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

June 5, 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. May 1, 2024, Meeting Minutes – Action Required
4. Emergency Agenda Item added: Review of HRSA Form 5A - Action Required
5. HSA Billing FO Policy Procedures 100.03 - Action Required
6. HSA Billing Ability to Pay Policy Procedures 100.04 – Action Required
7. HSA Credentialing and Privileging Policy 200.03 – Action Required
8. Review of Financial Responsibility document
9. Grant Application for Ryan White Part C - Action Required
10. Quality Management Update
11. Financial Update
12. CEO Update

Action Items from Previous Meetings: Action Item	Person(s) Responsible	Date Completed	Comments

Next meeting: Wednesday, July 3, 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. Commission will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454-2223,191727602# 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 June 5, 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
Marco Martinez-Galarce	Member
Maximus Grisso	Member
Tammi Rose	Member
Michael Angulo	Member
Miku Sodhi	County of Santa Cruz, Assistant Director HSA
Amy Peeler	County of Santa Cruz, Chief of Clinics
Raquel Ruiz	County of Santa Cruz, Acting Chief of Clinics
Julian Wren	County of Santa Cruz, Admin Services Manager
Mary Olivares	County of Santa Cruz, Admin Aide
Meeting Commenced at 4:01 pm and concluded at 5:09 pm	

Excused/Absent:
Excused: Dinah Phillips Excused: Maximus Grisso Absent: Gidget Martinez Absent: Michelle Morton
1. Welcome/Introductions
Introductions were done at this time.
2. Oral Communications:
Raquel stated some items needed to be added to the next agenda which were bylaws and Amy's evaluation need to put on the next agenda.
3. May 1, 2024, Meeting Minutes – Action Required
Review of May 1, 2024, Meeting Minutes – Recommended for Approval. Rahn moved to accept the minutes as submitted. Len second, and the rest of the members present were all in favor. Dinah abstained as she was not present at the previous meeting.
4. Emergency Agenda Item added: Review of HRSA Form 5A - Action Required
Rahn made a motion that this item be to the agenda as an emergency item. Len second, and the rest of the members present were all in favor. Raquel reviewed form 5A with commission. She went over changes and updates with commissioners. Len made a motion to accept changes as updated and presented. Michael second, and the rest of the members present were all in favor.
5. HSA Billing FO Policy Procedures 100.03 - Action Required
Julian presented Policy 100.03 - HSA Billing FO Policy Procedures. Julian stated the only changes to this form was specific language on waiver provisions. Julian went over changes and updates with commissioners. Rahn made a motion to accept changes as updated and presented. Dinah second, and the rest of the members present were all in favor.
6. HSA Billing Ability to Pay Policy Procedures 100.04 – Action Required
Julian presented HSA Billing Ability to Pay Policy Procedures 100.04. Julian stated this was a suggestion from their on-site visit reviewer. Julian stated one of the changes was to the title of the policy to title it Billing Department Ability to Pay (Sliding Fee Scale Program). Julian added there were only a few other small updates to policy. Len made a motion to accept changes as updated and presented. Marco second, and the rest of the members present were all in favor.
7. HSA Credentialing and Privileging Policy 200.03 – Action Required
Raquel presented HSA Credentialing and Privileging Policy 200.03. Raquel stated we did some edits and changes based on their HRSA consultant. Raquel went over edits to policy. Michael made a motion to accept changes as updated and presented. Tami second, and the rest of the members present were all in favor.
8. Review of Financial Responsibility document

Julian stated this document is provided to new patients which discusses financial responsibility. One of the edits that was suggested from the HRSA on site reviewer was adding language to the sliding Billing Department Ability to Pay (Sliding Fee Scale Program) document. Julian then reported for patients that that are receiving a medication from a pharmacy some do have a $4.00 co-pay, this was not listed on this form, it now will be added. This brought up many questions from commissioners on how this could be challenging for some patients and cause barriers. Julian lastly reported that for the sliding fee discount patients who qualify driver license is not required.

Follow Up at Next Meeting:
Julian has an expert on 340B will check to see what options are
Pie chart of distribution of meds that are distributed.
What do other FQ do with similar programs
Check in with Clinicians about co-pay and how do they feel about it.

9. Grant Application for Ryan White Part C - Action Required

Raquel stated generally we must bring grant request to the commission for approval. Raquel stated this is a continuation grant of $404,815.00, she stated this grant is received annually in a cycle of 3 years. Raquel stated this grant helps fund lab diagnostic services, health center visits and charges, specialty referrals, and staffing. Rahn vote to accept grant as presented. Tami second, and the rest of the members present were all in favor.

