San Joaquin County Clinics (SJCC) Finance Committee
Minutes of July 30, 2019 Meeting

San Joaquin General Hospital (SJGH)
Conference Room 1A&B
French Camp, CA

Present

Rod Place (SJCC Chair); Alicia Yonemoto (SJCC Vice-Chair): Luz Maria Sandoval (SJCC Treasurer); Esgardo Medina; Bradley Seng; Alice Souligne (SJCC Clinic Services Coordinator); Brian Watkins (SJCC Finance Director); Chris Roberts (SJGH CFO); David Culberson (SJGH CEO); Dr. Farhan Fadoo (SJCC Executive, Director); Greg Diederich (HCS Director); Lynn Kelly (Deputy Director Patient Financial Services); Adelé Gribble (ACS Office Tech Coordinator)

I. Call to Order

The meeting was called to order by Mr. Rod Place at 4:05 p.m.

II. Approval of Minutes from 6/25/19 & 7/30/19

Due to there not being a quorum last month, the finance committee needed to review and approve the minutes from both June and July. Luz Maria Sandoval made a motion to approve the minutes from 6/25/19 and 7/30/19. Alicia Yonemoto seconded the motion to approve. All present board members unanimously approved both minutes.

III. Introductions

There were no introductions.

IV. Informational Items

a. Follow up on issues from prior meetings
   i. WIPFLI Recommendations – Brian Watkins advised they had a meeting with Wipfli in July regarding the recommendation around clinic consolidation. They have promised a model by September 3rd which will be forthcoming by next month's meeting.
   ii. Audit Update – DHCS Audits for 2014-2015 for rate setting are ongoing. He has been in contact with Susan Uhl (auditor for DHCS) several times over the last month and they have shared information back and forth. She is scheduled to come out the third week of September to finalize any field work and gather any documents she hasn't received. If she has all the documents by the end of September, the plan is to finalize this by the end of November. The hospital audit is scheduled for the first week of September.
   iii. Billing Update – Brian advised they conducted a Revenue Cycle Review on two separate days, making sure all the activity in Cerner transferred over to PWPM that should and all activity from PWPM transferred over to TriZetto that should have. Anything that didn't make it across they analyzed to see what the items were. From PWPM, which is our billing software to TriZetto which is our clearing house. On two separate days there were three items and they were human error type items where we didn't have the right insurance listed. Everything else that didn't go across were self-pay which we don't expect to go across. The infrastructure is in place to do what we expect it to do. We just have to make sure we have the set up and interfaces tied-in the way they are supposed to be. Out of fifteen items that didn't go from Cerner to PWPM, six of them were the doctor wasn't in the system. The others were insurance items and things that were not entered timely.

   Alice Souligne advised all the issues were all human error, not software errors. The findings were very encouraging. Brian advised this exercise was very helpful for him and his staff to see the whole process from beginning to end. He stated we often think issues are all billing's

fault but they don't receive this until the end and there are multiple steps along the way that contribute to issues; registration, provider input etc. They have offered up some staff, both clinic and Brian's staff, to assist with the HIM staff, making sure all the codes are ready to go to make that process more correct than it currently is. Unfortunately, with these types of activities you don't necessarily see the progress until a few months down the road.

Mr. Culberson stated there was a question today during the HIM meeting about residents not being assigned to faculty and we aren't able to bill for those encounters. He asked if that is part of this discussion. Lynn Kelly stated this is not part of it. We do have some charging issues that aren't completed yet. By the time it gets to billing it is already timely. This is something Alice is very dedicated to resolving and they have a report they've generated so HIM can get those charges and the documentation done a little more timely. She stated we do have some issues with physician privileging that we are trying to work through now. Alice stated it is a two-step process; we cannot bill for the residents because they are not credentialed. They have to document and sign it; the attending has to sign off. If those two things happen, the bill goes out under the attendings name. If either of those two don't happen, the bill can't go out. Cindy said they had received some notes from residents that haven't been signed off by the attendings so they are working on these to see what went wrong.

b. New Items to Present
   i. Revenue Cycle Review of 4/12/19 – Brian Watkins advised the topics above covered the new items as well.

V. <u>Discussion of June 30, 2019 Financial Statements (unaudited)</u>

Brian Watkins apologized he had initially printed out the Financial Statement broken out by clinic but had to make a change immediately before this meeting. Below is the Financial Statement Comments (Year to Date through June 2019) and the Income Statement (6/30/2019 – unaudited) for the Finance Sub-Committee.

