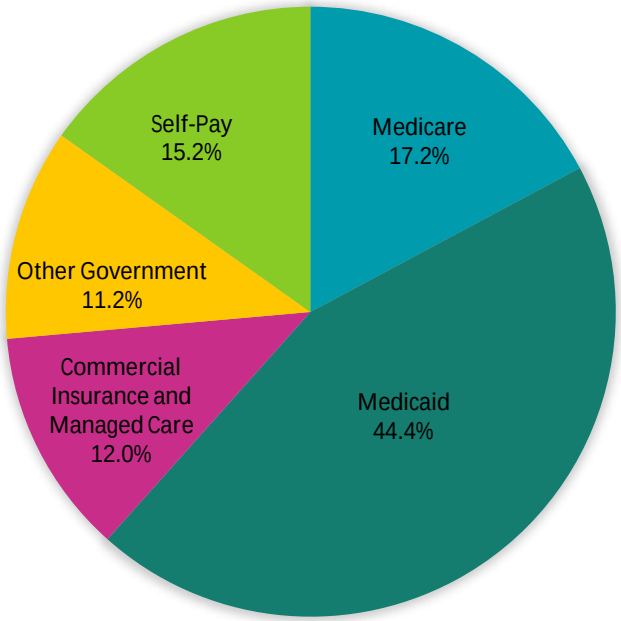
Year Ended June 30, 2023, Compared to Year Ended June 30, 2022	Year Ended June 30, 2022, Compared to Year Ended June 30, 2021
Net patient services revenue increased by $14.7 million or 3.0% from the prior year 2022. Other operating revenue increased $56.0 million, largely due to an increase in the new Arizona Health Care Cost Containment System (AHCCCS) program, HEALTHII, GME, 340B and retail pharmacy sales, and grant program related revenues.	Net patient services revenue increased by $5.4 million or 1.1% from the prior year 2021. Other operating revenue increased $3.5 million, largely due to an increase in the new Arizona Health Care Cost Containment System (AHCCCS) program, HEALTHII, and grant program related revenues.
Operating expense increased from $815.3 million in 2022 to $878.5 million in 2023, a $63.2 million or 7.8% increase from the prior year. These are largely due to the increase in salaries and outside contract labor usage due to staffing shortage and increase usage of supplies as part of higher cost of treating patients and related illnesses.	Operating expense increased from $755.1 million in 2021 to $815.3 million in 2022, a $60.2 million or 8.0% increase from the prior year. These are largely due to the increase in salaries and outside contract labor usage due to staffing shortage and increase usage of supplies as part of higher cost of treating patients with COVID-19 and related illnesses.

Gross charges by major payor financial class for fiscal years 2023, 2022, and 2021 are as follows:

	Year Ended June 30		
	2023	**2022**	**2021**
Medicare	17.2%	18.4%	18.5%
Medicaid	44.4	42.2	44.4
Commercial insurance and managed care	12.0	13.0	12.2
Other government	11.2	11.9	12.8
Self-pay	15.2	14.5	12.1
Total	100.0%	100.0%	100.0%

During fiscal year 2023, the District experienced an increase number of self pay/uninsured patients and significant decrease of Medicare patients. During fiscal year 2022, the District experienced an increased number of self pay/uninsured patients and significant decrease of Medicaid patients.

Year Ended June 30, 2023 Payor Mix

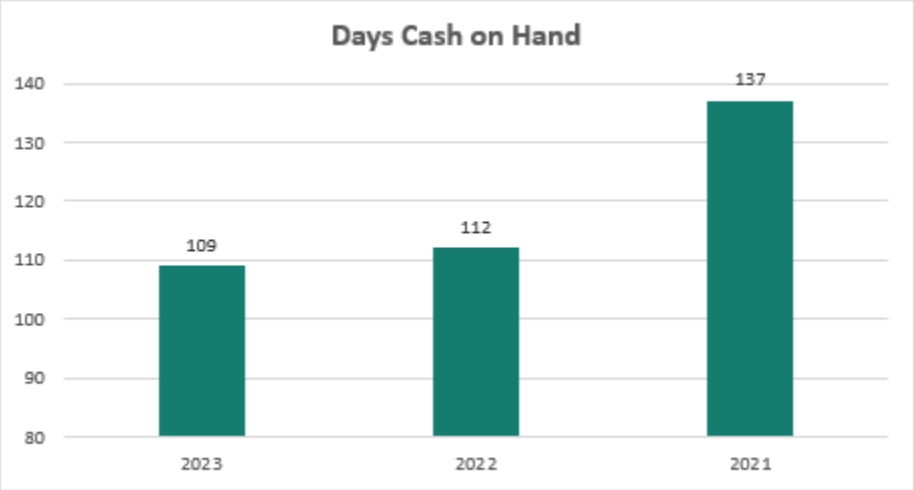


Condensed Statements of Net Position

	Year Ended June 30		
	2023	**2022**	**2021**
Assets			
Current assets	**$ 471,654,469**	$ 517,466,741	$ 526,969,313
Other assets	**125,536,461**	236,513,174	409,633,599
Capital assets	**796,596,154**	723,183,812	594,155,126
Total assets	**1,393,787,264**	1,477,163,727	1,530,758,038
Deferred outflows of resources	**56,462,313**	84,873,429	89,357,989
Liabilities			
Current liabilities	**232,589,943**	236,666,466	206,915,919
Risk claim payable, less current portion	**13,784,858**	12,512,090	9,283,822
Net pension and OPEB liability	**356,444,643**	287,090,884	394,175,117
Long-term debt	**645,751,295**	682,637,421	736,509,938
Total liabilities	**1,248,570,739**	1,218,906,861	1,346,884,796
Deferred inflows of resources	**18,778,412**	104,660,022	3,972,294
Net position			
Unrestricted deficit	**(307,808,207)**	(394,856,298)	(510,048,594)
Net investment in capital assets	**281,653,768**	296,238,100	298,100,940
Restricted for bonds	**166,504,192**	306,922,948	477,027,521
Restricted for grants	**42,550,673**	30,165,523	4,179,070
Total net position	**$ 182,900,426**	$ 238,470,273	$ 269,258,937

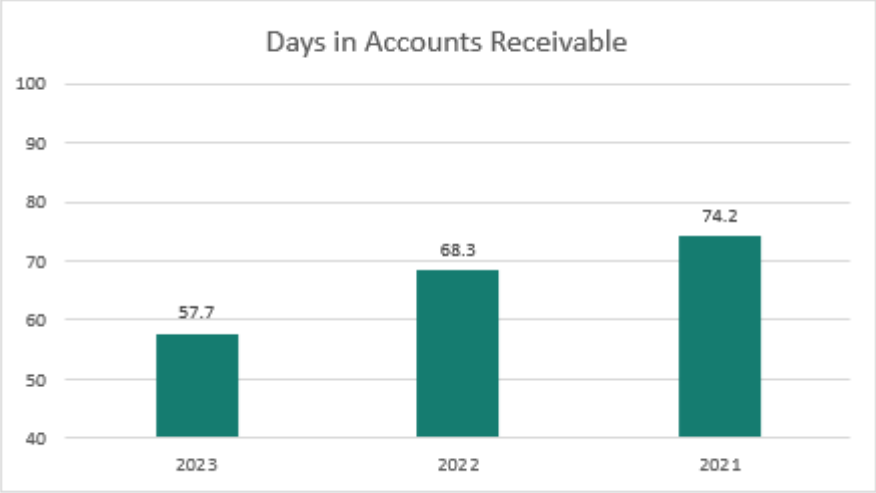
Cash and Cash Equivalents

Unrestricted cash and cash equivalents for fiscal year 2023 were approximately $241.2 million, an increase of approximately $7.8 million from the $233.4 million in fiscal year 2022. Days cash on hand decreased 2.5 days to 109.2 days in fiscal year 2023 from the fiscal year 2022 days of 111.7. This decrease in cash is due to increase in operating expenses specifically in salaries, wages, benefits, and purchased services. Unrestricted cash and cash equivalents for fiscal year 2022 were approximately $233.4 million, a decrease of approximately $28.8 million from fiscal year 2021. Days cash on hand decreased 25.8 days to 111.7 days in fiscal year 2022 from the fiscal year 2021 days of 137.5. Increased operating expenses primarily in labor costs contributed to the decrease in days cash on hand.



Accounts Receivable – Days Outstanding

While net accounts receivable decreased by approximately $6.9 million in fiscal year 2023 from fiscal year 2022, net days in accounts receivable decreased from the prior year by approximately 15.5%, from 68.3 to 57.7 days. Net account receivable in fiscal year 2022 decreased by $6.8 million from fiscal year 2021 and net days also decreased by 7.9% from 74.2 to 68.3 days. Increased cash collections contributed to the decrease in account receivable and number of days in fiscal year 2023 from fiscal year 2022 and the decrease in fiscal year 2022 from fiscal year 2021.



Capital Assets

As of June 30, 2023, 2022, and 2021 the District had $796.6 million , $723.2 million, and $594.2 million, respectively, and invested in capital assets, net of accumulated depreciation. For the years ended June 30, 2023, 2022 and 2021, the District purchased capital assets amounting to $129.3 million, $181.3 million, and $151.3 million, respectively. The organization has made significant investments in new facilities through the Care Reimagined project and plans to continue this investment within the coming years. These investments include:

- New Community Health Centers, which opened in 2022, providing ambulatory care in different cities of Maricopa County.
- New acute care hospital (Valleywise Health Medical Center), currently under construction and planned to be completed in April 2024.

Debt

As of June 30, 2023, 2022, and 2021, the District had bonds payable of $666.9 million $718.3 million, and $763.0 million, respectively. As set forth in the voter-approved Proposition 480 language, bond proceeds are used to purchase various equipment and to fund various improvement projects on the District's existing acute behavioral health facilities and outpatient health centers.

The following table summarizes net operating revenues, operating expenses, and non-operating revenues (expenses) for the fiscal years ended June 30, 2023, 2022, and 2021.

	Year Ended June 30		
	2023	**2022**	**2021**
Operating revenues			
Net patient service revenue	**$ 509,398,504**	$ 494,650,061	$ 489,209,495
AHCCS medical education revenue	**50,659,492**	47,113,700	51,866,779
Other revenue	**126,703,335**	74,234,388	66,022,660
Total operating revenues	**686,761,331**	615,998,149	607,098,934
Operating expenses			
Salaries and wages	**296,737,796**	287,796,627	278,443,621
Employee benefits	**99,974,978**	82,744,342	105,599,319
Purchased services	**258,558,270**	209,273,236	144,360,745
Medical claims and other expenses	**68,529,325**	81,838,190	72,572,408
Supplies	**98,744,775**	101,359,687	92,262,465
Depreciation	**55,921,558**	52,241,569	58,845,414
Total operating expenses	**878,466,702**	815,253,651	755,083,972
Operating loss	**(191,705,371)**	(199,255,502)	(147,985,038)
Nonoperating revenues (expenses)			
Property tax receipts	**138,392,868**	147,491,236	139,606,198
Noncapital grants	**9,263,795**	5,930,243	5,890,625
Noncapital subsidies from State	**3,547,896**	3,547,896	3,547,896
Other nonoperating revenues (expenses), net	**(4,246,685)**	27,834,946	3,212,369
Interest income	**7,601,696**	3,731,217	2,031,886
Interest expense	**(18,424,046)**	(20,068,700)	(15,027,454)
Total nonoperating revenues	**136,135,254**	168,466,838	139,261,520
Decrease in net position	**(55,569,847)**	(30,788,664)	(8,723,518)
Net position, beginning of year	**238,470,273**	269,258,937	277,982,455
Net position, end of year	**$ 182,900,426**	$ 238,470,273	$ 269,258,937

Revenues

Net Patient Services Revenue

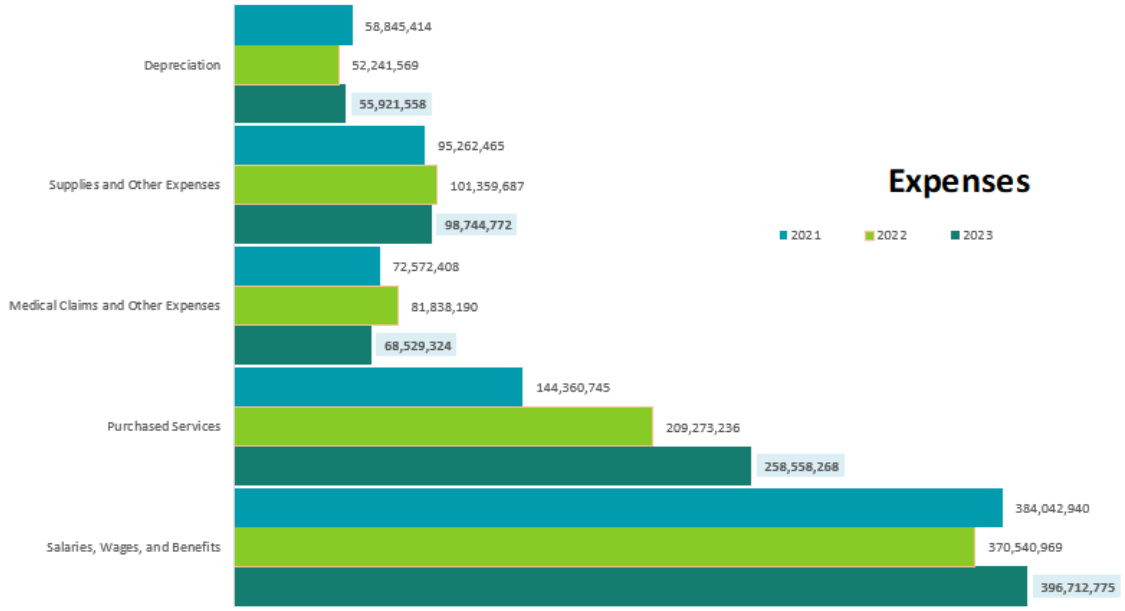
Net patient service revenue is derived from inpatient, outpatient, ambulatory, and emergency services provided to patients. Net patient service revenue for the year ended June 30, 2023, was $509.4 million, an increase from the prior year net patient service revenue of $494.7 million. Net patient service revenue increased $14.7 million or 3.0% in the year ended June 30, 2023, mainly due to changes in payor mix and volume increases in the ambulatory areas. Net patient service revenue for the year ended June 30, 2022, was $494.7 million, an increase from the prior year net patient service revenue of $489.2 million. Net patient service revenue increased $5.5 million or 1.1% in the year ended June 30, 2022, due to changes in payor mix.

