COASTAL HEALTH & WELLNESS

GOVERNING BOARD

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

AGENDA
Thursday, June 27, 2024 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 May 23, 2024 Governing Board Meeting

*Item #5 **ACTION** ..... Consider for Approval Ratification of the Action from the Executive Committee Special Meeting Friday, May 31, 2024

*Item #6 **ACTION** ..... Consider for Approval Ratification of the Action from the Executive Committee Special Meeting Thursday, June 13, 2024

*Item #7 **ACTION** ..... Consider for Approval No Show and Cancellation Policy

*Item #8 **ACTION** ..... Consider for Approval Coastal Health & Wellness Revenue Cycle Management Policies and Procedures

*Item #9 ..... Informational Report: Credentialing & Privileging Committee Reviewed and Approved the Following Providers Privileging Rights

a) Ashley Strain, NP Pediatric

Re-Credentialing

b) Chris Garcia, MD
c) Tandace McDill, MD
d) Jason Borillo, PA-C
e) Nadia Ahmed, MD

Item #10 **ACTION** ..... Consider for Approval April 2024 Financial Report Submitted by Kenna Pruitt

Item #11 **ACTION** ..... Consider for Approval Increase Pharmacy Build in the Amount of $18,500 Submitted by Kenna Pruitt

Item #12**ACTION**.....Consider for Approval Donnie VanAckeren, Community Representative, to Serve as Governing Board Chairperson

Item #13**ACTION**.....Consider for Approval the Reappointment of the following Coastal Health & Wellness Governing Board Members for a 2 Year Term Expiring June 2026:

- Kevin Avery (Consumer Member)
- Victoria Dougharty (Consumer Member)
- Sergio Cruz (Community Member)
- Clay Burton (Consumer Member)

Item #14.....Coastal Health & Wellness Updates

a) Organizational Updates Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Interim Chief Operating Officer/Director of Operations
c) Dental Updates Submitted by Dental Director
d) Medical Updates Submitted by Associate Medical Director

Item #15.....Comments from Board Members

Adjournment

Next Regular Scheduled Meeting: July 25, 2024

Appearances before the Coastal Health & Wellness Governing Board

A speaker whose subject matter as submitted relates to an identifiable item of business on this agenda will be requested by the presiding officer to come to the podium where they will be limited to three minutes (3). A speaker whose subject matter as submitted does not relate to an identifiable item of business on this agenda will be limited to three minutes (3) and will be allowed to speak before the meeting is adjourned. Please arrive prior to the meeting and sign in with Galveston County Health District staff.

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
June 2024
Item#3
Excused Absence(s)

Governing Board
June 2024
Item#4
Consider for Approval Minutes from May 23, 2024
Governing Board Meeting

Coastal Health & Wellness
Governing Board
May 23, 2024

Board Members:

Dr. Tello
Elizabeth Williams
Sharon Hall
Rev. Jones
Cynthia Darby
Sergio Cruz
Donnie VanAckeren

Staff:

Philip Keiser, Executive Director
Ami Cotharn, Chief Operating Officer
Jennifer Koch, Interim Chief Operating Officer
Director of Operations
Chris Garcia, Associate Medical Director
Hanna Lindskog, Dental Director
William Lewis, Chief Operating Officer
Kenna Pruitt
John Bearden
Brittany Rivers
Dianna Oliver
Christina Bates
Wendy Jones
Judie Olivares
Donna Salcido
Debra Howey
Pisa Ring
Virginia Lyle
Maria Aguirre
Chloe Murray
Megan Fric
Tikeshia Thompson-Rollins
Anthony Hernandez

Excused Absence: Samantha Robinson, Kevin Avery, Clay Bruton, Flecia Charles, Dr. Thompson, and Ivelissa Caban

Unexcused Absence: Victoria Dougharty

Guest: TJ Aulds, and Dr. Campbell

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

Items#2-7 Consent Agenda
A motion was made by Sergio Cruz to approve the consent agenda items two through seven. Cynthia Darby seconded the motion, and the Board unanimously approved the consent agenda.

Item#8 Informational Report

a) Recognizing Ami Cotharn, MSN, RN, for her Dedicated Services to Coastal Health & Wellness
b) Recognizing Samantha Robinson, RN for her Dedicated Services to Coastal Health & Wellness Governing Board
c) Recognizing Barbara Thompson, MD for her Dedicated Services to Coastal Health & Wellness Governing Board

Dr. Philip Keiser, Executive Director, presented a plaque to Ami Cotharn, Samantha Robinson, and Dr. Thompson for their dedicated service to Coastal Health & Wellness Governing Board.

Item#9 Consider for Approval March 2024 Financial Preliminary Report Submitted by Kenna Pruitt
Kenna Pruitt, Controller, asked the Board to consider for approval the March 2024 financial report. A motion to accept the February 2024 financials as presented was made by Donnie VanAckeren. Sergio Cruz seconded the motion and the Board unanimously approved.

Item#10 Consider for Approval the purchase of NextGen's Automated Document Sharing Submitted by Christina Bates
Christina Bates, HER System Administrator, asked the Board to consider for approval the purchase of NextGen's automated document sharing. A motion to accept the purchase of NextGen automated document sharing as presented was made by Sergio Cruz. Sharon Hall seconded the motion and the Board unanimously approved.

Item#11 Consider for Approval Kendall Campbell, MD, to fill the Ex-Officio Position Representing UTMB
Dr. Tello, Vice Chair, asked the Board to consider for approval Kendall Campbell, MD to fill the Ex-Officio position representing UTMB. A motion was made by Sharon Hall to approve Kendall Campbell, MD to fill the Ex-Officio position representing UTMB. Elizabeth Williams seconded the motion, and the Board unanimously approved the consent agenda.

Item#12 Coastal Health & Wellness Updates

a) Organizational Updates Submitted by Executive Director
a) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
b) Dental Updates Submitted by Dental Director
c) Medical Updates Submitted by Associate Medical Director

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

- April 2023 vs 2024 New vs. Established Patient (4.7%increase)
- April 2023 vs 2024 Confirmed Appointments (11%increase)
- April 2023 vs 2024 Resource Utilization (20.3% increase in available slots and a 15% increase in booked appointment slots)
- April 2023 vs 2024 Charges/Payments/Adjustment/Refunds (17.3% increase in charges, 90% increase in payment, 39% increase in

adjustments)

- April 2023 vs 2024 Kept/No-Show Comparison (14% increase in kept appointments, 8% increase in no-show, 12.7% increase in scheduled appointments)
- April 2023 vs 2024 Copay Collection (10%decrease)
- April 2023 vs 2024 New Pts. By Financial Class
- YTD 2023 vs 2024 Unduplicated Patients (2.2% increase)
- April 2023 vs 2024 Visits (15.25 % increase)
- Quarterly Visit & Analysis Report -Quarter 1 2024
- Strategic Health Plan Update Quarter 1-2024

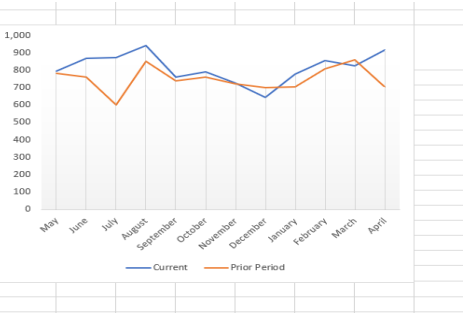
Brittany Rivers, Director of Community Engagement and Strategic Partnership, updated the Board on all outreach events.

- **Data Collection:**
  - During this reporting period members of the Health Equity Advisory Council conducted 2 focus groups which covered Mental Health and Financial Literacy. As of July 2023, the staff has been utilizing the (CNA) Community Needs Assessment to gather information on the needs within the different areas of community. In April 2024, 16 surveys were submitted online by community members.
- **Events:**
  - Health screenings for April 2024 were conducted at Dickinson Community Center (12 health screenings provided), Bayside Community Center (18 health screenings provided), and Wright Cuney (9 health screenings provided). At these events, the community engagement team also provides information available on upcoming events and services provided by Galveston County Health District (GCHD) & CHW.
  - Information on community services, healthy lifestyles and more is shared with local residents at Goodwill stores in League City and Galveston every Thursday of the month (81 individuals engaged for April 2024).
  - Community Engagement team members attended and/or hosted 6 health/resource fairs (456 individuals engaged), and 3 HEAL Classes (167 children present), 2 CET staff judged posters for the UTMB SPPH Public Health Symposium , CET hosted 1 financial literacy class (10 engaged) on Basic Budgeting, 3 CHW/GCHD presentations were conducted at ADA House (9 engaged), UTMB School of Nursing (10 students present) and City of La Marque Rotary Club Meeting (18 present), and 4 community events were attended (TC/LM Young Professionals Networking Project, TC/LM Chamber Wake up Wednesday Networking Event, Good Morning Mainland Networking Event, and the LC Chamber National Denim Day Luncheon).
  - CET members regularly check the Galveston community refrigerator to make sure it is stocked with various supplies such as masks and face shields and GCHD/CHW information.

Hanna Lindskog, DDS, updated the Board on Dental services in the Coastal Health & Wellness Clinic.

- Visit Numbers – Based on "FQHC Qual Enc" in NextGen –
  - We continue to see walk in patients in pain as we can fit them into our schedule.
  - We started releasing comprehensive exams on the 15th of every month, with December being the first month. The appointments continue to fill quicker each month.
  - For April 2024, we had an increase in qualifying encounters of 30.16% compared to April 2023.
  - We have an 8.15% increase in qualifying encounters comparing May 1, 2023 – April 30, 2024 with May 1, 2022 – April 30, 2023.

	Dental Visits		
	Current	Prior Period	Percentage Change
May	794	781	1.66%
June	869	763	13.89%
July	873	602	45.02%
August	941	850	10.71%
September	760	738	2.98%
October	790	759	4.08%
November	725	724	0.14%
December	646	699	-7.58%
January	777	705	10.21%
February	858	807	6.32%
March	828	862	-3.94%
April	915	703	30.16%
	6,398	5,916	8.15%



- Current projects, plans, department overview for dental
  - Dr. Lindskog continues to serve on the COM Hygiene School Advisory Board. They are planning to start Fall 2024 with their first class.
- Provider Education Opportunities
  - All providers continue to select and participate in continuing education of their choice. They also share knowledge from these courses with the other providers during monthly meetings.
- Barriers or Needs (if applicable)
  - Staffing
    - We have a Dental Office Manager scheduled to start on May 30th.

Chris Garcia, MD, updated the Board on Medical services in the Coastal Health & Wellness Clinic.

School Based Clinic: Total April visits: 46

Students:	2
Staff:	3
Existing CHW:	41
In person:	4
Telehealth:	42

Telehealth/ Doxyme visit: Total April visits: 132

Increase: +53

CHW clinic visits: Total April visits: 2298

Schedule visits:	3097
No Shows:	797
No Show Rate:	25%
Show Rate:	75%

Total charges: $558,985.57

Current Projects:

- We have been trained in the use of Retinal Cameras, working on integrating with Nextgen, hopefully go live in the next few weeks.
- We have been trained on the use of the Virtual Provider for use at the school-based clinic, we are awaiting IT approval to go live, (they are working on integrating with Nextgen as well as cybersecurity with the unit)
- We now have 3 new providers that have started, 2 are starting to see patients and 1 is completing his orientation.
- We continue working with the Gulf Coast Center on integration.
- We are working to expand services in Women's Health

Item #11 Comments from Board Members
No comments from the Board

The meeting was adjourned at 1:27p.m.

_____	_____
Vice Chair	Secretary/Treasurer
_____	_____
Date	Date

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Governing Board
June 2024
Item#5
Consider for Approval Ratification of the Action from the Executive Committee Special Meeting Friday, May 31, 2024

Coastal Health & Wellness
Governing Board Special Meeting
May 31, 2024

Board Members (Zoom):	**Staff (Zoom):**
Dr. Tello	Wendy Jones, Compliance and Risk Management Officer
Elizabeth Williams	Tikeshia Thompson-Rollins
	Anthony Hernandez

Item#1 Consider for Approval 2023 Annual Risk Management Report Submitted by Wendy Jones

Wendy Jones, Compliance and Risk Management Officer, asked the Board to consider for approval 2023 annual risk management report. A motion to accept 2023 annual risk management report for reporting year January 2023-December 2023 as presented was made by Dr. Tello. Elizabeth Williams seconded the motion and the Executive Committee approved.

The meeting was adjourned at 1:10p.m.

_____	_____
Vice Chair	Secretary/Treasurer
_____	_____
Date	Date

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Governing Board
June 2024
Item#6
Consider for Approval Ratification of the Action from the Executive Committee Special Meeting Thursday, June 13, 2024

Coastal Health & Wellness
Governing Board Special Meeting
June 13, 2024

Board Members (Zoom):	**Staff (Zoom):**
Dr. Tello	Jennifer Koch, Interim Chief Operating Officer/Director of Business
Elizabeth Williams	Christina Bates, HER System Administrator
	Chris Davis, IT Manager
	Tiffany Carlson, Nursing Director
	Tikeshia Thompson-Rollins
	Anthony Hernandez

Item#1 Consider for Approval Purchase of ECG Replacement
Christina Bates, EHR System Administrator, asked the Board to consider for approval purchase of ECG replacement. A motion to accept the purchase of ECG replacement as presented was made by Dr. Tello. Elizabeth Williams seconded the motion and the Executive Committee approved.

Item#2 Consider for Approval Upgrade of the Badge Access System for the Mid County Access Building Including the Texas City Clinic
Chris Davis, IT Manager, asked the Executive Committee to consider for approval upgrade of the badge access system for the mid county access building including the Texas City Clinic. A motion to accept upgrade of the badge access system as presented was made by Dr. Tello. Elizabeth Williams seconded the motion and the Executive Committee approved.

The meeting was adjourned at 1:13p.m.

_____	_____
Vice Chair	Secretary/Treasurer
_____	_____
Date	Date

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Governing Board
June 2024
Item#7
Consider for Approval No Show and Cancellation Policy

Governing Board
June 2024
Item#8
Consider for Approval Coastal Health & Wellness Revenue Cycle Management Policies and Procedures

Revenue Cycle Management Policies and Procedures

Updated June 24, 2024

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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 & PROCEDURE

Policy Name: Insurance Verification Policy & Procedure

Policy Number: 2.01
Last Revised: June 23, 2024
Related Policy: Billing and Collections, Payment Policy
Related Documents:
In-scope Teams: Revenue Cycle, OEE, Patient Services, Dental Front Desk
Board Approval Date: June 24, 2024

Policy

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

CHW makes every reasonable effort to enter contractual or other arrangements to optimize reimbursement of its costs with the appropriate agency(s) of the State which administers or supervises the administration of:

1. 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
2. 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

CHW acknowledges the importance of identifying and documenting appropriate payer sources. The insurance verification process is performed by the teams accountable for performing billing and registration functions to promote:

1. Accurate identification of insurance on a patient's account
2. Coordination of benefits so that claims are submitted timely and accurately filed
3. Identifying any patient responsibility
4. Determining the payer of last resort for patients with multiple coverages/payers.

Patient benefits/appropriate payers are verified forty-eight (48) hours prior to the patient's appointment.

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.

1. 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. 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 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 corresponds 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 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.

12. Medicaid Pending
    - 12.1.1. Use to check if patient has applied
    - 12.1.2. This report requires minimal input data.
    - 12.1.3. Choose insurance
    - 12.1.4. Click "View Report"

13. 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.

