The County of Santa Cruz
Integrated Community Health Center Commission
MEETING AGENDA
November 7, 2019 @ 11:00 am

Meeting Location: 1080 Emeline Ave., Suite D, DOC Conference Room, Santa Cruz, CA 95060
1939 Harrison Street, Suite 211, Oakland, CA 94612
40 Eileen St., Watsonville CA 95076

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

1. Welcome/Introductions

2. Oral Communications

3. September 5, 2019 Meeting Minutes – Recommend for Approval

4. Quality Management Committee Update

5. Pharmaceutical Rep Policy – Recommend for Approval

6. Warm Hand Off Policy – Recommend for Approval

7. Attendance - Integrated Community Health Center Commission Meetings

8. Update to HSA Billing Fiscal Office Policy and Procedures 100.03 – Recommend for Approval

9. Long Term Space Needs for South County

10. Financial Update

11. CEO Update

Action Items from Previous Meetings:

Action Item	Person(s) Responsible	Date Completed	Comments
Review and Visit metrics annually, Include IBH in future reviews.	Julian		
Raquel to research Dientes survey company and see how expensive it is and report back to the commission.	Raquel		
Julian to add expenditure in the "Impacts" section of the fiscal report.	Julian		
Add column and show comparison data to state and national averages.	Raquel		
Bring updated corrected UDS report.	Raquel		
New Calendar with back up meeting dates.	Mary		

Next meeting: December 5, 2019 11:00 am- 1:00 pm
1080 Emeline Ave., Bldg., D (DOC Conference Room, 2nd Floor) Santa Cruz, CA 95060

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held September 5, 2019

Attendance	
Christina Berberich	Member
Rahn Garcia	Member
Marco Martinez-Galarce	Member
Len Finocchio	Member
Caitlin Brune	Member
Pamela Hammond	Member
Raquel Ramírez Ruiz	County of Santa Cruz, Senior Health Services Manager
Julian Wren	County of Santa Cruz, Administrative Services Manager
Mary Olivares	County of Santa Cruz, Administrative Aide
Meeting Commenced at 11:09 am and Concluded at 1:03 pm	

1. Excused/Absent:

Absent: Gustavo Mendoza
Absent: Bertha Villalobos
Absent: Dinah Phillips
Excused: Amy Peeler

2. Welcome/Introductions

3. Oral Communications:

Dr. Michele Violich, Medical Director and Walter Espinoza, Health Center Manager thanked the Commission for coming to the Watsonville Health Center (WHC). They stated last month they saw an 18% patient increase. They would like to expand the OB care and have an expanding Medication Assisted Treatment Program, but space is a limiting factor. There was much discussion on plumbing, AC issues, and long-term county space needs and functions. The Commission stated it would be useful to have a presentation on the strategic plan to understand County's long-term planning for infrastructure needs. Raquel also mentioned there is an infrastructure grant available from the Central California Alliance for Health she will investigate for construction. The Commission would like this item added on future agendas to be called "long term space needs for south county".

4. September 5, 2019 Meeting Minutes - Action item

Review of September 5, 2019 Meeting Minutes - Recommended for Approval. One change to minutes was to correct next meeting date to state Sept. 5, 2019. Rahn moved to accept with change of date, Caitlin second, and the rest of the members present were in favour, Christina abstained.

5. Service Area Review-Recommend for Approval

Raquel presented the Integrated Community Health Center Commission Annual Services Area review for approval. Raquel stated the goal is to define and review the boundaries of the catchment area to be served, including the identification of the medically underserved. This is done once a year to ensure services provided are available and accessible to residents promptly and appropriately. Raquel went over the process: review and define services area, map of medically underserved populations, Health Center locations, service area zip codes declared on HRSA Form 5B: service sites, uniform data system and review analysis & conclusions. Staff recommended to update the zip codes to more accurately reflect the patient population. Rahn moved to accept, Marco second, and the rest of the members present were in favour.

6. Quality Management Committee Update

Raquel reported to Commission that the Peer Review Committee is working on a tool for our employees to have a formal way to address issues observed in clinic. This will be available to employees electronically and complaints will be sent directly to Raquel for review then she will triage the complaint to the Peer Review Committee, Chief Medical Officer, Chief of Clinic Services, Medical Directors, and/or Personnel. Raquel stated she hopes to have this launched to employees within the next 2 months. Raquel also gave an update on mortality data, she stated there were six deaths reported last month and that all had received proper treatment. Raquel also stated that she is looking for an agency to contract with to conduct the patient satisfaction surveys. This will streamline the process and will result in survey data collected year-round. This will improve patient feedback and will guide quality improvement projects.

7. Financial Update - Approval

Julian went over budget highlights. He stated telecommunication cost were higher than expected ($200k), $847,707 was transferred from trust fund to keep net county cost at estimated actuals. He stated efficiencies and improvements from open encounter to registration to business office team to increase collections. Expenditures were also down and revenue in

general was down due to provider vacancies and remodels. Julian presented visit metrics this is a weekly total of all arrived completed appointments, he stated at another meeting he will bring back break down by clinic. Other information Julian presented was General prioritization, increase collections, reduce cost to collect, and increase patient satisfaction. He stated in November he's having a billing expert come in to give suggestions on how we can be more efficient, Julian stated he will report back on this.

8. CEO update

Raquel gave an update on Amy's behalf on the following: She stated that Medication Assisted Treatment (MAT) received a grant through Janus that is helping fund position of 1 Admin Aide, and 2 Medical Assistants. She also stated that Clinics is looking at group therapy, and yoga sessions for our patients. The Health Services Agency hired Assistant Director, Marcus Pimentel.

