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

December 4, 2024 @ 4:00pm - 5:00pm

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

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

1. Welcome/Introductions
2. Oral Communications
3. November 6, 2024, Meeting Minutes – Action Required
4. HSA Billing FO Policy: adding payment plan guidelines – Action Required
5. Annual Service Area Review – Action Required
6. Prop 35 Overview – Len
7. Quality Management Update
8. Financial Update
9. CEO Update

Action Items from Previous Meetings: **Action Item**	**Person(s) Responsible**	**Date Completed**	**Comments**
Proposition 35 passed. Report back next couple of months what does that mean on revenues that will be coming into the clinic system.	Julian		

Next meeting: Wednesday, January 1, 2025, 4:00pm - 5:00pm **Meeting Location: In-Person** - 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454- 2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held December 4, 2024

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

Attendance	
Christina Berberich	Executive Board - Chair
Len Finocchio	Executive Board - Co-Chair
Rahn Garcia	Member
Dinah Phillips	Member
Marco Martinez-Galarce	Member
Michael Angulo	Member
Amy Peeler	County of Santa Cruz, Chief of Clinics
Raquel Ruiz	County of Santa Cruz, Senior Health Services Manager
Julian Wren	County of Santa Cruz, Admin Services Manager
Mary Olivares	County of Santa Cruz, Admin Aide
Miku Sodhi	County of Santa Cruz, Assistant Director/HSA
Meeting Commenced at 4:01 pm and concluded at 5:01 pm	

Excused/Absent:

Absent: Tammi Rose
Absent: Maximus Grisso
Absent: Michelle Morton

1. Welcome/Introductions

2. Oral Communications:

3. November 6, 2024, Meeting Minutes – Action Required

Review of November 6, 2024, Meeting Minutes – Recommended for approval. Rahn motioned to accept minutes as presented. Dinah second, and the rest of the members present were all in favor.

4. HSA Billing FO Policy: adding payment plan guidelines – Action Required

Julian presented HSA Billing FO Policy, stating he is adding payment plan guidelines to policy. Julian presented policy to commission staff. Rahn made motion to accept policy as staff recommends, Dinah second, and the rest of the members present were all in favor.

At this time of meeting Len stated in February he will do a presentation on what are some of the implications of the Trump administration taking over the health and human services and what their plans might be for Medicaid and Med-Cal programs.

5. Annual Service Area Review – Action Required

At this point of the meeting, it was decided to move January 1, 2025, commission meeting to a special meeting dated January 8, 2025.

Raquel presented on the annual service area review she stated the goal is to define and review the boundaries of the catchment area to be served, including the identification of the medically underserved population(s). This is to ensure services provided are available and accessible to residents promptly and appropriately and to maintain compliance with the Health Resources & Services Administration (HRSA). Raquel presented data to commission and is seeking approval to remove zip codes 95017 and 95065. Dinah made motion to accept changes as recommended. Len second, and the rest of the members present were all in favor.

6. Prop 35 Overview

Len presented an overview on proposition 35. Proposition 35 makes permanent the existing tax on managed care organizations (MCO), which provides revenues to pay for Medi-Cal health care services, voters approved Prop 35 68% Yes to 32% No.

Medi-Cal uses the tax revenue to "draw down" federal dollars. MCOs with enrollments between 1.25 and 4 million will be taxed for each: Medi-Cal enrollee - $274 and other enrollee – $1.75 in 2024, $2 in 2025 and $2.25 in 2026. Len reported some of the key takeaways are: Santa Cruz HSA clinics will benefit from increased revenues, Some $26.5 billion MCO tax revenue generated from FY2023-24 to FY2026-27, In 2025 and 2026 the tax revenues will support Medi-Cal health plans (like the Central California Alliance for Health) and nine broad categories for providers, workforce initiatives and general Medi-Cal program support, In 2027, revenues