	Year Ended June 30		
	2023	**2022**	**Increase (Decrease)**
Gross charges	**$ 2,617,939,822**	$ 2,562,415,380	2.2%
Contractual deductions	**1,873,553,660**	1,728,490,890	8.4%
As a percentage of gross charges	**(71.6)%**	(67.5)%	
Charity care	**209,374,248**	312,132,097	(32.9%)
As a percentage of gross charges	**(8.0)%**	(12.2)%	
Bad debt	**25,613,410**	27,142,332	(14.4%)
As a percentage of gross charges	**(1.0)%**	(1.1)%	
Net patient service revenue	**$ 509,398,504**	$ 494,560,061	3.0%
As a percentage of gross charges	**19.5%**	19.3%	

Total operating revenues in fiscal year 2023 were $686.8 million in comparison with the prior year of $616.0 million, due in great part to the quality of gross revenue and improved payor mix as noted above and increased other revenues, mainly in the new AHCCCS program, HEALTHII and increased grant programs related revenues.

Operating Expenses

Total operating expenses in fiscal year 2023 were $878.5 million, which is an increase of $63.2 million (7.8%) over the prior year operating expenses of $815.3 million. Total operating expenses in fiscal year 2022 were $815.3 million, which is an increase of $60.2 million (8.0%) over fiscal year 2021 operating expenses of $755.1 million. The primary driver of the year over year increases were driven by labor expenses, specifically contract labor.



Nonoperating Revenues and Expenses

Nonoperating revenues and expenses consist primarily of property tax receipts, both for maintenance and operation, bond debt service, and CARES Act funding. These amounts were $100.7 million, $37.7 million, and $0.4 million, respectively, for the year ended June 30, 2023, $89.5 million, $58.0 million, and $43.9 million respectively, for the year ended June 30, 2022, and $84.2 million, $55.4 million, and $18.2 million, respectively, for the year ended June 30, 2021. Also included in nonoperating revenues are noncapital grants and noncapital subsidies from the state. These amounts were $9.3 million and $3.5 million, respectively, for the year ended June 30, 2023, $5.9 million and $3.5 million, respectively, for the year ended June 30, 2022, and $5.9 million and $3.5 million, respectively, for the year ended June 30, 2021. Other nonoperating revenues and expenses consisted primarily of other revenue (expenses) from subsidies, interest income, and interest expense. These amounts were ($4.2) million, $7.6 million and ($18.4) million, respectively, for the year ended June 30, 2023, $27.8 million, $3.7 million and ($20.1) million, respectively, for the year ended June 30, 2022, and $3.2 million, $2.0 million and ($15.0) million, respectively, for the year ended June 30, 2021. A majority of the changes year over year in subsidies was due timing of payments received related to Provider Relief Funds. The year over year changes in interest income was due to changes in prevailing market conditions that influenced increase in interest rates. The interest expense year over year fluctuates based on the bond amortization schedule.

Contacting the District's Financial Management

This financial report is designed to provide the District's patients, suppliers, community members, and creditors with a general overview of the District's finances and to show the District's accountability for the money it receives. Questions about this report and requests for additional financial information should be directed to District Administration by telephoning (602) 344-8425.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Net Position

	Year Ended June 30 2023	2022
Assets		
Current assets:		
Cash and cash equivalents	**$ 241,214,127**	$ 233,412,109
Restricted cash – bond	**48,489,150**	77,286,783
Patient accounts receivable, net of allowances	**85,709,368**	92,605,989
Receivable from AHCCCS for medical education, net	**49,894,607**	46,875,590
Other receivables	**17,263,119**	39,377,126
Due from related parties	**3,376,279**	1,721,769
Supplies	**12,217,206**	11,730,777
Prepaid expenses	**13,490,793**	14,456,598
Total current assets	**471,654,649**	517,466,741
Other assets:		
Restricted cash – bond	**118,015,042**	229,636,165
Other assets	**7,521,419**	6,877,009
Total other assets	**125,536,461**	236,513,174
Capital assets:		
Land	**35,325,278**	35,615,279
Depreciable capital assets, net of accumulated depreciation	**761,270,876**	687,568,533
Total capital assets, net of accumulated depreciation	**796,596,154**	723,183,812
Total assets	**1,393,787,264**	1,477,163,727
Deferred outflows of resources		
Employer contributions made after measurement date	**34,467,520**	34,248,240
Difference between expected and actual experience	**3,256,622**	4,677,652
Changes in assumptions	**18,643,716**	39,477,696
Change in proportion and differences between employer contributions and proportionate share of contributions	**94,455**	6,469,841
Total deferred outflows of resources	**$ 56,462,313**	$ 84,873,429

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Net Position (continued)

	Year Ended June 30 2023	2022
Liabilities and net position		
Current liabilities:		
Current maturities of long-term debt	**$ 26,130,000**	$ 40,351,007
Accounts payable	**79,974,978**	56,365,202
Accrued payroll and expenses	**28,158,703**	38,205,132
Risk claims payable, current portion	**513,856**	553,457
Overpayments from third-party payors	**10,506,859**	29,549,513
Other current liabilities	**87,305,547**	71,642,155
Total current liabilities	**232,589,943**	236,666,466
Risk claims payable, less current portion	**13,784,858**	12,512,090
Net pension and OPEB liability	**356,444,643**	287,090,884
Other liabilities	**5,005,017**	4,699,069
Long-term debt	**640,746,278**	677,938,352
Total liabilities	**1,248,570,739**	1,218,906,861
Deferred inflows of resources		
Difference between expected and actual experience	**6,758,096**	3,937,296
Change in assumptions	**874,912**	1,052,464
Difference between projected and actual investment earnings	**10,161,450**	98,870,631
Change in proportion and differences between employer contributions and proportionate share of contributions	**983,954**	799,631
Total deferred inflows of resources	**18,778,412**	104,660,022
Net position		
Unrestricted deficit	**(307,808,207)**	(394,856,298)
Net investment in capital assets	**281,653,768**	296,238,100
Restricted for bonds	**166,504,192**	306,922,948
Restricted for grants	**42,550,673**	30,165,523
Total net position	**$ 182,900,426**	$ 238,470,273

See accompanying notes.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Revenues, Expenses and Changes in Net Position

	Year Ended June 30	
	2023	**2022**
Operating revenues		
Net patient service revenue	**$ 509,398,504**	$ 494,650,061
AHCCCS medical education revenue	**50,659,492**	47,113,700
Other revenue	**126,703,335**	74,234,388
Total operating revenues	**686,761,331**	615,998,149
Operating expenses		
Salaries and wages	**296,737,796**	287,796,627
Employee benefits	**99,974,978**	82,744,342
Purchased services	**258,558,270**	209,273,236
Medical claims and other expenses	**68,529,325**	81,838,190
Supplies	**98,744,775**	101,359,687
Depreciation	**55,921,558**	52,241,569
Total operating expenses	**878,466,702**	815,253,651
Operating loss	**(191,705,371)**	(199,255,502)
Nonoperating revenues (expenses)		
Property tax receipts	**138,392,868**	147,491,236
Noncapital grants	**9,263,795**	5,930,243
Noncapital subsidies from State	**3,547,896**	3,547,896
Other nonoperating (expenses) revenues, net	**(4,246,685)**	27,834,946
Interest income	**7,601,696**	3,731,216
Interest expense	**(18,424,046)**	(20,068,700)
Total nonoperating revenues, net	**136,135,524**	168,466,838
Decrease in net position	**(55,569,847)**	(30,788,664)
Net position, beginning of year	**238,470,273**	269,258,937
Net position, end of year	**$ 182,900,426**	$ 238,470,273

See accompanying notes.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Cash Flows

	Year Ended June 30	
	2023	**2022**
Operating activities		
Receipts from and on behalf of patients	**$ 516,295,125**	$ 501,458,115
Payments to suppliers and contractors	**(385,185,121)**	(388,718,427)
Payments to employees	**(394,875,938)**	(478,790,701)
Other operating receipts	**194,803,307**	237,497,910
Other operating payments	**(19,042,654)**	(12,895,861)
Net cash used in operating activities	**(88,005,281)**	(141,448,964)
Noncapital financing activities		
Property tax receipts supporting operations	**100,676,385**	89,530,796
Noncapital contributions and grants received	**9,263,795**	5,930,243
Noncapital subsidies and other nonoperating receipts	**(698,789)**	31,382,842
Net cash provided by noncapital financing activities	**109,241,391**	126,843,881
Capital and related financing activities		
Property tax receipts for debt service	**37,716,483**	57,960,440
Principal payments on long-term debt and capital leases	**(51,413,081)**	(44,678,125)
Purchase of capital assets	**(129,333,900)**	(181,270,255)
Interest paid on long-term debt	**(18,424,046)**	(20,068,700)
Net cash used in capital and related financing activities	**(161,454,544)**	(188,056,640)
Investing activities		
Interest from cash pool	**7,601,696**	3,731,217
Net cash provided by investing activities	**7,601,696**	3,731,217
Decrease in cash and cash equivalents	**(132,616,738)**	(198,930,506)
Cash and cash equivalents, beginning of year	**540,335,057**	739,265,563
Cash and cash equivalents, end of year	**$ 407,718,319**	$ 540,335,057

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Cash Flows (continued)

	Year Ended June 30	
	2023	**2022**
Reconciliation of operating loss to net cash used in operating activities		
Operating loss	**$ (191,705,371)**	$ (199,255,502)
Depreciation	**55,921,558**	52,241,569
Changes in operating assets and liabilities:		
Patient and other accounts receivable, and other assets	**54,402,727**	(15,415,921)
Due from related parties	**(1,654,510)**	44,696
Supplies and prepaid expenses	**479,376**	(2,803,266)
Overpayments from third-party payors	**(19,042,654)**	(12,895,861)
Risk claims payable	**1,233,167**	2,033,963
Accounts payable and accrued liabilities	**12,360,426**	34,601,358
Net cash used in operating activities	**$ (88,005,281)**	$ (141,448,964)

See accompanying notes.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Notes to Financial Statements

June 30, 2023

1. Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations and Reporting Entity

Maricopa County Special Health Care District d/b/a Valleywise Health (the District) is a health care district and political subdivision of the state of Arizona. The District is located in Phoenix, Arizona, and is governed by a five-member Board of Directors elected by voters within Maricopa County, Arizona (the County).

The District was created in November 2003 by an election of the voters of the County. In November 2004, the voters first elected the District's governing board. An Intergovernmental Agreement (IGA) between the District and the County was entered into in November 2004, which, among other things, specified the terms by which the County transferred essentially all of the assets, liabilities, and financial responsibility of the medical center facility to the District effective January 1, 2005. The District operates a medical center facility (the Medical Center), which was formerly owned and operated by the County, three freestanding inpatient behavioral health facilities located on the Medical Center campus and in Maryvale, Arizona and Mesa, Arizona; a specialty clinic located on the Medical Center campus; and various outpatient health centers throughout Maricopa County. The District has the authority to levy ad valorem taxes. The District had no significant operations prior to January 1, 2005. In conjunction with the IGA, the County and the District entered into a 20-year lease for the Medical Center real estate.

On September 3, 2013, a second Amended and Restated Intergovernmental Agreement (the Amended IGA) was entered into by the District, whereby all the land and real property located at the Maricopa Medical Center and Desert Vista campuses (the Property) subject to the prior 20-year lease were donated to the District. The Property was recorded at its fair value at the date of donation, determined by a third-party valuation services firm, totaling $117,075,000. The Property donated consisted of land of $9,000,000, buildings of $104,375,000 and land improvements of $3,700,000.

The Amended IGA also provided for the District's purchase of supplies from the County and the sublease of certain space to the County, and for the County to be able to purchase supplies and utilize the District's services, among other items.

If the Property is not used for county hospital purposes, the Property shall (at the election of the County) revert to the County.

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

Effective October 1, 2019, as a part of a rebranding initiative, the District, which was formerly known as Maricopa Integrated Health System, is now officially called Valleywise Health.

