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# Financial Management Change Package

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**RHNTC.ORG**



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# INTRODUCTION

**T**he Title X Family Planning Program is dedicated to providing comprehensive family planning services and related preventive health services to low-income families. To best serve the family planning needs of low-income and vulnerable populations, Title X grantees must ensure the financial health of their agencies and networks of clinics. Establishment of best practices for program management and operations is essential for financial viability.

According to the Title X Program Requirements, Title X grantees are responsible for oversight and compliance of policies and procedures for charging, billing, and collections, including third party payers.<sup>1</sup> Grantees are encouraged to earn income to defray program costs where appropriate. Additionally, grantees are responsible for performance and financial monitoring and reporting. This Financial Management Change Package offers quality improvement (QI) strategies to help Title X grantees adopt best practices for analyzing and improving financial health.

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# GOAL OF THE CHANGE PACKAGE

The goal of the Financial Management Change Package (FMCP) is to support Title X grantees' improvement of financial management practices and the factors that impact their organizations' financial health. It is designed to help Title X grantees develop comprehensive strategies for improving revenue.

Identification of three best practices incorporated several factors: 1) prior Title X grantee and subrecipient technical assistance requests; 2) a literature review of revenue cycle management issues and opportunities; 3) OPA's Title X Program Requirements; and 4) the need to improve financial management practices, guide strategic financial planning, and meet annual reporting requirements for family planning services.

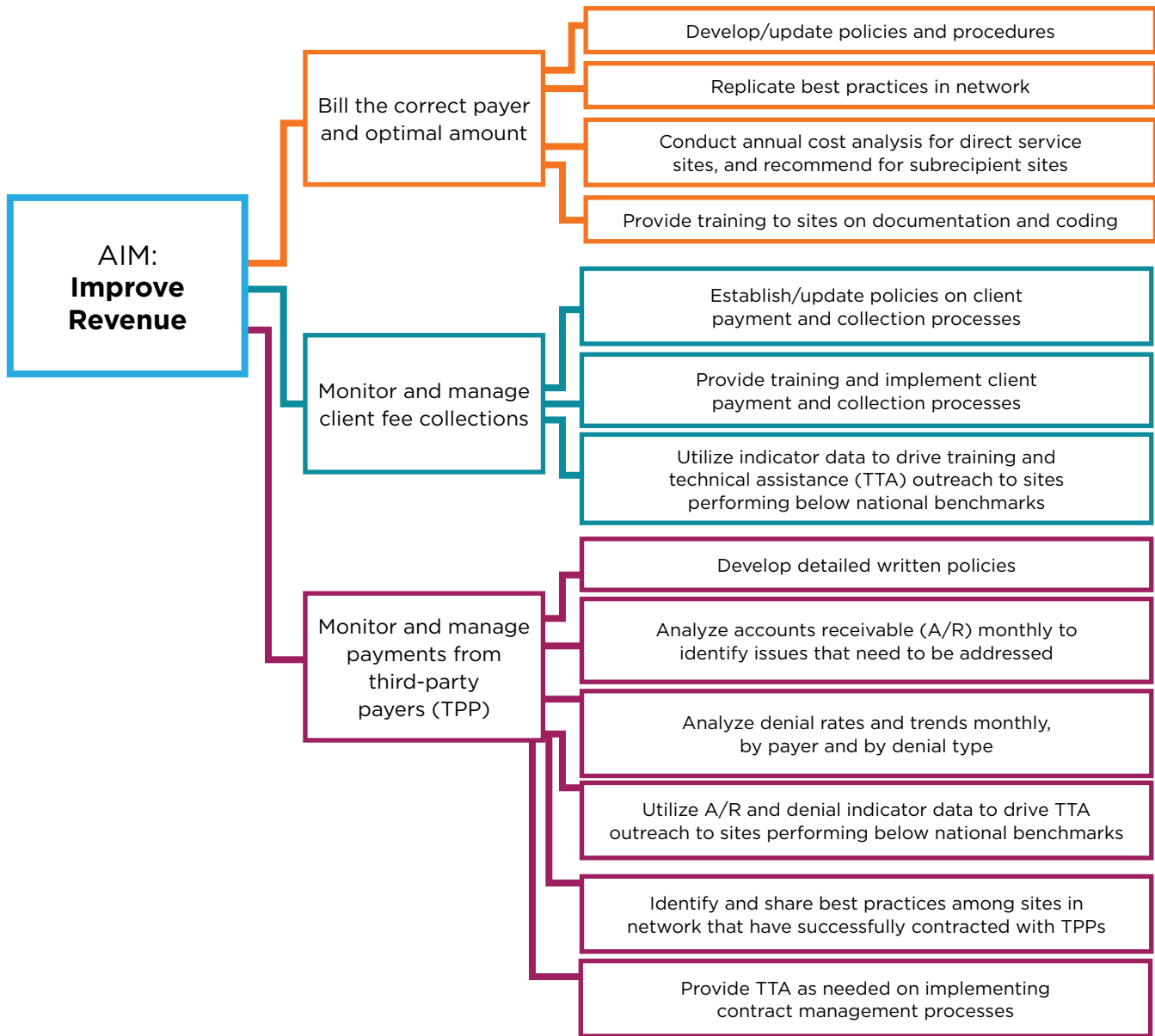
» **BEST PRACTICE 1. Bill the correct payer and optimal amount.** Routinely review Family Planning Annual Report (FPAR) and EHR/practice management (PM) measures to identify payer mix, charge, coding, and/or discount issues. Regularly conduct a cost analysis, and then compare these data to third-party payer contract rates and fee schedule.