flow to 14 accounts to support specific providers, facilities and services through rate increases, payment methodologies, and other strategies, California must get federal approval for the tax rates and renew the tax for 2027, and The incoming Trump Administration puts all of this in question.
7. Quality Management Update
Raquel reported on Hazards Vulnerability Analysis (HVA). She reported this is systematic approach to recognize, identify, & rank top hazards that may significantly impact health center operations. Raquel reported that factors in human, property, & business impacts to assess risk factors and risks associated with each hazard are analyzed to prioritize planning, mitigation, response, and recovery activities, Raquel reported on the three health centers hazards. Raquel lastly reported now that they have identified their hazards they are reviewing & assessing their preparedness levels for hazards indicated they will Identify areas that need strengthening, leverage resources accordingly, drills & exercises as appropriate, and continue discussion & planning in clinics & agency leadership meetings.
8. Financial Update
Julian reported fiscal year 25/26 will be challenging, and current data shows they are in the deficit 7.4 million dollars. Julian reported their 25/26 budget is due on 2/6/25 and he will present to commission for approval in the next 1-2 months. Julian lastly reported The CAO instructions are to address challenges by reviewing their budget carefully, considering potential federal funding changes and exploring cost-saving measures while maintaining essential services.
9. CEO Update
Amy reported they have generated 1.5 million dollars this year compared to last year but salary cost have 1.1 million dollars more than last year.

Next meeting: January 8, 2024, 4:00pm - 5:00pm

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

Health Centers Division

Budget Season for FY 25/26

Dr. J wren 12/4/24

County of Santa Cruz (HSA)
FY 24/25 HEALTH CENTERS (All)(All)
As of 10/31/2024

Division HEALTH CENTERS Choose Division
Sub Program (All)
GLKey (All)

Actual	Column Labels					
Row Labels	1-July	2-August	3-September	4-October	Grand Total	Adjusted Budget
REVENUE	3,374,406	(3,812,304)	(5,526,689)	(2,948,396)	(8,912,983)	(61,195,259)
15-INTERGOVERNMENTAL REVENUES	1,139,293	(695,431)	(851,430)	537,768	130,200	(6,893,054)
19-CHARGES FOR SERVICES	2,068,426	(3,042,386)	(4,564,666)	(3,516,480)	(9,055,105)	(53,727,619)
23-MISC. REVENUES	166,687	(74,488)	(110,593)	30,316	11,922	(574,586)
EXPENDITURE	2,380,608	4,187,039	3,701,899	6,056,361	16,325,908	60,111,517
50-SALARIES AND EMPLOYEE BENEF	2,056,518	2,674,766	2,734,696	4,893,407	12,359,387	36,922,899
60-SERVICES AND SUPPLIES	33,244	827,342	490,411	631,928	1,982,926	8,396,697
70-OTHER CHARGES	8,097	4,048	4,048	4,048	20,242	48,404
80-FIXED ASSETS	(2,183)	2,495		73,381	73,693	1,111,100
95-INTRAFUND TRANSFERS	284,933	678,387	472,743	453,596	1,889,660	13,632,417
Grand Total	5,755,015	374,735	(1,824,790)	3,107,965	7,412,925	(1,083,742)

County of Santa Cruz (HSA)
FY 24/25 (All) (All)(All)(All)
As of 10/31/2024

Division	HEALTH CENTERS
GLKey	(All)
JL Key & Title	(All)
FiscalMonth	(All)
Object	(All)

Row Labels	Adopted Budget	Adjusted Budget	2024 Actuals	2023 Actuals
REVENUE	(61,118,056)	(61,195,259)	(8,912,983)	(7,663,324)
15-INTERGOVERNMENTAL REVENUES	(6,815,851)	(6,893,054)	130,200	(474,139)
19-CHARGES FOR SERVICES	(53,727,619)	(53,727,619)	(9,055,105)	(6,762,145)
23-MISC. REVENUES	(574,586)	(574,586)	11,922	(428,120)
EXPENDITURE	60,034,314	60,111,517	16,325,908	13,923,397
50-SALARIES AND EMPLOYEE BENEF	36,922,899	36,922,899	12,359,387	9,925,770
60-SERVICES AND SUPPLIES	8,319,494	8,396,697	1,982,926	2,207,922
70-OTHER CHARGES	48,404	48,404	20,242	20,168
80-FIXED ASSETS	1,111,100	1,111,100	73,693	1,197
95-INTRAFUND TRANSFERS	13,632,417	13,632,417	1,889,660	1,768,341
Grand Total	(1,083,742)	(1,083,742)	7,412,925	6,260,073

