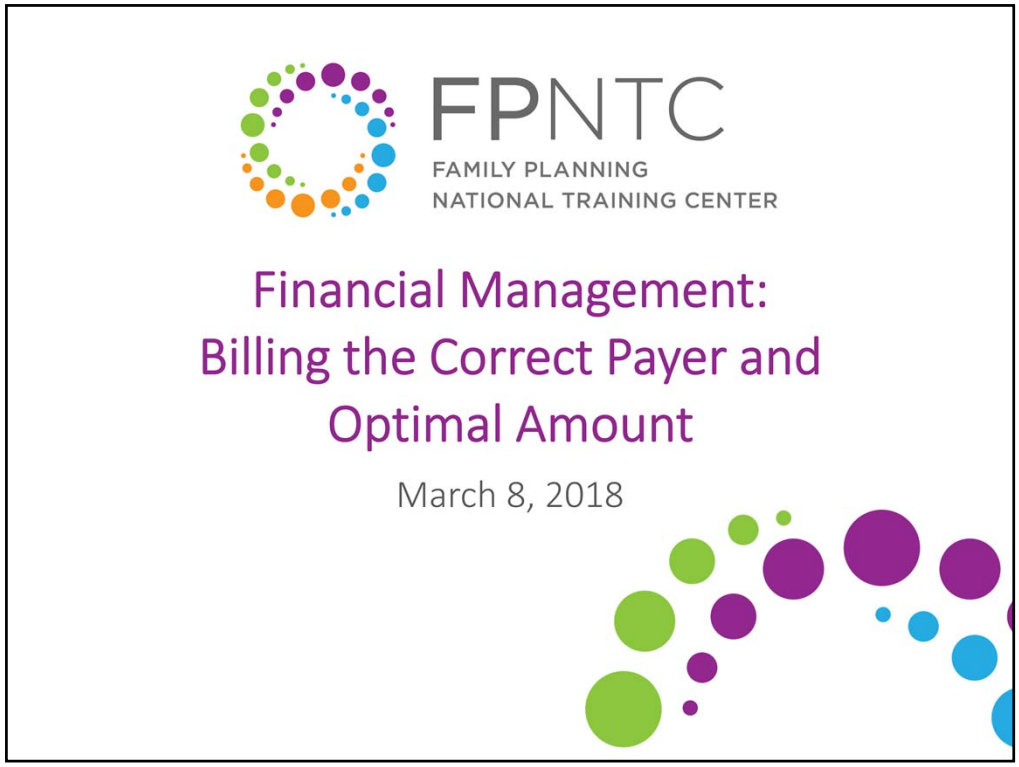


Katie Saul:

Hello everybody. We're excited to have you all with us today. This is Katie Saul from the Title X Family Planning National Training Center, and I am happy to welcome you all to today's webinar, Billing the Correct Payer and Optimal Amount. As many of you are aware, last year, the National Training Center conducted a family ... sorry, a Financial Management Learning Collaborative with a number of Title X grantees, and on January 24th, we also conducted a webinar to review both some of the best practices that were covered in that learning collaborative as well as some of the lessons learned by the grantees who were involved. We very briefly touched on the three financial management best practices on those webinars.

Today's webinar, along with the other two that we have scheduled, we'll take a deeper dive into each of those best practices. We're going to introduce a number of new resources today that are related to these best practices, and we'll talk about those a little bit later, but we're very excited to have you with us. Yeah, we'll get started. A few things before we begin, you all should have received a copy of the slides for today unless you registered just this morning, but we sent out the slides in the reminder that was emailed to participants yesterday. We're going to post the slides from today's webinar on FPNTC.org along with a recording of today's webinar and the slide deck and transcript by early next week, so please keep an eye

out for that.

We encourage you all to use these resources. They're great tools both to refer to and to help you train your networks. We're going to answer questions today in a couple of different ways. You can use the chat at the bottom left of your screen to ask questions at any time during the webinar. At the end of the presentation, we'll ask all questions submitted by chat. We're also going to open up the phone lines for Q and A today, just given the complexity of some of these issues and some of the questions that you may have, so we're happy to balance a little bit of both.

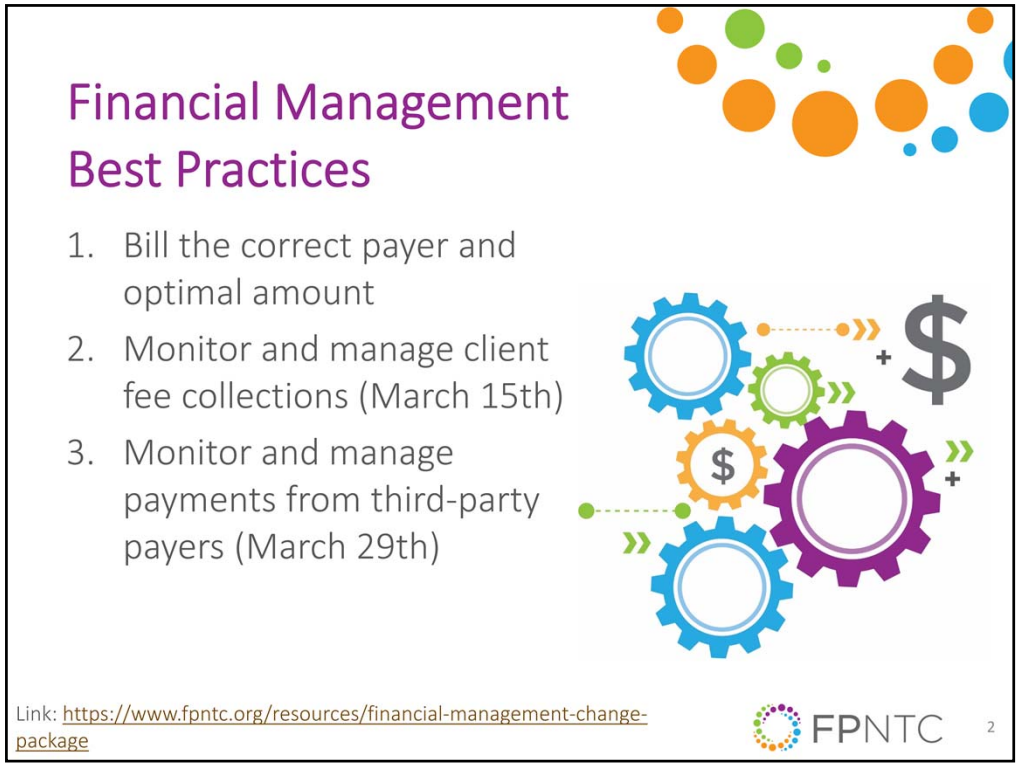
Today, I'd like to introduce our speaker, Debbie Sullivan, who many of you know is our healthcare consultant with over 20 years of healthcare management experience. She has extensive experience consulting on financial management and family planning settings, especially Title X. Debbie co-led the Financial Management Learning Collaborative with Caitlin Hungate from the FPNTC, and previously, Debbie spent over 10 years as the Chief Operating Officer at Adagio Health, a Title X grantee in Pennsylvania.

Caitlin Hungate from the FPNTC, who I mentioned, will also be presenting today. She's a Project Manager at the training center and on the technical assistance team. Caitlin co-led the Learning Collaborative with Debbie as I mentioned as well. With that, Caitlin, I think we're going to start with you today. I'll hand it over to you.

Caitlin Hungate:

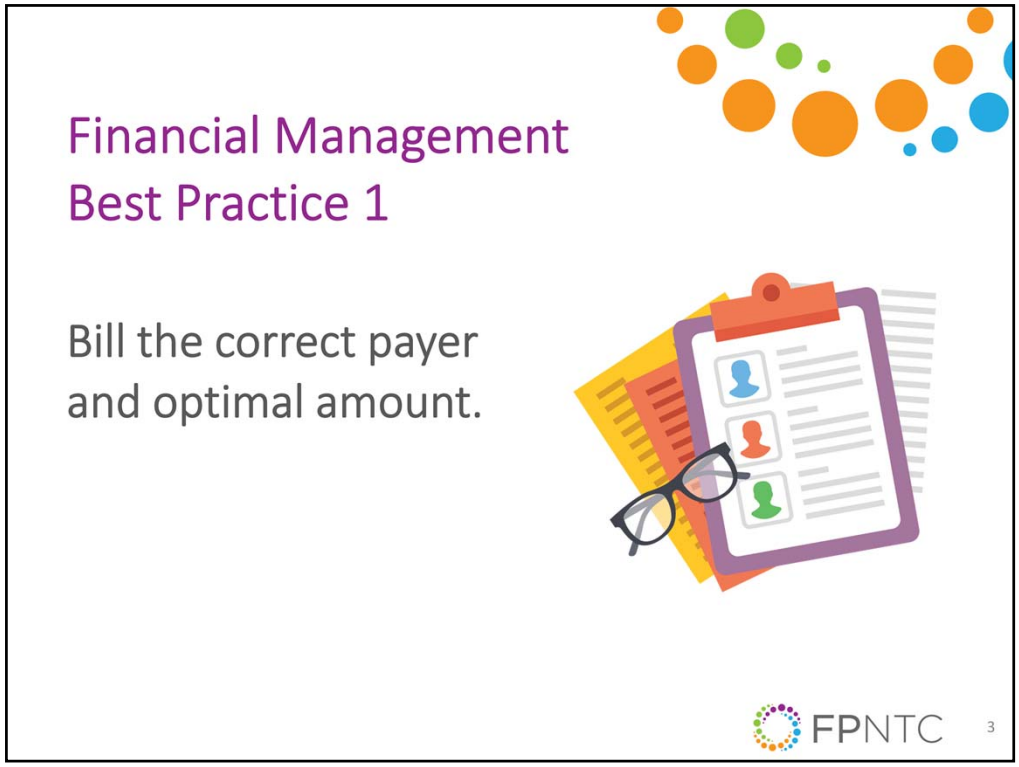
Thank you, Katie, and welcome everyone to today's webinar focusing on the first best practice, billing the correct payer and optimal amount, which is in the Financial Management Change Package. As you know, my name is Caitlin Hungate. I'm a member of the Family Planning National Training Center team, and will be one of your facilitators for today's 60-minute webinar. I'm joined by Debbie Sullivan, an external consultant. We've left plenty of time for Q and A at the end as well, so just know that there is plenty of time there.

Title X sites experience common missed steps such as not identifying and or gathering client third-party payer information, or incorrectly assessing family size and income, which often leads to inaccurate discounting. There are other common missteps that we will cover today. Today, during this one-hour webinar, we'll be taking a closer look at strategies to help you bill the correct payer and optimal amount for services provided. This is one of the three financial management best practices outlined in the Financial Management Change Package: A Quality Improvement Guide to Increase Revenue available on FPNTC.org.

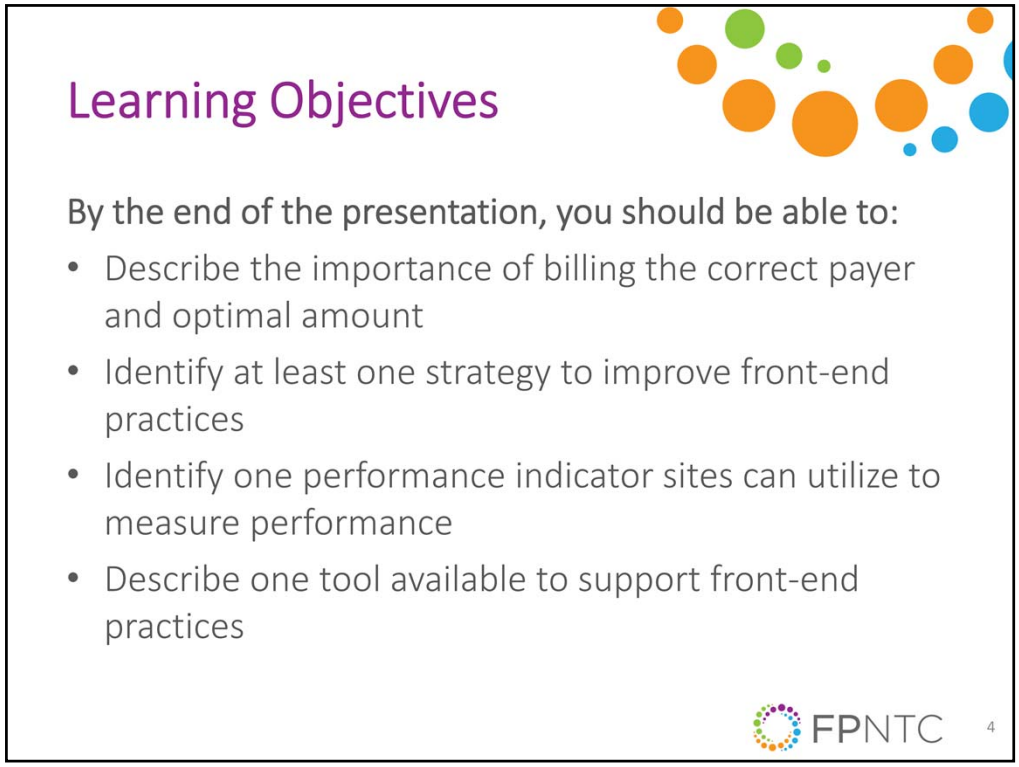


As I mentioned, the Financial Management Change Package, it draws from the literature and most current practice guidelines to improve financial management practices and factors that have an impact on organizational financial health. We'll discuss the two other best practices on upcoming webinars, the second, monitor and manage client fee collections as you see on the slide is on March 15th, and monitor and manage payments from third party payers on March 29th. In order to increase revenue, it's important to consider all three best practices, and utilize a comprehensive approach that addresses each. We strongly encourage you to refer to the financial management change package for more ideas about strategies and successes.