Other items discussed at this time:
- Commission wants 30-minute alone time prior to each meeting with clinic staff and management and to rotate each meeting to each of the sites with communication and forewarning as to what to expect.
- Commission would like someone from HPHP clientele on the commission.
- Commission would like ongoing communications about progress on the Clinic strategic plan.

Action items:

- Commission Committee would like an updated calendar to list back up meeting dates.
- Some of HRSA requirements have changed a bit Amy will report back at our next meeting.
- Commission would like this item added on future agendas to be called "long term space needs for south county".
- Julian presented visit metrics this is a weekly total of all arrived completed appointments, he stated at next meeting he will bring back break down by clinic.

Next Meeting: October 3, 2019 11:00 am – 1:00 pm
1080 Emeline, Santa Cruz, CA

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

SUBJECT: Pharmaceutical Representatives	POLICY NO.: **100.08** PAGE: 1 OF 1	
		COUNTY OF SANTA CRUZ
SERIES: 100 Administration	EFFECTIVE DATE: October 2019	HEALTH SERVICES AGENCY
APPROVED BY: Amy Peeler, Chief of Clinic Services	REVISED:	**Clinics and Ancillary Services**

GENERAL STATEMENT:

The practice of accepting free pharmaceutical samples risks interference with provider prescribing practices since industry representatives often provide the newest and most costly drugs. Therefore, free pharmaceutical samples and vouchers for free pharmaceutical samples may not be accepted.

REFERENCE:
None.

PROCEDURE:

Pharmaceutical samples must not be accepted except when samples are necessary for patient education (e.g., instructing patients in the use of inhalers), they may be accepted, provided they do not carry the name of a company or the name of the company is covered.

Free gifts such as non-educational lunches and items imprinted with product logos must never be accepted.

Health Center staff will inform patients of affordable options for obtaining medicines. Examples are pharmaceutical assistance programs, vouchers, and retail pharmacies with low-cost medicines.

To protect patients, patient care areas, and work schedules, access by pharmaceutical, medical testing and other industry representatives to individual providers must be restricted to non-patient care areas. Access will be permitted only on invitation from a medical director. Invitations should be appropriately communicated to health center staff.

SUBJECT: Integrated Behavioral Health Warm Handoffs	POLICY NO.: **300.30** PAGE: 1 OF 3	
		COUNTY OF SANTA CRUZ
		HEALTH SERVICES AGENCY
SERIES: 300 Patient Care and Treatment	EFFECTIVE DATE: October 2019	**Clinics and Ancillary Services**
APPROVED BY: Amy Peeler, Chief of Clinic Services	REVISED:	

GENERAL STATEMENT:

Physical and psychological wellness are intertwined. Systems of care that address the whole person contribute to better patient outcomes and greater patient satisfaction. It is the policy of the Health Services Agency Clinic Services Division to enlist psychologists, licensed clinical social workers, psychiatrists, and psychiatric nurse practitioners as well as medical assistants and other staff to provide a range of behavioral health services, including warm handoffs.

POLICY STATEMENT:

Warm handoffs are provided by members of the Integrated Behavioral Health (IBH) team in response to requests from clinic staff including but not limited to reception staff, providers, medical assistants, nurses, and health center managers. Warm handoffs support and extend the work of the medical staff by offering brief, immediate, high quality behavioral health contacts for patients who may benefit from services. Warm handoffs introduce behavioral health services and staff to patients and have been shown to increase show rates. Warm handoffs reduce the stigma often associated with mental health care. Warm handoffs may be used to address crisis and emergency situations.

It is understood that the warm handoff is an on-call function and, by definition, uniquely demanding as it frequently requires IBH staff to *simultaneously* address the needs of multiple individuals.

REFERENCE:
None.

PROCEDURE:

1. A warm handoff is appropriate and welcome anytime clinical or other staff believe it would be helpful for the patient. Reasons for referral may include a patient with depression who has not followed through with previous referral to IBH, a patient requesting support for substance use recovery, or a patient needing coping skills to deal with a life crisis or anxiety.

2. The warm handoff process differs by setting and is as follows:

   Emeline Clinic: any staff may contact the IBH provider on duty by calling the IBH line at x4808, or going to room 101 and requesting a warm handoff. If the door is closed, staff may knock on the door to interrupt. The provider on duty is responsible for taking the warm handoff or finding another provider to do so.

   Watsonville Health Center: staff contacts the IBH medical assistant (MA), who locates an IBH

provider to do a warm handoff. If the MA is not available, staff may look at the schedule to locate an available IBH provider and then contact them either by phone or in person. If the office door is closed staff may knock on the door to interrupt.

3. In emergent circumstances, IBH team meetings may be interrupted and any member of the IBH team can be asked for assistance and will either respond immediately or locate another member of the team to do so.

4. IBH will make every effort to assist our medical colleagues when a warm handoff is requested. Nevertheless, there will be times when a warm handoff is not available.

   The IBH staff providing the warm handoff will not automatically be assigned that patient for ongoing visits. The job of the IBH staff doing the warm handoff is to:

   a. Get information from the referring staff on the reason for the handoff.

   b. Listen to and assess the needs of the patient.

   c. Based on assessment, schedule the patient for an intake with an IBH clinician. The immediacy of scheduling will depend on the needs of the patient. The choice of clinician will also vary according to patient needs (e.g. requests for a therapist of a specific gender, need for a Spanish speaking therapist etc.).