Major Events Timeline

Event	**2025-26**	**Prior 2024-25**
Board sets hearing dates	10/08/24 (Tue)	10/17/23 (Tue)
2025-26 Budget Kickoff	12/05/24 (Thu)	12/07/23 (Thu)
Department Budgets Due!	**2/06/25 (Thu)**	2/01/24 (Thu)
Mid-Year	2/11/25 (Tue)	2/13/24 (Tue)
CAO Meetings	3/11 - 3/18	2/20-3/01
CAO Final Decision	3/26/25 (Wed)	3/07/24 (Thu)
Publish Budget	4/23/25 (Wed)	4/02/24 (Tue)
BH #1: Present budget	4/29/25 (Tue)	4/09/24 (Tue)
BH #2: Dept Budget Hearing	6/03/25 (Tue)	5/21/24 (Tue)
BH #3: Dept Budget Hearing	6/04/25 (Wed)	5/22/24 (Wed)
BH #4: Approved Proposed/Last Day	6/10/25 (Tue)	6/04/24 (Tue)
ADOPT Budget	9/30/25 (Tue)	9/24/24 (Tue)

Improved Salary Projections

Salary Projection

CAO is now the lead on creating Budget Salary Projection

Released WITH kickoff

Refined Assumptions

1. From low to mid for Vacant positions
2. Full budget for voluntary reductions
3. Reduce salary saving assumptions

Key Challenges

CAO instructions are to address these challenges by reviewing our budget carefully, considering potential federal funding changes and exploring cost-saving measures while maintaining essential services.

- Potential decrease in federal funding for FQHCs
- Increased pressure on county resources to support healthcare services
- Uncertainty in Medicaid and Medicare funding structures
- Possible coverage losses for vulnerable populations
- CAO mentioned hiring freezes
- CAO mentioned cost cutting in general

Project 2025 Impact on FQHCs and County Budget

Potential Effects on FQHCs

- Reduced Medicaid funding through block grants or per capita caps
- Increased state share of Medicaid costs
- Possible elimination of provider taxes used to finance Medicaid
- Restricted access for undocumented patients due to public charge rule restoration
- CA Proposition 35?

2024 Health Centers Hazard Vulnerability Analysis (HVA)

Santa Cruz County Health Centers 2025 Hazards Vulnerability Analysis

What is the HVA?

- HVA stands for "Hazards Vulnerability Analysis"
- Systematic approach to recognize, identify, & rank top hazards that may significantly impact health center operations
- Currently using Kaiser Permanente HVA tool
  - Factors in human, property, & business impacts to assess risk factors
- Risks associated with each hazard are analyzed to prioritize planning, mitigation, response, and recovery activities

Santa Cruz Healthcare Coalition {partner name}

Emergency Management

Hazards - Enter name of facility
Hazard and Vulnerability Assessment Tool
Naturally Occurring Events

Event	PROBABILITY	ALERTS	ACTIVATIONS	SEVERITY = (MAGNITUDE - MITGATION)						RISK
				HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur			Possibility of death or injury	Physical losses and damages	Interuption of services	Preplanning	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	* Relative threat
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	Number of Alerts	Number of Activations	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 = High 2 = Moderate 3 = Low	0 = N/A 1 =High 2 = Moderate 3 = Low	0 - 100%
Active Shooter										
Acts of Intent										
Bomb Threat										
Building Move										
Chemical Exposure, External										
Civil Unrest										
Communication / TelephonyFailure										
Dam Failure										
Drought										
Earthquake										
Epidemic										
Evacuation										
Explosion										
External Flood										
Fire										
Flood										
Forensic Admission										
Gas / Emmissions Leak										
Generator Failure										
Hazmat Incident										
Hazmat Incident with Mass Casulaties										
Hostage Situation										
Hurricane										
HVAC Failure										
Inclement Weather										

Why & when do we complete the HVA?

