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

February 7, 2024 @ 4:00pm - 5:00pm

MEETING LOCATION: In-Person - 150 Westridge Drive, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060 will connect through Microsoft Teams Meeting or call in (audio only) +1 916-318-9542, 500021499# United States, Sacramento Phone Conference ID: **500 021 499#**

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. January 3, 2023, Meeting Minutes – Action Required
4. 100.03 HSA Billing FO Policy Procedures – Action Required
5. 100.04 HSA Billing FO Policy Procedures – Action Required
6. Stipends for Commissioners
7. Board Composition and Meeting Times
8. Quality Management Update
9. Financial Update
10. CEO/COVID-19 Update

<u>Action Items from Previous Meetings:</u> Action Item	Person(s) Responsible	Date Completed	Comments
Invite EPIC site specialist, Jessica McElveny to next meeting, My-chart outreach to patients to use, orient patients to use My-chart, what does clinics plan to do to make better use	Raquel		
Updates at future meetings to hear what the call measures are, measures you will be tracking, workflows, and quarterly reports on how the call center is doing.	Raquel		

Next meeting: Wednesday, March 6, 2024, 4:00pm - 5:00pm **Meeting Location: In-Person** – 150 Westridge Drive, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) United States, Sacramento Phone Conference ID: **500 021 499#**

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held February 7, 2024

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

Attendance	
Christina Berberich	Chair Officer
Rahn Garcia	Member
Marco Martinez-Galarce	Member
Maximus Grisso	Member
Michael Angulo	Member
Tammi Rose	Member
Gidget Martinez	Member
Monica Morales	County of Santa Cruz, Director HSA
Miku Sodhi	County of Santa Cruz, Asst. Director of HSA
Amy Peeler	County of Santa Cruz, Chief of Clinics
Raquel Ramirez Ruiz	County of Santa Cruz, Sr. Health Services Manager
Julian Wren	County of Santa Cruz, Admin Services Manager
Mary Olivares	County of Santa Cruz, Admin Aide
Meeting Commenced at 4:03 pm and concluded at 4:55 pm	

Excused/Absent:

Excused: Len Finocchio
Excused: Dinah Phillips
Absent: Michelle Morton

1. Welcome/Introductions

Commissioner Marco Martinez-Galarce stated was elected to be a member on the board of Dientes.

2. Oral Communications:

None

3. January 3, 2024, Meeting Minutes – Action Required

Review of January 3, 2024, Meeting Minutes – Recommended for Approval. Rahn moved to accept minutes as presented. Marco second, and the rest of the members present were all in favor. Christina abstained as she was not in attendance at the last meeting.

4. 100.03 HSA Billing FO Policy Procedures – Action Required

Julian presented policy 100.03 HSA Billing FO Policy Procedures; he stated only minor corrections to policy were made. Tammi moved to accept policy with minor corrections. Marco second, and the rest of the members present were all in favor.

5. 100.04 HSA Billing FO Policy Procedures – Action Required

Julian presented policy 100.04 HSA Billing FO Policy Procedures. He stated no changes need to be done to sliding fee discount and this needs to be reviewed and approved every three years. Tammi moved to accept policy as presented. Marco second, and the rest of the members present were all in favor.

6. Stipends for Commissioners

Raquel reported commissioners are now eligible for $75.00 stipends. Mary will be sending out an e-mail with details.

7. Board Composition and Meeting Times

Raquel presented survey results that were submitted, there were seven responses to survey. A majority of the commission stated they had no conflict with keeping the same date and time. Mary to send out e-mail to those not in attendance to see what dates and times work for them.

8. Quality Management Update

Raquel reported that the quality management committee met and reported on the following. She stated that the Watsonville Health Center reported on their improvement project, well childcare visits and are continuing focusing on immunizations. Raquel also reported that the Central California Alliance for Health reviewed the based incentives, and they will be adding lead screening in children and will be retiring body mass index assessments and adult immunizations. Raquel reported and shared results of the

staff satisfaction survey she stated this is done on an annual basis. Lastly, Raquel reported on some of the QI Projects they are working on such as:

- Seek regular feedback-i.e. suggestion box, prioritize (grouping) projects to address feedback concerns, QR code to gather ideas and concerns on a regular basis-monthly, individual, in huddles, blocked time, team specific meetings.
- More part-time opportunities.
- QI subcommittee to address responses.
- Appreciation/Recognitions
- Closing the loop with various projects, survey results-verbal or written updates
- Burn out-giving resources

9. Financial Update

Julian reported currently the estimated actuals are $6,100,00.00 over budget in expenditures. Julian reported some of the things that they are looking at to help in spending are analyzing current spending, prioritizing critical spending, and deferring non-essential expenses. They are reviewing subscriptions, memberships, and other recurring costs for potential savings and negotiating with vendors for better pricing or payment terms. Julain reported he is evaluating cash flow by implementing automation, prioritizing projects that contribute directly to revenue generation, and identifying areas for streamlining processes. Julian reported some of the smart targets they are looking at are 45 days in accounts receivable (AR) by June 30, 2024, 30 days by January 31, 2025, increase average clinician (MDs/PA/NP) daily completed visits by 35% to 13.5 visits by June 30, 2024, and increase payments by 35% to $3,731,650 a month by June 30, 2024.

10. CEO/COVID 19 update

Raquel reported on Amy's behalf. She stated that Health Resources and Service Administration (HRSA) will be coming May 14, 15, and 16 2024. Commissioners are invited to attend. Raquel will report back on oversite at next meeting.

Next meeting: March 6, 2024, 4:00pm - 5:00pm

Meeting Location: In- Person- 150 Westridge Drive, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Santa Cruz, CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) +1 916-318-9542, 500021499# United States, Sacramento Phone Conference ID: **500 021 499#**

☐ Minutes approved ______________________________ __/__/____

(Signature of Board Chair or Co-Chair) (Date)

Health Centers Division

Quality Management Report

February 2024

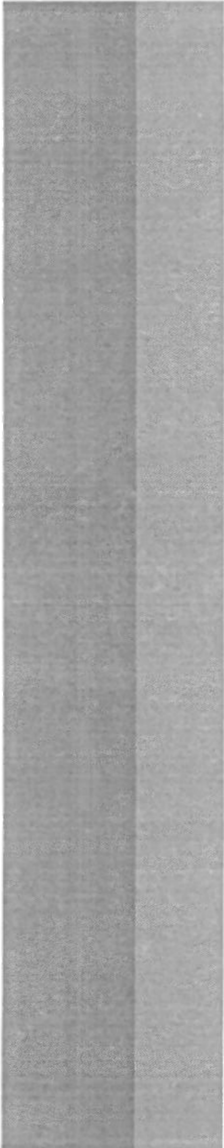
- Quarterly Quality Improvement Presentation-WHC.
  Well Child-Care Visits-Immunizations
- Staff Satisfaction Survey Results
- Central California Alliance for Health 2024 Care Based Incentive New Measures Update:
  - Lead Screening in Children
  - Retired Measures- Body Mass Index Assessment and Adult Immunizations.

QI Projects:

- Seek regular feed back-ie suggestion box, prioritize (grouping) projects to address feedback concerns, QR code to gather ideas and concerns on a regular basis-monthly, individual, in huddles, blocked time, team specific meetings
- More part-time opportunities
- QI subcommittee to address responses
- Appreciation/Recognitions
- Closing the loop with various projects, survey results-verbal or written updates
- Burn out-giving resources

Questions?

Thank You



Health Centers Division

FY 23-24 Monthly Budget Presentation

February 7, 2024

Vision

Santa Cruz County is a healthy, safe and thriving community for everyone.

Mission

To promote and ensure a healthy community and environment by providing education, outreach and comprehensive health services in an inclusive and accessible manner.

