



Session 3: Revenue Management in Title X

Presenter: Ann Finn
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AF Consulting, LLC
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Introductions / Contact



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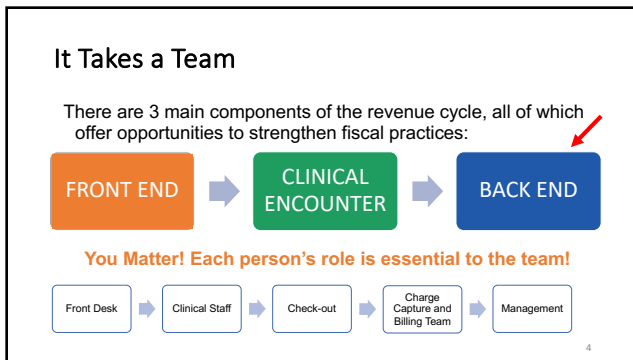
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Today's Agenda

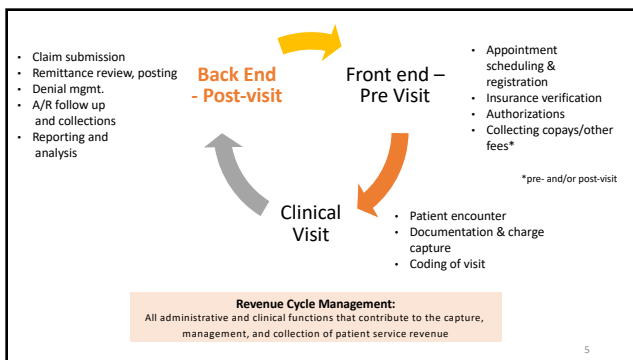
- Introductions
- Overview of RCM – Team Roles
- Billing and Claims Mgmt.
- KPI's
- Tools / Resources
- Key Takeaways from Our 2 Days Together
- Questions and Discussion

- **Session 1** – Front end Best Practices (prior day session 9:00 – 10:15am)
- **Session 2** – Capturing the Clinical Encounter (prior day session 10:30am – 12:30 pm)
- All are encouraged to join each session!

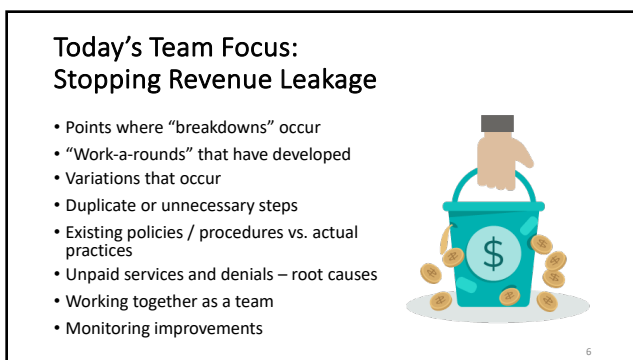
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Back-end Billing and Revenue Mgmt.

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Back End Key Players & Activities

 Billing	Submission of Claims Resolution of Rejected Claims Payment Posting and Review, and Write-offs Denials Management
 IT	Payer Submission Set Up Correctly Automatic vs. Manual Posting
 Clinic Management	Quality Assurance Monitoring and Managing KPIs and (A/R) Communicating with Team

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Poll Survey

How much of expected revenue do you believe your agency collects for your family planning services?

1. Over 90% of all revenue we expect – we are on top of this
2. Over 50% - We struggle a bit and know there is revenue being left on the table
3. 25% or more – we have opportunity here for improvement
4. I have no idea – we don't have a handle on this



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Billing - Key Questions To Ask

- What are the processes for A/R and denial management?
- Who is responsible for and able to identify, analyze, and resolve denials? Note: best practice is < 5% denial rate
 - Are claims corrected and resubmitted?
 - What are the timeframes for submitting and correcting claims? Are there denials for timely billing?
 - Are root causes of denials resolved? Are there a significant number of unpaid visits?
- Ages of outstanding receivables?
- How/when are write-offs addressed?