- Why?
  - Fulfills requirements for the Centers of Medicare & Medicaid Services (CMS) Emergency Preparedness Rule, HRSA, & the Santa Cruz County Health Care Coalition (HCC) membership
  - Serves as a needs assessment tool for emergency planning and preparedness
    - Health Centers can choose to focus based on incidents that have happened in the past year and/or where they feel further training, planning, and preparedness is needed.
  - Helps informs us of what exercises & drills we may need to prioritize in the upcoming year for our health centers

- When do we complete the HVA?
  - Each health center completes its own HVA typically around the beginning of the year, however, our HCC has decided to change it a few months before the new year.
  - Once completed the HVAs will be submitted to our HCC upon request

Emeline Health Center 2024 HVA

- EHC has identified their top 3 hazards to be:
  - Earthquake
  - Inclement Weather
  - Emerging Infectious Diseases

2024

TOP 10 SCHCC HVA HAZARDS	RANK
Earthquake	1
Inclement Weather	2
Emerging Infectious Diseases	3
Fire, External	4
Flood, Internal	5
Pandemic	6
Communication / Telephony Failure	7
Evacuation	8
Air Quality Issue	9
Bioterrorism	10

HPHP 2024 HVA

- HPHP has identified their top 3 hazards to be:
  - Flood, External
  - Inclement Weather
  - Earthquake

2024

TOP 10 SCHCC HVA HAZARDS	RANK
Flood, External	1
Inclement Weather	2
Earthquake	3
Communication / Telephony Failure	4
Fire, External	5
Workplace Violence / Threat	6
Evacuation	7
Epidemic	8
Emerging Infectious Diseases	9
Weapon	10

Watsonville Health Center 2024 HVA

- WHC has identified their top 3 hazards to be:
  - Dam/Levee Failure
  - HVAC Failure
  - Earthquake

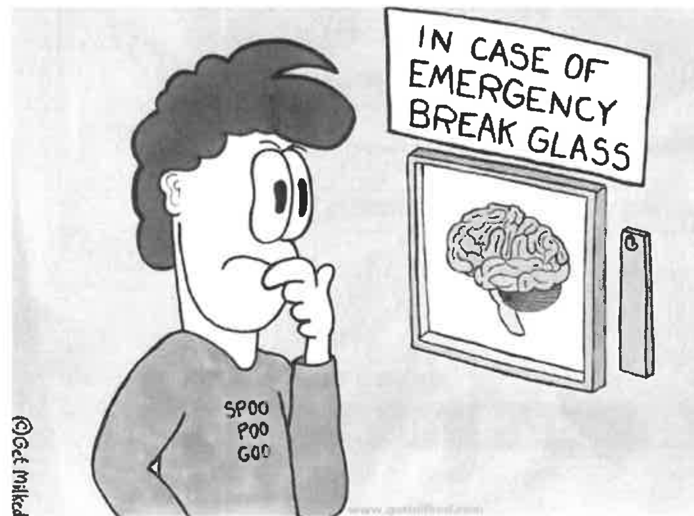
2024

TOP 10 SCHCC HVA HAZARDS	RANK
Dam / Levee Failure	1
HVAC Failure	2
Earthquake	3
Tsunami	4
IT System Outage	5
Epidemic	6
Drought	7
Flood, External	8
Inclement Weather	9
Emerging Infectious Diseases	10