» **BEST PRACTICE 2. Monitor and manage client fee collections.** Manage client fee collections, including time-of-visit fee collection (uninsured clients' fees and insured clients' copays) and post-visit billing (insured clients' deductibles and co-insurance payments).

» **BEST PRACTICE 3. Monitor and manage payments from third-party payers (TPP).** Review accounts receivable (A/R) aging and analyze denials to identify issues and affect changes on revenue. Implement strategies to manage TPP contract terms and relationships.

The best practices and strategies in this document are intended for Title X grantees that oversee family planning service sites directly as well as for grantees providing technical assistance to subrecipients and service sites on financial management QI.

**FIGURE 1.** Driver Diagram



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# HOW TO USE THIS CHANGE PACKAGE

This change package is designed to support sites that are developing strategies for improving their net revenue. Specifically, this package is meant to support efforts to:

- » Increase awareness of best practice strategies associated with improving revenue
- » Identify key financial indicators that have the largest impact on the best practice and/or are well below benchmarks or standards
- » Gather data necessary to calculate the measures
- » Adopt best practices to analyze financial data and improve financial management by gaining insight on high and/or low indicator outcomes
- » Assess the impact of implemented changes
- » Provide training and technical assistance (TTA) to subrecipients to help them improve their financial management skills

Grantees are encouraged to discuss implementation of these strategies and QI processes with other Title X grantees.

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# BEST PRACTICES

## BEST PRACTICE 1.

### **Bill the correct payer and optimal amount.**

Routinely review FPAR measures, EHR/PM measures to identify payer mix, charge, coding, and/or discount issues. Regularly conduct a cost analysis, and then compare these data to TPP contract rates and fee schedule. Utilize this information to adjust your fee schedule.

### **RATIONALE:**

Revenue optimization begins with assuring that the correct payer is billed the accurate amount for services provided. The correct payer, whether public or private, can be identified and billed for services by capturing clients' insurance and other required information accurately during front-end procedures. Additionally, charges for uninsured clients are appropriately optimized by gathering family size and income information accurately, so that the appropriate discount is calculated. Per the 2021 final rule, "If a client's income cannot be verified after reasonable attempts to do so, charges are to be based on the client's self-reported income." Specific issues that emerge when billing the correct payer the optimal amount can be identified by analyzing and comparing site(s) indicators—such as payer mix, charge per client, and percent of clients in each sliding fee discount category—and by conducting chart documentation and coding audits. In addition, reviewing site-specific TPP contract rates, cost analysis information, and fee schedule can lead to informed fee schedule and sliding fee discount schedule adjustments. All of these suggested activities often result in increased charges, leading to increased revenue opportunities. These best practice concepts can be applied to service sites that are directly managed by the grantee; they can also be incorporated into TTA provided to subrecipient sites.

## **STRATEGIES**

1. Develop and/or update policies and procedures. Involve key staff performing processes to ensure policies and procedures are accurate and efficient. Implement and manage these at direct service sites; provide TTA to subrecipient sites as appropriate.

- Example of policies and procedures: front-end procedures that include scheduling, collection/electronic verification of insurance information, and family size and income information, coding and billing, prior authorization process when required, leveraging practice management system technology and reports

2. Replicate best practices identified in the network by:

- Identifying sites in the network that are performing well by reviewing/analyzing FPAR data tables and other financial reports to which grantees have access
- Examining processes, policies, and procedures to pinpoint practices that led to high performance on indicators
- Providing training across network on identified policies, practice, and procedures of best practice sites to build network capacity

Conversely, utilize indicator data to identify sites performing below benchmarks to drive TTA outreach.

