Attachment A

Health Center Program Site Visit Report

TA Request Details

TA Request Number: TA001290

Grantee Information: **Contra Costa County Health Services Dept.**
597 Center Ave # 150
Martinez, CA 94553

Contact: Rachael Birch; rachael.birch@hsd.cccounty.us; (925) 313-6167

Type of Visit: Operational Site Visit

Date(s) of Visit: July 21 – 24, 2015

Consultants

Iris Sewell (**Board Authority**); rainbow1410@juno.com; (773) 548-1830
David Adams (**Team Leader - Clinical**); dadams@cp-tel.net; (318) 932-3829
William Turnley, Jr. (**Financial**); wctbill@aol.com; (972) 276-8770

Site Visit Participants

Name	Title	Interviewed	Entrance	Exit
Rachael Birch	HCH Project Director	Yes	Yes	Yes
Sue Crosby	Director of PHCS	Yes	Yes	Yes
Joseph Mega, MD	Medical Director HCH Program	Yes	Yes	Yes
William Walker, MD	Health Director/Health Officer/CCHS	No	Yes	Yes
Patrick Godley	COO/CFO	Yes	Yes	Yes
Chris Farnitano, MD	Ambulatory Care Medical Director	No	Yes	Yes
Jr Ang	Director of Patient Accounting	Yes	No	No
Mariano Mendoza	Accountant III	Yes	No	No

This report has been prepared on behalf of the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC) for the purposes of oversight and guidance of HRSA/BPHC programs. The report contains final findings and recommendations reviewed and approved by HRSA/BPHC. This report identifies any findings of non-compliance with Health Center program requirements and may also include a review of clinical and financial performance.

Ron C. Persevranza	Reimbursement Supervisor	Yes	No	No
Lucy delos Reyes	Accountant III	Yes	No	No
Alvin Silva	Nurse Program Manager	Yes	Yes	Yes

Program Requirement Compliance Review Summary

Program Requirement Compliance Review	Compliance Status
1. Needs Assessment	Met
2. Required and Additional Services	Met
3. Staffing Requirement	Not Met
4. Accessible Hours of Operation/Locations	Met
5. After-Hours Coverage	Not Met
6. Hospital Admitting Privileges and Continuum of Care	Met
7. Sliding Fee Discounts	Not Met
8. Quality Improvement/Assurance Plan	Not Met
9. Key Management Staff	Met
10. Contractual/Affiliation Agreements	Met
11. Collaborative Relationships	Met
12. Financial Management and Control Policies	Met
13. Billing and Collections	Not Met
14. Budget	Met
15. Program Data Reporting Systems	Not Met
16. Scope of Project	Not Met
17. Board Authority	Not Met
18. Board Composition	Met
19. Conflict of Interest Policy	Not Met

Attachment B

Patients Accessing Services at Contra Costa Regional Medical Center (CCRMC) who are Ineligible for the Basic Health Care, Medi-Cal and Commercial Insurance Programs (Sliding Fee Schedule)

I. PURPOSE

This policy is intended to address a single episode of care only and is not to be used for ongoing patient care requests. Specific benefit plans will be utilized when adults with incomes less than 200% of the Federal Poverty Level (FPL), are admitted to CCRMC, receive care in the Emergency Department (ED), or are referred to CCRMC for outpatient care. Individuals must be Contra Costa County residents in order to be eligible for this program.

II. REFERENCES

Board of Supervisors Resolution No. 2009/187
Welfare and Institutions Code Section 17000
Health Resources and Services Administration (HRSA)

III. AUTHORITY AND RESPONSIBILITY

Hospital and Health Centers Administration and Financial Counseling

IV. POLICY

When authorization for medical services has been granted by the Chief Medical Officer (CMO) or designee, the Financial Counselor will financially screen the patient to determine for which program the patient may be eligible and assign the appropriate plan code. Patients may receive medically necessary follow-up appointments, lab & radiology studies and specialty visits through Contra Costa Health Services (CCHS) while admitted or immediately upon discharge from CCRMC. Coverage Code 903001 - Administrative Override / Rx Coverage Only will cover costs for prescription medication for patients who are admitted and discharged from CCRMC for a thirty (30) day period or are discharged from the emergency room for a five (5) day period. If it is necessary for follow-up care to go beyond the initial requested timeframe, authorization must be obtained from the CMO or designee.

V. PROCEDURE

A. Financial Screening - Sliding Fee Schedule for Services

1. The Financial Counselor will conduct an initial screening to determine if the patient is eligible for Presumptive Medi-Cal, which includes PRUCOL, restricted or emergency Medi-Cal, Breast and Cervical Cancer Treatment Programs and Long Term Care/Kidney Dialysis. Additionally, patients will be screened to

determine if they are eligible for insurance through Covered California or the Basic Health Care Program (Note: Individuals who fail or have failed to apply for insurance through Covered California, are not eligible for a sliding fee scale adjustment).

