COASTAL HEALTH & WELLNESS

GOVERNING BOARD

9850-A.106 Boardroom Emmett F. Lowry Expressway, Texas City

AGENDA
Thursday, December 8, 2022 – 12:30 PM

CONSENT AGENDA: ALL ITEMS MARKED WITH A SINGLE ASTERICK (*) ARE PART OF THE CONSENT AGENDA AND REQUIRE NO DELIBERATION BY THE GOVERNING BOARD. ANY BOARD MEMBER MAY REMOVE AN ITEM FROM THIS AGENDA TO BE CONSIDERED SEPARATELY.

PROCEED TO BOTTOM OF THIS DOCUMENT FOR APPEARANCE & EXECUTIVE SESSION GUIDELINES

In accordance with the provisions of the Americans with Disabilities Act (ADA), persons in need of a special accommodation in order to participate in this proceeding should, within two (2) days prior to the proceeding, request necessary accommodations by contacting CHW's Executive Assistants at 409-949-3406, or via email at trollins@gchd.org or ahernandez@gchd.org

ANY MEMBERS NEEDING TO BE REACHED DURING THE MEETING MAY BE CONTACTED AT 409-938-2288

REGULARLY SCHEDULED MEETING

Meeting Called to Order
Pledge of Allegiance

Item #1.....Comments from the Public

***Item #2 ACTION**.....Agenda

***Item #3 ACTION**.....Excused Absence(s)

*Item #4 **ACTION**.....Consider for Approval Minutes from November 10, 2022 Governing Board Meeting

*Item #5 **ACTION**.....Consider for Approval FY2023 Audit Engagement with Bankole, Okoye & Associates, PC

*Item #6 **ACTION**.....Consider for Approval Revenue Cycle Management Policies and Procedures

*Item #7 **ACTION**.....Informational Report
a) Proposed 2023 Board Meeting Dates

Item #8.....Coastal Health & Wellness Updates
a) Update on COVID-19 Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director

Item #9 **ACTION**.....Consider for Approval October 2022 Financial Report Submitted by Trish Bailey

Item #10 **ACTION**.....Consider for Approval Coastal Health & Wellness Fund Balance Reserve as of September 30, 2022 Submitted by Trish Bailey

Item #11 **ACTION**.....Consider for Approval Pharmacy Design Blueprint submitted by Ami Cotharn

Item #12.....RCM Quality Project Update Submitted by Ami Cotharn

Item #13.....Comments from Board Members

Adjournment

Next Regular Scheduled Meeting: January 26, 2023

Appearances before the Coastal Health & Wellness Governing Board

The Coastal Health & Wellness Governing Board meetings are conducted under the provisions of the Texas Open Meetings Act, and members of the public that wish to address the Board about an item presented on the agenda shall be offered three minutes to do so. The Board cordially requests that individuals desiring to make a such a statement notify the Board of their intention by writing their name on the sign-in sheet located at the Boardroom's main entrance.

A citizen desiring to make comment to the Board regarding an item not listed on the agenda shall submit a written request to the Executive Director by noon on the Thursday immediately preceding the Thursday of the Board meeting. A statement of the nature of the matter to be considered shall accompany the request. The Executive Director shall include the requested appearance on the agenda, and the person shall be heard if he or she appears.

Executive Sessions

When listed, an Executive Session may be held by the Governing Board in accordance with the Texas Open Meetings Act. An Executive Session is authorized under the Open Meetings Act pursuant to one or more the following exceptions: Tex. Gov't Code §§ 551.071 (consultation with attorney), 551.072 (deliberation regarding real property), 551.073 (deliberation regarding a prospective gift or donation), 551.074 (personnel matters), 551.0745 (personnel matters affecting Coastal Health & Wellness advisory body), 551.076 (deliberation regarding security devices or security audits), and/or 551.087 (deliberations regarding economic development negotiations). The Presiding Officer of the Governing Board shall announce the basis for the Executive Session prior to recessing into Executive Session. The Governing Board may only enter into Executive Session if such action is specifically noted on the posted agenda.

Governing Board
December 2022
Item#3
Excused Absence(s)

Governing Board
December 2022
Item#4
Consider for Approval Minutes from November 10, 2022
Governing Board Meeting

Coastal Health & Wellness
Governing Board
November 10, 2022

Board Members:

Samantha Robinson (zoom)
Dr. Tello
Elizabeth Williams
Rev. Walter Jones
Donnie VanAckeren
Ivelisse Caban
Clay Burton
Flecia Charles
Sergio Cruz
Miroslava Bustamante
Cynthia Darby
Sharon Hall

Staff:

Dr. Keiser, Executive Director
Ami Cotharn, Chief Operations Officer
Dr. Choi, Medical Director
Hanna Lindskog, Dental Director
Neal Pathak
Kenna Pruitt
Tiffany Carlson
Jennifer Koch

Chris Davis
Virginia Lyle
Judie Olivares
J.D. Taliaferro
Tikeshia Thompson-Rollins
Anthony Hernandez

Excused Absence: Kevin Avery
Unexcused Absence: Victoria Dougharty, and Dr. Thompson

Items#1 Comments from the Public
There were no comments from the public.

Items#2-4 Consent Agenda
A motion was made by Sergio Cruz to approve the consent agenda items two through four. Sharin Hall seconded the motion, and the Board unanimously approved the consent agenda.

Item#5 Coastal Health & Wellness Updates

a) Current Public Health Concerns and Status:
   COVID/Flu/Monkey Pox Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director

Ami Cotharn, Chief Operating Officer, updated the Board on clinical operations.

New Hire

- One position filled this month.
  - Health Information Specialist

Outreach

- Four outreach events scheduled for the month of October
  - CHW went out to the Food Bank and started registration
  - GCHD Health Fair – Texas City Moore Memorial Library
  - Diabetes Ed Class – Santa Fe Library
  - Day of the Dead – Texas City

- Two outreach events scheduled for the month of November
  - League City Health and Wellness Expo
  - Heal Turkey Trot – Texas City

Hanna Lindskog, updated the Board on dental services in the Coastal Health & Wellness Clinic:

- The dental clinic continues to follow CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel which has a section dedicated to Dental Facilities. We are wearing N95 respirators for all aerosol generating procedures.
- The College of the Mainland is continuing to develop their Dental Hygiene Program. We have our next meeting on November 15th, 2022.
- In the month of October, we completed 77 comprehensive exams on new patients (increase of 4). We continue to offer new patients acute appointments to address immediate needs so that no one in pain is waiting. We had a total of 221 Acute visits in the month October, which is a slight decrease compared to September. 69 of those patients were either new to our clinic or had not been here in over 3 years. In the month of October, 151 extractions (increase of 37 compared to September) and 221 restorative procedures (increase of 10 compared to September) were completed.
- We had our third meeting for the NNOHA Teledentistry Collaborative on November 2nd. This is a virtual collaborative and several dental clinic staff members are participating including one of our full-time dentists (Dr. Shetty), the Dental Director, and Dental Assistant Supervisor. The third meeting included the introduction of the collaborative measures. Our goal is to have at least one teledentistry visit by our next meeting on December 7th.
- Staffing: We are fully staffed currently but were approved today to hire another dental hygienist.
- The dental clinic will have a table at the TurkeyTrot event this weekend on November 12, 2022.
- Wait list: 817, but we do have open comprehensive exams in the month of December

Item#6 Consider for Approval Updated Bad Debt Policy and Write off Over 180 Days Submitted by Ami Cotharn

Ami Cotharn, Chief Operating Officer, asked the Board to consider for approval updated bad debt policy and write off over 180 days. Ami informed the Board all policies and procedures that pertain to revenue cycle has been combined into one policy. A motion to accept the Revenue Cycle Management Policy/write off over 180 days as presented was made by Miroslava Bustamante. Cynthia Darby seconded the motion and the Board unanimously approved.

Item#7 Consider for Approval Community Representative, Sergio Cruz to Serve as Lead on the Finance Committee

Elizabeth Williams, Board Secretary/Treasurer, asked the Board to consider for approval Community Representative, Sergio Cruz to serve as lead on the finance committee. A motion to accept Sergio Cruz to serve as lead on the finance committee was made by Ivelisse Caban. Miroslava Bustamante seconded the motion and the Board unanimously approved.

Item#8 RCM Quality Project Update Submitted by Ami Cotharn

Ami Cotharn, Chief Operating Officer, updated the Board on the RCM Quality Project.

Item #9 Comments from Board Members

Samantha Robinson, Board Chair, reminded Governing Board members the importance of reviewing the Bylaws and being in compliance as a Board member.

Ivelisse Caban, shared with the Board she was able hand out cookies to the Coastal Health & Wellness staff with UBoH as a thank you for all your hard work and enjoyed meeting staff.

The meeting was adjourned at 1:16p.m.

_____ _____

Chair Secretary/Treasurer

_____ _____

Date Date

Back to Agenda

Governing Board
December 2022
Item#5
Consider for Approval FY2023 Audit Engagement with Bankole, Okoye & Associates, PC

November 7, 2022

To The Galveston County United Board of Health and
The Coastal Health & Wellness Governing Board and
The Management of
Galveston County Health District
Mid-County Annex
9850-A Emmett F. Lowry Expressway
Texas City, TX 77591

We are pleased to confirm our understanding of the services we are to provide Galveston County Health District (the "District") for the fiscal year ended September 30, 2022.

Audit Scope and Objectives

We will audit the financial statements of the District, which comprise the following that collectively comprise the basic financial statements:

1) Statement of net position as of September 30, 2022.
2) Statement of activities for the fiscal year ended September 30, 2022.
3) Balance Sheet – Governmental Funds as of September 30, 2022.
4) Reconciliation of the Balance Sheet of Governmental Funds to the Statement of Net Position.
5) Statement of Revenues, Expenditures and Changes in Fund Balances – Governmental Funds for the fiscal year ended September 30, 2022.
6) Reconciliation of the Statement of Revenues, Expenditures and Changes in Fund Balances – Governmental Funds to the Statement of Activities for the fiscal year ended September 30, 2022.
7) The related Notes and Disclosures accompanying the financial statements.

U.S. generally accepted accounting principles ("GAAP") provide for certain required supplementary information ("RSI"), such as Management's Discussion and Analysis ("MD&A"), to supplement the District's basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board ("GASB") who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. As part of our engagement, we will apply certain limited procedures to the District's RSI in accordance with U.S. generally accepted auditing standards ("GAAS"). These limited procedures will consist of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We will not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance. The following RSI are required by GAAP and will be subjected to certain limited procedures, but will not be audited:

1) Management's Discussion and Analysis.
2) Schedule of Revenues, Expenditures and Changes in Fund Balance – Budget and Actual, General Fund.

3) Schedule of Revenues, Expenditures and Changes in Fund Balance – Budget and Actual, Coastal Health & Wellness Fund.
4) Schedule of Revenues, Expenditures and Changes in Fund Balance – Budget and Actual, Galveston Area Ambulance Authority Fund.
5) Notes to Required Supplementary Information.
6) Texas County and District Retirement System – Schedule of Changes in Net Pension Liability (Assets) and Related Ratios.
7) Texas County and District Retirement System – Schedule of Employer Contributions.
8) Notes and Disclosures to the Schedule of Contributions.

We have also been engaged to report on supplementary information other than RSI that accompanies the District's financial statements. We will subject the following supplementary information to the auditing procedures applied in our audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS, and we will provide an opinion on it in relation to the financial statements as a whole, in a report combined with our auditor's report on the financial statements:

1) Schedule of Revenues – Budget and Actual, General Fund.
2) Schedule of Expenditures – Budget and Actual, General Fund.
3) Schedule of Revenues – Budget and Actual, GAAP Basis to Financial Status Report Basis Comparison – Coastal Health & Wellness Fund.

Our opinion on the District's following supplementary information, in relation to the financial statements as a whole, will be in a separate written report accompanying our report on the financial statements:

1) Schedule of Expenditures of Federal Awards.

The objectives of our audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and issue an auditor's report that includes our opinions about whether your financial statements are fairly presented, in all material respects, in conformity with GAAP, and report on the fairness of the supplementary information referred to in the fourth paragraph when considered in relation to the financial statements as a whole. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. Misstatements, including omissions, can arise from fraud or error and are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment of a reasonable user made based on the financial statements. The objectives also include reporting on:

1) Internal control over financial reporting and compliance with provisions of laws, regulations, contracts, and award agreements, noncompliance with which could have a material effect on the financial statements in accordance with *Government Auditing Standards*.
2) Internal control over compliance related to major programs and an opinion (or disclaimer of opinion) on compliance with federal statutes, regulations, and the terms and conditions of federal awards that could have a direct and material effect on each major program in accordance with the Single Audit Act Amendments of 1996 and Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform*

Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (the "Uniform Guidance"), as well as the State of Texas Single Audit Circular.

Auditor's Responsibilities for the Audit of the Financial Statements and Single Audit

We will conduct our audit in accordance with GAAS; the standards for financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; the Single Audit Act Amendments of 1996; and the provisions of the Uniform Guidance, and will include tests of accounting records, a determination of major program(s) in accordance with Uniform Guidance, and other procedures we consider necessary to enable us to express such opinions. As part of an audit in accordance with GAAS and *Government Auditing Standards*, we exercise professional judgment and maintain professional skepticism throughout the audit.

We will evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management. We will also evaluate the overall presentation of the financial statements, including the disclosures, and determine whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation. We will plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the District or to acts by management or employees acting on behalf of the District. Because the determination of waste and abuse is subjective, *Government Auditing Standards* do not expect auditors to perform specific procedures to detect waste or abuse in financial audits nor do they expect auditors to provide reasonable assurance of detecting waste or abuse.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, and because we will not perform a detailed examination of all transactions, there is an unavoidable risk that some material misstatements or noncompliance may not be detected by us, even though the audit is properly planned and performed in accordance with GAAS and *Government Auditing Standards*. In addition, an audit is not designed to detect immaterial misstatements or violations of laws or governmental regulations that do not have a direct and material effect on the financial statements or on major programs. However, we will inform the appropriate level of management of any material errors, any fraudulent financial reporting, or misappropriation of assets that come to our attention. We will also inform the appropriate level of management of any violations of laws or governmental regulations that come to our attention, unless clearly inconsequential. We will include such matters in the reports required for a Single Audit. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any later periods for which we are not engaged as auditors.

In connection with this engagement, we may communicate with you or others via email transmission. As emails can be intercepted and read, disclosed, or otherwise used or communicated by an unintended third party, or may not be delivered to each of the parties to whom they are directed and only to such parties, we cannot guarantee or warrant that emails from us will be properly delivered and read only by the addressee. Therefore, we specifically disclaim and waive any liability or responsibility whatsoever for interception or unintentional disclosure of emails transmitted by us in connection with the performance of this engagement. In that regard, you agree that we shall have no liability for any loss or damage to any person or entity resulting from the use of email transmissions, including any consequential, incidental, direct, indirect, or special damages, such as loss of revenues or anticipated profits, or disclosure or communication of confidential or proprietary information.

We will also conclude, based on the audit evidence obtained, whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the government's ability to continue as a going concern for a reasonable period of time.

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts, and direct confirmation of receivables and certain assets and liabilities by correspondence with selected individuals, funding sources, creditors, and financial institutions. We may, if considered necessary, also request written representations from your attorneys as part of the engagement and they may bill you for responding to this inquiry.

We have identified the following significant risks of material misstatement of financial statements or material noncompliance with contract agreements, as part of our audit planning:

1. Risk of incorrect classifications of Federal programs' expenditures by the appropriate grant contracts, potentially resulting in questioned program costs.
2. Risk of omission of Federally funded grants on the Schedule of Expenditures of Federal Awards.
3. Risk of noncompliance with direct and material compliance requirements of major Federally funded and State funded programs.
4. Risk of incorrect inventory of property and equipment.

Our audit of financial statements does not relieve you of your responsibilities.

Audit Procedures—Internal Control

We will update our understanding of the District and its environment, including internal control relevant to the audit, sufficient to identify and assess the risks of material misstatement of the financial statements, whether due to error or fraud, and to design and perform audit procedures responsive to those risks and obtain evidence that is sufficient and appropriate to provide a basis for our opinions. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentation, or the override of internal control. Tests of controls may be performed to test the effectiveness of certain controls that we consider relevant to preventing and detecting errors and fraud that are material to the financial statements and to preventing and detecting misstatements resulting from illegal acts and other noncompliance matters that have a direct and material effect on the financial statements. Our tests, if performed, will be less in scope than would be necessary to render an opinion on internal control and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to *Government Auditing Standards*.

As required by the Uniform Guidance and the State of Texas Single Circular, we will perform tests of controls over compliance to evaluate the effectiveness of the design and operation of controls that we consider relevant to preventing or detecting material noncompliance with compliance requirements applicable to each major federal award program. However, our tests will be less in scope than would be necessary to render an opinion on those controls and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to the Uniform Guidance.

An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weaknesses. Accordingly, we will express no such opinion. However, during the audit, we will communicate to management and those charged with governance internal control related matters that are required to be communicated under AICPA professional standards, *Government Auditing Standards*, and the Uniform Guidance.

Audit Procedures—Compliance

As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we will perform tests of the District's compliance with provisions of applicable laws, regulations, contracts, and agreements, including grant agreements. However, the objective of those procedures will not be to provide an opinion on overall compliance, and we will not express such an opinion in our report on compliance issued pursuant to *Government Auditing Standards*.

The Uniform Guidance requires that we also plan and perform the audit to obtain reasonable assurance about whether the auditee has complied with federal statutes, regulations, and the terms and conditions of federal awards applicable to major programs. Our procedures will consist of tests of transactions and other applicable procedures described in the *OMB Compliance Supplement* for the types of compliance requirements that could have a direct and material effect on each of the District's major programs. For federal programs that are included in the Compliance Supplement, our compliance and internal control procedures will relate to the compliance requirements that the Compliance Supplement identifies as being subject to audit. The purpose of these procedures will be to express an opinion on the District's compliance with requirements applicable to each of its major programs in our report on compliance issued pursuant to the Uniform Guidance.

Other Services

We will also assist in preparing the financial statements, schedule of expenditures of federal awards, and related notes of the District in conformity with accounting principles generally accepted in the United States of America and the Uniform Guidance based on information provided by you. These nonaudit services do not constitute an audit under *Government Auditing Standards* and such services will not be conducted in accordance with *Government Auditing Standards*. We will perform the services in accordance with applicable professional standards. The other services are limited to the financial statements, schedule of expenditures of federal awards, and related notes services previously defined. We, in our sole professional judgment, reserve the right to refuse to perform any procedure or take any action that could be construed as assuming management responsibilities.