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Key Questions to Ask (con't)

- How are contract terms monitored?
 - Do contracts include language covering all BC methods, payment for insertion, device, and visit for LARC methods? Are contracts in place with all relevant TPP's?
- How often is fee schedule updated (ideally yearly)?
 - Related to fee schedule adjustment, is the schedule of discounts reviewed as well?
- Are KPIs (Key Performance Indicators) tracked and analyzed regularly? Corrective actions implemented as a result?

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LARC Tracking Grid Example

- LARC billing errors often cost agencies significant revenue
- Understanding and tracking reimbursement is a best practice

Codes / Reimbursement	Cost	Medicaid FP 07.2024	Plan 2	Plan 3	Plan 4
86300 IUD insertion		\$70.50			
86301 IUD removal		\$70.93			
86301, 86300-51 IUD Reinsertion		\$106.18			
J7296 Kyleena IUD		\$550.85			
J7297 Liletta IUD		\$422.55			
J7298 Mirena IUD		\$550.85			
J7300 ParaGard IUD		\$297.82			
J7301 Skyla IUD		\$458.68			
T1981 Implant Insertion		\$61.54			
T1982 Implant removal		\$71.14			
T1983 Implant Reinsertion		\$80.95			
J7307 Nexplanon		\$578.14			
Same Day Counseling Visit Separately Payable from LARC (Y/N)		YES			
Contraceptive Separately Payable from Visit (Y/N)		YES			

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Poll Survey

What percent of your claims are rejected or denied for payment when you submit them?

1. 5% or less – we have monitored this and resolve denials efficiently
2. 20% or less – we monitor denials but not all are resolved in a timely manner costing us revenue
3. ~ 50% of our claims – feels hard to get on top of this
4. Yikes - I have no idea



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Claims Submission

95% Clean Claim Upon First Submission

- Clean claims: claims that are submitted correctly the first time and paid – track this!
- **Best practice – 5% or less of your claims should be rejected or denied for payment when submitted**
- Use internal and clearing house scrubbers / edits to avoid errors
- Examine denial rates by type, payor and staff related to the submission data and process
- Track KPI's to monitor by payer, service, staff
- MDHHS allows 12 months to submit claims for payment



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Title X Guidelines - Collections

- Reasonable efforts to collect charges without jeopardizing client confidentiality must be made (8.4.8)
 - Past due accounts for "no contact" clients cannot be referred to a collection agency
 - If client comes expecting to pay for service at time of appointment – need to invoice may be avoided
 - Accept credit cards, Venmo other?



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QI: Increased Fee Collections Impact



Charges (adjusted) for uninsured / self-pay client services for a month - \$10,000

Scenario 1: 50% collection rate - \$5,000

Scenario 2: 95% collection rate - \$9,500

A difference of \$4,500, or \$54,000 annually

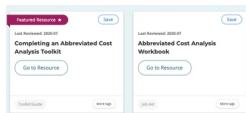
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Fee Schedules / Chargemaster



- An annual review of your Fee Schedule / Chargemaster should be specifically addressed in your policies and procedures
- Review Sliding Fee Scales
- Perform a cost analysis annually - <https://rhntc.org/training-packages/cost-analysis>



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Payment Check

• We noticed our LARC device payments may be lower than our contractual rates for a few commercial payers. Are we getting underpaid?

- Yes – if your charge on the claim is less than your contractual amount, the payer will most likely pay you the lower amount reported
- Review your contracts and ensure your charges on your fee schedule are set above the highest contractual amount to ensure you don't lose revenue



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Reporting NDC

- National Drug Code
- Traditionally NDC is a 10-digit code on package
- Report as 11 digit on claim - 5-4-2 format required

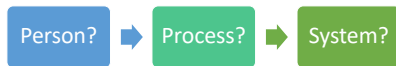
Package NDC Number Configuration	Correct Leading Zero Placement for 5-4-2 = 11
XXXX-XXXX-XX 4 + 4 + 2 = 10	0XXXX-XXXX-XX 5 + 4 + 2 = 11
XXXXX-XXXX-XX 5 + 3 + 2 = 10	XXXXX-0XXXX-XX 5 + 4 + 2 = 11
XXXXXX-XXXX-X 5 + 4 + 1 = 10	XXXXXX-XXXX-0X 5 + 4 + 2 = 11

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Denials are Costly

- Must have a process for reviewing and resubmitting claims
- Rejections and denials take place for **many and multiple reasons**
 - Some can be addressed with minimal outlay of time, others take more effort
 - Prioritize easy fixes and expensive LARC devices
- What are the root causes of denials?