Values

INTEGRITY

QUALITY

COMPASSION & RESPECT

EQUITY & JUSTICE

COLLECTIVE IMPACT

CAPACITY BUILDING

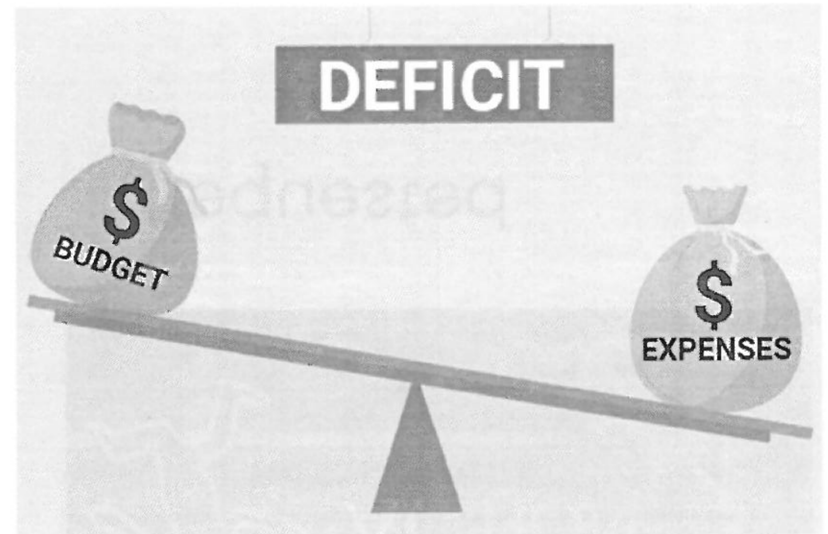
POSITIVITY

No

Requested

Fiscal Year 23-24 Estimated Actuals

$-6,100,000



Spending

- **Analyze** current spending
- **Prioritizing** critical spending and **deferring** non-essential expenses
- Reviewing subscriptions, memberships, and other recurring costs for **potential savings**
- **Negotiating** with vendors for better pricing or payment terms

Optimization

- **Evaluating** cash flow
- Implementing **automation**
- Prioritizing projects that contribute directly to **revenue generation**
- Identifying areas for streamlining processes

CONTINUOUS PROCESS IMPROVEMENT & FINANCIAL RESILIENCE

Revenue

- Strategic position filling
- Adjusting clinician templates to accommodate more visits
- Increasing Telemedicine visits

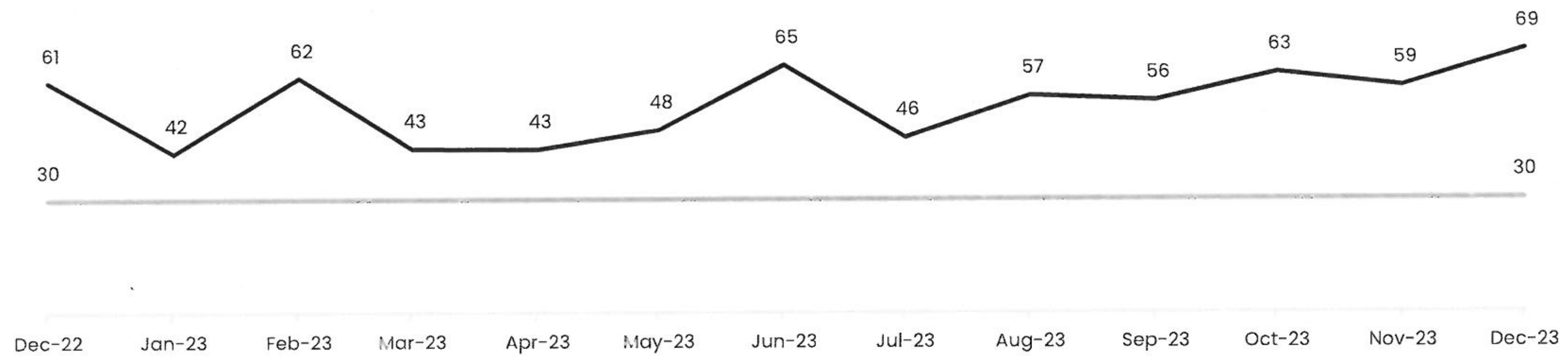
CONTINUOUS PROCESS IMPROVEMENT & FINANCIAL RESILIENCE

SMART Targets

- **45 Days** in Accounts Receivable (AR) by June 30, 2024
- **30 Days** by January 31, 2025
- Increase average clinician (MDs/PA/NP) daily completed visits by 35% to **13.5 visits** by June 30, 2024
- Increase Payments by 35% to **$3,731,650 a month** by June 30, 2024