Basis of Accounting and Presentation

The District prepares its financial statements as a business-type activity in conformity with applicable pronouncements of the Governmental Accounting Standards Board (GASB). The financial statements of the District have been prepared on the accrual basis of accounting using the economic resources measurement focus. Revenues, expenses, gains, losses, assets, and liabilities from exchange and exchange-like transactions are recognized when the exchange transaction takes place, while those from government-mandated and voluntary non-exchange transactions (principally federal and state grants and appropriations from the County) are recognized when all applicable eligibility requirements are met. Operating revenues and expenses include exchange transactions and interest on capital assets-related debt are included in nonoperating revenues and expenses. The District first applies its restricted net position when an expense or outlay is incurred for purposes for which both restricted and unrestricted net position are available. The District primarily earns revenues by providing inpatient and outpatient medical services.

Use of Estimates

The preparation of these basic financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the basic financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents and Restricted Cash

For purposes of the statements of cash flows, the District considers all liquid investments, including those that are restricted, with original maturities of three months or less, to be cash equivalents. At June 30, 2023 and 2022, the District had approximately $407,718,000 and $540,335,000, respectively, of cash and cash equivalents and restricted cash. Restricted cash includes cash and cash equivalents that are restricted for use and includes approximately $48,489,000 and $77,287,000 as of June 30, 2023 and 2022, respectively, of tax proceeds restricted

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

for debt service on the general obligation bonds and approximately $118,015,000 and $229,636,000 as of June 30, 2023 and 2022, respectively, of bond proceeds restricted for use under the bond agreement. A portion of the restricted cash has been classified as a long-term asset as the funds will be used to purchase long-term assets.

Risk Management

The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries; medical malpractice; and natural disasters. The District participated in the County's self-insurance program through December 3, 2012. The IGA between the District and County was amended to reflect that the District would no longer participate in the County's self-insurance program effective December 4, 2012, except for workers' compensation claims. The Amended IGA also stipulated that the County would provide a mutually agreed-upon amount to fund estimated outstanding losses and estimated future claim payments for the period January 1, 2005 through December 3, 2012. In return, the District accepted responsibility for the payment and management of these claims on an ongoing basis.

The District, through its Risk Management Department, is now responsible for identifying and resolving exposures and claims that arise from employee work-related injury, third-party liability, property damage, regulatory compliance, and other exposures arising from the District's operations. Effective December 4, 2012, the District's Board of Directors approved and implemented risk management, self-insurance, and purchased insurance programs under the Maricopa Integrated Health System Risk Management Insurance and Self-Insurance Plan (the Insurance Plan). As authorized under the Insurance Plan, the District purchases excess insurance over the District's self-insured program to maintain adequate protection against the District's exposures and claims filed against the District. It is the District's policy to record the expense and related liability for professional liability, including medical malpractice and workers' compensation, based upon annual actuarial estimates.

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

Patient Accounts Receivable

The District reports patient accounts receivable for services rendered at estimated net realizable amounts due from third-party payors, patients, and others. The District provides an allowance for uncollectible accounts based upon a review of outstanding receivables, historical collection information, and existing economic conditions. The District bills third-party payors directly and bills the patient when the patient's liability is determined. Patient accounts receivable are due in full when billed. Accounts are considered delinquent and subsequently written off based on individual credit evaluation and specific circumstances of the account.

Supplies

Supplies inventories are stated at the lower of cost or market, determined using the first-in, first-out method.

Capital Assets

Capital assets are recorded at cost at the date of purchase, or fair value at the date of donation if acquired by gift. The dollar threshold to capitalize capital assets is $5,000. Depreciation is computed using the straight-line method over the estimated useful life of each asset. Assets under capital lease obligations and leasehold improvements are amortized over the shorter of the lease term or the assets' respective estimated useful lives. The following estimated useful lives are being used by the District:

Land improvements	2–25 years
Buildings and leasehold improvements	5–40 years
Equipment	3–20 years

Compensated Absences

District policies permit most employees to accumulate vacation and sick leave benefits (personal leave) that may be realized as paid time off or, in limited circumstances, as a cash payment. Expense and the related liability are recognized as personal leave benefits and are earned whether the employee is expected to realize the benefit as time off or as a cash payment. Employees may accumulate up to 240 hours of personal leave, depending on years of service, but any personal

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

leave hours in excess of the maximum amount that are unused by the calendar year-end are converted to the employee's extended illness bank (EIB). Generally, EIB benefits are used by employees for extended illness or injury, or to care for an immediate family member with an extended illness or injury. EIB benefits are cumulative but do not vest and, therefore, are not accrued. However, upon retirement, employees with accumulated EIB in excess of 1,000 hours are entitled to a $3,000 bonus. The total compensated absence liabilities are computed using the regular pay and termination pay rates in effect at the statement of net position date plus an additional amount for compensation-related payments such as social security and Medicare taxes, computed using rates in effect at that date.

Net Position

Net position of the District is classified into three components. Net investment in capital assets consists of capital assets net of accumulated depreciation and reduced by the outstanding balances of borrowings used to finance the purchase or construction of those assets. Restricted net position consists of noncapital assets that must be used for a particular purpose as specified by creditors, grantors, or donors external to the District. Unrestricted net position consists of the remaining assets plus deferred outflows of resources less remaining liabilities plus deferred inflows of resources that do not meet the definition of net investment in capital assets, or restricted net position.

Net Patient Service Revenue

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered and includes estimated retroactive adjustments and a provision for uncollectible accounts. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such estimated amounts are revised in future periods as adjustments become known. The District participates in the Federally Qualified Health Center (FQHC) program and receives supplemental payments from Arizona Health Care Cost Containment System (AHCCCS). The payments are made based on information filed with AHCCCS on the Annual Reconciliation and Rebase Data (ARRD) report. The District is currently in the process of reconciling with AHCCCS and various health plans regarding the federal fiscal year 2022 ARRD report.

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

Charity Care

The District provides services at amounts less than its established rates to patients who meet the criteria of its charity care policy. The criteria for charity care take into consideration the patient's family size and income in relation to federal poverty guidelines and type of service rendered. The total net cost of charity care provided was approximately $56,068,000 and $84,878,000 for the years ended June 30, 2023 and 2022, respectively. Charity care cost is based on the percentage of total direct operating expenses less other operating revenue divided by the total gross revenue for the Medical Center. This percentage is applied to the amount written off as charity care to determine the total charity care cost. The net cost of charity care is total charity care cost less any payments received. Payments received were approximately $10,161,000 and $8,697,000 for the years ended June 30, 2023 and 2022, respectively.

Property Taxes

On or before the third Monday in August, the County levies real property taxes and commercial personal property taxes on behalf of the District, which become due and payable in two equal installments. The first installment is due on the first day of October and becomes delinquent after the first business day of November. The second installment is due on the first day of March of the next year and becomes delinquent after the first business day of May.

The County also levies mobile home personal property taxes on behalf of the District that are due the second Monday of the month following receipt of the tax notice and become delinquent 30 days later. A lien assessed against real and personal property attaches on the first day of January after assessment and levy.

Proposition 480 allows the County to levy additional property taxes for principal and interest debt service related to general obligation bonds (see Note 9).

Income Taxes

The District is a health district and political subdivision of the state of Arizona and is exempt from federal and state income taxes.

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

Pension and Postemployment Benefits Other Than Pensions (OPEB)

The District participates in the Arizona State Retirement System (ASRS) pension plan for employees. For purposes of measuring the net pension and OPEB liability, deferred outflows of resources and deferred inflows of resources related to pension and OPEB, and pension and OPEB expense, information about the fiduciary net position of ASRS and additions to/deductions from ASRS's fiduciary net position have been determined on the same basis as they are reported by ASRS. For this purpose, benefit payments are recognized when due and payable in accordance with the benefit plan terms. Investments are reported at fair value.

2. Net Patient Service Revenue

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. These payment arrangements include the following:

- Medicare – Inpatient acute care services, certain inpatient non-acute care services, and substantially all outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic, acuity, and other factors. Inpatient psychiatric services are paid based on a blended cost reimbursement methodology and prospectively determined rates. The District is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare fiscal intermediary. The Medicare fiscal intermediary has audited the District's cost reports through June 30, 2018.

- AHCCCS – Inpatient acute services are paid at prospectively determined rates. Inpatient psychiatric services are paid on a per diem basis. Outpatient services rendered to AHCCCS program beneficiaries are primarily reimbursed under prospectively determined rates.

2. Net Patient Service Revenue (continued)

- The District has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Approximately 55% and 56% of net patient service revenues were from participation in the Medicare and state-sponsored AHCCCS programs for the years ended June 30, 2023 and 2022, respectively. Laws and regulations governing the Medicare and AHCCCS programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

3. Deposits, Pooled Funds, and Investment Income

Deposits

Custodial credit risk is the risk that in the event of a bank failure, an entity's deposits may not be returned to it. The District's deposit policy for custodial credit risk requires compliance with the provisions of state law.

The District's deposits are held by Maricopa County (the County) in conjunction with other County funds and are reported as cash and cash equivalents. The County has represented to the District that there is sufficient collateral to cover all of the County's deposits, including the District's deposits. The County issues a Comprehensive Annual Financial Report. Further information regarding County deposits and investments are contained within the basic financial statement notes to the Comprehensive Annual Financial Report. The most recent report can be obtained by writing to Maricopa County Department of Finance, 301 W. Jefferson, Suite 960, Phoenix, Arizona 85003, or at www.maricopa.gov.

3. Deposits, Pooled Funds, and Investment Income (continued)

Pooled Funds

By state statute, the County is required to ensure that all County funds are either insured by the Federal Deposit Insurance Corporation, collateralized by securities held by the cognizant Federal Reserve Bank, or invested in U.S. government obligations. The District's cash held by the County is pooled with the funds of other county agencies and then, in accordance with statutory limitations, placed in banks or invested as the County may determine. The District's pooled funds are reported as part of cash and cash equivalents, and restricted cash – bond and were approximately $380,036,000 and $501,815,000 as of June 30, 2023 and 2022, respectively.

4. Patient Accounts Receivable

The District grants credit without collateral to its patients, many of whom are area residents and are insured under third-party payor agreements. Patient accounts receivable is presented net of allowance for uncollectible accounts of $57,580,000 and $54,585,000 for the years ended June 30, 2023 and 2022, respectively.

5. Receivables From AHCCCS for Medical Education

During the years ended June 30, 2023 and 2022, the District entered into intergovernmental agreements with AHCCCS such that AHCCCS provided available medical education funds from CMS. At June 30, 2023 and 2022, available funds from CMS for medical education totaled approximately $66,022,000 and $61,508,000, respectively. At June 30, 2023 and 2022, the amount due to the District is approximately $49,895,000, which is net of the $16,127,000 matching funds to be provided by the District, and $46,876,000, which is net of the $14,632,000 matching funds provided by the District, respectively.

6. Other Receivables

At June 30, 2023 and 2022, significant components of other receivables included amounts due from third party payors, such as:

	2023	2022
Retail pharmacy accounts receivable	**$ 2,263,000**	$ 1,763,000
340B program	**1,407,000**	786,000
Home Assist Health	**700,000**	806,000
Grants receivable	**5,739,000**	2,546,000
CARES Act – Provider Relief Funds	**–**	27,083,000
Other	**7,154,000**	6,393,000
Total other receivables	**$ 17,263,000**	$ 39,377,000

7. Capital Assets

Capital assets activity for the year ended June 30, 2023, was as follows:

	Beginning Balance	Additions	Disposals	Transfers	Ending Balance
Capital assets not being depreciated:					
Construction-in-progress	**$ 369,061,921**	**$ 129,623,900**	**$ –**	**$ (54,248,424)**	**$ 444,437,397**
Capitalized software-in-progress	**330,119**	**–**	**–**	**–**	**330,119**
Land	**35,615,278**	**–**	**(290,000)**	**–**	**35,325,278**
Capital assets being depreciated:					
Buildings and leasehold improvements	**419,366,459**	**–**	**–**	**42,557,433**	**461,923,892**
Capitalized software	**49,516,241**	**–**	**–**	**–**	**49,516,241**
Equipment	**238,294,027**	**–**	**–**	**11,690,991**	**249,985,018**
Total capital assets	**1,112,184,045**	**129,623,900**	**(290,000)**	**–**	**1,241,517,945**
Accumulated depreciation	**389,000,233**	**55,921,558**	**–**	**–**	**444,921,791**
Capital assets, net	**$ 723,183,812**	**$ 73,702,342**	**$ (290,000)**	**$ –**	**$ 796,596,154**

7. Capital Assets (continued)

Capital assets activity for the year ended June 30, 2022, was as follows:

	Beginning Balance	Additions	Disposals	Transfers	Ending Balance
Capital assets not being depreciated:					
Construction-in-progress	$ 238,432,510	$ 182,475,787	$ –	$ (51,846,376)	$ 369,061,921
Capitalized software-in-progress	330,119	–	–	–	330,119
Land	26,342,487	–	(380,000)	9,652,791	35,615,278
Capital assets being depreciated:					
Buildings and leasehold improvements	393,737,421	–	(7,903,574)	33,532,612	419,366,459
Capitalized software	49,516,241	–	–	–	49,516,241
Equipment	229,935,513	–	(302,459)	8,660,973	238,294,027
Total capital assets	938,294,291	182,475,787	(8,586,033)	–	1,112,184,045
Accumulated depreciation	344,139,165	52,241,569	(7,380,501)	–	389,000,233
Capital assets, net	$ 594,155,126	$ 130,234,218	$ (1,205,532)	$ –	$ 723,183,812

The District recognized $10,484,000 in accelerated depreciation expenses during both years ended June 30, 2023 and 2022 due to the anticipated decommissioning of the current medical center building.

