

The County of Santa Cruz

Integrated Community Health Center Commission

MEETING AGENDA

February 6, 2020 @ 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. January 2, 2020 Meeting Minutes – Recommend for Approval
4. Quality Management Committee Update
5. Biographies
6. Availability to pay survey results
7. Approval of updated Sliding Fee Discount Scale (Ability to Pay) – Action Required
8. Approval of updated HSA Billing FO Policy Procedures Section 100.3 – Action Required
9. Approval of HSA Billing Ability to Pay Policy Procedures Section 100.4 – Action Required
10. Financial Update
11. Attendance - Integrated Community Health Center Commission Meetings
12. New Officers
13. CEO Update

Action Items from Previous Meetings:

Action Item	Person(s) Responsible	Date Completed	Comments
Bring updated corrected UDS report.	Raquel		
New Calendar with back up meeting dates.	Mary		
Contact Commission members that have not been at meetings to see if still interested or not to stay on commission.	Amy		
Report back in January on long term space.	Amy		

Next meeting: March 5, 2020 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: Raquel Ramirez Ruiz

Minutes of the meeting held January 2, 2020

Attendance	
Rahn Garcia	Member
Marco Martinez-Galarce	Member
Christina Berberich	Member
Dinah Phillips	Member
Caitlin Brune	Member
Pamela Hammond	Member
Len Finocchio	Member
Marcus Pimentel	County of Santa Cruz, Health Services Agency Assistant Director
Amy Peeler	County of Santa Cruz, Chief of Clinic Services
Raquel Ramirez Ruiz	County of Santa Cruz, Senior Health Services Manager
Meeting Commenced at 11:10 am and Concluded at 12:20 pm	
Excused/Absent:	
Absent: Gustavo Mendoza Absent: Eddie Mendoza	
1. Welcome/Introductions	
2. Oral Communications:	
3. December 5, 2019 Meeting Minutes - Action item	
Review of December 5, 2019 Meeting Minutes - Recommended for Approval. Marco moved to review and accept, Len second, Christina Abstained. The rest of the members present were in favour.	
4. Quality Management Committee Update	
Raquel reported to the Commission the clinic staff are voting to select one of three draft mission statements that resulted from the Strategic Planning meeting on December 13 th . The Quality Council Members are drafting clinical and operational objectives for the next 6 months. The staff satisfaction survey is currently under way and will close on January 17 th . Clinics Services Division is exploring the California Department of Health Care Behavioral Health Integration Grant. Peer Review Committee Reporting Form is being reviewed by County Counsel prior to launching to staff on the HSA Intranet. The Policy and Procedures Committee will resume meeting in January.	
5. Attendance – Integrated Community Health Center Commission Meetings	
Amy addressed attendance and identified members with chronic absences. Amy connected with all commissioners that have been absent multiple times and confirmed their interest to continue. Amy will mail the bylaws to absent members and inform them the Commission will put an action item on the agenda to vote on each member that has missed multiple meetings to remove them as Commissioners. The need to recruit more patients with a focus on Homeless Patients was voiced and Amy agreed she will reach out to HPHP staff to identify more patients for the Commission. Reviewed the bylaws regarding attendance. Giving consideration for removal prior notice will be sent to those absent.	
6. Financial Update	
Amy gave an update on financial report as of 11-30-2019. Revenues are under revenue but so are expenditures. We are projecting to come out ahead by the end of the year. Vacancy Report was shared and showed a 16.46% vacancy rate.	
7. New Officers	
By laws state there needs to be an election of new officers. Rahn moved and Dinah second his motion to elect: Christina as Chair; Marco as Vice Chair; Caitlin as Member at Large. After some discussion the motion was withdrawn. Rahn moved and Marco second to elect: Christina as Chair; Len as Vice Chair; Caitlin as Member at Large. All members present were in favour.	
8. CEO update	
Marcus Pimentel gave an update on long term space planning and reported the County is contracting with an organization to look at renovating/redesigning 701 Ocean, Freedom and Emeline Campuses. There is a desire to leverage other partners to bring dynamic services to our county campuses. The project is in the data collection phase. It is likely that the County will start with the Freedom campus first. Rahn asked about lease space that the Human	

Services Department occupies. Dinah asked if it is in the city of Watsonville and Marcus confirmed. Rahn asked about coordination with city of Watsonville. Marcus discussed that preliminary talks with mayor and city manager are already underway. The County will focus on short term improvements with suite B in Watsonville and reposition services that make better sense for operations. Pam mentioned the inconvenience of navigating from suite D to suite C in Watsonville. Marco mentioned that the exit to freedom boulevard needs attention, the tree root is lifting payment. Pam asked about the aging population and is concerned about outreach. She mentioned that she knows of individuals that are boarding on being homeless due to medical concerns. Amy mentioned this is an issue that will be taken to the Quality Council to focus on outreach, food security, and housing security. Amy gave an update on the Staff Retreat at the Watsonville Woman's club. It was well attended with nearly 140 individuals represented. The retreat started with a "conocimiento" getting to know you activity", a panel on Complementary and Alternative Medicine, and finished with a panel on Substance Use Disorders.