10. Quality Management Update

Raquel reported on quality management. Raquel reported that the Emeline Clinic reported on their quarterly quality improvement presentation, well childcare visits. Raquel reported some of the barriers/challenges: reaching members invalid numbers, patients on our list are assigned however seeking elsewhere, members have relocated, no phone number listed, and 21 patients not found in EPIC. Lastly Raquel stated some of the Lessons Learned: more outreach, MA has scheduled 74 WCC visits she has made 266 calls this equals a 28% success rate, Change PCP forms must be utilized to have a more accurate list, and send a letter to patient as part of outreach.

Raquel reported on Peer Review and Risk Management. Raquel reported on mortality data, 7 were reviewed, 2 had substance use disorders, proper care was given to all.

Raquel also reported as part of the HRSA on site visit it was suggested some changes to the Peer Review Policy the suggestion was on how long we are reviewing and what we will be adding to the policy such as:

- Once a year 4 charts per person in a large staff meeting with small groups breakouts
- One every, other month, individually
- Episodic Chart Review-initiated by complaint
- Ongoing Professional Practice Reviews (3-months, 6-months, 12-months and then annually).

11. Financial Update

Julian reported he had just completed estimated actuals and that clinic had made some progress the potential deficit is $5,316,829.00, he stated they trying to bring this down by the end of this fiscal year. Julian also reported on Days in A/R the goal is 53 they are currently at 58.8. He also reported on claims over 90 days, they are currently at 30%. Lately Julian reported on claims in our system, he stated they are currently at 32.9%.

12. CEO Update

Amy was happy to report on how successful the May 2024 Operational Site Visit was, she stated it was the best they ever had. She wanted to give a shout out to HPHP and stated they were impressed with peer review and they will be writing it up as a promising practice.

Next meeting: July 10, 2024, 4:00pm - 5:00pm
Meeting Location: In- Person- 150 Westridge Drive, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. Clinic. 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#**

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

SUBJECT: Billing Department and Front Office Operations Policies and Procedures **SERIES:** **100** Administration **APPROVED BY:** Amy Peeler, Chief of Clinic Services	**POLICY NO.:** **100.03** **PAGE:** 1 **OF** 12 **EFFECTIVE DATE:** August 2014 **REVISED:** May 2024 January 2024 June 2021 February 2020 August 2018 August 2017	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY **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. The purpose of the policy is to define request for waiver and or reduction of patient charges/payments regarding clinic visit (s). Waiver provisions are applicable to any/all patients, regardless of their income status. Criteria for financial hardship experienced by patient (s) and or their family may be suggested. Include the date of the request and include any supporting documentation to justify the request.

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Examples to consider for waiver/reduction of fees/payments include but are not limited to: death of wage-earner in family; Loss of housing; extended illness in the immediate family; experiencing national disaster, e.g. ~~Patients who are unable to pay for services due to special circumstances may request for fees to be waived.~~

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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.

~~4.~~5. To improve cash flow and reduce administrative costs, a prompt pay discount may be applied to outpatient visit fees if the patient pays in full on the date of service. Registration and business office staff are authorized to apply this discount.

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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-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.

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.

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) [1841]	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

Cancelación de Cita

Por favor llame con anticipación si una cita programada debe ser cancelada, idealmente 24 horas antes, para asegurar que otros pacientes que necesitan atención médica tengan acceso durante ese tiempo.

He leído y entiendo la Política de Responsabilidad Financiera del Paciente de HSA y acepto cumplir con sus términos y condiciones.

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. The self-declaration/provisional application period expires after 30 calendar days. 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.

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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)~~Sliding Fee Discount Scale Program (ATP) 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.

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

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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**	
SERIES: 100 Administration	**PAGE:** 1 OF 4	
APPROVED BY: Amy Peeler, Chief of Clinic Services	**EFFECTIVE DATE:** March 2020	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
	REVISED: May 2024 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.

SUBJECT: Credentialing and Privileging	POLICY NO.: **200.03**	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY **Clinics and Ancillary Services**
SERIES: 200 Personnel	**EFFECTIVE DATE:** July 2001	
APPROVED BY: Amy Peeler, Chief of Clinic Services	**REVISED:** February 2017 August 2018 September 2018 March 2020 June 2021 September 2021 July 2022	

GENERAL STATEMENT:

Credentialing and privileging are processes of formal recognition and attestation that an independent licensed practitioner or other licensed or certified practitioner is both qualified and competent.

