Definitions of Key Financial Management Terms for Title X Family Planning Agencies

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Note that some definitions have been modified to address Title X settings.

Allowed amount

The maximum amount an insurance company will pay a clinician based on the clinician's contract to reimburse for a health care service or procedure (source: Medical Billing & Coding). It is the amount the clinician expects to receive for third-party payer-covered services, and is a combination of third-party payer and client payment (copay, deductible, and/or coinsurance) amounts. The amount the Title X clinician actually receives may be less, depending on the agency's sliding fee scale (client's family size and income). Allowed amount is also referred to as "payment allowance" or "negotiated rate." (Source: HealthCare.gov)

Accounts receivable (A/R)

A term used to denote money owed to an agency for services rendered. (Source: Physicians Practice)

A/R aging

This term refers to the length of time an account balance has been outstanding and is frequently used as an indicator of the ability to collect receivables (Source: FPNTC Financial Dashboard). A/R dollars are typically sorted or grouped by length of time from date of service (i.e., 30, 60, 90 days post-date of service) for reporting and monitoring purposes. These time periods and corresponding balances are sometimes referred to as *buckets*.

Bad debt

Amount not recoverable from a client or third-party payer following exhaustion of all collection efforts. (Source: Healthcare Financial Management Association (HFMA))

Benchmarks

A standard, or set of standards, used as a point of reference for evaluating performance or level of quality. Benchmarks may be drawn from an agency's own experience, from the experience of other agencies in the industry, or from legal requirements. (Source: FPNTC Financial Dashboard)

Bundled charges/payments

A single payment to clinicians or agencies for all services to treat a given condition or to provide a given treatment. (Source: RevCycleIntellingence)

Charges

Charges are referred to as *full* or *gross charges* if they have not been adjusted in any way, and are the top rate billed to any client or insurer when a fee scale or contract is not in place. If a client is on a sliding scale, or has insurance that pays a set rate lower than the charge, the accounting/administrative staff or practice management/electronic health record system should adjust the *gross charge* by the amount reflected in the

Gross Charges Example

A client's visit gross charge is $200 based on the fee schedule for the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) used in the visit. The client, however, is on a sliding scale to pay only $50, so the charge would be adjusted to $50 and $150 becomes a write-off. Similarly, if an insurance plan contract specifies that the plan will pay $150 for that service, the charge would be adjusted to $150 and $50 written-off as a contractual adjustment/allowance. If the client then pays $50, her account is considered paid in full based on the adjusted or net charge. If the plan, for some reason, pays $100 instead of $150, there will be an outstanding balance of $50 which then must be addressed by staff responsible for accounts receivable.

fee scale or contract; this adjustment is often known as making an "allowance" or "contractual allowance." Once a charge has been adjusted, it is referred to as an "adjusted charge" or "net charge" or the "allowed amount" for an insurance contracted amount. This amount becomes the reference point for determining how much should be collected for that service (sometimes called expected payment/revenue). (Source: National Family Planning & Reproductive Health Association (NFPRHA))

Clearinghouse

This is a service that transmits claims to insurance carriers. Prior to submitting claims, the clearinghouse scrubs them and checks for errors. This minimizes the number of rejected claims, as most errors can be easily corrected. Clearinghouses electronically transmit claim information that is compliant with the strict HIPPA standards. (Source: All Things Medical Billing)

Client responsibility

The amount for services rendered that a client is responsible for paying that is not covered by the insurance plan. (Source: All Things Medical Billing). For an insured client, insurance companies and/or clients may be financially responsible for the costs associated with care; these responsibilities are outlined in the third-party payer contract.

Coinsurance[1]

Portion of the cost of an insurance plan's covered service that the insured client/insured pays. Coinsurance is usually expressed as a percent of the allowed amount for the service. For example, in an 80/20 policy, the client would pay 20% of the allowed amount. Coinsurance begins only after client has met the deductible. (Source: HFMA)

1 Third-party payer clients must not pay more in copays, deductibles, and coinsurance than they would as uninsured clients.

Contractual adjustment/allowance

Adjustment made to *gross charges* (see Charges definition above) based on the contractual amount an agency is paid by each insurance company for the service or supply that is charged on a bill. This adjustment becomes a contractual write-off. Also called a "contractual allowance," this practice of applying allowances to the accounts receivable (see definition) adjusts the amount projected for collection by the clinician, so that staff can accurately monitor revenue received compared to adjusted charges. Adjusted charges are also referred to as *net charges* (versus *gross charges*). (Source: NFPRHA)

Copayment (or copay)[2]

A type of cost-sharing arrangement under which the insured (client) pays a predetermined fixed dollar amount per episode of service, with the insurer paying the remainder (source: HFMA). Title X agencies can collect this at time of service for eligible visit types. Note: essential health services are typically exempt from copays.