5. Warm handoffs must be documented in EPIC by IBH staff in the form of a SOPA note which includes who requested the warm handoff and why and by using the following:

   a. Encounter type: Interim note

   b. Chief complaint when entered by a therapist: Behavioral health staffing note

   c. Chief complaint when entered by psychiatry: Psychiatry consult

   d. Header of note should state "Warm Handoff"

6. Warm handoffs are documented in EPIC by the referring provider and include a statement that the warm handoff occurred, why the referral was made (e.g. concerns about low mood), and name of the staff who provided the handoff.

7. Warm handoff procedure for medical staff:

   a. Provide IBH staff with name, age, and date of birth of the patient

   b. Explain why the handoff is needed.

   c. Escort IBH staff to exam room, unless the room is needed. If this is the case, the patient can be escorted to the IBH staff office or to another vacant office.

d. Introduce IBH staff. For MDs and psychologists use of the honorific "Dr." is appropriate.

e. Briefly explain the reason for the handoff, "Dr. Brooks thought it might be helpful for you to talk with Dr. Willkie about the loss of your cat."

f. If possible, inject hope that IBH can help. Some examples:

"I refer to these guys all the time, they really help a lot of my patients."

"You're in good hands with IBH."

"Our IBH psychiatry group is excellent; you will get great care."

g. Inform IBH staff of intended disposition for patient (e.g., after handoff, patient to wait for MA to bring after visit summary, or patient to go to lab for blood draw, etc.)

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: **100.03** PAGE: 1 OF 14	
SERIES: **100** Administration	EFFECTIVE DATE: October 20~~1~~94	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
APPROVED BY: Amy Peeler, Chief of Clinic Services	REVISED: ~~August~~ October ~~July~~ ~~2017~~219	**Clinics and Ancillary Services**

POLICY STATEMENT:

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

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

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

PROCEDURE:

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

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

   2. ~~Screening~~ The screening will include exploration of the patient's possible qualification for specialized payer programs. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.

   3. The Business Office Manager and Health Center Managers are authorized to waive patient fees due to expressed financial hardship or disputes.

B. General Payers

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

      a. Assigned to HSA~~CSD~~ for their primary care; or

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

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

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

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

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

C. Specialized Payers

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

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

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

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

      d. MediCruz: Locally funded program that provides specialty care to undocumented patients who fall at or below 100% of the Federal Poverty Level. Patients fill out an application and provide verification documents.

D. Self-Pay Payers

1. Uninsured patients, or patients with non-contracted insurance types, are responsible to pay for visit costs, including ancillary services. Uninsured and underinsured patients are encouraged to apply for the Ability to Pay (Sliding Fee) Program, if eligible.

E. Verification of Eligibility and Benefits Determination by Payer

1. Medi-Cal

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

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

2. Central California Alliance for Health (CCAH)

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

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

3. Medicare

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

    b. Benefits Determination: Co-insurances are due on the date of service. Normally Medicare requires an annual deductible that must be met prior to accessing benefits. ~~benefits however HSA at CHS allows a waiver of deductible Medicare patients programs programs~~

4. Other Government Funded Programs

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

    b. Benefits Determination

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

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

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

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

5. Commercial Insurance

    ~~a.~~ Eligibility Verification: Eligibility will ~~may~~ be verified with contracted insurances using the insurance company's website or via the telephone number provided on the patient's insurance card. ~~Patients requesting courtesy billing for non-contracted insurances are informed of their financial obligation to pay for any services amounts CSD is not reimbursed for.~~

    ~~b.~~a. Benefits Determination: As insurance plan benefits vary significantly, it is the patient's responsibility to understand their insurance benefits prior to obtaining services. Since understanding health insurance benefits can be challenging, as a courtesy, HSA ~~CSD~~ staff may assist patients with obtaining coverage information.

F. Enrollment: Other State Funded Programs

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

1. CHDP ~~Children's Health & Disability Prevention (CHDP)~~

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

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

2. Family PACT ~~act (FamPACT)~~

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

3. ~~Cancer Detection Program (CDP)~~ Every Woman Counts (EWC)

a. EWC Cancer Detection Program (CDP) provides free clinical breast exams, mammograms, pelvic exams, and Pap tests to California's underserved women. The mission of the EWCCDP is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and treatment, and integrated preventive services, with special emphasis on the underserved. Income qualification and age-age-related service information are available at the EWCCDP website.

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

G. Patient Information Policy

1. Exchange of Information

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

2. Patient Scheduling

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

3. No Show and Late Cancels Defined

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

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

4. Follow-up

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

H. Ability to Pay Program

1. Ability to Pay is a sliding fee program available to uninsured or underinsured patients who qualify according to family size and income (individuals/families living at or below 200% of the Federal Poverty Level (FPL). Patients must first be screened for other public insurance eligibility. Nominal fee charges apply to individuals and families with annual incomes at or below 100% of the Federal Poverty Guidelines. Nominal fees shall be waived for patients who are experiencing homelessness.

2. Patients interested in applying for this program are required to complete an application and provide proof of household income and identification. Registration staff collects preliminary income and family size documentation for each applicant, then enters the information into the appropriate EPIC module for payment range determination in accordance with FPL. Self-declaration of income and household information will be accepted for the first 30 days; however, supporting documentation must be submitted for full qualification (one year). If required documentation is not submitted within 30 days, full visit charges will be applied.