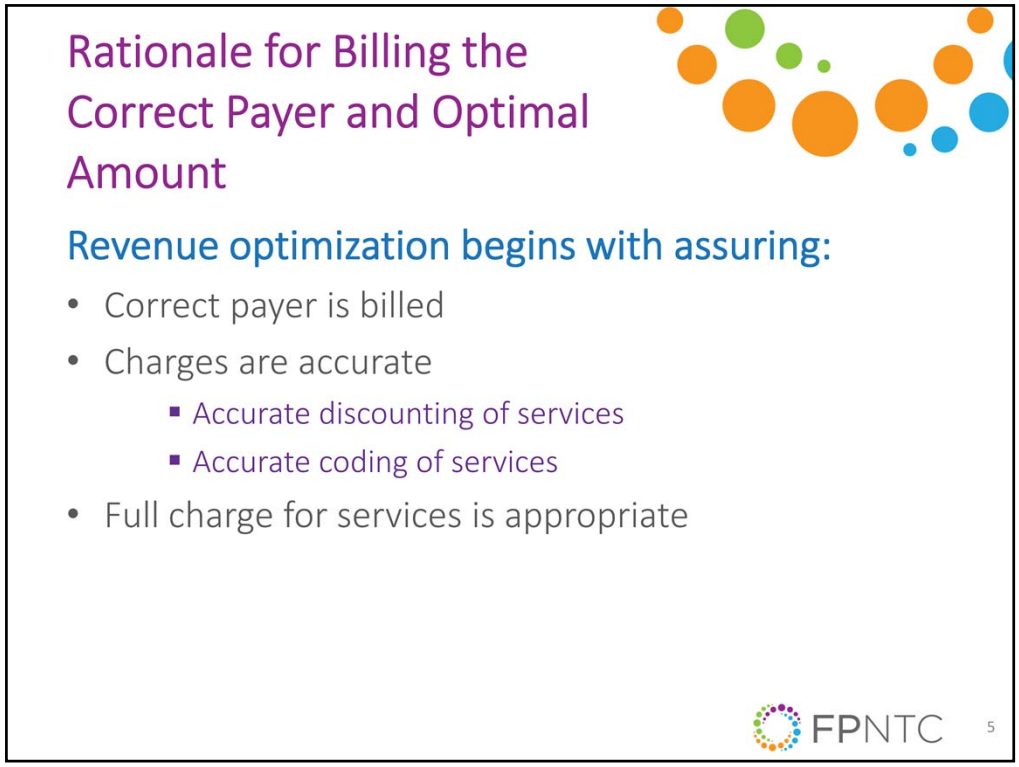
It could be found on fpntc.org as I've said already.



The first best practice as we mentioned is build the correct payer and optimal amount. This also could be phrased as charge the correct payer and optimal amount. The words charge and bill in this situation are synonymous. A Title X agency or site may consider working on billing the correct payer an optimal amount if it identifies payer mix issues, or if is concerned about the number of third party payer client. If the fee schedule has not been appropriately adjusted recently, if it has concerns or questions about the thoroughness of the charge coding and or charge per client, and if it has concerns about the number or percentages of fully discounted clients.



By the end of the presentation today, you should be able to describe the importance of billing or charging the correct payer and optimal amount. Identify at least one strategy to improve front-end procedures or practices. Identify one performance indicator that sites can use to utilize to measure performance, and lastly, describe one tool available to support front-end practices. At this point, I'm going to turn it over to Debbie, who's going to dive into describing and talking about the rationale for this best practice.



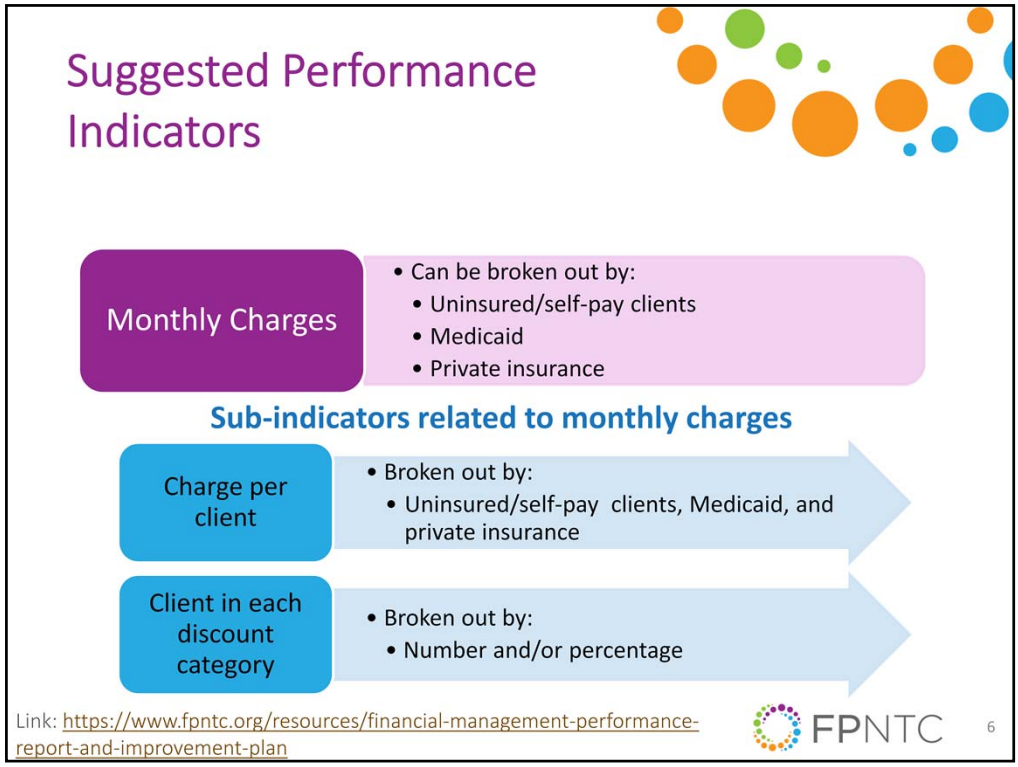
Debbie Sullivan:

Thanks Caitlin. Hi everyone. Well, revenue optimization starts with assuring that the correct payer is billed or charged the accurate amount for services. Often, clinics will concentrate on accounts receivable to improve revenue, which is good, but if accounts receivable amounts are not as high as they should be to start due to inaccurate payer or charge information, you're collecting at a lower starting point, so identify and build a correct payer public or private. It's important to capture client's insurance and other required information accurately during those front-end procedures. Third party payer insurance, it's not only the payer and agency must bill according to Title X requirements, but also, third party insurance reimbursement is almost always higher than what an uninsured or a self-pay client would pay.

Second, to actually charge uninsured self-pay clients, and calculate fees due for third party payer covered clients, gathering family size and income information accurately is critical. Additionally, an important component of starting with an optimal charge is to assure documenting patient and coding are complete and accurately capture services render. The last concept of the rationale billing and optimal amount is to ensure that charges are high enough to capture third party payer negotiated rates. To clarify, if your agency's full charge is less than the negotiated rate for a service, the insurance company will pay your agencies full

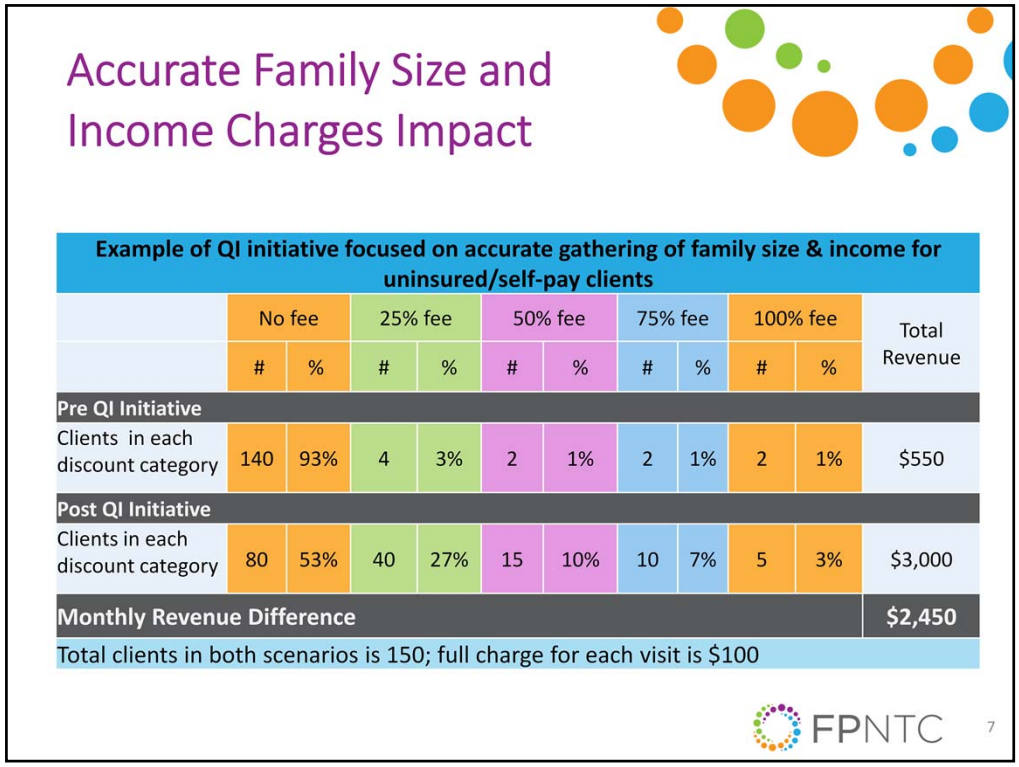
charge, not the negotiated rate, and you won't be able to capture that additional revenue, that difference between the charge and the negotiated third party payer rate for the service.

That's contractually due to you. I have an example forthcoming, so stay tuned.



Indicators can point to which areas are in need of improvement on the topic of charges. Start by looking at and trending overall monthly charges, and break out by payer. This is useful when working on payer mix initiatives. You can measure charges for each payer as a percent of total charges, or initiatives related to accurate discounts to assess uninsured self-pay clients and or a third party payer client fees. We've also identified sub-indicators that sites or agencies can look at. These include charge per client. You can even look at that in each payer category. Charge per client is useful when working on coding initiative, and when you look at that in the fee payer category, that's really helpful when you're looking at initiatives to assure appropriate discounts for uninsured clients.

Clients in each discount category can be broken or measured by the number of clients in each discount category, or as a percentage in each discount category. I wanted to remind you that this data is submitted to FPAR currently by you, so the number of payers in each category, something you already collect and have to assess. This can be really useful when you're measuring or working an accurate discounting of uninsured or self-pay clients.