14. Ryan White Insurance 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

15. Self-Pay & Sliding Scale
    - 15.1.1. For office visits (including well exam, HRT, and STD testing) follow the Sliding Fee Scale.
    - 15.1.2. Primary Care Verification
    - 15.1.3. Traditional – no PCP assignment
    - 15.1.4. Star/Star Plus – PCP should be CHW
    - 15.1.5. No copay
    - 15.1.6. Primary care, FP services, annual wellness, some immunizations
    - 15.1.7. If active TPA is listed, Medicaid is secondary
    - 15.1.8. As secondary, covers copays and co-ins for services covered under plan

16. Medicare NGS / Medicare Novitas Insurance Verification
    - 16.1.1. No PCP assignment
    - 16.1.2. Copay – slide if applicable
    - 16.1.3. Primary care, FP services, annual wellness, some immunizations
    - 16.1.4. As secondary, covers copay and co-ins for services covered under plan

17. Medicare Advantage Plans Insurance Verification
    - 17.1.1. Replace original Medicare
    - 17.1.2. May be PPO or HMO

17.1.3. May require PCP assignment

17.1.4. Must determine in or out of network

17.1.5. Copays and co-ins vary

17.1.6. Primary care, FP services, annual wellness, some immunizations

17.1.7. As secondary, covers copays and co-ins for services covered under plan

18. Private Insurance Verification

18.1.1. Must determine in or out of network

18.1.2. Ensure service is covered

18.1.3. Copays and co-ins vary

18.1.4. Deductible may apply

18.1.5. Has secondary plan?

18.1.6. Health funds or accounts?

19. CHC – Harris Health Insurance Verification

19.1.1. No copays

19.1.2. Must be referred by Harris Health

20. PHC Grant –Beaumont Clinics Only

20.1.1. Active for one year from certification

20.1.2. Primary care, FP services, annual wellness, immunizations

21. Ryan White Grant – LMC & BCC Clinics Only

21.1.1. Payer of last resort – Must check for Medicare & Medicaid

21.1.2. Eligibility verified through CPCDMS

21.1.3. If FPL over 100%, must verify copay & cap amount

22. Healthy Texas Women Program Insurance Verification

22.1.1. Covers females only for 3 providers visit for the plan year

22.1.2. Annual family planning and preventative healthcare visit

22.1.3. Contraceptive services, all methods except elective abortion & emergency contraception (includes follow-up and surveillance)

22.1.4. Preconception care

22.1.5. Basic infertility services

22.1.6. Certain screening, diagnostic, and treatment services:

22.1.7. Pregnancy testing

22.1.8. Screening and treatment of Cervical Intraepithelial Neoplasia, dx of cervical cancer

22.1.9. Screening and outpatient treatment of STD's and STI's

22.1.10. HIV testing

22.1.11. Breast cancer screening and dx

22.1.12. Recommended immunizations

22.1.13. Screening and treatment of postpartum depression

22.1.14. Diabetes screening and treatment

22.1.15. Hypertension screening and treatment

22.1.16. Screening and treatment of elevated cholesterol

Pediatric Insurance Verification

23. Traditional Medicaid

23.1.1. No PCP assignment

23.1.2. No copay

23.1.3. Acute care, FP services, well child, immunizations

23.1.4. If an active TPA is listed, Medicaid is secondary

23.1.5. As secondary, covers copays and co-ins for services covered under plan

24. Star & Star Plus Medicaid / CHIP

24.1.1. PCP should be CHW

24.1.2. MCD no copay / CHIP copay varies

24.1.3. MCD - Acute care, FP services, well child, immunizations

24.1.4. CHIP – Acute care, well child, NO FP, immunizations

24.1.5. If an active TPA is listed, plan is secondary

24.1.6. As secondary, covers copays and co-ins for services covered under plan

25. Private Insurance

25.1.1. Must determine in or out of network

25.1.2. Ensure service is covered

25.1.3. Copays and co-ins vary

25.1.4. Deductible may apply

25.1.5. Has secondary plan

26. Medicaid Pending

26.1.1. Check TMHP for coverage

26.1.2. Coverage Found

26.1.3. Add coverage to registration

26.1.4. Update collections staff

27. No Coverage Found
    - 27.1.1. Newborn Under 3 months – keep Medicaid pending status
    - 27.1.2. Newborn over 3 months – send to eligibility
    - 27.1.3. Infants & older with Medicaid pending status less than 2 months – keep Medicaid pending status
    - 27.1.4. Infants & older with Medicaid pending status over 2 months – send to eligibility

28. Sports Physicals
    - 28.1.1. Uninsured follow slide
    - 28.1.2. Private Insurance Copay applies
    - 28.1.3. Traditional MCD – no coverage, self-pay
    - 28.1.4. CHIP Plans
    - 28.1.5. TCHP, AMG, Molina – Charge copay
    - 28.1.6. CHC, UHC – No copay

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

    29.2. OB/GYN Verification
    - 29.2.1. Copays and co-ins vary
    - 29.2.2. We are a non-delivery provider. Phone call is required to determine coverage.
    - 29.2.3. Deductible may apply
    - 29.2.4. Has secondary plan?
    - 29.2.5. Health funds or accounts?

30. Healthy Texas Women
    - 30.1.1. Covers females only
    - 30.1.2. Annual family planning and preventative healthcare visit
    - 30.1.3. Contraceptive services, all methods except elective abortion & emergency contraception (includes follow-up and surveillance)
    - 30.1.4. Preconception care
    - 30.1.5. Basic infertility services
    - 30.1.6. Certain screening, diagnostic, and treatment services:
    - 30.1.7. Pregnancy testing
    - 30.1.8. Screening and treatment of Cervical Intraepithelial Neoplasia, dx of cervical cancer
    - 30.1.9. Screening and outpatient treatment of STD's and STI's

30.1.10. HIV testing

30.1.11. Breast cancer screening and dx

30.1.12. Recommended immunizations

30.1.13. Screening and treatment of postpartum depression

30.1.14. Diabetes screening and treatment

30.1.15. Hypertension screening and treatment

31. Specialty Services - Endocrinology/Geriatrics

31.1.1. 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 Insurance Verification

32. Routine Vision

32.1.1. An optometrist 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.

32.1.2. 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.

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

32.1.4. RX Check – Should be done within short period after REE/glasses dispensed. There is no charge.

32.1.5. CLS F/U – Appointment is to order supplies of contact lens after the trial period is over.

33. Medical Vision

33.1.1. 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.

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

33.1.3. 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.

33.1.4. 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.

33.1.5.

*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.

34. Traditional Medicaid and Medicaid MQMB

34.1.1. Cover both REE and medical vision visits with no copayment.

34.1.2. Adults 19 and up – one exam and 1 pair of glasses every TWO YEARS

34.1.3. Children through 18 – one exam and 1 pair of glasses every year

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

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

35. Medicare

35.1.1. 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.

35.1.2. 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

35.1.3. Medicare/MQMB client – No copayment is collected. Create/apply MQMB case to all routine visits.

35.1.4. 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.

36. Ryan White

36.1.1. 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.

36.1.2. Charge the usual Self Pay or Sliding Scale fees.

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

37. Medical Vision

37.1.1. When calling to verify 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.

38. Routine Vision

38.1.1. 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.

38.1.2. 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.

38.1.3. 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.

39. Star, Star Plus, & CHIP

    39.1.1. 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 Insurance Verification

40. 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 Insurance Verification

41. 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.
    41.1.1. Copays do not apply to nutrition visits.
    41.1.2. The patient is allowed 12 counseling visits per contract year by a licensed dietician.
    41.1.3. The patient may receive up to a 90-day supply of supplements on a single visit.

Dental Insurance Verification

42. Dental Vendor for Medicaid patients can be found on TMHP.
43. 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 Payer Insurance Verification

44. All others are not billable and do not need verification.

III. SLIDING FEE DISCOUNT PROGRAM POLICY & PROCEDURE

Policy Name: Sliding Fee Discount Program Policy & Procedure

Policy Number: 3.01
Last Revised: June 23, 2024
Related Policy: Fee Scheduling Establishment and Maintenance
Related Documents: Sliding Fee Checklist, Patient Responsibility
In-scope Teams: Billing, OEE, Patient Services, Dental Front Desk
Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to establish a sliding fee discount schedule (SFDS) 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.

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.

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 of 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
   3.1. No sliding Fee discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200% of the FPG].
   3.2. CHW's nominal fee for medical visits for patients at or under 100% of FPG is $20.00.
4. CHW will update the Sliding Fee Discount Schedule related to changes in the Federally Poverty Guidelines. The Federal Poverty Guidelines are updated by the Department of Health and Human Services annually in mid-January. It is the goal of CHW to update their Sliding Fee Discount Schedule within three weeks 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:
   6.1. Signage at all desks
   6.2. Brochures that are given to patients during initial visits
   6.3. 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:
   8.1. 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]
   8.2. Allows for a nominal fee may to be charged to assure access.
   8.3. Includes reasonable efforts are made to collect payment from self-pay patients.[5]
   8.4. 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: 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 dental lab and material costs for certain designated procedures unless they are above 200% of the federal poverty level and required to pay full charges.

Procedure

1. Staff will ensure 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:
   2.1.1. Definition of Income and Family Size
   2.1.2. Documents required to be provided by patients to support definition of income
   2.1.3. Determination of eligibility guidelines
   2.1.4. Structure of the Sliding Fee Discount Scale
   2.1.5. Definition of Income and Family Size Documents required to be provided by patients to support definition of income
   2.1.6. Determination of eligibility guidelines
   2.1.7. Structure of the Sliding Fee Discount Scale
3. CHW defines Income and Family Size as follows:
   3.1.1. **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.
   3.1.2. **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.
   3.1.3. **Family Size:** The number of individuals in the family.
4. Acceptable forms of support for documentation of Income are as follows:
   4.1.1. Self-Declaration (if applicable)
   4.1.2. 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)
   4.1.3. Current Tax Return or W2 Forms
   4.1.4. Employment Verification Form (EVF) or Letter from Employer
   4.1.5. Unemployment Benefits or Wage Detail from Workforce (if unemployed and not receiving unemployment)
   4.1.6. Assistance Statement Verification (Supporter Statement that indicates unemployment and/or zero income) Retirement or Social Security Benefits Letter
   4.1.7. Child Support
   4.1.8. Public Assistance Verification letter
   4.1.9. Letter from Homeless Shelter attesting income/no income
5. CHW's patient eligibility process for sliding fees is based on the following:
   5.1.1. 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.

5.1.2. 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

5.1.3. The SFDS is structured in a manner that adjusts based on a patient's ability to pay.

5.1.4. A 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.

5.1.5. 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%.

5.1.6. 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.

5.1.7. 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.

5.1.8. 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. Services including DME, dental lab and dental material costs are examples of fees that are not included in the sliding fee discount. Some of these services may require payment in advance of ordering. Exceptions will be assessed and determined 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

6.1.1. 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.

6.1.2. 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.

6.1.3. 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

7.1.1. 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:

7.1.1.1. 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 the 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:
    10.1.1. A random sample of sliding fee applications will be selected from patients seen during the audit year.
    10.1.2. The auditor reviews all accompanying documents for accuracy and completeness.
    10.1.3. The approval/disapproval decision and the selection of the sliding fee discount category are also reviewed for accuracy by auditor.
    10.1.4. Any necessary sliding fee discount corrections will be documented and included in CHW Administrative General Sessions.

Patient Responsibilities for Sliding Fee Discounts

1. To satisfactorily comply with all regulations and policies, CHW's patients have responsibilities to cooperate with the SFDS requirements:
    1.1.1. They will need to complete the sliding fee discount application (Application for Health Care Assistance)
    1.1.2. 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 a 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 patients 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 assess/reassess 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 AND MAINTENANCE POLICY & PROCEDURE

Policy Name: Fee Schedule Establishment and Maintenance Policy & Procedure

Policy Number:	4.01
Last Revised:	June 23, 2024
Related Policy:	Sliding Fee Schedule Policy
Related Documents:	Master Fee Schedule Report
In-scope Teams:	Billing, OEE, Patient Services, Dental Front Desk
Board Approval Date:	June 24, 2024

Policy

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 Governing Board of Directors.

The schedule of fees will be billed for services and supplies rendered/provided to patients to help ensure compliance with Federal, State, and other regulatory authorities.

1. 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.
2. 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:
    2.1. Commercial sources fee analyzer utilizing an adjustment corresponding with a geographic index
    2.2. Medicare Physician Fee Schedule available through CHW's MCR intermediary
    2.3. Private providers* in CHW's community or other, similarly situated communities
    2.4. Other information available
3. 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.
    3.1. Each CPT, CDT, and HCPCS code entered into CHW's system, manually or via yearly coding updates, is assigned a fee.

3.2. 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, FAIR Health data, Wasserman Medical Publishers, LTD and Centers for Medicare and Medicaid Services National Physician Fee Schedule RVU data.

3.3. 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.

Procedure

1. CHW will develop and maintain a list of procedure (CPT/HCPC & CDT) codes representing services and supplies that will be available to patients. These codes, along with the related unit charges, will be maintained in NextGen, CHW's practice management system.
2. CHW will include a sample of at least one (1) private payor contract allowed amounts by procedure (CPT/HCPC & CDT) code associated with CHW when setting charges with the goal of setting charges at or above the maximum allowed amount, some exceptions may be warranted.
3. CHW will utilize local prevailing rate data at the 65th percentile for Medical and the 60th percentile or lab costs for Dental as the method used in setting and maintaining charges.
4. CHW will develop and maintain a process to ensure individual FQHC Medicare G-code charge amounts that represent a Prospective Payment System (PPS) encounter are set based on a relationship to the detail procedure (CPT/HCPC & CDT) codes as defined by CHW.
5. 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.
   5.1. 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, and/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:
      5.1.1. When supplies or equipment related to a given service will result in separate charges from the service
      5.1.2. The total amount of out-of-pocket costs for these supplies or equipment
      5.1.3. Available payment plans
6. CHW will not charge different fees for the same procedure (CPT/HCPC & CDT) code unless exceptions are warranted. An example of an exception would be a charge for a vaccine as part of the Vaccines for Children Program where CHW does not incur a cost versus a charge for the same vaccine that is purchased and used for private stock.
7. CHW will not seek reimbursement for non-cost items as noted in Section 1862(a)(2) of the Social Security Act.
8. CHW will annually review fees and determine if updates are necessary based on the criteria above.
9. The Governing Board of Directors will review analysis prepared by CHW's management team and approve proposed fee updates and methodologies to allow an understanding of the impact to our patients and help to ensure a financial barrier to care does not exist.
10. CHW will perform self-assessments or engage a third-party to perform an evaluation of the fee schedule based on the criteria above at a minimum of every three (3) years.

References or Regulations

- *Health Center Program Compliance Manual | Bureau of Primary Health Care (hrsa.gov)*
- *Federally Qualified Health Centers (FQHC) Center | CMS*
- *Medicare Claims Processing Manual (cms.gov)*

V. PAYMENT POSTING POLICY & PROCEDURE

Policy Name: Payment Posting Policy & Procedure

Policy Number:	5.01
Last Revised:	June 23, 2024
Related Policy:	Charge Entry Policy, Billing and Collections Policy
Related Documents:	Master Fee Schedule Report
In-scope Teams:	Billing, OEE, Patient Services, Dental Front Desk
Board Approval Date:	June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to assure the appropriateness of applying payments to CHW patient accounts with the following guardrails:

1. Patient and third-party payments will be posted and managed in the electronic practice management system (EPM).
2. Appropriate contractual and other adjustments are posted in the EPM.
3. Post all payments into the EPM within 5 business days upon receipt.
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.

Procedure

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.

CHW accepts all non-electronic payments, including non-electronic third-party payer and patient checks, managed through CHW accounting department.

1. Payments are tracked and logged by accounting.
2. 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 is 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 via credit or 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.

18. Unidentified/Incentive/Capitation Payments
    - 18.1. CHW may receive payments that cannot be directly linked to a client's chart.
        - 18.1.1. Those payments will be posted to the unidentified payments dummy account. These payments will be referred to the AR team for research and resolution.
    - 18.2. CHW may receive incentive payments that are not directly linked to a client's chart.
        - 18.2.1. Those payments will be posted in the incentive payments dummy account.
        - 18.2.2. Incentive payments will be posted according to date of receipt.
    - 18.3. CHW may receive capitation payments that cannot be directly linked to a client's chart.
        - 18.3.1. Those payments will be posted in the capitation payments dummy account.
        - 18.3.2. Capitation payments will be posted according to date of receipt.
19. 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.
20. Small Balances Write Offs
    - 20.1. Patient small balances will be automatically written off after 180 days.
    - 20.2. 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.
    - 20.3. 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.
    - 20.4. On a monthly basis, a report is generated that identifies accounts that meet these criteria.