Cost analysis

Measures the cost of providing clinical services, and is conducted to provide information for establishing charges. The charge for a service delivered is typically developed by identifying how much staff time is utilized in the delivery of a specific clinical service and the salary and benefit cost of relevant staff time. Then the amount for the use of the facility for that amount of time, an additional percentage for administrative processing of the client for the visit, and the overall administrative costs for operating the site are added in. The charge for a supply item is developed by taking the cost of the item plus an amount for staff time utilized in inserting/removing a device, delivering a drug, etc., and an additional administrative percentage, same as with services. Once developed, charges should be compared to the rates paid by all of that agency's payers (Medicaid, Medicare, and private insurance plans) to ensure that charges are set at, or above, the highest reimbursement rate paid by the insurers for that service or supply. (Source: FPNTC, Cost Analysis)

Credentials/credentialing

Process of reviewing licensure, certification, qualifications, evidence of malpractice insurance, etc. of clinicians that is required by insurance plans (source: HFMA). Credentialing clinicians requires submission of these documents to plans for review and approval prior to approving payments for services provided by these clinicians. The approval process often takes several months.

Deductible[3]

Amount (expense) that the client must pay before the insurer will assume liability for all—or part of—the remaining cost of the covered services (source: HFMA). Typically essential health services are exempt from

2 Third-party payer clients must not pay more in copays, deductibles, and coinsurance than they would as uninsured clients.

3 Ibid.

the deductible, so insurance pays for them even if the client's deductible has not been met. An insured client is responsible for 100% of the allowed amount until meeting her (or his) deductible.

Denial

Claim that is not paid by an insurance carrier. Denials can be made for many reasons: non-credentialed clinician, client not insured on date of service, service not covered, prior authorization needed but not on claim, etc. Denials can often be appealed under the terms of the agency's contract. (Source: NFPRHA)

Direct service site

Title X grantee network sites that are directly owned/operated by the grantee.

Explanation of benefits (EOB)

A document attached to a processed claim that explains to the clinician and client which services an insurance company will cover. EOBs may also explain what is wrong when a claim is denied (source: Medical Billing & Coding). EOBs may be a concern for clients receiving confidential services. They are sent to the policyholder, **not** the person receiving the services, and this can breach confidentiality.

Electronic remittance advice (ERA)

A digital version of the EOB, this document describes how much of a claim the insurance company will pay, and in the case of a denied claim, it explains why the claim was returned. (Source: Medical Billing & Coding)

Eligibility verification system (EVS)

Eligibility verification is the process of checking and verifying the client's insurance eligibility and benefits prior to the treatment (source: American HealthCare Billing Services). Most practice management systems and clearinghouses offer an electronic process/system that can verify third-party payer coverage at registration or in batches the evening before services are delivered.

Fee-for-service

A reimbursement method in which clinicians are paid for each service performed. (Source: HealthCare.gov)

Fee schedule/chargemaster

A list of full fees for specific clinician services or supplies, often presented in a table with all visit types, procedures, and items a practice offers/uses. It includes a description of the service or supply, a CPT or HCPCS code, and a dollar amount that is considered the "charge" for performing that service or providing that supply. Charges included in an agency's chargemaster are developed specifically for that organization based on its cost of operations and service delivery and are not set by any external body. (Source: NFPRHA)

Financial dashboard

Provides at-a-glance views of key performance indicators (KPI) relevant to a particular objective or business process. An easy-to-read, often single page, real-time user interface, shows a graphical presentation of the current status (snapshot) and historical trends of an agency's KPIs that enables and informed decisions to be made at a glance. Administrators can select a menu of KPIs for financial monitoring, analysis, and application to pursue business objectives and inform decision making. (Source: FPNTC Financial Dashboard)

Financial policies

Policies related to the regulation, supervision, oversight, and practice of the financial and payment systems. Financial policies are written documents that have been reviewed by legal counsel. The client signs and receives a copy of the policy. A financial policy provides guidance to the client regarding collection of copayments and unpaid balances, the client's responsibilities regarding insurance requirements and supplying insurance information, the medical practice's accepted payment (cash, credit card, etc.), financial arrangements for unpaid balances, charity care or sliding scale payment arrangements, and method of paying for services not covered by insurance. A sound financial policy manual will include information about billing, late fees, and working with insurance.

Full-time equivalent (FTE)

A measure utilized in productivity and other calculations. A full-time employee is quantified as a 1.0 FTE.