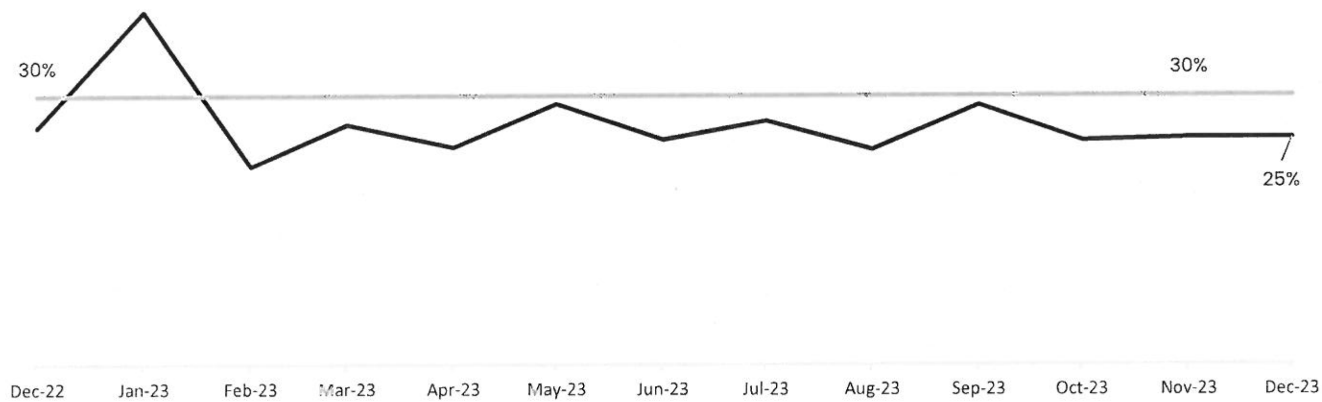
MEASUREABLE & CONTINUOUS PROCESS IMPROVEMENT

Days in Account Receivable (AR)