VI. CHARGE ENTRY POLICY & PROCEDURE

Policy Name: Charge Entry Policy & Procedure

Policy Number:	6.01
Last Revised:	June 23, 2024
Related Policy:	Payment Posting Policy, Billing and Collections Policy
Related Documents:	Master Fee Schedule
In-scope Teams:	Billing, OEE, Patient Services, Dental Front Desk, Providers, Nursing, Lab
Board Approval Date:	June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to capture the services performed by its providers in an accurate and timely manner.

It is the policy of CHW to facilitate timely and efficient billing and collections. 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.

Charges for services rendered should be accurately posted by Health Center staff within 5 days of the date of service.

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.

Procedure

1. Office Procedures
    1.1. 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.
    1.2. 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.)
        1.2.1. Patient name
        1.2.2. Patient identification
        1.2.3. Date of birth
        1.2.4. Attending provider
        1.2.5. Place of service
        1.2.6. Date of service(s)
        1.2.7. Procedure code(s)
        1.2.8. Diagnosis code(s) – appropriately linked to procedure codes, if applicable
        1.2.9. Additional information as needed to process the charge
        1.2.10. Referring physician, if applicable
    1.3. The provider documents all services rendered to the patient in the electronic medical record.
    1.4. The provider completes charge documentation at the time the service is rendered.
    1.5. Diagnosis "rule outs" are not permitted. A diagnosis must be made and coded based on information available and symptoms presented.
    1.6. 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.
    1.7. 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.
    1.8. 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.
2. Billing Staff Procedures
    2.1. 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.
    2.2. 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.
    2.3. Using available electronic or manual tools and resources, CHW staff are responsible for reviewing and editing charges before they are submitted.
        2.3.1. During the review process, any discrepancies are resolved immediately.
        2.3.2. 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.
        2.3.3. Providers have two business days to respond to questions about charges.
        2.3.4. Charge edits are resolved within three business days.

2.4. CHW staff submits prepared claims within two business days of charge entry.

2.5. CHW staff monitor the period of the claim's submission to payment by the payer.

2.6. 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:

2.6.1. Date-of-service to date-of-charge submission versus documentation and coding must occur within a reasonable timeframe.

2.6.2. Date-of-charge submission to date-of-claim submission

2.6.3. Date-of-claim submission to date-of-payment by third-party payer

If applicable, additional key processes will be identified and monitor

VII. CLAIMS SUBMISSIONS POLICY & PROCEDURE

Policy Name: Claims Submission Policy & Procedure

Policy Number:	7.01
Last Revised:	June 23, 2024
Related Policy:	Payment Posting Policy, Billing and Collections Policy, Charge Entry Policy
Related Documents:	Master Fee Schedule
In-scope Teams:	Billing, OEE, Patient Services, Dental Front Desk, Providers, Nursing, Lab
Board Approval Date:	June 24, 2024

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

Procedure

1. Following the editing process, clean claims are sent electronically in 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 & PROCEDURE

Policy Name: Billing Records Retention Policy & Procedure

Policy Number:	8.01
Last Revised:	June 23, 2024
Related Policy:	Medical Records Policy, Patient Financial Policy
Related Documents:	Release of Medical Records
In-scope Teams:	Billing
Board Approval Date:	June 24, 2024

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.

Procedure

1. Confidentiality
    1.1. 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.
    1.2. 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.

2. Record Release and Retention
    2.1. 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.
    2.2. 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 & PROCEDURE

Policy Name: Billing and Collection Retention Policy & Procedure

Policy Number:	9.01
Last Revised:	June 23, 2024
Related Policy:	Medical Fee Waiving Policy, Refusal to Pay Policy, Sliding Fee Adjustment Policies
Related Documents:	Patient Refund Request Form
In-scope Teams:	Billing, Finance
Board Approval Date:	June 24, 2024

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 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.

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.

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.

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.

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.

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.

To assure data integrity, CHW will perform daily balancing and full monthly closing procedures as soon as reasonable after the last day of each month.

Procedure

1. Patient Payments and Collections
    1.1. Patients will be offered screening for program eligibility and/or sliding fee program.
    1.2. Dues from insured patient (co-payment, co-insurance and/or deductible):
        1.2.1. The co-payment, 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.
        1.2.2. 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).
    1.3. Dues from self-pay patient:
        1.3.1. 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.
        1.3.2. 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).
    1.4. 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.
    1.5. 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.
    1.6. 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.
    1.7. CHW provides education to patients on insurance and, if applicable, related third party coverage options available to them.
2. Aging and Write-off
    2.1. 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.
    2.2. 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.
    2.3. Accounts with balances greater than 365 days and in a bad debt status will be adjusted off an account as uncollectible.
    2.4. To be considered for write-off, the billing department must be able to demonstrate that adequate steps were taken to collect the amount due.
    2.5. Anything found questionable must have approval from the Chief Operating Officer.
3. Patient Complaints about Patient Fees

3.1. The patient support specialist should explain the billing process to the patient.

3.2. If the patient's concerns are not adequately addressed, the patient support specialist should refer the patient to site lead.

3.3. Site lead will use their discretion in resolving the patient's concern. Patient concerns and resolutions must be noted on the EHR. Potential resolutions include, but are not limited to the following:

3.3.1. Accepting partial payment for services that day and defer remainder of the balance to the next visit.

3.3.2. Initiate arrangement for payment plan.

4. Refunds/Credits

4.1. 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.

4.2. Overpayments are flagged at the time the payment is posted and the ticket is moved into overpayment status.

4.2.1. CHW billing staff works these refunds ensuring the overpayment status if appropriate.

4.2.2. The staff member completes a Refund Request Form to request the refund check be processed.

4.2.3. A thorough review of the account is conducted to determine the cause of the credit balance.

4.2.4. If a posting error caused the credit balance, a refund is not made.

4.2.5. Thorough documentation of the refund is placed in the notes section of the patient's account.

4.3. In addition to proactively refunding credits created during the posting process, the billing department is responsible for refunding outstanding credits.

4.3.1. The accounts should be reviewed thoroughly.

4.4. Credit invoices are identified and refunded to the patient, guarantor, or third-party payer within 30 days.

4.4.1. Any credits identified that can be transferred to another outstanding invoice are done within 30 days of creation date.

4.4.2. The oldest credits should be processed and refunded first.

4.5. 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.

4.6. Refunds are posted to the patient's account when the refund check is issued.

4.7. 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

5. Insufficient Fund Checks and Unredeemed Refund Checks

5.1. Insufficient Fund Checks will be handled by the finance department.

5.2. 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 be voided

5.2.1. Leave the credit balance on the patient account or

5.2.2. Report to the Texas State Comptroller as unclaimed property by the finance department.

6. Changes in Assigned Billing Codes

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

6.2. 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.

6.3. 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.

7. Denials/ Rejections

7.1. All claims 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:

7.1.1. Claim denied for incorrect information.

7.1.1.1. Incorrect provider information.

7.1.1.2. Incorrect coverage information.

7.1.1.3. Lack of information.

7.1.2. Claim denied as inclusive with the primary procedure

7.1.2.1. 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.

7.1.3. Claim denied as services not provided or authorized

7.1.3.1. File the claim along with appropriate authorization#.

7.1.3.1.1. If we do not have authorization #, sometimes we can appeal the claim along with necessary medical document. Confirm if the visit had an authorization.

7.1.3.1.2. If no authorization is on file, contact carrier and request retroactive authorization; resubmit claim.

7.1.3.1.3. If no authorization can be obtained, adjustment should be made.

7.1.4. Claim denied because of incorrect medical coding

7.1.4.1. 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.

7.1.5. Claim denied due to invalid CPT code

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

7.1.6. Claim denied because primary insurance changed

7.1.6.1. File the claim to patient primary insurance if additional coverage is on file.

7.1.6.1.1. 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.

7.1.6.1.2. 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.

7.1.6.1.3. 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 additional payer sources.

7.1.7. Claim denied for coordination of benefits

7.1.7.1. Patient needs to update the COB information to insurance. If patient has more than one insurance, patient needs to call the insurance and inform them 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.

7.1.8. Claim denied for maximum benefits reached.

7.1.8.1. 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 additional payer sources.

7.1.9. Claim denied for retroactive termination date

7.1.9.1. 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.

7.1.10. Claim denied for invalid referral number

7.1.10.1. 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).

7.1.11. Claim denied for not covered by the patient's plan

7.1.11.1. Update visit to self-pay. Balance will be posted to patient's account.

7.1.11.2. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify additional payer sources.

7.1.12. Claim denied due to dates of service past filing deadline (timely filing)

7.1.12.1. 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.

7.1.12.2. Confirm filing / batch information and resubmit claim with proof of timely filing. If no proof of timely filing exists, submit it to billing supervisor for adjustment.

7.1.13. Claim denied due to bundling inclusive

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

7.1.14. Claim denied due to primary insurance paid in full

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

7.1.15. Claim denied because CHW is not PCP on file with payor

7.1.15.1. 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.

7.1.16. Claim denied due to non-billable service or provider

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

8. Insurance Follow Up

8.1. 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.

8.2. 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.

8.3. 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.

8.4. CHW Billing management or designee generates and provides reports from the practice management system to support Health Center staff engaged in follow up.

8.5. All actions taken on an account are documented, including the nature of the action, the date and the individual taking the action.

8.6. 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.

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

9. Rejected Claims

9.1. CHW Billing staff is required to identify, monitor, and act on all submitted claims that are rejected by third-party payers.

9.2. CHW staff is assigned responsibility for reviewing and acting on all rejected or denied claims.

9.3. These staff members receive all correspondence regarding rejections within one business day of receipt at the CHW (during the payment posting process).

9.4. All rejections are reviewed and acted upon within 2-3 business days of receipt.

9.5. 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.

9.6. 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.

9.7. 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.

9.8. Rejected claims are not resubmitted without corrections. Resubmitting a rejected claim without correcting it is grounds for disciplinary action.

9.9. 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.

9.10. CHW staff will work to proactively identify and resolve any problems with open or outstanding claims from third-party payers.

9.11. A CHW staff member assigned responsibility for insurance follow up runs an open claims report once a month, at minimum.

9.12. 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.

9.13. 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 act, as appropriate. Action may include, but is not limited to:

9.13.1. Identifying that the claim was never received and resubmitting the claim.

9.13.2. Submitting medical documentation to third-party payers if the claim is under review.

9.13.3. Appealing an adverse decision for payment; or

9.13.4. Communicating with the patient if the third-party payer is waiting for information from the patient.

10. 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.

11. 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.

12. Write Offs

12.1. 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

12.2. 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.

12.3. 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.

12.4. 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 accuracy.

X. MEDICAL FEE WAIVING POLICY & PROCEDURE

Policy Name: Medical Fee Waiving Policy & Procedure

Policy Number: 10.01
Last Revised: June 23, 2024
Related Policy: Refusal to Pay Policy, Sliding Fee Program Policy
Related Documents:
In-scope Teams: Billing, OEE, Patient Services, Dental Front Desk
Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to ensure that the lack of means does not hinder care while additionally ensuring that each of our patients is treated equally and fairly.

Procedure

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 identified 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:
    5.1. Chronic illness
    5.2. Financial problems related to transportation or other unexpected expenses
    5.3. Natural disasters
        5.3.1. House fire
        5.3.2. Loss of primary income sources
        5.3.3. Death of a family member defined above
    5.4. 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.
    5.5. 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.
    5.6. 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.
    5.7. The decision to waive fees will be applied and made available consistently to all qualified patients

XI. REFUSAL TO PAY POLICY & PROCEDURES

Policy Name: Refusal to Pay Policy & Procedure

Policy Number:	11.01
Last Revised:	June 23, 2024
Related Policy:	Medical Fee Waiving Policy; Sliding Fee Program Policy
Related Documents:	Registration Form; Payment Plan Form
In-scope Teams:	Billing, OEE, Patient Services, Dental Front Desk
Board Approval Date:	June 24, 2024

Policy

In accordance with the mission of Coastal Health & Wellness (CHW) and as a Federally Qualified Health Center (FQHC), it is the policy of CHW to ensure 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.

CHW distinguishes the difference between refusal to pay and inability to pay.

CHW notifies patients that refuse to pay that:

1.1. Amounts owed and the time recommended to make such payments.

1.2. They will receive statements for their services.

1.3. CHW offers other assistance such as meeting with a financial counselor, establishing payment plans, and looking for additional programs that may assist the patient.

1.4. 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.

2. A patient is deemed unwilling to pay if they:

2.1. Declare they will not pay for anything at the time of service.

2.2. Have a balance due more than $200 and have not made a payment within the last 3 months.

2.3. Refuse or fail to make a payment as agreed in the formal payment plan after a payment plan has been signed.

2.4. Refuse to meet with an eligibility specialist to have their financial status re-evaluated.

Procedure

1. Patients who express an unwillingness or refuse to pay will be referred to a billing eligibility specialist to assess their current financial and/or medical hardship status as per CHW's policy.
2. CHW provides several options to patients to pay, and those options include:
   2.1. Payment plans
   2.2. Waiver policies, and
   2.3. Financial counseling.
3. CHW does not choose to limit or deny services if accounts are unpaid.
4. 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*).
5. 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).
6. 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 of the option to set up a payment plan for amounts owed to CHW.
7. 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.
8. If the patient does not try to pay or fail to respond within 60 days, this constitutes refusal to pay.
9. 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.
   9.1. 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

Policy Name: Sliding Fee Adjustment Policy & Procedure

Policy Number:	12.01
Last Revised:	June 23, 2024
Related Policy:	Sliding Fee Program Policy, Billing and Collections Policy, Discount Eligibility Schedule
Related Documents:	CHW Registration Form
In-scope Teams:	Billing, Patient Services, HITT
Board Approval Date:	June 24, 2024

Policy

In accordance with the mission of Coastal Health & Wellness (CHW), a Federally Qualified Health Center (FQHC), it is the policy of CHW to ensure no one is denied care based on their inability to pay.

To maintain its compliance with the requirement to serve all patients regardless of ability to pay, CHW offers a sliding fee schedule of discounts to patients who are uninsured for all services and/or the particular service they seek. For underinsured patients, CHW offers sliding fee discounts to co-pays/co-insurances for covered services.

It is the policy of CHW to provide full or partial discounts for all services provided to patients based on their inability to pay. Eligibility is assessed and determined according to the CHW Sliding Fee Discount Policy & Procedure approved by The Governing Board ("The Board") and using the current year's Discount Eligibility Schedule/Sliding Fee Discount Schedule (SFDS).

The SFDS is calculated based on the Federally Poverty Guidelines (FPG). The FPGs are updated by the Department of Health and Human Services annually in January.

All uninsured and underinsured patients with self-pay balances after claims are adjudicated by a 3rd party payor who have been evaluated and meet eligibility criteria, will have their fee identified and documented in NextGen, CHW's designated Electronic Practice Management (EPM) System. Adjustments will be made to in scope encounters using Sliding Fee Adjustment (SFA) code.