Action items:

- Send Bylaws to both Gustavo and Eddie regarding attendance.
- Place two separate agenda items in February to vote on absent commissioners' removal.
- Direct Quality Council work on outreach to the aging population and address housing and food insecurities.

Next Meeting: February 6, 2020 11:00 am - 1:00 pm
1080 Emeline, Santa Cruz, CA

Minutes approved _____
(Signature of Board Chair or Co-Chair)

_____/_____
(Date)

Current Commission Characteristics Survey for HRSA

Name: _____

Current Commission Office Position (Chair, Co-Chair, Member): _____

Area of Expertise: _____

Are you an employee of the health center? YES NO

Are you an immediate family member of current health center employee(s) (i.e., spouses, children, parents, or sibling through blood, adoption, or marriage)? YES NO

Is more than 10% of your income from the health industry? YES NO

Are you a health center patient? YES NO

Are you a special population representative? (i.e., individuals experiencing homelessness, migratory & seasonal agricultural workers & families, residents of public housing, etc.) YES NO

a. If **YES**, please identify: _____

Do you live or work in the service area? Live Work Both

PLEASE COMPLETE THE COMMISSION MEMBER BIOGRAPHY SECTION ON THE BACK PAGE

For Patient Commission Members ONLY:

1. What is your gender? Please circle.

Male Female Decline to report

2. What is your ethnicity? Please circle.

Hispanic or Latino Non-Hispanic or Latino Decline to Report

3. What is your race? Please circle.

Native Hawaiian Other Pacific Islanders Asian

Black/African American American Indian/Alaska Native White

More than one race Decline to report

Commission Member Biography for HRSA

When the Health Resources and Services Administration (HRSA) comes to perform our site visit they would like to know a little information about our commission members. Please tell us a little about yourself. If you would like to e-mail this information instead please feel free to send it to Jennifer.Phan@santacruzcounty.us. Thank you so much for your help and time!

Integrated Community Health Center Commission Evaluation Survey

All Commission Board members are requested to fill out the following survey to evaluate the Commission for efficiency, effectiveness, and compliance.

1. Does the Commission Board hold monthly meetings? YES NO I DON'T KNOW

Comment: _____

2. Is there a quorum established at the monthly meetings? YES NO I DON'T KNOW

Comment: _____

3. Did the Commission Board perform a CEO evaluation this year? YES NO I DON'T KNOW

Comment: _____

4. In the last 3 years, has the Commission Board adopted, reviewed, and/or evaluated the following:

- | | | | |
|----------------------------------|-----|----|--------------|
| a. Sliding Fee Discount Program | YES | NO | I DON'T KNOW |
| b. Quality Improvement/Assurance | YES | NO | I DON'T KNOW |
| c. Billing and Collections | YES | NO | I DON'T KNOW |

Comment: _____

5. Please list below any comments, suggestions, or ideas for the Integrated Community Health Center Commission.

Thank you!

Ability to Pay Program

Do you know about the Ability to Pay (ATP) Program? Yes No

Are you a member of the Ability to Pay (ATP) Program? Yes No

If you use the Ability to Pay (ATP) Program, do you feel that the fees are affordable?

Very much Somewhat Neutral Not really Absolutely not N/A

If you use the Ability to Pay (ATP) Program, do you feel that the program makes clinic services more accessible to you?

Very much Somewhat Neutral Not really Absolutely not N/A

FPL This section will be filled out by Business Office Staff

0-100% 101%-133% 134%-166% 167%-200% over 200%

Programa Habilidad de Pagar

¿Sabe usted sobre el Programa Habilidad de Pagar (ATP)? Sí No

¿Es miembro del programa Habilidad de Pagar (ATP)? Sí No

¿Si participa en el programa Habilidad de Pagar (ATP), ¿cree que las tarifas son razonables?


Mucho Más o Menos Neutral Realmente no Absolutamente no No se aplica

¿Si participa en el programa Habilidad de Pagar (ATP), ¿cree que el programa hace que los servicios clínicos sean más accesibles para usted?