You agree to assume all management responsibilities for the financial statements, schedule of expenditures of federal awards, and related notes, and any other nonaudit services we provide. You will be required to acknowledge in the management representation letter our assistance with preparation of the financial statements, the schedule of expenditures of federal awards, and related notes and that you have reviewed and approved the financial statements, the schedule of expenditures of federal awards, and related notes prior to their issuance and have accepted responsibility for them. Further, you agree to oversee the nonaudit services by designating an individual, preferably from senior management, with suitable skill, knowledge, or experience; evaluate the adequacy and results of the nonaudit services; and accept responsibility for them.

Responsibilities of Management for the Financial Statements and Single Audit

Our audit will be conducted on the basis that you acknowledge and understand your responsibility for (1) designing, implementing, establishing, and maintaining effective internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error, including internal controls over federal awards, and for evaluating and monitoring ongoing activities to help ensure that appropriate goals and objectives are met; (2) following laws and regulations; (3) ensuring that there is reasonable assurance that government programs are administered in compliance with compliance requirements; and (4) ensuring that management and financial information is reliable and properly reported. Management is also responsible for implementing systems designed to achieve compliance with applicable laws, regulations, contracts, and grant agreements. You are also responsible for the selection and application of accounting principles; for the preparation and fair presentation of the financial statements, schedule of expenditures of federal awards, and all accompanying information in conformity with accounting principles generally accepted in the United States of America; and for compliance with applicable laws and regulations (including federal statutes), rules, and the provisions of contracts and grant agreements (including award agreements). Your responsibilities also include identifying significant contractor relationships in which the contractor has responsibility for program compliance and for the accuracy and completeness of that information.

You are also responsible for making drafts of financial statements, schedule of expenditures of federal awards, all financial records, and related information available to us and for the accuracy and completeness of that

information (including information from outside of the general and subsidiary ledgers). You are also responsible for providing us with (1) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, identification of all related parties and all related-party relationships and transactions, and other matters; (2) access to personnel, accounts, books, records, supporting documentation, and other information as needed to perform an audit under the Uniform Guidance; (3) additional information that we may request for the purpose of the audit; and (4) unrestricted access to persons within the government from whom we determine it necessary to obtain audit evidence. At the conclusion of our audit, we will require certain written representations from you about the financial statements; schedule of expenditures of federal awards; federal award programs; compliance with laws, regulations, contracts, and grant agreements; and related matters.

Your responsibilities include adjusting the financial statements to correct material misstatements and confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements of each opinion unit taken as a whole.

You are responsible for the design and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the government involving (1) management, (2) employees who have significant roles in internal control, and (3) others where the fraud could have a material effect on the financial statements. Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the government received in communications from employees, former employees, grantors, regulators, or others. In addition, you are responsible for identifying and ensuring that the government complies with applicable laws, regulations, contracts, agreements, and grants. You are also responsible for taking timely and appropriate steps to remedy fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements that we report. Additionally, as required by the Uniform Guidance, it is management's responsibility to evaluate and monitor noncompliance with federal statutes, regulations, and the terms and conditions of Federal awards; take prompt action when instances of noncompliance are identified including noncompliance identified in audit findings; promptly follow up and take corrective action on reported audit findings; and prepare a summary schedule of prior audit findings and a separate corrective action plan. The summary schedule of prior audit findings should be available for our review by December 15, 2022.

You are responsible for identifying all Federal and State awards received and understanding and complying with the compliance requirements and for the preparation of the schedules of expenditures of Federal and State awards (including notes and noncash assistance received, and COVID-19-related concepts, such as lost revenues, if applicable) in conformity with the Uniform Guidance and the State of Texas Single Audit Circular. You agree to include our reports on the schedules of expenditures of Federal and State awards in any document that contains, and indicates that we have reported on, the schedules of expenditures of Federal and State awards. You also agree to include the audited financial statements with any presentation of the schedules of expenditures of Federal and State awards that includes our report thereon or to make the audited financial statements readily available to intended users of the schedules of expenditures of Federal and State awards no later than the date the schedules of expenditures of Federal and State awards are issued with our reports thereon. Your responsibilities include acknowledging to us in the written representation letter that (1) you are responsible for presentation of the schedules of expenditures of Federal and State awards in accordance with the Uniform Guidance and the State of Texas Single Audit Circular; (2) you believe the schedules of expenditures of Federal and State awards, including their forms and contents, are stated fairly in accordance with the Uniform Guidance and the State of Texas Single Audit Circular; (3) the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (4) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the schedules of expenditures of Federal and State awards.

You are also responsible for the preparation of the other supplementary information, which we have been engaged to report on, in conformity with U.S. generally accepted accounting principles (GAAP). You agree to include our report on the supplementary information in any document that contains, and indicates that we have reported on, the supplementary information. You also agree to include the audited financial statements with any presentation of the supplementary information that includes our report thereon or to make the audited financial statements readily available to users of the supplementary information no later than the date the supplementary information is issued with our report thereon. Your responsibilities include acknowledging to us in the written representation letter that (1) you are responsible for presentation of the supplementary information in accordance with GAAP; (2) you believe the supplementary information, including its form and content, is fairly presented in accordance with GAAP; (3) the methods of measurement or presentation have not changed from those used in the prior period (or, if they have changed, the reasons for such changes); and (4) you have disclosed to us any significant assumptions or interpretations underlying the measurement or presentation of the supplementary information.

Management is responsible for establishing and maintaining a process for tracking the status of audit findings and recommendations. Management is also responsible for identifying and providing report copies of previous financial audits, attestation engagements, performance audits, or other studies related to the objectives discussed in the Audit Scope and Objectives section of this letter. This responsibility includes relaying to us corrective actions taken to address significant findings and recommendations resulting from those audits, attestation engagements, performance audits, or studies. You are also responsible for providing management's views on our current findings, conclusions, and recommendations, as well as your planned corrective actions for the report, and for the timing and format for providing that information.

With regard to publishing the financial statements on your website, you understand that websites are a means of distributing information and, therefore, we are not required to read the information contained in those sites or to consider the consistency of other information on the website with the original document.

HIPAA Business Associate Agreement

We agree not to use or disclose Protected Health Information of your (patients/employees) (hereinafter referred to as "PHI") obtained or produced in any form of media during the course of our work in a manner prohibited by HIPAA, as amended. We may use or disclose PHI for purposes of (a) performing our engagement, (b) management and administration of Bankole, Okoye & Associates PC, or (c) carrying out legal responsibilities of Bankole, Okoye & Associates PC. We will not further disclose information except as permitted or required by this contract or as required by law. When using or disclosing PHI in relation to this engagement, we will limit disclosures as required by HIPAA. We will not use PHI in any marketing activities in a manner that would violate HIPAA. We represent to you that we have implemented what we consider to be appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your PHI as required for us as a business associate to comply with HIPAA.

With respect to your PHI, we will report to you any breach (as defined in 45 CFR 164.402), material security incident or use or disclosure not authorized by this agreement and, to the extent practical, assist you in mitigating any harmful effects caused by breaches, material security incidents or unauthorized uses or disclosures of which we become aware. To assist you in fulfilling your responsibility to notify impacted individuals and others of a breach involving unsecured PHI (as required under 45 CFR 164.400 et seq.), in this report we will identify to you, to the extent reasonably possible:

1) Each individual whose unsecured PHI was subject to the breach.
2) Any other available information you are required to include in your notification to such individual(s) or others under 45 CFR 164.404(c).

We agree that any material violation of these confidentiality provisions by us entitles you to terminate this engagement. Similarly, if we become aware of a violation of HIPAA by you that cannot be or is not timely cured, we may be obligated to terminate this engagement.

Bankole, Okoye & Associates PC agrees to:

1) Upon their request, make available to the Secretary of the U.S. Department of Health and Human Services ("HHS") our internal practices and books and records relating to the use and disclosure of PHI for purposes of determining your compliance with the Security and Privacy Rule, subject to any applicable legal privileges.

2) Make available information necessary for you to make an accounting of disclosures of PHI about an individual.

3) To the extent we maintain information that is part of a Designated Record Set, make available information necessary for you to respond to requests by individuals for access to PHI that is not in your possession but is considered part of a Designated Record Set.

4) Upon receipt of a written request from you, incorporate any amendments or corrections to PHI contained in our workpapers in accordance with the Security and Privacy Rule to the extent such PHI is considered part of a Designated Record Set.

For purposes of this agreement, the term "Security and Privacy Rule" refers to the final rules published to implement the Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996*, specifically 45 CFR Parts 160 and 164. The terms "Protected Health Information" and "Designated Record Set" have the same meaning as defined in the Security and Privacy Rule.

At the conclusion or termination of this engagement, any PHI retained by us will be subject to the same safeguards as for active engagements.

We will obtain from any agents, including subcontractors, to whom we provide PHI received from you, or created or received by us on behalf of you, an agreement to the same restrictions and conditions that apply to us with respect to such PHI.

To the extent that any relevant provision of HIPAA is eliminated or held to be invalid by a court of competent jurisdiction, the corresponding portion of this agreement shall be deemed of no force and effect for any purpose. To the extent that any relevant provision of HIPAA is materially amended in a manner that changes the obligations of business associates or covered entities that are embodied in term(s) of this engagement, the Parties agree to negotiate in good faith appropriate amendment(s) to this engagement to give effect to such revised obligations. In addition, the terms of this engagement should be construed in light of any interpretation and/or guidance on HIPAA issued by HHS from time to time.

Engagement Administration, Fees, and Other

We understand that your employees will prepare all cash, accounts receivable, or other confirmations we request and will locate any documents selected by us for testing.

At the conclusion of the engagement, we will complete the appropriate sections of the Data Collection Form that summarizes our audit findings. It is management's responsibility to electronically submit the reporting package (including financial statements, schedule of expenditures of federal awards, summary schedule of prior audit findings, auditor's reports, and corrective action plan) along with the Data Collection Form to the federal audit clearinghouse. We will coordinate with you the electronic submission and certification. The Data Collection Form and the reporting package must be submitted within the earlier of 30 calendar days after receipt of the auditor's reports or nine months after the end of the audit period.

We will provide copies of our reports to the District; however, management is responsible for distribution of the reports and the financial statements. Unless restricted by law or regulation, or containing privileged and confidential information, copies of our reports are to be made available for public inspection.

The audit documentation for this engagement is the property of Bankole, Okoye & Associates PC and constitutes confidential information. However, subject to applicable laws and regulations, audit documentation and appropriate individuals will be made available upon request and in a timely manner to the Texas Health and Human Services Commission or its designee, a federal agency providing direct or indirect funding, or the U.S. Government Accountability Office for purposes of a quality review of the audit, to resolve audit findings, or to carry out oversight responsibilities. We will notify you of any such request. If requested, access to such audit documentation will be provided under the supervision of Bankole, okoye & Associates PC personnel. Furthermore, upon request, we may provide copies of selected audit documentation to the aforementioned parties. These parties may intend, or decide, to distribute the copies or information contained therein to others, including other governmental agencies.

The audit documentation for this engagement will be retained for a minimum of five years after the report release date or for any additional period requested by the Texas Health and Human Services Commission or the U.S. Department of Health and Human Services. If we are aware that a federal awarding agency, pass-through entity, or auditee is contesting an audit finding, we will contact the party(ies) contesting the audit finding for guidance prior to destroying the audit documentation.

Godwin Okoye, CPA, is the engagement partner and is responsible for supervising the engagement and signing the reports or authorizing another individual to sign them. Our audit engagement ends on delivery of our audit report. Any follow-up services that might be required will be a separate, new engagement. The terms and conditions of that new engagement will be governed by a new, specific engagement letter for that service. We expect to begin our audit on approximately January 3, 2023. We can begin the audit sooner if the District so desires.

Our fee for these services is estimated at $49,060. This fee estimate is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the audit. If significant additional time is necessary due to circumstances beyond our control, we will discuss it with you and arrive at a new fee estimate. Based on the projected timeline for the audit, we anticipate that our invoices for the audit services fees will be rendered as follows and are payable on presentation:

Amount	Approximate Billing Date
$15,000	February 15, 2023
$20,000	March 30, 2023
$14,060	April 30, 2023

In accordance with our firm policies, work may be suspended if your account becomes 30 days or more overdue and will not be resumed until your account is paid in full. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our report. You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket expenditures through the date of termination.

Our audit engagement ends on delivery of our audit report. Any follow-up services that might be required will be a separate, new engagement. The terms and conditions of that new engagement will be governed by a new, specific engagement letter for that service.

Reporting

We will issue written reports upon completion of our Single Audit. Our reports will be addressed to the United Board of Health and the Coastal Health & Wellness Governing Board of the District. Circumstances may arise in which our report may differ from its expected form and content based on the results of our audit. Depending on the nature of these circumstances, it may be necessary for us to modify our opinions, add a separate section, or add an emphasis-of-matter or other-matter paragraph to our auditor's report, or if necessary, withdraw from this engagement. If our opinions are other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed opinions, we may decline to express opinions or issue reports, or we may withdraw from this engagement.

The *Government Auditing Standards* report on internal control over financial reporting and on compliance and other matters will state that (1) the purpose of the report is solely to describe the scope of testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance, and (2) the report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. The Uniform Guidance report on internal control over compliance will state that the purpose of the report on internal control over compliance is solely to describe the scope of testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance and the State of Texas Single Audit Circular. Both reports will state that the report is not suitable for any other purpose.

We appreciate the opportunity to be of service to the District and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this letter, please sign and return a copy of this letter to us.

Very truly yours,

Bankole, Okoye & Associates PC

Bankole, Okoye & Associates PC
Certified Public Accountants & Business Advisors

RESPONSE:

Acknowledged and agreed to on behalf of:

GALVESTON COUNTY HEALTH DISTRICT

Authorized Signature: _____

Title: _____

Date: _____

GALVESTON COUNTY UNITED BOARD OF HEALTH

Authorized Signature: _____

Title: _____

Date: _____

Galveston County Health District
FY2022 Financial and Compliance Audit Engagement Letter
Continuation

COASTAL HEALTH & WELLNESS

Authorized Signature: _____

Title: _____

Date: _____

COASTAL HEALTH & WELLNESS GOVERNING BOARD

Authorized Signature: _____

Title: _____

Date: _____

Back to Agenda

Governing Board
December 2022
Item#6
Consider for Approval Revenue Cycle Management
Policies and Procedures

Revenue Cycle Management Policies and Procedures

Updated November 2022

TABLE OF CONTENTS

I. COASTAL HEALTH & WELLNESS MISSION, VISION, & VALUES

Our Mission

Providing high quality healthcare to all

Our Vision

Healthy people in healthy communities

Our Values

I CARE

Integrity- We are honest, trustworthy and transparent in all we do.

Customer Service- We are committed to providing exceptional customer service.

Accountability- We hold ourselves to high standards and take responsibility for our actions.

Respect- We uphold a standard of conduct that recognizes and values the contributions of all.

Equality- We equally value and serve all members of the community.

Coastal Health & Wellness does not discriminate any person based on race, color, national origin, sex, age, religion, or disability in our programs, services, or employment.

II. INSURANCE VERIFICATION POLICY & PROCEDURES

Related Form: Patient Responsibility

Related Policy: Billing and Collections, Payment Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1. It is the policy of Coastal Health & Wellness (CHW) to verify patient benefits, including any payers that may have payment responsibilities. While verifying and documenting patient and insurance responsibilities, specific processes are to be followed so that the information is accurate, stored correctly, easily accessible and documented in an understandable manner. These processes also promote the sending of claims to the proper payer source to avoid delays in payments.
2. CHW makes every reasonable effort to enter into contractual or other arrangements to collect reimbursement of its costs with the appropriate agency(s) of the State which administers or supervises the administration of:
    a. A State Medicaid plan approved under title XIX of the Social Security Act (SSA) [42 U.S.C.1396, et seq.] for the payment of all or a part of the center's costs in providing health services to persons who are eligible for such assistance; and
    b. The Children's Health Insurance Program (CHIP) under title XXI of the SSA [42 U.S.C. 1397aa, et seq.] with respect to individuals who are State CHIP beneficiaries
3. CHW acknowledges the importance of identifying and documenting appropriate payer sources. The insurance verification process is performed by the billing /registration departments to promote: (i) listing the proper insurance on a patient's account; (ii) coordinating benefits so that claims are timely and accurately filed; (iii) identifying any patient responsibility and (iv) determining the payer of last resort for patients with multiple coverages/payers.
4. Patient benefits/appropriate payers are verified forty-eight (48) hours prior to the patient's appointment.
5. Medicaid eligibility can change from one month to the next. As a result, Medicaid eligibility is verified on the first business day of the month of the appointment.
6. Patients with a Medicaid application pending approval from the state are assigned an insurance carrier/status of "Medicaid pending" until Medicaid coverage is confirmed.

Procedure

The verification process for each department can vary. As such, specific instructions for verification are separated by area of specialty. Team members are assigned individual schedules to verify. Generally, schedules should be verified at least two days in advance. This allows the verification specialist, front desk,

and call-center staff the time to clarify any issues of coverage with the insurance plan and the member prior to the appointment.

1. The patient registration is where information is recorded by verification team members. While determining and documenting patient and insurance responsibility, there are specific processes that must be followed to ensure that the information is stored correctly and in a manner that can be seen and understood by all. These processes also help to ensure that the claims are sent to the proper payer source.
2. Determine the primary payer source for medical visits. This information should be entered into the Insurance tab in the patient's registration. All other insurance carriers should be unchecked, even if they are active.
3. Click Insurance Eligibility to open the Additional Policy Information tab. Enter in effective dates, coinsurance and deductible amounts, and any other relevant eligibility data. Click Active Coverage for active policies or Pending Verification for policies that require additional information to verify. Any policy that is known to be inactive should not be primary.
4. Ensure that the Financial Class correspond to the primary payer.
5. Verify that the patient's name, date of birth, and ID number match the insurance plan if applicable.
6. Verify if any secondary or ancillary policies are active and enter Insurance Eligibility information in the Additional Policy information tab. Do not leave the policy checked, even if it is active.
7. Open the Appointments tab and find the appointment for which you are verifying insurance.
8. Right click on the appointment and choose Modify Appointment.
9. Build or apply any relevant case information.
10. Double click the space next to the line labeled Appointment. Enter in any information that needs to be conveyed or has been conveyed to the patient for that particular appointment. The note should include the dollar amount the patient is responsible for and the payer source for the visit should be identified. End the note with the date and your initials. Click OK to save and close.
11. Save and exit the patient registration.