San Joaquin County Clinics

Financial Statement Comments

Year to Date through June 2019

Summary of Year to Date

As clean-up of balance sheet accounts and adjustments for contractual allowances and bad debt distort June Financial reports, it is helpful to look at Year to Date financials for the 2018-19 Fiscal Year. Total billable visits for the year are slightly lower than what was budgeted (108,902 compared to 110,156). Revenue clean up and a deep dive into the Balance Sheet accounts for A/R and allowances led to extensive clearing that reduced total Gross Revenue from $26,200,367 ($20,658,952 + $5,541,415) down to a Total Revenue of $14,695,499. There is a change in methodology in how A/R is valued (that ties back to hospital policy).

Gross patient revenue is lower than projected as some clean up work was done in getting encounters posted to correct payer types and the payer mix was different from what was budgeted. Capitation Revenue is lower than budgeted as there were fewer managed Medi-Cal lives assigned to SJCC than was projected in the budget.

Much was done during the year to keep costs down. Salaries were significantly lower due to reduced FTE count, particularly on the provider FTE count. The Supplies line item is significantly higher than budget ($244,774) due primarily to write-off of pharmacy inventory variance. Under the purchased services category, there was significant savings in this area due to a reduction in temporary providers (locums). The major expense in this category is at Hazelton (over $1 million), where there is a significant cost for staff that was inherited from Public Health. The major challenge with this staff is that we have an expense, but as an FQHC we are not able to bill for services being provided. Depreciation is over budget due to a correction of accrued depreciation at Manteca where useful lives of equipment had to be adjusted to coincide with the term of the lease.

Clean up of the balance sheet drove Net Income lower than had been the case in prior months, but overall the YTD totals reflect $3,419,743 better than the 2018-2019 budget.

San Joaquin County Clinics
Income Statement
6/30/2019 (Unaudited)

	YTD TOTALS	BUDGET	Variance	Notes
Total Visits	114,898	122,645	-7,747	
Billable Visits	108,902	110,156	-1,254	
Total FTEs	129.3	138.0	-8.7	
Patient Revenue				
Medicare	5,118,447	2,997,247	2,121,200	
Medi-Cal Fee-for-Service	3,874,251	3,284,587	589,664	
Medi-Cal Managed Care	15,608,634	16,373,751	(765,117)	Payer mix differs from Budget
Insurance	(4,716,486)	349,895	(5,066,381)	
Self Pay	774,106	654,298	119,808	
Gross Patient Revenue	20,658,952	23,659,778	(3,000,826)	
Contractual Adjustments	(11,504,868)	(13,142,481)	1,637,613	Year End Clean up and Bad Debt Write Expense
Net Patient Revenue	9,154,084	10,517,297	(1,363,213)	
Capitation Revenue	5,541,415	6,145,864	(604,449)	Fewer assigned lives than Budget
Total Revenue	14,695,499	16,663,161	(1,967,662)	
Operating Expense				
Salaries	9,914,538	12,687,866	(2,773,328)	Fewer FTEs than Budget
Benefits	5,548,785	5,434,299	114,486	
Total Salaries & Benefits	15,463,323	18,122,165	(2,658,842)	
Pro Fees/ Registry	781,897	757,400	24,497	
Supplies	1,393,239	1,148,465	244,774	Write off of pharmacy inventory variance
Purchased Svcs	1,783,773	3,851,459	(2,067,686)	Less temporary providers. Major expense in this category is staff at Hazelton from Public Health
Depreciation	320,995	144,822	176,173	Correction of Accrued Depreciation at Manteca
Other Expense	449,771	465,001	(15,230)	
Total Direct Expense	20,192,998	24,489,312	(4,296,314)	
Allocation of Direct Admin	-	-	-	
Overhead Allocation	6,936,708	8,027,799	(1,091,091)	
Total Expenses	27,129,706	32,517,111	(5,387,405)	
Net Income (Loss)	(12,434,207)	(15,853,950)	3,419,743	
Key Ratios				
Gross Pt Rev/Billable Visit	189.70	214.78	(25.08)	
Ttl Revenue/Billable Visit	134.94	151.27	(16.33)	
Direct Costs/Billible Visit	185.42	222.31	(36.89)	
Indirect Costs/Billable Visit	63.70	72.88	(9.18)	
Ttl Med Costs/Billable Visit	249.12	295.19	(46.07)	
Net Inc/(loss)/Billable Visit	(166.57)	(143.92)	(22.64)	

Brian advised there were a lot of adjustments for the contractual allowances and bad debt that were not cleaned up in previous years. He and Chris Roberts wanted to have a clean starting point going forward.