Mucho Más o Menos Neutral Realmente no Absolutamente no No se aplica

FPL (this section will be filled out by Business Office Staff)

0-100% 101%-133% 134%-166% 167%-200% over 200%

<p>SUBJECT: Billing Department Ability to Pay (Sliding Fee Scale Program) Policies and Procedures</p> <p>SERIES: 100 Administration</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 100.04</p> <p>PAGE: 1 OF 14</p> <p>EFFECTIVE DATE: February 2020</p> <p>REVISED: December 2019</p>	<div style="text-align: center;">  </div> <hr/> <p style="text-align: center;">COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <p style="text-align: center;">Clinics and Ancillary Services</p>
---	---	--

PURPOSE:

The purpose of this policy is to reduce and/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.

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 2 OF 14	
---	---	---


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).

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

1. Ability to Pay 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 are provided for individuals and families with incomes above 100% of the current FPL and at or below 200% of the current FPG.
2. 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.
3. 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. 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.
4. 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.~~

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 3 OF 14	
--	---	---

5. 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
6. The ATP shall apply to all required and additional health services within the HRSA-Approved scope of project for which there are distinct fees.
7. 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.
8. HSA will annually assess the ATP activity and present findings to the Community Health 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.

<p>SUBJECT: Billing Department and Front Office Operations Policies and Procedures</p> <p>SERIES: 100 Administration</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 100.03</p> <p>PAGE: 1 OF 13</p> <p>EFFECTIVE DATE: February 2020</p> <p>REVISED: December 2019</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
--	---	---

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. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.
 - 4. The Business Office Manager and Health Center Managers are authorized to waive patient fees due to expressed financial hardship or disputes. 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.


SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 2 OF 13	
---	---	---

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. 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.

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 3 OF 13	
---	---	---

- 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 (CAAH)

- 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

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 4 OF 13	
---	---	---


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

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 5 OF 13	
--	---	---

5. Commercial Insurance


- 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.
- b. 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.

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 6 OF 13	
---	---	---

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).

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 7 OF 13	
---	---	---

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

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 8 OF 13	
---	---	---

- 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.

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 9 OF 13	
--	---	---

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

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 10 OF 13	
---	--	---

- 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 by Payer
- a. Medicare - Use uncollectible adjustment code
 - Write off balances over 12 months from Date of Post (DOP) when Medicare is primary.
 - Write off balances over 12 months from DOP when Medicare is secondary.
 - b. Commercial Insurance - Use uncollectible adjustment code

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 11 OF 13	
--	--	---

- Write off balances over 12 months from the DOP when insurance is primary.
- Write off balances over 12 months from the DOP when insurance is secondary.
- c. EWC - Use uncollectible adjustment code
 - Write off any balance 12 months from DOP.
- d. Family PACT - Use uncollectible adjustment code
 - Write off any balance 12 months from DOP.
 - Write off any unpaid lab work balance over 12 months from DOP.
- e. CHDP - Use uncollectible adjustment code
 - Write off any balance over 12 months from DOP.
 - Write off any unpaid lab work balance over 12 months from DOP.
- f. Medi-Cal - Use uncollectible adjustment code
 - Write off any balance 12 months from DOP.
- g. CCAH - Use uncollectible adjustment code
 - Write off any unpaid lab work balance over 12 months from DOP.
 - Write off any balance over 12 months from DOP.
 - Write off any balance over 12 months from the DOP when Alliance is secondary.
- h. Self-Pay - Use bad debt adjustment code

SUBJECT: Billing Department and Front Office Operations Policies and Procedures	POLICY NO.: 100.03 PAGE: 12 OF 13	
---	--	---

- Write off any balance over 12 months from DOP.
- Write off any balance for patients not assigned to HSA 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.

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-remittance 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.



SECURITY RISK ASSESSMENT

PROTECTING PATIENT PRIVACY



James Dyer – HIPAA Privacy Officer

TWO CATEGORIES

Privacy

- Protected Health Information
 - Electronic & Paper Records, Verbal
 - Sharing Information for Treatment

Security

- Physical & Electronic World
 - Buildings, Floor Plans, Office Eqpt.
 - Computers, Networks, Internet

THE OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

- ONC Developed the Assessment Tool
- Recommended – Office for Civil Rights
- Industry Standard



ASSESSMENT SUMMARY

Risk Breakdown



Risk Assessment Rating Key	Acceptable little to no effect	Tolerable moderate effect	Intolerable critical effect
Improbable risk unlikely to occur	Low	Medium	High
Possible risk likely to occur	Low	Medium	Critical
Probable risk will occur	Medium	High	Critical