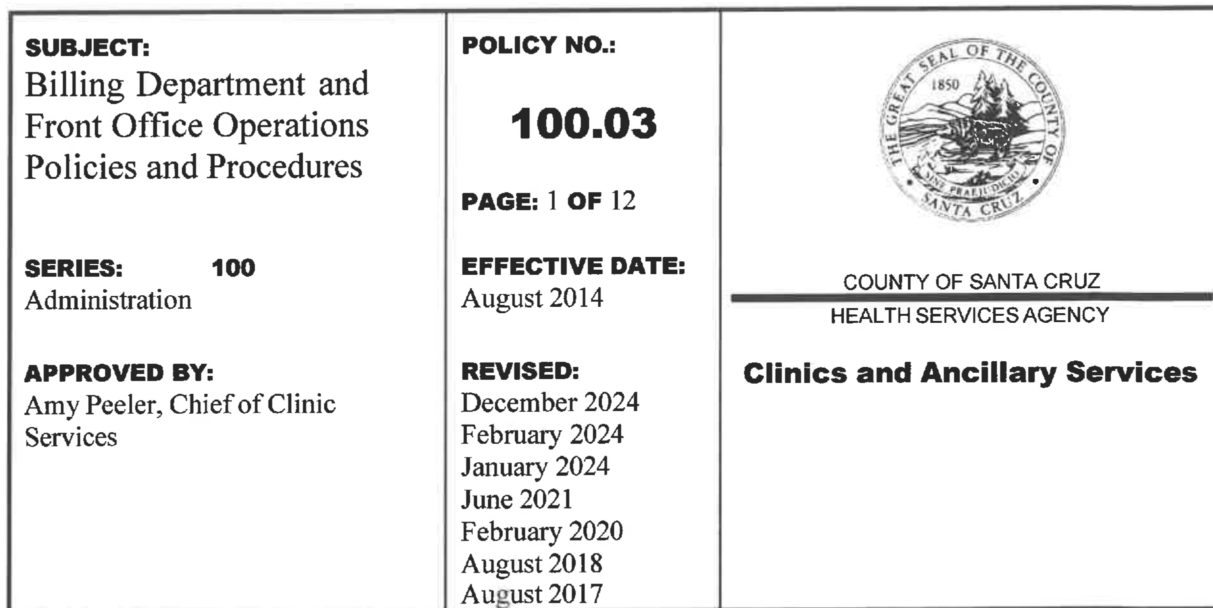
We've identified our hazards… now what?

Plan for the hazards indicated by:

- Reviewing & assessing our preparedness levels for hazards indicated
- Identify areas that need strengthening
- Leverage resources accordingly
- Drills & exercises as appropriate
- Continue discussion & planning in Clinics & Agency Leadership meetings



Questions?



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

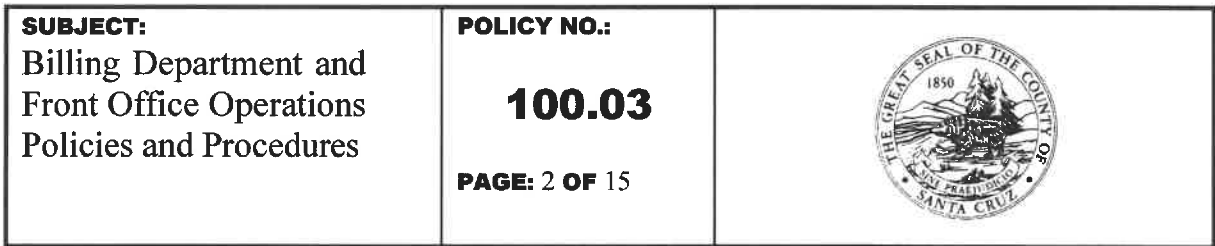
PROCEDURE:

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.



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.

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

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

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

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

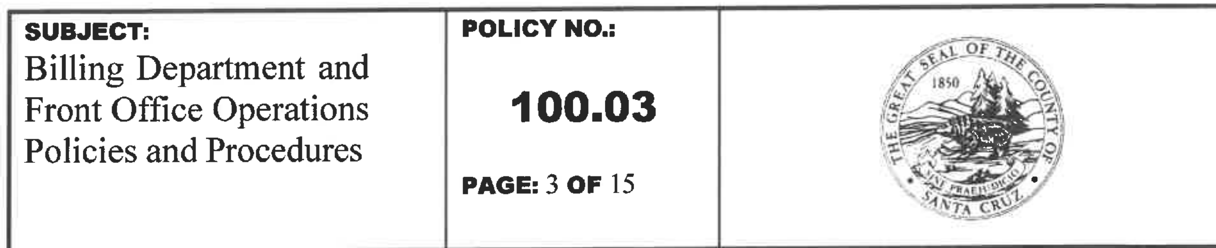
   d. Limitations:
   i. No interest charges
   ii. No late fees
   iii. Cancel plan after 90 days of non-payment.