Credentialing verifies that the staff meets standards by reviewing such items as the individual's license, experience, certification, education, training, malpractice and adverse clinical occurrences, clinical judgment and character by investigation and observation, as applicable.

Privileging defines an independent, licensed practitioner's scope of practice and the clinical services the clinician may provide.

POLICY STATEMENT:

Health Services Agency Clinic Services Division shall credential, and privilege all employed, contracted, locum tenens, or volunteer licensed and certified practitioners in accordance with the Bureau of Primary Health Care (BPHC) guidelines and standards.

Credentialing and privileging shall be conducted without regard to race, ethnicity, national origin, color, gender, age, creed, sexual orientation, or religious preference.

Reference:

HRSA Health Center Compliance Manual

KEY DEFINITIONS:

Credentialing: The process of assessing and confirming the qualifications for a licensed or certified health care practitioner.

Privileging: The process of authorizing a licensed or certified health care practitioner's specific scope and content of patient care services. This is performed in conjunction with an evaluation of an individual's

clinical qualification and/or performance.

Licensed, Independent Practitioner (LIP): Physician, dentist, physician assistant, nurse practitioner, psychiatrist, licensed clinical social workers (LCSW), or psychologist permitted by law to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. This includes contracted practitioners providing care at any Clinic Services Division Health Center.

Other Licensed or Certified Practitioner (OLCP): An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without direction or supervision; this includes laboratory technicians, medical assistants (MA), licensed practical nurses (LPN), registered nurses (RN), public health nurses (PHN), registered dieticians (RD), and registered dental assistants (RDA). This includes contracted OLCPs providing care at any Clinic Services Division Health Center.

Primary Source Verification (PSV): Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. PSV methods include direct correspondence, telephone verification, internet verification or reports from credential verification organizations (e.g., American Medical Association (AMA) Masterfile or American Osteopathic Association (AOA) Physician Database).

Secondary Source Verification (SSV): Verification of a specific credential by a source other than the original source; SSV is used to verify credentials when PSV is not required. SSV methods include the original credential, a notarized copy of the credential or a copy of the credential (when made from an original by Clinic Services Division staff).

Peer Review and Risk Management Committee: The goal of the medical peer review is to improve quality and patient safety by learning from past performance, errors and near misses. Educational peer review, for both the provider and the health center, is a tool for identifying, tracking, and resolving suboptimal inappropriate clinical performance and medical errors in their early stages. Plan, Do, Study Act cycles are used for providing feedback and developing strategies for improvement. Both the medical and educational peer reviews will be conducted annually by the Peer Review and Risk Management Committee made up of the Medical Director and Provider Members of the Quality Management Committee. Aggregated data and summaries of the PDSA cycles will be presented to the Co-Applicant Board.

PROCEDURES:

Verification of credentials will occur for all LIPs and OLCPs by obtaining Primary Source or Secondary Source Verification using accepted national verification sites. Credentialing documents requiring verification and the verification sites for licensed, registered, and certified staff are utilized and maintained by the Administrative Services Officer II (ASO). The candidate must submit applicable documentation for review.

SUBJECT: Credentialing and Privileging	POLICY NO.: 200.03	

Through a formal contract between Health Services Agency and Dignity Health patients can be admitted by the Emergency Department physician and will be followed by a hospitalist.

RESPONSIBILITIES:

The completed Credentialing Application and additional materials will be reviewed by the ASO for verification. Any missing information will be requested from the applicant. The additional requested materials must be returned within two weeks to the ASO or designee.

1. ASO verifies credentials and enters all documents into the HSA Documents Database (Database). The ASO maintains the database to accurately track all practitioners' credentials.

2. County Personnel Department will complete query of Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) criminal index systems pursuant to standard process. LIPs and OLCP additionally have a query of the National Practitioner Data Bank (NPDB) and Medi-Cal Suspended, and Ineligible Provider List completed by the ASO. Clearance of query is filed in the LIP or OLCP Database. The LIP or OLCP bears the burden of establishing and resolving any reasonable doubts about his/her qualifications. A copy of government issued photo identification is requested by the ASO during the credentialing process and additionally, will be kept in the Database. Failure to meet this burden may result in denial of the application. Verification of Basic Life Support Training for LIPs and OLCPs.