Medicaid Pending

- Use to check if patient has applied
- This report requires minimal input data.
- Choose insurance
- Click "View Report"

Creating and Applying Cases

Cases are created when a visit requires a different insurance carrier for a service rather than their primary medical insurance. For example, Traditional Medicaid does not cover sports physicals and patients must Self-Pay for this. Therefore, you would want to apply a Self-Pay case to **THAT APPOINMENT only**. This

ensures that their primary medical insurance continues to be billed for all covered services and that no claims go out to the wrong carrier for non-covered services.

Ryan White Verification

Part of the verification process for Ryan White patients is to eliminate the possibility of other payer sources before assigning responsibility to the grant. Verification must check that each patient does not have access to Medicaid or Medicare and the front desk must ask the patient if they have insurance prior to every visit.

Patients are qualified for the grant at registration sites and are assigned character codes that can be entered into the Centralized Patient Care Data Management System (CPCDMS/Aries) to verify. They are then assigned copays based on their poverty level. If FPL is over 100%, they are assigned a cap. Medicare and Medicaid verification is done by either running the Emdeon Report daily or manually on each website (typically done when it's a same day appt). Please see instructions on how to access and run the "Emdeon Report" under the Insurance Verification section

Self-Pay & Sliding Scale

For office visits (including well exam, HRT, and STD testing) follow the Sliding Fee Scale.

Primary Care Verification

- Traditional – no PCP assignment
- Star/Star Plus – PCP should be CHW
- No copay
- Primary care, FP services, annual wellness, some immunizations
- If active TPA is listed, Medicaid is secondary
- As secondary, covers copays and co-ins for services covered under plan

Medicare NGS / Medicare Novitas

- No PCP assignment
- Copay – slide if applicable
- Primary care, FP services, annual wellness, some immunizations
- As secondary, covers copay and co-ins for services covered under plan

Medicare Advantage Plans

- Replace original Medicare
- May be PPO or HMO
- May require PCP assignment
- Must determine in or out of network
- Copays and co-ins vary
- Primary care, FP services, annual wellness, some immunizations
- As secondary, covers copays and co-ins for services covered under plan

Private Insurance

- Must determine in or out of network

- Ensure service is covered
- Copays and co-ins vary
- Deductible may apply
- Has secondary plan?
- Health funds or accounts?

CHC – Harris Health

- No copays
- Must be referred by Harris Health

PHC Grant –Beaumont Clinics Only

- Active for one year from certification
- Primary care, FP services, annual wellness, immunizations

Ryan White Grant – LMC & BCC Clinics Only

- Payer of last resort – Must check for Medicare & Medicaid
- Eligibility verified through CPCDMS
- If FPL over 100%, must verify copay & cap amount

Health Texas Women Program

- Covers females only for 3 providers visit for the plan year
- Annual family planning and preventative healthcare visit
- Contraceptive services, all methods except elective abortion & emergency contraception (includes follow-up and surveillance)
- Preconception care
- Basic infertility services
- Certain screening, diagnostic, and treatment services:
- Pregnancy testing
- Screening and treatment of Cervical Intraepithelial Neoplasia, dx of cervical cancer
- Screening and outpatient treatment of STD's and STI's
- HIV testing
- Breast cancer screening and dx
- Recommended immunizations
- Screening and treatment of postpartum depression
- Diabetes screening and treatment
- Hypertension screening and treatment
- Screening and treatment of elevated cholesterol

Pediatric

Traditional Medicaid

- No PCP assignment

- No copay
- Acute care, FP services, well child, immunizations
- If an active TPA is listed, Medicaid is secondary
- As secondary, covers copays and co-ins for services covered under plan

Star & Star Plus Medicaid / CHIP

- PCP should be CHW
- MCD no copay / CHIP copay varies
- MCD - Acute care, FP services, well child, immunizations
- CHIP – Acute care, well child, NO FP, immunizations
- If an active TPA is listed, plan is secondary
- As secondary, covers copays and co-ins for services covered under plan

Private Insurance

- Must determine in or out of network
- Ensure service is covered
- Copays and co-ins vary
- Deductible may apply
- Has secondary plan

Medicaid Pending

- Check TMHP for coverage
- Coverage Found
- Add coverage to registration
- Update collections staff

No Coverage Found

- Newborn Under 3 months – keep Medicaid pending status
- Newborn over 3 months – send to eligibility
- Infants & older with Medicaid pending status less than 2 months – keep Medicaid pending status
- Infants & older with Medicaid pending status over 2 months – send to eligibility

Sports Physicals

- Uninsured follow slide
- Private Insurance Copay applies
- Traditional MCD – no coverage, self-pay
- CHIP Plans
- TCHP, AMG, Molina – Charge copay
- CHC, UHC – No copay

Immunizations

- Medicaid/Medicaid HMOs – No charge
- Private insurance verifies independently – if no coverage, self-pay rate applies.

OB/GYN Verification

- Copays and co-ins vary
- We are a Non-delivering provider. Phone call is required to determine coverage.
- Deductible may apply
- Has secondary plan?
- Health funds or accounts?

Healthy Texas Women

- Covers females only
- Annual family planning and preventative healthcare visit
- Contraceptive services, all methods except elective abortion & emergency contraception (includes follow-up and surveillance)
- Preconception care
- Basic infertility services
- Certain screening, diagnostic, and treatment services:
- Pregnancy testing
- Screening and treatment of Cervical Intraepithelial Neoplasia, dx of cervical cancer
- Screening and outpatient treatment of STD's and STI's
- HIV testing
- Breast cancer screening and dx
- Recommended immunizations
- Screening and treatment of postpartum depression
- Diabetes screening and treatment
- Hypertension screening and treatment

Specialty Services - Endocrinology/Geriatrics

When verifying for Specialty Services visits a phone call is required to all commercial plans (Aetna, BCBS, Cigna, Humana, etc.) to determine if visit is a specialist copay and/or if referral is required. Create/apply case if applicable.

Vision

Routine Vision

An optometrist and diagnoses refractive vision errors. He writes prescriptions for eyeglasses and contact lenses. He can see patients for medical issues, but this is usually only if an ophthalmologist is not available.

A Certified Ophthalmological Assistant assists patients with glasses and contact lenses. The two appointment types you will see on her schedule are Dispense and Frame Style.

Associated terms: REE/CEE – Routine/Complete Eye Exam, CLS – Contact Lens, RX check

- RX Check – Should be done within short period after REE/glasses dispensed. There is no charge.
- CLS F/U – Appointment is to order supplies of contact lens after the trial period is over.

Medical Vision

An ophthalmologist is a Specialty MD. He/she screens, diagnoses, and treats diseases of the eyes. A Certified Ophthalmological Assistant assists the Ophthalmologist and also assists patients with glasses and contacts. The two appointment types for her are Visual Field and Dispense.

Associated terms: CMV – Cytomegalovirus (screening), Diabetic Retinopathy, Visual Field

- Visual Field – A patient will be put on both Eva and Dr. Sawyer's schedule for a visual field exam. For Self-Pay/Sliding Scale patients, the cost is included in the price of Dr. Sawyer's visit.
- Dispense Visits – For RW visits, check eligibility as usual, but no copayment is collected. Self-Pay, Sliding Scale, and Medicaid Dispense visits are included in the cost of the glasses.

***HIV positive patients will usually be scheduled to see both doctors on the same day. This means you will have to ask for two/three separate benefits when calling to verify for these patients.**

Traditional Medicaid and Medicaid MQMB

Cover both REE and medical vision visits with no copayment.

- Adults 19 and up – one exam and 1 pair of glasses every TWO YEARS
- Children through 18 – one exam and 1 pair of glasses every year

The date of their last exam and pair of glasses will be listed in the limits segments in TMHP.

MEDICAID QMB DOES NOT COVER REE OR GLASSES, ONLY MCR COINSURANCE.

Medicare

Medicare will cover **ONLY** medical vision visits, subject to coinsurance. Routine vision visits or contact lens exams will go the patient's secondary payer if applicable or will be the patient's responsibility.

- Medicare/Ryan White client – Charge the Medicare coinsurance for the medical visit and the Ryan White copayment for the routine visit. Create/apply the Ryan White case to Dicks appointment
- Medicare/MQMB client – No copayment is collected. Create/apply MQMB case to all routine visits.
- Medicare/Self Pay client – Collect coinsurance as usual for medical visit. Collect Self Pay or Sliding Scale payment for routine visit. Create/apply Self-Pay/Sliding Scale case to routine appointments.

Ryan White

Ryan White will cover both the routine eye exam and medical vision visits for patients <300% of FPL. Ryan White will **NOT** cover glasses or contact lens fittings. Ryan White patients are provided with one pair of free glasses every two years, regardless of FPL. The vision staff is to determine eligibility for courtesy glasses. Ryan White patients only pay ONE copayment if BOTH visits are covered under Ryan White for the cost of BOTH visits and glasses if visit is scheduled on the same day.

Charge the usual Self Pay or Sliding Scale fees.

Commercial Insurance (BCBS, Aetna, Humana, UHC Private, etc.)

Medical Vision

When calling to verify for an Ophthalmology visit, you will ask for Specialist office visit benefits. *BCBS requires that you give **the Ophthalmologist's NPI** when verifying, or they will quote you out of network benefits.

Routine Vision

Some of these policies will have a routine eye exam available through the medical piece of their insurance. Deductibles and coinsurance may apply (usually only if Dr. Dicks is an out of network provider). Most of these plans will have **vision vendors** to handle routine eye exams, contact lens fittings, and discounts on glasses. We are out of network with most of these vendors.

You can call to verify if the client has OON benefits. When asking for routine vision benefits from the customer service representative ALWAYS ask if the eye is exam is handled through the medical policy or through a vendor. If the representative says that the eye exam is ONLY covered as a screening with a routine preventative visit, or that refraction is NOT included, then the visit is NOT covered. Very rarely, if ever, will contact lens fittings or eyeglasses be covered through the medical policy. If a representative tells you that glasses or contact lens fittings are covered and gives you an allowance amount, call back and speak to another representative to verify.

When a patient has a non-contracted policy and no out of network benefits, has already used their routine vision benefit, or has a discount plan, the cost of the exam becomes the patient's responsibility. Ryan White will not pick up the cost of these services since they do have coverage. As a courtesy, call the patient to let them know that we are not in network, their benefits cannot be used here, or that they have already used their benefits. Inform them of the amount that they will owe at the time of the visit.

Star, Star Plus, & CHIP

Some insurance plans use vision vendors for routine and medical vision. Please see chart below for more information. You must verify if services are covered, if benefits are available, and if authorization is required. Create cases for alternate carriers and apply them appropriately.

Psychiatry

For all commercial plans (Aetna, BCBS, Cigna, Humana, etc.) require a call to obtain benefit information. Some plans will use vendors for BH (Value Options, Optum, Magellan, etc.) for which you need to apply cases and pre-authorization may be required.

Ryan White Grant

Ryan White is billable for nutritional counseling and nutritional supplements. If a patient is on the schedule for Nutrition, follow the "*Ryan White Verification*" process under the Primary Care Verification section.

- Copays do not apply to nutrition visits.
- The patient is allowed 12 counseling visits per contract year by a licensed dietician.

- The patient may receive up to a 90-day supply of supplements on a single visit.

Dental Verification

Dental Vendor for Medicaid patients can be found on TMHP. For all commercial plans (Aetna, BCBS, Cigna, Humana, etc.) require a call to obtain vendor information. Once vendor is identified create/apply case with dental vendor.

All Other Payers

All others are not billable and do not need verification.

III. SLIDING FEE DISCOUNT PROGRAM POLICY & PROCEDURES

Related Form: Sliding Fee Checklist, Patient Responsibility

Related Policy: Fee Scheduling Establishment and Maintenance

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

Sliding Scale is a discount program that is provided to all eligible clients based on the patient's ability to pay. Ability to pay is determined by the household income and family size.

It is Coastal Health & Wellness' (CHW's) policy to establish a sliding fee discount schedule based on a patient's ability to pay for all services within the health center's approved scope of project regardless of the mode of delivery i.e., Column I, II, or III of Form 5 for which there is an established charge. The SFDS is established and implemented to ensure that uniform and reasonable fees and discounts are consistently and appropriately applied to all health center patients to address financial barriers to care. Eligibility for the SFDS will be based on income and family size and no other factors.

1. CHW provides access to services without regard for a person's ability to pay for such services. The Clinic has established a Board-approved sliding fee discount program in accordance with current requirements.
2. The Board of Directors shall examine the nominal fees about whether they are a potential barrier to care. The quarterly patient satisfaction survey findings shall be shared with the Board of Directors as one means off assessing the nominal fee.
3. A full discount to individuals and families with annual incomes at or below those set forth in the most recent *Federal Poverty Guidelines (FPG)* [100% of the FPG], except that nominal charges for service may be collected from such individuals and families where imposition of such fees is consistent with project goals; and
    a. No discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200% of the FPG].
    b. CHW's nominal fee for medical visit for patients at or under 100% of FPG is $35.00.
4. CHW will update the Sliding Fee Discount Schedule related to changes in the Federally Poverty Guidelines. Federal Poverty Guidelines are updated by the Department of Health and Human Services annually and it is the goal of Monarch to update their Sliding Fee Discount Schedule within three months of the release of the new guidelines. The review will conclude with the board providing guidance and direction to the CFO to ensure that this and other related policies and / or operating procedures are updated appropriately.

5. It is the policy of CHW to screen all patients to determine qualification for the center's sliding fee discount program.[1] To maintain its compliance with the requirement to serve all patients regardless of ability to pay, a center must also offer a sliding fee schedule of discounts to patients who are uninsured for all services or the particular service they seek; also, for underinsured patients, the center should apply the sliding fee discount to co-pays for covered services.
6. CHW utilizes multiple methods for informing patients of the availability of the SFDS in languages and at literacy levels that are appropriate for the patient population (currently in English and Spanish). The methods used to inform patients are as follows:
    a. Signage at all desks
    b. Brochures that are given to patients during initial visits
    c. CHW's website
7. CHW allows for a process and criteria for waiver of fees and nominal charges on a case-by-case basis.
8. CHW will prepare a schedule of fees to charge that allows for a "sliding fee discount" that will assure:
    a. That full fees to any patient with an annual income greater than 200% of the amount set forth in the Federal Poverty Guidelines (FPG)[3] and gives a full discount for those making less than 100% of the amount set forth in the poverty guidelines.[4]
    b. Allows for a nominal fee may to be charged to assure access.
    c. Includes reasonable efforts are made to collect payment from self-pay patients.[5]
    d. After the collection process has been followed, the uncollected amount should be written off to avoid the appearance of collectable accounts receivable that overstate the center's financial assets.
9. CHW will provide notice using more than one method to patients of the sliding fee discount that is appropriate for the language and literacy level of patients. Such notice should include what services outside the center's scope of project the patient may be billed for separately by the center or a third party.
10. CHW will review what other government or community programs that they may participate in to provide the following services to clients who are not necessarily eligible for Medicaid or CHIP:

1) See 42 USC 254b(k)(3)(G), 42 CFR 51c.303(f), and the HRSA Health Center Site Visit Guide, especially pages 13-15. Covering costs should include covering a margin. The Medicare and Medicaid fee schedules offer guidance.
2) Id. Please note that centers may not automatically apply discounts or waivers to Medicare co-pays, but must review whether the patient is eligible on a case by case basis. See 42 CFR §1001.952(k)(2).
3)The Federal Poverty Guidelines are here and usually updated in the first quarter of each calendar year.
4) See 42 USC 254b(k)(3)(G), 42 CFR 51c.303(f), and PIN 2014-02.
5) See 42 USC 254b(k)(3)(F), 42 CFR 51c.303(g).

primary healthcare (PHC), family planning, breast and cervical cancer treatment, HIV/STD treatment, services for children with special healthcare needs and school-based services.[2]

11. Not all services are covered under the sliding fee program. Medical services provided "in-house" are eligible for a sliding fee discount. "In-house" refers to medical services provided at the clinic such as some labs, EKG's, some immunizations, and office visits. All Non-Vaccines for Children (VFC) or Non-Adult Safety Net (ASN) immunizations and/or injections, in addition to administration cost, and in house testing and procedures (e.g., INR (coagulation), A1C, biopsy, sutures) as well as IUD's, Birth Control Implants, and durable medical equipment are not included in the encounter rate and uninsured patients will be responsible for payment for these services/supplies.
12. Current Dental patients who qualify for the sliding fee discount program are required to pay for any associated lab costs for certain designated procedures unless they are above 200% of the federal poverty level and required to pay full charges

Procedures

1. Staff will assure that any fees or payments required by the center for health care services will be reduced or waived to assure that no patient will be denied such services due to an individual's inability to pay for such services.
2. The components of the sliding fee discount schedule are as follows:
    a. Definition of Income and Family Size
    b. Documents required to be provided by patients to support definition of income
    c. Determination of eligibility guidelines
    d. Structure of the Sliding Fee Discount Scale
    e. Definition of Income and Family Size Documents required to be provided by patients to support definition of income
    f. Determination of eligibility guidelines
    g. Structure of the Sliding Fee Discount Scale
3. CHW defines Income and Family Size as follows:
    a. **Income:** Money received by a household head and/or spouse/significant other for money received, especially on a regular basis, for work or through investments.
    b. **Family:** A family is defined as a person living alone or a group of two or more persons related by birth, marriage (including common-law), or adoption, which reside together and are legally responsible for the support of the other person. Unborn children are also included in family size.
    c. **Family Size:** The number of individuals in the family.

[2] Texas Department of Health & Human Services https://yourtexasbenefits.hhsc.texas.gov/programs or Texas 211 https://www.211texas.org for more information about programs.