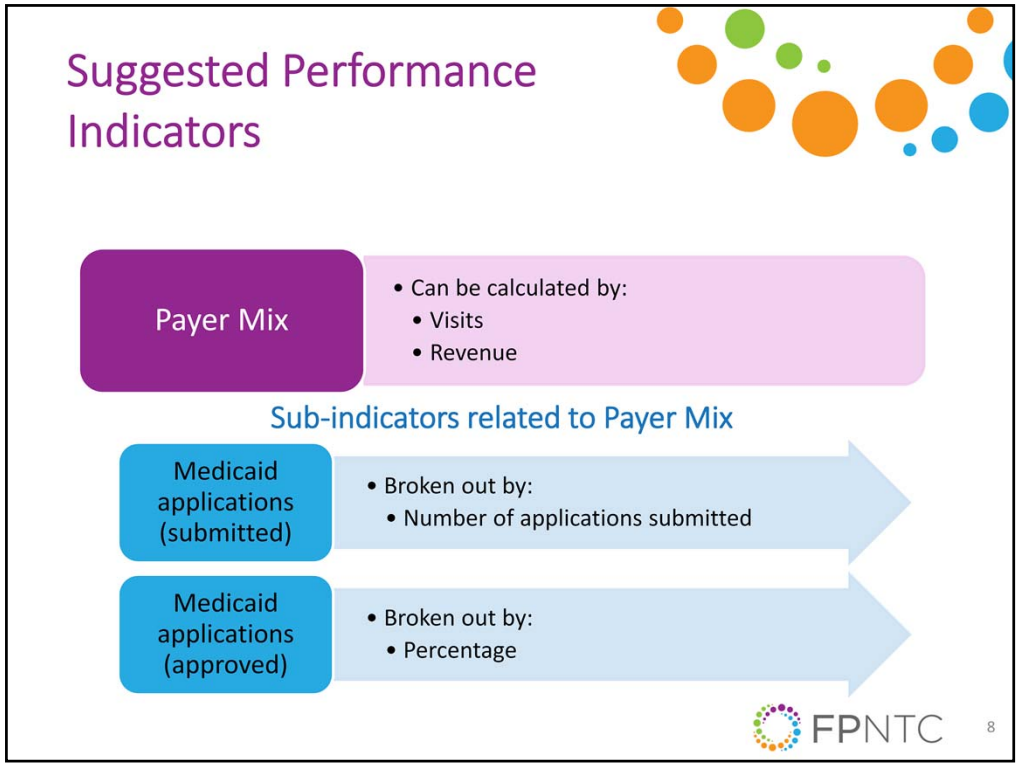
Let's look at an example to examine the impact on charges by gathering accurate family size and income information. This is a sample quality improvement initiative that focus on gathering a family size and income information for clients. You can see two rows of data. The first row is the QI information. Before the initiative in the second is Post QI Initiative.

I'll point out that this example of monthly data for uninsured clients has some assumptions, and that's that the full charge for each service is $100, and that 150 clients are in each example for illustrative purposes. Let me go back to this first row, pre QI initiative. What you can see is those 150 clients are divided up into each of the fee pay categories with 140 falling in the no fee category, four falling in the 25% fee category, two in the 50, two in the 75, and two that fell into the 100% fee category. When we added up the total of all those charges, given that breakdown, we came up with charges for the month of $550. Let's look at the post QI initiative.

That same number 150 now is spread out amongst the different categories. You'll note that 80 fell into the no fee category. 40 of the 150 fell into the 25% fee category. 15 into the 50% discount, 10 in the 75, and five into the 100% fee. The total of all those charges based on those slides is $3,000. The monthly difference in charges went from $550 to $3,000, which was a difference in charges of $2,450. Now, if you'd take that number, and if you assume a 95% collection rate,

which is a best practice, and you annualized that, you come up with $27,930. Again, that math is $2,450 times .95, again, collecting 95% of that, then times 12, taking that monthly revenue to an annualized basis, so close to $28,000. That's a significant amount of money.

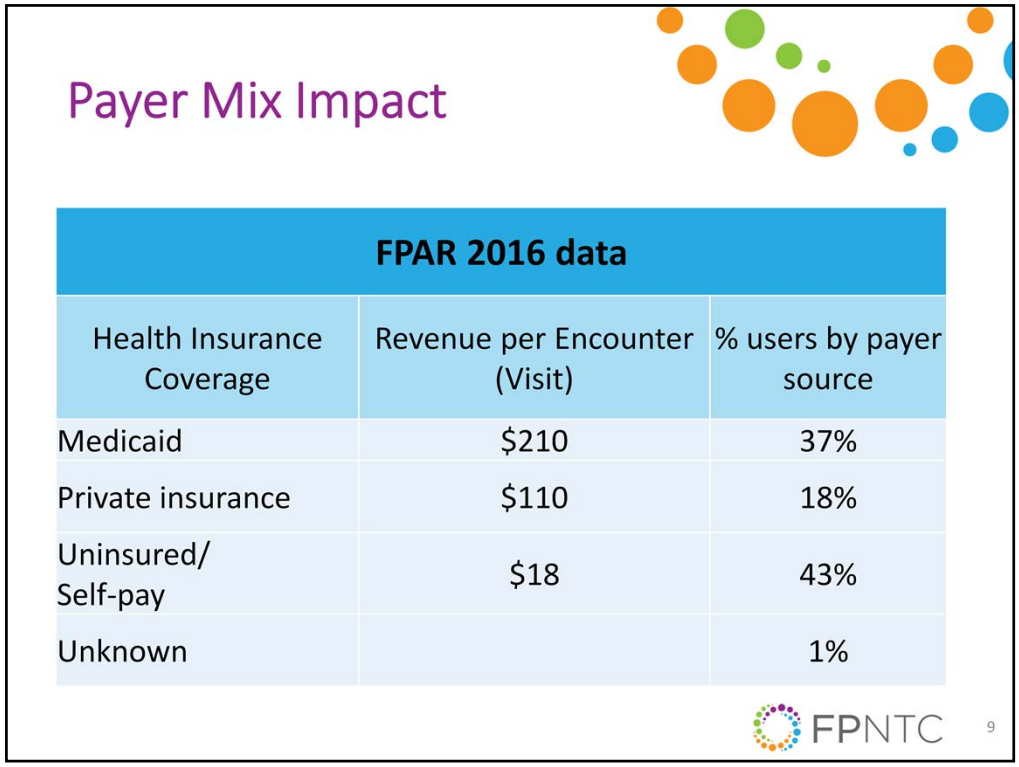
I'd also like to make a couple of points. Consider comparing your agency's distribution to the national averages into your grantee's averages and percentages in each of these categories to identify any potential opportunities you might have. I also wanted to highlight the national averages. Data for the entire Title X network in 2016 showed 64% of the users falling into that full discount category. 14% fell into the 101 to 150% category. 6% fell into the 151 to 200% category. 3% fell into the 201 to 250% category, and seven were at full fee or above 250%.



You can also look at payer mix to help identify areas in need of improvement for this best practice. While this is typically calculated use of revenue or visits, it can be an important indicator for billing the correct payer, and improving charges.

Charges overall can increase when more clients are covered by either Medicaid and private insurance versus an uninsured or self-pay, where again, charges are often discounted, so billing the correct payer will most likely result in increase charges, which often leads to increased revenue. Sub-indicators can help you measure or track process changes, and lead to improvement and overall performance indicators as is the case with this indicator. For example, when Medicaid enrollments are conducted on site, a sub-indicator could be number of Medicaid applications submitted, or Medicaid applications approved. A percentage approval rate can be calculated by dividing the number of applications completed by the number of applications approved, or excuse me, opposite, the number approved by the number completed.

Honing in on air reasons, and improving the sub-indicator will improve the payer mix performance indicator. In this scenario, a site would increase the Medicaid percentage in their payer mix by increasing MAF approved.

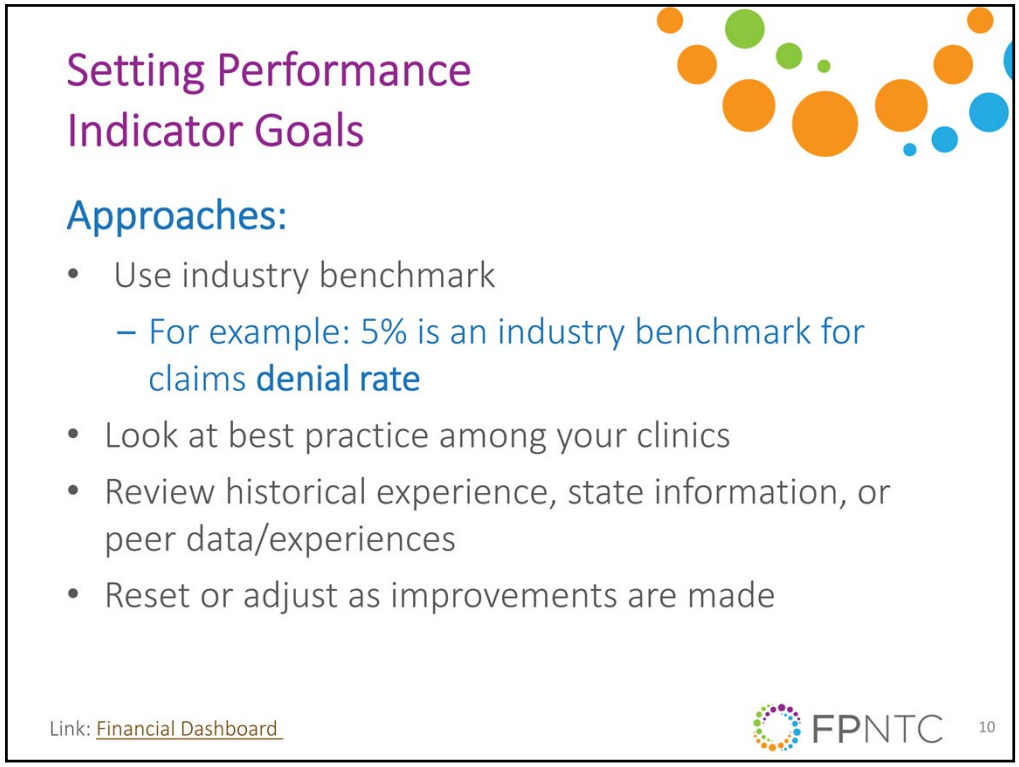


To demonstrate the importance of payer mix, let's look at another example. Let's review the table on this slide to determine the impact of payer mix. Payer mix is the percentage of visits and or revenue in each payer mix category for Medicaid, private insurance, and uninsured or self-pay clients. Now, each agency's payer mix might vary. It might vary depending on your state, possibly on the type of facility, the number of third party payer contracts you have amongst other things.

Note, this slide highlights thus far the information that Title X grantees are required to collect from some recipients and service sites, so it's data again that grantees and or sites should already be collecting and have available. This table in particular highlights revenue information from a specific grantee, not charges, but it illustrates the importance of payer mix related to revenue, which flows from charges. A couple of points to highlight on this table, you'll note that revenue per encounter or visit for Medicaid is 210 for this grantee, and a private insurance revenue per encounter is 110. Revenue per encounter for the uninsured clients is 18. Again, the revenue per encounter for Medicaid and private insurance are higher than the uninsured, which is typically almost always the case.

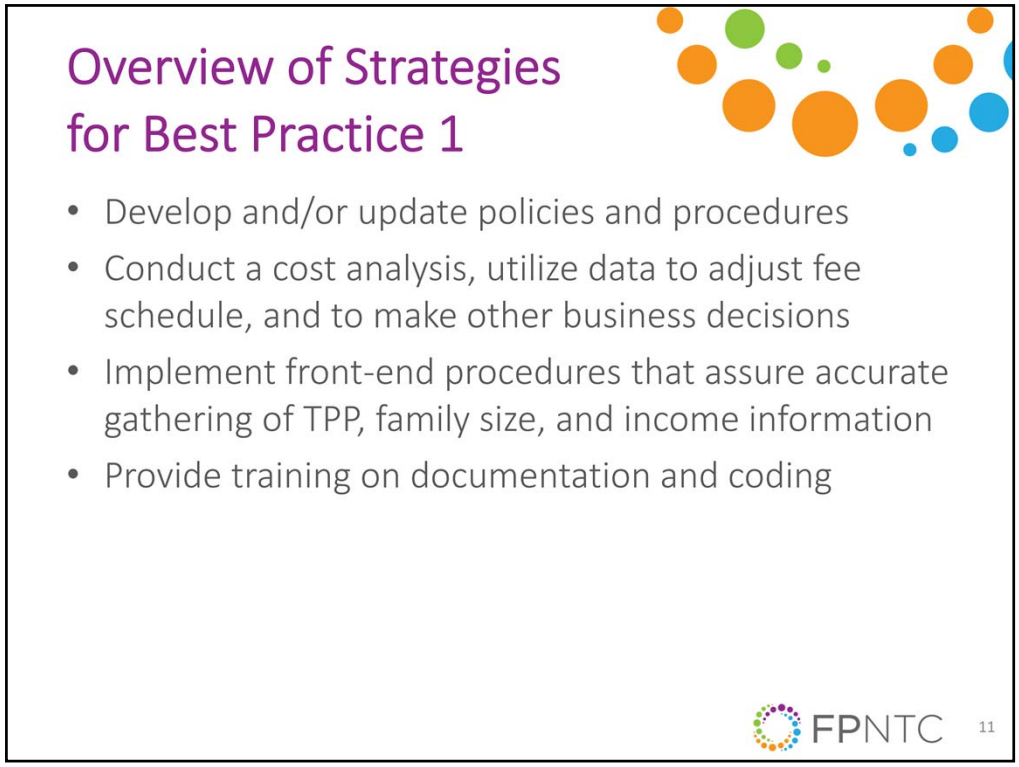
I often get asked when I share this example why the private insurance is lower than the Medicaid. I can share with you that typically, private insurance revenue is higher than Medicaid, and most likely in this situation, there are some account receivable issues related to the private insurance. This data should lead you

to investigate accounts receivable and denial reports related to this indicator to potentially resolve some issues. A final point I want to make on this slide is that if the front desk or registration staff wasn't consistently gathering Medicaid insurance, some of these visits or some of those visits might have become self-pay visits, which in this case would reimburse at $18 versus the 210. That's 192 less per visit. That adds up.