3. All adverse information found on the background check is evaluated by the Chief of Clinic Services, the Medical Director, ASO, and hiring supervisor.

4. A pre-employment physical is completed in accordance with County Personnel Procedures. Fitness for duty is evaluated at time of hire with a physical exam reviewing immunizations and PPD status. Annually, thereafter fitness for duty will be documented in the annual evaluation for LIPs and OLCPs. Additionally, every two years the LIPs and OLCPs will attest they are physically and cognitively able to perform their job duties on the privileging form.

5. The Supervising Practitioner completes proctoring of twenty patient encounters for LIPs during initial evaluation of competency. Peer chart audits are completed at least twice a year thereafter at designated Provider meetings. Each Practitioner will review up to ten charts to assess current competencies. If issues arise it will be elevated to a supervisory review to determine if corrective action is needed. All other licensed, registered, and certified practitioners will have clinical competencies evaluated during orientation and annually thereafter. The evaluation data shall be provided to the Clinic Services Division designated staff for placement into credentialing database.

6. Practitioner shall complete a Clinical Privileges/Procedure Application prior to providing clinical services. Practitioners, employed and contracted, shall have the burden of producing all necessary information in a timely manner for an adequate evaluation of their qualifications and suitability for clinical privileges. The applicant's failure to sustain this burden may be grounds for denial or termination of

privileges.

7. At any time based on an incident and competency issues, Medical Director or Supervising Practitioner may revise or revoke privileges of the LIP or OLCP. A corrective action will be issued and LIP or OLCP will have the right to appeal to the Chief of Clinic Services. The Chief of Clinic Services will have five business days to respond to the LIP or OLCP. If revocation is reversed the LIP/OLCP must complete a renewal of privileges document and competencies will be reviewed by the Medical Director at six months and then again at twelve months.

APPROVAL PROCESS

Health Services Agency Co-Applicant Board authorizes the Medical Directors, in combination with the appropriate Supervising Practitioner, to approve credentialing and privileging of health care practitioners who meet the standards for verification. The Supervising Practitioner and Medical Directors will assess the credentials of each health care practitioner as outlined in the Credentialing Application.

Upon the final decision by the Medical Directors, the ASO will notify the physician in a timely manner of the approval and the next re-credentialing period. If the Medical Director denies the practitioner's application the Medical Director will work with the Personnel Department on next steps.

RE-CREDENTIALING AND RE-PRIVILEGING:

Credentialing and privileging of current LIPs and other Licensed or Certified Practitioners shall be reviewed at a minimum of every two years. Application for reappointment will be sent to practitioner sixty days prior to their appointment expiration day. The Practitioner shall complete attestation for completion of continuing education and attestation questionnaire. Primary source verification of expiring or expired credentials shall be completed by ASO on an on-going basis. A performance evaluation shall be completed annually by the Supervising Practitioner. All reappointment information will be forwarded to the Medical Director for review.

TEMPORARY PRIVILEGING:

Temporary privileges may be granted to a LIP by the Medical Director to fulfill a patient care need. This includes providing temporary privileges to a locum tenens LIP or extra help LIP who is covering for an employed or contracted LIP who is ill or taken a leave of absence. Privileges may be granted to a LIP who has the necessary skills to provide care to a patient that a LIP currently privileged does not possess. Temporary privileges may be granted provided current licensure and current competence has been verified.

EXPIRED LICENSURE:

Each month, Clinic Services Division staff, will audit the database to determine which providers have a

SUBJECT:	POLICY NO.:	
Credentialing and Privileging	**200.03**	

California Professional License, DEA Certificate, or current Board certification that will be expiring in sixty (60) and thirty (30) days. An e-mail notice is sent to the provider 60 days prior to expiration and a final notice is sent 30 days prior to expiration. E-mail notifications are copied to their Health Center Managers and the Medical Director.

If provider fails to respond and the license expires the Medical Director will have the provider perform limited duties, if possible, until the next steps are coordinated with the Personnel Department.

County of Santa Cruz Health Services Agency
Clinic Services Division
Patient Financial Responsibility Policy

Thank you for choosing the County of Santa Cruz Health Services Agency (HSA) as a partner in addressing your health care needs. The following terms and conditions describe HSA's Patient Financial Responsibility Policy. Copies are available upon request.