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

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

B. General Payers

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



a. Assigned to HSA for their primary care; or

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

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

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

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

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

C. Specialized Payers

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

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

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

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

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

D. Self-Pay Payers

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

E. Verification of Eligibility and Benefits Determination by Payer

1. Medi-Cal

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

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

2. Central California Alliance for Health (CCAH)

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

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

3. Medicare

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

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

4. Other Government Funded Programs

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

   b. Benefits Determination

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

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

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

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

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

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

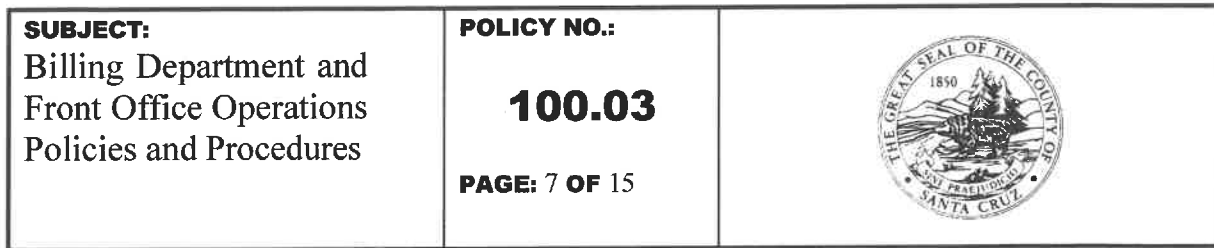
F. Enrollment: Other State Funded Programs

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

1. CHDP

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

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



2. Family PACT

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

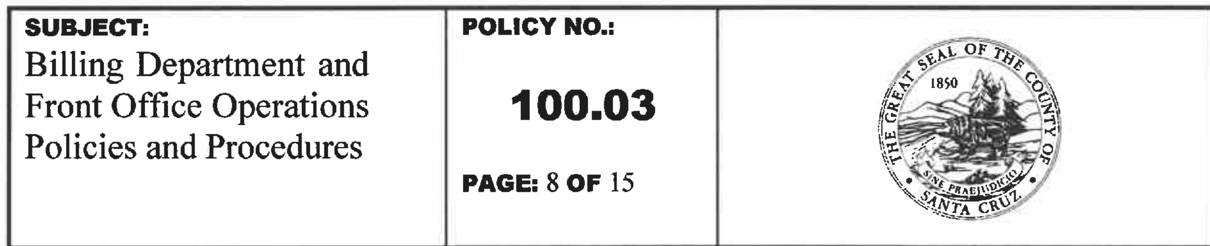
3. Every Woman Counts (EWC)

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

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

4. Ryan White HIV/AIDS Program (RWHAP)

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



G. Patient Information Policy

1. Exchange of Information

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

2. Patient Scheduling

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

3. No Show and Late Cancels Defined

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

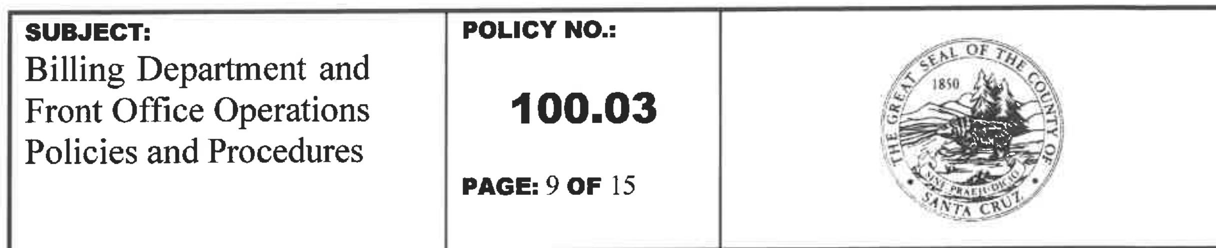
   b. Late Cancel Appointment: The patient cancels appointment less than 24 hours prior.