2. If found to be ineligible for the programs listed above, patients will be screened by a Financial Counselor to verify their income. Patients will be required to pay a discounted rate for services based upon where their income falls in the current Federal Poverty Level Guidelines and will not be discriminated against on the basis of age, gender, race, creed, disability or national origin. See Attachment A for the sliding fee schedule and income guidelines.

3. Patients with incomes above 200% of the Federal Poverty Level will be evaluated for the Discount Program. See Health Services Policy # 707-C, Discount Payment Program for more information.

4. Patients who are identified as homeless or at risk for homelessness and are ineligible for a coverage program specified in Section I.1, a Financial Counselor will enter the Homeless benefit plan into ccLink. See policy, Homeless Patients Accessing Inpatient, Emergency and Outpatient Services at Contra Costa Regional Medical Center (CCRMC), for more information about access to health care services for the homeless population.

5. Patients will be required to complete an application for the Sliding Fee Scale Program. Upon receipt of a Verifications Request Notice from the Financial Counseling Unit, patients will be required to provide documentation to verify their residency and income as well as submit a signed Rights and Responsibilities Form. Patients will receive written notification of their Sliding Fee Discount payment or, if applicable, the reason for denial of their application.

6. Patient Accounting will adjust the charges for services per the sliding fee schedule and income guidelines per notes entered by a Financial Counselor in ccLink.

7. If ineligible or if a Financial Counselor does not interview the patient prior to discharge from Inpatient or the ED, the financial coverage will remain Private Pay.

8. Medical services will be provided regardless of one's ability to pay. The Patient Accounting Director will inform the Health Services Department's Chief Financial Officer (CFO) of the extenuating circumstance(s) that impacts a patient's abilty to

pay the nominal or discounted fee per the Sliding Fee Schedule. The CFO will make the decision to waive the entire or partial amount of what the patient owes for medical services rendered.

B. Attending Physician determines that specialty or ancillary follow-up care is REQUIRED after discharge from the Inpatient Unit.

1. **Making the decision to provide specialty follow-up care at CCHS** should only be done for select patients with complex medical or surgical conditions and in which specialty follow-up care will result in a significantly earlier discharge from the hospital.

    a. If the attending physician determines that the patient needs follow-up care, the physician is required to send an authorization request to the Chief Medical Officer (CMO) or designee indicating the medical necessity.

    b. The CMO will use the following criteria to approve the requested services: Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
        i. Placing the patient's health in serious jeopardy
        ii. Serious impairment to bodily functions
        iii. Serious dysfunction to any bodily organ or part

    c. The CMO will send the approved authorization to the Financial Counseling Health Services Administrator to verify coverage for the patient and provide final authorization to proceed with the medical services.

    d. A Financial Counselor will screen the patient to determine for which program the patient may be eligible. If the patient is ineligible for a payment plan, the patient will remain Private Pay.

    e. Utilization Review (UR) and the attending provider will be notified of the approved authorization if services are provided within the CCRMC system or if an authorization is needed for specialty services outside of CCRMC.

2. **Follow-up appointments**: The attending physician will submit a referral for CCHS specialty clinics in ccLINK.

3. **Discharge medications:** When an uninsured patient is discharged from the inpatient unit, the patient will receive a 30 day supply of medication. A Financial Counselor will enter 903001 - Administrative Override / RX Coverage Only coverage into ccLink, which allow the patient to obtain medication from Walgreens.

4. **Lab tests and radiology studies:** At discharge, patients authorized to obtain specialty follow-up care with CCHS will obtain lab and radiology studies up to one month post-discharge.

5. **Discharge medical records:** Medical records will send the discharge summary, medication list, and recent labs upon request to a local health care organization or community clinic if the patient chooses to receive follow-up care outside of CCHS.

C. Attending Physician determines specialty or ancillary follow-up care is REQUIRED after discharge from the Emergency Room.

1. **Making the decision to provide specialty follow-up care at CCHS**: Financially eligible patients discharged from the emergency room can obtain authorization to receive specialty clinic visits, labs and studies through CCHS for up to 30 days post ED visit. This should only be done for select patients who have complex medical or surgical issues.

    a. The attending physician will use the following criteria to determine if the follow-up care is medically necessary: Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
        i. Placing the patient's health in serious jeopardy
        ii. Serious impairment to bodily functions
        iii. Serious dysfunction to any bodily organ or part

    b. The attending physician will send an email to the Financial Counseling Health Services Administrator explaining the need to proceed with the medically necessary services. The Health Services Administrator will verify the patient's coverage and provide final authorization to proceed with the medical services.

    c. After an authorization has been granted for follow-up care, the Financial Counselor will financially screen the patient and assign the appropriate

benefit plan code. If the patient is ineligible for a payment plan, the patient will remain Private Pay.

d. The Health Services Administrator will request authorization for follow-up services from the CMO or designee in the event the patient remains Private Pay and there is a question regarding the medical necessity of the services requested by the attending physician based upon the emergency criteria.