4. Acceptable forms of support for documentation of Income are as follows:
    a. Self-Declaration (if applicable)
    b. Check stubs for the current month (if paid weekly last 4 paystubs, if paid bi-weekly last 2 paystubs, if paid monthly last 3 paystubs)
    c. Current Tax Return or W2 Forms
    d. Employment Verification Form (EVF) or Letter from Employer
    e. Unemployment Benefits or Wage Detail from Workforce (if unemployed and not receiving unemployment)
    f. Assistance Statement Verification (Supporter Statement that indicates unemployment and/or zero income) Retirement or Social Security Benefits Letter
    g. Child Support
    h. Public Assistance Verification letter
    i. Letter from Homeless Shelter attesting income/no income
5. CHW's patient eligibility process for sliding fees is based on the following:
    a. Patient eligibility will be updated annually, and patients will be notified of their benefit term at the time of the application. CHW has records of assessing/re-assessing patient income and family size annually, except in situations where a patient has declined or refused to provide such information for further enrollment.
    b. CHW has supporting processes/operating procedures in place for assessing and verifying income and household size for patients that it uses to train personnel on the program and
    c. The SFDS is structured in a manner that adjusts based on a patient's ability to pay.
    d. Patient's eligibility is determined by FPL % based on the household's income and family size, using the current Poverty Level Guidelines showing income ranges and categories.
    e. Individuals and families with incomes at or below 100% of the FPG pay a "nominal charge." Individuals and families with incomes above 100% and at or below 200% of the FPG are charged amounts that are tied to graduated income levels. CHW has a minimum of 3 discount pay-classes above 100% and below 200%.
    f. Individuals and families with incomes above 200% of the FPG are not eligible for sliding fee discounts and thus are charged a full fee for services. These charges may be reduced by other funding sources that contain terms and conditions relating to specific services.
    g. CHW is permitted to utilize multiple sliding fee discount schedules. All schedules should be structured using the criteria previously mentioned in this section. Each Sliding Fee Discount Schedule will be based on either broad service types (such as medical and dental), distinct subcategories or service types (such as preventive dental and additional dental services), and/or on service delivery method (such as services provided by CHW

directly vs. provided through a formal written contract). All sliding fee discount schedules by CHW will be approved by the Board of Directors annually.

h. CHW will include information on every sliding fee discount schedule that indicates if a patient will be financially responsible for supplies that might be used during the provision of services. Certain services including contact lenses, vision hardware are examples of fees that are not included in the sliding fee discount. Some of these services may require payment in advance of ordering. Under CHW care card services, an "immediate medical need" will be determined and assessed by the provider or department providing the service to the patient. More extensive treatments or procedures may also be excluded.

6. Patients with Third Party Coverage

   a. It is CHW's Policy that the charge for each SFDS pay class is the maximum amount an eligible patient in that pay class is required to pay for a certain service, regardless of insurance status.

   b. If an insured patient qualifies for the sliding fee discount schedule, the patient will be placed on the sliding fee discount schedule and charged the lesser of the amount due per the sliding fee discount schedule or the co-pay, deductible, etc.

   c. CHW does and cannot require individuals to enroll in public or private insurance and this is not a factor when determining eligibility. However, it is CHW's Policy to educate patients based on their eligibility for public or private insurance for which they might qualify.

7. Services provided via formal referral arrangement

   a. For services provided through a formal referral arrangement (Form 5A, Column III), CHW will ensure that the fees for such services are either discounted as described in paragraph 5, sub-section 4 or discounted in such a manner that:

      i. Individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an equal or greater discount for these services than if CHW's SFDS were applied to the referral provider's fee schedule, and Individuals and families at or below 100 percent of the FPG receive a full discount or a nominal charge for these services.

8. Patients who refuse to pay will be offered one of the following 3 options: sliding fee discount, a payment plan, or a grace period (See *Refusal to Pay Policy & Procedures*).

9. The 3-month CHW Presumptive Sliding Fee Eligibility program documentation deadline period shall be extended in case of declaration of emergencies or disaster by the national, state, or local officials, as well as reviewed based on case-by-case situation to reduce barriers to care. There will also be an extension of presumptive sliding fee discount eligibility deadline under special circumstances.

10. **Annual Audit:** As a component of CHW's annual financial audit, the sliding fee discount program audit will be performed by External Auditors each Fiscal Year. The audit will include the following:

a. A random sample of sliding fee applications will be selected from patients see during the audit year.

b. The auditor reviews all accompanying documents for accuracy and completeness.

c. The approval/disapproval decision and the selection of the sliding fee discount category are also reviewed for accuracy by auditor.

d. Any necessary sliding fee discount corrections will be documented and included in the following meeting of the Continuous Quality Improvement (CQI).

Patient Responsibilities for Sliding Fee Discounts

1. To satisfactorily comply with all regulations and policies, CHW's patients have responsibilities to cooperate with the SFSD requirements:

    a. They will need to complete the sliding fee discount application (Application for Health Care Assistance)

    b. Provide requested personal information as listed under the "clinic responsibilities" to the Clinic. Failure or denial to provide all required information will result in denial of eligibility.

2. If supporting document is not available or is insufficient to determine eligibility, the patient will be placed on a 3-month Presumptive Eligibility. The goal of Presumptive Eligibility is to reduce barriers to immediate care for patients and to ensure patient have enough time to present required documentation for Sliding Fee Program. If the patient does not present the appropriate documentation to CHW within the 3 months, he/she will not be eligible for sliding fee discount program and will automatically be assigned standard office visit fee until the following year.

3. CHW will for assess/re-assess all patients for income and family size consistent with board-approved sliding fee discount program policies annually. This assessment will be documented in the practice management system. Patients are required to provide updated information at that time.

IV. FEE SCHEDULE ESTABLISHMENT & MAINTENANCE POLICY & PROCEDURES

Related Form: Master Fee Schedule Report

Related Policy: Sliding Fee Schedule Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1. It is the policy of Coastal Health & Wellness (CHW) to prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and that is designed to cover its reasonable costs of operation. The fee schedule will be developed based off the services approved by the CHW Board of Directors.
2. CHW's fee schedule is intended to generate revenue to cover the costs associated with providing services and assist in ensuring the financial viability and sustainability of the health center. Additionally, the fee schedule will be CHW's basis for seeking reimbursement from patients as well as third party payers. CHW's fee schedule will address all required and additional in scope services.
3. It is CHW's Policy that fees will be set to cover reasonable costs and will be consistent with locally prevailing rates or charges for the service. CHW will perform an analysis to associate costs with the provision of services for consideration in the pricing analysis. Locally prevailing charges will be analyzed through a possible review of the following:
    a. Commercial sources fee analyzer utilizing an adjustment corresponding with a geographic index
    b. Medicare Physician Fee Schedule available through CHW's MCR intermediary
    c. Private providers* in CHW's community or other, similarly situated communities
    d. Other information available
4. It is the policy of CHW to have a formal review of fees performed by an independent, outside source every two to three (2-3) years. CHW will perform the analysis internally as codes are added or modified throughout the year.
    a. Each CPT and HCPCS code entered into CHW's system, manually or via yearly coding updates, is assigned a fee.
    b. CHW uses various software products to determine its fees (which may include, but is not limited to, Physician's Fee Reference software for coding pricing, Wasserman Medical Publishers, LTD and Centers for Medicare and Medicaid Services National Physician Fee Schedule RVU data.
    c. CHW analyzes its fees using commercially available billing information that considers the geographic areas that CHW serves.

* CHW will seek the advice of private legal counsel when gathering fee-related information from other providers to ensure that it does not violate anti-trust regulations.

Procedures

1. After the analysis of cost and locally prevailing charges above, CHW will decide on an appropriate pricing strategy for the fee schedule given the patient population and current reimbursement environment. CHW will document this analysis to provide support in the event of an inquiry by third parties.
2. If the board of directors approves of the provision of out-of-scope services provided by an entity other than CHW (such as a hospital) CHW will inform patients that they may be billed for the services/goods by another entity in accordance with the other entity's policies and procedures.
    a. Additional supplies non-incident to the service are priced via alternate method. Patients will be notified of additional fees in advance.
3. CHW has elected to acquire, purchase, and facilitate access to equipment, supplies, and pharmaceuticals that are related to but not included in, the services provided by CHW as part of prevailing standards of care (examples would include eyeglasses and dentures). CHW chooses to do so to improve access to these items as a means of reducing barriers to care and improving health outcomes for its patient population. Revenue generated from these charges will be used to further the project objectives.
    a. CHW will determine a charge for these items by analyzing its costs and the needs of the target population. CHW will, at its discretion, determine how to charge its patients for such supplies or equipment (for example, flat discounts, at cost, or on the sliding fee scale). Charge information for these items will be presented to the Board of Directors for approval. Prior to the provision of a service, patients will be informed by CHW of the following:
        i. When supplies or equipment related to a given service will result in separate charges from the service
        ii. The total amount of out-of-pocket costs for these supplies or equipment
        iii. Available payment plans
4. The Practice Management System will be updated annually based on release of new CPT codes, updated cost reviews, and/or carrier reimbursement reviews.

References or Regulations

- Centers for Medicare and Medicaid Services
- Physicians Fee Reference

V. PAYMENT POSTING POLICY & PROCEDURES

Related Form: Master Fee Schedule Report

Related Policy: Charge Entry Policy, Billing and Collections Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1. Coastal Health & Wellness (CHW) assures the appropriateness of applying payments to CHW patient accounts and making the appropriate adjustments in the practice management system (PMS).
2. It is CHW's policy to post all payments into the practice management system appropriately and in a timely manner. All payments should be posted within 5 business days upon receipt in a postable format.
3. All Patient and third-party payments will be posted and managed in the electronic PMS.
4. When possible, all electronic payments should be posted electronically. Only those carriers that do not allow electronic reports will continue to be posted manually.

Procedures

1. CHW accepts payments remitted and transferred directly from third-party payers by all payers offering electronic remittance advice (ERA) and electronic funds transfer (EFT). Remittances are accepted when available from the payer but are not posted until CHW accounting department staff confirms the remittance total to the funds transferred.
2. CHW accepts all non-electronic payments, including non-electronic third-party payer and patient checks, managed through CHW accounting department.
    a. Payments are tracked and logged in accounting.
    b. Payments received are posted based on deposit date.
3. All staff balance the batches assigned to them each day.
4. A transaction code is posted to the charge level on the account to identify the type of rejection.
5. Correspondence is relayed to the Billing staff member assigned to working on account follow up.
6. Health Center staff members posting payments are responsible for accurate posting on a line-item basis.
7. Health Center staff members who post payments are responsible for the transfer of the account balance to the patient or to secondary or tertiary payers (and manually or electronically mark the primary explanation of benefits unless the claim is an automatic crossover by the primary payer).

8. Payment posting is monitored closely to ensure timeliness and accuracy, as well as to identify opportunities for improvement.
9. Correspondence, including rejections, with no payment attached is flagged manually or electronically.
10. A summary of all batches posted are reconciled to the daily deposit and provided to the business office manager or designee.
11. The deposit date and posting date should match. These dates are sent with the deposit batch from accounting.
12. The batch number will include the deposit date for tracking purposes.
13. Payments received over the phone paying via credit or with debit card will be charged and posted to the patient account by the medical records specialist or designated personnel from other departments outside of billing department.
14. Payments received thru mail will be posted by the patient support specialist and reconciled and deposited by finance administrative assistant.
15. Payments will be posted to the oldest date of service with an outstanding balance unless the patient specify what date of service the payment is for.
16. Payments received at time of Service will be posted to the patient account by the patient support specialist.
17. Payments from program or third-party funding sources will be deposited by the finance administrative assistant and posted by biller and/or payment posting specialist. Remittance advices will be posted to the encounter by the payment posting specialist for reconciliation of patient accounts. The posting will occur within 7 days of receipt. Payments will be reconciled monthly based on deposit reports from the finance department.

**Claim Status should be updated to reflect any claim that is not paid in full or needs additional follow up. This is the primary search method for billing staff working accounts and is imperative to the process.

Unidentified/Incentive/Capitation Payments

1. CHW may receive payments that cannot be directly linked to a client's chart.
    a. Those payments will be posted to the unidentified payments dummy account. These payments will be referred to the AR team for research and resolution.
2. CHW may receive incentive payments that are not directly linked to a client's chart.
    a. Those payments will be posted in the incentive payments dummy account.
    b. Incentive payments will be posted according to date of receipt.
3. CHW may receive capitation payments that cannot be directly linked to a client's chart.
    a. Those payments will be posted in the capitation payments dummy account.

b. Capitation payments will be posted according to date of receipt.

4. Periodically, the business office manager or designee will select a sample of remittances from each payer and compare the payments and contractual adjustments indicated on the remittance to the payments and adjustments posted in the practice management system. Any discrepancies between information on the remittance and payments and adjustments posted in the practice management system will be addressed by the business office manager or other supervisor and the staff person responsible for posting the payments and adjustments.

Small Balances Write Offs

1. Patient small balances will be automatically written off after 180 days.
2. Small balances are amounts equal to or less than $5, which will cost more to bill for the balance than the value of the balance.
3. If the account balance is less than or equal to $5, is more than 180 days old, and there are no insurance due balances, the account balance is written off. These transactions are marked with the applicable “small balance write off” code.
4. On a monthly basis, a report is generated that identifies accounts that meet these criteria.

VI. CHARGE ENTRY POLICY & PROCEDURES

Related Form: Master Fee Schedule

Related Policy: Payment Posting Policies, Billing and Collections Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1. It is the policy of the Coastal Health & Wellness (CHW) to capture the services performed for a patient in an accurate and timely manner.
2. It is the policy of CHW to facilitate a timely and efficient billing and collections process. To that end, CHW complies with predetermined lag times for key billing processes, including submissions of claims to third-party payers in a timely manner as a courtesy to patients and to receive prompt payment for services rendered.
3. Charges for services rendered should be accurately posted by Health Center staff within 5 days of the date of service.
4. CHW will take the appropriate steps to capture services performed for a patient in an accurate and timely manner. The charges are captured via electronic medical record system or paper superbill.

Procedures

Office Procedures

1. CHW providers are responsible for submitting all procedure and diagnosis codes on the same day when rendering services in the office, and 72 hours for services rendered out of the office.
2. Charge capture includes the following information for every patient encounter regardless of the site of service. (Note the practice management system provides several of these elements electronically.)
    a. Patient name
    b. Patient identification
    c. Date of birth
    d. Attending provider
    e. Place of service
    f. Date of service(s)
    g. Procedure code(s)
    h. Diagnosis code(s) – appropriately linked to procedure codes, if applicable
    i. Additional information as needed to process the charge

j. Referring physician, if applicable

3. The provider documents all services rendered to the patient in the electronic medical record.
4. The provider completes charge documentation at the time the service is rendered.
5. Diagnosis "rule outs" are not permitted. A diagnosis must be made and coded based on information available and symptoms presented.
6. Providers must match procedure codes to the appropriate diagnosis codes using a numeric method and/or via the methodology provided by the practice management system for linking diagnosis codes when multiple procedures codes are used.
7. Providers are responsible for documenting and coding all procedure and diagnosis codes into the EHRS or on n the charge ticket. Procedure and diagnosis codes are created for each unique patient visit.
8. Encounters or charge tickets with incomplete or illegible charge data are flagged or returned to the originating provider for completion to ensure expedient billing and collection.

Billing Staff Procedures

1. Timeliness and accuracy of charge coding and medical record documentation are regularly reviewed. Every effort is made to eliminate errors in registration, procedure and diagnosis coding and charge entry to ensure timely reimbursement.
2. Charges are posted in the practice management system within one business day of being received at the business office, through the electronic medical record or data entry by a staff member from a paper charge ticket.
3. Using available electronic or manual tools and resources, CHW staff is responsible for reviewing and editing charges before they are submitted.
    a. During the review process, any discrepancies are resolved immediately.
    b. If necessary, the provider rendering the service for which the charge is being billed is contacted in person, via an internal email communication regarding the charge.
    c. Providers have two business days to respond to questions about charges.
    d. Charge edits are resolved within three business days.
4. CHW staff submits prepared claims within two business days of charge entry.
5. CHW staff monitor the period of the claim's submission to payment by the payer.
6. The lag times for the following key processes are monitored by Billing staff. Outliers are reported to the service line directors. The key processes are:
    a. Date-of-service to date-of-charge submission versus documentation and coding must occur within a reasonable timeframe.
    b. Date-of-charge submission to date-of-claim submission
    c. Date-of-claim submission to date-of-payment by third-party payer

d. If applicable, additional key processes will be identified and monitored by the business office manager and/or executive team or designee.

VII. CLAIMS SUBMISSIONS POLICY & PROCEDURES

Related Form: Master Fee Schedule

Related Policy: Payment Posting Policies, Billing and Collections Policy, Charge Entry Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

It is the policy of Coastal Health & Wellness (CHW) to conform to industry standards to assure prompt billing and collections from insurance carriers and patients. Billing of claims are processed and followed up in a timely manner

Procedures

1. Following the edit process, clean claims are sent electronically real time or by the end of the business day.
2. Exception reports generated from the submission are worked on a same-day basis.
3. Claims are not suspended / held unless necessary.
4. Claims placed on hold status and monitored by the billing directors to ensure suspended/ held claims are resolved expediently.
5. CHW submits secondary claims in the event a patient maintains a secondary insurance policy and the primary insurance carrier does not pay the full amount of the charge. The secondary insurance carrier is billed for the remainder of the balance CHW makes best efforts to work with payers to crossover secondary claims automatically. If not, the primary explanation of benefits (EOB) is flagged manually or electronically and submitted to a CHW staff member to bill the secondary insurance carrier.
6. Within 24 hours of notification of responsibility of the secondary payer, the secondary claim(s) are submitted.
7. The full balance of primary and secondary claims submitted to third-party payers with whom the CHW does not participate may be transferred to patient responsibility.
8. For services covered under a capitated plan, charges are automatically adjusted by the practice management system. If a patient receives a service for which the patient is covered, but which is not included in the capitation agreement, a claim is sent to the third-party payer.

VIII. BILLING RECORDS RETENTION POLICY & PROCEDURES

Related Form: Release of Medical Records, Patient Financial Policy

Related Policy: Medical Records Policies

Responsible Department: Billing Department

Board Approval Date:

Policy

It is the policy of Coastal Health & Wellness (CHW) to maintain original billing and financial documents in accordance with CHW medical records retention policies.