3. For full program qualification, patients must provide photo identification and income verification documents to support their application, such as:

     a. Most recent Federal tax return

     b. IRS form W-2 or 1099

     c. 2 recent consecutive paystubs

     d. Social Security, disability or pension benefit statements

     e. Documentation of other governmental assistance

     f. Verification of Student status and FAFSA form

     g. Unemployment Benefits / Workman's Compensation

I. ~~Patient Dismissal Policy~~

   0. ~~HSA makes every effort to retain patients; however, at times it is not possible to maintain an effective working relationship. In those rare instances, it may be necessary for HSA to dismiss a patient. Acceptable reasons for dismissal include (adapted from CCAH policies):~~

      . ~~Patient Fraud~~

      . ~~Insistence upon non-medically necessary medication~~

      . ~~Abusive/Disruptive behavior~~

      . ~~Violation of controlled substance agreement~~

      . ~~Non-compliance with recommended treatment that may endanger their health or significantly aggravate their medical condition~~

      . ~~Ineffective relationship~~

      . ~~Failure to keep appointments (repeated no-shows — 3 in a 12 month period) with good-faith attempts to contact the patient~~

   0. ~~Acceptable reasons for dismissal of CCAH patients:~~

      . ~~Alleged/ Actual Fraud or Theft~~

      . ~~Alleged Abusive/Disruptive Behavior~~

      . ~~Violation of Medication Management Agreement~~

   0. ~~Dismissals must be approved by a Medical Director. If the patient is a managed care member, the plan provider will be notified in writing, documenting one of the above~~

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~~reasons for dismissal, and signed by the Medical Director. The plan provider is responsible for responding to HSA's request and subsequently notifying the member of reassignment.~~

~~0.   Patients being dismissed will be given 30 day written notice advising them to find a new medical provider. During the interim 30 days, HSA shall continue to provide medical care as necessary.~~

~~X.~~I. Financial Policies

1. Accepted Forms of Payment

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

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

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

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

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

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

4. Non-sufficient Funds (NSF) Returned Checks: NSF Returned Checks are received by mail, email, or identified via bank account review by HSA Finance. The payment is

reversed on the patient's account; a new billing claim is created and the County's NSF fee charge of $40 is posted and billed to the patient.

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

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

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

~~Y.~~J. Billing Procedures

1. Encounter Development and Management

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

2. Encounter to Claim Process

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

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

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

3. Collections: HSA~~CSD~~ makes every reasonable effort to collect reimbursement for services provided to patients. This includes collection at the time of service, as well as follow-up collection methods including statement dispatch and account notes.

4. Denial Management Procedure

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

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

5. Patient Account Balances: ~~Patient'~~ Patients with account balances of $15 or more are sent a monthly statement. Patients with ~~high~~ unpaid balances ~~aremight also b~~ are flagged during the appointment registration process, and directed to the Business Office. Patients with account balances under $15 and that are 6 months old will be adjusted off using the uncollectable adjustment code.

6. Uncollectable and Bad Debt Adjustments

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

7. Write-off Adjustments by Payer

   a. Medicare - Use uncollectible adjustment code

      - Write off balances over ~~one year~~12 months from the ~~Date of Service~~Date of Post (~~DOS~~DOP) when Medicare is primary.

      - Write off balances over ~~18 months~~12 months from ~~DOS~~DOP when Medicare is secondary.

   b. Commercial Insurance - Use uncollectible adjustment code

      - Write off balances over ~~one year~~12 months from the ~~DOS~~DOP when insurance is primary.

      - Write off balances over ~~18 months~~12 months from the ~~DOS~~DOP when insurance is secondary.

   c. EWC~~BCEDP/CDP~~ - Use uncollectible adjustment code

      - Write off any balance ~~over a year~~over 12 months from ~~DOS~~DOP.

   d. Family PACT - Use uncollectible adjustment code

      - Write off any balance over ~~one year~~12 months from ~~DOS~~DOP.

      - Write off any unpaid lab work balance over 12 months from DOP ~~6 months~~.

   e. CHDP - Use uncollectible adjustment code

      - Write off any balance ~~over a year~~over 12 months from ~~DOS~~DOP.

- ~~CHDP Alliance   Use uncollectible adjustment code~~

  - ~~Write off any balance over 18 months from DOS.~~

  - Write off any unpaid lab work balance over 12 months from DO? ~~6 months.~~   Formatted: Highlight

f. Medi-Cal - Use uncollectible adjustment code

  - Write off any balance ~~over a year~~over 12 months old.

g. CCAHAlliance - Use uncollectible adjustment code

- Write off any unpaid lab work balance over 12 months 6 months from DOPold.

- Write off any balance over a year12 months from DOSDOP

- Write off any balance over 18 months12 months from the DOSDOP when Alliance is secondary.

h. Self-Pay - Use a bad debt adjustment code

- Write off any balance over one year12 months from date of first billing old.

- Write off any balance for patients not assigned to HSACSD following Referral Authorization Form (RAF) denial or denial for out of county managed care.

i. Beacon - Use uncollectible adjustment code

- Write off any balance 12 months from DOP

9.8. Other Adjustments

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

b. Professional Courtesy (PC) – For charges disputed by patients or hardship waivers.

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

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

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

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

Santa Cruz County
Health Services Agency
Clinics

Fiscal Presentation

10/3/2019

Dr. Julian N. Wren MSW, Ed.D.