2. **Follow-up appointments**: The attending physician will submit a referral for CCHS specialty clinics in ccLINK.

3. **Discharge Medications**: When an uninsured patient is discharged from the ED, the patient will receive a 5 day supply of medication. A Financial Counselor will enter 903001 - Administrative Override / RX Coverage Only coverage into ccLink, which will allow the patient to obtain medication from Walgreens. During the hours a Financial Counselor is unavailable, the patient may call the main number for CCRMC between the hours of 7:00 AM and 7:00 PM to be directed to a Financial Counselor.

4. **Lab and radiology studies** – At discharge, patients authorized to obtain specialty follow-up care with CCHS will obtain lab and radiology studies up to one month post-discharge.

5. **Discharge Medical Records:** Medical records will send the discharge summary, medication list, and recent labs upon request to a local health care organization or community clinic if the patient chooses to receive follow-up care outside of CCHS.

D. Referrals from External Providers for Specialty Services

1. Referring provider will contact the CMO, Financial Counseling Health Services Administrator and/or the CCRMC UR Unit to request CCRMC to receive a medically necessary transfer for specialty care services.

2. The CMO will use the following criteria to approve the requested services: Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    i. Placing the patient's health in serious jeopardy
    ii. Serious impairment to bodily functions
    iii. Serious dysfunction to any bodily organ or part

3. If the patient is new to the CCRMC system, the Health Services Administrator will send a request for a new medical record number to the Registration Manager to create a shell Hospital Account Record (HAR).

4. Financial Counseling will verify coverage and the initiation of a PRUCOL application if applicable.

5. A Financial Counselor will update the benefit plan code in e2Search and ccLink.

6. Utilization Review (UR) will be notified of the approved authorization if services are provided within the CCRMC system or if an authorization is needed for specialty services outside of CCRMC.

7. The patient will be advised to receive follow-up primary care with the health care organization from which the patient was referred.

Benefit Plan codes:

248001 UNDOC FPL 0-100
248002 UNDOC FPL 101-133
248003 UNDOC FPL 134-150
248004 UNDOC FPL 151-200
248005 UNDOC FPL Above 200
249001 SELF PAY FPL 0-100
249002 SELF PAY FPL 101-133
249003 SELF PAY FPL 134-150
249004 SELF PAY FPL 151-200
249005 SELF PAY Above 200
903001 - Administrative Override / RX Coverage Only

Attachments:

Attachment A - Sliding Fee Schedule FPL

Authored by

Health Services Administrator

Approved by

Chief Operations Officer / Chief Financial Officer

Original Date: January 2014

Date Revised: January 1, 2016

Note: This policy replaces the August 2013 policy, Patients Accessing Inpatient and Emergency Department Services at Contra Costa Regional Medical Center (CCRMC)- Sliding Fee Schedule.

FPL Guidelines with Sliding Fee and Discount Schedules

2015/2016 FEDERAL HHS POVERTY GUIDELINES [48 States]

		Monthly Income Thresholds by Sliding Fee and Discount Pay Class and Percent Poverty (At or Below FPL%)						
	Poverty Level	100%	133%	150%	200%	250%	300%	350%
		Sliding Fee Discount				Discount Program		
Family Size	Annual Income	$25	65%	50%	45%	35%	35%	35%
1	$11,770	$981	$1,305	$1,472	$1,962	$2,453	$2,943	$3,434
2	$15,930	$1,328	$1,766	$1,992	$2,656	$3,320	$3,984	$4,648
3	$20,090	$1,674	$2,226	$2,511	$3,348	$4,185	$5,022	$5,859
4	$24,250	$2,021	$2,688	$3,032	$4,042	$5,053	$6,063	$7,074
5	$28,410	$2,368	$3,149	$3,552	$4,736	$5,920	$7,104	$8,288
6	$32,570	$2,714	$3,610	$4,071	$5,428	$6,785	$8,412	$9,499
7	$36,730	$3,061	$4,071	$4,592	$6,122	$7,653	$9,183	$10,714
8	$40,890	$3,408	$4,533	$5,112	$6,816	$8,520	$10,224	$11,928
For each additional person add,	$4,160							

NO ASSET TEST REQUIRED - Percent Reduction from Charges

Reference: Federal Register, Vol. 78, No. 16, January 22,2015
https://www.federalregister.gov/articles/2015/01/22/2015-01120/annual-update-of-the-hhs-poverty-guidelines

SLIDING FEE SCHEDULE BY INCOME RANGE (0-200%)
DISCOUNT FEE SCHEDULE BY INCOME RANGE (201-350%)

* Includes Emergency, Inpatient , Outpatient, Specialty and Dental Services

Attachment C

Contra Costa Health Care for the Homeless, Quality Assurance and Performance Improvement Plan 2016-2017

MISSION

The mission of the Contra Costa County Health Care for the Homeless Program (HCH) is to improve the health care status of the homeless population in our county by providing accessible, culturally sensitive, non-traditional clinics in the community and to assist the homeless with access to the traditional primary health care system.