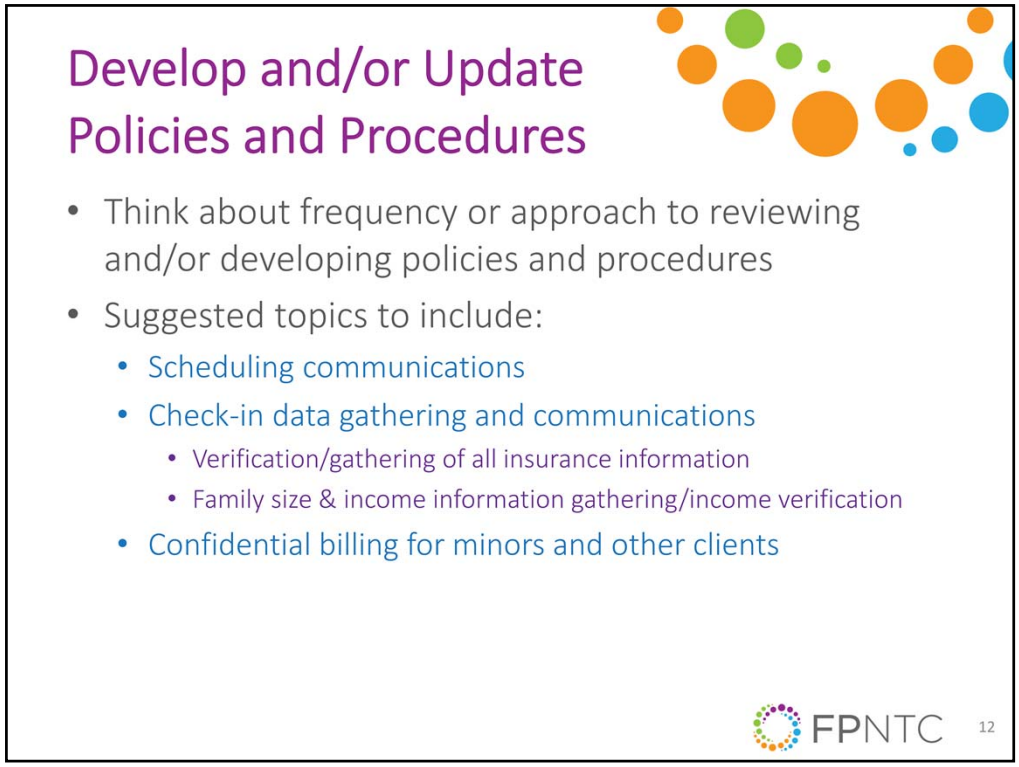
A few points about setting goals, measures really mean nothing if they're not compared to a goal or a benchmark. There are several ways to set goals for performance indicators. Some of them such as a denial rate have clear industry benchmarks. Another approach though is to look at best practices in your network of site. For example, you could identify which site has the lowest denial rate percentage, and use that percentage as your goal for the other sites in your network. Third, you can set goals based on historical experience such as denial rates experienced with other third party payers as you add a new third party payer.

You can use state information. An example of that might be using state Medicaid enrollment percentages as a Medicaid utilization benchmark, or you could consider using peer data, perhaps using their payer mix data as a goal or a benchmark. Lastly, I just wanted to point out that it's important to note that regardless of the approach you take in setting your indicator goals, these goals can always be reset or incrementally adjusted as improvements are made.



Now that we've highlighted measures and a few scenarios to indicate the importance of billing the correct payer and optimal amount, let's review the four strategies the FPNTC has identified. Number one, develop and or update policies and procedures related to this.

Two, conduct a cost analysis, and utilize that data to adjust your fee schedule, and to make other business decisions. Three, implement front-end procedures that assure accurate gathering of third party payer information and family size, and income information so that the correct payer is identified, and billed for services, and the correct amount is calculated for the fee. This is a strategy we're going to spend most of our time discussing today. Then the fourth strategy, provide training on documentation and coding and front-end procedures. We'll talk a little bit about each of these, and then take a deeper dive into the front-end procedure.



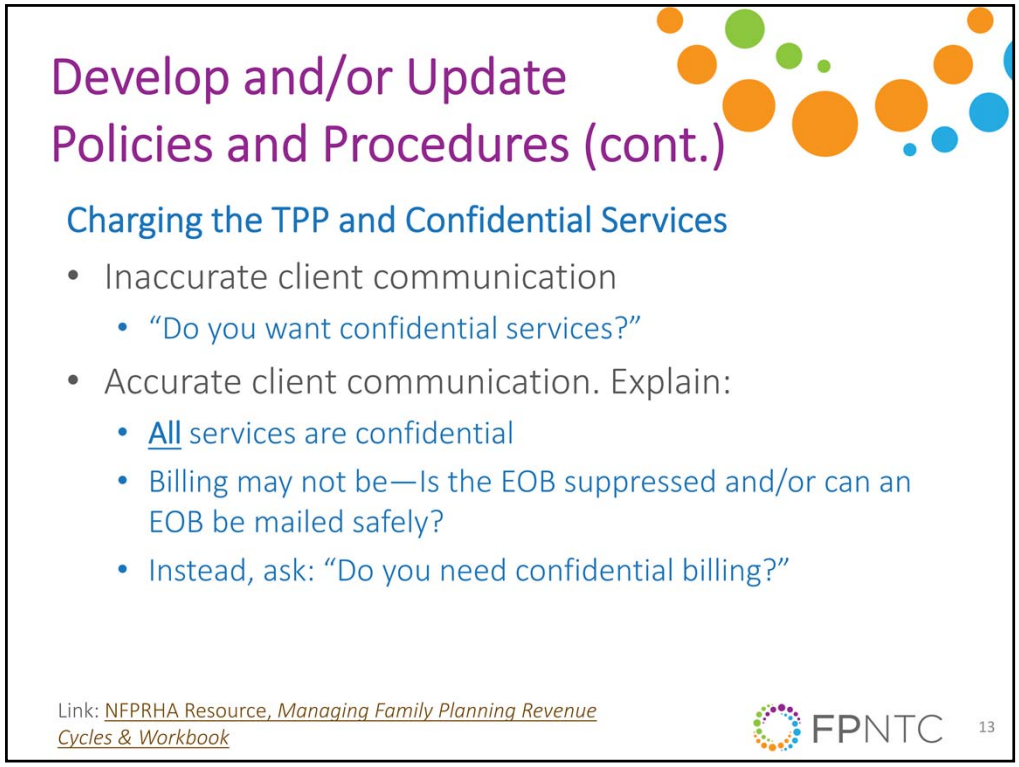
Let's start with those policies and procedures. The first strategy is to develop and or update policies and procedures to ensure that they cover all your processes, and are accurate, specific, and efficient. If each procedure isn't clearly outlined, mistakes can occur, and then with turnover, your processes then gets further away from best practices. You may want to assess front-end procedures such as scheduling, collection, and verification of insurance information, and family size and income information gathering to determine if you need to include or revive any of these in your policies and your procedures.

Some suggested topics related to charges to include in your site's policies and procedures, one would be scheduling, including process and scheduling template information, and expected client communications at the time of scheduling such as documents a client should bring in when they come, and the past due balances. For uninsured clients, ensure scheduling policy outlines, the payment is expected, or what your payment expectations are. For insured clients, ensure the policy outline communications for balances not paid by the third party payer, those copays, deductibles, and co-insurances. Check-in is another area to outline in your policies. Outline the process to assure that all insurance information is gathered and accurate.

Repeat those communications outlined at time of scheduling. Document confidential billing process. Document your process for verifying, third

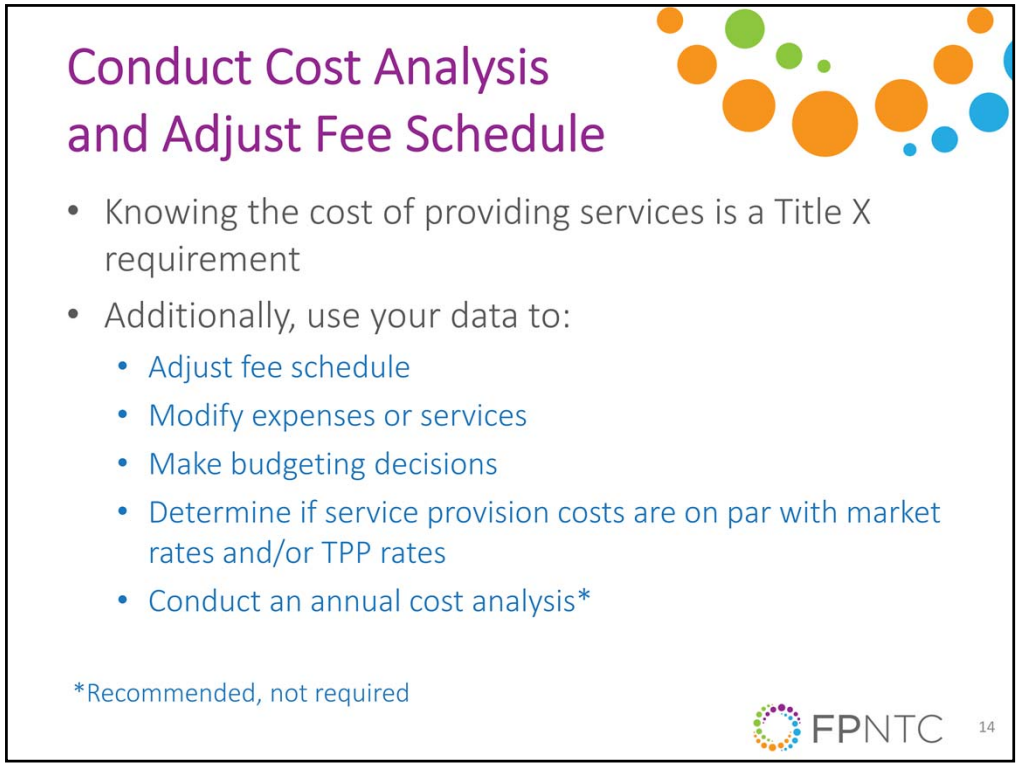
party payer insurance coverage. A best practice is electronically verifying the day prior to and or a time of service. Document your agency's income verification process, and whether or not your policy includes proof of income or an income declaration. Also, outline in your policy what counts as income. Your policy should include gathering this information for all your clients, not just your uninsured of self-pay clients, so that appropriate discounts can be calculated for not only your uninsured client fees, but also for those third party payer fees, the copays, deductibles, and co-insurances.

Outline what to do if the client does not bring income information in with them. Include your intake form in your policies, and consider any needed enhancements or modifications to assure accurate family size and income information is gathered as well as any other pertinent communications such as an assignment or release for third party payers, and fee collection policies or HIPAA. Assure your policy clarifies when third party payers can be billed for a minor, and appropriate assessment of income for a minor. Remember, if a minor requests confidential services, only the minor's income is assessed. It shouldn't be assumed though that a minor is requesting confidential services. If a minor is not requesting confidential billing, then a third party payer can and should be billed, and family income and household size should be assessed.