Bradley Seng asked what the process is for cleaning up the payer mix-ups and billing problems. Brian explained the Payer Mix is how many encounters we get for each type, it is not mix ups. There was a problem in the mapping in terms of how some of these accounts, the revenue was going from PWPM into PeopleSoft (the accounting software). He advised Theresa Avila has been working on cleaning that up. There are a lot of simultaneous projects going on to get these tidied up.

Brian stated, in terms of us having negative $4 million in the insurance, that numbers stands out like a sore thumb. What that means is in the prior years we had charges in there that we are correcting now. There were charges in the private insurance bucket that should have been perhaps Managed MediCal but when they were sent over from PWPM to PeopleSoft, they weren't mapped properly.

Chris Roberts stated the importance to that is, if you map to the wrong payer, you don't know what your revenue is going to be. You know your gross revenue; but your estimated net revenue is just that, estimated. It is based on the type of payer and the type of expected reimbursement by the payer. If it mapped to the wrong payer, you are making wrong assumptions on collectability for that gross revenue so it is really important to make sure you are mapping correctly.

Brian advised there was a lot done to keep the expenses down. Fewer FTEs than what was budgeted created lower salaries. There were 8.8 providers we were under and 0.1 of Medical Assistants that we were over.

Mr. Culberson asked Brian to explain what type of write-off of pharmacy inventory would be applicable for this line item since we don't have much inventory. Chris explained on the books (this carries over from prior years) there was over $270,000.00 worth of pharmacy inventory for the clinics. They don't do inventory, it is expensed monthly. What is on the shelf, the hospital has set aside about $20,000.00. That is where the balance should be. He stated there needs to be more control over that. It is one of those cases where every account, every line item in this clean-up is weeks' worth of going through every GL account in the balance sheet and challenging every item. Pharmacy Inventory was one of those. They found out that balance was created in the prior year, no one did anything with it last year. The FQHC is mostly caught up in the review. There were over 250 accounts in total in the balance sheet and they touched over 200. Over 1/3 of these had balances from prior years.

Brian stated in his notes, he did not touch on the benefits of Chris' review where things were favorable for the FQHC. He touched more on things that created more expense for us (negative impact for financials).

Mr. Culberson asked what the correlation is for the number of supplies in the FQHC. Somewhere along the line, we should have thrown out a quarter million dollars of supplies. Chris stated they looked at the distribution of supplies going out to the clinics on a monthly basis and kept a thirty day of supply of value of what that equated to and came out to what the pharmacy said, about $20,000.00. In the current year, everything was expensed. They were adjusting prior years so we are taking a hit for those years.

Brian advised for Purchased Services, we did very little in the way of temporary providers this year. The biggest number that is in here is for Hazelton, which is for the expense of the staff before we inherited them from Public Health.

In the depreciation, the Year to Date totals are significantly higher than budgeted. Chris explained as part of the review he asked questions around the original lease for the Manteca Clinic. There was over a million dollars' worth of leasehold improvements done a couple of years ago when this was set up. After reviewing the entries, the accounting was incorrect. There are several accounts that were changed. The asset value was mis-stated by over $100,000.00. They depreciated the structure over fifteen years which is not uncommon based on the American Hospital Association standards. However, when it is a lease, you have to take the lesser of the term of the lease or the standards. In this case, it is a 10-year lease, it was fifteen years and it needed to be adjusted to a ten year. Three years have already gone by so we had to make that adjustment to bring it current. Interest expensing was also adjusted. All incorrect issues have been addressed now.

Rod Place asked Chris if we can take another look at the overhead allocation, as it does not appear to be correct. At $7 million you are talking about 40% allocation that does not seem right against revenue. In his experience it is usually a percentage of revenue unless it is some services like IT services. Chris stated the difference in the cost report approach (dictated by CMS on how we do this), everything rolls into everything else throughout the hospital (support departments) and then gets spread amongst the final resulting revenue generating departments to create a cost to charge ratio. That allocation, because there is so much overhead within the hospital itself, is applying that level,

whether the clinics use them or not. It is not a true direct allocation. This is the reason this will always be really high. This is just a standard healthcare methodology.