GOALS

The goals of HCH Program are to: increase access to medical, dental, and behavioral health care for the homeless population; to provide high quality medical, dental, and behavioral health care for the homeless population; and to help homeless patients transition into the mainstream health care delivery system with an appropriate primary care provider and a medical home.

STRUCTURE AND ACCOUNTABILITY

Board of Supervisors

The Contra Costa County Board of Supervisors is charged with fiscal and administrative oversight for the Contra Costa Health Services Department (CCHS), which includes the Health Care for the Homeless Program. To that end, the Board of Supervisors approves the CCHS annual budget. The Board of Supervisors ("Board") retains overall responsibility and accountability for the quality of patient care, including the safety of patients, staff and visitors and the appropriate utilization of resources. The Board holds the Contra Costa Health Care for the Homeless Medical Director and the Public Health Division Director accountable for the quality of patient care.

The Project Director and members of the Contra Costa Inter-jurisdictional Council of Homelessness make an annual oral and written report to the County Board of Supervisors Family and Human Services Committee, along with a second written report to the full Board

Contra Costa Inter-jurisdictional Council on Homelessness

Consumer input to our quality of care is through an advisory board, the "Contra Costa Inter-jurisdictional Council on Homelessness," ("CCICH" or "the Council"). The Council includes homeless and formerly homeless consumers, staff from interfaith programs, Healthcare for the Homeless, the Homeless Program, Social Services and others. The Council meets monthly and makes written formal reports to the Board of Supervisors at least twice per year.

Consumer Advisory Board

There is a Consumer Advisory Board that meets at least 10 times a year with Health Care for the Homeless staff. They provide input on the quality of care and Issues from these meetings are taken up the CCICH.

FRAMEWORK

The framework of the HCH Quality Improvement Program is developed from data:

1) Clinical Audits including Peer Review
2) HRSA Clinical and Financial Measures as part of UDS reporting
3) Patient Satisfaction Surveys
4) Consumer meetings and focus groups
5) Unusual Occurrence Reports
6) Patient Complaints
7) Monthly staff meetings
8) Weekly case rounds at Homeless shelters and clinics

Data is reviewed and analyzed by the Medical Director, the Project Director, the Nurse Program Manager and other nursing staff.

RISK MANAGEMENT

All unusual, unexpected, or untoward occurrences, including "near misses" at HCH sites are reported by staff witnessing the event using an unusual occurrence form. Unusual Occurrences include falls, medication errors, equipment failures, assaults, property theft, treatment events, etc. including events which have the potential to harm a patient even if no harm occurs.

HCH is a small program and unusual occurrences and errors are unusual. Unusual occurrences and errors are analyzed immediately by the Nurse Program Manager and sent to the Medical Director as indicated. They are also reviewed for trends annually by the Nurse Program Manager and discussed with the team. Reports are filed for three to five years to trend infrequent occurrences. High risk and high-volume unusual occurrence events are used to identify quality improvement initiatives.

QUALITY OVERSIGHT

The Medical Director and Nurse Program Manager shall be accountable for the quality of patient care:

1. Medical Error Reduction:

a. If trends are identified the Medical Director and Nurse Program Manager shall assure there is measurable improvement in indicators with a demonstrated link to the reduction of medical errors.

b. The Medical Director and Nurse Program Manager shall review the experiences of other Healthcare for the Homeless Programs as they become available and assure that measures shown to be effective in reducing medical errors are implemented within the organization.

2. **Quality Indicators:** The Medical Director and Nurse Program Manager shall oversee measurement, and shall analyze and track quality indicators, including adverse patient events and other measures of the effectiveness and safety of services and quality of care.

3. Prioritization: The Medical Director and Nurse Program Manager shall prioritize performance improvement activities to assure they have an appropriate focus. They focus on issues of known frequency, prevalence or severity and shall give precedence to issues affecting health outcomes, quality of care and patient safety.

4. Quality Improvement Projects: The Medical Director and Nurse Program Manager shall oversee quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the services offered.

HCH Clinical Quality of Care

Care provided by Nurse Practitioners
Care provided by an NP is authorized by their California NP license and as an authorized employee of Contra Costa Health Services.

Care by Registered Nurses and Public Health Nurses:
RNs and PHNs providing clinical care operate within the scope of their nursing license. For straightforward common situations when there is no doctor or nurse practitioner available, they also operate under Standing Orders from the licensed Medical Director. They also have access to the Medical Director and HCH FNPs who can give verbal orders for urgently needed care. Such orders are cosigned by adding a note to the electronic medical record.