8. Risk Claims Payable

The District maintains insurance through a combination of programs utilizing purchased commercial insurance and self-insurance for professional liability claims, including medical malpractice and workers' compensation claims. The District is self-insured for workers' compensation in Arizona. In connection with the aforementioned programs, the District has accrued estimates for asserted and incurred but not reported claims. The actuarially determined claims payable is approximately $14,299,000 and $13,066,000, of which $514,000 and $553,000 has been recorded as a current liability and approximately $13,785,000 and $12,513,000 has been recorded as a noncurrent liability on the accompanying statements of net position as of June 30, 2023 and 2022, respectively. Risk claims payable are undiscounted.

8. Risk Claims Payable (continued)

As of June 30, 2023, the District maintained commercial insurance as follows:

Insurance	Limits	Self-Insured Retention/Deductible
Workers' compensation	Statutory	$500,000 each claim
Medical malpractice	$15,000,000 each incident – first layer Additional $15,000,000 – second excess layer Additional $20,000,000 – third excess layer	$2,000,000 each incident Additional $2,000,000 one claim layer buffer

The insurance policies listed above became effective December 1, 2012, and remain current through June 30, 2023.

The following is a reconciliation of the risk claims payable as for the years ended June 30:

	2023	2022	2021
Beginning balance	**$ 13,065,547**	$ 11,031,584	$ 12,145,246
Total incurred	**6,926,933**	6,191,156	2,949,206
Total paid	**(5,693,766)**	(4,157,193)	(4,062,868)
Ending balance	**$ 14,298,714**	$ 13,065,547	$ 11,031,584

9. Other Current Liabilities

At June 30, 2023 and 2022, significant components of other current liabilities included amounts such as:

	2023	2022
Interest payable	**$ 14,570,000**	$ 15,579,000
Deferred revenue – Grants & Research	**21,829,000**	19,364,000
Deferred revenue – Foundation	**21,873,000**	10,802,000
Other current liabilities	**29,034,000**	25,897,000
Total other current liabilities	**$ 87,306,000**	$ 71,642,000

The grants and research deferred revenue includes amounts received by the District as a sub-recipient of American Rescue Plan Act (ARPA) funds that were not recognized as revenue as of the year ended June 30, 2023 and 2022. The foundation deferred revenue includes amounts received by the District from the Valleywise Health Foundation to support the completion of the Care Reimagined project and were not recognized as revenue as of the year ended June 30, 2023 and 2022.

10. Long-Term Debt

The following is a summary of long-term debt transactions for the District for the years ended June 30:

	Beginning Balance	Additions	Reductions	Ending Balance	Current Portion
2023					
General obligation bonds, series C	**$ 422,188,095**	**$ –**	**$ (19,134,289)**	**$ 403,053,806**	**$ 16,130,000**
General obligation bonds, series D	**296,101,264**	**–**	**(32,278,792)**	**263,822,472**	**10,000,000**
Total long-term debt	**$ 718,289,359**	**$ –**	**$ (51,413,081)**	**$ 666,876,278**	**$ 26,130,000**

10. Long-Term Debt (continued)

2022					
General obligation bonds, series C	$ 440,953,718	$ –	$ (18,765,623)	$ 422,188,095	$ 15,351,007
General obligation bonds, series D	305,008,663	–	(8,907,399)	296,101,264	25,000,000
Direct placement general obligation bonds	17,000,000	–	(17,000,000)	–	–
Total long-term debt	$ 762,962,381	$ –	$ (44,664,028)	$ 718,289,359	$ 40,351,007

General Obligation Bonds

On November 4, 2014, the voters of the County approved Proposition 480. Proposition 480 allows the District to issue up to $935,000,000 in general obligation bonds to be repaid over 30 years to fund outpatient health facilities, including improvement or replacement of existing outpatient health centers; construction of new outpatient health centers in northern, eastern, and/or western Maricopa County, behavioral health facilities, including construction of a new behavioral health hospital; and acute care facilities, including replacement of the District's public teaching hospital Valleywise Health Medical Center and its Level One Trauma Center and Arizona Burn Center, on the existing campus. Through June 30, 2023, the District has issued $935,000,000 in general obligation bonds.

On October 12, 2017, the District closed on its second offering of general obligation bonds in the amount of $75,000,000 in order to continue the various improvement projects. The bonds bear interest at the rate of 1.61% through maturity in fiscal year 2022. Financing for the District's first and second offering were both private placements.

On October 30, 2018, the District closed on its third offering of general obligation bonds in the amount of $422,125,000 in order to continue the various improvement projects. The bonds were issued at a premium of $42,870,000. The bonds bear coupon interest at the rate of 5.00% through maturity in fiscal year 2038. Financing for the District's third offering were public placements.

On June 10, 2021, the District closed on its fourth offering of general obligation bonds in the amount of $244,070,000 in order to continue the various improvement projects. The bonds were issued at a premium of $60,939,000. The bonds bear coupon interest at the rate of 5.00% through maturity in fiscal year 2035. Financing for the District's fourth offering were public placements.

10. Long-Term Debt (continued)

Proposition 480 allows the County to levy property taxes for principal and interest debt service related to the general obligation bonds.

The bond purchase agreements also contain certain nonfinancial covenants, including the maintenance of property and annual reporting requirements. Management believes it is in compliance with these covenant requirements at June 30, 2023.

Credit Facility, Maricopa County

On June 25, 2020, the County agreed to extend the District a $30,000,000 line of credit through its credit facility in response to the COVID-19 pandemic crisis. The District did not have any outstanding borrowings on the line of credit at June 30, 2023 and 2022.

Scheduled maturities of long-term debt, excluding a net premium of $66,541,000 as of June 30, 2023, for the years ending June 30 are as follows:

	General Obligation Bonds	
	Principal	Interest
2024	$ 26,130,000	$ 28,487,350
2025	30,070,000	27,082,350
2026	31,575,000	25,541,225
2027	33,150,000	23,923,100
2028	34,810,000	22,224,100
2029–2033	201,975,000	82,507,125
2034–2038	209,410,000	28,420,800
2039–2041	33,215,000	664,300
	$ 600,335,000	$ 238,850,350

11. Restricted Net Position

Restricted net position at June 30, 2023 and 2022, consists of grant funds received for specific purposes that are expected to be expended as defined on the agreement, in the amount of approximately $42,551,000 and $30,166,000, respectively.

Restricted net position at June 30, 2023 and 2022, also consists of bond funds expected to be expended for specific purposes as defined in the bond agreement, in the amount of approximately $166,504,000 and $306,923,000, respectively.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset)

General Information About the Pension and OPEB Plans

Plan Description

The District contributes to a cost-sharing, multiple-employer, defined benefit pension plan and OPEB plans administered by the ASRS. Benefits are established by state statute and generally provide retirement, death, long-term disability, survivor, and health insurance premium benefits. ASRS is governed by the ASRS Board according to the provisions of Arizona Revised Statutes Title 38, Chapter 5, Article 2.

ASRS issues a Comprehensive Annual Financial Report that includes financial statements and required supplementary information. The most recent report may be obtained at www.azasrs.gov/content/annual-reports or by writing the Arizona State Retirement System, 3300 North Central Avenue, P.O. Box 33910, Phoenix, Arizona 85067-3910, or by telephoning (602) 240-2000 or (800) 621-3778.

Funding Policy

The Arizona State Legislature establishes and may amend contribution rates for active plan members, including the District. For the years ended June 30, 2023 and 2022, active plan members, including the District, were required by statute to contribute at the actuarially determined rate of 12.17% (11.92% retirement, 0.11% health benefit supplement, and 0.14% long-term disability) and 12.41% (12.01% retirement, 0.21% health benefit supplement, and 0.19% long-term disability), respectively, of the members' annual covered payroll.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

Benefits Provided

ASRS provides retirement, health care, and long-term disability benefits. The Defined Benefit Plan provides monthly retirement benefits to members who have reached retirement eligibility criteria, terminated employment, and applied for retirement benefits. At retirement, members have seven different payment options to choose from, including a straight-life annuity that guarantees monthly payments only for the lifetime of the member, or term certain and joint and survivor annuities that will continue to make monthly payments to a beneficiary in the event of the member's death. The amount of a member's monthly benefit is calculated based on his or her age, his or her years of service, his or her salary at retirement, and the retirement option chosen. In the event a member dies before reaching retirement eligibility criteria, the defined benefit plan will pay a lump sum or annuity to the member's beneficiary(ies). The Retiree Health Benefit Supplement (also called Premium Benefit Supplement) provides health insurance coverage for retirees and a monthly health insurance premium benefit to offset the cost of retiree health insurance. Long Term Disability provides a monthly disability benefit to partially replace income lost as a result of disability.

Contributions

The contribution rate for the pension and OPEB plans are calculated by an independent actuary at the end of each fiscal year based on the amount of investment assets the ASRS has on hand to pay benefits, liabilities associated with the benefits members have accrued to date, projected investment returns, and projected future liabilities.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

Liabilities, Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions and OPEB

At June 30, 2023, the District reported a liability of approximately $369,080,000 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2022. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2021, and was rolled forward using generally accepted actuarial procedures to June 30, 2022. The District's proportion of the net pension liability was based on a projection of the District's long-term share of contributions to the pension plan relative to the projected contributions of all participating employers and the state, as actuarially determined. At June 30, 2022, the District's proportion was 2.26%, which represents a slight change from its proportion measured as of June 30, 2021.

At June 30, 2022, the District reported a liability of approximately $297,858,000 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2021. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2020, and was rolled forward using generally accepted actuarial procedures to June 30, 2021. The District's proportion of the net pension liability was based on a projection of the District's long-term share of contributions to the pension plan relative to the projected contributions of all participating employers and the state, as actuarially determined. At June 30, 2021, the District's proportion was 2.27%, which represents no change from its proportion measured as of June 30, 2020.

At June 30, 2023, the District reported a net (asset) of approximately ($12,635,000) for its proportionate share of the net OPEB liability. The net OPEB liability was measured as of June 30, 2022. The total amount used to calculate the net OPEB liability was determined by an actuarial valuation as of June 30, 2021, and was rolled forward using generally accepted actuarial procedures to June 30, 2022. The District's proportion of the net OPEB liability was based on a projection of the District's long-term share of contributions to the OPEB plan relative to the projected contributions of all participating employers and the state, as actuarially determined. At June 30, 2022 and 2021, the District's proportion was 2.30% and 2.31%, respectively.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

At June 30, 2022, the District reported a net (asset) of approximately ($10,767,000) for its proportionate share of the net OPEB liability. The net OPEB liability was measured as of June 30, 2021. The total amount used to calculate the net OPEB liability was determined by an actuarial valuation as of June 30, 2020, and was rolled forward using generally accepted actuarial procedures to June 30, 2021. The District's proportion of the net OPEB liability was based on a projection of the District's long-term share of contributions to the OPEB plan relative to the projected contributions of all participating employers and the state, as actuarially determined. At June 30, 2021 and 2020, the District's proportion was 2.31% and 2.30%, respectively.

Within employee benefits, the District recorded pension expense of $47,306,000 and $33,298,000 for the years ended June 30, 2023 and 2022, respectively. At June 30, 2023, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Employer contributions made after measurement date	**$ 33,719,162**	**$ –**
Differences between expected and actual experience	**3,144,779**	**–**
Changes in assumptions	**18,318,139**	**–**
Difference between projected and actual investment earnings	**–**	**(9,721,916)**
Change in proportion and differences between employer contributions and proportionate share of contributions	**–**	**(969,137)**
Total	**$ 55,182,080**	**$ (10,691,053)**

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

At June 30, 2022, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Employer contributions made after measurement date	$ 32,711,475	$ –
Differences between expected and actual experience	4,540,570	–
Changes in assumptions	38,768,596	–
Difference between projected and actual investment earnings	–	(94,371,882)
Change in proportion and differences between employer contributions and proportionate share of contributions	6,371,328	(779,921)
Total	$ 82,391,969	$ (95,151,803)

Of the amount reported as deferred outflows of resources as of June 30, 2023, $748,000 related to pension results from District contributions subsequent to the measurement date that will be recognized as a reduction of the net pension liability in the year ending June 30, 2023. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pension will be recognized in pension expense (benefit) as follows:

Year ending June 30:	
2024	$ 16,797,286
2025	(4,706,275)
2026	(16,879,531)
2027	15,560,385

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

Within employee benefits, the District recorded OPEB (benefit) of ($1,793,000) for the year ended June 30, 2023. At June 30, 2023, the District reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Employer contributions made after measurement date	**$ 748,358**	**$ –**
Differences between expected and actual expenses	**111,843**	**(6,758,096)**
Changes in assumptions	**325,577**	**(874,912)**
Difference between projected and actual investments earnings	**–**	**(439,534)**
Change in proportion and differences between employer contributions and proportionate share of contributions	**94,455**	**(14,817)**
Total	**$ 1,280,233**	**$ (8,087,359)**

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

Within employee benefits, the District recorded OPEB (benefit) of ($926,000) for the year ended June 30, 2022. At June 30, 2022, the District reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Employer contributions made after measurement date	$ 1,536,765	$ –
Differences between expected and actual expenses	137,082	(3,937,296)
Changes in assumptions	709,100	(1,052,464)
Difference between projected and actual investments earnings	–	(4,498,749)
Change in proportion and differences between employer contributions and proportionate share of contributions	98,513	(19,710)
Total	$ 2,481,460	$ (9,508,219)

Of the amount reported as deferred outflows of resources, $1,537,000 related to OPEB results from District contributions subsequent to the measurement date that will be recognized as a reduction of the net OPEB liability in the year ending June 30, 2022. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB (benefit) as follows:

Year ending June 30:	
2024	$ (1,988,873)
2025	(2,174,578)
2026	(2,428,854)
2027	(352,442)
2028	(439,054)
Thereafter	(171,683)

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

Actuarial Assumptions

The June 30, 2021 and 2020 actuarial valuation of the total pension liability was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.30%
Salary increases	2.90% – 8.40% average, including inflation
Discount rate	7.00%

Rates are based on the 2017 State Retirees of Arizona (SRA) mortality table. Generational mortality improvements in accordance with the Ultimate MP scales (beginning in 2020) and projected from the year 2017.