Procedure

1. CHW screens patients to determine qualification for the center's Sliding Fee Discount Program.
2. The Health Information Technology Team (HITT) updates the *Sliding Fee Verification* tablespace in NextGen (See Illustration A) annually with the criteria derived from the current year's Discount Eligibility Schedule/Sliding Fee Discount Schedule (SFDS) created by the Revenue Cycle Management (RCM), billing team. (See Illustration B)

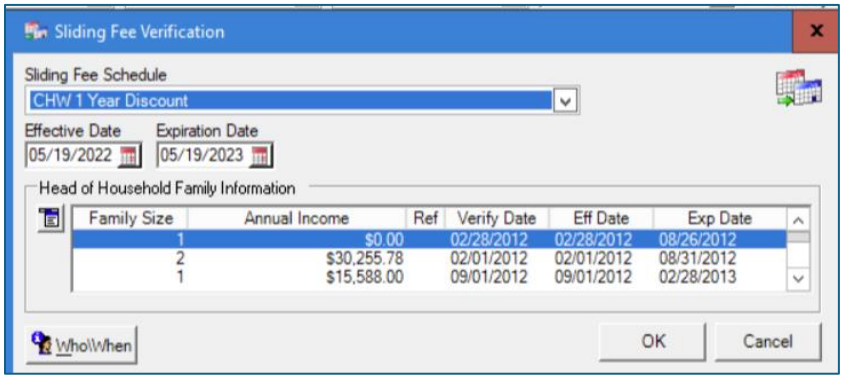
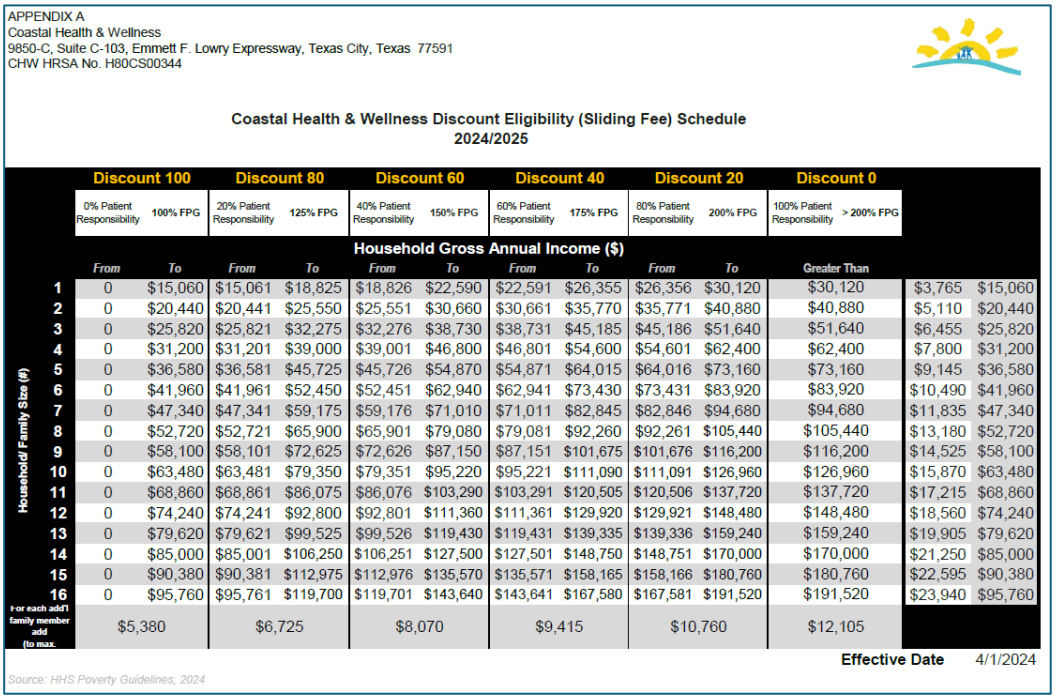


Illustration A: Sample Sliding Fee Verification Tablespace in NextGen



APPENDIX A
Coastal Health & Wellness
9850-C, Suite C-103, Emmett F. Lowry Expressway, Texas City, Texas 77591
CHW HRSA No. H80CS00344

Coastal Health & Wellness Discount Eligibility (Sliding Fee) Schedule
2024/2025

Household Family Size (#)	Discount 100		Discount 80		Discount 60		Discount 40		Discount 20		Discount 0		
	0% Patient Responsibility	100% FPG	20% Patient Responsibility	125% FPG	40% Patient Responsibility	150% FPG	60% Patient Responsibility	175% FPG	80% Patient Responsibility	200% FPG	100% Patient Responsibility	> 200% FPG	
	Household Gross Annual Income ($)												
	From	To	From	To	From	To	From	To	From	To	Greater Than		
1	0	$15,060	$15,061	$18,825	$18,826	$22,590	$22,591	$26,355	$26,356	$30,120	$30,120	$3,765	$15,060
2	0	$20,440	$20,441	$25,550	$25,551	$30,660	$30,661	$35,770	$35,771	$40,880	$40,880	$5,110	$20,440
3	0	$25,820	$25,821	$32,275	$32,276	$38,730	$38,731	$45,185	$45,186	$51,640	$51,640	$6,455	$25,820
4	0	$31,200	$31,201	$39,000	$39,001	$46,800	$46,801	$54,600	$54,601	$62,400	$62,400	$7,800	$31,200
5	0	$36,580	$36,581	$45,725	$45,726	$54,870	$54,871	$64,015	$64,016	$73,160	$73,160	$9,145	$36,580
6	0	$41,960	$41,961	$52,450	$52,451	$62,940	$62,941	$73,430	$73,431	$83,920	$83,920	$10,490	$41,960
7	0	$47,340	$47,341	$59,175	$59,176	$71,010	$71,011	$82,845	$82,846	$94,680	$94,680	$11,835	$47,340
8	0	$52,720	$52,721	$65,900	$65,901	$79,080	$79,081	$92,260	$92,261	$105,440	$105,440	$13,180	$52,720
9	0	$58,100	$58,101	$72,625	$72,626	$87,150	$87,151	$101,675	$101,676	$116,200	$116,200	$14,525	$58,100
10	0	$63,480	$63,481	$79,350	$79,351	$95,220	$95,221	$111,090	$111,091	$126,960	$126,960	$15,870	$63,480
11	0	$68,860	$68,861	$86,075	$86,076	$103,290	$103,291	$120,505	$120,506	$137,720	$137,720	$17,215	$68,860
12	0	$74,240	$74,241	$92,800	$92,801	$111,360	$111,361	$129,920	$129,921	$148,480	$148,480	$18,560	$74,240
13	0	$79,620	$79,621	$99,525	$99,526	$119,430	$119,431	$139,335	$139,336	$159,240	$159,240	$19,905	$79,620
14	0	$85,000	$85,001	$106,250	$106,251	$127,500	$127,501	$148,750	$148,751	$170,000	$170,000	$21,250	$85,000
15	0	$90,380	$90,381	$112,975	$112,976	$135,570	$135,571	$158,165	$158,166	$180,760	$180,760	$22,595	$90,380
16	0	$95,760	$95,761	$119,700	$119,701	$143,640	$143,641	$167,580	$167,581	$191,520	$191,520	$23,940	$95,760
For each add'l family member add (to max.	$5,380		$6,725		$8,070		$9,415		$10,760		$12,105		

Effective Date 4/1/2024

Source: HHS Poverty Guidelines, 2024

Illustration B: 2024-2025 CHW Discount Eligibility Schedule

3. NextGen, CHW's designated Electronic Practice Management (EPM) System, automatically calculates the Sliding Fee Adjustment (SFA) amount based on the patient's gross household income and family size sourced from the CHW Registration performed by Patient Services (PS).

4. Sliding Fee Adjustments will automatically be posted at the encounter level on the patient account in NextGen for in scope date(s) of service within one business day according to the sliding fee percentage to which the patient qualified.
    4.1. Sliding Fee Adjustment (SFA) code will automatically append to the encounter(s) for the duration of the assessment period.

XIII. GOOD FAITH ESTIMATES

Policy Name: Good Faith Estimate Policy & Procedure

Policy Number:	13.01
Last Revised:	June 23, 2024
Related Policy:	Sliding Fee Program Policy, Billing and Collections Policy
Related Documents:	
In-scope Teams:	Billing
Board Approval Date:	June 24, 2024

Policy

In accordance with the mission of Coastal Health & Wellness (CHW) and as a Federally Qualified Health Center (FQHC), it is the policy of CHW to comply with a Patient's 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 with 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 CHW provides 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.

Procedure

CHW provides patients with a Good Faith Estimate in writing at least 1 business day before their scheduled medical service or item.

Patients can also request from CHW a Good Faith Estimate before scheduling an item or service.

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Governing Board
June 2024
Item#9
Informational Report: Credentialing & Privileging Committee
Reviewed and Approved the Following Providers Privileging Rights

a) Ashley Strain, NP Pediatric

Re-Credentialing

b) Chris Garcia, MD
c) Tandace McDill, MD
d) Jason Borillo, PA-C
e) Nadia Ahmed, MD

Back to Agenda

Governing Board
June 2024
Item#10
Consider for Approval April 2024 Financial Report
Submitted by Kenna Pruitt

COASTAL HEALTH & WELLNESS

Governing Board

FINANCIAL SUMMARY

For the Period Ending

April 30, 2024

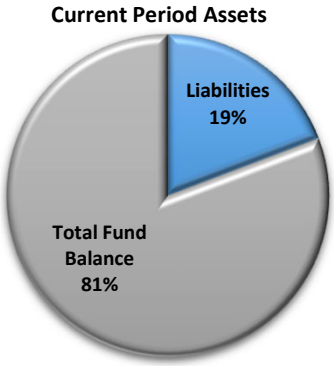
GCHD Board Room | 9850-A Emmett F. Lowry Expy. | Texas City, TX 77591

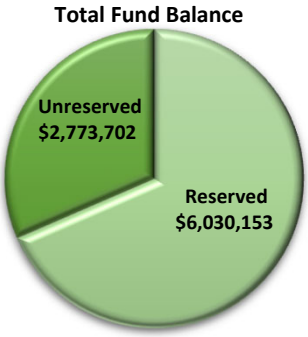
June 27, 2024

CHW - BALANCE SHEET

as of April 30, 2024

	Current Month Apr-24	Prior Month Mar-24	Increase (Decrease)
ASSETS			
Cash & Cash Equivalents	$2,273,657	$2,786,732	($513,075)
Accounts Receivable	8,576,876	8,033,292	543,584
Allowance For Bad Debt	(1,160,995)	(1,120,153)	(40,843)
Pre-Paid Expenses	887,793	798,434	89,359
Due To / From	321,869	(127,619)	449,488
Total Assets	**$10,899,200**	**$10,370,686**	**$528,514**
LIABILITIES			
Accounts Payable	$506,438	$522,337	($15,899)
Accrued Expenses	1,072,518	981,232	91,286
Deferred Revenues	516,389	24,642	491,748
Total Liabilities	**$2,095,345**	**1,528,210**	**$567,135**
FUND BALANCE			
Fund Balance	$8,847,856	$9,562,785	($714,929)
Current Change	(44,002)	(720,309)	676,308
Total Fund Balance	**$8,803,855**	**$8,842,476**	**($38,621)**
TOTAL LIABILITIES & FUND BALANCE	**$10,899,200**	**$10,370,686**	**$528,514**