Care provided by non-licensed staff:
Unlicensed staff such as Community Health Workers, Substance Abuse Counselors,

and Mental Health Specialists are restricted to activities permitted for non-licensed personnel and all care is performed under the supervision of licensed personnel.

HCH Framework for Chronic Care Improvement

A. The Chronic Care Model was developed by the Dr. Ed Wagner and spread by the Improving Chronic Illness Care Group of the MacColl Institute and by the Institute for Healthcare Improvement. The Chronic Care Model (CCM) has been adopted for FQHC sites by the Health Disparities Collaboratives of the Bureau of Primary Care. It has been piloted by numerous collaborative teams within and without of Contra Costa Health Services. In order to improve clinical quality of care Contra Costa HCH strives to implement these sections of the CCM:

1) Community -- identifies resources and collaborations that enhance the system of care
2) Organization of Health Care -- how the organization supports the care of chronic diseases through Board awareness and senior management leadership
3) Clinical Delivery System Design-- how the team operates to provide care
4) Decision Support – knowledge and information for providers in making care decisions
5) Self-Management Support – Skills that staff use to support patients in activities to manage their disease
6) Clinical Information System – comprehensive electronic medical record and patient care registries to track individual patient's progress and healthcare team performance

B. The Model for Improvement , popularized by the Institute for Healthcare Improvement, is a scientifically tested method of using data to test small changes. Resources for major quality improvement efforts are limited, but to the extent possible HCH improvement projects will be guided by the Model for Improvement. To improve patient outcomes, the organization must design processes well and systematically monitor, analyze, and improve its performance. The essential processes for improvement are Plan, Do, Study Act.

PLAN
Measure current performance
Analyze information gathered
Improvement Opportunity identified
Design improvement w/ performance expectations

DO
Test/Implement

STUDY
Leadership collects, analyzes, and measures against standard
Feedback to team
Expectations met?

ACT
Yes, expectations met: educate staff & standardize
No, expectations not met: re-design

C. Program Evaluation Annually: To assure the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities on the basis of assessment; and maintaining achieved improvements, the organizational quality assessment & performance improvement program is evaluated for effectiveness at least annually and revised as necessary.

HCH Quality Improvement Work Plan 2016-2017

Priorities for 2016-2017:

*Improve Self-Management Support to all patients

*Improve Chronic Disease care with a focus on Diabetes and Hypertension

*Improve outcomes on all HRSA Clinical and Financial Measures

*Improve Health Care Maintenance Compliance with a focus on Cervical and Colorectal Cancer Screenings

Evaluation:

1. Quarterly Case Rounds by Medical Director and Nurse Program Manager & Peer Review

2. HRSA Clinical Measures as part of UDS reporting. ccLink, the CCHS EHR system, will be used to collect patient data and report on the following performance measures. Reports are published on the County's intranet site.

    - Increase percentage of homeless diabetic patients whose HbA1c levels are less than or equal to 7 percent.
    - Decrease percentage of homeless diabetic patients whose HbA1c levels are greater than or equal to 9 percent.
    - Increase percentage of homeless adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90.
    - Increase percentage of homeless women who received one or more Pap tests.
    - Increase percentage of homeless pregnant women beginning prenatal care in the first trimester.
    - Decrease percentage of births less than 2,500 grams to health center homeless patients
    - Increase percentage of homeless children with completed appropriate immunizations by 2nd birthday
    - Increase percentage of homeless patients receiving mental health/substance abuse services
    - Increase percentage of patients receiving dental services.
    - Increase percentage of patients aged 2 to 17 years who had a BMI percentile documentation, counseling for nutrition, and counseling for physical activity.
    - Increase the percentage of patients age 18 years or older who had their BMI calculated at the last visit or within the last six months and, if they were overweight or underweight, had a follow-up plan documented.
    - Increase percentage of patients age 18 and older who are users of tobacco and who received advice to quit smoking or tobacco use.

- Increase percentage of patients age 5 to 40 years with a diagnosis of persistent asthma who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy.
- Increase percentage of patients with a diagnosis of CAD prescribed a lipid lowering therapy.
- Increase percentage of patients who were discharged alive for AMI, CABG, PRCA or who had a diagnosis of IVD and who had documentation of use of aspirin or another antithrombotic during the measurement year.
- Increase percentage of patients 50 to 75 years who had appropriate screening for colorectal cancer.
- Increase percentage of patients screened for depression with appropriate follow-up plan documented if screened positive

3. Patient Satisfaction Surveys: Surveys are conducted by HCH staff at the point of care and are reviewed by managers and program staff to develop planned actions. Results are reported annually to CCICH general council meetings.

4. Consumer meetings are held monthly and used to gather data on reported health needs. Data is analyzed and report to CCICH at monthly meetings. Focus Groups are held bi-monthly.