Procedures

Confidentiality

1. Patients as well as the billing staff will be made aware that the electronic medical record and the information contained within are to be held in strict confidence. This will be done by providing a written privacy policy to all patients (or their legal guardian) and posting the privacy policy in a public area within CHW. HIPAA training upon hire and ongoing annual HIPAA refreshers will make the clinic staff aware of this.
2. A patient must give written permission for the release of medical information for billing purposes. A parent or legal guardian must supply this permission for a minor. The patient Financial Policy will be signed to give permission to release records as needed for billing purposes. The only exception to this is when records are released from provider-to-provider for continuing medical care for the patient.

Record Release and Retention

1. Original billing records such as EOBs, Patient Financial Statements, Signed Sliding Fee documentation shall be maintained in HIPAA secure storage in accordance with CHW medical records retention policies.
2. A billing Manager will review documents and approve the release of medical records to support patient charges or insurance or regulatory audits prior to the release of records.

IX. BILLING & COLLECTION POLICY & PROCEDURES

Related Form: Patient Refund Request Form

Related Policy: Medical Fee Waiving Policy; Refusal to Pay Policy, Sliding Fee Adjustment Policies

Responsible Department: Billing Department

Board Approval Date:

Policy

1. It is the policy of Coastal Health & Wellness (CHW) to conform to industry standards to assure prompt billing and collections from insurance carriers and patients. Billing processes including but not limited to assignment of codes, electronic submission of claims, appeals for denied claims as well as collections processes are processed and followed up in a timely manner.
2. Although we do not utilize an outside collection agency, collection efforts are continued for a minimum of 120 days. These are conducted in an efficient, respectful, and culturally appropriate manner, that assures that procedures do not present a barrier to care, and patient privacy and confidentiality are protected throughout the process. At 120 days with no payment or activity on account the balance will be adjusted following the guidelines for aging of patient accounts.
3. It is CHW's policy to maximize revenue from public and private third-party payers and make reasonable efforts to obtain reimbursement from those parties, including public health agencies.
4. It is the goal of CHW to submit clean claims to third-party payers in a timely manner as a courtesy to patients and to receive prompt payment for services rendered.
5. CHW will participate in Medicaid, Medicare, CHIP, and as appropriate, other public and / or private assistance programs or health insurance. CHW has procedures in place to educate patients on health insurance options available to them based on their eligibility for insurance and / or related third party coverage.
6. All reasonable efforts to secure payment from patients for services rendered are made by billing and front desk to collect the payment in full. Payment plans are acceptable and offered when appropriate. Collection attempts are made and continued, and additional meeting with eligibility to determine if additional financial hardship is needed.
7. To assure data integrity, CHW will perform daily balancing and full monthly close procedures as soon as reasonable after the last day of each month.

Procedures

Patient Payments and Collections

1. Patients will be offered screening for program eligibility and/or sliding fee program.
2. Dues from insured patient (co-payment, co-insurance and/or deductible):

a. The copayment, co-insurance or deductible is the minimum amount expected for the services provided and are requested at each visit. No patient will be refused service based on inability to pay.

b. At each visit, the patient support specialist will notify the patient of the current amount due and any outstanding balance(s) and will attempt to collect on the balance(s), remind the patient of their financial obligation, and/or inform the patient of the financial arrangement option(s).

3. Dues from self-pay patient:

    a. Patients are expected to make a payment before seeing the provider. The patient support specialist will request the payment upon check-in. No patient will be refused service based on inability to pay.

    b. At each visit, the patient support specialist will notify the patient of the current amount due and any outstanding balance(s) and will attempt to collect on the balance(s), remind the patient of their financial obligation, and/or inform the patient of the financial arrangement option(s).

4. Patients who are unable to pay for their services on the day of the visit should be referred to *Refusal to Pay Policy and Procedure* to establish a financial arrangement option. Payment arrangements can be initiated by patient support specialist and must be approved by site lead and above at the clinic. The payment arrangements are only available on accounts with balances greater than $25.00.

5. A statement will be sent to the patient with outstanding balance due on their patient account. The patient has an option to pay by cash or with credit card at one of CHW location, mail in check or credit card information.

6. CHW is committed to assuring that all reasonable collections efforts are made prior to writing off unpaid balances to bad debt. A minimum of 3 statements will be sent to patients with balances over $25.00.

7. CHW provides education to patients on insurance and, if applicable, related third party coverage options available to them.

Aging and Write-off

1. Accounts with remaining balances (positive or negative) of less than one ($1- $10) dollars may be written off within a reasonable amount of time at billing and insurance verification coordinator discretion.

2. All self-pay balances and patient owed after insurance paid that are greater than 180 days and/or 3 statements have been mailed out shall have their account verified that they have at least 3 statements, then the account shall be written off as bad debt.

3. Accounts with balances greater than 365 days and in a bad debt status will be adjusted off an account as uncollectible.

4. To be considered for write-off, the billing department must be able to demonstrate that adequate steps were taken to collect the amount due.
5. Anything found questionable must have approval from the Chief Operating Officer.

Patient Complaints about Patient Fees

1. The patient support specialist should explain the billing process to the patient.
2. If the patient's concerns are not adequately addressed, the patient support specialist should refer the patient to site lead.
3. Site lead will use their discretion in resolving the patient concern. Patient concerns and resolutions must be note on the EHR. Potential resolutions include, but are not limited to the following:
    a. Accepting partial payment for services that day and defer remainder of the balance to the next visit.
    b. Initiate arrangement for payment plan.

Refunds/Credits

1. It is the goal of CHW to return all monies that are not due to the Health Center. These may include overpayments from patients or third-party payers. CHW is committed to complying with state and federal laws, as well as to minimize the impact that refunds have on receivables (i.e., refunds negate receivables) and management reports regarding business office performance.
2. Overpayments are flagged at the time the payment is posted and the ticket is moved into overpayment status.
    a. CHW billing staff works these refunds ensuring the overpayment status if appropriate.
    b. The staff member completes a Refund Request Form to request the refund check be processed.
    c. A thorough review of the account is conducted to determine the cause of the credit balance.
    d. If a posting error caused the credit balance, a refund is not made.
    e. Thorough documentation of the refund is placed in the notes section of the patient's account.
3. In addition to proactively refunding credits created during the posting process, the billing department is responsible for refunding outstanding credits.
    a. The accounts should be reviewed thoroughly.
4. Credit invoices are identified and refunded to the patient, guarantor, or third-party payer within 30 days.
    a. Any credits identified that can be transferred to another outstanding invoice are done within 30 days of creation date.
    b. The oldest credits should be processed and refunded first.

5. If a credit balance occurs for a guarantor with multiple patients on the account and a debit balance remains on the total account, the credit is posted as an open balance payment.
6. Refunds are posted to the patient's account when the refund check is issued.
7. Requests for refund checks are submitted to the business office manager or designee in writing or via internal email on the Refund Request Form and require the designated supervisor's signature

Insufficient Fund Checks and Unredeemed Refund Checks

Insufficient Fund Checks will be handled by the finance department. Refund checks written to patients that are not redeemed within 90 days, the finance department will reach out to the patient. If the patient is not reachable within a reasonable time period, the check will voided and either leave the credit balance on the patient account or report to the Texas State Comptroller as unclaimed property by the finance department.

Changes in Assigned Billing Codes

The Billing Department does not change codes other than written procedure, or with permission from the attending provider.

If provider clarification is needed either because of an internal chart review or at the request of an insurance carrier, communication from billing leadership regarding the requested clarification will be made to the rendering provider. The communication will request appropriate documentation/charting and provide a clear, concise request for the clarification needed.

Any change or update to codes will have the reason for the code change appropriately documented and will comport with CHW's PMS procedure and appropriate coding guidelines (see AAPC and AHIMA standards). The reason for code changes will be appropriately documented.

Denials/ Rejections

All claim rejected by clearinghouse must be identified, corrected, and resubmitted within 5 business days. All claim denied by insurance should have valid reason behind the claim denial and appropriate action to be taken within reasonable time period. Below are the most common denial reasons:

Claim denied for incorrect information.

- Incorrect provider information.
- Incorrect coverage information.
- Lack of information.

Claim denied as inclusive with the primary procedure

Some service covered with primary procedure; hence we need to write off the claim balance after primary CPT paid. This is important to watch for claims that go out with both a T1015 and a CPT code. If T1015 pays the encounter rate and the visit is paid in full, any balance should be adjusted off appropriately. However, if CPT is payable separately - will resubmit the inclusive procedure with modifier.

Claim denied as services not provided or authorized

- File the claim along with appropriate authorization#.

- If we do not have authorization #, sometimes we can appeal the claim along with necessary medical document. Confirm if the visit had an authorization.
- If no authorization is on file, contact carrier and request retroactive authorization; resubmit claim.
- If no authorization can be obtained, adjustment should be made.

Claim denied because of incorrect medical coding

- Billing department email list of charts to be corrected to CHW provider. After the charts being corrected, billing staff reviews the charts to confirm correct information and resubmit/ appeal the claim with correct diagnosis (DX) and CPT.

Denied insurance claims due to invalid CPT code

- The claim should be filed with valid CPT. The billing department needs to contact EHR administrator to update the database if need.

Claim denied because primary insurance changed

- File the claim to patient primary insurance if additional coverage is on file.
  - Check copy of the insurance card to see if additional coverage is listed (for example – TCHP will list primary coverage if it exists). Update registration, re-file claim.
  - If we don't have patient primary insurance details, we need to call the patient and get the insurance information. Verify new coverage, update registration and re-file appropriate claims.
  - If patient has no coverage, update visit to self- pay. Balance will be posted to patient's account. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify for additional payer sources.

Claim denied for coordination of benefits

- Patient needs to update the COB information to insurance. If patient has more than one insurance, patient need to call the insurance and inform which insurance is primary and secondary for patient. Update registration; refile claims appropriately. Check copy of the insurance card to see if additional coverage is listed (for example – TCHP will list primary coverage if it exists). If we can confirm term date with patient, we can contact carrier with term date; update registration; refile claims appropriately.

Claim denied for maximum benefits reached.

- File the claim to secondary along with denied EOB. If patient does not have secondary insurance, update visit to self- pay. Balance will be posted to patient's account. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify for additional payer sources.

Claim denied for retroactive termination date

- Contact the patient to verify updated coverage. If no coverage in place, change financial class to self-pay and invoice the patient. Payment plan option is available.

Claim denied for invalid referral number

- The claim should be filed with valid referral number. If we do not have valid referral number, we can request the same from referring doctor and refile the claim with valid referral. (May apply for specialty services where patient has another PCP).

Denied benefits is not covered by the patient's plan

- Update visit to self-pay. Balance will be posted to patient's account. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify for additional payer sources.

Claim denied dates of service over filing limit

- Claims should be filed within the filing limit according to CHW guidelines. If the denial for TFL is received, we can appeal the claim with TFL proof. Confirm filing / batch information and resubmit claim with proof of timely filing. If no proof of timely filing exists, submit to billing supervisor for adjustment.

Claim denials bundling inclusive

- Needs to differentiate the service by using appropriate modifier and DX code.

Claim denied primary paid in full

- Need to adjust the claim balance. (T1015 plus CPT code – adjust off once full encounter rate is paid, if CPT is not payable individually).

Claim denied because we are not PCP

- Contact carrier to confirm PCP was updated to CHW; if so, request retroactive date to accommodate claim. If not, contact patient and have them update the PCP to CHW and request retroactive date to accommodate visit date. Update visit and re-file appropriately. If unable to contact patient, make a note on EHR to have PCP updated prior to next visit.

Claim denied due to non-billable service or provider

- If a service and/or the provider is non billable, adjust visit.

Insurance Follow Up

1. CHW Billing Department is required to follow up on all monies owed to the Health Center by third-party payers in a timely and effective manner.
2. Insurance follow-up work is divided among CHW staff members equitably, based on the amount of work; according to the volume of accounts; work required by each payer as determined by the availability of automation, ease of communication, clarity of payment policies; and other factors that may dictate the time required to work the account.
3. CHW staff assigned the duty of insurance follow up are responsible for using all available resources and making all appropriate efforts to obtain outstanding payment on claims.
4. CHW Billing management or designee generates and provides reports from the practice management system to support Health Center staff engaged in follow up.
5. All actions taken on an account are documented, including the nature of the action, the date and the individual taking the action.
6. It is the responsibility of CHW staff members engaged in follow up to track future work generated, such as reviewing an account 30 days after an appeal letter is sent. Every staff member involved

should use the practice management system's automated follow-up tickler system, if available, or an automated calendar reminder system on his or her desktop.

7. Insurance follow up is divided into two distinct, but related responsibilities: rejection or denial management and open or outstanding claims.

Claims Rejections

1. CHW Billing staff is required to identify, monitor, and act on all submitted claims that are rejected by third-party payers.
2. CHW staff is assigned responsibility for reviewing and acting on all rejected or denied claims.
3. These staff members receive all correspondence regarding rejections within one business day of receipt at the CHW (during the payment posting process).
4. All rejections are reviewed and acted upon within 2-3 business days of receipt.
5. CHW staff use all available resources to research and correct the claim, including but not limited to documentation of the service, medical literature, precertification and authorizations, procedure and diagnosis coding manuals and reference materials, specialty society policy statements, third-party payers' payment policies, and state and federal government coverage policies.
6. Depending on the nature of the rejection, a claim is corrected and resubmitted, or an appeal is communicated over the telephone, via the payer's website or in writing to the third-party payer.
7. Rejected claims are not resubmitted without documentation of the service. Identifying claims without documentation of the service must be brought to the attention of the CHW compliance officer immediately.
8. Rejected claims are not resubmitted without corrections. Resubmitting a rejected claim without correcting it is grounds for disciplinary action.
9. The business office monitors, and research claims denied by third-party payers to determine the causes of rejections. The claims rejection report, generated from a manual tracking report by CHW staff or automatically from the practice management system, is analyzed to determine specific claims that have been denied and the causes for denial. The analysis is used to train providers and staff.
10. CHW staff will work to proactively identify and resolve any problems with open or outstanding claims from third-party payers.
11. A CHW staff member assigned responsibility for insurance follow up runs an open claims report once a month, at minimum.
12. A report is run that identifies all outstanding claims, by payer and based on the payer's average payment timeframe. For example, if CHW expects all clean Medicare claims to adjudicate properly within 14 days, an open claims report is run for all outstanding claims more than 15 days. The report is organized in hierarchical order, with the highest dollar amount outstanding listed first.

13. The staff member responsible for this function uses all of his or her skills, experience, resources and knowledge to identify the status of an outstanding claim and take action. Action may include, but is not limited to:
    a. Identifying that the claim was never received and resubmitting the claim;
    b. Submitting medical documentation to third-party payers if the claim is under review;
    c. Appealing an adverse decision for payment; or
    d. Communicating with the patient if the third-party payer is waiting for information from the patient.
14. If the staff member identifies a series of open claims from a specific date-of-claim transmission, the billing management or designee is alerted to determine if the source of the open claims was a failed batch (i.e., it failed to transmit to third-party payers). In that case, the affected claims are resubmitted immediately.
15. The staff member is expected to follow up on all outstanding claims until payment is received or a determination is made that the claim should be transferred to another party's responsibility or written off.

Write Offs

1. CHW billing staff will track and monitor all monies that are written off from the original charge submitted to a third-party payer. Two distinct categories of write offs are handled and monitored separately: contractual amounts, which are considered uncollectible because of a contractual agreement with a third-party payer and non-contractual amounts, which are considered uncollectible for reasons other than the contract. See Adjustments for Sliding Fee Policy
2. To track and monitor all write offs, CHW maintains a dictionary of detailed adjustment codes for contractual and noncontractual write offs. The noncontractual write offs also may be attached with transaction message codes, if applicable.
3. Billing office staff may write off contractual adjustment amounts when payments are posted to the practice management system. These write offs must be done using appropriate contractual adjustment codes.
4. From time to time, CHW staff may work on an account that has an outstanding balance with a health plan that cannot be collected. The reasons for CHW's inability to collect on the account may include, but are not limited to, a missed timely filing or appeal deadline, or failure to obtain an appropriate authorization or referral. Billing management reviews adjustment batches daily for accurateness.

X. MEDICAL FEE WAIVING POLICY & PROCEDURES

Related Form:

Related Policy: Refusal to Pay Policy; Sliding Fee Program Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

In accordance with the mission of Coastal Health & Wellness (CHW) and as an FQHC, it is our fundamental policy that the lack of means does not hinder care while additional ensuring that each of our patients are treated equally and fairly.

Procedures

1) Patients who present for care without the means for payment should follow first the policy for Sliding Fee Program to determine their poverty level. The patient who falls into a category that they are unable to fulfill must further discuss with the eligibility specialist on their current financial hardship (e.g. bankrupt, loss of employment, loss head of household) and/or medical hardship (e.g. terminally ill) to provide protection from undue financial burden. The fees may be reduced or waived all together.
2) It is CHW's Policy to identify specific circumstances for patients when CHW will waive or reduce fees or payments required by the center due to any patient's inability to pay. CHW's waiver process is as follows:
3) All attempts are made by billing and front desk to collect the payment in full. In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by eligibility, billing or designated staff. Any waiving of charges should be documented in the patient's file along with an explanation.
4) Patients that are screened and identify as homeless may fall into a category also known as CHW Care. Patients approved under CHW Care are allotted under a $0 fee for "immediate medical needs". All other services that don't fall under this criterion, will be charged under a category I.
5) Other waiver criteria include but is not limited to the following:
    a) Chronic illness
    b) Financial problems related to transportation or other unexpected expenses
    c) Natural disasters
        i) House fire
        ii) Loss of primary income sources
        iii) Death of a family member defined above

d) The site lead and above may make an exception in the fees once the financial hardship is established. Documentation of the required fee, the amount of fee to be waived and the specific reason and length of hardship must be documented in the patient record. All documentation must be completed, and the additional hardship will be in effect for a period of up to 3 months and then re-evaluated.

e) It is the responsibility of front office department to follow guidelines to prevent and detect the occurrence of fraud and abuse of medical fee waiving.

f) In the case of patient deceases and a copy of death certificate is provided, the outstanding balance on deceased patient account shall be waived or written off by billing department.

g) The decision to waive fees will be applied and made available consistently to all qualified patients

XI. REFUSAL TO PAY POLICY & PROCEDURES

Related Form: Registration Form; Payment Plan Form

Related Policy: Medical Fee Waiving Policy; Sliding Fee Program Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1) In accordance with the mission of Coastal Health & Wellness (CHW) and as an FQHC, it is our fundamental policy that the lack of means does not hinder care while additional ensuring that each of our patients are treated equally and fairly. This policy provides guidance for identifying and handing refusal or unwillingness to pay.
2) CHW distinguishes the difference between refusal to pay and inability to pay and notifies patients that refuse to pay of:
    a) Amounts owed and the time recommended to make such payments.
    b) That they will receive statements for their services.
    c) That CHW offers other assistance such as meeting with a financial counselor, establishing payment plans, and looking for additional programs that may assist the patient.
    d) That some optional services, such as special dental services, contact lenses, referred out services, or supplies will not be given for patients that completely refusal to pay or comply with Sliding Scale policies.
3) A patient is deemed unwilling to pay if they:
    a) Declare they will not pay for anything at the time of service.
    b) Have a balance due more than $200 and have not made a payment within the last 3 months.
    c) Refuse or fail to make a payment as agreed in the formal payment plan after a payment plan has been signed.
    d) Refuse to meet with an eligibility specialist to have their financial status re-evaluated.