3. Conduct annual cost analysis for direct service sites, and, if applicable, recommend one

- annually for subrecipient sites. Compare costs of services to the current fee schedule and TPP contractual rates to make decisions regarding fee schedule, budgets, expense management, and service modifications.
4. Provide training to direct service sites and subrecipients, when appropriate, on complete and correct documentation of clinical care and processes to ensure all corresponding charges/codes are captured. Training topics could include conducting internal audits of these processes, or maintaining TPP contractual obligations with regard to services/codes.

### SUGGESTED INDICATORS

- » Monthly Charges (by site) broken out by:
  - Uninsured/self-pay clients
  - TPP (Medicaid and private insurance)
- » Charge per client (by payer types, such as by Medicaid, private insurance, and/or uninsured/self-pay)

### TOOLS AND RESOURCES

- » [Getting Started with Your Focused Cost Analysis eLearning \(Module 1\)](#) (Source: RHNTC.org)
- » [Cost Analysis: All About Relative Value Units eLearning \(Module 2\)](#) (Source: RHNTC.org)
- » [Putting the Pieces Together for an Effective Cost Analysis eLearning \(Module 3\)](#) (Source: RHNTC.org)
- » [Insurance Verification Form](#) (Source: STDTAC.org, STD Billing and Reimbursement Toolkit, Module 2: Develop Billing Systems, Policies and Procedures)
- » [Eligibility and Income Verification Form](#) (Source: STDTAC.org, STD Billing and Reimbursement Toolkit, Module 2: Develop Billing Systems, Policies and Procedures)
- » [Evaluation and Management Coding Tool](#) (Source: RHNTC.org)

### SUCCESS STORY:

The **Florida Department of Health**, a Title X grantee, sought to increase the number of clients approved and enrolled in its state family planning Medicaid waiver by 4% over a five-month time frame. Staff determined that 46% of the family planning Medicaid waiver applications submitted in 2016 were either denied and/or had errors. The grantee chose to focus on the family planning Medicaid waiver application with one site in its network.

First, the grantee dedicated staff time to focus on the Medicaid waiver data and application process. Grantee staff analyzed application errors to identify common reasons for errors, wrote step-by-step directions for the client application process, and

developed a flow chart and script for the service site to use. They shared the flow chart and script with the site, and modified them based on feedback from the service site staff involved in the application process. Training on the use of the flow chart and script was conducted statewide. The approval rate for family planning waiver applications increased from 49% at baseline to 59% after a five-month period at the target site. Additionally, statewide error rates decreased by 38%, while Medicaid application approvals increased by 10%.

Staff turnover remains a challenge. The Florida Department of Health grantee learned that ongoing or periodic updates and trainings statewide are critical to maintaining results.



## **TOOLS AND RESOURCES, CONT.**

- » [Collecting Copays and Applying Sliding Fee Scales: A Job Aid for Front Desk Staff](#)  
(Source: RHNTC.org)
- » [Program Requirements for Title X Funded Family Planning Projects](#) (Source: OPA)
- » [Coding in the Reproductive Health Care Environment: The Fundamentals of Coding eLearning \(Module 1\)](#) (Source: RHNTC.org)
- » [Coding in the Reproductive Health Care Environment: The Coding Process eLearning \(Module 2\)](#) (Source: RHNTC.org)
- » [Coding in the Reproductive Health Care Environment: Advanced Case Studies in Coding eLearning \(Module 3\)](#) (Source: RHNTC.org)

## BEST PRACTICE 2.

**Monitor and manage fee collections.** Manage client fee collections, including time of visit fee collection (uninsured clients' fees and insured clients' copays) and post-visit billing (insured clients' deductibles and co-insurance payments).

### RATIONALE:

Collecting client fees for services provided is an important component of managing financial health. This can be best achieved by establishing and monitoring policies and practices on payment and collections, educating clients on these policies, and training staff. Communicating with clients about financial obligation and payment expectations at time of visit is critical. It is equally important to assure the message is welcoming, positive, and accommodating to a client who cannot pay or is experiencing difficulty paying. Once a client leaves, collecting payment becomes more difficult and time-consuming. When staff are knowledgeable of client insurance plans, as well as policies and procedures, they can have a positive impact on the fees collected at time of visit. Fee collection strategies can be applied to service sites that are directly managed by the grantee and can also be incorporated into TTA provided to subrecipient sites.