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Review / Understand Remittance Reports

- Targeted review of payer remittance reports to identify process and payment issues:
 - Line items paid as expected?
 - Procedures ALWAYS billed with E/M even if it's a scheduled procedure?
 - Same E/M code used repeatedly?
 - Necessary modifiers present or missing?
 - Demographic input errors?
 - Trend in denial reason codes?
 - Compare to other payers



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Denial Resolution Strategies

Most denial types can be avoided by efforts before filing:

- Registration denials
 - Strategy: implement insurance verification processes, QI input errors
- Credentialing denials
 - Strategy: Maintain credentials; have point-person
- Timely filing denials
 - Strategy: bill weekly; monitor reports


- Prior authorization denials
 - Strategy: identify services requiring prior authorization / track
- Medical necessity / charge entry denials
 - Strategy: chart audits, scrubbing software
- Bundled/non-covered denials
 - Strategy: manage contract terms, scrubbing software

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Resolve Unpaid or Denied Claims

- **Foster a good relationship with insurer contact**
 - Call claims representative, ask specific questions, have specific claim examples available
- **Provide feedback regarding errors and corrections**
 - Document findings to minimize future denials of same type



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Accounts Receivable (A/R)

- Involves follow-up on unpaid claims and self-pay patient accounts with outstanding balances
- Trend outstanding balances by payor and type of service
- Group outstanding balances into buckets of timing such as < 30 days, 30-90 days, > 90 days

Establish reports and frequency of review:

- A/R aging
- Claims receivable
- Charges
- Insurance payments
- Denied claims
- Adjustments/write-offs
- Payment posting

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Possible QI Activities

Compare TPP contracted rates to fee schedule	Submit claims on time – create a payer grid	Monitor modifier usage – focused training	Identify payers w outstanding balances & strategies to resolve
Identify KPIs to track & identify root causes & actions	Assist w establishing TPP contractual worksheet	Model expected payments for common visits	Set performance targets & monitor KPIs

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Key Performance Indicators (KPIs)

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Why KPI's

Metrics organizations use to track, measure, and analyze and optimize the financial health of their agency

- **What gets measured gets managed...and improves!**
- Measuring particular business objectives or processes helps identify problem areas to address
- Shows historical trends – enables informed decisions



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- Establishing measures and benchmarks
- Analyzing your data
- PDSA (plan, do, study, act)
- Examples

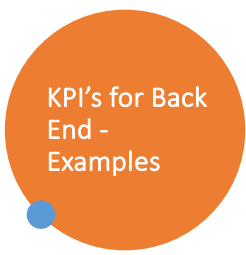
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- Payer Mix (# visits per payer vs unknown, self pay)
- Number/% of Clients in Each Discount Category
- Number/% of Denials due to front desk errors
 - Demographic errors
 - Payer coverage denials
 - Prior authorizations not gotten
- Productivity
 - Clinical visits (visits/FTE)
 - No show rates / Walk in rates
- Other?

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- Charges and Revenue per patient
- Coding Related:
 - Denials related to coding
 - E/M Coding Levels
 - # LARC insertions to paid LARC devices
- Productivity
 - Clinical visits (visits/FTE or RVU's/clinician)
- Other?

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KPI's for Back End - Examples

- Payer Mix (visits), visit total
- Charges
- A/R Aging
- Charges and Revenue per patient
- Net Collection Rate
- Rejections / Denials related to back end
 - Timely filing
 - Payer errors
 - Coverage issues



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Other Indicators

Why use other/additional indicators?