Chris stated this is the reason in internal management reports, a lot of time you include your direct allocation so there is a truer picture of what is going on. Rod asked if Brian could do an internal report that includes the clinic administrative and put this below the line for the board. He stated any business will look at its outlying businesses standalone first and see if it makes sense. If it does you have something that is tangible and potentially sellable. If you throw overhead from corporate on top of that and it throws it underwater, that's ok. It also would help Dr. Fadoo in looking at that report that way because if you look at a clinic by itself, and it can't stand alone by itself, you probably shouldn't do it.

Rod stated in board meetings where Mr. Culberson and Dr. Fadoo have to go before the County Board of Supervisors, he thinks it should be below the line. Chris advised there is one caveat to this. Part of your reimbursement rate (PPS rate) includes overhead. You would have to reduce some of your revenue that is associated with some of that overhead. You would have to go back to how much overhead was included when the rates were established. Rod stated he is merely talking about a report that shows the breakdown, similar to the report Chris provided showing the PRIME dollars.

VI. Accounts Receivable Status (Lynn Kelly)

Lynn Kelly advised cash collections were low for the month of June because at fiscal year-end Medi-Cal usually holds off on their check runs. We received an additional $329,000 and they are pending processing an additional $254,000 so if she adds those together along with our existing cash collections, we would be slightly over $1 million.

Gross A/R includes accounts in PWPM which is $8.1 million. They did not include the eCW legacy system which currently has a balance of $376,806. They have worked those accounts to the point where there is no more cash that is collectable. They have double appealed all of these so they will probably go ahead and write these off. Credits are now included in Gross A/R going forward as part of reporting changes they have made. The Gross A/R is slightly lower for the month of June which includes a PFS project they are working which is the HPSJ capitated claims.

KEY PERFORMANCE INDICATORS												
PFS Summary	Target	08/31/18	09/30/18	10/31/18	11/30/18	12/31/18	01/31/19	02/28/19	03/31/19	04/30/19	05/31/19	06/30/19
Cash Collections	Actual	$2,075,066	$526,141	$840,614	$1,081,089	$1,009,853	$659,646	$379,021	$921,450	$1,475,133	$1,091,369	$678,304
Gross AR incl Credits		$3,513,791	$3,857,194	$3,457,954	$3,167,177	$6,824,070	$7,563,741	$8,897,914	$9,028,721	$8,660,873	$8,477,537	$8,103,315
Credits												($551,615)
Gross AR Days												160.0
Net A/R												$ 3,161,334
Net A/R Days												78

- Cash Collections decreased from previous month due to Medi-Cal fiscal year end "Check Write" holds. Subsequent checks received in July = $329K and pending processing amount = $254K
- Gross A/R includes accounts in PWPM but not eCW (legacy system = $376,806)
- Credits are also included in Gross A/R going forward, as part of reporting changes.
- Gross A/R slightly lower for the month of June which includes a PFS project to adjust charges for HPSJ capitated claims.

Chris Roberts advised on Lynn's report you will notice there is a net A/R number of $3.1 million. That represents our estimated collectable amount of the $8.1 million. There was a methodology change from an Income Statement Approach to the Balance Sheet Approach in contractual allowances. Income Statement Approach opens you up for a lot of variability, especially based on billing and collecting processes (which happened here for the past 1-1/2 years). Chris stated our income statement was misstated every month because they were taking a very straightforward income statement approach. When they went to the balance sheet in their clean up, they had balances going in the wrong directions. As they look at the A/R bucket they are adjusting every month so they are constantly updating. They use a Zero Balance Account (ZBA reports). They take the actual history to support the valuations they are putting in.