Procedures

1) Patients who express an unwillingness or refuse to pay will be referred to a billing / eligibility specialist to assess their current financial / medical hardship status as per CHW's policy. CHW provides several options to patients to pay and those options include payment plans, waiver policies, and financial counseling. CHW does not choose to limit or deny services if accounts are unpaid.
2) All patients who present for care without the means for payment should follow first the policy for sliding fee program to determine their poverty level; specifically filling out the sliding fee discount program registration form and income documentation (refer to *Sliding Fee Adjustment Code Policy &*

Procedures). A patient who falls into a category that they are unable to fulfill must further discuss with the billing/ eligibility specialist on their current financial hardship (refer to Medical Fee Waiving Policy).

3) If a patient verbally expresses an unwillingness to pay, they will be made aware of the option to apply for the sliding fee discount program and/or they will be informed option to set up a payment plan for amounts owed to CHW.

4) If a patient leaves the premises without paying for services, applying for the sliding fee discount program or establishing a payment plan, a billing alert shall be documented by the front office personnel. The patient will then be notified regarding their financial responsibility either via phone call and/or mailing statement.

5) If the patient does not try to pay or fail to respond within 60 days, this constitutes refusal to pay.

6) If the patient who has been deemed unwilling to pay presents with an acute medical problem that requires immediate attention, the patient will receive care as scheduling allows without regard to ability to pay. The patient will be informed of the current balance owed to CHW and made aware of the expectation for future payment.

XII. SLIDING FEE ADJUSTMENT CODE POLICY & PROCEDURES

Related Form:

Related Policy: Sliding Fee Program Policy, Billing and Collections Policies

Responsible Department: Billing Department

Board Approval Date:

Policy

In accordance with the mission of Coastal Health & Wellness (CHW) as an FQHC, it is our fundamental policy that no one will be denied care for their inability to pay. Therefore, if a patient is qualified for sliding fee program, a sliding fee adjustment (SFA) code will be applied as a write off code.

This policy is to set forth procedures that assure the SFA code is applied to only those transactions that are subject to sliding fee discount program.

All self-pay patients will have their fee identified (Category A thru Category E). The difference between the full price and the fee/payment received will be written off using Sliding Fee Adjustment (SFA) code. On a monthly basis, the billing coordinator will review charts with SFA code applied to the patient chart.

Procedures

Note that SFA code only applies to office visit CPT code (992xx and 993xx). Therefore, the sliding fee adjustment amount would be office visit price – patient payment for office visit. From the sample above, the sliding fee adjustment would be $345 - $35 = $310.

1) On a monthly basis, the Billing Representative will review sliding scale list of patients with balances greater than 180 days.
2) Adjustments shall be made according to agreed upon sliding fee percentage.

XIII. GOOD FAITH ESTIMATES

Related Form:

Related Policy: Sliding Fee Program Policy, Billing and Collections Policies

Responsible Department: Billing Department

Board Approval Date:

Policy

Patients have the right to receive a "Good Faith Estimate" (GFE) explaining how much your medical care will cost.

Under the law, health care providers need to provide patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

Our patients have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, etc.

Make sure patients are aware and you give them you a Good Faith Estimate in writing at least 1 business day before their medical service or item. Patients can also ask their health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

Patients receiving a bill that is at least $400 more than your Good Faith Estimate, can dispute the bill. The Billing Manager is responsible for researching any patient concerns regarding a GFE. The clinical leaders will respond to a patient's concern withing 5 business days of receipt.

A copy or picture of your Good Faith Estimate shall be saved in the patient's record. For questions or more information about Good Faith Estimates, visit www.cms.gov/nosurprises or contact our Billing and Collection Specialist at (409) 938-2248 or email@gchd.org.

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Governing Board
December 2022
Item#7
Informational Report

a) Proposed 2023 Board Meeting Dates

Governing Board
2023 Meeting Dates

January 26, 2023

February 23, 2023

March 30, 2023

April 27, 2023

June 1, 2023

June 29, 2023

July 27, 2023

August 31, 2023

September 28, 2023

October 26, 2023

November 9, 2023

December 7, 2023

Back to Agenda

Governing Board
December 2022
Item#8
Coastal Health & Wellness Updates

a) Update on COVID-19 Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director

Back to Agenda

Don't skip out on flu vaccine this year

It's not too late to get your flu vaccine! Dec. 5-9 marks National Influenza Vaccination Week, and serves as a reminder for everyone ages 6 months and older to get their annual flu vaccine if you haven't already.

The flu vaccine is the best way to prevent becoming sick with the seasonal illness, and now is the time to get vaccinated.

Children who need two doses of vaccine to protect against the flu should start the process soon since the two doses must be given at least four weeks apart. People 6 months and older should be vaccinated against the flu. Vaccination is especially important in high-risk groups including those ages 65 and older, pregnant women, young children and those with chronic health conditions who are at higher risk for complications or even death if they get the flu.

Call us today at 409.938.2234 to schedule your flu vaccine appointment. Learn more about this flu season.

Don't wait to sign up for Marketplace Insurance

In need of affordable health insurance for you and your family? You've still got time to sign up for coverage through Marketplace Insurance. You can enroll by Dec. 15 for coverage that starts Jan. 1.

If you don't have health insurance through your job, Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or another source that provides qualifying health coverage, Health Insurance Marketplace can help you get coverage.

All offered plans cover essential health benefits, pre-existing conditions and preventive services including maternity care, mammograms and other preventive care services. You cannot be denied health coverage for having pre-existing conditions such as diabetes, hypertension and cancer.

The certified application counselors at Coastal Health & Wellness stand ready to assist Galveston County residents apply for coverage in the 2023 Marketplace. Give us a call at 409.949.3439 for assistance.

Learn more about Open Enrollment for 2023 Marketplace.

CHW celebrates National Radiologic Technology Week

Coastal Health & Wellness celebrated National Radiologic Technology Week, Nov. 6-12, with our wonderful CHW radiology technicians!

This week highlights the important role medical imaging and radiation therapy professionals play in patient care and health care safety.
Thank you to our fantastic CHW XRay team: Jessica Rodriguez, Cherree Windham, Luisa Martinez, Virginia Lyle and Celina Bullock.

CHW kicks off Unite Us collab to serve patients

Coastal Health & Wellness last month kicked off its collaboration with Unite Us, a program that allows CHW to connect patients to local organizations and resources to meet their health and social care needs.

CHW hosted a networking breakfast with Unite Us and area organizations to learn more about the program and how they can combine efforts to help patients in need.

CHW patient thanks medical team for dedication

Coastal Health & Wellness patient Lucina Lezama recently delivered pizza to the Coastal Health & Wellness medical team as a thank you to Julio Garza, PA-C and the medical team's hard work and dedication to patients.

Thank you for the kind gesture, Ms. Lezama!

National Handwashing Awareness Week, Dec. 4-10

CHW unveils new ads on local transit buses

Coastal Health & Wellness in November began advertising with the Gulf Coast Transit District on transit buses with routes in Texas City, Dickinson, Bacliff/ San Leon and La Marque.

CHW signed a 12-month contract with the bus transit company and kicked off the new marketing initiative with Marketplace Insurance open enrollment ads. Other marketing campaigns will focus on specific services, target patient populations and highlighting new programs for patients.

Tips to keep it healthy this holiday season

How do you stick to your healthy eating plan this holiday season when everyone around you seems to be splurging? Check out these tips that can help:

Holiday-proof your plan: Eat close to your usual times to keep your blood sugar steady.

Make healthier choices: Have a small plate of all the foods you enjoy. Start with veggies to take the edge off your appetite.

Fit in favorites: No food is on the naughty

Stay in touch with Patient Portal

Have you heard about our new patient portal? It's an easy way to get in touch with your Coastal Health & Wellness team.

- Request and view appointments
- Send a message to your medical provider and CHW team
- View a summary of your health record and lab results
- Request prescription refills
- Pay statements

Call us at 409.938.2234 to learn more!

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Governing Board
December 2022
Item#9
Consider for Approval October 2022 Financial Report
Submitted by Trish Bailey

COASTAL HEALTH & WELLNESS

Governing Board

FINANCIAL SUMMARY

For the Period Ending

October 31, 2022

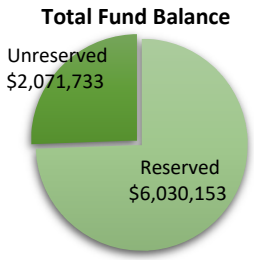
December 8, 2022

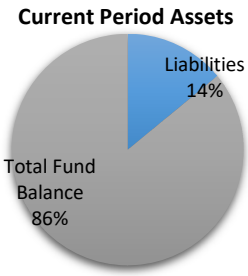
GCHD Board Room | 9850-A Emmett F. Lowry Expy. | Texas City, TX 77591

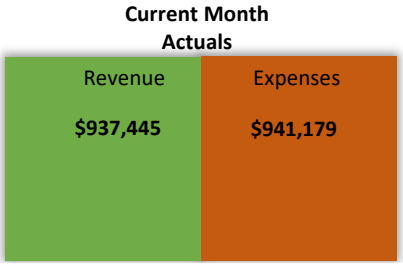
CHW - BALANCE SHEET

as of October 31, 2022

	Current Month Oct-22	Prior Month Sep-22	Increase (Decrease)
ASSETS			
Cash & Cash Equivalents	$7,682,856	$7,787,149	($104,294)
Accounts Receivable	3,778,121	2,879,920	898,200
Allowance For Bad Debt	(1,470,131)	(1,426,676)	(43,455)
Pre-Paid Expenses	301,504	314,187	(12,683)
Due To / From	(144,896)	(289,259)	144,362
Total Assets	**$10,147,453**	**$9,265,323**	**$882,130**
LIABILITIES			
Accounts Payable	$273,396	$53,940	$219,456
Accrued Salaries	574,954	464,324	110,630
Deferred Revenues	580,420	24,642	555,778
Total Liabilities	**$1,428,770**	**$542,906**	**$885,864**
FUND BALANCE			
Fund Balance	$8,131,580	$8,131,580	0
Current Change	587,103	590,836	(3,734)
Total Fund Balance	**$8,718,683**	**$8,722,417**	**($3,734)**
TOTAL LIABILITIES & FUND BALANCE	**$10,147,453**	**$9,265,323**	**$882,130**