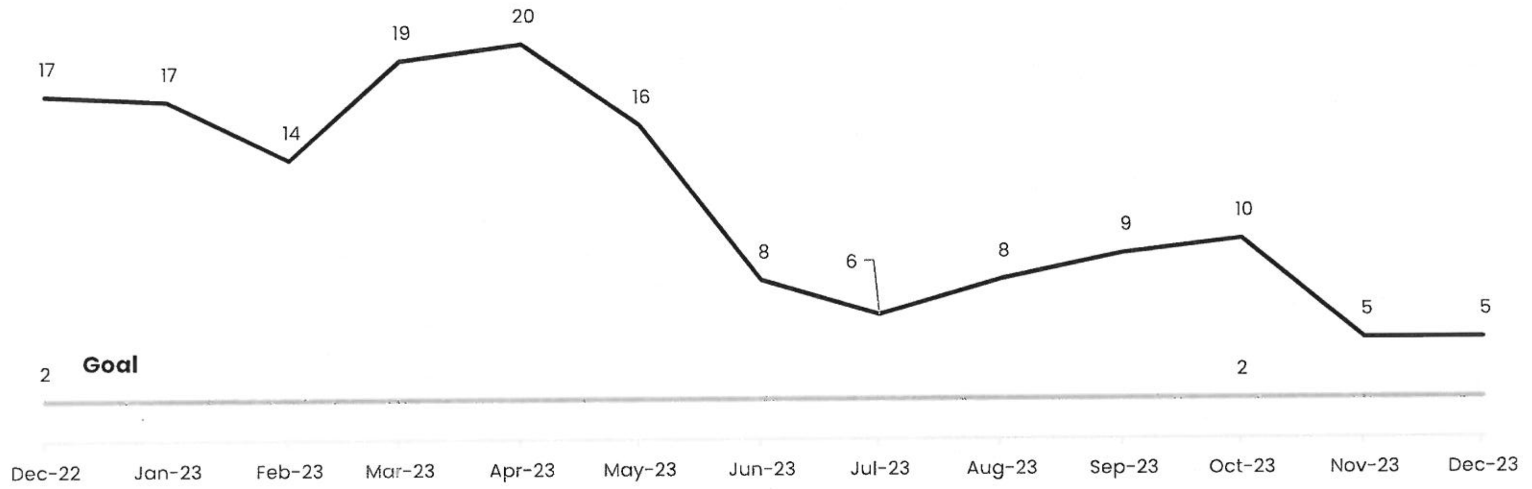


MEASUREABLE & CONTINUOUS PROCESS IMPROVEMENT

Percentage of Claims aged > 90 Days

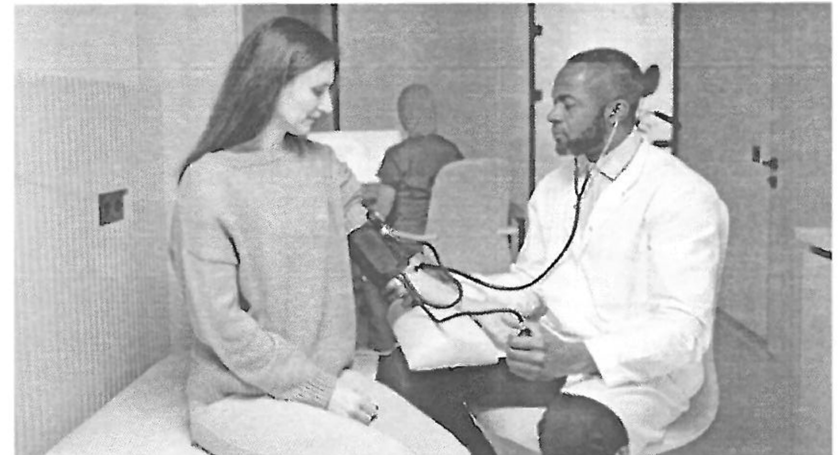


Charge Review Days



Revenue Generating Vacancies

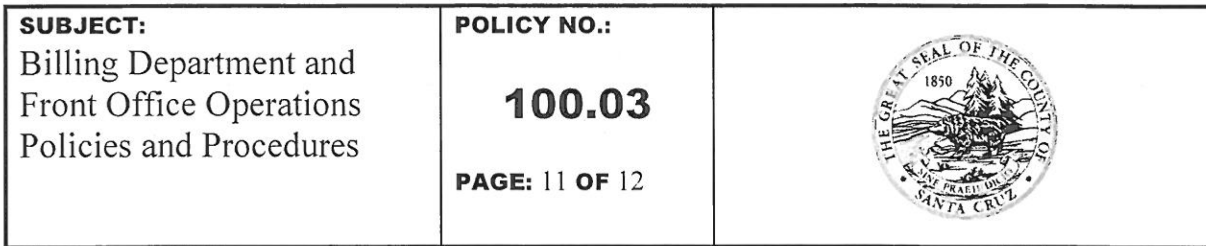
3 Clinic Physicians
2 Physician Assistant/Nurse Practitioners
2 Clinical Psychologists
1 Psychiatrist
1 Psychiatric MH Nurse Practitioner
1 Medical Director



ACCESS TO HEALTH AND WELLBEING

ADDENDUM 1

PAYOR	DESCRIPTION	TIMELY FILING DEADLINE (days)	CODE	REASON CODE
Self Pay	No Payor; in addition, write-off any balance for patient not assigned to HSA following Referral Authorization Form (RAF) denial or denial for out of county managed care	180	UNCOLLECTABLE SELF PAY (CR ACC) [1864]	N/A
Carelon	Behavioral Health Visits	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
Medicare	Straight Medicare Visits	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
FAMPACT	Family Planning Visits	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
O/P Medi-Cal	Straight Med-Cal	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
Alliance Medi-Cal	Managed Medi-Cal	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
Commercial	Commercial	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
ALT Medi-Cal	Wrap Visits	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
EWC	Every Women Counts	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29
CHDP	Child Health and Disability Prevention	365	INSURANCE UNCOLLECTIBLE (CR INS) [1754]	29



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

8. Other Adjustments

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

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

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

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

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

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

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

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

5. Patient Account Balances: Patient's with account balances of $15 or more are sent a monthly statement. Patients with unpaid balances are flagged during the appointment registration process and directed to the Business Office.