Insurance
As HSA's commitment to ensure health care access for all Santa Cruz County residents, Medi-Cal and Medicare (non-managed) are accepted insurances. If you are not insured by a plan HSA is contracted with, payment in full is expected at each visit. Payment in full is also required if coverage cannot be verified at the time of visit. Insurance benefits are the patient's responsibility; insurance providers should be contacted by the patient for explanation of benefits.

Co-payments and Deductibles
Co-payments and deductibles must be paid at the time of service. Such fees are coordinated by insurance providers. HSA is legally required to make an effort to collect these fees at the time of service. For Sliding Fee Discount Scale (ATP) patients there is a nominal co-pay for prescribed medication through our 340B discount program.

Non-Covered Services
Services that are not covered by insurance, or not considered reasonable or necessary by Medicare or other insurers, may become the patient's responsibility to pay.

Proof of Insurance
All new patients must complete HSA's patient information form and provide a driver's license and proof of current medical insurance, if any. For Sliding Fee Discount Scale patients, a driver's license is not required to qualify.

Claims Submission
HSA submits insurance claims in an effort to capture costs associated with providing medical care. Unpaid balances may become the patient's responsibility to pay.

Coverage Changes
Patients are responsible to notify HSA of insurance changes prior to their scheduled appointment.

Nonpayment
Unpaid patient balances of more than 120 days may be referred to a collection agency.

Appointment Cancelation
Please call in advance if a scheduled appointment must be missed, ideally 24 hours in advance, to ensure other patients in need of healthcare will have access during that time.

I have read and understand HSA's Patient Financial Responsibility Policy and agree to abide by its terms and conditions.

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Signature of Patient or Responsible party Date

Condado de Santa Cruz Agencia de Servicios de Salud
División de Servicios Clínicos
Política de Responsabilidad Financiera del Paciente

Gracias por elegir la Agencia de Servicios de Salud del Condado de Santa Cruz (HSA) como la agencia para atender sus necesidades de atención médica. Los siguientes términos y condiciones describen la Política de Responsabilidad Financiera del Paciente de HSA. Las copias están disponibles bajo petición.

Seguro

Como compromiso de HSA es asegurar el acceso a la atención médica para todos los residentes del Condado de Santa Cruz, Medi-Cal y Medicare (no administrados) como seguros aceptados. Si no está asegurado por un plan con el cual HSA tiene contratado, se espera un pago completo en cada visita. El pago completo también se requiere si la cobertura no se puede verificar en el momento de la visita. Los beneficios del seguro son responsabilidad del paciente; los proveedores de seguros deben ser contactados por el paciente para la explicación de los beneficios.

Copagos y Deducibles

Los copagos y los deducibles deben ser pagados en el momento del servicio. Estos honorarios son coordinados por los proveedores de seguros. HSA está legalmente obligado a hacer un esfuerzo para recoger estos honorarios en el momento del servicio. Para los pacientes de la Escala de Descuento de Cuota Variable (ATP) hay un copago simbólico para los medicamentos recetados a través de nuestro programa de descuento 340B.

Servicios No Cubiertos

Los servicios que no están cubiertos por un seguro o que no son considerados razonables o necesarios por Medicare u otros aseguradoras, pueden convertirse en responsabilidad del paciente en pagar.

Prueba de seguro

Todos los pacientes nuevos deben completar el formulario de información del paciente de HSA, proporcionar una licencia de conducir y una prueba del seguro médico actual, si tiene alguno. Para los pacientes de la escala de descuentos [sliding fee discount scale], no se necesita licencia de conducir para calificar.

Presentación de reclamaciones

HSA presenta reclamaciones de seguros en un esfuerzo por capturar los costos asociados con la prestación de atención médica. Los saldos no pagados pueden convertirse en la responsabilidad del paciente de pagar.

Cambios en la cobertura

Los pacientes son responsables de notificar a HSA de los cambios del seguro antes de su cita programada.

Falta de pago

Los saldos de pacientes no pagados de más de 120 días pueden ser referidos a una agencia de cobro.