Grandfathered plans

An individual health insurance policy purchased on or before March 23, 2010. These plans weren't sold through the Marketplace, but by insurance companies, agents, or brokers. They may not include some rights and protections provided under the Affordable Care Act. (Source: HealthCare.gov)

HEDIS

Health plan employer data and information set. (Source: National Committee for Quality Assurance)

Key performance indicators (KPIs)

Measures of performance that are used by organizations to compare how well they are performing against targets or expectations. KPIs measure performance by showing trends to demonstrate that improvements are being made over time.

Medicaid

Insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Many states have expanded their Medicaid programs to cover all people below certain income levels. (Source: HealthCare.gov)

Managed care organizations (MCOs)

Agencies contracted with state Medicaid agencies that provide Medicaid health benefits and additional services. MCOs accept a set payment per member per month (capitation) for services. (Source: Medicaid.gov)

Net collection rate

The net collection rate looks at the amount of money collected from third-party payers versus the amount of expected payments. Because third-party payers will reimburse agencies (or clinicians) the contracted rate— or what an agency charges if lower than the contracted rate—most clinicians establish charges at levels higher than negotiated third-party payer contractual rates. For various reasons, charges may vary widely in terms of how much higher they are. Therefore, to understand how well your agency is performing in collecting money actually due, it is important to compare expected revenue (negotiated third-party payer rates) to collection. (Source: FPNTC Financial Dashboard)

Out-of-pocket limit

The maximum amount a client with third-party payer coverage has to pay for covered services under their insurance policy in a plan year (sources: All Things Medical Billing and HealthCare.gov). After the out-of-pocket amount is spent on copays, deductibles, and coinsurance, the health plan pays 100% of the costs of covered benefits. This includes copays, deductibles, and coinsurance, but **not** services that the client's insurance does **not** cover. The costs of non-covered services are 100% the responsibility of the client.

Payer mix

Payer mix can be calculated using a variety of measurements, including unduplicated client numbers, revenue, or encounter numbers. "Payer mix determined by unduplicated clients" is the percentage of a clinic's annual unduplicated client volume associated with each revenue source (e.g., Medicaid, Medicare, commercial insurance, uninsured/self-pay clients). "Payer mix determined by revenue" is the percentage of a clinic's annual revenue that is comprised of each revenue source (e.g., Medicaid, Medicare, commercial insurance, uninsured/self-pay). (Source: FPNTC Financial Dashboard)

Premium

The amount the insured and/or employer pays (usually monthly) to the health insurance company for coverage (source: All Things Medical Billing). This is separate from the amount that an individual pays for services.

Private Insurance

Third-party payers that are not funded by the government.

Prior authorization

Health insurance companies use the prior authorization or pre-approval process to verify that a certain

prescription drug, procedure, or health care service is medically necessary before it is done. Sometimes called *prior approval* or *precertification*.

Revenue cycle management (RCM)
All administrative and clinical functions that contribute to the capture, management, and resolution of client services revenue.

Revenue
Income that results from the rendering of services.

Schedule of discounts
Also called a sliding fee schedule, this table consists of fees that have been discounted, so eligible clients owe amounts for services based on their ability to pay. Eligibility for applying this schedule is based on clients' insurance status, family size, and income.

Sub-recipient site
Title X grantee network sites that are not owned/operated directly by the grantee.

Third-party payer (TPP)
Refers to Medicaid and private insurance.

Uninsured/self-pay client
Clients who do not have third-party payer insurance coverage or who cannot use that coverage due to confidentiality billing concerns. They are responsible for paying the full charge minus any discount on an agency's sliding fee schedule the client is eligible for, based on family size and income.

Value-based payment
A form of reimbursement that ties payments for care delivery to the quality of care provided and also rewards providers (including clinicians) for both efficiency and effectiveness. This form of reimbursement has emerged as an alternative and potential replacement for fee-for-service. Value-based care aims to advance the triple aim of providing better care for individuals, improving population health management strategies, and reducing health care costs. Value-based care models center on client outcomes and how well health care providers can improve quality of care based on specific measures, such as reducing hospital readmissions, using certified health information technology, and improving preventive care. Value-based reimbursements are calculated by using measures of quality and determining the overall health of populations. Unlike the traditional model, value-based care is driven by data because providers must report to payers on specific metrics and demonstrate improvement. Providers may have to track and report on hospital readmissions, adverse events, population health, client engagement, and more. (Source: RevCycleIntellingence)

Write-offs

An amount that an agency deducts from a charge and does not expect to collect. There are write-offs that are necessary or approved, either in the context of a third-party payer contract (contractual write-off) or in terms of a practice's philosophy/policy (such as a small balance write-off). Other write-offs are considered unnecessary, and are typically due to billing mistakes or situations that should have been controlled but were not. Two examples: filing write-offs in an untimely fashion (past the date required by the payer) or an un-credentialed clinician write-off (filing a claim for a clinician before credentialed with the payer). (Source: Manage My Practice)