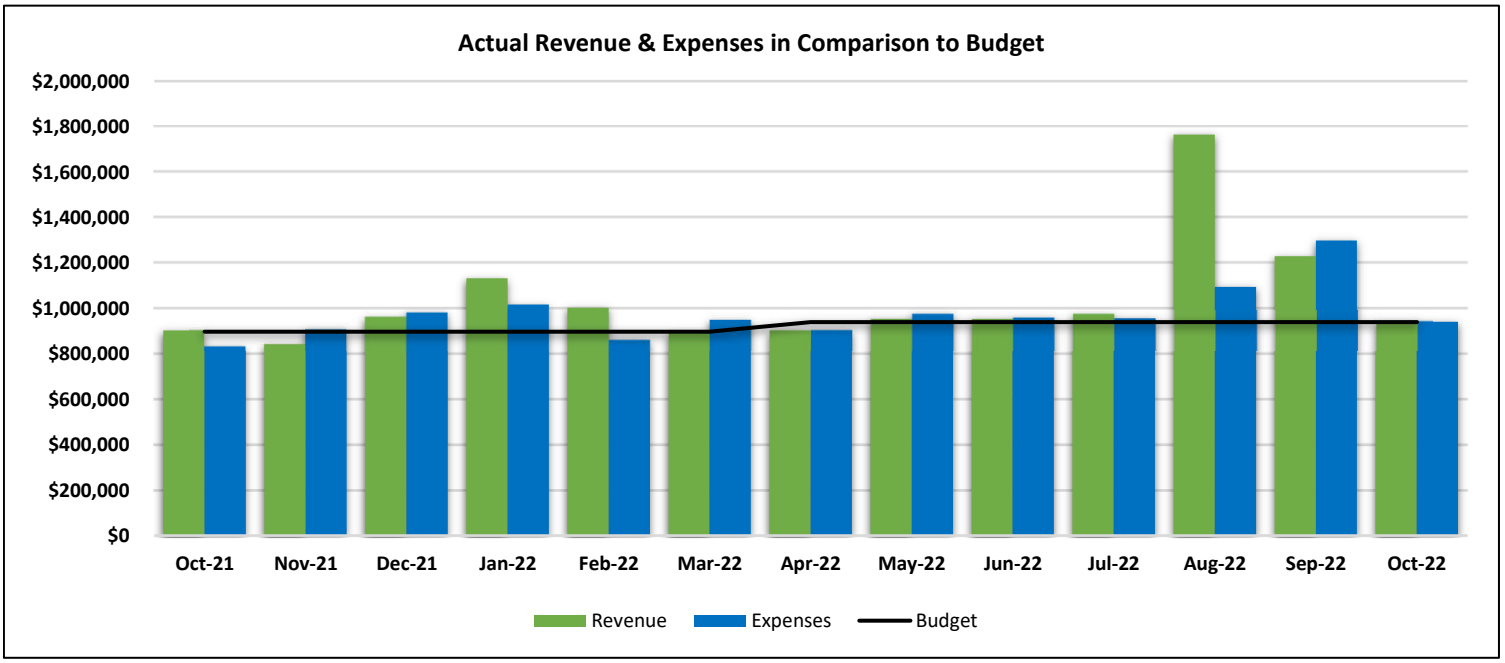
CHW - REVENUE & EXPENSES

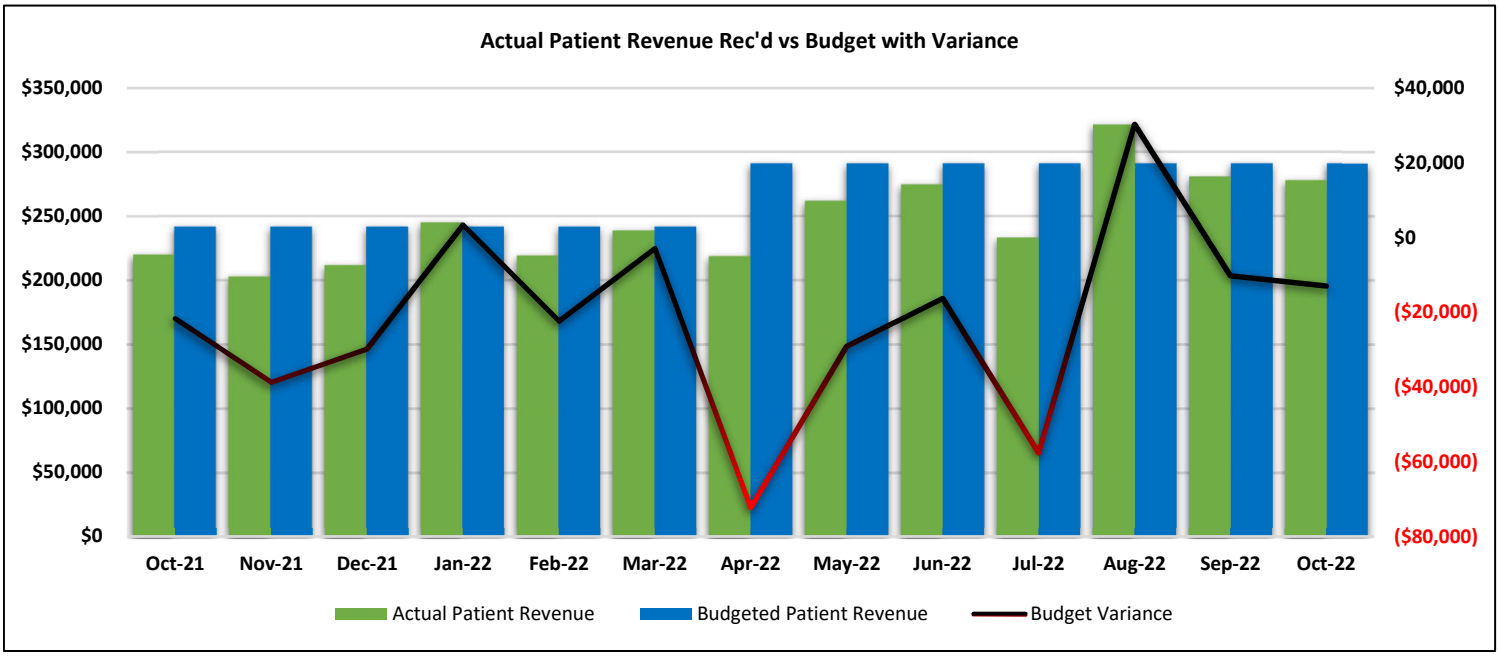
as of October 31, 2022

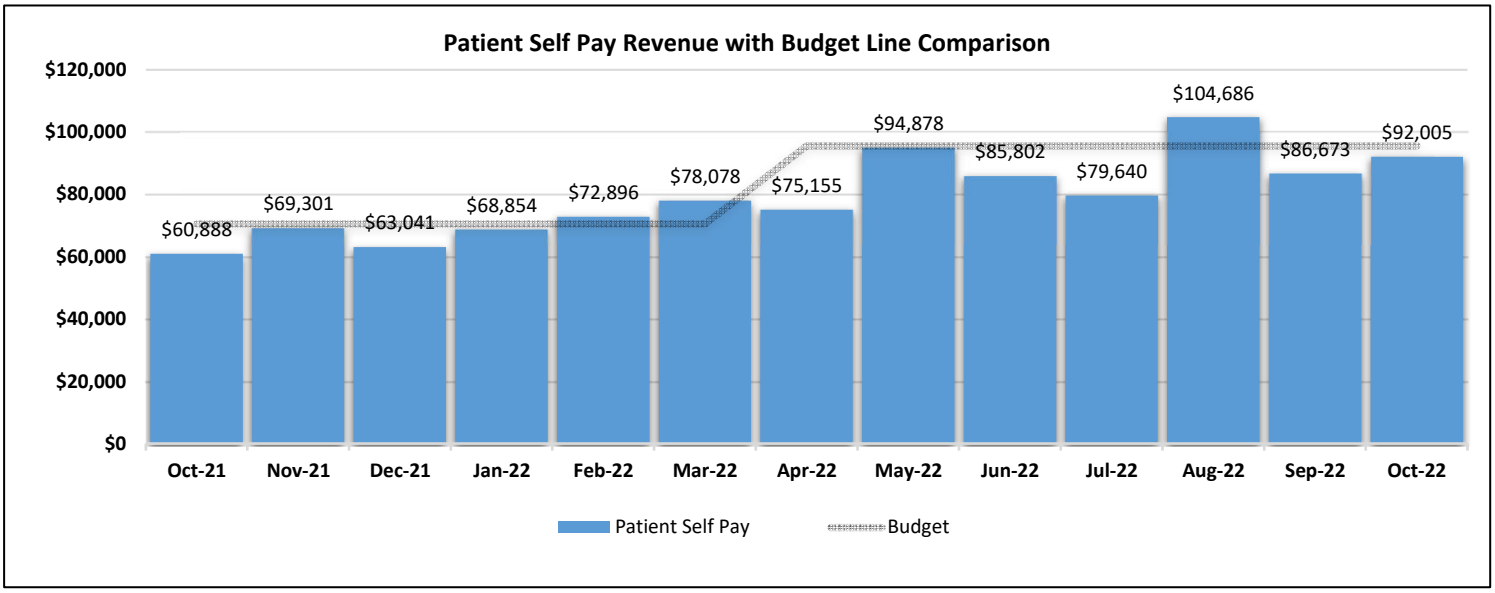
	MTD Actual Oct-22	MTD Budgeted Oct-22	MTD Budget Variance	YTD Actual thru Oct 2022	YTD Budget thru Oct 2022	YTD Budget Variance
REVENUE						
County Revenue	$277,889	$311,222	($33,333)	2,145,222.42	$2,178,556	(33,333)
DSRIP Revenue	0	62,500	(62,500)	712,500	437,500	275,000
HHS Grant Revenue	372,994	269,783	103,211	2,913,822	1,888,483	1,025,338
Patient Revenue	277,997	290,952	(12,955)	1,868,505	2,036,663	(168,159)
Other Revenue	8,566	4,976	3,590	67,669	34,830	32,839
Total Revenue	**$937,445**	**$939,433**	**($1,988)**	**7,707,717**	**$6,576,032**	**1,131,685**
EXPENSES						
Personnel	$725,885	$618,574	($107,311)	4,645,550.30	$4,330,015	($315,535)
Contractual	7,572	77,767	70,194	534,197	544,368	10,171
IGT Reimbursement	0	20,569	20,569	235,125	143,981	(91,144)
Supplies	45,288	84,323	39,035	555,679	590,263	34,584
Travel	0	3,278	3,278	16,924	22,945	6,021
Bad Debt Expense	43,455	33,454	(10,001)	298,949	234,177	(64,772)
Other	118,978	101,469	(17,509)	834,190	710,282	(123,907)
Total Expenses	**$941,179**	**$939,433**	**($1,745)**	**7,120,614**	**$6,576,032**	**($544,582)**
CHANGE IN NET ASSETS	**($3,734)**	**$0**	**($3,734)**	**587,103**	**$0**	**587,103**

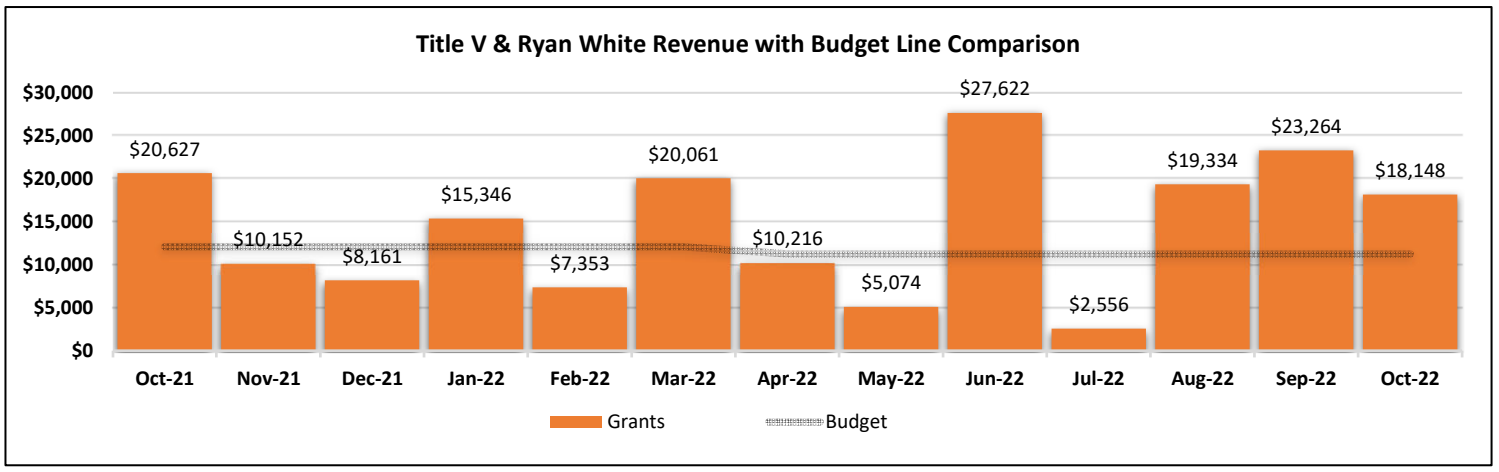
HIGHLIGHTS

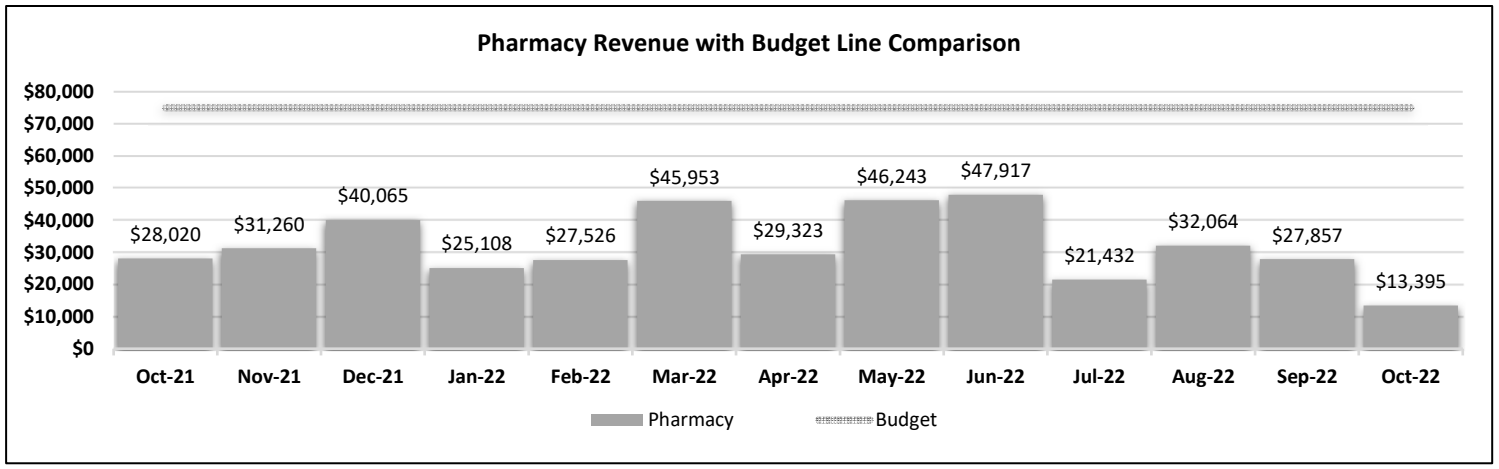
- ***Fund Balance:*** For the month of October the total fund balance was $8,718,683, a decrease of $3,734 from September.
- ***Revenue:*** MTD revenue was $937,445 which is under budget by $1,988. YTD revenue was $7,707,717 and is over budget by $1,131,685. The large difference between actual and budget for YTD is due to the extra funding from HHS and the DSRIP revenue coming in all at once.
- ***Expense:*** MTD expenses were $941,179 which is $1,745 over budget. YTD expenses were $7,120,614 which are $544,582 over budget. This difference between actual and budget is due to the increase in personal and other personal changes as well as IGT reimbursement. The overage in personnel is offset by revenue from the HRSA ARP grant and IGT Reimbursement is offset by DSRIP revenue.

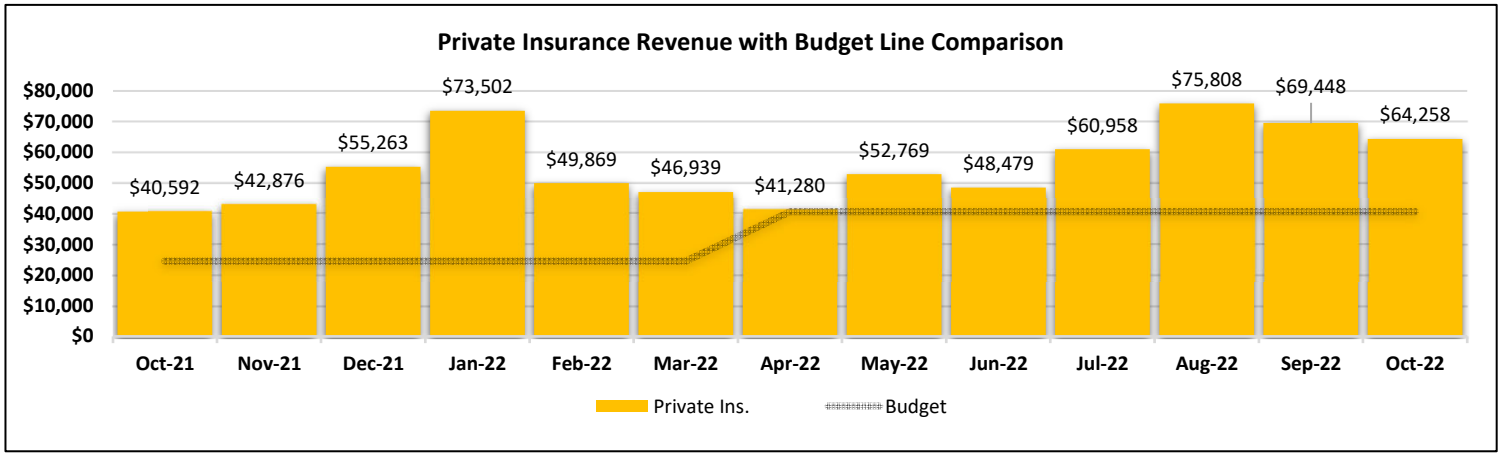

Actual Revenue & Expenses in Comparison to Budget
$2,000,000
$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Revenue
Expenses
Budget

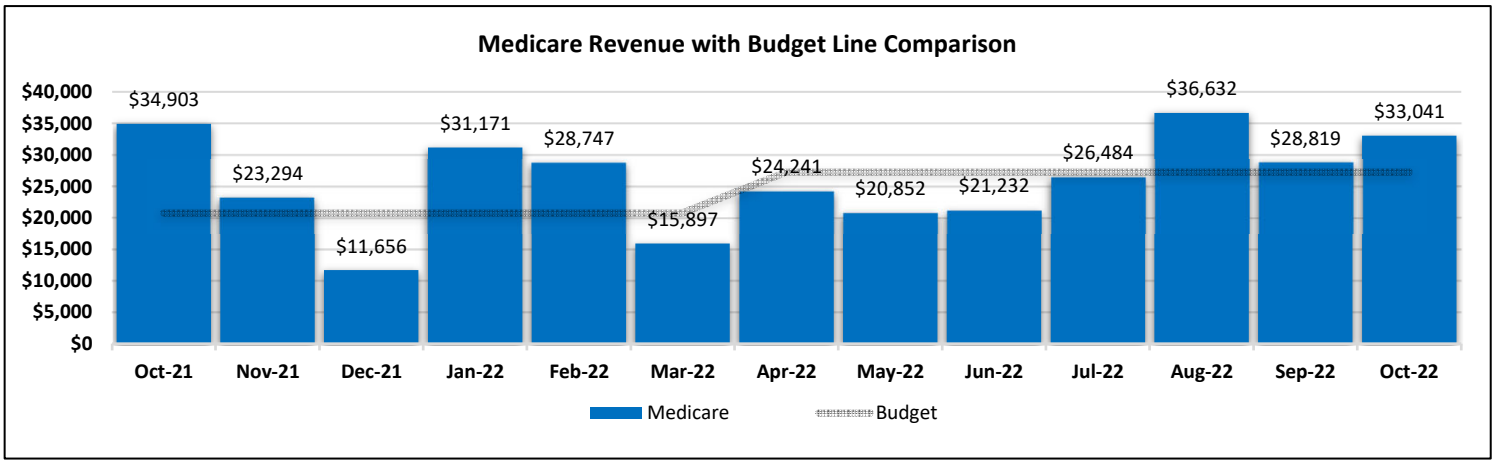

Actual Patient Revenue Rec'd vs Budget with Variance
$350,000
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$0
$40,000
$20,000
$0
($20,000)
($40,000)
($60,000)
($80,000)
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Actual Patient Revenue
Budgeted Patient Revenue
Budget Variance

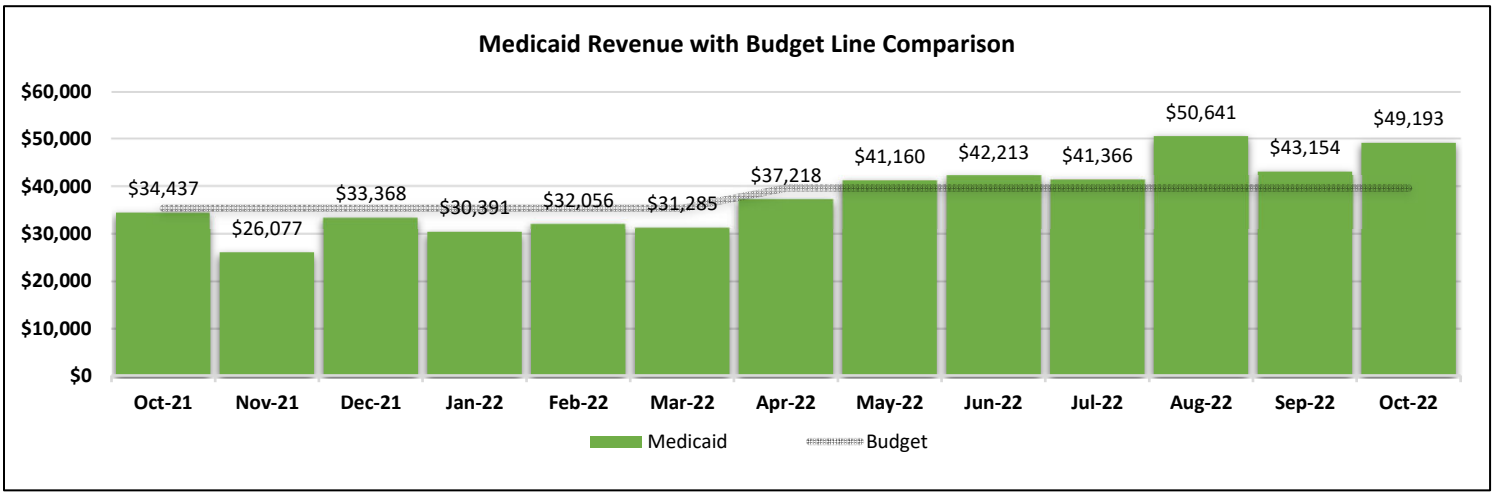

Patient Self Pay Revenue with Budget Line Comparison
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
$60,888
$69,301
$63,041
$68,854
$72,896
$78,078
$75,155
$94,878
$85,802
$79,640
$104,686
$86,673
$92,005
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Patient Self Pay
Budget

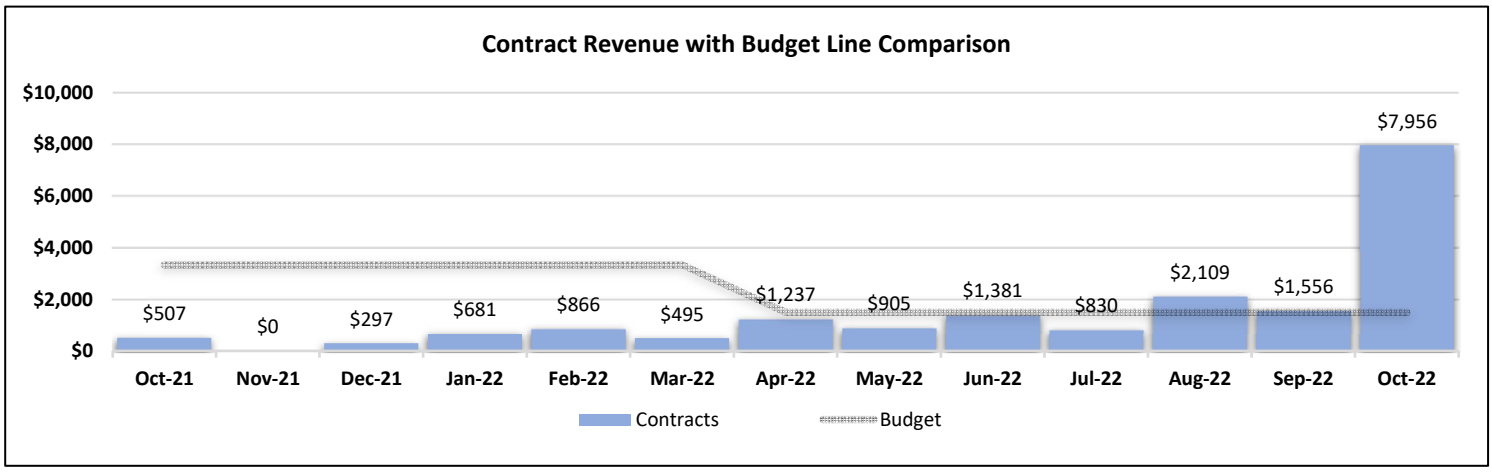

Title V & Ryan White Revenue with Budget Line Comparison
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0
$20,627
$10,152
$8,161
$15,346
$7,353
$20,061
$10,216
$5,074
$27,622
$2,556
$19,334
$23,264
$18,148
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Grants
Budget