- Data collection challenges
- Meaningful to staff
- Solutions/process changes may involve multiple steps, "sub-indicators" measure these steps
 - Indicator: Increase Medicaid in Payer Mix
 - Other/Sub-indicators: number of Plan First applications completed or approved
- Measuring specific initiatives

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KPI's - Getting Started

<p style="font-size: small; margin: 0;">Selecting KPIs:</p> <ul style="list-style-type: none"> Easy to gather data and calculate No more than 5-7 Have largest impact Keep it simple! 	<p style="font-size: small; margin: 0;">Developing a KPI Report:</p> <ul style="list-style-type: none"> Work with IT or vendor, identify key reports to run and frequency for consistent data extraction Develop one using an excel spreadsheet (example forthcoming) Set benchmarks <p style="font-size: small; margin: 0;">• TIP: You may choose to add/delete certain indicators over time</p>
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Setting Performance Indicator Goals/ Benchmarks

Benchmarks – standards used as a point of reference for evaluating performance

Approaches:

- Industry standards
 - For example: 5% is an industry benchmark for claims denial rate
- Drawn from internal best practices
- Determined based on historical experience, state information, or peer data/experiences
- Can be reset, incrementally adjusted as improvements are made

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Using a KPI Report

Implement and analyze KPI report data monthly

Questions to Ask:

- Is the data accurate? Does it make sense?
 - Data collection challenges and Q/A
- What questions result from data analysis?
- What other data would be helpful to review?



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Analyzing Financial Data

- Compare, analyze, interpret data and trends
- Compare sites, identify best practices
- Compare to benchmarks - what stands out?
- Share with team
 - Your analysis
 - Seek their insights
 - Actions to implement to affect change
 - Follow up monthly to assure actions had desired outcome
 - If not, identify new actions
 - Provide feedback
 - Change/add measures as needed



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Example - KPI Report Using FPAR Data

	JULY		AUGUST		SEPTEMBER		BENCHMARK
	#	%	#	%	#	%	
1 PS and Income							
Under 100%							
101-150%							
151-200%							
200-250%							
251%+							
Unknown							
2 Patients (Payer Mix)	#	%	#	%	#	%	
Medicaid (MA)							
Private Insurance (PI)							
Uninsured							
Unknown							
Total Patients							
3 Productivity	Encounters (visits)	CSP FTE	Encounters (visits)	CSP FTE	Encounters (visits)	CSP FTE	
Visits/FTE							
4 Revenue/patient	Revenue	Rev/pt	Revenue	Rev/pt	Revenue	Rev/pt	
Uninsured							
PI							
MA							

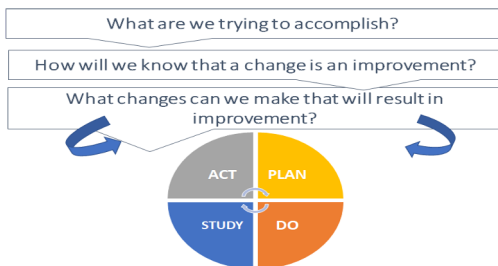
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Example - KPI Report

	SEPTEMBER		OCTOBER		NOVEMBER		DECEMBER		BENCHMARK
	\$	%	\$	%	\$	%	\$	%	
1 Fee Collections									
Monthly Fee Charges									
Monthly Fee Collections	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		90-95%
2 Visits (Payer Mix)	#	%	#	%	#	%	#	%	
Medicaid (MA)	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		
Private Insurance (PI)	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		
Uninsured	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		
Other	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		
Total Visits	0		0		0		0		
3 Productivity	# Work Days	Clinical FTE	# Work Days	Clinical FTE	# Work Days	Clinical FTE	# Work Days	Clinical FTE	
Visits/FTE	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		
4 New Visits	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		
5 Total Charges									
Charge/Visit	#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		
6 Denials	0	#DIV/0!	#DIV/0!		0	#DIV/0!	0	#DIV/0!	less than 5%
7 Rejections									
8 TPP (PLMA, PF) Net Collection*			Charges	Revenue					90-95% of expected revenue**
			#DIV/0!						

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Model for Improvement



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PDSA

Plan

- What do you want to accomplish and by when?
- Tasks to accomplish?
- Who will do them and by when?
- Measure - how will you know you have been successful?

Do – Study - Act

- Do - What progress has been made?
- Study - What do the measures show? What are your observations?
- Act - What are your next steps?