Health Centers Division

Grant Application Approval

June 2024

HRSA Ryan White HIV/AIDS Part C- Continuation Grant

- Application Due Date: 6/17/2024
- Term: 1/1/2025-12/31/2027
- Award Amount: $404,815 (annual award amount)
- Funding:
  - Lab and diagnostic services
  - Health center visits and charges
  - Specialty medical care referrals
  - Dental
  - Staffing

HRSA Behavioral Health Service Expansion

- Application Due Date: 6/21/2024
- Term: 9/1/2024-8/31/2026
- Award Amount: $600K year 1; $500K year 2
- Funding:
  - Increase access to behavioral health services through expanding Mental Health Services and Substance Use Disorder services

Central California Alliance for Health

- Application Due Date: 7/16/2024
- Term: 9/13/2024
- Award Amount: $250,000
- Funding:
  - To recruit and hire new health care professionals who will serve the Medi-Cal population in the Alliance service areas.
    - First year Salary, relocation expenses, liability insurance, recruitment agency, sign on bonus

HRSA Expanded Hours

- Application Due Date: 7/23/2024
- Term: 12/1/2024-11/30/2026
- Award Amount: $500K per year
- Funding:
- Will expand access to health center services by increasing health center operating hours to meet identified patient and community needs.

Questions?

Thank You

Health Centers Division

Quality Management Report

June 2024

Quality Management Committee

- Quarterly Quality Improvement Presentation- Emeline: Well Child Care Visits
- Update the Quality Management Plan
- Ryan White Committee Update

Barriers/Challenges:

- Reaching Members invalid numbers
- Patients on our list are assigned however seeking elsewhere
- Members have relocated
- No phone number listed
- 21 patients not found in EPIC

Photo Example

Lessons Learned:

- More outreach: MA has scheduled 74 WCC visits she has made 266 calls this equals a 28% success rate
- Change PCP forms must be utilized to have a more accurate list
- Send a letter to patient as part of outreach

Peer Review and Risk Management Committee

- Mortality Data: 7 reviewed; 2 had a Substance Use Disorders
- Peer Review Policy
  - Once a year 4 charts per person in a large staff meeting with small groups breakouts
  - One every, other month, individually
  - Episodic Chart Review-initiated by complaint
  - Ongoing Professional Practice Reviews (3-months, 6-months, 12-months and then annually).

Health Centers Division

Integrated Health Care Commission Monthly Budget

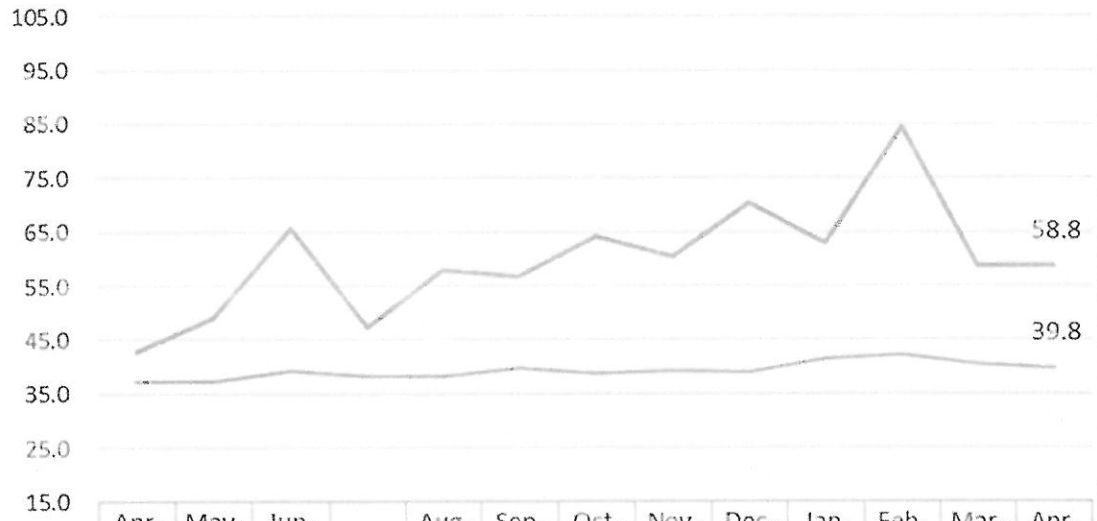
6/4/24

Row Labels	Adopted Budget	Actual	Division EA's 4.8.24	Division EA's 5.15.24	Variance Adjusted Budget to EA's
⊞ REVENUE	(58,801,253)	(25,025,761)	(47,142,541)	(48,803,085)	10,331,913
⊞ EXPENDITURE	56,833,410	36,887,937	51,953,288	52,152,071	(5,015,084)
Grand Total	(1,967,843)	11,862,176	4,810,747	3,348,986	5,316,829