### STRATEGIES:

1. Establish and/or update policies on client payment and collection processes as appropriate.
2. Provide training and implement client payment and collection processes to direct service sites and subrecipient sites, where appropriate, on the following:
  - Accept cash, credit card, debit card, and check as payment
  - Collect appropriately discounted fees for services provided to uninsured clients at time of visit
  - Identify and bill for accurately discounted copays, deductibles, and/or co-insurances not covered by TPP. Per the 2021 final rule, with regards to insured clients, clients whose family income is at or below 250% of the federal poverty level (FPL) should not pay more in copays or additional fees than what they would otherwise pay when the schedule of discounts is applied.
  - Bill client for outstanding balances at 30-60-90-120 days post- service delivery
  - Implement client payment plans, as appropriate
  - Communicate with consistent messaging during scheduling, at time of visit, and in written correspondence about charges, fees, payment expectations, and collection policies. Ensure messages are trauma-informed and client-centered.
3. Ask subrecipient sites to share indicator data, and then utilize this information to identify sites performing below national benchmarks to drive TTA outreach on these payment and collection practices and policies.

### SUGGESTED INDICATORS:

- » Time of service collection rate (best practice 90% or better)<sup>2</sup>
  - » Percent of fees receivable over 120 days (best practice under 25%)<sup>3</sup>
  - » Monthly fees (client) collected
- » [Sample Policies and Procedures](#) (Source: STD-TAC.org, STD Billing and Reimbursement Toolkit, Module 2: Develop Billing Systems, Policies and Procedures)
  - » [Financial dashboard](#) (Source: FPNTC.org)

### TOOLS AND RESOURCES

- » [Collecting Copays and Applying Sliding Fee Scales: A Job Aid for Front Desk Staff](#) (Source: FPNTC.org)

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### SUCCESS STORY:

**Southern Nevada Health District (SNHD)**, a Title X grantee with two service sites, sought to improve its overall fee collection rate for both time-of-visit services and past due balances. Additionally, SNHD wanted to improve client income information gathering and calculations to be able to determine client discounts and fees more accurately. SNHD aimed to accomplish these goals over a four-month time frame.

Staff at SNHD revised and simplified the financial intake form and added more specific income questions. This resulted in better income information gathering for each client, and staff were able to more accurately estimate clients' monthly income to determine the appropriate discount. Additionally, staff were trained to identify past due balances for clients when they called to schedule new appointments. Staff were also trained to communicate to all clients, including those with past

due balances, what payment was due both when scheduling an appointment and also at time a visit.

SNHD increased collections per uninsured client from an average of \$8.31 to \$25.35 over a four-month period, resulting in an increase of nearly \$8,000 in monthly fees collected from month one to month four.

Staff at SNHD realized that making small changes can make a big difference. Trying to implement many changes at once is not always effective. SNHD also learned about the importance of building and having a strong relationship with their finance department and that working together was key to their success.

## BEST PRACTICE 3.

**Monitor and manage payments from third-party payers.** Review accounts receivable (A/R) aging and analyze denials to identify issues and affect change on revenue. Implement strategies to manage TPP contract terms and relationships.

### RATIONALE:

To ensure that expected payments are received in a timely manner, it is necessary to assure that processes are implemented and monitored prior to and post claim submission. Regular analysis of data and reports—such as A/R aging, denial reports, receivable payment trend reports, and claims receivable reports—is necessary to identify issues and develop action plans. In addition to applying these strategies to sites that are directly managed, they can be shared with subrecipients to improve their management of TPPs.

### STRATEGIES:

1. Develop detailed written policies for direct service sites and subrecipient sites as appropriate. Involve key staff performing processes to ensure policies and procedures are accurate and efficient. Implement and manage these at direct service sites and provide TTA at subrecipient sites, where appropriate.
  - Examples of policies and procedures include: claim submission process/time frames, payment posting, A/R follow-up, denials management
2. Analyze A/R on a monthly basis to identify issues that need to be addressed at direct service sites, and provide TTA to subrecipient sites on analysis and follow-up skills, as appropriate.
  - Examples of analysis include: review the data by age, by site, by payer, by clinical services provider, by code, etc. to identify and address areas in need of attention. Compare data to established benchmarks.
3. Analyze denial rates and trends on a monthly basis, by payer and by denial type. Implement strategies to reduce denial rates at direct service sites, and provide TTA to subrecipient sites on these skills. Compare denial rates to national benchmarks.
  - Implement improvement strategies to reduce denial rates. For example, if prior authorization denials are higher than a benchmark, service sites could implement a prior authorization process at the front desk. Utilize a contractual obligation tracking tool to identify TPPs and specific services requiring prior authorization. Manage A/R after services are delivered/post claim submission.
4. Ask subrecipient sites to share A/R and denial indicator data and utilize this information to identify sites performing below national benchmarks to drive TTA outreach. Replicate best practices in managing A/R and denial rates identified in network by:
  - Identifying sites in the network that are performing at or above national standards
  - Examining processes, policies, and procedures in identified sites to pinpoint specific practices that led to high performance on indicators
  - Providing training across network on identified policies, practice, and procedures of best practice sites to build network capacity
5. Identify best practices among direct and subrecipient sites that have successfully contracted with TPPs and share across network to leverage lessons learned and build capacity.
6. Provide TTA as needed on implementing contract management processes in conjunction with a process to track important TPP contractual elements and clinical services provider credentials.