Proportion of Self Pay Patients in Clinic Visit Population

4.6%

Revenue Cycle Flow of Billing and Claims
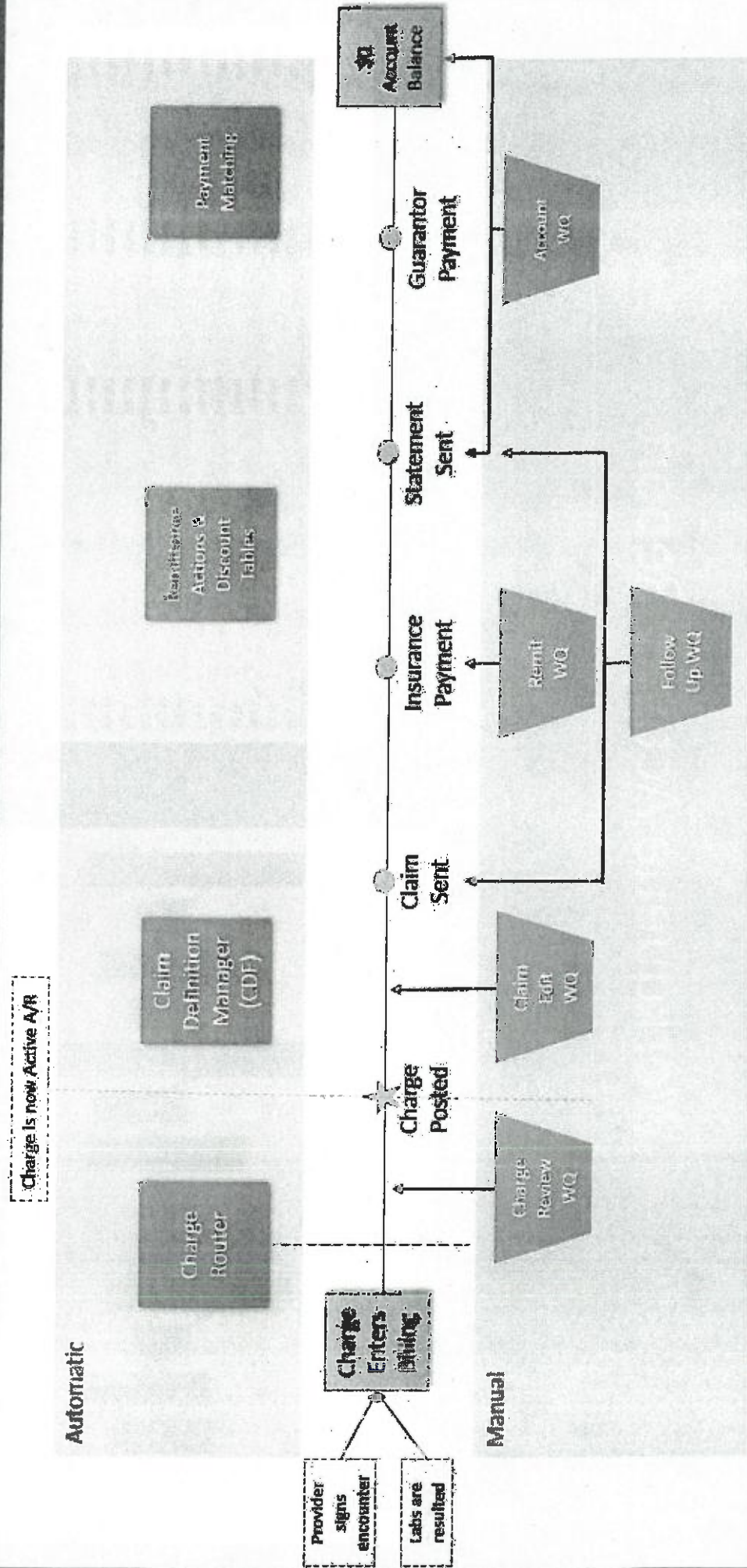
Workqueue Activity Report

PB Workqueue Activity - All Owning Areas by Amount

© Data collected: Fri 9/27 03:12 AM

☑ Add ☑ Remove ☑ ◆ Net Change
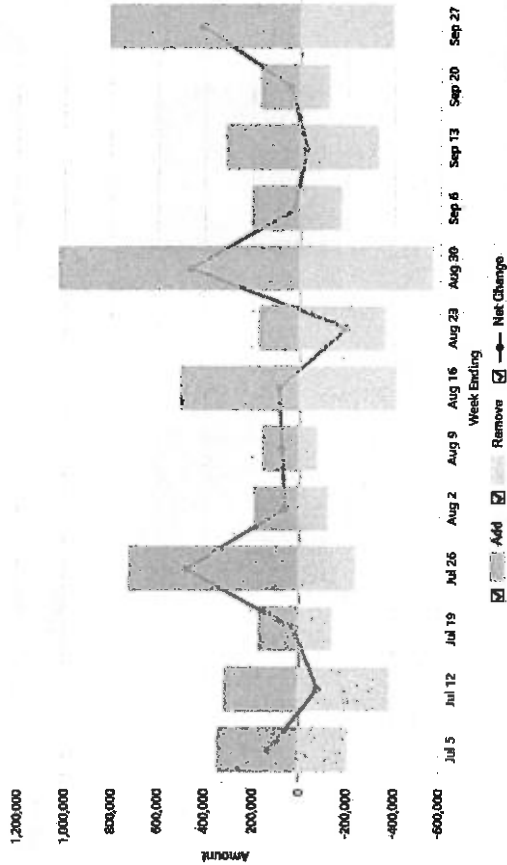
Week Ending	Add	Remove	Net Change
Jul 5	337,665	-211,869	125,796
Jul 12	312,192	-389,362	-77,170
Jul 19	166,688	-144,597	22,090
Jul 26	719,818	-243,056	476,762
Aug 2	188,421	-125,131	63,290
Aug 9	154,425	-80,214	74,211
Aug 16	503,194	-416,154	87,040
Aug 23	170,846	-365,760	-194,914
Aug 30	1,026,813	-567,415	459,398
Sep 6	200,218	-175,917	24,301
Sep 13	312,001	-336,495	-23,494
Sep 20	165,909	-124,630	41,279
Sep 27	809,988	-397,943	412,045