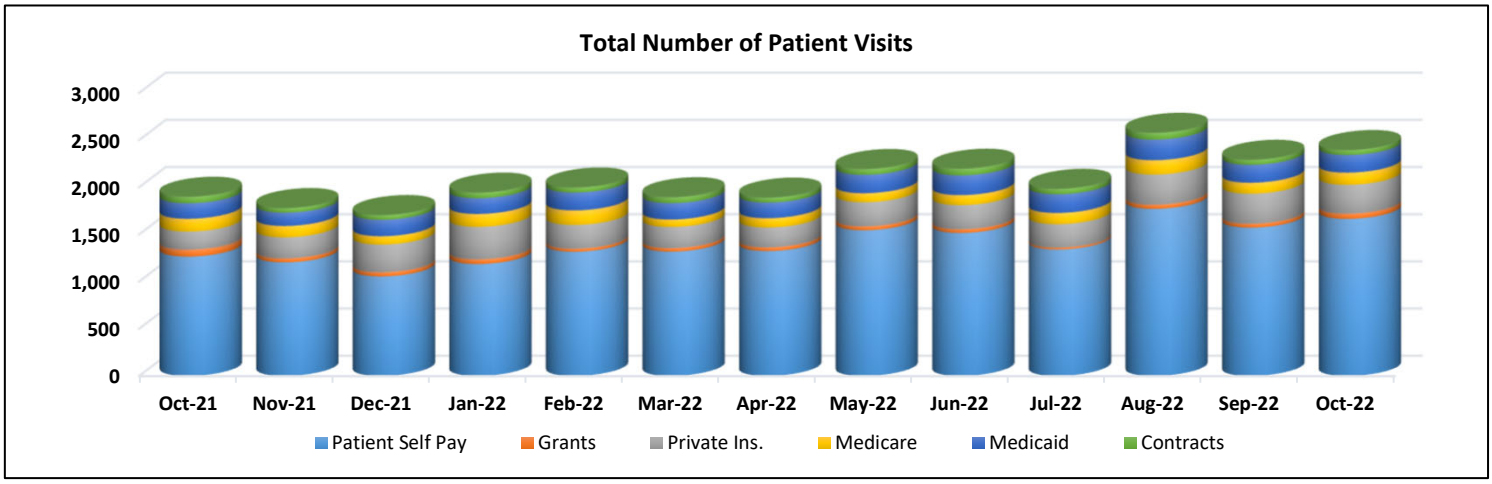

Pharmacy Revenue with Budget Line Comparison
$80,000
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
$28,020
$31,260
$40,065
$25,108
$27,526
$45,953
$29,323
$46,243
$47,917
$21,432
$32,064
$27,857
$13,395
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Pharmacy
Budget


Private Insurance Revenue with Budget Line Comparison
$80,000
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
$40,592
$42,876
$55,263
$73,502
$49,869
$46,939
$41,280
$52,769
$48,479
$60,958
$75,808
$69,448
$64,258
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Private Ins.
Budget

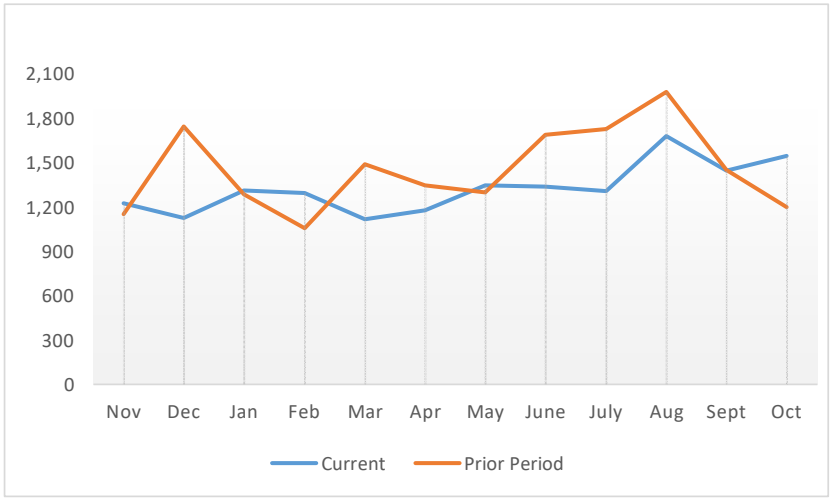

Medicare Revenue with Budget Line Comparison
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0
$34,903
$23,294
$11,656
$31,171
$28,747
$15,897
$24,241
$20,852
$21,232
$26,484
$36,632
$28,819
$33,041
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Medicare
Budget


Medicaid Revenue with Budget Line Comparison
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
$34,437
$26,077
$33,368
$30,391
$32,056
$31,285
$37,218
$41,160
$42,213
$41,366
$50,641
$43,154
$49,193
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Medicaid
Budget

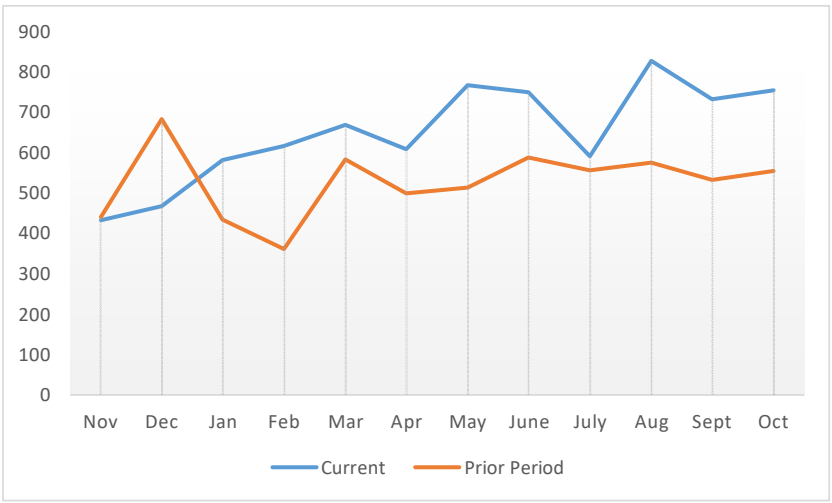

Contract Revenue with Budget Line Comparison
$10,000
$8,000
$6,000
$4,000
$2,000
$0
$507
$0
$297
$681
$866
$495
$1,237
$905
$1,381
$830
$2,109
$1,556
$7,956
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Contracts
Budget


Total Number of Patient Visits
3,000
2,500
2,000
1,500
1,000
500
0
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Patient Self Pay
Grants
Private Ins.
Medicare
Medicaid
Contracts

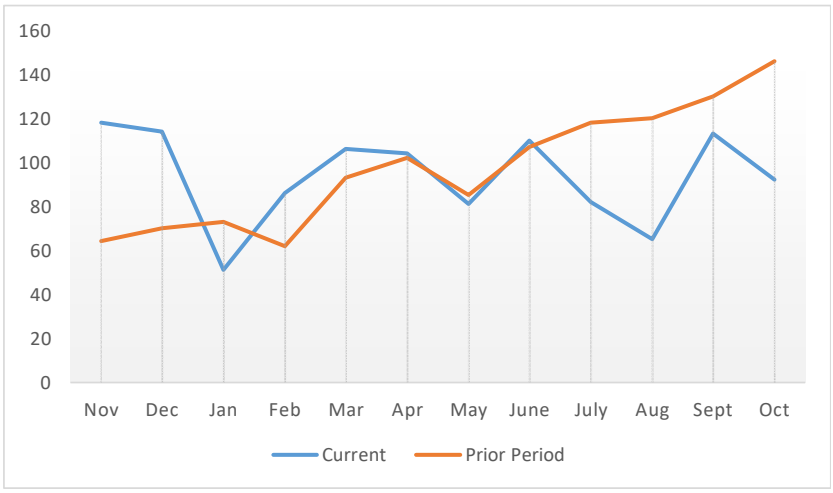
	Medical Visits	
	Current	**Prior Period**
Nov	1,227	1,150
Dec	1,124	1,745
Jan	1,311	1,288
Feb	1,294	1,058
Mar	1,119	1,488
Apr	1,178	1,345
May	1,345	1,299
June	1,337	1,689
July	1,309	1,727
Aug	1,684	1,980
Sept	1,445	1,450
Oct	1,547	1,198
	15,920	17,417



	Dental Visits	
	Current	**Prior Period**
Nov	433	440
Dec	466	682
Jan	580	433
Feb	616	361
Mar	668	582
Apr	607	499
May	766	512
June	748	587
July	591	555
Aug	827	574
Sept	732	532
Oct	754	554
	7,788	6,311



	Counseling Visits	
	Current	**Prior Period**
Nov	118	64
Dec	114	70
Jan	51	73
Feb	86	62
Mar	106	93
Apr	104	102
May	81	85
June	110	107
July	82	118
Aug	65	120
Sept	113	130
Oct	92	146
	1,122	1,170



Vists by Financial Class - Actual vs. Budget
As of October 31, 2022 (Grant YTD 04/01/22 - 10/31/22)

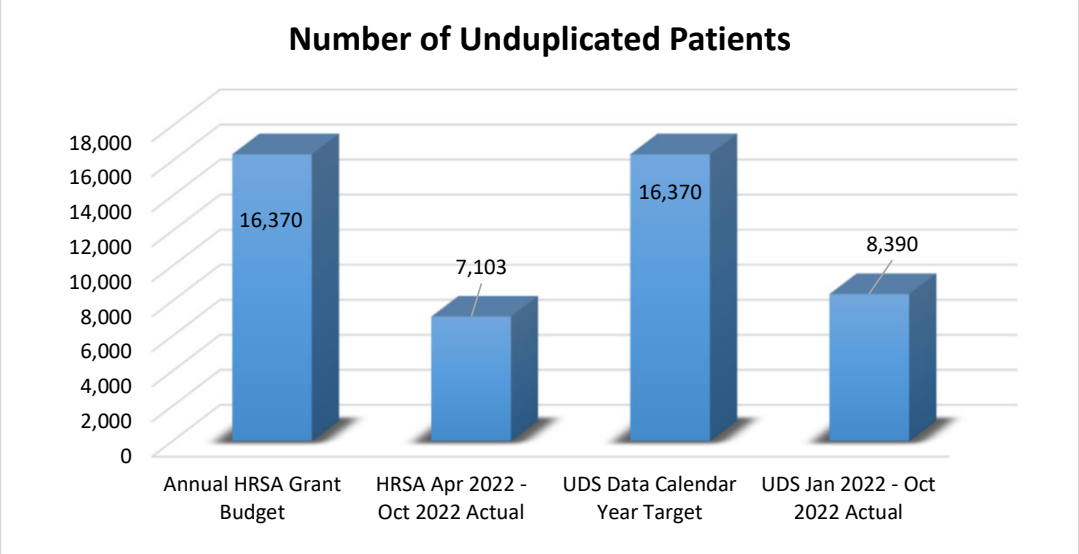
	Annual HRSA Grant Budget	MTD Actual	MTD Budget	Over/(Under) MTD Budget	YTD Actual	YTD Budget	Over/(Under) YTD Budget	% Over/(Under) YTD Budget
Medicaid	3,400	187	283	(96)	1,579	1,983	(404)	-20%
Medicare	2,425	130	202	(72)	845	1,415	(570)	-40%
Other Public *(Title V, Contract, Ryan White)*	993	107	83	24	703	579	124	21%
Private Insurance	4,435	305	370	(65)	1,962	2,587	(625)	-24%
Self Pay	24,404	1,664	2,034	(370)	10,555	14,236	(3,681)	-26%
	35,657	**2,393**	**2,971**	**(578)**	**15,644**	**20,800**	**(5,156)**	**-25%**

Unduplicated Patients - Current vs. Prior Year
UDS Data Calendar Year
January through December

	Current Year Annual Target	Jan 2021 - Oct 2021 Actual	Jan 2022 - Oct 2022 Actual	Increase/ (Decrease) Prior Year	% of Annual Target
Unduplicated Patients	16,370	7,619	8,390	771	51%

Unduplicated Patients - Current vs. Prior Year
HRSA Grant Year
April through March

	Annual HRSA Grant Budget	Apr 2021 - Oct 2021 Actual	Apr 2022 - Oct 2022 Actual	Increase/ (Decrease) Prior Year	% of Annual Target
Unduplicated Patients	16,370	6,643	7,103	460	43%



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Governing Board
December 2022
Item#10
Consider for Approval Coastal Health & Wellness Fund Balance Reserve as of September 30, 2022 Submitted by Trish Bailey

Coastal Health & Wellness
Proposed Annual Board Approval - Fund Balance Reserve
FY 2023

	Board Approved Reserve at 9/30/21	Increase / (Decrease)	Fund Balance Reserve at 9/30/22
IT Expenditures (Equipment, Software & Consultant Services)	**$100,000**	$0	**$100,000**
Medical / Dental Equipment additions/replacements	**$120,153**	$0	**$120,153**
Galveston Clinic Renovations	**$900,000**	$0	**$900,000**
Texas City Furniture/Fixtures/Remodel	**$10,000**	$0	**$10,000**
Employee One-Time Supplemental Payment	**$0**	$0	**$0**
Total Operating Reserve	**$4,900,000**	$0	**$4,900,000**
Total Board Approved Reserve	**$6,030,153**	**$0**	**$6,030,153**
Unreserved	**$1,921,457**	$770,807	**$2,692,264**
Total Fund Balance	**$7,951,610**	**$770,807**	**$8,722,417**

Operating Reserve	**$4,900,000**
Budgeted Expenses ending 3/31/23	**$11,273,198**
Months of Reserves available	**5.2**

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Governing Board
December 2022
Item#11
Consider for Approval Pharmacy Design Blueprint
submitted by Ami Cotharn

TOWN SQUARE ARCHITECTURE

November 23, 2022

CLIENT
Galveston County Health District
9850 Emmett F Lowry Expressway – Suite C
Texas City, TX 77591

Thank you for the opportunity to submit a proposal to you for the above referenced project. Below is an outline of our proposed services and fees:

Remodel areas included:

- Existing waiting room to pharmacy conversion
- Existing waiting room to counseling office conversion

Phase 1 - Site Assessment / CAD Creation / Design Development

- Measure existing key dimensions and input existing dimensional layout into AutoCAD
- Provide new floor plan reconfiguration options of each remodel area based on client feedback.
  - Utilize screenshare for meetings for discussion and updates

Phase 2 - Architectural Permit and Construction Set to include:

- Architectural Permit and Construction Set to include: - $6,000
  - Title Sheet with building code information, occupancy type, construction type, occupancy load etc.
  - Demo/existing floor plan
  - New floor plan layout with detailed dimensions and notes
  - Interior elevations at millwork including cabinet sections
  - Wall partition type sheet (including security requirements)
  - Window, door and hardware schedule
  - Reflected ceiling plan – showing light fixtures and ceiling details
  - Finish floor plan – based on owner selected finishes
  - Power layout plan- showing electrical and data outlet locations

- MEP Engineering Permit and Construction Set to include: - $3,500
  - Mechanical Plan, Mechanical schedule, details and specs
  - Electrical lighting plan to meet current energy code
  - Electrical power plan, electrical one-line, electrical schedule
  - Plumbing Plan, plumbing risers, plumbing schedule and plumbing specs
  - Energy code compliance / Comcheck report (if required)

- Structural engineering coordination, drawings & fees - $1,500

- Additional misc items included within scope: - $3,000
    - TDLR (ADA) coordination - registration, plan review, and inspection fees
    - Printing & plan expediting for building permit
    - Building permit fees

Project Exclusions:

- Fire alarm & fire sprinkler drawings
- Interior finish selections
- Construction Administration
- Signage shop drawings
- Value engineering revised selections after documents have been issued
- Additional design work for unforeseen conditions prior to and during construction

Assumptions:

- Base building drawings to be provided by client
- Asbestos report to be provided by client
- Town Square Architecture to communicate with engineering and contractors as required to support design questions
- Agreement is not contingent on final plans being submitted for permit or construction occurring
- Client changes to the design after client provides approval of final floor plan / start of Bid & Permit Set detailing could incur additional fees
- Existing dimensional layout & final plan layout to be delivered to client in electronic pdf format.

Project Fee & Terms:

- **A fixed fee of $14,000 for Scope of Work noted above**

    - 34% to be invoiced upon acceptance of proposal
    - 33% to be invoiced upon new floor plan acceptance
    - 33% to be invoiced upon completion of Permit & Construction Set

All invoices should be paid upon receipt by client.

Separate line item available upon request:

Interior 3D renderings - $600 (initial angle), $300/ea additional angles

- Renderings to be completed upon agreement of 90% design development completion

In the event of project delay/termination, Town Square Architecture shall be compensated for all services performed up to the date of termination. Written notice is required to stop project progress.

As the client listed above, please sign and print below to confirm agreement to the work outlined.

Signature_____ Print Name_____

Date_____

Thank you again for the opportunity to submit this proposal to you. Please let us know if you have any questions or need additional information.

Sincerely,
Steven Sartain
Town Square Architecture

Limitation of Liability:

Any reuse without written verification or adaptation by Town Square Architecture for the specific purpose intended or any changes to the documents of the construction work they describe, shall be at the Client's sole risk without liability or legal exposure to Town Square Architecture and Client shall indemnify and hold harmless Town Square Architecture from all claims, damages, losses, and expenses including fees arising out of or resulting therefrom.
In recognition of the relative risks, regards and benefits of the project to both Town Square Architecture and Client, Town Square Architecture's total liability to Client for any and all injuries, claims, losses, expenses, damages or claims expenses arising out of this agreement from any cause or causes, shall not exceed Town Square Architecture's fee. Such causes included, but are not limited to, Town Square Architecture negligence, errors, omissions, strict liability, breach of contract.

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Governing Board
December 2022
Item#12
RCM Quality Project Update
Submitted by Ami Cotharn

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Governing Board
December 2022
Item#13
Comments from Board Members

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