Row Labels	Adopted Budget	Actual	Division EA's 4.8.24	Division EA's 5.15.24	Variance Adjusted Budget to EA's
- REVENUE	(58,801,253)	(25,025,761)	(47,142,541)	(48,803,085)	10,331,913
+ 05-LICENSES, PERMITS AND FRANCHIS	0	0	0	0	0
+ 15-INTERGOVERNMENTAL REVENUES	(7,638,506)	(2,877,714)	(4,511,740)	(6,141,971)	1,765,280
+ 19-CHARGES FOR SERVICES	(50,905,161)	(21,035,429)	(39,866,390)	(39,676,278)	10,844,597
+ 23-MISC. REVENUES	(257,586)	(1,112,618)	(2,764,411)	(2,984,836)	(2,277,964)
- EXPENDITURE	56,833,410	36,887,937	51,953,288	52,152,071	(5,015,084)
+ 50-SALARIES AND EMPLOYEE BENEF	35,325,814	23,634,721	31,209,114	31,209,114	(4,173,272)
+ 60-SERVICES AND SUPPLIES	7,409,191	6,190,369	9,174,033	9,372,816	1,686,452
+ 70-OTHER CHARGES	4,508,292	40,335	48,404	48,404	0
+ 80-FIXED ASSETS	734,388	43,177	630,393	630,393	(103,995)
+ 90-OTHER FINANCING USES	97,875	0	0	0	(97,875)
+ 95-INTRAFUND TRANSFERS	8,757,850	6,979,335	10,891,344	10,891,344	(2,326,394)
Grand Total	(1,967,843)	11,862,176	4,810,747	3,348,986	5,316,829