☑ Add ☑ Remove ☑ ◆ Net Change

Week Ending

Amount

Visit Metrics

8/24/19
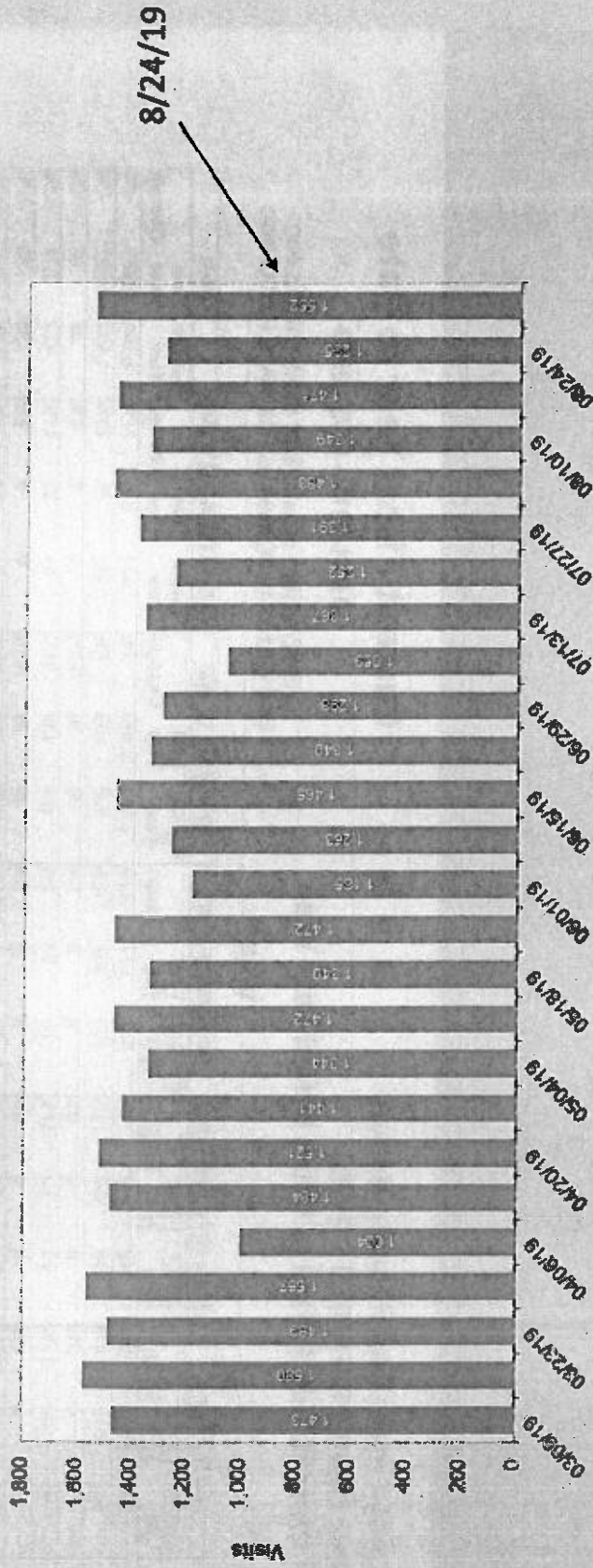
Visit Volume: Weekly total of all arrived or completed appointments.

FQHC Defined Visits Report

FQHC-Defined Visits and Patients Report
(includes Open Charts and CRWQ)
Compare Current Year Period to Same Period Last Year

Current Fiscal Year to Date
07/01/2019 - 08/31/2019

SCZ SC CLINIC includes SCZ SC ORTHO CLINIC
SCZ WATS CLINIC includes SCZ WATS HDC CLINIC

Visits

	SCZ SC CLINIC			SCZ SANTA CRUZ IBH			SCZ HPHP CLINIC			SCZ WATS CLINIC			SCZ WATSONVILLE IBH			Totals		
	Current Year	Last Year	Change	Current Year	Last Year	Change	Current Year	Last Year	Change	Current Year	Last Year	Change	Current Year	Last Year	Change	Current Year	Last Year	Change
MEDI-CAL	1,391	1,392	0%	719	722	0%	439	577	-24%	2,371	2,460	-4%	444	535	-17%	5,364	5,687	-6%
MEDI-MEDI	445	445	0%	216	257	-16%	123	197	-38%	598	599	0%	107	95	13%	1,489	1,593	-7%
CHDP	2	0	0%	0	0	0%	0	0	0%	26	16	63%	0	0	0%	28	16	75%
MEDICARE	95	109	-13%	71	52	37%	52	52	0%	164	135	21%	41	29	41%	423	378	12%
FAMPACT	6	6	0%	0	0	0%	0	0	0%	24	44	-45%	0	0	0%	30	50	-40%
SELF PAY	176	68	159%	21	12	75%	77	1	7,600%	385	241	60%	24	19	26%	683	341	100%
OTHER	24	16	50%	5	1	400%	9	1	800%	95	84	13%	16	24	-33%	149	126	18%
MEDICRUZ	40	38	5%	0	7	-100%	0	0	0%	211	237	-11%	10	9	11%	261	291	-10%
HPHP	3	2	50%	0	0	0%	147	138	7%	34	16	113%	5	0	0%	189	156	21%
FEES	9	11	-18%	0	0	0%	0	0	0%	6	8	-25%	4	0	0%	19	19	0%
Totals	2,191	2,087	5%	1,032	1,051	-2%	847	966	-12%	3,914	3,841	2%	651	712	-9%	8,635	8,657	0%