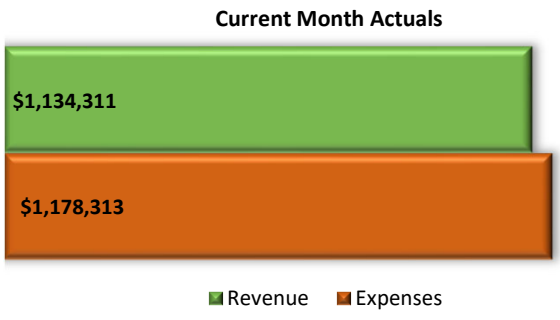


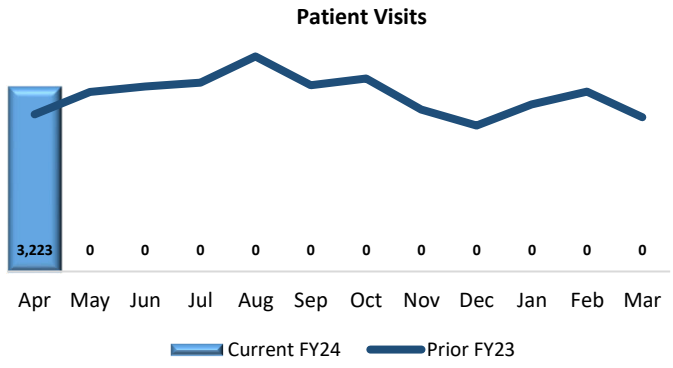


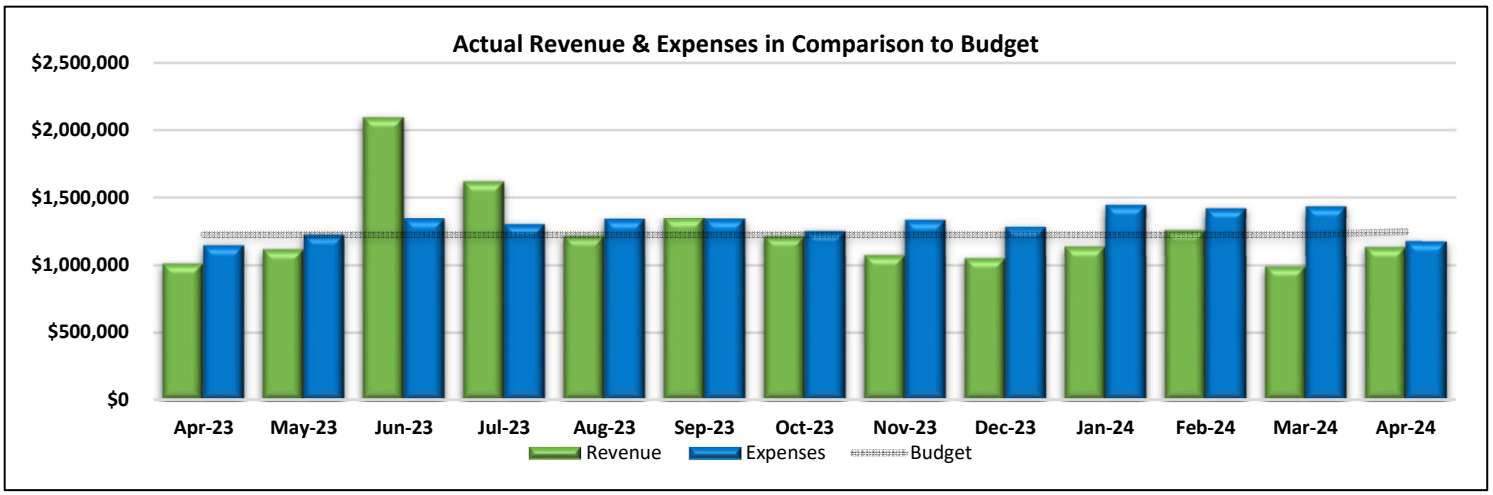
CHW - REVENUE & EXPENSES

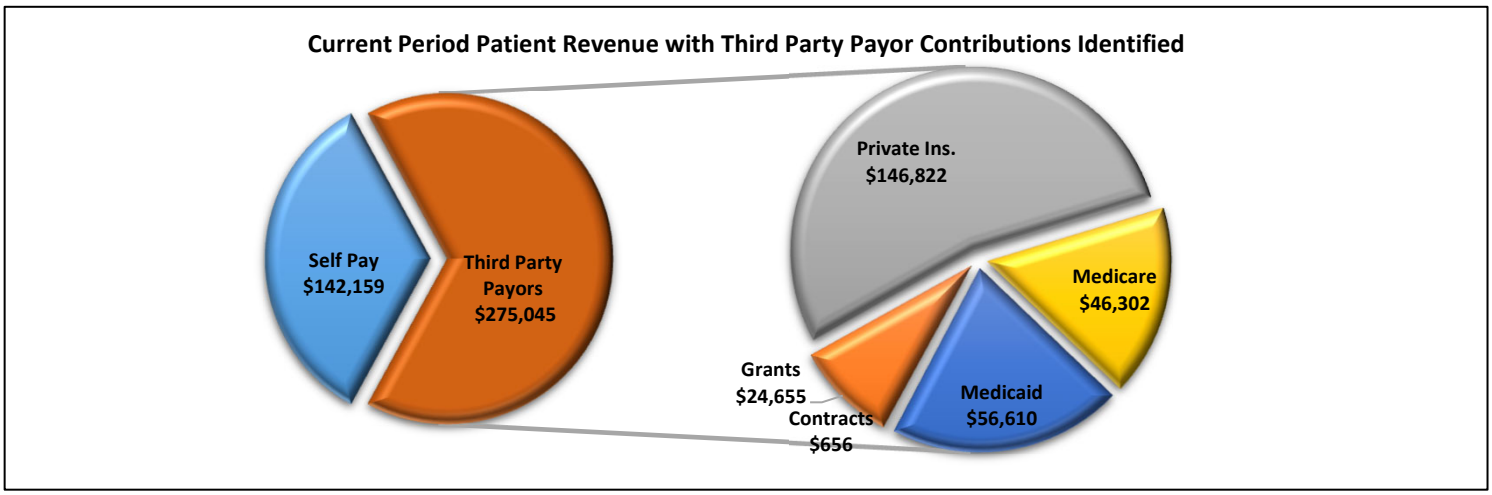
as of April 30, 2024

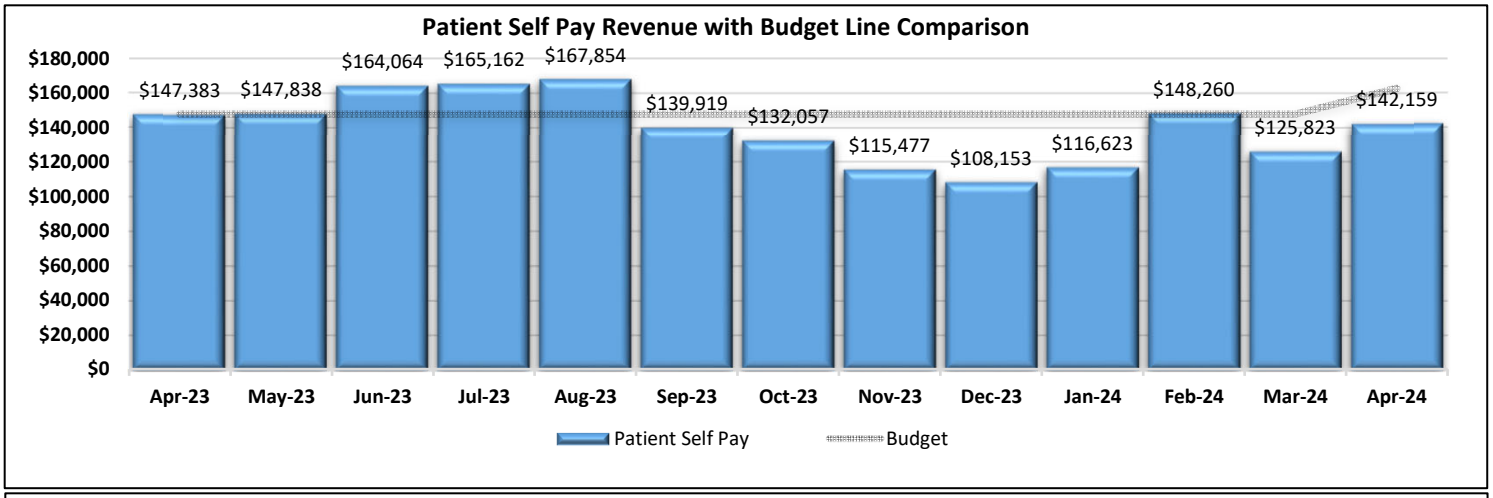
	MTD Actual Apr-24	MTD Budget Apr-24	MTD Budget Variance	YTD Actual thru Apr-24	YTD Budget thru Apr-24	YTD Budget Variance
REVENUE						
County Revenue	$244,556	$244,556	$0	$244,556	$244,556	$0
HHS Grant Revenue	235,148	269,783	(34,636)	235,148	269,783	(34,636)
Patient Revenue	643,121	701,772	(58,651)	643,121	701,772	(58,651)
Other Revenue	11,487	29,500	(18,013)	11,487	29,500	(18,013)
Total Revenue	**$1,134,311**	**$1,245,611**	**($111,300)**	**$1,134,311**	**$1,245,611**	**($111,300)**
EXPENSES						
Personnel	$815,176	$1,017,304	$202,127	$815,176	$1,017,304	$202,127
Contractual	173,351	99,740	(73,611)	173,351	99,740	(73,611)
Supplies	48,688	140,969	92,281	48,688	140,969	92,281
Travel	1,491	2,017	525	1,491	2,017	525
Equipment/Capital	33,767	0	(33,767)	33,767	0	(33,767)
Bad Debt Expense	40,843	57,536	16,693	40,843	57,536	16,693
Other	64,997	141,845	76,847	64,997	141,845	76,847
Total Expenses	**$1,178,313**	**$1,459,409**	**$281,097**	**$1,178,313**	**$1,459,409**	**$281,097**
CHANGE IN NET ASSETS	**($44,002)**	**($213,798)**	**$169,797**	**($44,002)**	**($213,798)**	**$169,797**






Actual Revenue & Expenses in Comparison to Budget
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
Revenue
Expenses
Budget


Current Period Patient Revenue with Third Party Payor Contributions Identified
Self Pay
$142,159
Third Party
Payors
$275,045
Private Ins.
$146,822
Medicare
$46,302
Medicaid
$56,610
Grants
$24,655
Contracts
$656


Patient Self Pay Revenue with Budget Line Comparison
$180,000
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
$147,383
$147,838
$164,064
$165,162
$167,854
$139,919
$132,057
$115,477
$108,153
$116,623
$148,260
$125,823
$142,159
Apr-23
May-23
Jun-23
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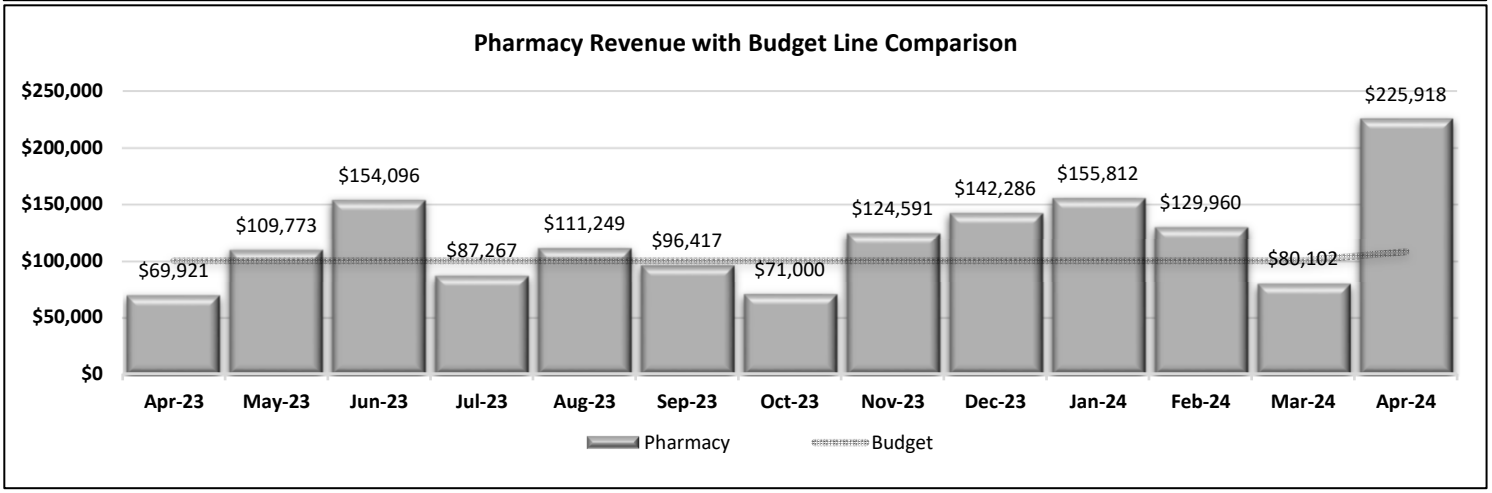
Jan-24
Feb-24
Mar-24
Apr-24
Patient Self Pay
Budget


Pharmacy Revenue with Budget Line Comparison
$250,000
$200,000
$150,000
$100,000
$50,000
$0
$69,921
$109,773
$154,096
$87,267
$111,249
$96,417
$71,000
$124,591
$142,286
$155,812
$129,960
$80,102
$225,918
Apr-23
May-23
Jun-23
Jul-23
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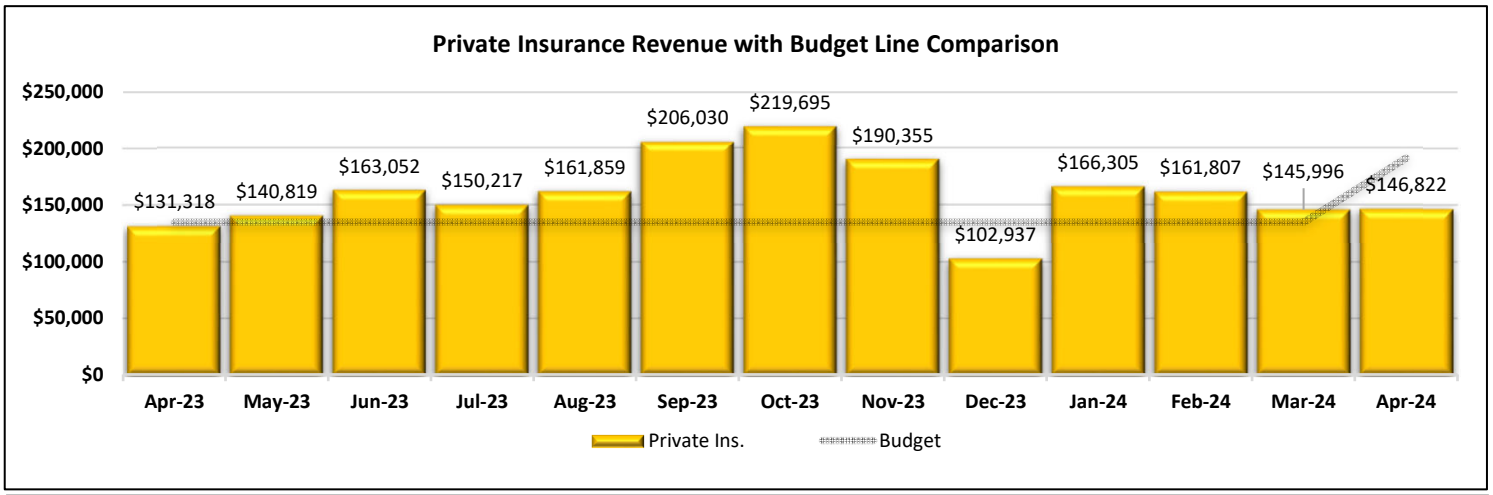
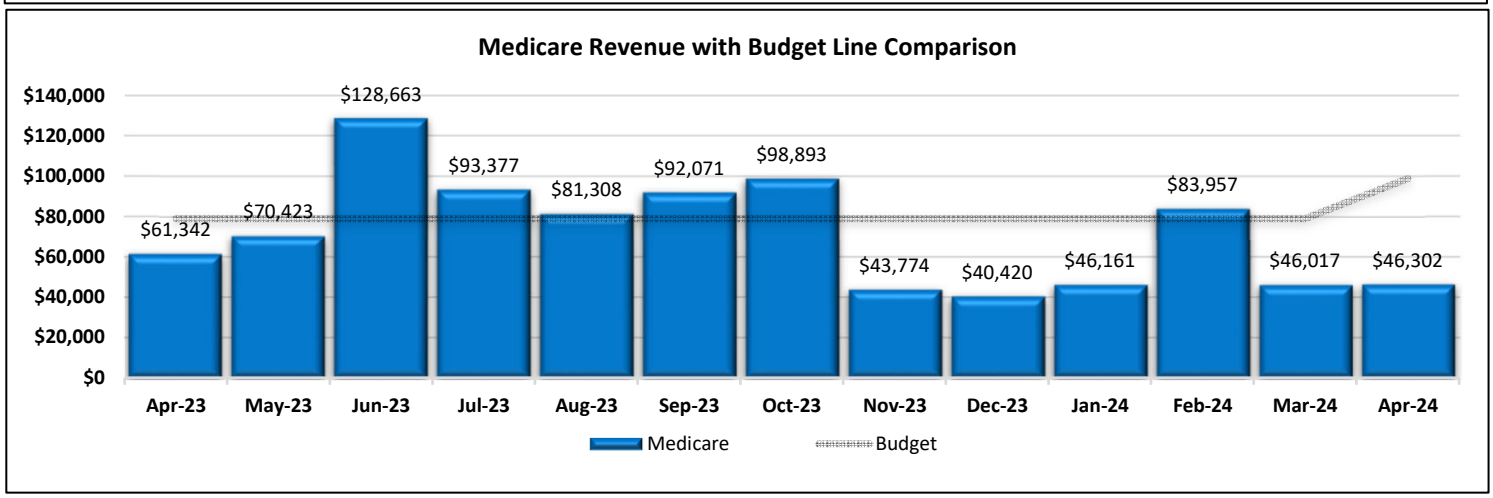
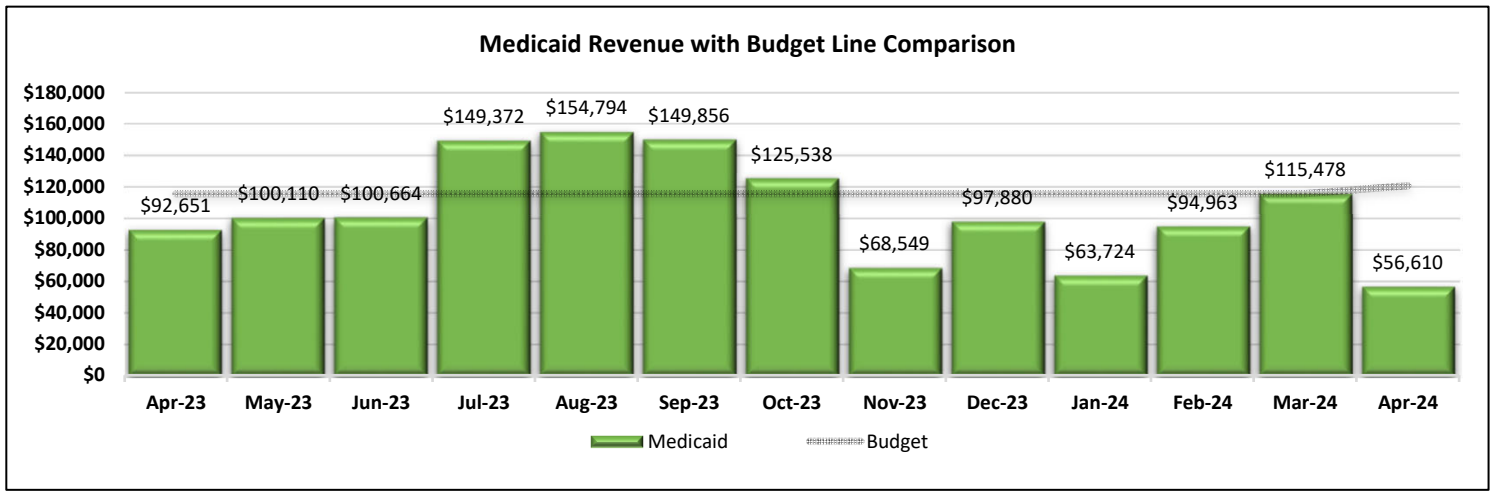
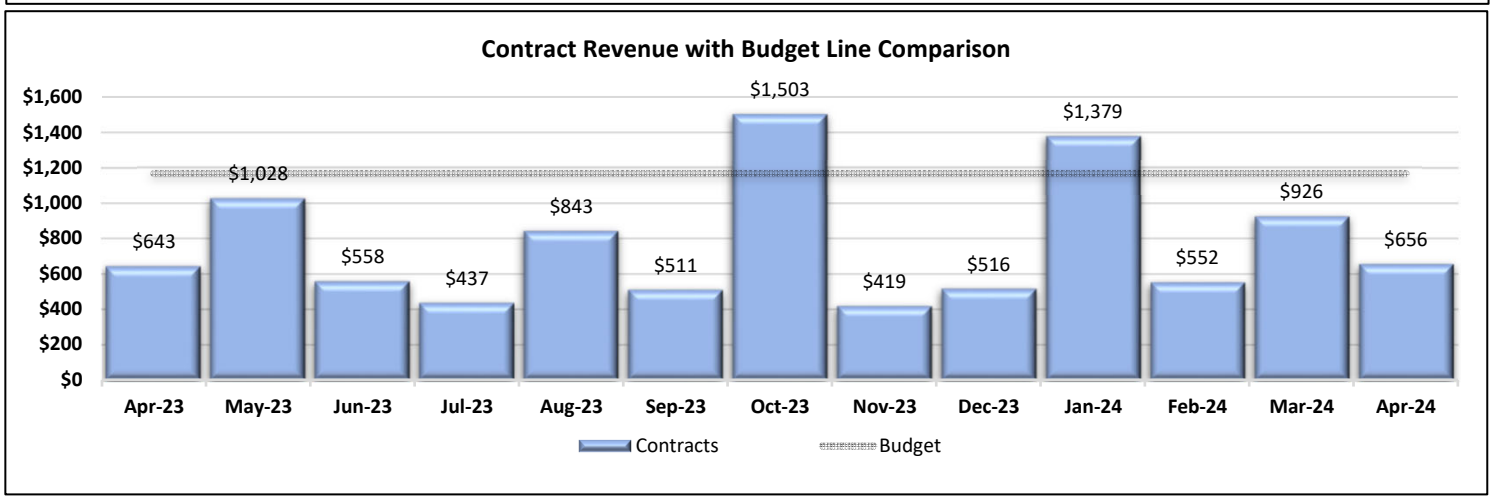
Jan-24
Feb-24
Mar-24
Apr-24
Pharmacy
Budget









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Governing Board
June 2024
Item#11
Consider for Approval Increase Pharmacy Build in the Amount of $18,500 Submitted by Kenna Pruitt

Coastal Health & Wellness

GALVESTON COUNTY HEALTH DISTRICT

CONTRACT AWARD

AMENDMENT 1

CONTRACT FOR: GCHD Pharmacy Buildout RFP 23-009

THIS AMENDMENT ("AMENDMENT") IS ENTERED INTO BETWEEN THE GALVESTON COUNTY HEALTH DISTRICT AND THE CONTRACTOR NAMED BELOW PURSUANT TO THE REFERENCED INVITATION TO BID. THIS AMENDMENT IS EFFECTIVE JUNE 12, 2024.