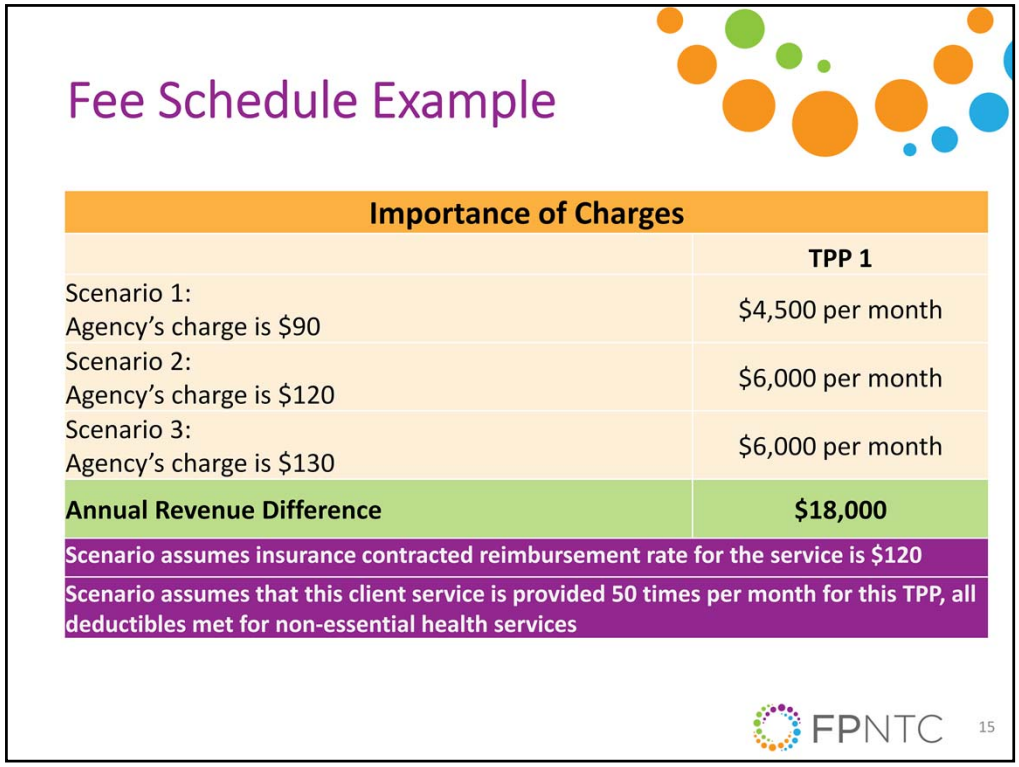
When developing your policies and procedures, a key aspect relates to client communication, so pay particular attention to them. Review communications at the front desk to assure that staffs correctly communicate messages to clients. As an example, do they correctly explain that all services are confidential, and that billing the third party payer will involve an explanation of benefits being sent to the home? Staffs should ask, "Do you require confidential billing?" Instead of asking, "Do you want confidential services?" Staffs should then explain that an EOB will be mailed to the home if there is no EOB suppression arranged with that particular third party payer in question.

Remember, all clients want confidential services, so asking that question can lead to less third party payer billing. I've also observed this only communicated in writing, and often, it's left for the client to figure out, which can also lead to less third party payer billing. Consider developing a script for the front desk staff to follow when communicating with clients and or including this in your policy and procedure.



The second strategy to support billing the correct payer and optimal amount includes conducting a cost analysis, and utilizing that data to adjust your site's fee schedules as well as to make other business decisions. A cost analysis is a great tool for all Title X agencies.

Having it sound rationale and processed for determining the cost of services is a Title X requirement. Title X sites or agencies can utilize cost analysis data, not only to meet that requirement, but also to adjust fee schedules in a meaningful way, and to make informed business decisions such as modifying expenses or services, making budget decisions, so determining if a service costs are on par with market rates and or third party payer rates to name several. Since costs and utilization change from year to year, agencies or sites should consider conducting a cost analysis annually. As a sub recipient or a service site, your grantee may have a required cost analysis frequency identified in their sub contracts with your site.



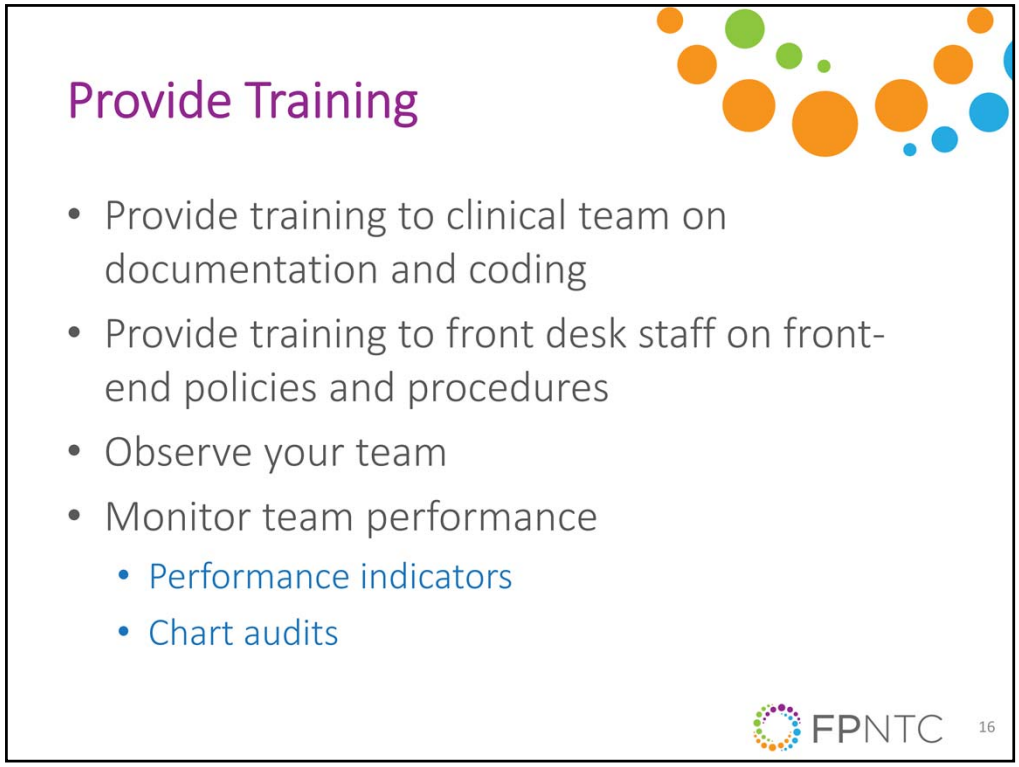
Let's review another example to demonstrate the impact of fee adjustment considering a contracted third party payer rates for a particular service. There are three scenarios that are available on this slide. In all three scenarios, for illustrative purposes, the negotiated contract rate for this particular service is $120. This example assumes that this particular service is provided 50 times a month. In scenario one, the current charge is $90, and remembering that it's done 50 times a month, we can see that our monthly charges are 90 times 50 or $4,500 of charges and potential payments from third party payers.

In scenario two, we can see that there is a proposed charge fee of $120, which is equal to the contractual rate in this example, and so 120 times 50 amounts to $6,000. In this case, that would be $6,000 of monthly charges and potentially payments. Then scenario three has the agency considering setting their charges higher than the contracted rate at 130. You can see that in this case, it will lead to the same amount of charges and potential revenue of that contractual rate. The monthly difference between scenarios one and two by adjusting your fees to at least the highest contractual rate amounts to $1,500 per month, which over a course of the year is $18,000. Again, that's $1,500 times 12 to get to that $18,000.

To review, if your agency's full charge is less than the negotiated rate, in this case, if you were charging the $90, you're only going to capture $90 for the services. The insurance company will only pay that full charge, not the negotiated

rate. I sometimes get asked what are the pros and cons of raising your rate to an amount that's higher than the highest contractual rate. I would suggest that a pro is that if you often get or sometimes get adjustments periodically throughout the year from various third party payers, that happens sometimes with Medicaid. You aren't constantly checking and adjusting your rate, so the pro to going a little higher is that you cover those types of adjustments.

A con might be that if it's too high, depending on your discount fee schedule percentages, that can become an issue for an uninsured client. You can adjust your percentage discounts as a potential solution to combat that issue.

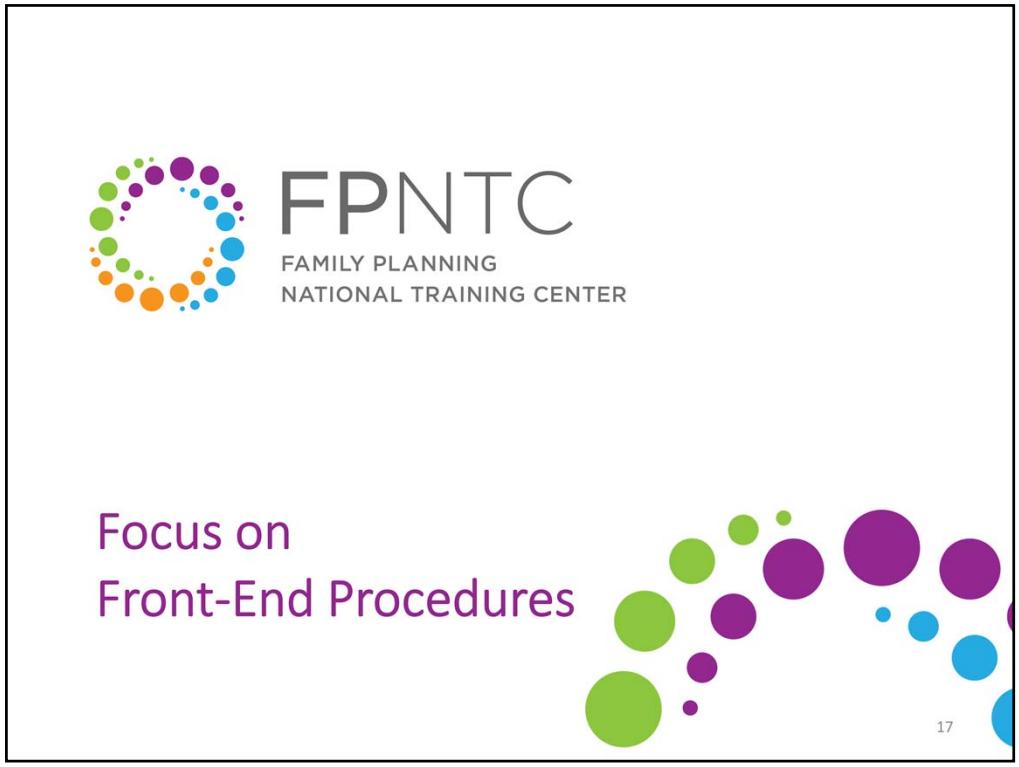


I'm going to move on next to ... We're going to skip to the last strategy now, and talk about training. This was the fourth strategy that was talked about. The fourth strategy to support billing the correct payer and optimal amount is to provide training on documentation and coding, and those front-end procedures. Training is needed to ensure accurate implementation of the policies and procedure. They can include efforts focused on documentation and coding with your clinical team, and of course, on those front-end policies and procedures for your front-desk staff.

Often, policies and procedure books are handed out for review in considered training. Certain elements can be missed or misinterpreted. As a suggestion, review policies and procedures in person, and allow for dialog and questions with the staff. One strategy to utilize in training staff is observation. Do staff behaviors match your agency's policies? You can use observation and monitoring of indicators as a way to identify when more training might be necessary, so I recommend doping this periodically. A few questions to consider, how often are your agency's policies reviewed and updated? When and how are new staffs trained on the policies? When and how are staffs notified of changes to the policies?

I've seen sites that just send out emails, and I highly encourage you to make sure those are discussed at monthly meetings as an example. Are

opportunities for staff to discuss these changes available? Again, that's why doing it in a meeting can be helpful. Is there a mechanism in place for staff to provide feedback and or input on the policies and procedure? If there are barriers or challenges related to implementing to the policies, how is that if management informed of those?