The June 30, 2021 and June 30, 2020 actuarial valuation of the OPEB (asset) was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.30%
Investment rate of return	7.00%
Mortality rates	2017 SRA Scale U-MP
Health care trend rate	N/A

Rates are based on the 2017 State Retirees of Arizona (SRA) mortality table. Generational mortality improvements in accordance with the Ultimate MP scales (beginning in 2020) and projected from the year 2017.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

The benefits paid by the plan are not impacted by health care cost trend rates. As a result, changes in the health care cost trend rate assumption will have no impact on the net OPEB (asset).

The actuarial assumptions used in the June 30, 2021 pension and OPEB valuations were based on the results of an actuarial experience study for the period July 1, 2015–June 30, 2020. The ASRS Board adopted the experience study, which recommended changes, and those changes were effective as of the June 30, 2021, actuarial valuation. The actuarial assumptions used in the June 30, 2020 pension and OPEB valuations were based on the results of an actuarial experience study for the period July 1, 2011–June 30, 2016. The ASRS Board adopted the experience study, which recommended changes, and those changes were effective as of the June 30, 2017, actuarial valuation.

The long-term expected rate of return on pension and OPEB plans' investments were determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation.

The target allocation and best estimates of geometric real rates of return for each major asset class for the pension and OPEB plans measured as of June 30, 2022, are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Equity	50%	1.95%
Fixed income	30	1.04
Real estate	20	1.20
Total	100%	4.19%

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

The target allocation and best estimates of geometric real rates of return for each major asset class for the pension and OPEB plans measured as of June 30, 2021, are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Equity	50%	2.45%
Fixed income	30	1.11
Real estate	20	1.14
Total	100%	4.70%

Discount Rate

The discount rate used to measure the overall pension liability as of June 30, 2023 and 2022, was 7.0%, and the OPEB (asset) as of June 30, 2023 and 2022, was 7.0%. The projection of cash flows used to determine the discount rate assumed that employee contributions will be made at the current contribution rate, contributions from the District will be made at contractually required rates (actuarially determined), and contributions from the participating employers will be made at current statutorily required rates. Based on those assumptions, the plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on plan investments was applied to all periods of projected benefit payments to determine the total pension liability and OPEB (asset).

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

Sensitivity of the District's Proportionate Share of the Net Pension Liability to Changes in the Discount Rate

The following presents the District's proportionate share of the net pension liability reported at June 30, 2023, using the discount rate of 7.0% as well as what the District's proportionate share of the net pension liability would be if it were calculated using a discount rate that is one percentage point lower 6.0% or one percentage point higher 8.0% than the current rate:

	1-Point Decrease (6.0%)	Discount Rate (7.0%)	1-Point Increase (8.0%)
District's proportionate share of the net pension liability	**$ 544,566,115**	**$ 369,079,692**	**$ 222,751,434**

The following presents the District's proportionate share of the net pension liability reported at June 30, 2022, using the discount rate of 7.0% as well as what the District's proportionate share of the net pension liability would be if it were calculated using a discount rate that is one percentage point lower 6.0% or one percentage point higher 8.0% than the current rate:

	1-Point Decrease (6.0%)	Discount Rate (7.0%)	1-Point Increase (8.0%)
District's proportionate share of the net pension liability	$ 468,505,634	$ 297,857,967	$ 155,585,029

The following presents the District's proportionate share of the net OPEB (asset) reported at June 30, 2023, using the discount rate of 7.0% as well as what the District's proportionate share of the net OPEB (asset) would be if it were calculated using a discount rate that is one percentage point lower 6.0% or one percentage point higher 8.0% than the current rate:

	1-Point Decrease (6.0%)	Discount Rate (7.0%)	1-Point Increase (8.0%)
District's proportionate share of the net OPEB (asset)	**$ (8,883,591)**	**$ (12,635,048)**	**$ (15,835,147)**

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (Asset) (continued)

The following presents the District's proportionate share of the net OPEB (asset) reported at June 30, 2022, using the discount rate of 7.0% as well as what the District's proportionate share of the net OPEB (asset) would be if it were calculated using a discount rate that is one percentage point lower 6.0% or one percentage point higher 8.0% than the current rate:

	1-Point Decrease (6.0%)	Discount Rate (7.0%)	1-Point Increase (8.0%)
District's proportionate share of the net OPEB (asset)	$ (6,825,194)	$ (10,767,083)	$ (14,135,798)

Pension and OPEB Plans Fiduciary Net Position

Detailed information about the pension and OPEB plans' fiduciary net position are available in the separately issued ASRS Comprehensive Annual Financial Report.

13. Commitments and Contingencies

Litigation

In the normal course of business, the District is, from time to time, subject to allegations that may or do result in litigation. Some of these allegations are in areas not covered by the County's risk management program (see Note 1) or by commercial insurance, for example, allegations regarding employment practices or performance of contracts. The District evaluates such allegations by conducting investigations to determine the validity of each potential claim. Based upon the advice of legal counsel, management records an estimate of the amount of ultimate expected loss, if any, for each allegation. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

14. Disproportionate Share Settlement

Section 1923 of the Social Security Act establishes federal requirements designed to aid entities that provide medical services to a disproportionate share of medically indigent patients. These requirements were met for the state fiscal years ended June 30, 2023 and 2022, through disproportionate share settlements established in Laws 2016 Second Regular Session Chapter 122 and Laws 2015 First Regular Session Chapter 14. AHCCCS was directed to distribute such settlements based on various qualifying criteria and allocation processes. The District recorded approximately $4,202,000 of disproportionate share settlements in other operating revenue in each of fiscal years 2023 and 2022.

15. Related-Party Transactions

During the years ended June 30, 2023 and 2022, net patient service revenues included approximately $3,776,000 and $3,037,000, respectively, of payments received from Maricopa County Correctional Health for medical services rendered, and approximately $8,704,000 and $1,789,000, respectively, in grant funds from the Maricopa County Department of Public Health.

During the years ended June 30, 2023 and 2022, nonoperating revenues included approximately $334,000 and $952,000 in payments received from Maricopa County Industrial Development Authority (MCIDA) for program support in the District's Simulation and Training Center in fiscal years 2023 and 2022, respectively.

16. CARES Act

Through the passage of the Families First Coronavirus Response Act (Families First) and the Coronavirus Aid, Relief and Economic Security (CARES) Act, Congress provided financial support to hospitals and health care providers during the pandemic for financial stabilization. This allowed for financial support to the District in fiscal year 2022 through the Provider Relief Fund.

The District has attested to the receipt of distributions of Provider Relief Funds under the CARES Act and recorded $0 and $39,376,000 in other nonoperating revenue for the years ended June 30, 2023 and 2022, respectively. These distributions were used to offset expenses to prevent, prepare for, and respond to the COVID-19, or lost revenues that are attributable to COVID-19.

17. Subsequent Events

Effective July 1, 2023, the District elected to levy a secondary property tax on all taxable property in the defined surrounding area at the rate necessary to generate approximately $96,225,000 of annual tax revenue. The tax revenue is to be used to support operations of the District.

Effective July 1, 2023, the District elected to levy property tax on all taxable property in the defined surrounding area, in the amounts of $13,849,000 and $18,684,000 for the fifth year principal and interest debt service, respectively, related to the $422,125,000 third bond offering.

Effective July 1, 2023, the District elected to levy property tax on all taxable property in the defined surrounding area, in the amounts of $9,816,000 and $10,855,000 for the third year principal and interest debt service, respectively, related to the $244,070,000 fourth bond offering.

Required Supplementary Information

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of District's Proportionate Share of the Net Pension Liability

Last 10 Fiscal Years*

	2023	2022	2021	2020	2019	2018	2017	2016	2015
District's proportion or the net pension liability	**2.26%**	2.27%	2.27%	2.14%	2.15%	1.96%	2.11%	2.15%	2.25%
District's proportionate share of the net pension liability	**$ 369,079,692**	$ 297,857,967	$ 394,058,778	$ 311,132,978	$ 300,238,443	$ 304,619,435	$ 339,937,627	$ 334,641,881	$ 332,820,645
District's covered payroll	**$ 270,682,087**	$ 252,938,151	$ 236,809,991	$ 225,450,955	$ 211,945,416	$ 188,850,966	$ 195,634,317	$ 196,475,917	$ 203,989,176
District's proportionate share of the net pension liability a percentage of its covered payroll	**136.35%**	117.76%	166.40%	138.00%	141.66%	161.30%	173.76%	170.32%	163.16%
Plan fiduciary net position as a percentage of the total pension liability	**74.26%**	78.58%	69.33%	73.24%	73.40%	69.92%	67.06%	68.35%	69.49%

*The amounts presented for each fiscal year were determined as of the end of the prior fiscal year. Ten years of information is not yet available.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of District's Proportionate Share of the Net OPEB Liability (Asset)

Last 10 Fiscal Years*

	2023	2022	2021	2020	2019	2018
District's proportion or the net OPEB liability (asset)	**2.30%**	2.31%	2.30%	2.17%	2.14%	2.14%
District's proportionate share of the net OPEB liability (asset)	**$ (12,635,048)**	$ (10,767,083)	$ 116,339	$ 812,445	$ 347,486	$ (361,250)
District's covered payroll	**$ 270,682,087**	$ 252,938,151	$ 236,809,991	$ 225,450,955	$ 211,945,416	$ 188,850,966
District's proportionate share of the net OPEB liability (asset) as a percentage of its covered payroll	**(4.67)%**	(4.26)%	0.05%	0.36%	0.16%	(0.19)%
Plan fiduciary net position as a percentage of the total OPEB liability (asset)	**132.71%**	125.56%	99.73%	98.07%	99.13%	101.03%

*The amounts presented for each fiscal year were determined as of the end of the prior fiscal year. Ten years of information is not yet available.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Contributions – Pension Plan

Last 10 Fiscal Years

	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014
Contractually required contribution	**$ 33,719,162**	$ 32,711,475	$ 29,724,443	$ 28,321,667	$ 25,950,721	$ 22,402,719	$ 20,360,215	$ 21,226,490	$ 21,396,442	$ 21,827,065
Contributions in relation to the contractually required contribution	**(33,719,162)**	(32,711,475)	(29,724,443)	(28,321,667)	(25,950,721)	(22,402,719)	(22,259,196)	(21,387,917)	(21,690,643)	(20,471,268)
Contribution deficiency (excess)	**$ –**	$ –	$ –	$ –	$ –	$ –	$ (1,898,981)	$ (161,427)	$ (294,201)	$ 1,355,797
District's covered payroll	**$ 288,670,536**	$ 270,682,087	$ 252,938,151	$ 236,809,991	$ 225,450,955	$ 211,945,416	$ 188,850,966	$ 195,634,317	$ 196,475,917	$ 203,989,176
Contributions as a percentage of covered payroll	**11.68%**	12.08%	11.75%	11.96%	11.51%	10.57%	10.78%	10.85%	10.89%	10.70%

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Contributions – OPEB

Last 10 Fiscal Years

	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014
Contractually required contribution	**$ 748,358**	$ 1,536,765	$ 1,375,302	$ 1,579,258	$ 1,396,082	$ 1,273,313	$ 1,321,018	$ 1,213,587	$ 1,395,848	$ 1,715,385
Contributions in relation to the contractually required contribution	**(748,358)**	(1,536,765)	(1,375,302)	(1,579,258)	(1,396,082)	(1,273,313)	(1,321,018)	(1,213,587)	(1,395,848)	(1,715,385)
Contribution deficiency (excess)	**$ –**	$ –	$ –	$ –	$ –	$ –	$ –	$ –	$ –	$ –
District's covered payroll	**$ 288,670,536**	$ 270,682,087	$ 252,938,151	$ 236,809,991	$ 225,450,955	$ 211,945,416	$ 188,850,966	$ 195,634,317	$ 196,475,917	$ 203,989,176
Contributions as a percentage of covered payroll	**0.26%**	0.57%	0.54%	0.67%	0.62%	0.60%	0.70%	0.62%	0.71%	0.84%

Reports

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Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

Management and the Board of Directors
Maricopa County Special Health Care District
d/b/a Valleywise Health

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (*Government Auditing Standards*), the financial statements of the Maricopa County Special Health Care District d/b/a Valleywise Health (the District), which comprise the statement of net position as of June 30, 2023, and the related statements of revenues, expenses and changes in net position and cash flows for the year then ended, and the related notes to the financial statements (collectively referred to as the "financial statements"), and have issued our report thereon dated November 21, 2023.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the District's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Building a better working world

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 21, 2023

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Report of Independent Auditors on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance Required by the Uniform Guidance

Management and the Board of Directors
Maricopa County Special Health Care District
d/b/a Valleywise Health

Report of Independent Auditors on Compliance for Each Major Federal Program

Opinion on Each Major Federal Program

We have audited Maricopa County Special Health Care District d/b/a Valleywise Health's (the District) compliance with the types of compliance requirements identified as subject to audit in the U.S. Office of Management and Budget (OMB) *Compliance Supplement* that could have a direct and material effect on each of the District's major federal programs for the year ended June 30, 2023. The District's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

In our opinion, the District complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2023.