Projected Net Charges YTD and FY 19/20

Projected Charges FY 19-19

Post Group	Projected Units	Projected Charges
MEDI-CAL	82,911	19,964,608
MCA	0	0
MEDICARE	23,484	3,055,836
MEDI-CRUZ	4,398	366,423
HPHP	1,768	254,153
FBS	576	77,193
INTERFUND	342	30,104
MCWP	0	-1,669
MENTAL HLTH	747	101,149
OTHER	13,696	586,467
No Group Assigned	1,426	38,837
Total Charges:		24,473,101
Less Projected Reserve Amount:		510,436
Total Net Charges:		23,962,665

Projected Charges = Net Charges / Workdays * Total Workdays (248.5)
Projected Units = Units / Workdays * Total Workdays (plus extra 2% for second half of FY)

Unit Counts and Total Net Charges by Department Group and Fiscal Posting Group - Projection Report

Post Dates through: 08/31/2019 (44 workdays)
All Departments

PostGroup	FY 17-18 Units	%	Net Charges	%	FY 18-19 Units	%	Net Charges	%	FY 19-19 Units	%	Net Charges	%
MEDI-CAL	100,455	71.1%	23,048,469	83.4%	81,112	73.5%	22,442,683	84.2%	14,535	64.1%	3,534,981	81.6%
MCA	150	0.1%	-10,647	0.0%	1	0.0%	0	0.0%	0	0.0%	0	0.0%
MEDICARE	17,012	12.0%	3,152,391	11.4%	10,390	9.4%	2,820,949	10.6%	4,117	18.2%	541,074	12.5%
MEDI-CRUZ	4,364	3.1%	435,112	1.6%	3,056	2.8%	361,396	1.4%	771	3.4%	64,880	1.5%
HPHP	1,553	1.1%	173,900	0.6%	1,336	1.2%	203,808	0.8%	310	1.4%	45,001	1.0%
FBS	285	0.2%	31,920	0.1%	297	0.3%	56,887	0.2%	101	0.4%	13,666	0.3%
INTERFUND	273	0.2%	39,687	0.1%	522	0.4%	8,766	0.0%	60	0.3%	5,330	0.1%
MCWP	436	0.3%	47,439	0.2%	336	0.3%	124,419	0.5%	0	0.0%	-295	0.0%
MENTAL HLTH	380	0.3%	217,512	0.8%	224	0.2%	140,377	0.5%	131	0.6%	17,910	0.4%
OTHER	16,425	11.6%	497,282	1.8%	10,949	10.0%	473,409	1.8%	2,401	10.6%	103,841	2.4%
No Group Assigned	0	0.0%	75	0.0%	208	0.2%	11,441	0.0%	250	1.1%	6,877	0.2%
Totals:	141,283		27,631,518		110,031		26,644,487		22,676		4,333,265	
Less Reserve Amount:			197,854				1,039,567				90,379	
Actual Recognition:			27,433,664				25,604,890				4,242,884	

Professional Billing Accounts Receivable

PB AR Snapshot

Data collected: Fri 9/27 03:12 AM

84.3 AR Days

	Transaction Count	Amount	Amount (%)	Days
> Outstanding Insurance Debits				
> Outstanding Self-pay Debits				
∨ Totals				
Outstanding Debits	74,548	4,108,006	103 %	86.8
Undistributed Insurance Credits	12,144	11,562	0 %	0.2
Undistributed Self-pay Credits	6,263	-127,943	-3 %	-2.7
AR (Outstanding - Undistributed)		3,991,625	100 %	84.3
Pre AR	10,514	1,943,768	49 %	41.1
AR + Pre AR		5,935,393		

AR Days calculated using an Average Daily Revenue of 47,334 (based on a 90 day average)

Accounts Receivable Undistributed
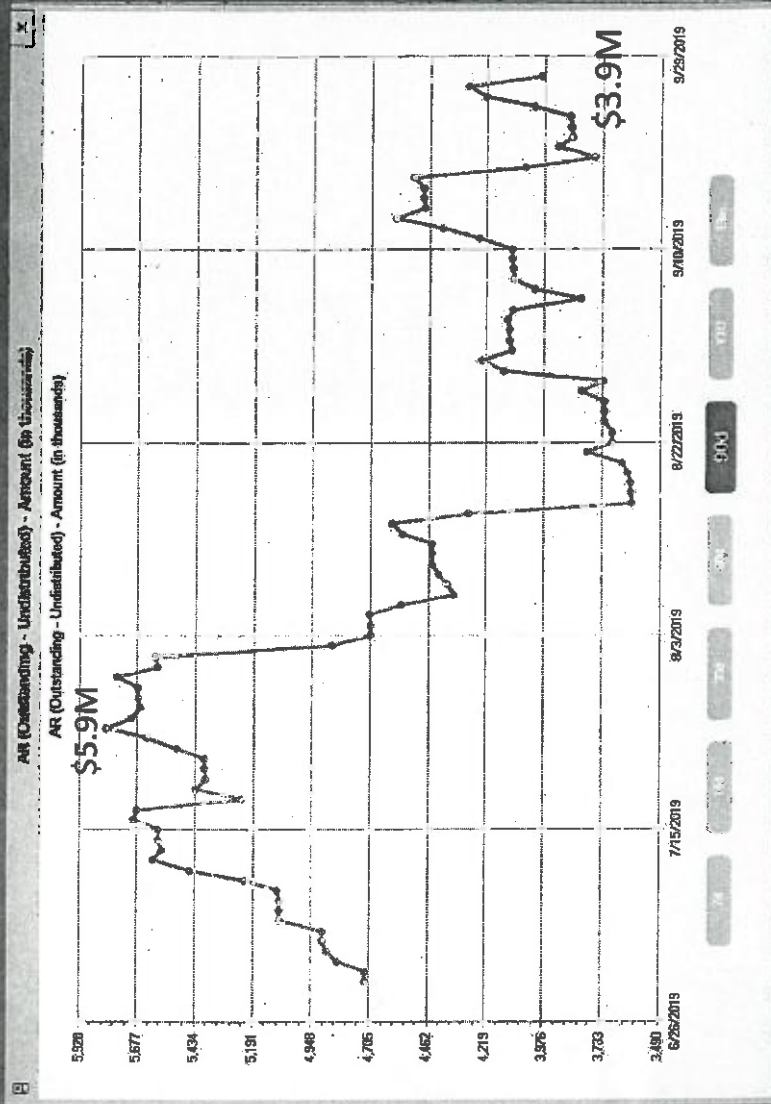
Professional Billing: Ave Daily Revenue