Days In A/R

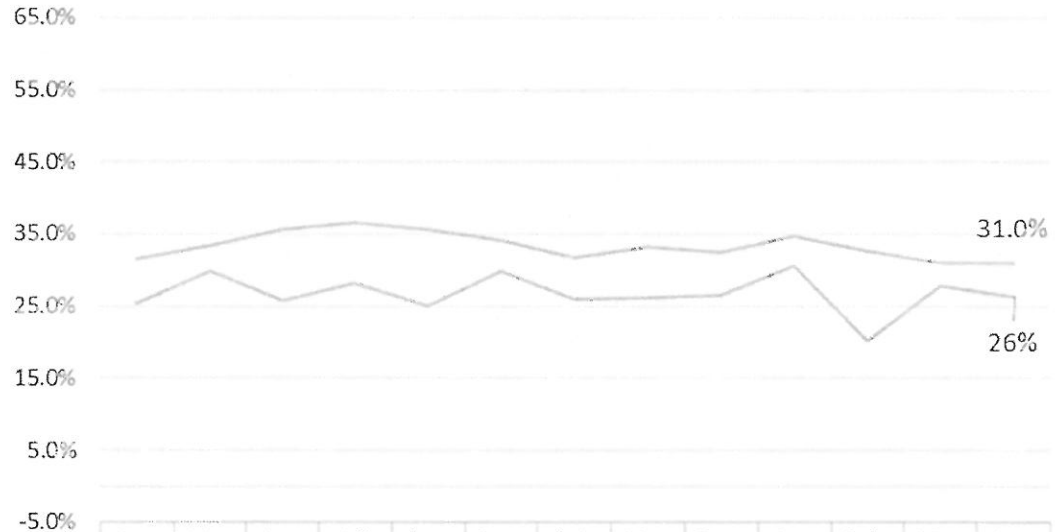
Top Performers are less than 25 days



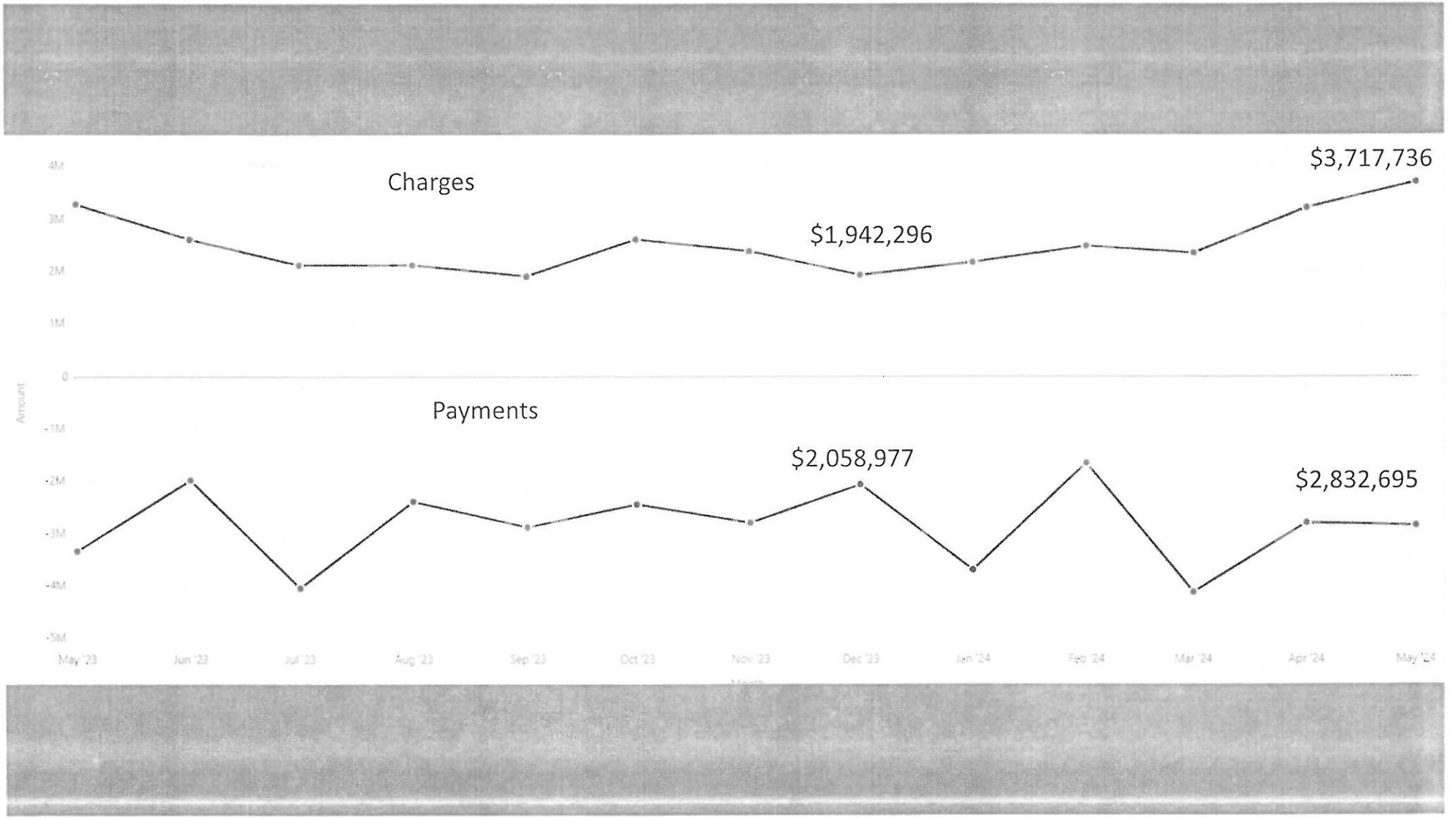
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Days In A/R	37.4	37.4	39.3	38.2	38.3	39.6	38.7	39.1	39.1	41.4	42.1	40.4	39.8
Days In A/R	42.9	49.1	65.7	47.2	58.0	56.7	64.1	60.5	70.4	62.8	84.5	58.8	58.8

% Over 90 (Debits Only)

Top Performers are less than 14%



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
% > 90 (Debits)	31.5%	33.4%	35.7%	36.6%	35.6%	34.1%	31.8%	33.2%	32.4%	34.8%	32.6%	31.0%	31.0%
% > 90 (Debits)	25%	30%	26%	28%	25%	30%	26%	26%	26%	31%	20%	28%	26%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$1,942,296
Payments
$2,058,977
$2,832,695
4M
3M
2M
1M
0
-1M
-2M
-3M
-4M
-5M
Amount
May '23
Jun '23
Jul '23
Aug '23
Sep '23
Oct '23
Nov '23
Dec '23
Jan '24
Feb '24
Mar '24
Apr '24
May '24


Min: 30.4% Max: 37.1% Most Recent: 32.9%
40
38
36
34
32
30
%
Apr 1 2023
May 14
Jun 26
Aug 8
Sep 20
Nov 2
Dec 15
Jan 27 2024
Mar 10
Apr 22
7 Days
14 Days
30 Days
60 Days
90 Days
13 Months
MTD
YTD