Caitlin Hungate:

Great. Thank you, Debbie. Now, for the rest of the webinar, we're going to focus on front-end procedures. Before we get started, we have a poll for everyone to complete. If you can take a minute and answer what challenges do you or your staff experience related to front-end procedures? Feel free to check all that apply, and these include time, training, policies and procedures, data extraction, agency or site culture and or client mindset. Go ahead. We see some poll results coming in, but we'll give it another few seconds for everyone to complete the poll, and then, we'll go into looking at those challenges as it relates to front-end procedures.

All right, so based on the results, it looks like 66% of you felt that time was a challenge, 59 or about 60% for training, 44% for policies and procedures, 39% for data extraction, and then nearly, excuse me, 48% for agency culture and client mindset. Debbie, I'm going to turn that back over to you to talk through some of those challenges.

Debbie Sullivan:

Thank you. Actually, the two that were most popular, time and training, I lumped those together. Often, training can be challenging. You get new staff or continued training for your staff. It can be challenging giving the day to day operations in a busy clinic. Sometimes, it's a good idea to consider external training simply because you may not have all the knowledge of how to follow up on for example, accounts receivable, and utilize the resources available for the national training center. If you don't know, for sure, someone in your organization has the best practices in those areas.

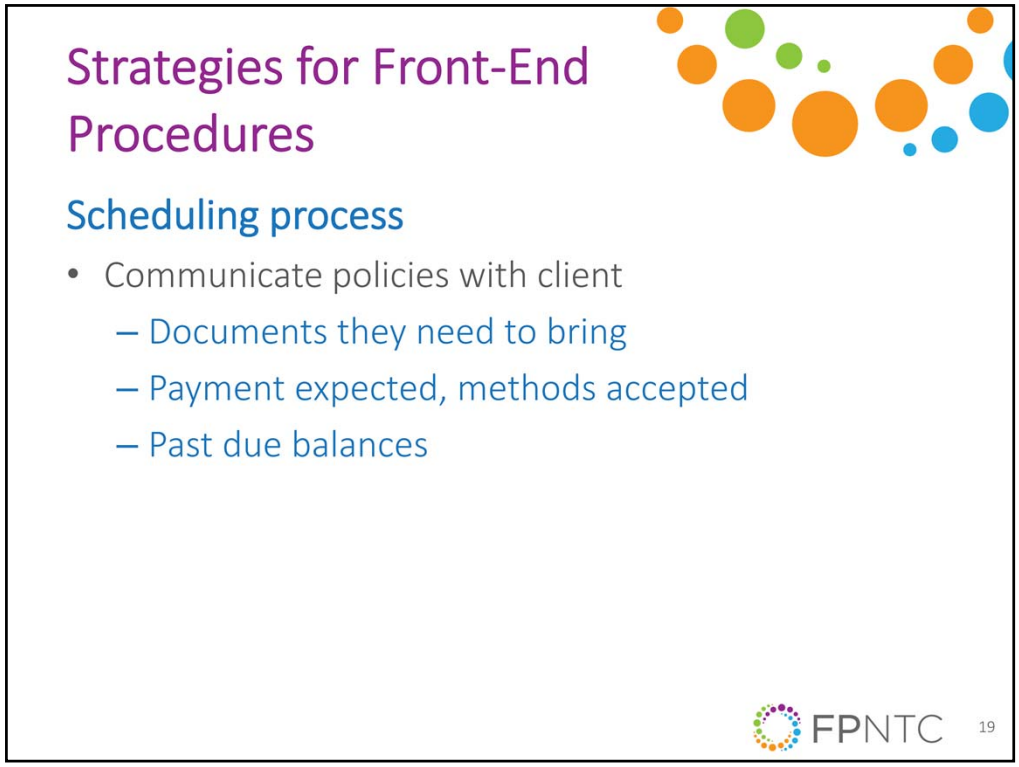
Remember, cost and time of mistake is more sometimes than the cost and time of training. Another idea on training is if you are conducting, and I highly recommended a monthly meeting, it's a great idea to incorporate just so you have a certain policy each month to just review the process. You'd be surprised how often staff will say, "Well, wait, I didn't know I was supposed to do it that way, or but wait, we do it this way." It might be a time to update the policy. Time, it certainly can be a challenge. It takes time at the front-desk for example to check insurance information, gather family size and income information, but again, when registration mistakes are made, the time that it takes to correct them and or deal with the denial is way more than the extra few minutes it takes to get it right the first time.

Those are typically some strategies that I use when I talk to folks about challenges in those areas. Culture is a big one as well. I think, that was the next one. Culture is important to consider not only with your staff, but also with the clients. With your staff, often, I hear clinic teams saying, "Hey, managing money is not my job." It's important to remind staff. We aren't a free clinic, and our clientele has shifted from predominantly uninsured and self-pay to more and more having either Medicaid or private insurance. That shift has started to really cement itself, and grant funding has decreased, so services should be reimbursed at appropriate discounted fees for all uninsured clients. Insurance should be charged for clients with third party payer.

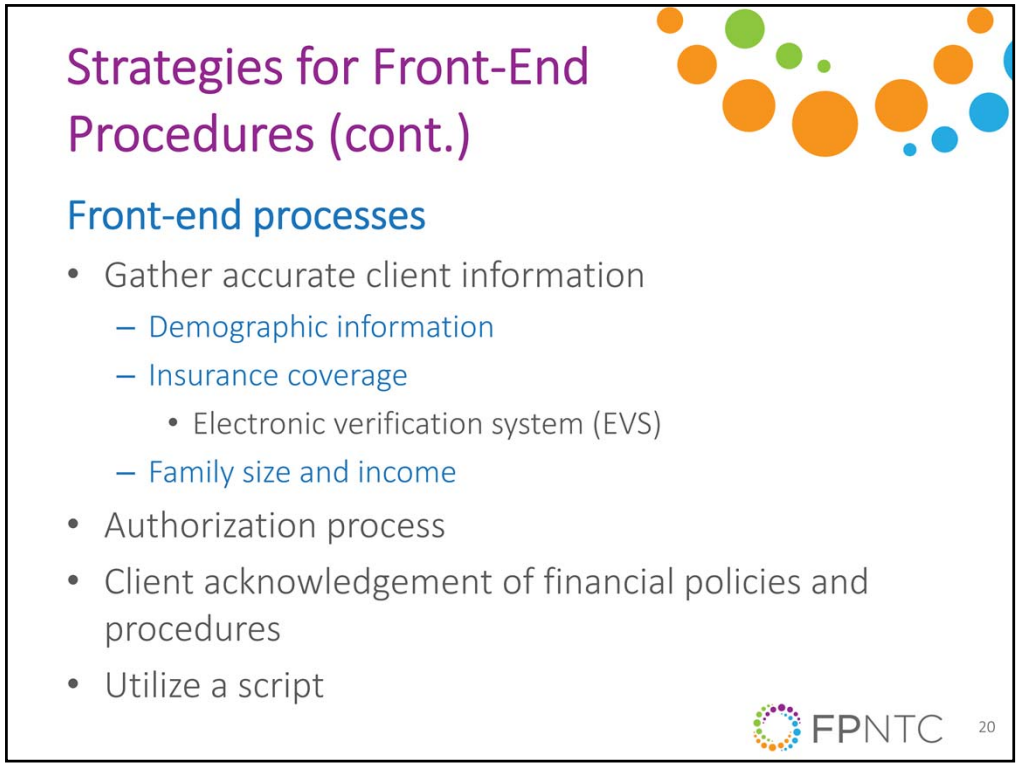
In copay, co-insurances, and deductibles should be charged and paid. Sharing the financial information at least some, and reinforcing these messages is a way to continue to get the mindset of your staff to change. With the clients, I know that in some cases, many of them become accustomed to receiving services and making little or no payment when payment's due. Changing their expectation around payments being due at time of services takes consistent persistent messaging during scheduling, a time of visit, at exit, and in written correspondence, but I have seen that change time and time again in clinics. I do want to say though, balancing these messages, and assuring the customer service doesn't sacrifice, and clients aren't denied services for their inability to pay with good cause is important.

I had mentioned scripting before, and I'm going to recommend that again in terms of achieving that balance. Just a comment on polices and procedures, I was glad to see that that came up, because often, people don't think about that as I'm working in clinics. It's hard to be successful with revenue cycle management when you don't have clear policies and procedures, or they don't cover all of the processes. Often, we assume staff's been around, and they know how to do this, but again, staffs turn over, and as time goes on, sometimes, we get further and further away from best practices. Again, I had mentioned the strategy of maybe reviewing one policy each month, or coming up with a way to review that manual.

Maybe you have one meeting totally dedicated to just reviewing policies and procedures. Lastly, just a word about data extraction, that can be a challenge. Most of it is typically user knowledge of how to extract the data in the reports, and sometimes, it's really a system limitation as well. If possible, get some help from a system vendor, and figure out what data extraction issues you're having or what data you want to extract. It's recommended that you and your team compile a list of necessary reports to run, and the frequency of them. I can share with you that more information is not always better. You need to arrive at a manageable number of daily, weekly, monthly reports and data to review so that it doesn't consume you.



Moving on to front-end strategies, during the scheduling process, communicate to your clients what your agency's policies are. Communicate specifically documents they need to bring in, which would include the insurance cards and proof of income if it's required, clearly outlining which document you accept. That payment is expected, and best practice again is collecting at time of visit, specifically for uninsured clients. Payment methods that would be accepted, for example, charge, so a credit card, check, cash, or debit card. Past due balances, assure your front-desk staff is able to identify past due balances in the system during the scheduling process, and can communicate that payment is expected at that next appointment, or whatever your agency's policy is about past due balances.



Observe and talk to your staff about the policies, and when we're trying to observe do the practices match the policy. As an example, I worked with a client recently, and their policy around walk-ins was that all walk-ins would be accepted and fit into the schedule on the day they walked in. When I observed what happened with the walk-in, that didn't occur, and so in talking to the front-desk person, she said no. The clinician doesn't allow me to do that. Again, you might think your policy is what's happening, but sometimes, that's not the case, so that observation and talking to staff is key. Well, it's important to have and communicate policies to clients. Remember that a client's inability to pay or to prove income should never be a barrier.

Front-end processes, so in addition to communicating your site's policies with clients when scheduling visits, it's important to think about front-end processes when they come in. Gathering that accurate client's information, in addition to any other required client forms, obtaining the demographic information, and that should all be on your intake form. Be specific and accurate. As an example of that, spell the name, the client's name the same way it's spelled on the insurance cards. That's how it's going to be recognized by the third party payer. The third party payer information, verifying the identification cards that clients give you electronically is a best practice.

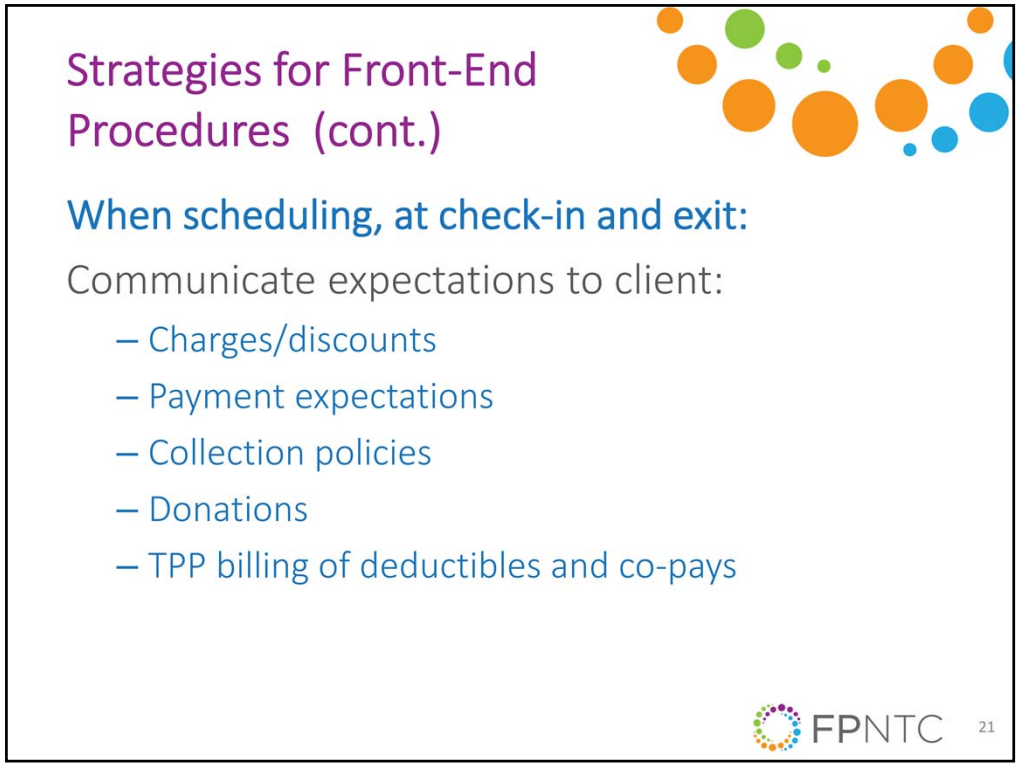
Also, you can verify that through your practice management system,

or just Medicaid, through your state's Medicaid system, again, doing that the night before and or a time of service. Consider checking all your clients by the way through the Medicaid state system. Sometimes, clients have coverage, and they don't disclose that information. Family size and income information, if you don't have specific income gathering and family size questions on your intake form, I suggest that you consider a script to gather specific income information. For example, income prompt, they may include questions not only about a client's employment income, but also about other types of income such as the spouse or partner's income, child support, alimony, unemployment, social security, work study wages, or other sources that you've encountered.