6. Uncollectable and Bad Debt Adjustments

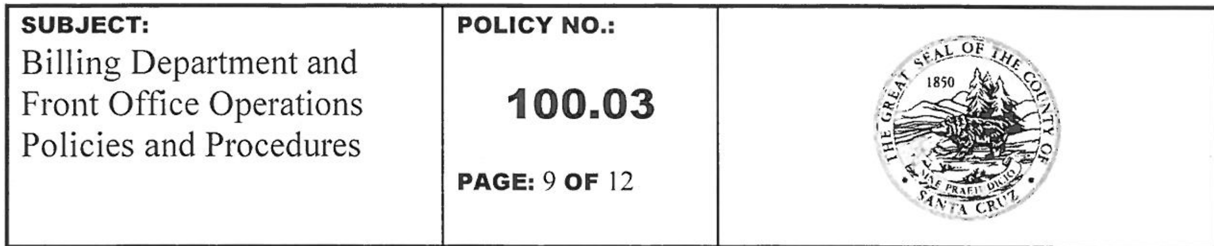
   a. Under the direction of the Business Office Manager, staff will adhere to the following write-off guidelines. The Business Office Manager has the authority to approve write-offs. Write-offs will be measured by HSA Fiscal Department after the month-end close and accounts will be audited as part of standard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

7. Write-off Adjustments

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

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

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



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

I. Billing Procedures

1. Encounter Development and Management

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

2. Encounter to Claim Process

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

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

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

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

4. Denial Management Procedure

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

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

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

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

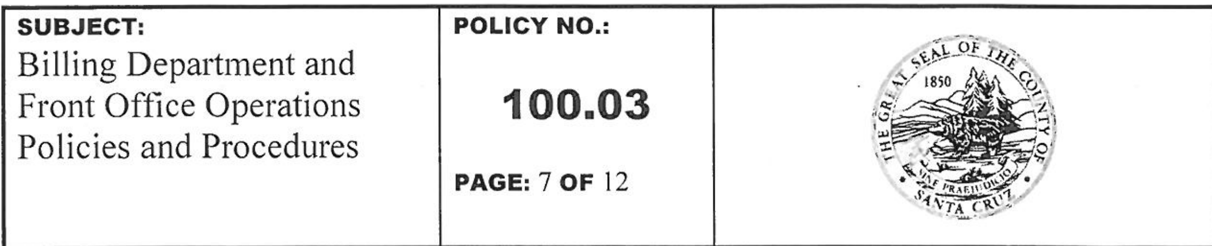
2. Payment Agreements: Payment agreements may be negotiated between the patient and BO staff, providing up to three payment installments for past due charges (over 30 days).

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

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

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

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



G. Patient Information Policy

1. Exchange of Information

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

2. Patient Scheduling

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

3. No Show and Late Cancels Defined

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

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

4. Follow-up

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

H. Financial Policies

1. Accepted Forms of Payment

2. Family PACT

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

3. Every Woman Counts (EWC)

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

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

4. Ryan White HIV/AIDS Program (RWHAP)

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

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

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

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

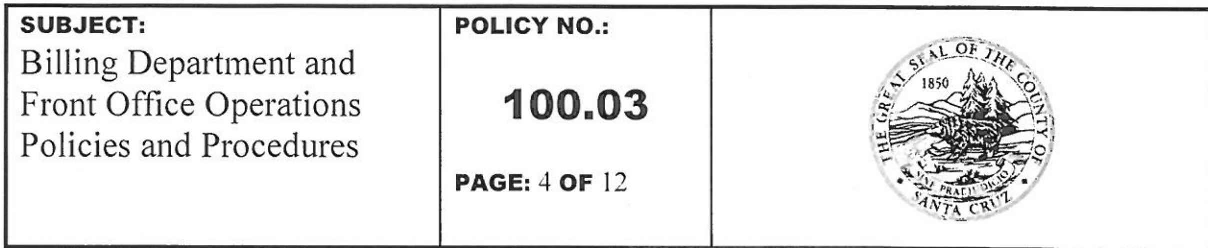
F. Enrollment: Other State Funded Programs