4. Follow-up

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

H. Financial Policies

1. Accepted Forms of Payment



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

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

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

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

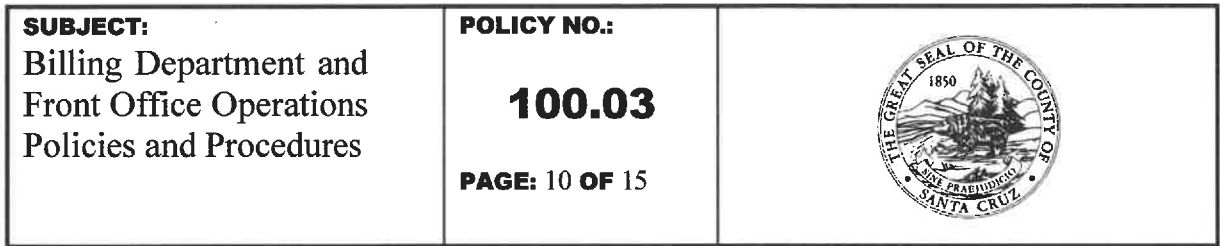
2. Payment Agreements: Payment agreements may be negotiated between the patient and BO staff, providing up to three payment installments for past due charges (over 30 days).

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

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

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

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



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

I. Billing Procedures

1. Encounter Development and Management

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

2. Encounter to Claim Process

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

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

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

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

4. Denial Management Procedure

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

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

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

6. Uncollectable and Bad Debt Adjustments

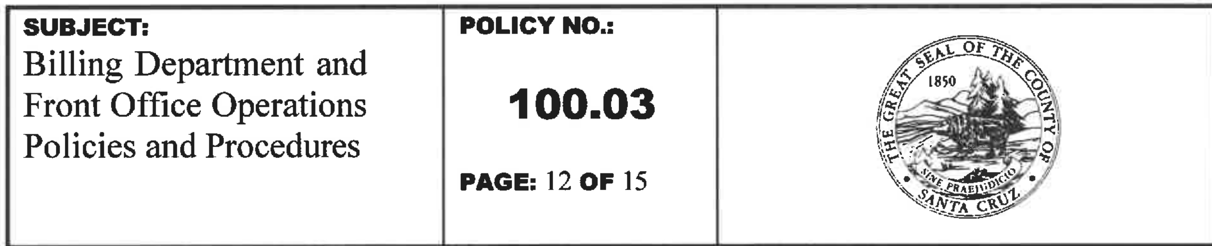
   a. Under the direction of the Business Office Manager, staff will adhere to the following write-off guidelines. The Business Office Manager has the authority to approve write-offs. Write-offs will be measured by HSA Fiscal Department after the month-end close and accounts will be audited as part of standard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



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.

10. Vaccines for Children (VFC) Billing Policy

   a. Introduction

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

b. VFC Vaccine Cost

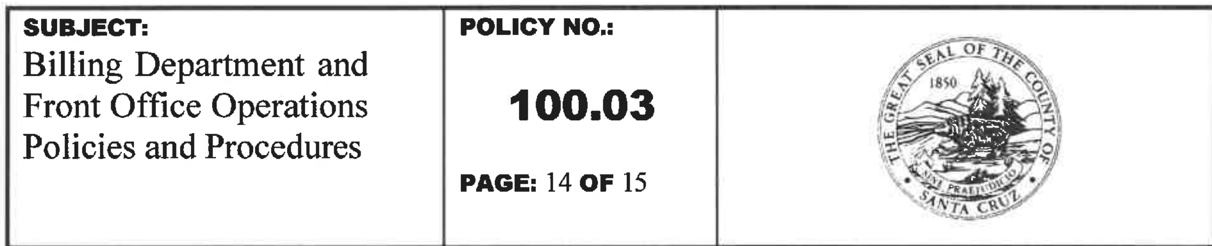
- VFC vaccines are provided **free of charge** to all eligible children.
- **No charges** for the vaccine itself can be billed to the patient, their insurance, or any other payer.

c. Vaccine Administration Fees

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

d. Billing Procedures

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



e. Recordkeeping

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

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

ADDENDUM 1

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