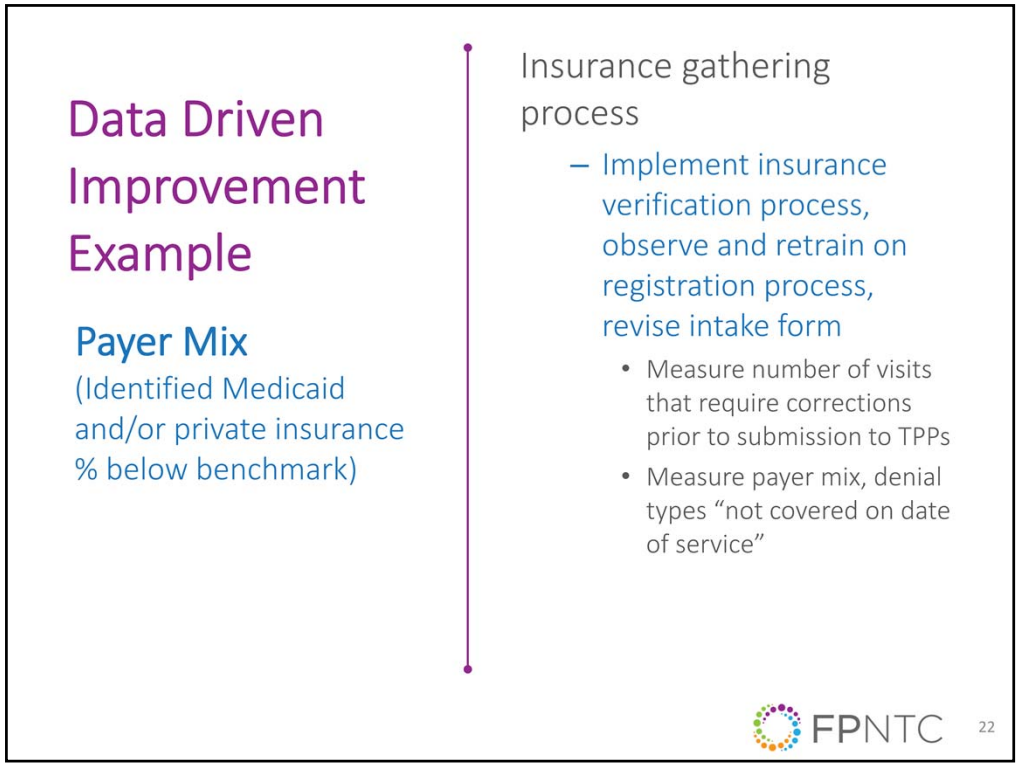
Again, having a checklist or a script for your staff to review them specifically might allow you to get more accurate income information. Then consider how often you gather this information. A best practice is every visit. Confidentiality may change from visit to visit as income and third party payer may as well. Implement an authorization process for any services that require a prior authorization by a third party payer. Consider utilizing a contractual obligation tracking tool, which would highlight third party payer contractual requirements for a third party payer in an easy to read spreadsheet. You can identify which third party payers and which services require that prior authorization, and have that posted at the front-desk for them to make sure that occurs prior to the service.

For all these topics mentioned, it's important to obtain a client acknowledgment of your agency's policies and procedures. One strategy is to create a one-page overview of the pertinent policies and procedures, have the clients read and then sign this one pager, and give them a copy of that. Pertinent information would be the payments expected, a time of visit, what forms of payment you accept, the payments will be discounted based on their family size and income, and clients and a third party payer coverage that there still might be some fee still. Again, while these are important strategies, remember that family client services should be provided regardless of their ability to pay.

Again, consider using that script so that these messages become balanced, and customer service isn't sacrificed.

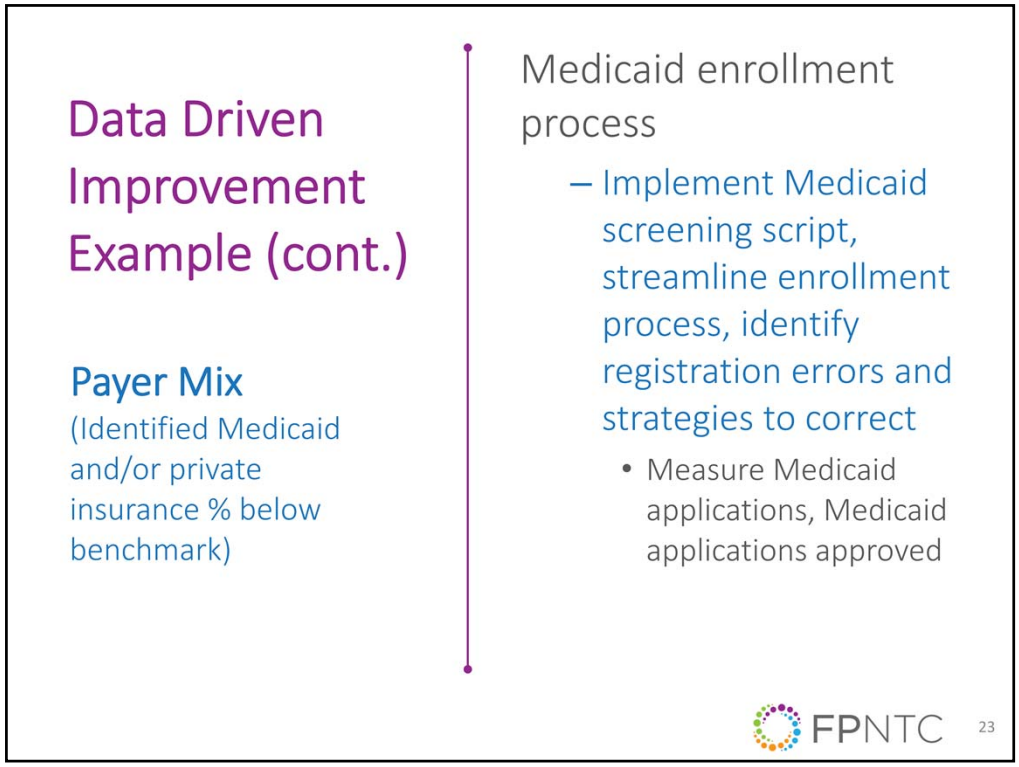


To reiterate and emphasize, consistent communications of your agency's policies to client when scheduling at check-in and at exit are important. This messaging is going to help with that culture change that we talked about as well as help to assure their best opportunity to charge the correct payer the optimal amount. Consider communicating the payments expected at time of visit, what payment methods you accept, and again, for insured clients telling them to bring their insurance information explaining there may be fees for balance not paid by the third party payer, and your agency's policy on collecting those balances.



Remember, consistent communication and detailed accurate implementation of these best practices and policies are critical to improve your financial results. The next few slides are a few potential QI or quality improvement examples. Let's take this strategy focusing on front-desk practices and policies, and talk through possible QI initiatives that you can focus on. First, to reiterate across all the possible QI initiatives, it's important to monitor indicators against benchmarks to identify possible issues. By monitoring indicators against benchmarks, you're going to be able to identify where performance can be improved. Earlier, we had discussed measuring payer mix, number of clients in each discount category, and charge for clients as measures related to best practices of billing the correct payer and optimal amount.

Any one of these when they're less than the benchmark could lead you to investigate and develop focus-targeted improvement plans. When payer mix indicated is below benchmarks, specifically Medicaid and or private insurance percentage of visits, consider reviewing front-desk processes to identify practices the site or agency can improve. Continue to measure payer mix, but based on the process you identify as needing improvement, there may be a meaningful sub-indicator to use. We'll review two examples of processes, possible tasks to improve, and corresponding indicators. In this first example, insurance gathering process is the process to examine. You would consider implementing or reviewing or enhancing your insurance verification process.



Observe and retrain your front-desk team on registration processes. As an example, how do they communicate that confidential service versus confidential billing? You might revise an intake form. For example, maybe how you even talk about confidential billing on that form, and a sub-indicator might be those number of visits that require corrections prior to being able to submit to your third party payer. Also, you would continue to measure payer mix, but you might also measure denials, and specifically, a denial type not covered on date of service as you're looking at your progress in this area. The second example applies specifically to sites that perform any enrollments, and when Medicaid percentages or visits are below your payer mix goals.

Now, they could be below your goals because Medicaid applications are being denied or because applications are not being completed, or because clients are not being informed of the opportunity to enroll, but the first step in this example is to identify that your mix of payer specifically Medicaid is below your goals you may delve into your Medicaid enrollment process, and implement a Medicaid screening script to be used at check-ins. You might streamline your enrollment process and or identify registration errors, and strategies to correct them. A sub-indicator to measure might be Medicaid applications or applications improved. You might also review the scheduling process to assure client communications around program enrollment information and or potential eligibility are included.

Data Driven Improvement Example (cont.)

Clients in each discount category
(identified a high percentage of fully discounted clients)

Family size and income gathering process

- Improve related policies, enhance intake from, staff training
  - Measure % of clients in each discount category

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Data Driven Improvement Example (cont.)

Charge per client
(identified charge per client is below benchmark)

Coding and charge entry process

- Train clinical and billing team, conduct documentation and coding audit, establish ongoing audit process
  - Measure charge/client, consider measuring for each clinician

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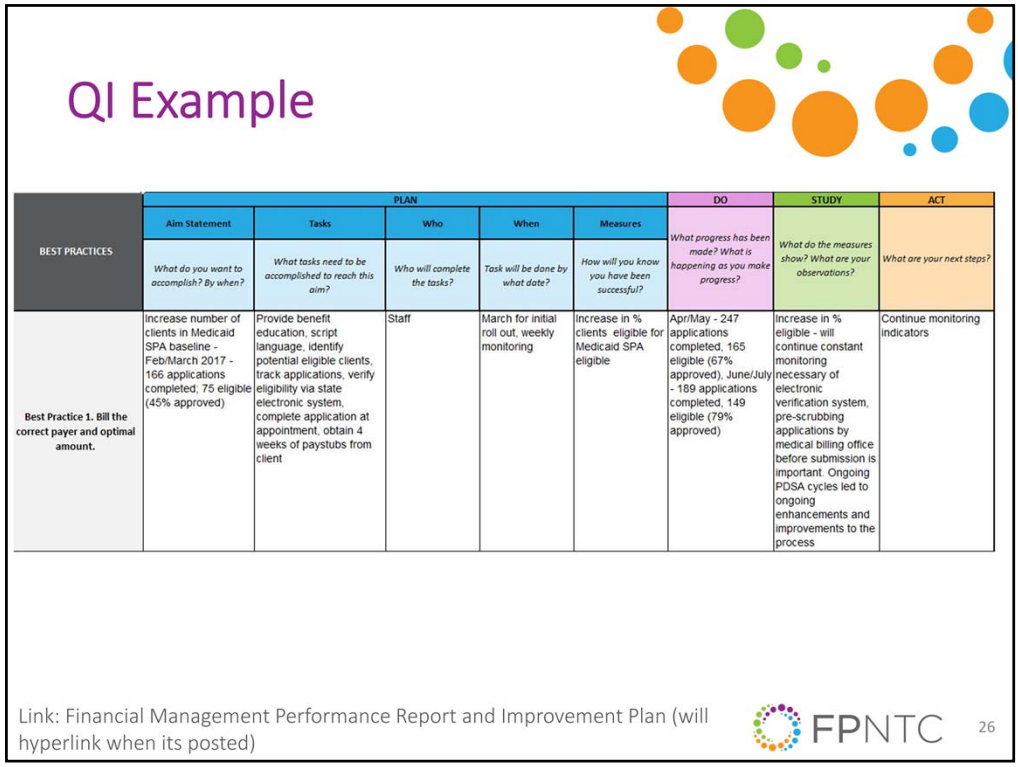


Katie Saul:

Debbie, it's Katie. I'm just going to jump in here. Just given the time, I want to make sure we do have a few questions coming in. I'm wondering if we can skip past these other two examples since they are in the slide, and that the talking points will be in the slides that we put online. Is there any chance we could skip ahead to the performance tools?