Basis for Opinion on Each Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States (*Government Auditing Standards*); and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of the District and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on compliance for each major federal program. Our audit does not provide a legal determination of the District's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules, and provisions of contracts or grant agreements applicable to the District's federal programs.

Auditor's Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on the District's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about the District's compliance with the requirements of each major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the District's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.

- Obtain an understanding of the District's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Building a better working world

Report on Internal Control Over Compliance

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations during our audit, we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Ernst & Young LLP

March 22, 2024

Supplementary Information

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Expenditures of Federal Awards

Year Ended June 30, 2023

Federal Grantor / Program Title / *Pass-Through Grantor*	Assistance Listing Number	Pass-Through Entity Identifying Number	Health Center Program Cluster	Other Expenditures	Total Expenditures	Federal Expenditures Passed Through to Subrecipients
U.S. Department of Labor:						
WIOA Cluster:						
COVID-19 – WIOA Adult Program – *State of Arizona, The Office of the Governor*	17.258	IGA-WIOA-ARPA-VWH-070121-01	$ –	$ 965,081	$ 965,081	$ –
COVID-19 – WIOA Youth Activities – *State of Arizona, The Office of the Governor*	17.259	IGA-WIOA-ARPA-VWH-070121-01	–	1,419,281	1,419,281	–
COVID-19 – WIOA Dislocated Worker Formula Grants – *State of Arizona, The Office of the Governor*	17.278	IGA-WIOA-ARPA-VWH-070121-01	–	2,615,638	2,615,638	–
Total WIOA Cluster			–	5,000,000	5,000,000	–
Total U.S. Department of Labor			–	**5,000,000**	**5,000,000**	–
U.S. Department of Transportation:						
Highway Safety Cluster:						
State and Community Highway Safety – *Arizona Governor's Office of Highway Safety*	20.600	HS-FY 2016	–	17,304	17,304	–
Total Highway Safety Cluster			–	17,304	17,304	–
Total U.S. Department of Transportation			–	**17,304**	**17,304**	–
U.S. Department of Treasury:						
COVID-19 – Coronavirus State and Local Fiscal Recovery Funds – *State of Arizona, The Office of the Governor*	21.027	IGA-WIOA-ARPA-VWH-070121-01	–	5,000,000	5,000,000	–
COVID-19 – Coronavirus State and Local Fiscal Recovery Funds – *State of Arizona, The Office of the Governor*	21.027	IGA-ARPA-VWH-020323-01	–	2,507,751	2,507,751	–
COVID-19 – Coronavirus State and Local Fiscal Recovery Funds – *Maricopa County*	21.027	C-95-22-025-X-01	–	2,287,823	2,287,823	–
COVID-19 – Coronavirus State and Local Fiscal Recovery Funds – *Maricopa County*	21.027	90-23-100-1	–	1,223,132	1,223,132	–
COVID-19 – Coronavirus State and Local Fiscal Recovery Funds – *Maricopa County*	21.027	C-95-22-025-X-00	–	697,118	697,118	–
COVID-19 – Coronavirus State and Local Fiscal Recovery Funds – *Arizona Alliance of Community Health Centers*	21.027	MCDPHCAP2	–	262,100	262,100	–

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Expenditures of Federal Awards (continued)

Year Ended June 30, 2023

Federal Grantor / Program Title / *Pass-Through Grantor*	Assistance Listing Number	Pass-Through Entity Identifying Number	Health Center Program Cluster	Other Expenditures	Total Expenditures	Federal Expenditures Passed Through to Subrecipients
COVID-19 – Coronavirus State and Local Fiscal Recovery Funds – *Arizona Alliance of Community Health Centers*	21.027	MCDPHCAP5	$ –	$ 108,082	$ 108,082	$ –
Total 21.027			–	12,086,006	12,086,006	–
Total U.S. Department of Treasury			–	**12,086,006**	**12,086,006**	–
Federal Communications Commission:						
COVID-19 – COVID-19 Telehealth Program	32.006		–	971,710	971,710	–
Total Federal Communications Commission			–	**971,710**	**971,710**	–
U.S. Department of Health and Human Services:						
Maternal and Child Health Federal Consolidated Programs – *Arizona Department of Health Services*	93.110	CTR054270	–	22,800	22,800	–
Coordinated Services and Access to Research for Women, Infants, Children, and Youth	93.153		–	701,694	701,694	–
Family Planning Services – *Arizona Family Health Partnership*	93.217	CTR063883	–	86,050	86,050	–
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224		868,730	–	868,730	–
COVID-19 – Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224		8,347,065	–	8,347,065	–
Total 93.224			9,215,795	–	9,215,795	–
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243		–	366,814	366,814	–

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Expenditures of Federal Awards (continued)

Year Ended June 30, 2023

Federal Grantor / Program Title / *Pass-Through Grantor*	Assistance Listing Number	Pass-Through Entity Identifying Number	Health Center Program Cluster	Other Expenditures	Total Expenditures	Federal Expenditures Passed Through to Subrecipients
Immunization Cooperative Agreements – *Arizona Alliance of Community Health Centers*	93.268	CTR050821	$ –	$ 145,671	$ 145,671	$ –
Viral Hepatitis Prevention and Control – *Arizona Department of Health Services*	93.270	CTR059355	–	84,992	84,992	–
Cooperative Agreement to Support Navigators In Federally-facilitated Exchanges – *Arizona Alliance of Community Health Centers*	93.332	NAVCA210401-01-00	–	7,610	7,610	–
The National Cardiovascular Health Program – *Arizona Department of Health Services*	93.426	CTR041891	–	27,008	27,008	–
COVID-19 – Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution	93.498		–	12,784,970	12,784,970	–
Grants for Capital Development in Health Centers	93.526		–	269,479	269,479	–
COVID-19 – Grants for New and Expanded Services under the Health Center Program	93.527		284,142	–	284,142	–
Teaching Health Center Graduate Medical Education Payment	93.530		–	120,467	120,467	–
Refugee and Entrant Assistance Discretionary Grants – *Mercy Maricopa Integrated Care*	93.576	CTR057399	–	210,375	210,375	–
Ending the HIV Epidemic: A Plan for America — Ryan White HIV/AIDS Program Parts A and B – *Maricopa County Department of Human Health*	93.686	C-86-22-145-x-00	–	30,220	30,220	–

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Expenditures of Federal Awards (continued)

Year Ended June 30, 2023

Federal Grantor / Program Title / *Pass-Through Grantor*	Assistance Listing Number	Pass-Through Entity Identifying Number	Health Center Program Cluster	Other Expenditures	Total Expenditures	Federal Expenditures Passed Through to Subrecipients
Children's Health Insurance Program – *Arizona Alliance of Community Health Centers*	93.767	CMS-1Y1-19-002 CK2C-01	$ –	$ 27,628	$ 27,628	$ –
National Bioterrorism Hospital Preparedness Program – *Arizona Department of Health Services*	93.889	ADHS19-205773	–	100,446	100,446	–
Cancer Prevention and Control Programs for State, Territorial and Tribal Organizations – *Maricopa County Department of Human Health*	93.898	ADHS CTR059657	–	466,200	466,200	–
HIV Emergency Relief Project Grants – *Maricopa County Department of Human Health*	93.914	C-86-22-145-x-00	–	2,122,871	2,122,871	–
HIV Care Formula Grants – *Arizona Department of Health Services*	93.917	ADHS 17-145508	–	2,160,898	2,160,898	–
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918		–	785,270	785,270	–
HIV Prevention Activities Health Department Based – *Arizona Department of Health Services*	93.940	CTR056404	–	430,600	430,600	–
Block Grants for Community Mental Health Services – *Mercy Maricopa Integrated Care*	93.958	YH17-0003-03	–	893,380	893,380	–
Maternal and Child Health Services Block Grant to the States – *Arizona Department of Health Services*	93.994	CTR063883	–	232,905	232,905	–
Total U.S. Department of Health and Human Services			**9,499,937**	**22,078,348**	**31,578,285**	**–**
Total Expenditures of Federal Awards			**$ 9,499,937**	**$ 40,153,368**	**$ 49,653,305**	**$ –**

Maricopa County Special Health Care District
d/b/a Valleywise Health

Notes to Schedule of Expenditures of Federal Awards

Year Ended June 30, 2023

1. Summary of Significant Accounting Policies

Basis of Accounting

The accompanying Schedule of Expenditures of Federal Awards (SEFA) includes the federal grant activity of Maricopa County Special Health Care District d/b/a Valleywise Health (the District) and is presented on the accrual basis of accounting. The information in this SEFA is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Costs Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). The SEFA does not include payments received under the traditional Medicare and Medicaid reimbursement programs, as these programs are outside the scope of the Uniform Guidance. There were no donated goods and personal protective equipment received from federal sources that required recognition or disclosure in the notes to the SEFA.

2. Indirect Costs

The Uniform Guidance provides for a 10% de minimis indirect cost rate election; however, the District did not make this election and uses a negotiated indirect cost rate.

3. Provider Relief Fund

The amount presented on the SEFA for Assistance Listing Number 93.498, COVID-19 – Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution, is for the year ended June 30, 2023. The amount presented below was derived from the Provider Relief Fund (PRF) information reported to the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA):

Name of Reporting Entity for HRSA Reporting Period PRF Report	Period	Reporting Entity Tax Identification Number	Type of Distribution	Total ARP and Other Provider Relief Fund Expenses	Total Lost Revenues	Total
Maricopa County Special Health Care District	4	860830701	ARP	$ –	$ 466,247	$ 466,247
Maricopa County Special Health Care District	5	860830701	General	–	12,318,723	12,318,723
Total PRF Expenditures				$ –	$ 12,784,970	$ 12,784,970

3. Provider Relief Fund (continued)

HHS has indicated the PRF on the SEFA be reported corresponding to reporting requirements of the HRSA PRF Reporting Portal. Payments from HHS for PRF are assigned to 'Payment Received Periods' (each, a Period) based upon the date on which each payment was received. Each Period has a specified Period of Availability and timing of reporting requirements. Entities report into the HRSA PRF Reporting Portal after each Period's deadline to use the funds (i.e., after the end of the Period of Availability).

The SEFA includes $12,784,970 of PRF received from HHS between July 1, 2021 through June 30, 2022. In accordance with guidance from HHS, these amounts are presented as Period 4 and Period 5. Such amounts were recognized as other nonoperating revenues in the District's financial statements for the year ended June 30, 2022.

Schedule Required by the Uniform Guidance

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Findings and Questioned Costs

For the Year Ended June 30, 2023

Section I – Summary of Auditor's Results

Financial Statements

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	Unmodified	
Internal control over financial reporting:		
Material weakness(es) identified?	**Yes**	**X No**
Significant deficiency(ies) identified?	**Yes**	**X None reported**
Noncompliance material to financial statements noted?	**Yes**	**X No**

Federal Awards

Internal control over major federal programs:		
Material weakness(es) identified?	**Yes**	**X No**
Significant deficiency(ies) identified?	**Yes**	**X None reported**
Type of auditor's report issued on compliance for major federal programs:	Unmodified	
Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	**Yes**	**X No**

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Findings and Questioned Costs (continued)

For the Year Ended June 30, 2023

Section I – Summary of Auditor's Results (continued)

Identification of major federal programs:

Assistance Listing Numbers	**Name of federal program or cluster**
17.258, 17.259, 17.278	WIOA Cluster
21.027	COVID-19 – Coronavirus State and Local Fiscal Recovery Funds
93.224, 93.527	Health Center Program Cluster
93.498	COVID-19 – Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution
93.917	HIV Care Formula Grants
93.918	Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease

Dollar threshold used to distinguish between Type A and Type B programs: $ 1,489,599

Auditee qualified as low-risk auditee? ____ **Yes** __X__ **No**

Section II – Financial Statement Findings

No matters were reported.

Section III – Federal Award Findings and Questioned Costs

No matters were reported.

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Summary Schedule of Prior Audit Findings
For the Year Ended June 30, 2023

Federal Award Findings and Questioned Costs

Finding 2022-001

Internal control deficiency and noncompliance over amounts reported in the Schedule of Expenditures of Federal Awards (SEFA).

Auditee Status Update:

An additional review process of the SEFA was implemented that is performed by both the Vice President of Financial Services and the Chief Financial Officer to ensure the SEFA contains complete and accurate reporting of expenditures, and to ensure that applicable guidance is reviewed prior to its finalization.

Finding 2022-002

Internal control deficiency and noncompliance over program income requirements.

Auditee Status Update:

Valleywise Health management developed and implemented internal controls to ensure that program income is accurately calculated and reported in the federal financial report.

Finding 2022-003

Internal control deficiency and noncompliance over small purchase procurement requirements.