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

1. CHDP

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

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



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

4. Other Government Funded Programs

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

   b. Benefits Determination

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

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

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

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

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

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

D. Self-Pay Payers

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

E. Verification of Eligibility and Benefits Determination by Payer

1. Medi-Cal

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

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

2. Central California Alliance for Health (CCAH)

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

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

B. General Payers

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

   a. Assigned to HSA for their primary care; or

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

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

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

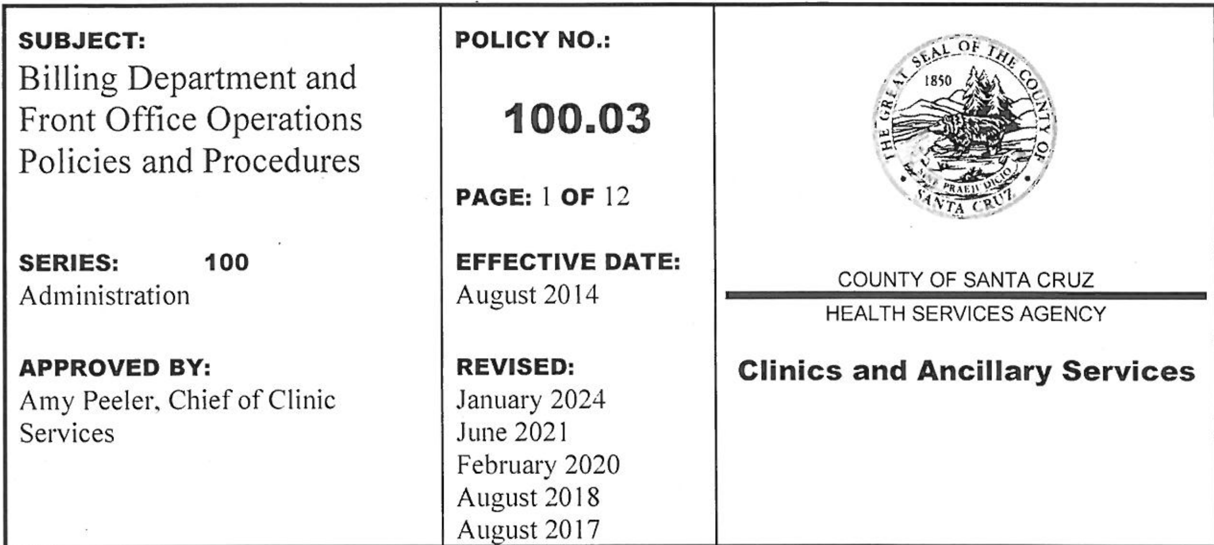
3. Medicare: (non-managed care type) Recipients may qualify due to age and/or disability or may be dependent of an aged and/or disabled person.

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

C. Specialized Payers

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

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



SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: **100.03** PAGE: 1 OF 12	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
SERIES: 100 Administration	EFFECTIVE DATE: August 2014	
APPROVED BY: Amy Peeler, Chief of Clinic Services	REVISED: January 2024 June 2021 February 2020 August 2018 August 2017	**Clinics and Ancillary Services**

POLICY STATEMENT:

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

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

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

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

PROCEDURE:

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

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

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

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

a. Most recent Federal tax return

b. IRS form W-2 or 1099

c. Two (2) most recent consecutive paystubs

d. Social Security, disability or pension benefit statements

e. Documentation of other governmental assistance

f. Verification of Student status and FAFSA form

g. Unemployment Benefits / Worker's Compensation

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

13. The ATP shall apply to all required and additional health services within the HRSA-Approved scope of project for which there are distinct fees.

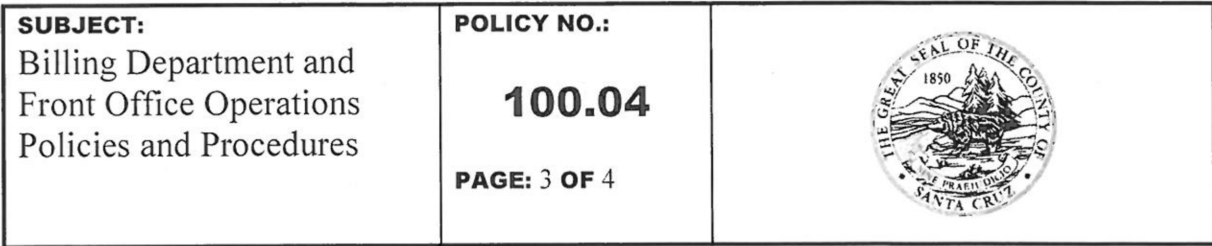
14. All documentation received from the patient related to the ATP application are filed and kept on site until the HSA Fiscal retention date has expired.