5. Incident Reports: gathered quarterly and discussed with staff. If trends are identified remediation will be planned.

6. Patient Complaints: are dealt with on an individual basis

7. Staff meetings provide opportunity for identifying real time operational or clinical problems and brainstorming solutions. The HCH QI committee will meet monthly to review UDS Clinical performance measures and evaluate results. Data will be used to promote management decision-making.

8. CCHS Quality Improvement Reports: The HCH team will report quarterly to the CCHS Patient Safety and Performance Improvement Committee to review progress towards selected Clinical Performance measures. Reports to the Board of Supervisors will be made quarterly to include both fiscal and clinical performance measure data.

9. Fiscal Reports: The HCH Program will report on Financial Performance measures to the CCHS CFO monthly and to the Board of Supervisors twice per year. Report will include YTD fiscal data relating to operations and revenue.

Attachment D

Contra Costa Regional Medical Center **Policy 8025**
Contra Costa Health Centers
Ambulatory Care, ER/Admission Registration and Communication Center

Insurance Verification

I. PURPOSE

The provide guidelines to the clerk during the insurance verification process.

II. REFERENCE

Refer to internal procedures.

III. POLICY

The clerk will request insurance information from the patient, patient's parent, legal guardian or designee presenting for care during the registration process.

IV. AUTHORITY AND RESPONSIBILITY

Clerks, Clerical Supervisors and Manager

V. PROCEDURE

A. The patient, patient's parent, legal guardian or designee presents to the registration unit to register for a scheduled or unscheduled visit.

B. The clerk will screen the patient, patient's parent, legal guardian or designee for insurance coverage during the registration process.

1. **Insurance card is provided.** The clerk will:
   a. Scan the insurance card in the patient's Electronic Health Record (EHR) if the insurance card is not on file.
   b. Use the coverage if it exist and is active, or add the coverage to the patient's EHR and verify the coverage, as applicable

2. **Patient has Insurance but the card is NOT provided.** The clerk will:
   a. Use existing coverage if it is still *active*, OR, add the new insurance information to the patient's EHR only when *sufficient* insurance information is provided so that it can be *electronically* verified.
      1) Verify coverage electronically, if applicable.
      2) In good faith use the existing coverage if unable to verify coverage electronically and the billers on the backend will confirm if the coverage is still effective for the date of service.
   b. If the coverage is not *active* in the patient's HER, or the coverage could not be electronically verified, the clerk will "self pay" the account and provide the patient, patient's parent, legal guardian or designee with a Patient Accounting self-addressed envelope and request a copy of the insurance card (front and back) be mailed to Patient Accounting.

3. **Patient has NO Insurance**. The clerk will:
   a. Screen the patient, patient's parent, legal guardian or designee to determine if the patient qualifies for any insurance the clerk can complete during the registration process.

b. For a patient who presents to the Emergency Department, or who is admitted to the hospital the clerk and/or Financial Counselor will screen the patient, patient's parent, legal guardian or designee to determine if the patient qualifies for any insurance.

C. CCHS Contra Costa Health Centers Wallet Card with Financial Counselor contact information will be provided to the patient, patient's parent, legal guardian or designee, as applicable.

Authored by
Registration and Staffing Manager

Approved by
Chief Nursing Officer
Director, Patient Accounting

Date Reviewed
11/12/2015

Date Revised
11/12/2015

Attachment E

CLAIMS FILING AND GENERAL A/R COLLECTIONS

I. PURPOSE

To outline the procedures for filing claims to the payer and collecting monies due to Contra Costa Health Services from payers and patients.

II. REFERENCE

CAO Bulletin 206 – Accounts Receivable
CCRMC/HCs Policy and Procedure Manual, Policy No. 810 – Completion of Patient Encounter for Billing
CCRMC/HCs Policy and Procedure Manual, Policy No. 175 – Contract Payment

III. POLICY

It is the policy of Contra Costa Health Services to attempt to collect the total charges incurred for patient services from a patient's health insurance carrier. If the patient has no third party coverage, we explore whether the patient is eligible for any program that provides medical coverage or whether they qualify for a self-pay/charity discount. Claims are sent to eligible payer(s) and unpaid balances, including deductibles, co-pays, co-insurance and any non-covered items or services are billed to the patient's guarantor.

IV. AUTHORITY/RESPONSIBILITY

Patient Accounting Manager

V. PROCEDURE

We attempt to collect outstanding balances on the accounts receivable as quickly as possible. We submit claims to the insurance carriers then look at other programs that provide coverage, and then bill the patient for any unpaid account balance.

1. Claim Filing

a. Claim Editing – to help expedite claim adjudication/reimbursement and reduce claim denials from payers, claim edits are configured in both Epic and our third party electronic billing system to scrub institutional and professional claims against payer-specific billing edits. Billing staff correct any errors and the clean claims are filed electronically in most cases or hard-copy via mailing.

b. Claim Follow-Up – the Epic system is configured to select denied claims and unpaid accounts and place in Work Queues for the biller to follow-up with the payer or the patient.

c. Denied Claims – billers appeal specific types of denials and work with medical records, utilization review and third party agencies for assistance in appealing the denial through supporting documentation.