Debbie Sullivan:

Sure. Absolutely.

Katie Saul:

Okay.

Caitlin Hungate:

Great. Thank you. This is Caitlin again. Apologies that this slide is really hard to see. When you do receive the slides already, you'll be able to zoom in. This is a screenshot from the financial management performance report and improvement plan. That is a great tool that we developed that you can document a

Plan-Do-Study-Act approach to all of these best practices. What you see on the screen, it's hard to tell, but it is the sample improvement initiative from one of the learning collaborative participants to increase the number of clients in their Medicaid State Plan Amendment or SPA. That was what they wanted to ... That was their aim of trying to assess to bill the correct payer an optimal amount.

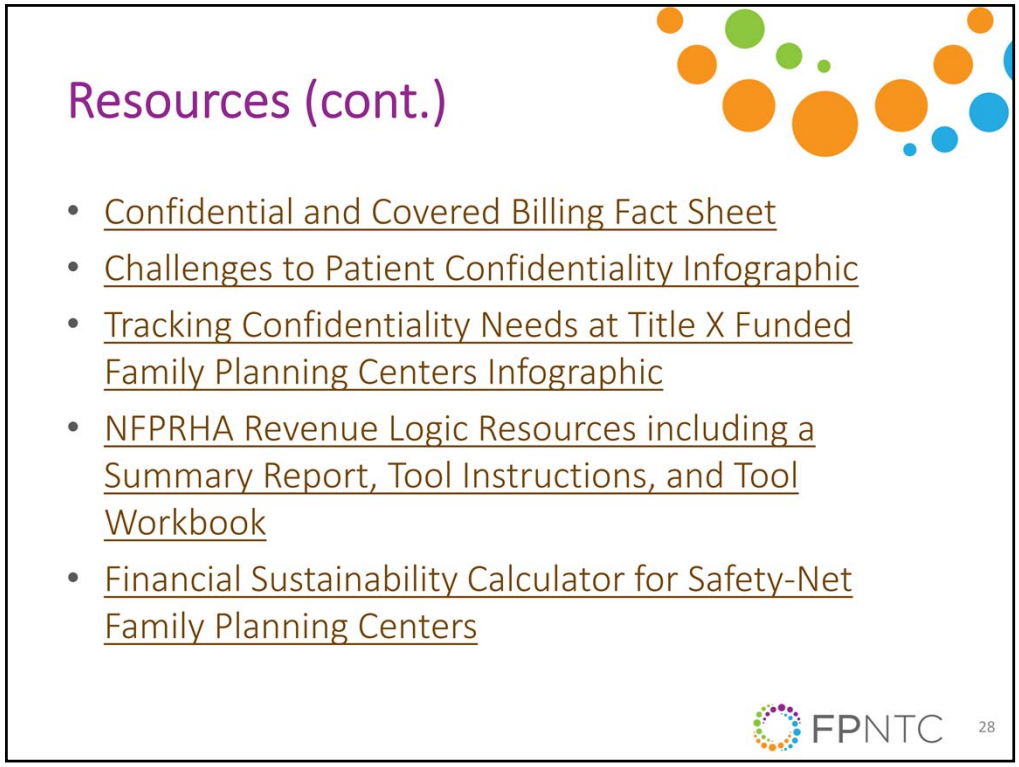
As you look through the plan do study act column, hopefully you can see the different tasks that the team identified, the quality improvement team. That included providing benefit education, script language, identifying possible or potential eligible clients, tracking applications and other activities. What they did was they decided to initially look at this in March, and then weekly, they're after for monitoring. This is a great example for sites and agencies that are on the call to utilize this example in a way that makes sense for you. If you also have Medicaid as Debbie talked about Medicaid enrollment, if you are doing Medicaid enrollment on site, some of the tasks that they utilize may be helpful for you.

There are measures that they identified where to increase the percentage of clients eligible in the Medicaid, the SPA as well. I'm going to go along to the do and the study, and so as you can see, in initially in April and May, they had over nearly 250 applications completed, identified that 165 were eligible. Then in June and July, 189 applications were completed, and 149 eligible, so a 79% of the applications approved, which was slightly higher than the April, May 57% approved. They continue to study what happened in the quality improvement initiative to increase the percentage of the clients eligible. We'll continue to constantly monitor that.

One of the things when thinking through this possible example is that this PDSA cycle, the Plan-Do-Study-Act can help you and your team work through an initiative, but you still may want to study it and refine and further enhance tasks that were completed to see what worked and what didn't work, and where there are still opportunities for continued enhancement. They've decided to continue monitoring the indicators. That's a quick overview of a sample quality improvement initiative, and how you can utilize the financial management performance report and improvement plan that is available.

These are a few of the resources available from the family planning national training centers including the financial management change package, which we talked about, the performance report and improvement plan that I just highlighted one of the tabs in. We've got discussion guides and slides for this best practice to bill the correct payer and optimal amount. That's separate from this webinar today. We have a job aid around collecting copays, and applying sliding fee scales. That's a source of confusion, and it's a great job aid to support collecting that accurate information. Debbie mentioned in her presentation the contractual obligations tracking spreadsheet. This is a great resource from another ... It was an SPD training center, but unfortunately, that website, that project has ended, and so that website will be up through August 31st of this year.

If you're interested in the contractual obligations tracking spreadsheet, make sure to download that tool now. Last but not the least, our training packages in this arena that could help your site or agency to work on this best practice around third party billing and cost analysis.



There's additional resources that we have on our website that come from a variety of sources including NFPRHA, the confidential and covered billing fact sheet, which is really great. There is a couple infographics that Altarum Institute developed around patient or client confidentiality, so there are two great infographics that are available on the fpntc.org website now. NFPRHA has a great revenue logic suite of resources that include a report, a tool instruction, and a tool workbook.

Last but not the least, the financial sustainability calculator developed by Guttmacher Institute. All of those additional resources are on fpntc.org. We want to dive into questions at this time. I'm sorry that I rushed through those resources. What questions do you have?

Katie, maybe I'll turn it over to you, and you should determine whether you go to the chat or the phone line first. If you have questions, please know you can use the phone lines for questions as well.

Katie Saul:

John, our operator, I think, you probably have some instructions for the participants. We do have some chat questions, so maybe you can provide the instructions for asking on the phone. As we wait for folks to join that too, I'll read out some of the chat questions.

John:

Yes, absolutely. If you'd like to ask a question over the phone, please signal now by pressing star one on your telephone keypad. A voice prompt on the phone line will indicate when your line is open. Again, that is star one for any questions over the phone.

Katie Saul:

Great. While we're waiting for those, a few questions that came in over the chat. One is from Stephanie. She's asking where she can find national

benchmark information.

Debbie Sullivan:

There is a tool on the National Training website that outlines, I think, it's called the financial dashboard. It does outline some benchmarks for some of the core indicators. Again, that's one area to look. Those were resourced throughout a thorough study and analysis of many sources out there. I'd say those are pretty standard core indicators. Also, again, some of the other strategies that I mentioned in the slide just amongst looking of your own, but check out the financial dashboard on the FPNTC.

Katie Saul:

Okay. We have two related questions from Peggy and Cora that asks, "To help staff determine what to include in client's income, are there any tools or references that list the items they should or shouldn't include?" As a follow up, one participant said they were actually told that child support, alimony, and foster care payments couldn't be included as income, so just wanted to clarify that.

Debbie Sullivan:

I am not aware of a specific resource, and please if anyone is if you can please chat in and answer, or type in, but I'm not aware of a specific resource. I have seen many organizations the best practice being that they outlined it clearly in their policy what elements or items they are looking at. I am not aware of those two as being income sources that should not be counted. If that's the case, maybe if someone from OPA is on, they could weigh in on that, that would be great, but I think it's more important to make sure it's very established in your policy so the team knows what they could or should be looking for.

Katie Saul:

We have a question from Gayle. Is an additional discount for a full payment received on the day of service allowed for those that are self-pay?

Debbie Sullivan:

I have seen that gone in some sites, and I think that that is an area where you want to check with your grantee, and share what your fee schedule is, and share what your practice or your policy is. If that's outlined clearly, and if it's followed

clearly, I've seen where it's become problematic when it's done for certain patients and not for others. I think, some of this is around the clear policy establishment and then following that policy.

Katie Saul:

We have one more question via chat, and then John will check the phone lines. It asks, "Is it acceptable for Title X to bill private insurance for clients who say that receiving an EOB is acceptable, and to not bill the private insurance of clients who do not want an EOB sent to their home if private insurance refuses to suppress statements for confidential clients?"

Debbie Sullivan:

If I understand this correctly, what the question and the answer is that if a client comes into the office, and they have a certain type of third party payer coverage that you contract with, and the client says that it's okay to bill, and they don't mind than an EOB is going to come to the home. There is no issue. Then certainly, you would bill that third party payer. That same client can come back six months later, and say, "I can't have you bill. My situation has changed." There is a domestic violence situation that is developed, or whatever, and I can't have you bill. It could be the same client or a different client with the same insurance. Indeed, if the client is concerned about that because of the confidentiality, you should not bill the third party payer in that situation.

Katie Saul: John, do we have any questions in the cue on the phone?

John:

We do. We'll take that question now.

Susan:

Hi, this is Susan from Iredell County. I have seen very frequently that the statement payment is expected at the time of service, but is it best practice to collect the money prior to the service being rendered, or is that considered being, I guess, too forceful, and we should collect it after the service?

Debbie Sullivan: Certainly, there is no rule around before or after, but I do know that the majority of the clients that I'm now working with are leaning more towards post visit collections, specifically if they're looking at copays, and the whole second section, or excuse me, second best practice focuses a little bit on this, but just to give you a bit of that information, sometimes, the type of visit can change, or the charges might not be really set because what happens or what the patient scheduled

for might not match what actually happened, and so waiting until the end sometimes gives you a more accurate idea of what the charges are and what the discounts should then be, specifically also then for third party payer clients looking at the copay, and determining if there is a copay or not if that is collected at time of visit. I usually see it post.

Susan:

Can you better define what is unwillingness to pay and inability to pay?

Debbie Sullivan:

Some of this is a little bit gray, and you know your patients better than anyone else, but some of these are individual discussions with patients, and determinations that need to be made by your clinic manager when the front-desk staff is unsure of what to do, but having just clear policies around that whether in ... We'll talk about this again in the next session, whether payment plans are an option, or what you can do to obviously not deny services but continue to certainly try to collect what is due you. If we are accurately discounting them, which is very important, it is okay to expect the client to pay.

Given their situation, if Title X does allow for, you can certainly waive fees, but again, those are policies that you should spell up very clearly. We talked about that again in the second session to have some clear guidelines and or a direct line for your front-desk staff to go if they are concerned or confused.

Susan:

Thank you.

Katie Saul:

I can see that we're at the end of our time, so I just want to make a couple of quick announcements before we wrap up. One is that one of our participants kindly sent some information from the IRS regarding resources for income. We're going to circle back to OPA about that, and we'll be able to clarify that in the webinar transcript, so please keep an eye out for that. We might also send a note out to all of you, participants, just so that we're all clear on the guidelines for that. We will have a recording and a transcript of today's session available within the next few days or early next week. We will be addressing the other two best practices as we mentioned at the start in the next couple of weeks, before the end of the month.

If you haven't registered for those, please go to fpntc.org. Then finally, Caitlin mentioned this at the start. As a result of the financial management learning collaborative, we have developed discussion guides and slides that very closely mirror today's session so that you all can conduct these types of sessions with your staff and your network. Those are training tools that are available to you, so please take a look at those on our website as well. Then finally, we do ask you to complete the evaluation today. Your input greatly impacts the work that we do, and especially considering we have two more webinars in this series, we will take your feedback to heart.

Please let us know what you like and what we can do differently on the following two webinars, and if not, in general. Finally, thank you all for joining us today.

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