Bid No: **RFP 23-009**

Contractor: Unbehagen Construction / Tucon LLC

The parties desire to amend the construction cost and the scope of work in the original contract award dated September 6th, 2023, under the same terms and conditions contained in the Contract as follows:

The Contract Sum: GCHD shall pay the Contractor for performance of the Contract, the revised sum of **$ 234,500.00** Dollars and **00**/100, which is an increase of $18,500.00 from the current contract amount of $216,000.00 to accommodate for the additional 354sf of construction space with the new design.

The following are clarifications to the scope of work:

1. Exclude the access control scope of work. We will provide the wall boxes for the devices if needed.
2. IT data cables 26ea CAT 6 are included to locations shown on drawings. We will punch down cables at IT Close and new wall outlets, and certify installation. We exclude all equipment, terminal blocks, racks, etc.
3. New acoustic ceiling system will be installed below the existing wood ceiling. The existing skylight opening will most likely remain exposed for air flow, but the mechanical contractor will decide this.
4. The plan west and north walls have vinyl wall cover that will be removed and walls to be painted.
5. The door to room 103 is shown to be a sliding pocket door. We exclude the lockset for this door and recommend having your access control contractor secure this door with a mag lock.
6. Ceiling heights may vary from those shown on drawings due to existing conditions.

7. Existing flooring to remain. We will repair the flooring along the plan west wall at existing cabinets. The repair will not be a match to the existing floor but will can create a border with a brown material similar to the existing conditions in other areas of the building.
8. Cabinet standard key locks are included where noted.
9. Exclude tinting of existing storefront windows. There is not a specification for this material and there is a large cost variation between different material.
10. Exclude shutters at the three interior counter windows. Counter window to be aluminum frame with ½" thick clear tempered safety glass.
11. Existing light fixture style is obsolete and new fixtures will not match them.

Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms.

EXECUTED this 12.00 day of JUNE, 2024.00.

GALVESTON COUNTY HEALTH DISTRICT

BY: DocuSigned by: Dr. Philip Keiser 2F97610968347A...

Dr. Philip Keiser, Executive Director

CONTRACTOR

UNBEHAGEN CONSTRUCTION / TUCON LLC

BY: DocuSigned by: Mike Unbehagen 4002FF3838304914... CEO

Signature – Title

Mike Unbehagen

Printed Name

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Governing Board
June 2024
Item#12
Consider for Approval Donnie VanAckeren, Community Representative, to Serve as Governing Board Chairperson

Back to Agenda

Governing Board
June 2024
Item#13
Consider for Approval the Reappointment of the following Coastal Health & Wellness Governing Board Members for a 2 Year Term Expiring June 2026:

a) Kevin Avery (Consumer Member)
b) Victoria Dougharty (Consumer Member)
c) Sergio Cruz (Community Member)
d) Clay Burton (Consumer Member)

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Governing Board
June 2024
Item#14
Consider for Approval the Reappointment of the following Coastal Health & Wellness Governing Board Members for a 2 Year Term Expiring June 2024:

a) Organizational Updates Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Interim Chief Operating Officer/Director of Operations
c) Dental Updates Submitted by Dental Director
d) Medical Updates Submitted by Associate Medical Director

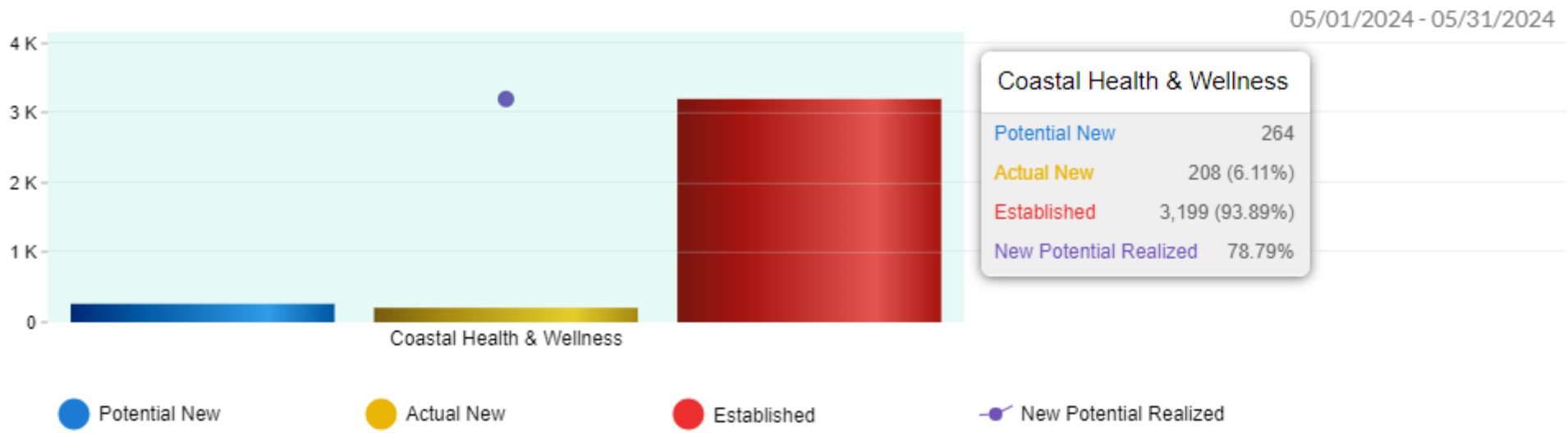
Coastal Health & Wellness *May 2024* Health Center Update

Coastal Health & Wellness
Galveston County's Community Health Center

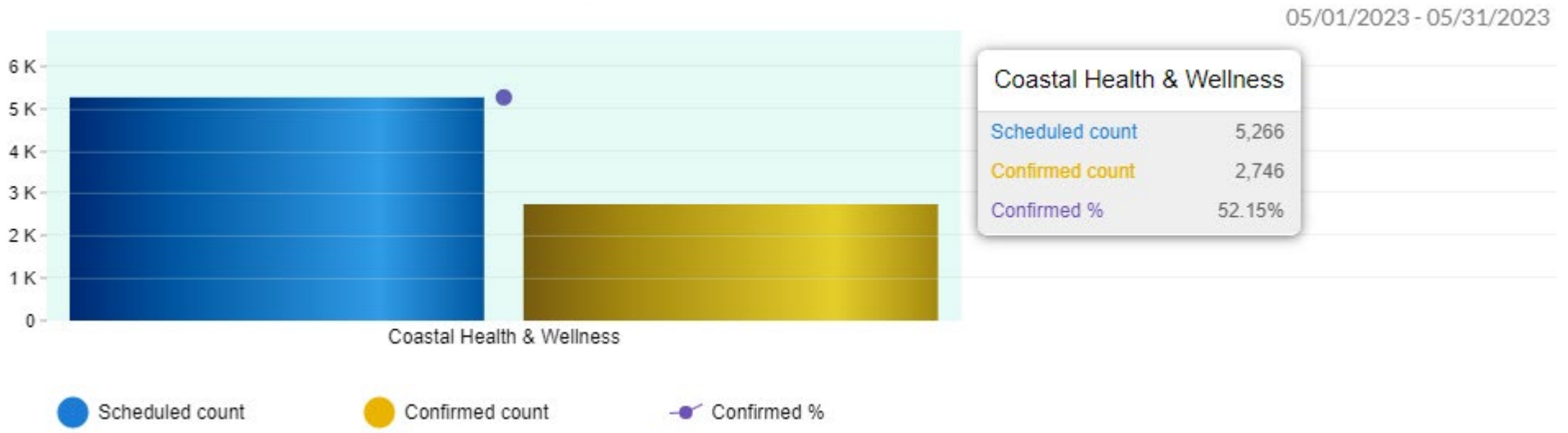
coastalhw.org

Providing high quality healthcare to all..

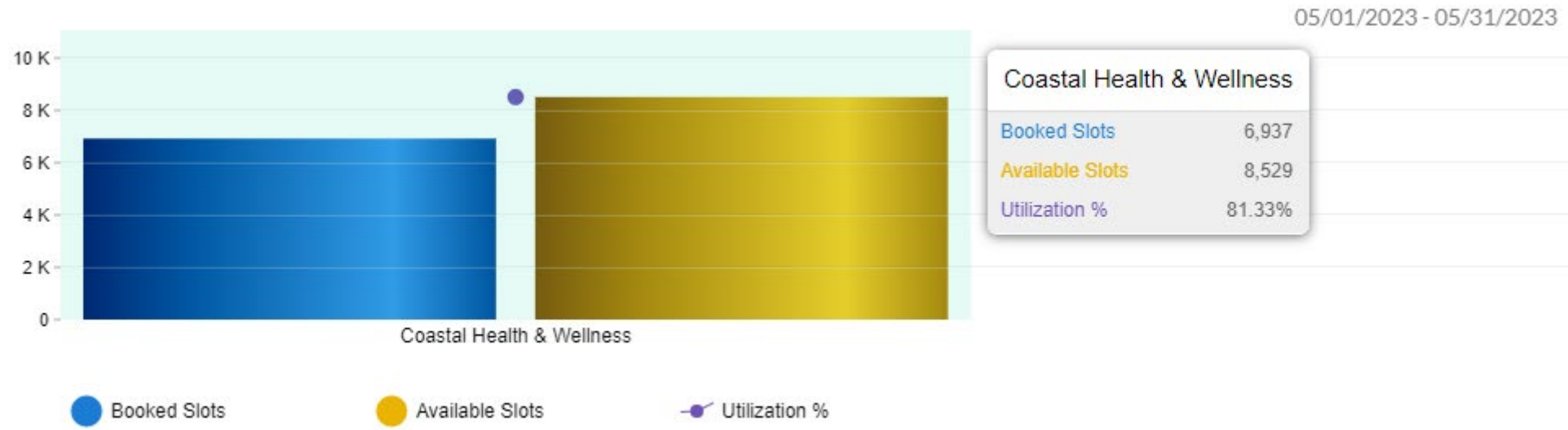
May 2023 vs. 2024
New vs. Established Patients (36.5% decrease in New Patients and a 9% decrease in Established Patients)



May 2023 vs. 2024
Confirmed Appointments (4.6% decrease, note that scheduled appts are down as well by 10.5%)

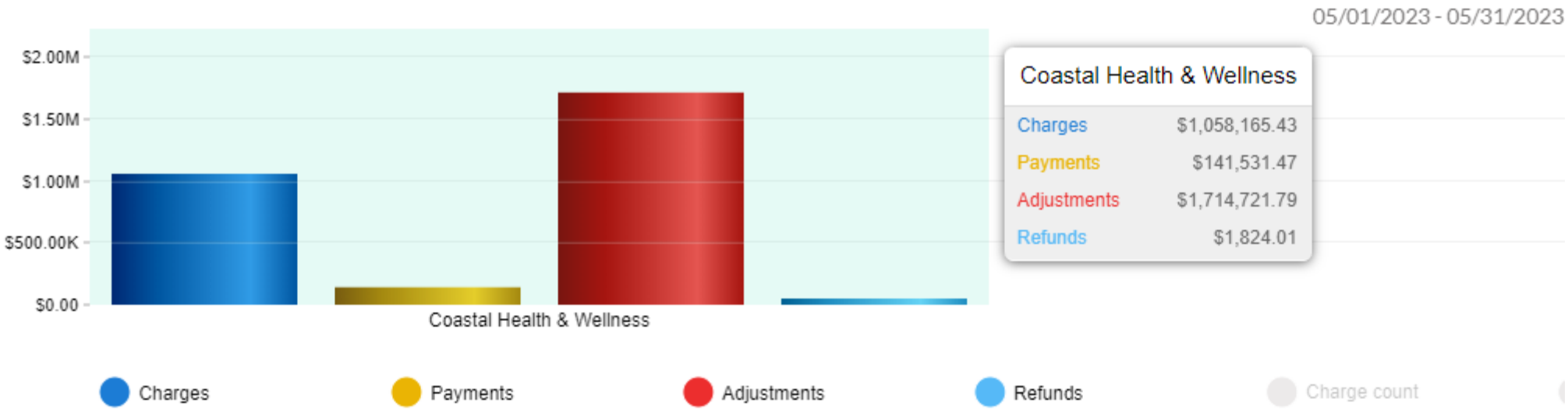


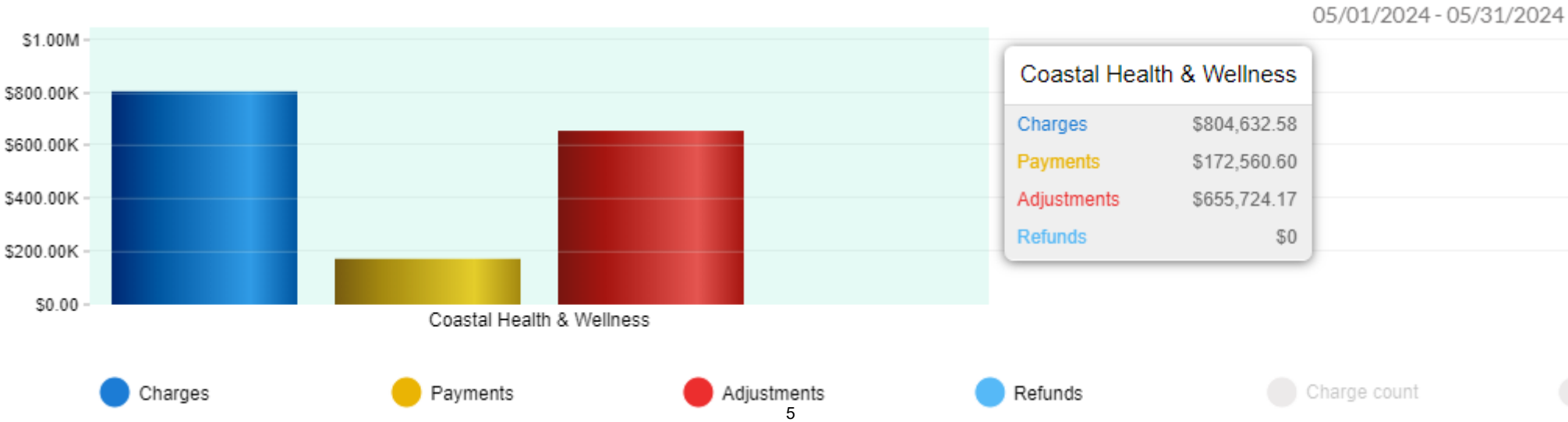
May 2023 vs. 2024
Resource Utilization (0.6% decrease in available slots and a 3.5% decrease in booked appointment slots, making utilization lower)