2. **Health Coverage Programs** – for patients that are eligible for one of the health coverage programs, the balance due is appropriated to the specific program through account adjustments.
3. **Self-Pay Billing**
   a. Charity/Discounts – financial counselors screen patients to determine if they qualify for a percentage discount based on family income and/or high out-of-pocket medical expenses.
   b. Guarantor Statements – guarantors are sent a minimum of 4 monthly statements to collect on the outstanding self-pay balance and are informed of their urgency to remit based on dunning messages that change as the account ages.
   c. Timed Payments/Contract Payment – payment contracts may be established for patients/guarantors who can settle their balance within three months of initial billing. If the patient requires more than three months to make payments, the account is referred to a 3rd party agency for long-term payment arrangements.
   d. Delinquent Accounts – are referred to a 3rd party collection agency following their Final Notice statement or when a mail return is received and skip tracing is unsuccessful.

VI. RESPONSIBLE STAFF PERSON

Chief Financial Officer of Contra Costa Health Services

Attachment F

PAYMENT POSTING

I. PURPOSE

To outline the procedures for posting payments to patient accounts.

II. REFERENCE

CAO Bulletin 206 – Accounts Receivable

III. POLICY

It is the policy of Contra Costa Health Services to post payments to patient accounts on either the day the payment is received or the first business day following receipt of payment.

IV. AUTHORITY/RESPONSIBILITY

Patient Accounting Manager

V. PROCEDURE

Payments are collected and posted in multiple departments depending on the payee and the time in which the payment is received.

1. **Patient Check-Out/Discharge -** staff attempts to collect self-pay balances/deposits, share of cost balances, and co-payments at the time of service before the patient is discharged. These payments are posted electronically to the patient's account using a Point of Sale system and a receipt is issued to the patient.
2. **Business Office Window** – patients may come to the business office to make a payment and the same process is followed as above with the Point of Sale system.
3. **Mail Receipt –** payments received in the mail from either an insurance company or patient are sent to a central location in the business office and are batched, scanned and posted to the accounts the same day or by the next business day.
4. **Electronic Remittance Advice –** payments received electronically from insurance companies are posted to accounts the same day using the Epic ERA application**.**

VI. RESPONSIBLE STAFF PERSON

Chief Financial Officer of Contra Costa Health Services

Attachment G

COMPLETION OF PATIENT ENCOUNTER FOR BILLING

I. PURPOSE

To outline the procedures for collecting the information necessary to bill insurance carriers, other programs that provide medical coverage, or the patient for the total charges of the services rendered.

II. REFERENCE

CAO Bulletin 206 – Accounts Receivable
CCRMC/HCs Policy and Procedure Manual, Policy No. 175 – Contract Payment

III. POLICY

It is the policy of Contra Costa Health Services to complete the patient encounter with the information necessary to bill and collect the total charges incurred for services rendered. This information includes but is not limited to patient and guarantor demographics, insurance coverage information, charges, procedures, diagnoses, and providers.

IV. AUTHORITY/RESPONSIBILITY

Patient Accounting Manager. Additionally, individual responsibilities reside with the managers of the departments outlined below.

V. PROCEDURE

We attempt to complete the patient encounter as quickly as possible to ensure timely and accurate billing of services. We rely on different departments to collect and complete the encounter information and we utilize the Epic System to configure and perform the checks and balances to ensure completion of information prior to billing

1. **Registration**
   a. Insurance Eligibility Checks – are performed to verify insurance benefits and subscriber information.
   b. Registration Edits – alert the registrar to correct errors or complete missing information at time of registration check-in and check-out.
   c. Patient Work Queues – identify missing information or data nconsistencies that still exist after completing the registration.
2. **Financial Counselors** – work with uninsured patients to enroll them in programs that provide medical coverage, screen them for charity discounts or make payment arrangements for private pay patients
3. **Healthcare Providers and Clinicians**
   a. Charge Capture – providers and clinicians are responsible for submitting accurate charges for services rendered and supplies used that are consistent with the documentation on the patient's medical chart.
   b. Closing Encounters – In order to generate charges, providers must complete the clinical workflows and documentation to accurately reflect each service rendered to a patient.