Vulnerabilities

Section 4: Security & Data Vulnerabilities & Threats

Inadequate procedures for evaluating user activity logs

Information disclosure or theft (ePHI, proprietary, intellectual, or confidential)

Unknown source of a security/privacy related incident

Information system access granted to unauthorized personnel

Unauthorized access to or modification of ePHI/sensitive information

LOW

LOW

LOW

LOW

**Section 7: Contingency Planning
Vulnerabilities & Threats**

Failure to update or review contingency plan procedures

Information disclosure or theft (ePHI, proprietary, intellectual, or confidential)	LOW
Unauthorized access to or modification of ePHI/sensitive information	LOW
Out-of-date documentation not reflecting the most recent expected procedures	LOW
Inconsistent or inadequate contingency response due to uncertainty	LOW
Unguided procedures during downtime or unexpected event	LOW

▼ Areas for Review

Section	Question	Your Answer	Education
3	Q:3. Are procedures in place for monitoring log-in attempts and reporting discrepancies?	Log-in monitoring tools are available but we do not actively utilize them.	Consider revising your procedures to include roles and responsibilities, how to identify a log-in discrepancy, and how to respond to an identified discrepancy. If doing so is determined to not be reasonable and appropriate, document the reason why and what compensating control takes its place.

Section	Question	Your Answer	Education
4	Q8. Do you use encryption to control access to ePHI?	No.	<p>You might not be able to ensure access to ePHI is denied to unauthorized users if you do not use encryption/decryption methods to control access to ePHI and other health information. Whenever, reasonable and appropriate implement a mechanism to encrypt and decrypt ePHI.</p>
4	Q11. Have you evaluated whether encryption is reasonable to implement in any of the following locations?	Other.	<p>Consider reviewing and evaluating all the locations where you are processing, storing, or transmitting ePHI and whether it is reasonable to implement encryption. Encryption can help safeguard your ePHI, whether you're transmitting it over the Internet, backing it up on a server, or just carrying a mobile device or your laptop to and from your facility. Encrypting ePHI makes it completely unreadable to anyone but you or its intend recipient.</p>

Section	Question	Your Answer	Education
5	<p>Q5. Do you have physical protections in place, such as cable locks for portable laptops, screen filters for screen visible in high traffic areas, to manage electronic device security risks?</p>	<p>Yes. We have some physical protections in place for some, but not all, electronic devices.</p>	<p>Implement physical safeguards for all electronic devices that access electronic protected health information, to restrict access to authorized users.</p>
5	<p>Q6. What physical protections do you have in place for electronic devices with access to ePHI?</p>	<p>We have limited procedures for electronic device access control including some but not all of those listed above.</p>	<p>Consider which physical safeguards to protect access to ePHI can be reasonably and appropriately implemented in your practice. Consider an authorization process for issuing new electronic device access and removing electronic device access. Or using screen filters, docking stations with locks, and/or cable locks for portable devices, privacy screens [walls or partitions], and/or secured proximity for servers and network equipment.</p>

Section	Question	Your Answer	Education
7	Q1. Does your practice have a contingency plan in the event of an emergency?	No.	Ensure your practice can operate effectively and efficiently under emergency by having a contingency plan. This should be included in your documented policies and procedures. The contingency plan should be reviewed, tested, and updated periodically. As part of this you should determine what critical services and ePHI must be available during an emergency.
7	Q14. How would your practice maintain security of ePHI and crucial business processes before, during, and after an emergency?	We have contingency plans which will be used to maintain continuity of security processes during an emergency setting.	Establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of electronic protected health information while operating in emergency mode.

CRITICAL ACTION PLANS (CAPS)

REPORT TO LEADERSHIP

Agency Executive Team

- Agency Director & Asst. Director
- Division Directors
- Key Upper Management

HIPAA COMMITTEE

Representative From Each Division

- Admin
- Clinics
- Public Health
- Behavioral Health
- Environmental Health

DEVELOPMENT TEAMS

Separated by Division & Focus Area

- Driven by HIPAA Privacy Officer
- Division - Multiple Teams
- Development > Implementation

SOME KEY FINDINGS

CONSTRUCTION

Opportunities

- Micro-Assessments
- Communication to Staff

PHISHING

Education

- Social Engineering
- Phishing
- Ransomware

CONTINGENCY PLANS

Development

- Formal Plans Needed
- Some Documentation Exists
- Emergency Preparedness Plans
- PG&E (PSPS)

QUESTIONS ?





THANK YOU!

James Dyer

Health Services Agency

HIPAA Privacy Officer

(831) 454-4613

james.dyer@santacruzcounty.us