Auditee Status Update:

The Valleywise Health Administrative Policy and Procedure policy was updated for procurement procedures to be followed. The policy is now included in the Compliance 360 portal.

Valleywise Health

Summary Schedule of Prior Audit Findings
For the Year Ended June 30, 2023 (continued)

Federal Award Findings and Questioned Costs (continued)

Finding 2021-001

Noncompliance over Activities Allowed or Unallowed, Allowable Costs/Cost Principles, and Eligibility.

Auditee Status Update:

All accounts submitted under the COVID-19 – HRSA COVID-19 Claims Reimbursement for the Uninsured Program and the COVID-19 Coverage Assistance Fund were reviewed for eligibility coverage to revalidate the uninsured status of the patients at the time the services were provided. The questioned costs identified were refunded.

Finding 2021-002

Internal control deficiency and noncompliance over amounts reported in the Schedule of Expenditures of Federal Awards (SEFA).

Auditee Status Update:

An additional review process of the SEFA was implemented that is performed by both the Vice President of Financial Services and the Chief Financial Officer to ensure the SEFA contains complete and accurate reporting of expenditures, and to ensure that applicable guidance is reviewed prior to its finalization.

Finding 2021-003

Internal control deficiency and noncompliance over the calculation of lost revenues attributable to Coronavirus.

Auditee Status Update:

The Vice President of Financial Services performed an additional layer of review on the calculation of lost revenues attributable to Coronavirus. The latest audited financial statements were used for the data included in the calculation.

Valleywise Health

Summary Schedule of Prior Audit Findings
For the Year Ended June 30, 2023 (continued)

Federal Award Findings and Questioned Costs (continued)

Finding 2021-004

Internal control deficiency and noncompliance over program income requirements.

Auditee Status Update:

Valleywise Health management developed and implemented internal controls to ensure that program income is accurately calculated and reported in the federal financial report.

Finding 2021-005

Internal control deficiency over procurement and suspension and debarment.

Auditee Status Update:

A new internal committee headed by the Compliance Department that also includes Accounts Payable, Supply Chain, Finance, Grants and Contracts department had been developed with the sole purpose of reviewing vendors currently doing business with Valleywise Health. The committee meets to review the listing of vendors and send them over to a third party that specializes in vendor screening for suspension and debarment.

Agenda item intentionally omitted

9. Ambulatory Operational Dashboards

FQHC Measures

as of March 2024

Access

Average of Appointment Fill Rates FYTD

90.2%

New Patient Availability (Days)

16.1

No Show Rate FYTD

16.7%

Referrals Ready to Book in ≤ 3 Days by Percentage (MTD)

95.7%

Patient Satisfaction

Net Promoter Score FYTD

74.2

Quality

Quality measures at or Above Target CYTD

Meet or Exceeding Target Goal	46%
Within 10% of the Target Goal	23.0%
>10% Outside target Goal	31%

Financial

% Variance of Revenue FYTD

0.0%

% Variance of Expenses FYTD

-1.0%

% Variance of Visits MTD

-6.6%

Valleywise Health

Ambulatory Pillars Dashboard

March 2024

Community Health Centers

Other FQHC Clinics

PATIENT EXPERIENCE - Ambulatory

	Target	Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen	McDowell **	McDowell - Mesa ***		VCHCs FYTD	Peoria Primary Care	Women's Clinic	Antepartum Testing	Diabetes Ed	Internal Medicine P	Peds Primary		Other FQHC-Peoria FYTD	Grand Total
Net Promoter Score FYTD *(Would recommend facility)*	≥73.0	75.4	71.7	66.7	79.8	68.6	75.5	74.6	73.8	81.9	89.4		74.5	74.8	73.9	73.4	82.1	72.1	73.5		73.7	74.2
	n-size	2,015	2,514	729	1,353	2,293	2,656	2,351	1,980	1,913	104		17,908	2,468	2,324	357	156	2,702	1,338		9,345	27,253

ACCESS - Ambulatory

	Target	Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen	McDowell **	McDowell - Mesa ***		VCHCs FYTD	Peoria Primary Care	Women's Clinic	Antepartum Testing	Diabetes Ed	Internal Medicine P	Peds Primary		Other FQHC-Peoria FYTD	Grand Total
Appointments Scheduled FYTD		22,572	26,806	10,622	24,155	26,048	28,131	29,042	19,918	31,407	1,564		220,265	35,524	29,620	12,488	3,638	24,559	21,244		127,073	347,338
Appointment Fill Rate FYTD		89.1%	93.1%	91.6%	91.5%	92.6%	93.3%	90.2%	94.1%	94.9%	90.6%		92.4%	84.6%	87.3%	100.0%	n/a	96.6%	70.8%		85.7%	90.2%
Scheduled Appointment No-Shows FYTD		2,802	3,705	1,876	4,123	4,470	5,151	5,742	3,562	6,734	314		38,479	5,066	4,343	1,115	864	4,071	4,102		19,561	58,040
No Show Rate FYTD	<18%	12.4%	13.8%	17.7%	17.1%	17.2%	18.3%	19.8%	17.9%	21.4%	20.1%		17.5%	14.3%	14.7%	8.9%	23.7%	16.6%	19.3%		15.4%	16.7%

FINANCE - Ambulatory

		Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen	McDowell **	McDowell - Mesa ***		VCHCs FYTD	Peoria Primary Care	Women's Clinic	Antepartum Testing	Diabetes Ed	Internal Medicine P	Peds Primary		Other FQHC-Peoria FYTD	Grand Total FQHC ****	FYTD FQHC *****
In-Person Visits FYTD		12,938	13,753	4,695	12,991	13,460	13,374	15,350	10,657	11,402	685		109,305	17,584	15,167	8,044	1,055	14,006	13,055		68,911		201,273
Virtual Visits FYTD		1,121	1,207	756	619	1,011	1,914	946	493	2,972	138		11,177	2,238	252	19	12	231	24		2,776		31,983
Total Actual Visits (includes Nurse Only Visits) FYTD		14,059	14,960	5,451	13,610	14,471	15,288	16,296	11,150	14,374	823		120,482	19,822	15,419	8,063	1,067	14,237	13,079		71,687		233,256
Budgeted Visits FYTD		14,068	16,898	6,504	14,534	15,084	16,275	15,961	12,529	12,857	764		125,474	21,672	14,916	7,086	1,080	14,840	13,290		72,884		236,500
Variance FYTD		(9)	(1,938)	(1,053)	(924)	(613)	(987)	335	(1,379)	1,517	59		(4,992)	(1,850)	503	977	(13)	(603)	(211)		(1,197)		(3,244)
Variance by % FYTD		-0.1%	-11.5%	-16.2%	-6.4%	-4.1%	-6.1%	2.1%	-11.0%	11.8%	7.7%		-4.0%	-8.5%	3.4%	13.8%	-1.2%	-4.1%	-1.6%		-1.6%		-1.4%
Total Number of Patients seen by provider FYTD		13,591	14,513	5,219	12,557	13,972	14,752	15,968	10,637	12,437	658		114,304	19,278	13,984			13,938	12,560		59,760	174,064	

BEHAVIORAL HEALTH - Ambulatory

Finance	Target	Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen		BH Psychiatry		BH FYTD	PEC	PXC
In-Person Visits FYTD		494	425	195	384	901	606	87	193		190		4,989	541	973
Virtual Visits FYTD		2,067	1,240	1,136	1,041	2,562	1,053	1,967	1,233		3,119		18,030	2,612	0
Total Actual Visits FYTD		2,561	1,665	1,331	1,425	3,463	1659	2,054	1426		3309		23,019	3,153	973
Budget Visits FYTD		2,374	1,352	1,273	1,199	2,885	1082	3,135	1367		2150		20,482	3,274	391
Variance FYTD		187	313	58	226	578	577	(1081)	59		1159		2,537	(121)	582
Variance by % FYTD		7.9%	23.2%	4.6%	18.8%	20.0%	53.3%	-34.5%	4.3%		53.9%		12.4%	-3.7%	148.8%

DENTAL - Ambulatory

Finance		Avondale	Chandler							McDowell **			Dental FYTD	PEC	PXC
Actual Visits FYTD		2,130	2,252							2,459			18,068	3,877	7,350
Budget Visits FYTD		1,889	1,892							2,812			17,660	3,755	7,312
Variance FYTD		241	360							-353			408	122	38
% Variance FYTD		12.8%	19.0%							-12.6%			2.3%	3.2%	0.5%

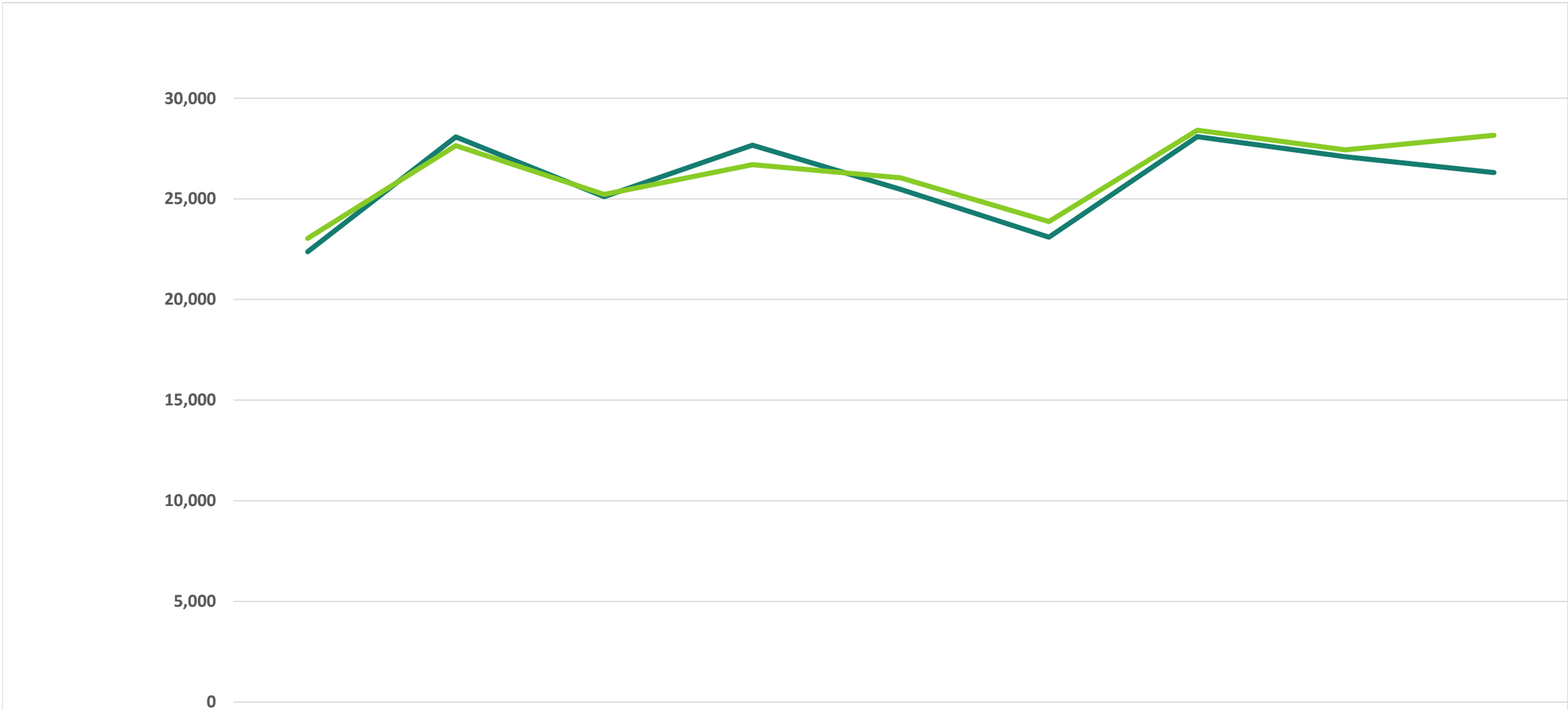
LEGEND:

- Not in Target
- 5% less than the target
- Target ≥ 95%

** Specialty HIV Community Health Center
*** Specialty HIV Community Health Clinic - McDowell Services
**** Grand Total FQHC for Total Number of Patients seen by provider FYTD includes Community Health Centers & Other FQHCs
***** FYTD FQHC for Actual/Budgeted Visits includes Community Health Centers, Other FQHCs, Dental, & OP Behavioral Health Clinics

Valleywise Health

FQHC Grand Total Actual vs Budgeted Visits
FY 2024 Trend



	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
FYTD Actual Visits	22,371	28,071	25,108	27,666	25,472	23,095	28,088	27,084	26,301
FYTD Budgeted Visits	23,039	27,639	25,218	26,692	26,040	23,871	28,417	27,429	28,155