PB Average Daily Revenue

$49,258

$50,273

$43,618

Organization Data — SANTA CRUZ COUNTY

Sep '18 Oct '18 Nov '18 Dec '18 Jan '19 Feb '19 Mar '19 Apr '19 May '19 Jun '19 Jul '19 Aug '19 Sep '19
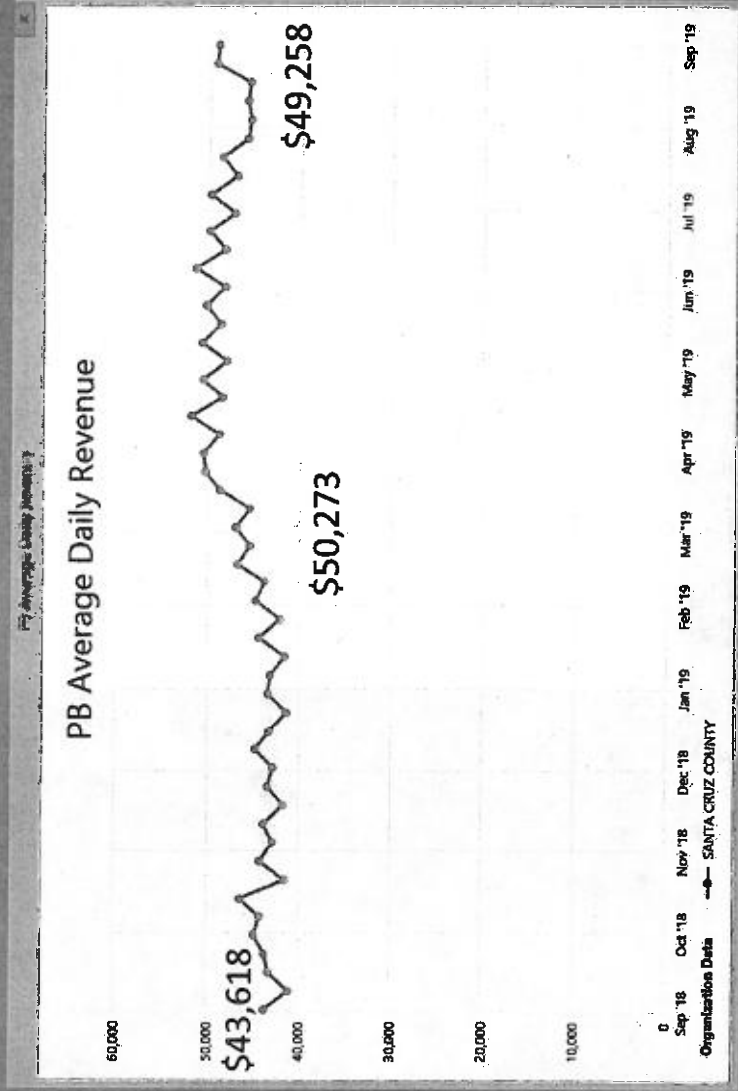
One Touch Billing

PB Clean Charges and Claims Summary

Data collected: Fri 9/27 12:00 AM

44 % 91 Day Clean Claims

Metric	Yesterday	Clean	Total	91 Day	Clean	Total
˅ Charges Posted						
No Charge Review	57 %	343	601	47 %	29,350	62,090
˅ Claims Accepted						
No Claim Edits	99 %	950	955	100 %	40,111	40,305
No Charge Review or Claim Edits	46 %	440	955	50 %	20,020	40,305
˅ Claims Resolved						
No Denials	86 %	220	256	90 %	21,569	24,079
No Charge Review, Claim Edits, or Denials	16 %	42	256	44 %	10,585	24,079

Takeaways

- Self-Pay patients are a small percentage of our total patient population.
- Over the last 13 weeks, we have not been removing more workqeue items than are being added each week.
- There were 257 more clinic visits in week ending 8/24 then the previous week.
- Compared to last fiscal YTD period, Santa Cruz Clinic is up 5% in FQHC visits.
- All clinic visits compared to the same period last FY, visits are flat.
- The projected end of FY net charges is $23,962,665.
- There is $1,943,768 to be reviewed for claiming.
- There is $3,991,625 in payments to be reviewed for distribution.
- Our current average daily revenue ($49,258) is near our high for the last 12 months.
- Our One-Touch Billing is up by 4% over the last 91 days.

References

- August 2019 Net Charges Projection Report
- August YTD FQHC Defined Visits and Patients Report
- Epic Professional Billing Finance Dashboard (9/27/19)