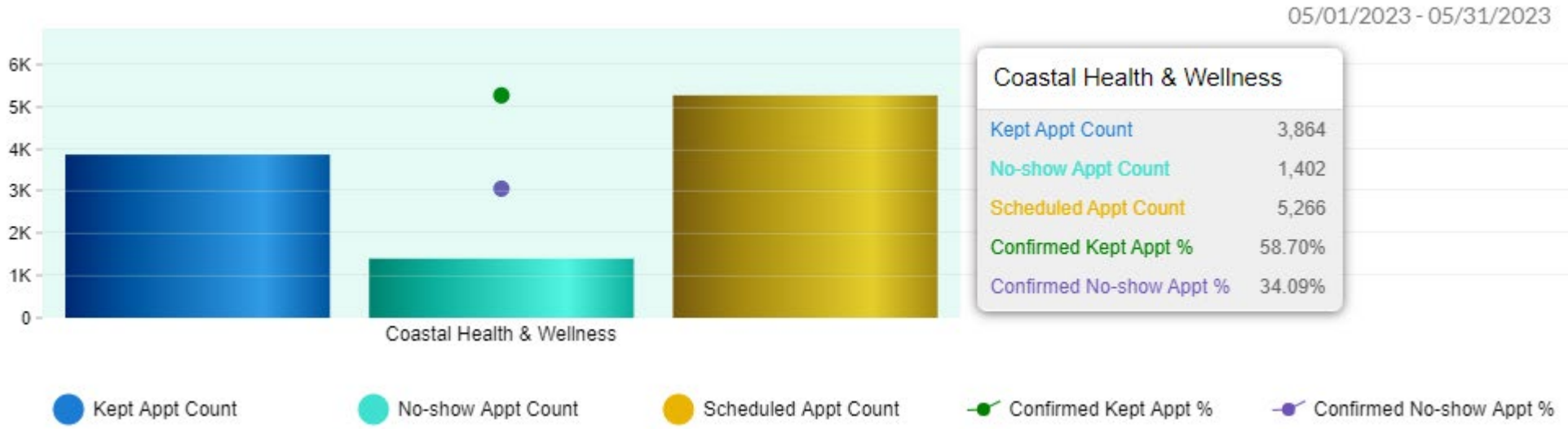
May 2023 vs. 2024 Charges/Payments/Adjustments/Refunds

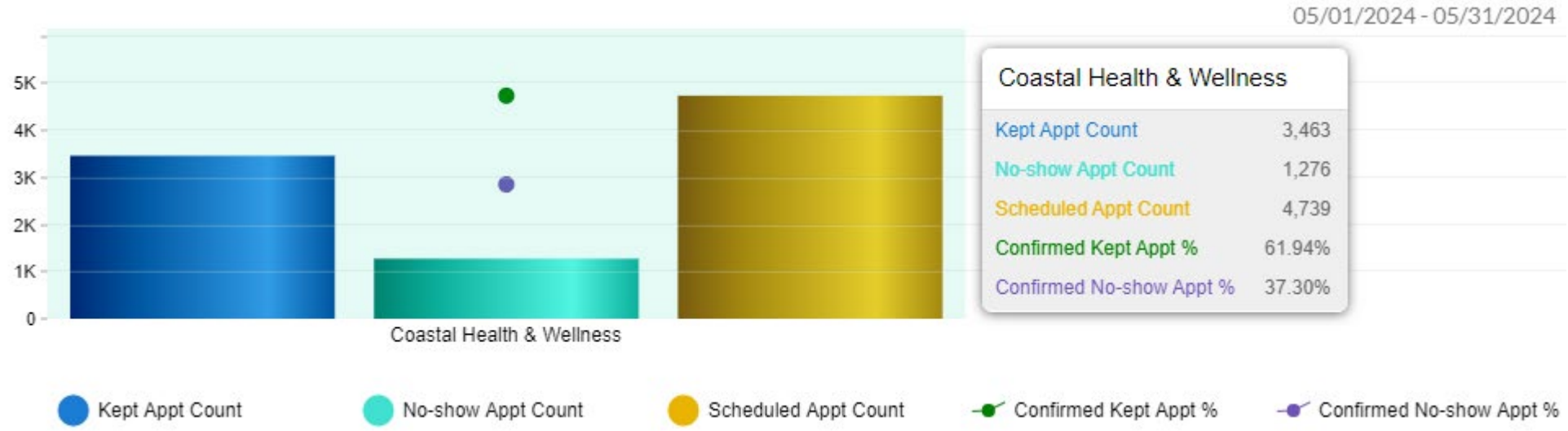
(27% decrease in charges, 20% increase in payments, 89% decrease in adjustments)



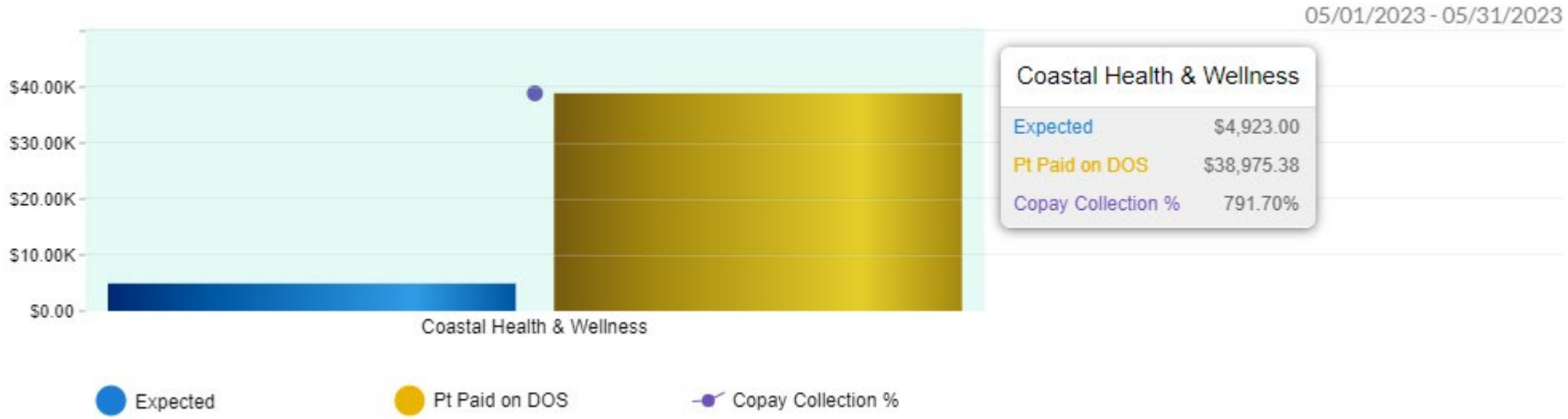


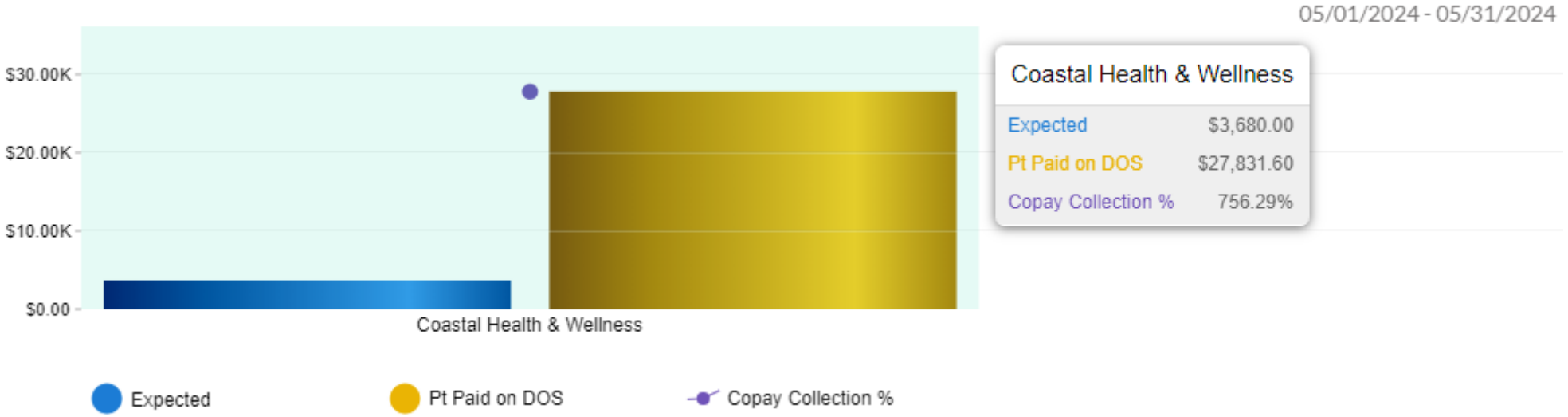
May 2023 vs. 2024
Kept/No-Show Comparison (11% decrease in kept appointments, 9% increase in no-shows, 11% decrease in scheduled appointments)



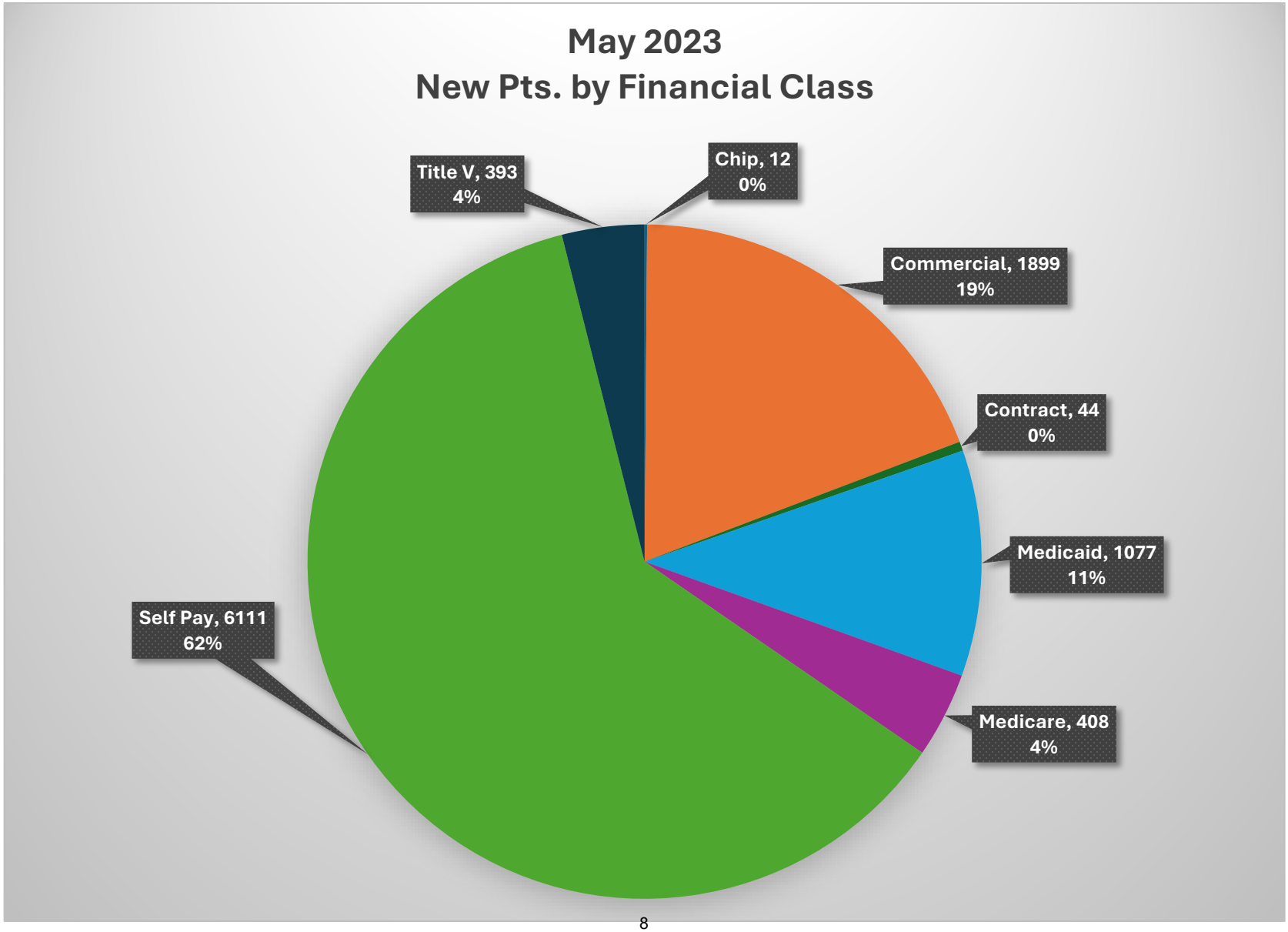


May 2023 vs. 2024
Copay Collection (5% decrease)