Ambulatory Care

Quality /Regulatory Metrics	Reporting Program	2022 UDS National Average	CYTD 2023	Desired Direction	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	YTD
Unified Data System																	
Body Mass Index (BMI) Screening and Follow-Up Plan	HRSA	> 61.04%	92.31%	↑	✓ 88.52%	✓ 90.00%											✓ 90.00%
Numerator					11,701	18,898											18,898
Denominator					13,219	20,997											20,997
Cervical Cancer Screening	HRSA	> 53.99%	57.20%	↑	✓ 56.60%	✓ 55.73%											✓ 55.73%
Numerator					4,087	6,271											6,271
Denominator					7,221	11,252											11,252
Childhood Immunization Status (CIS)	HRSA	> 33.23%	37.62%	↑	✗ 15.90%	✗ 16.88%											✗ 16.88%
Numerator					62	108											108
Denominator					390	640											640
Colorectal Cancer Screening	HRSA	> 42.82%	46.18%	↑	✗ 33.81%	✗ 36.12%											✗ 36.12%
Numerator					2,646	4,444											4,444
Denominator					7,827	12,303											12,303
Controlling High Blood Pressure	HRSA	> 63.40%	58.07%	↑	✗ 55.02%	! 57.13%											! 57.13%
Numerator					2,889	4,729											4,729
Denominator					5,251	8,277											8,277
Diabetes: Hemoglobin A1c Poor Control	HRSA	< 30.42%	29.87%	↓	✗ 60.66%	✗ 52.48%											✗ 52.48%
Numerator					2,222	3,044											3,044
Denominator					3,663	5,800											5,800
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	HRSA	> 76.83%	76.08%	↑	! 76.52%	! 76.76%											! 76.76%
Numerator					528	849											849
Denominator					690	1,106											1,106
Screening for Clinical Depression and Follow-Up Plan if positive screen	HRSA	> 70.02%	73.77%	↑	! 67.06%	! 69.50%											! 69.50%
Numerator					7,743	12,607											12,607
Denominator					11,546	18,139											18,139
Tobacco Use: Screening and Cessation Intervention	HRSA	> 84.60%	90.12%	↑	! 81.84%	✓ 84.96%											✓ 84.96%
Numerator					3,222	7,640											7,640
Denominator					3,937	8,992											8,992
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	HRSA	> 69.81%	78.14%	↑	✗ 46.99%	✗ 50.71%											✗ 50.71%
Numerator					1,016	1,823											1,823
Denominator					2,162	3,595											3,595
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	HRSA	> 76.07%	75.29%	↑	✓ 76.40%	✓ 76.88%											✓ 76.88%
Numerator					3,470	5,543											5,543
Denominator					4,542	7,210											7,210
Breast Cancer Screening	HRSA	> 50.28%	61.32%	↑	✓ 53.51%	✓ 55.39%											✓ 55.39%
Numerator					1,829	2,937											2,937
Denominator					3,418	5,302											5,302
HIV Screening	HRSA	> 43.82%	67.50%	↑	✓ 71.15%	✓ 70.15%											✓ 70.15%
Numerator					8,937	13,823											13,823
Denominator					12,561	19,706											19,706

‡ -

****Data is pulled from the UDS dashboard on the 1st Friday of every month**

Data Not Available	~
Data is not final and subject to change	‡
Equal or greater than benchmark	✓
Less than 10% negative variance	!
Greater than 10% negative variance	✗

**Known issue* - childhood immunizations measure logic not currently recognizing PCV15 or PCV20 vaccine formulations
-Result/Impact : false negative scoring on measure
-Resolution : 2024 value set update expected in Q3 Epic Upgrade

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

	Data Source	Owner	Frequency	System
PATIENT EXPERIENCE - Ambulatory				
Net promoter score (Would recommend facility)	A customer loyalty index calculated based on a patient's response on a scale of 1-10 to the question "How likely would you be to recommend this facility to your family and friends?". The NPS = % Promoters (9 or 10 responses) - % Detractors (0-6 responses) *Scores are limited to include only FQHC departments by clinic cost center on this dashboard for: 416603, 416608, 416609, 416704, 416707, 416711, 416601, 416701, 416613, 476707, 576130, 576101, 476101, 476102, 476104, 476106, 476105* *Dental, Financial Counseling, Lab, Radiology, Ophthalmology, and other Specialty departments within each community health center are excluded from locational roll ups*	NRC Real Time Score Summary *pulled by Amanda Jacobs	Monthly	NRC Health - Department Summary Report
ACCESS - Ambulatory				
Appointments Scheduled FYTD	All appointment visits are included, except from Dental, Financial Counseling, Lab, Radiology, Ophthalmology, and other Specialty departments. *For FYTD. *Note: For active providers only - FYTD does not account for historical provider information	FQHC Appointment Statistics by Clinic Details (Prior Month) Report *last modified 6/2/2020 by Vondra Dee Nason *pulled by Amanda Jacobs	Monthly	EPIC Report
Appointment Fill Rate FYTD	Provider schedule utilization metric calculated by number of patients to appointment slots available. *For MTD and FYTD. Data is pulled from Epic Clarity: Availability table, which looks at the Provider Templates. *Limited to MD, NP, PA, and Midwives - as of February 2024 data*	FQHC Clinic Performance Dashboard FQHC Provider Availability *pulled by Amanda Jacobs	Monthly	Tableau
Scheduled Appointment No-Shows FYTD	All No- show appointment visits are included, except from Dental, Financial Counseling, Lab, Radiology, Ophthalmology, and other Specialty departments. *For FYTD.	FQHC Appointment Statistics by Clinic Details (Prior Month) Report *last modified 6/2/2020 by Vondra Dee Nason *pulled by Amanda Jacobs	Monthly	EPIC Report
No Show Rate FYTD	Percentage of Scheduled Patients who were a "No show" patient or same day cancellation. *For FYTD.	Amanda Jacobs	Monthly	Formula
FINANCE - Ambulatory				
In-Person Visits FYTD	Total Actual Visits (includes nurse only visits) FYTD - Virtual Visits FYTD	Nancy Horskey	Monthly	Axiom
Virtual Visits FYTD	Virtual Telemedicine Visits (telephonic/audio/visual/other virtual type) FYTD	Nancy Horskey	Monthly	Axiom
Total Actual Visits (includes nurse only visits) FYTD	All visits per Clinic (visit count methodology). For the Fiscal Year to Date	Nancy Horskey	Monthly	Axiom
Budgeted Visits FYTD	All budgeted visits per Clinic (visit count methodology) For the Fiscal Year to Date	Nancy Horskey	Monthly	Axiom
Variance FYTD	Actual Visits FYTD (includes nurse only visits) - Budgeted Visits FYTD. For the Fiscal Year to Date	Amanda Jacobs	Monthly	Formula
Variance by % FYTD	Variance FYTD / Budgeted Visits FYTD (%) For the Fiscal Year to Date	Amanda Jacobs	Monthly	Formula
Total Number of Patients seen by provider	Completed visits for provider only	Maria Aguirre	Monthly	Epic - Clarity Query
Grand Total FQHC	Includes Month Totals from Community Health Centers, Dental, Other FQHC, and OP Behavioral Health clinics	Amanda Jacobs	Monthly	Formula
FYTD FQHC	Includes FYTD Totals from Community Health Centers, Dental, Other FQHC, and OP Behavioral Health clinics	Amanda Jacobs	Monthly	Formula

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

	Data Source	Owner	Frequency	System
FINANCE - BEHAVIORAL HEALTH				
In-Person Visits FYTD	Total Actual Visits (includes nurse only visits) FYTD - Virtual Visits FYTD	Nancy Horskey	Monthly	Axiom
Virtual Visits FYTD	Virtual Telemedicine Visits (telephonic/audio/visual/other virtual type) FYTD	Nancy Horskey	Monthly	Axiom
Total Actual Visits FYTD	Actual Visits per BH Clinic (all visits per Valleywise Health month end visit count methodology) For fiscal year to date	Nancy Horskey	Monthly	Axiom
Budgeted Visits FYTD	Budgeted Visits per BH Clinic (all visits per Valleywise Health month end visit count methodology) For fiscal year to date	Nancy Horskey	Monthly	Axiom
Variance FYTD	Actual Visits FYTD (includes nurse only visits) - FYTD Budgeted Visits	Amanda Jacobs	Monthly	Formula
Variance by % FYTD	Variance FYTD/ Budgeted Visits FYTD (%)	Amanda Jacobs	Monthly	Formula
FINANCE-DENTAL				
Actual Visits FYTD	All visits per Dental Clinic (visit count methodology) For fiscal year to date	Nancy Horskey	Monthly	Axiom
Budgeted Visits FYTD	All budgeted visits per Dental Clinic (visit count methodology) For fiscal year to date	Nancy Horskey	Monthly	Axiom
Variance FYTD	Actual Visits FYTD (includes nurse only visits) - FYTD Budgeted Visits	Amanda Jacobs	Monthly	Formula
Variance by % FYTD	Variance FYTD/ Budgeted Visits FYTD (%)	Amanda Jacobs	Monthly	Formula

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

		Data Source	Owner	Frequency	System
QUALITY - Ambulatory					
Quality /Regulatory Metrics	**Required by:**		Quality	Monthly	
Body Mass Index (BMI) Screening and Follow-Up	**CMS69v11**	**Description:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the measurement period AND who had a follow-up plan documented if BMI was outside of normal parameters **Numerator:** Patients with a documented BMI during the encounter or during the measurement period, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the measurement period **Denominator:** All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms069v11*	Quality	Monthly	EPIC/UDS
Cervical Cancer Screening	**CMS124v11**	**Description:** Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: * Women age 21-64 who had cervical cytology performed within the last 3 years * Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years **Numerator:** Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: * Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test * Cervical human papillomavirus (HPV) testing performed during the measurement period or the four years prior to the measurement period for women who are 30 years or older at the time of the test **Denominator:** Women 24-64 years of age by the end of the measurement period with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms124v11*	Quality	Monthly	EPIC/UDS
Childhood Immunization Status (CIS)	**CMS117v11**	**Description:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (Hib); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday **Numerator:** Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday **Denominator:** Children who turn 2 years of age during the measurement period and who have a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms117v11*	Quality	Monthly	EPIC/UDS

		Data Source	Owner	Frequency	System
Colorectal Cancer Screening	**CMS130v11**	**Description:** Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer **Numerator:** Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: * Fecal occult blood test (FOBT) during the measurement period * Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period * Colonoscopy during the measurement period or the nine years prior to the measurement period * FIT-DNA during the measurement period or the two years prior to the measurement period * CT Colonography during the measurement period or the four years prior to the measurement period **Denominator**: Patients 45-75 years of age by the end of the measurement period with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms130v11*	Quality	Monthly	EPIC/UDS
Controlling High Blood Pressure	**CMS165v11**	**Description**: Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period **Numerator:** Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period **Denominator:** Patients 18-85 years of age by the end of the measurement period who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period. ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms165v11*	Quality	Monthly	EPIC/UDS
Diabetes: Hemoglobin A1c Poor Control	**CMS122v11**	**Description:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period **Numerator:** Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period. **Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms122v11*	Quality	Monthly	EPIC/UDS
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	**CMS164v7**	**Description:** Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period or who had an active diagnosis of IVD during the measurement period, and who had documented use of aspirin or another antiplatelet during the measurement period **Numerator:** Patients who had an active medication of aspirin or another antiplatelet during the measurement year **Denominator:** Patients 18 years of age and older with a visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had a diagnosis of IVD overlapping the measurement year ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS164v7.html*	Quality	Monthly	EPIC/UDS

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

		Data Source	Owner	Frequency	System
Screening for Clinical Depression and Follow-Up Plan	**CMS2v12**	**Description:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter **Numerator:** Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter **Denominator**: All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms002v12*	Quality	Monthly	EPIC/UDS
Tobacco Use: Screening and Cessation Intervention:	**CMS138v11**	**Description:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user **Numerator:** *Patients who were screened for tobacco use at least once during the measurement period and *Who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user **Denominator:** Patients aged 18 years and older seen for at least two medical visits in the measurement period or at least one preventive medical visit during the measurement period. ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms138v11*	Quality	Monthly	EPIC/UDS
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	**CMS155v11**	**Description:** Percentage of patients 3–17* years of age who had an outpatient visit with a primary care physician or OB/GYN and who had evidence of height, weight, and body mass index (BMI) percentile documentation, who had documentation of counseling for nutrition, and who had documentation of counseling for physical activity during the measurement period **Numerator:** Children and adolescents who have had: *their height, weight, and BMI percentile recorded during the measurement period and *counseling for nutrition during the measurement period and *counseling for physical activity during the measurement period **Denominator:** Patients 3 through 17 years of age by the end of the measurement period, with at least one outpatient visit with a PCP or OB/GYN during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms155v11*	Quality	Monthly	EPIC/UDS

		Data Source	Owner	Frequency	System
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	**CMS347v6**	**Description:** Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: *All patients with an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or ever had an ASCVD procedure; OR *Patients aged >= 20 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR *Patients aged 40-75 years with a diagnosis of diabetes **Numerator:** Patients who are actively using or who receive an order (prescription) for statin therapy at any time during the measurement period **Denominator:** All patients who have an active diagnosis of clinical ASCVD or ever had an ASCVD procedure. Patients aged >= 20 years at the beginning of the measurement period who have ever had a laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia. Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes. ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms347v6*	Quality	Monthly	EPIC/UDS
Breast Cancer Screening	**CMS125v11**	**Description:** Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the Measurement Period **Numerator:** Women with one or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period **Denominator:** Women 52-74 years of age by the end of the measurement period with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms125v11*	Quality	Monthly	EPIC/UDS
HIV Screening	**CMS349v5**	**Description:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for Human immunodeficiency virus (HIV) **Numerator:** Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday **Denominator:** Patients 15 to 65 years of age at the start of the measurement period AND who had at least one outpatient visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms349v5*	Quality	Monthly	EPIC/UDS