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

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

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

    c. Identify and implement changes as needed.



8. Patients will self-report income and family size on the ATP self-declaration/provisional application if the individual or family does not have the proof of income at the time of the visit. Patients applying for the ATP program are re-assessed if income or family size changes, as self-reported or the ATP eligibility period expires, and a new application is received.

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

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

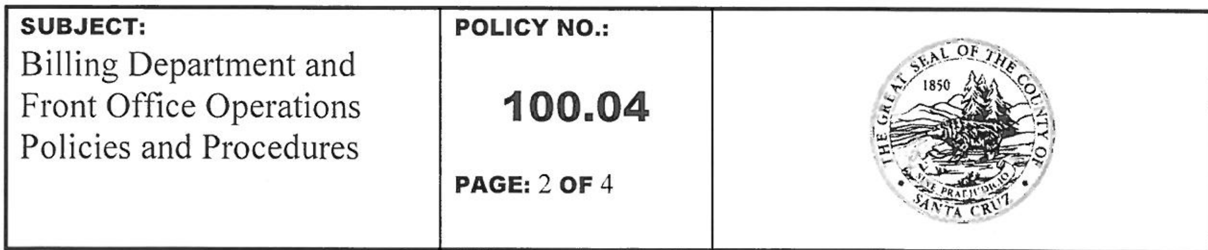
   B) Staff will screen patient for eligibility for the ATP program by asking the patient to complete the application and provide proof of income.

   C) Once the sliding fee level for the patient is assessed, the patient may pay the lesser of the charge discounted to the patient's sliding fee level OR the patient's out of pocket costs.

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

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

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



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

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

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

B. Ability to Pay Program (Sliding Fee Discount Program)

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

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

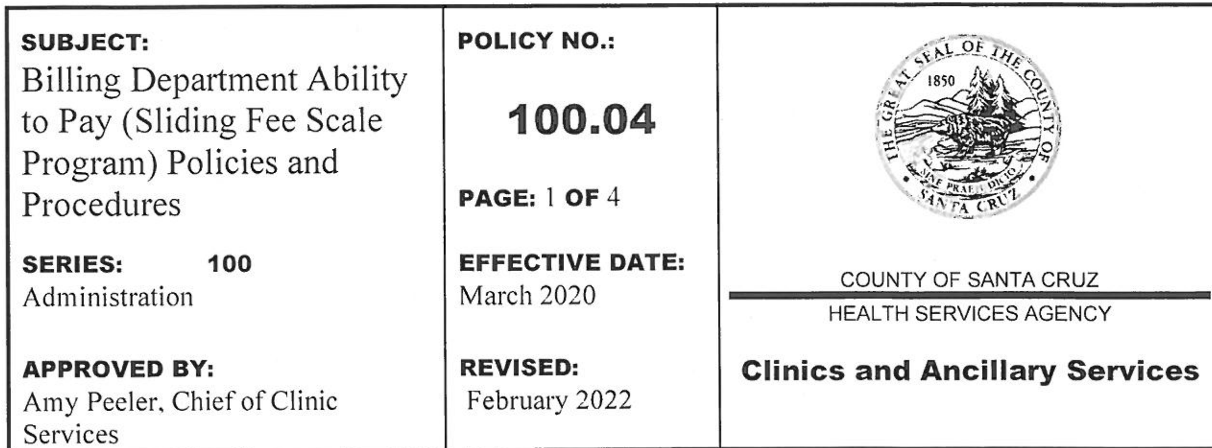
3. The Sliding Fee Discount Program incorporates the most recent Federal Poverty Level Guidelines published by the Federal Health and Human Services.

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

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

6. Eligibility will be honored for 12 months.

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



SUBJECT: Billing Department Ability to Pay (Sliding Fee Scale Program) Policies and Procedures	**POLICY NO.:** 100.04 **PAGE:** 1 **OF** 4	
SERIES: 100 Administration	**EFFECTIVE DATE:** March 2020	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
APPROVED BY: Amy Peeler, Chief of Clinic Services	**REVISED:** February 2022	**Clinics and Ancillary Services**

PURPOSE:

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

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

POLICY STATEMENT:

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

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

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

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

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.