Payer Type Name	Enc Bal	% Payer	1 - 30 Days	% of Enc Balance	31 - 90 Days	% of Enc Balance	91 - 120 Days	% of Enc Balance	121 - 180 Days	% of Enc Balance	181 - 365 Days	% of Enc Balance	366 Days And Over	% of Enc Balance
Unassigned	$ 56,090	0.69%	$ (147)	-0.26%	$ 6,395	11.40%	$ 5,382	9.60%	$ 9,976	17.78%	$ 27,803	49.57%	$ 6,682	11.91%
Contracted Commercial Ins	3,313	0.04%	(192)	-5.78%	427	12.88%	-	0.00%	1,244	37.55%	1,560	47.08%	274	8.27%
CDCR	190	0.00%	-	0.00%	-	0.00%	-	0.00%	-	0.00%	190	100.00%	-	0.00%
Charity	397	0.00%	106	26.67%	30	7.55%	-	0.00%	10	2.52%	20	5.03%	231	58.23%
Commercial (Non-Contracted) Ins	496,299	6.12%	87,469	17.62%	65,320	13.16%	24,206	4.88%	35,138	7.08%	150,924	30.41%	133,241	26.85%
Contract	39,347	0.49%	1,877	4.77%	1,606	4.08%	2,033	5.17%	5,266	13.38%	20,568	52.27%	7,997	20.32%
Correctional Department	1,173	0.01%	472	40.24%	272	23.19%	235	20.03%	-	0.00%	194	16.54%	-	0.00%
Insurance Pending	415	0.01%	-	0.00%	-	0.00%	-	0.00%	40	9.63%	198	47.67%	177	42.70%
Medicare Advantage	61,673	0.76%	12,385	20.08%	11,565	18.75%	4,050	6.57%	12,687	20.57%	14,734	23.89%	6,252	10.14%
Medi-Cal	1,388,524	17.14%	78,642	5.66%	257,318	18.53%	95,391	6.87%	199,648	14.38%	563,155	40.56%	194,371	14.00%
Med-Cal HMO	3,747,452	46.25%	661,125	17.64%	422,394	11.27%	179,347	4.79%	301,301	8.04%	1,215,128	32.43%	968,157	25.84%
Medicare	2,130,105	26.29%	186,183	8.74%	262,882	12.34%	145,847	6.85%	370,510	17.39%	955,674	44.87%	209,009	9.81%
County Managed Medi-Cal	128	0.00%	-	0.00%	-	0.00%	-	0.00%	-	0.00%	128	100.00%	-	0.00%
Self Pay	177,698	2.19%	(11,844)	-6.67%	39,646	22.31%	19,873	11.18%	28,793	16.20%	76,433	43.01%	24,797	13.95%
Work Comp	511	0.01%	106	20.74%	-	0.00%	-	0.00%	405	79.26%	-	0.00%	0	0.00%
REPORT TOTAL	$ 8,103,315	100.00%	$ 1,016,181	12.54%	$ 1,067,855	13.18%	$ 476,364	5.88%	$ 965,018	11.91%	$ 3,026,708	37.35%	$ 1,551,189	19.14%

Mr. Culberson stated it appears a predominant large portion of our A/R is 181-365. 30% of our Commercial Revenue; 41% of Medi-Cal; 32% of Medi-Cal HMO and 45% of Medicare. He said he assumed those over 365 will be written off but that is an awful lot of stuff that has got a lot of exposure. Chris stated as far as written off, from a financial statement, it is fully reserved. This does not mean we can't collect on it, it just means on our books financially it is being reserved as zero value. Lynn advised the Medi-Cal and the Medi-Cal Managed Care are HPSJ and we are working to go ahead and adjust them.

Brian Watkins advised when we have an encounter for Managed Medi-Cal we send an invoice to HPSJ so that they can capture the HEDIS measures. If there is any activity on that bill that is reimbursable, they will pay us for it. At the same time, we send a bill to the state for the wrap payment. On a traditional capitated patient, we would go ahead and write off this balance that was billed to HPSJ. That was not being done. A lot of the balances seen on Medi-Cal Managed Care and Medi-Cal HMO, those are items that needs to be written off. It was adjudicated it just wasn't cleared. They are inflated balances. Chris stated we received the funds for the capitation but the account is sitting there with this expected collection that is not going to happen. He stated they are developing a way to do it systematically on the front end of the billing so it is not aging out.

Mr. Culberson asked how are we doing on those accounts that are 181-365 that are collectable but haven't been written off because there is zero expected, are we catching up on those? How is that process working. Lynn stated she currently has a report Angela has given them on accounts they need to rebill or appeal because of error codes that were received. They are working on those. She stated a lot of the accounts she looked at had to do with payment being posted but an adjustment was not applied so some of these are false numbers.

VII. Other

There were no other comments

VIII. Adjournment

The meeting adjourned at 4:52 p.m.

Attachments: Financial Statement Comments Year to Date through June 2019
Income Statement 6/30/2019 (unaudited)
Accounts Receivables Report for June 2019