## SUGGESTED INDICATORS:

- » Denial rate at or below benchmark (the best practice is below 5-10%, less than 5% is optimal)<sup>4</sup>
- » A/R aging – achieving benchmarks in bucket categories (the best practice for A/R greater than 120 days ranges between 12% and 25%; less than 12% is desirable)<sup>5</sup>
- » Monthly TPP payments

*\*Financial Dashboard has suggested benchmarks. Benchmarks can also be established based on experience or internal best practices.*

## TOOLS AND RESOURCES

- » [Financial Dashboard](#) (Source: RHNTC.org)
- » [Contractual Obligation Tracking Spreadsheet](#) (Source: STD-TAC.org, STD Billing and Reimbursement Toolkit, Module 4: Initiate Contract Process, Credentialing)
- » [Accounts Receivable \(A/R\) Management Tool](#) (Source: RHNTC.org)
- » [Provider Credentialing Tracking Workbook](#) (Source: STD-TAC.org, STD Billing and Reimbursement Toolkit, Module 4: Initiate Contract Process, Credentialing)

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## SUCCESS STORY:

The **Louisiana Department of Health**, a Title X grantee, identified through analysis that denials were a significant issue, with a 15% baseline denial rate. Specifically, they noted eligibility denial types as the top denial reason, and sought to decrease this denial type, and, consequently, reduce the overall denial rate. To address this issue, the Louisiana grantee team sent out a memorandum on when and how to complete eligibility verifications. However, denial rates did not improve after the memorandum was distributed to sites. This prompted the team to seek feedback from sites. They then incorporated this feedback and hosted a webinar on September 27, 2017 on the eligibility verification process. The

team also provided one-on-one trainings at the clinics with the highest rates of eligibility denials. Also, the regional directors were trained to explain the insurance eligibility verification process to their staff. At the end of the project, the Louisiana Department of Health saw a 4% decrease in denials by October 2017. A follow-up webinar is being planned.

The team learned it was important to be open to changing training methodology related to household assessment and eligibility checks to include greater interaction between staff and increase the timing between implementing each training task.

## **TOOLS AND RESOURCES, CONT.**

- » [Tips for Credentialing Providers](#) (Source: STD-TAC.org, STD Billing and Reimbursement Toolkit, Module 4: Initiate Contract Process, Credentialing)
- » [How to Credential Family Planning Providers with Health Plans](#) (Source: FPNTC.org)
- » [Provider Credentialing: Overview and Checklist](#) (Source: STD-TAC.org, STD Billing and Reimbursement Toolkit, Module 4: Initiate Contract Process, Credentialing)
- » [Value Proposition Document](#) (Source: FPNTC.org)
- » [Answers About Health Plan Contracting](#) (Source: FPNTC.org)
- » [Frequently Asked Questions about Contracts with Third-Party Payers](#) (Source: STD-TAC.org, STD Billing and Reimbursement Toolkit, Module 4: Initiate Contract Process, Contracting Basics)
- » [Ten Steps on Contracting with Insurance Companies](#) (Source: STD-TAC.org, STD Billing and Reimbursement Toolkit, Module 4: Initiate Contract Process, Contracting Basics)
- » [RCM: Best Practices for Public Health](#) (Source: STD-TAC.org, STD Billing and Reimbursement Toolkit, Module 3: Manage Revenue Cycle, Revenue Cycle Management Basics)
- » [Revenue Cycle Management Series: Before and During the Client Visit Webinar \(Part 1\)](#) (Source: FPNTC.org)
- » [Revenue Cycle Management Series: After the Client Visit Webinar \(Part 2\)](#) (Source: FPNTC.org)
- » [Revenue Cycle Management Series: Contracting with Payers Webinar \(Part 3\)](#) (Source: FPNTC.org)

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