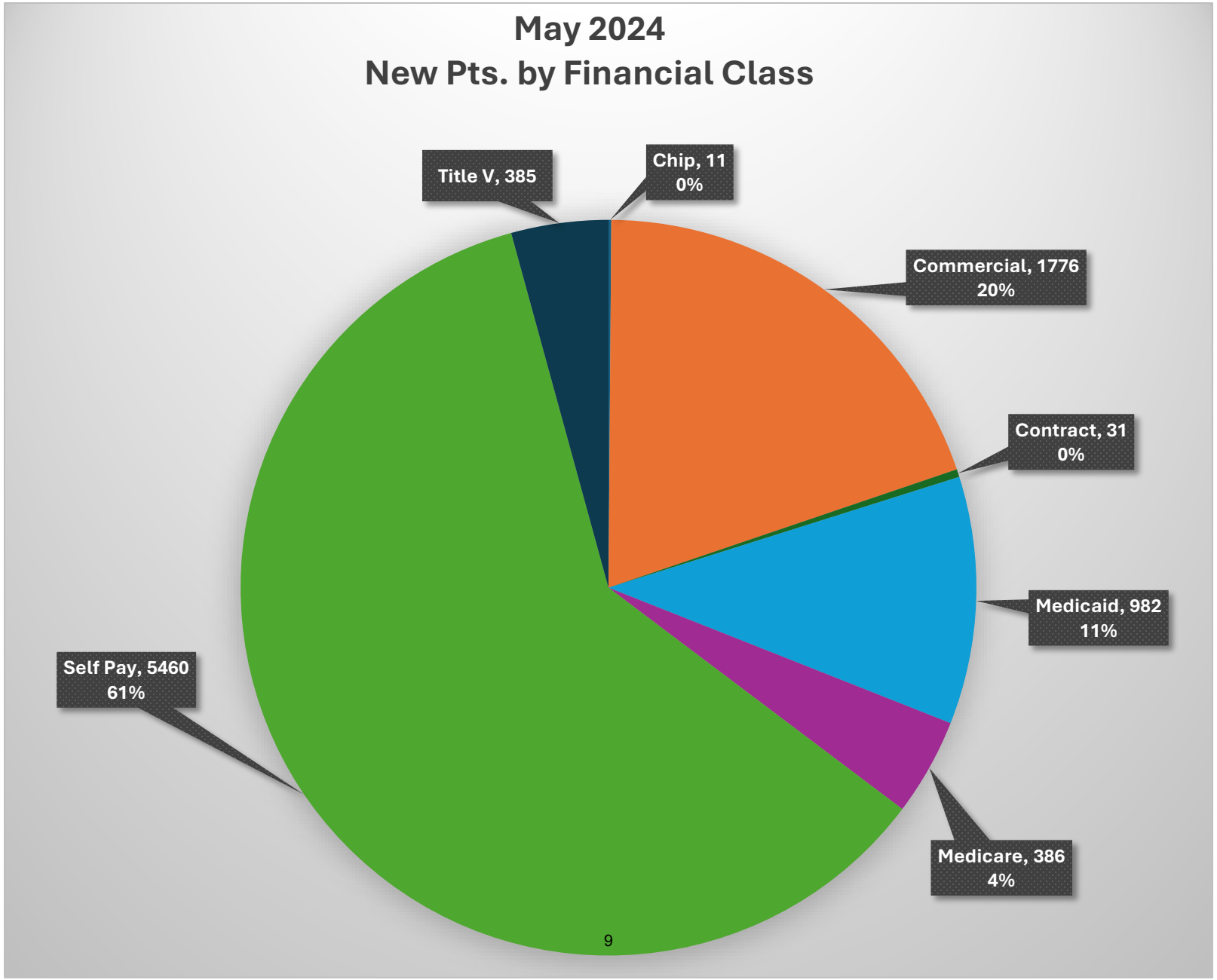




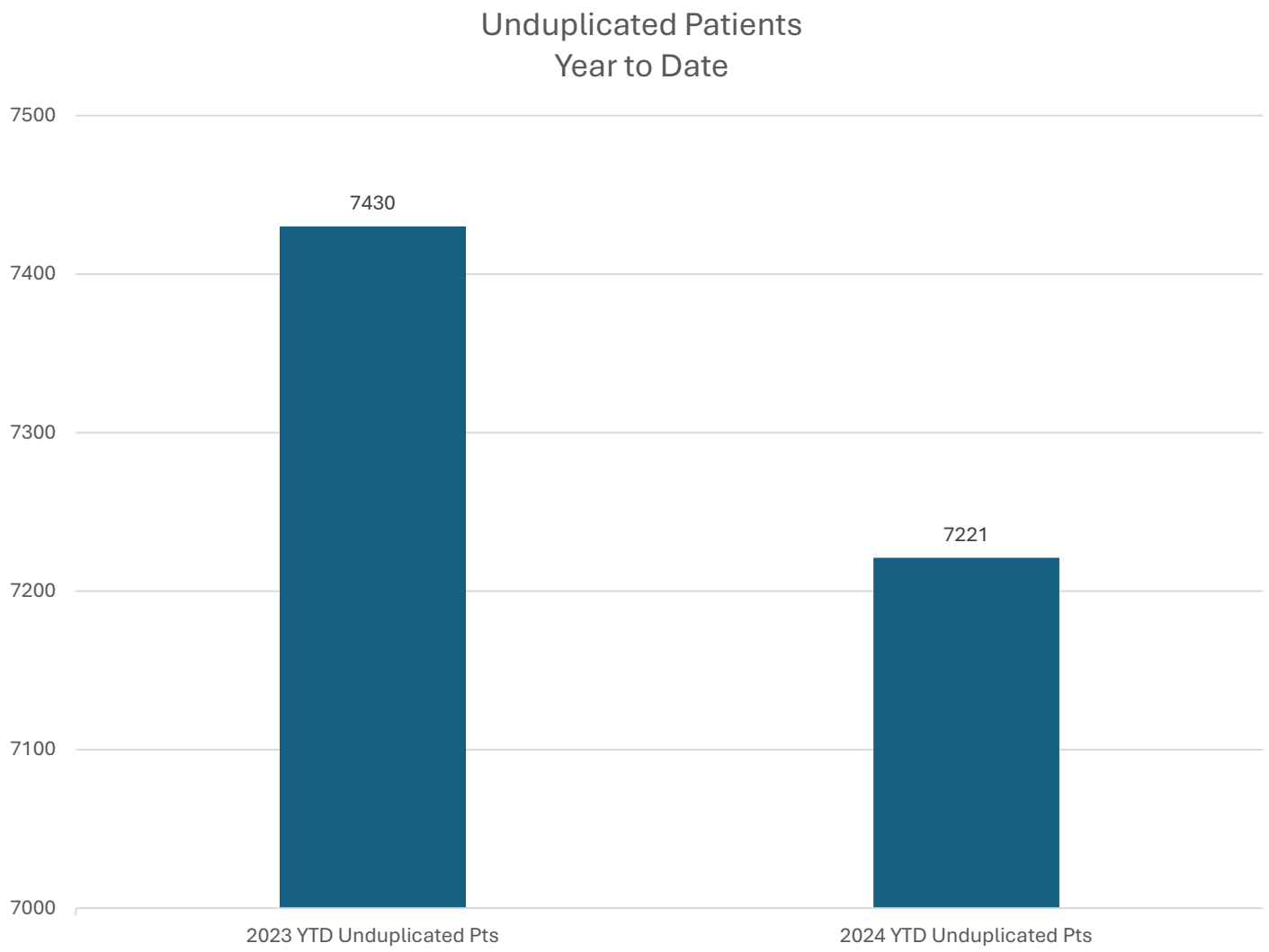
May 2023 vs. 2024
New Pts. by Financial Class



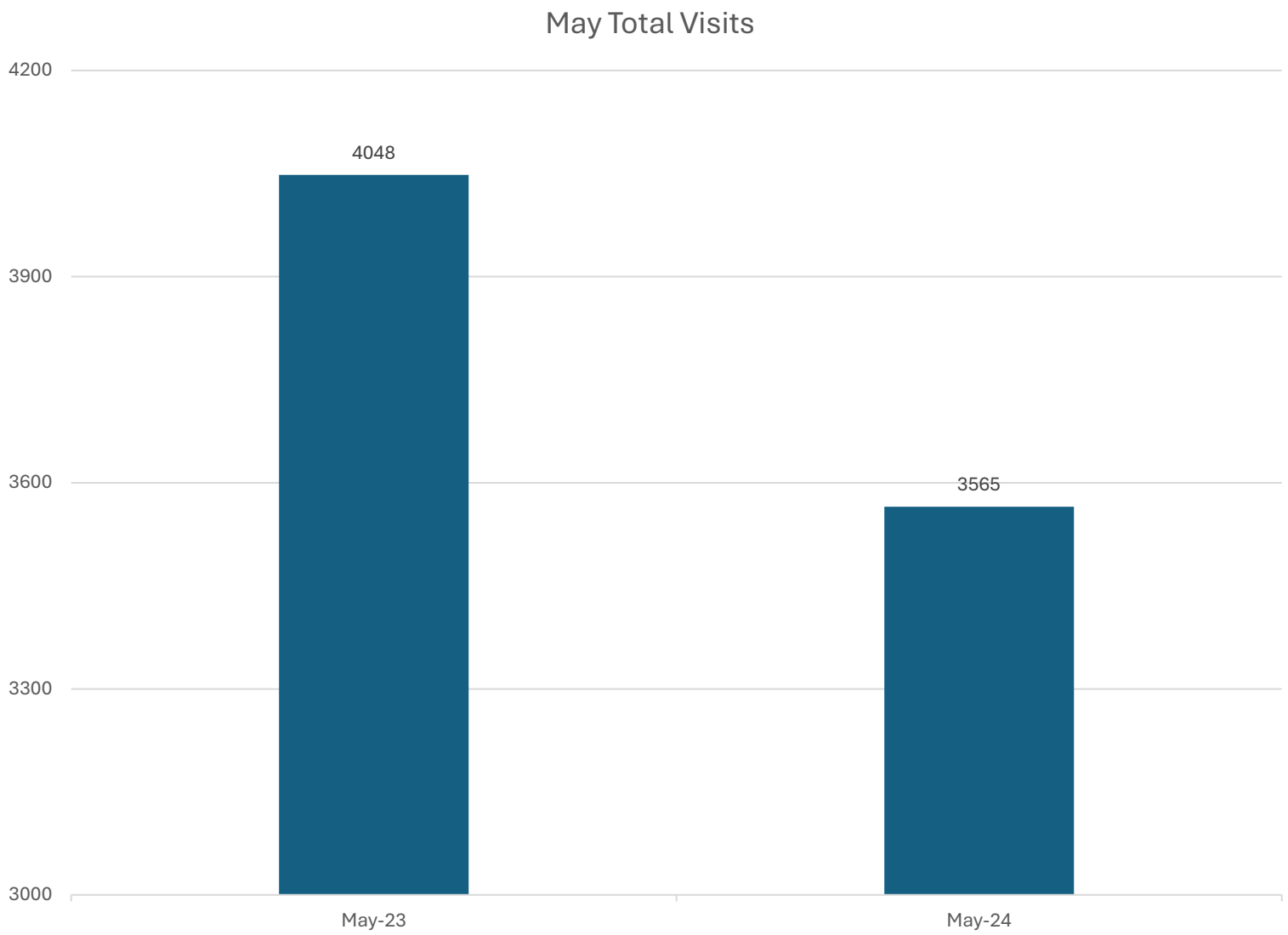
May 2023 vs. 2024
New Pts. by Financial Class



YTD 2023 vs. 2024
Unduplicated Patients* (3% decrease)



May 2023 vs. 2024
Visits (13% decrease)



Community Outreach Events

Provided by Director of Community Engagement

Thank you!!!

Updates…

- 2024 FTCA application was submitted successfully! Thank you, Ami, Wendy, and Lisa.
- Preparing for CHW's HRSA Operational Site Visit August 20-22, 2024. Board involvement **mandatory** per HRSA. Mark your calendar now!
- Employee survey results are in and being compiled. More to come!
- EHR Optimization continues.
- Recruitment & Retention Plans in progress.
- Pharmacy in progress.
- RCM onboarding new staff as planned.
- Strategic Health Plan update in the works.

Coastal Health & Wellness
Galveston County's Community Health Center

coastalhw.org

Providing high quality healthcare to all..

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Community Engagement

Data Sharing:

90-day Analysis sent to Community Partners/Stakeholders (January 16-April 15, 2024) based on 543 surveys

Analysis Link: https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:6e14118a-87e2-43c0-96d6-dcee3f1ece7f

Health Screenings:

- Bayside Community Center-2
- Dickinson Community Center- 13
- Wayne Johnson Community Center-11

Community Engagement

Health/Resource Fairs:

- Goodwill (every Tuesday/Thursday)-46
- Kroger-50
- Ignite (Career Day)-65
- Dunbar Middle School (Career Day)- 650
- Travis Elementary (Career Day)- 70
- La Marque High School (Career Day)- 153
- Lobitt Middle School (Career Day)- 600
- Limones Productions Cinco de Mayo-5
- The Fellowship Church- 200
- City of Texas City Employee Fair- 220
- Santa Fe ISD End of the Year Awards & Resource Fair-200

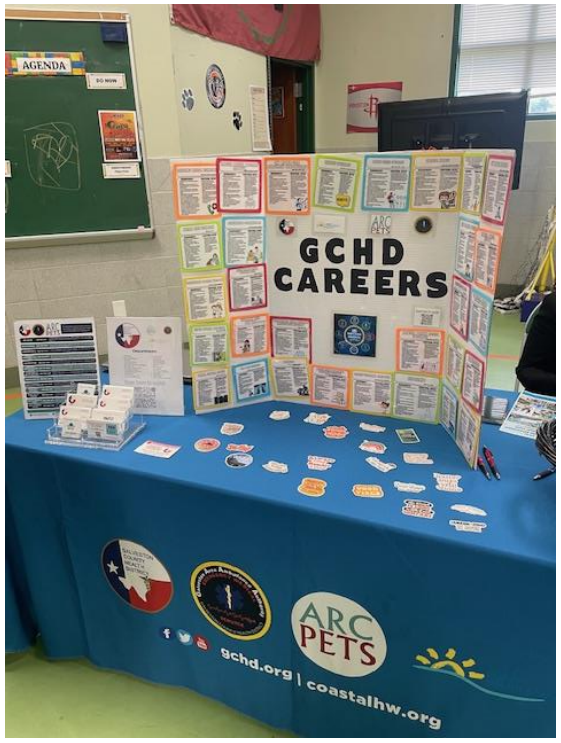
Community Engagement

Events CHW/GCHD Hosted:
Cinco De Mayo Employee Event (Food truck, desserts provided by Wellby Financial)
Financial Literacy Class on "Mortgages"- 5

Community Partner Events/Meetings Attended:
Ministers, Police, & Leaders Breakfast
Good Morning Mainland
LC Chamber Breakfast 101
Sunrise w/ Santa Fe
League City Networking Breakfast
Good Morning Galveston
Leadership in Communication Luncheon
BAHEP New Members Breakfast
Seaside Senior Expo Planning Committee Meeting (Fridays)
African American Health Coalition Meeting
UTMB Program Evaluation Workshop
Young Professionals Council Meeting
BAHEP Healthcare Committee Meeting
Frost Bank Collaboration Meeting
YMCA HEAL Collaboration Meeting

Presentations:
UTMB SPPH Guest Lecturer
ADA House

Event Highlights



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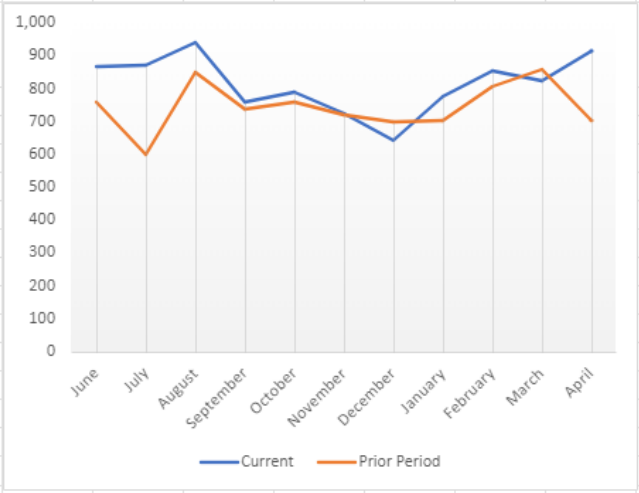
Dental Clinic Board Update 6/27/2024

- Visit Numbers – Based on "FQHC Qual Enc" in NextGen –
    - We continue to see walk in patients in pain as we can fit them into our schedule.
    - We started releasing comprehensive exams on the 15th of every month, with December being the first month. The appointments continue to fill quicker each month.
    - For May 2024, we had an increase in qualifying encounters of 12.85% compared to May 2023.
    - We have an 9.68% increase in qualifying encounters comparing June 1, 2023 – May 31, 2024 with June 1, 2022 – May 31, 2023.

	Dental Visits		
	Current	Prior Period	Percentage Change
June	869	763	13.89%
July	873	602	45.02%
August	941	850	10.71%
September	760	738	2.98%
October	790	759	4.08%
November	725	724	0.14%
December	646	699	-7.58%
January	777	705	10.21%
February	858	807	6.32%
March	828	862	-3.94%
April	915	703	30.16%
May	896	794	12.85%
	9,878	9,006	9.68%



- Current projects, plans, department overview for dental
    - Dr. Lindskog continues to serve on the COM Hygiene School Advisory Board. They are planning to start Fall 2024 with their first class.
    - We will be transitioning the dental front desk staff to become part of the dental team
- Provider Education Opportunities
    - All providers continue to select and participate in continuing education of their choice. They also share knowledge from these courses with the other providers during monthly meetings.
- Barriers or Needs (if applicable)
    - Staffing
        - Our Dental Office Manager, Tamesha Hampton, started on May 30th and is doing great. She is working with Revenue Cycle Management to make sure that we optimize our processes with insurance. She is also working with the dental front desk and clinical team to optimize their work flows as well.

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Governing Board June Agenda

School Based Clinic: Total May visits: 76

Students:	3
Staff:	0
Existing CHW:	73
In person:	3
Telehealth:	73

Telehealth/ Doxyme visit: Total May visits: 294

Increase: +162

CHW clinic visits: Total May visits: 2001

Schedule visits:	2812
No Shows:	811
No Show Rate:	29%
Show Rate:	71%

Total charges: $5,725,651.92

Current Projects:

We are working to finalize agreement/paperwork with “Do as I have done” to use our mobile clinic (RV) to provide foot care

Staff have been trained on the use of the Retinal Cameras. We should start using these soon. We will be uploading images manually until Nextgen integration is complete in late July/early August.

I am training providers that are interested, in minor procedures such as ingrown toenails, mole removals, cyst removal/treatments, and cryotherapy

Our 3 new providers are seeing patients. We are increasing their schedules as they get more familiar with EHR, workflows, and clinic procedures.

We are working to improve our processes to improve reimbursement for our services in Women’s Health.

We are working to fill chronic care management/transitional care management coordinator as our current coordinator has resigned.

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Governing Board
June 2024
Item#15
Comments from Board Members

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