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**Applying This Process -
Examples**

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Data Driven Improvement Example #1

KPI Measure: Payer Mix (Identified Medicaid and/or private insurance visit % below benchmark)

Example of Actions/Plans: Investigate insurance gathering process

- Implement insurance verification process, observe and retrain on registration process, revise intake form, modify P&P as needed, provide monthly feedback on progress, modify plan if needed
- Add sub-measures:
 - number of visits that require corrections prior to submission to TPP's
 - denial types "not covered on date of service"

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Data Driven Improvement Example #2

KPI Measure: Denial Rate (Identified high percentage of denials)

Example of Actions/Plans: Gather more information such as sorting denials by type, by payer, by clinician, talk with billing staff to get their input. After doing this, you identify that a large % of denials are "prior authorization required"

Subsequent Actions/Plans: Investigate prior authorization processes

- Ask staff how they identify services requiring prior auth/how they perform prior auth, identify services/TPP contracts and services requiring prior authorization, complete spreadsheet (COTS) and outline process for front desk staff. Train staff, modify policy if needed
- Add sub-measure:
 - Denial by type - continue to monitor this sub-measure

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Data Driven Improvement Example #3

KPI Measure: Time of Visit Fee Collections (Identified fee collections at time of visit are less than benchmark of 95%)

Example of Actions/Plans: investigate fee collection process, review policy

- Observe staff during fee collection process as well as when they discuss fees during scheduling and registration, create a script for staff utilizing their input, train all staff, modify policy as needed, provide monthly feedback on progress, modify plan if needed
- Observe exiting of clients – are all clients stopping at desk after visit?
- Continue monitoring this indicator

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Success Story

An agency identified through analysis that denials were a significant issue, with a baseline of 15%. Specifically, they noted eligibility denial types as the top denial reason and sought to decrease this denial type, and therefore their overall denial rate.

Actions taken:

- Sent a memorandum on when/how to complete eligibility verifications
- When denial rates did not improve, the agency sought feedback from network service sites
- Conducted a webinar training on the process, provided one-one trainings at the clinics with highest rates of eligibility denials
- Regional directors were trained to explain eligibility verification process
- A second follow-up webinar training is planned

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Success Story (continued)

Results:

End-point measure: a 6% decrease in denials within 90 days.

Key points/Lessons Learned:

Be open to changing training methodology related to household assessment and eligibility checks to include more interaction with staff.

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Session 3 Closing

IDENTIFY 1-2 BACK-END CHALLENGES THAT
RESONATED WITH YOU FROM SESSION

WHAT STRATEGIES CAN YOU SHARE WITH
YOUR TEAM TO RESOLVE THE CHALLENGE?

WHO ON YOUR TEAM DO YOU NEED TO
WORK WITH?



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Resources – see handout for full list

- RHNTC: Filter Title X Financial Operations Resources
<https://rhntc.org/resources/title-x-financial-operations?topicId3561=356>
- RHNTC: Financial Management Toolkit
<https://rhntc.org/resources/financial-management-toolkit>
- RHNTC: Title X Key Performance Indicators Workbook
<https://rhntc.org/resources/title-x-key-performance-indicators-workbook>
- RHNTC: Abbreviated Cost Analysis Workbook
<https://rhntc.org/resources/abbreviated-cost-analysis-workbook>
- RHNTC: Introduction to Financial Management in Family Planning Settings Training Guide
<https://rhntc.org/resources/introduction-financial-management-family-planning-settings-training-guide>
- RHNTC: Accounts Receivable Management Tool
<https://rhntc.org/training-packages/financial-management>

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MDHHS Resources

- MDHHS Medicaid Family Planning – Information for Providers
<https://www.michigan.gov/mdhhs/adult-child-serv/childrentamires/familyhealth/familyplanning/providers>
- MDHHS Provider Billing Manual
<https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>
- Michigan Title X Family Planning Program Standards & Guidelines Manual 2024
https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder50/Folder1/Program-Standards-and-Guidelines_2024_FINAL.pdf?rev=09db185230a444038800c0f8b304615b&hash=9CC37EEE2AF6DC5D9AD8872299F39E39

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Disclaimer

- The guidance and scenarios provided today are meant as examples and for education purposes only.
- Review material presented with ED/CFO prior to making changes to be aware of any other programs or payer issues that require consideration.
- Any questions should be reviewed with grantee.

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