4. **Medical Records/Health Information Management**
   a. Coding Work Queues – identify accounts that need coding completed or that have coding errors/conflicts that need to be corrected prior to billing.
   b. Chart Completion Tools – identify incomplete charts so that the medical records staff can work with the providers to ensure completion of required information.
5. **Patient Accounting**
   a. Discharged/Not Billed Work Queues – catch accounts that require verification or correction of information prior to billing based on payer-specific billing requirements.
   b. Claim Editing – claim edits are configured in both Epic and our third party electronic billing system to scrub the claims against payer-specific billing edits. Fixing the errors prior to billing expedites payment and reduces denials..
   c. Dashboard Reporting - to help ensure timely billing, reports are configured to allow managers and supervisors to monitor work queue activity and identify work queues that are being neglected, including accounts approaching the payer's timely filing deadline

VI. RESPONSIBLE STAFF PERSON

Chief Financial Officer of Contra Costa Health Services

Attachment H

REFUND AND OVERPAYMENT PROCESSING

I. PURPOSE

To outline the procedures for identifying overpayments on accounts and issuing refunds to the payer or patient.

II. REFERENCE

CAO Bulletin 206 – Accounts Receivable
CCRMC/HCs Policy and Procedure Manual, Policy No. 820 – Payment Posting

III. POLICY

It is the policy of Contra Costa Health Services to refund overpaid accounts when the patient/guarantor notifies us or when we discover them through routine follow-up on credit balance accounts.

IV. AUTHORITY/RESPONSIBILITY

Patient Accounting Manager

V. PROCEDURE

We issue refund checks to insurance companies and patient/guarantors as quickly as possible when overpayments are discovered. We assign staff to work credit balance Work Queues to identify overpayments and initiate the refund process.

1. **Credit Balance Work Queues** – accounts are routed to Credit Balance Work Queues when a credit balance exists on the account. Staff review the accounts and initiate the refund process when an overpayment is confirmed.
2. **Refund Request Work Queues** – accounts are routed to Refund Request Work Queues when staff has completed the necessary paperwork so that the refund clerk can obtain approvals and forward paperwork to the Auditor-Controller to issue the refund check. Upon receipt of the check from the Auditor-Controller, the refund clerk posts the refund to the patient's account and mails the check to the payee.
3. **Credit Balance Reporting** - to help monitor credit balances, the Dashboard includes credit balance totals and totals by credit balance work queues.

VI. RESPONSIBLE STAFF PERSON

Chief Financial Officer of Contra Costa Health Services

Attachment I

Contra Costa Regional Medical Center **Policy 8014**
Contra Costa Health Centers
Ambulatory Care, ER/Admission Registration and Communication Center

MEDICARE SECONDARY PAYER SCREENING

I. PURPOSE
The clerk will screen all Medicare patients to determine if Medicare is a secondary payer to any other health coverage or program.

II. REFERENCES
Department of Health and Human Services Centers for Medicare & Medicaid Services.

III. POLICY
The clerk will complete a Medicare Secondary Payer Screening questionnaire for every Medicare patient who presents to register for outpatient or inpatient services.

IV. AUTHORITY AND RESPONSIBILITY
Clerks, Lead Specialist, Clerical Supervisors, Manager

V. PROCEDURE

A. Medicare Secondary Payer Screening questionnaire will be completed for all Medicare patients registering for outpatient and inpatient services.

B. Every Medicare patient will be asked the Medicare Secondary Payer Screening questions and answered, as applicable.

C. If, during the registration process the clerk determines that there is a primary responsible insurer, a responsible employer or that the patient does have alternate health insurance, then the patient should be registered with the appropriate primary payer. Medicare should be identified in the registration as the secondary payer.

E. The Medicare Secondary Payer Screening Questionnaire will be electronically filed as part of the registration visit.

Authored by
Registration and Staffing Manager

Approved by
Chief Nursing Officer
Director, Patient Accounting

Date Reviewed
7/29/2015

Date Revised
7/29/2015

Attachment J

Contra Costa Regional Medical Center **Policy 8017**
Contra Costa Health Centers
Ambulatory Care, ER/Admission Registration and Communication Center

Registration Intake and Checkout Process

I. PURPOSE

The provide guidelines to the clerk during the registration intake and checkout process.

II. REFERENCE

Refer to the internal procedures.

III. POLICY

All patients who present for care at Contra Costa Regional Medical Center and Health Centers will be checked in and checked out using the Electronic Health Record (EHR) system.

IV. AUTHORITY AND RESPONSIBILITY

Clerks, Clerical Supervisors and Manager

V. PROCEDURE

A. The patient, patient's parent, legal guardian or designee presents to the registration unit to register for a scheduled or unscheduled visit.

B. The clerk will complete the registration intake process. The intake process will consist of the following:

1. Patient Demographic Information
2. Responsible Party Information (Guarantor Account)
3. Emergency Contact Information
4. Insurance Information
5. Visit Information
6. Provide Applicable Notice(s)
7. Sign Applicable Form(s)

C. The clerk completes the checkout process once the registration intake process is complete.

D. The clerk will direct the patient, patient's parent, legal guardian or designee to the designated clinical area.

Authored by
Registration and Staffing Manager

Approved by
Director, Patient Accounting

Date Reviewed: 2/10/2016

Date Revised: New