Managing Family Planning Revenue Cycles

Solutions from the Field

LIFE AFTER 40

PROJECT CASE STUDY

National Family Planning & Reproductive Health Association

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Introduction

The National Family Planning & Reproductive Health Association (NFPRHA) is working to assist publicly funded family planning providers adapt to the changes created by the Affordable Care Act (ACA). Grant funding supports the *Life After 40: The Family Planning Network and the ACA* project, which focuses on the sustainability of the family planning service delivery network in the years following the fortieth anniversary of Title X, the federal family planning program, in 2010. The project's work includes a series of case studies detailing the best practices and lessons learned within the family planning network; companion workbooks which include examples of tools used by the case study sites in their work; an online resource directory; presentations and workshops at NFPRHA's national conference and regional meetings; and topic-specific support such as billing and coding training.

The first *Life After 40* case study looked at how the Massachusetts family planning provider network adapted to state health reform after its legislature enacted reforms similar to the ACA in 2006. While many of the Massachusetts case study sites are representative of the NFPRHA membership, the Massachusetts network of Title X-funded health centers consists only of non-profit providers. As a result, one large segment of the NFPRHA membership and the Title X service provider network – health department grantees and sites - was not represented in that initial case study.

The second case study focused solely on state and local health departments. Four state health departments were selected for the case study - South Carolina, Colorado, Maryland, and Iowa. These Title X grantees took leadership roles to address health reform-driven changes with their health department-operated service delivery sites. The study presented innovative strategies and described newly implemented common practices used by these publicly operated providers related to sustainability.

This third case study focuses on billing, coding, and collections, or what is commonly called the revenue cycle process. With the expansion of coverage provided by the ACA, it is estimated that ten million people will gain Medicaid coverage and 19 million people are expected to gain other forms of health insurance starting in 2014.[1] For family planning agencies that have been caring for many of these previously uninsured individuals, this expansion of coverage represents an opportunity to increase and diversify their revenue streams through third-party reimbursement mechanisms. In addition, under the ACA, women's preventive health care services – such as mammograms, screenings for cervical cancer, and other services – are now covered with no cost sharing under many health plans.[2] In order to provide services to the growing number of patients who will have health insurance, family planning agencies must establish more effective and efficient systems to ensure that they receive an appropriate reimbursement to cover the costs of the services they provide. Thus, NFPRHA's *Life After 40* project chose to develop this case study, which describes the experiences of three organizations that have implemented effective systems to increase their revenue through third-party claims submission and collection.

The goal of the case study is to provide the reader with opportunities to examine different models and methods for structuring the tasks and activities of the revenue cycle process. It will describe the approach the team used to select the member organizations, the development of the data collection strategies, and an overview of the revenue cycle process. It will then document the key findings from each of the site visits that focus on those components of the revenue cycle process which occur either in anticipation of or during the patient visit. The case study will also highlight the following processes:

- Creation of a claim
- Claims submission
- Payment processing
- Accounts receivable management
- Management reporting

In addition, a companion workbook has been produced as a supplement to the case study. Materials and resources used by the three selected agencies are included in the workbook. This includes the following:

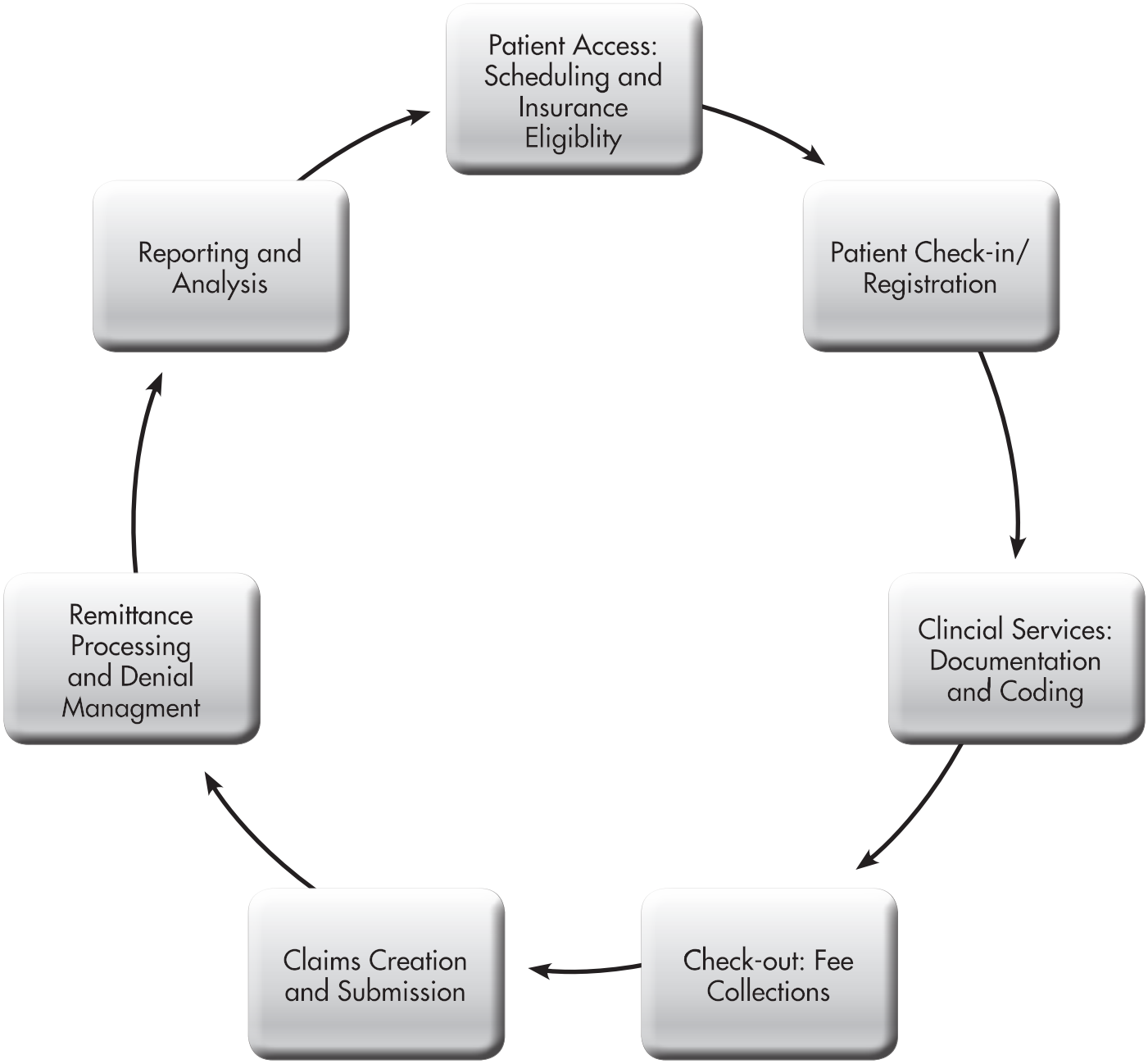
- policies and procedures for billing, coding, and collections;
- staff job descriptions;
- documentation of center operation processes including registration, appointment scheduling, and claims creation and submission; and
- sample tools for management of revenue cycle processes.

References to the resources included in the companion workbook will be made throughout the case study.

Overview of Revenue Cycle Process

The revenue cycle comprises the numerous tasks of the billing and collection process — namely, gathering and entering data about professional services rendered and ensuring that bills are paid in full. The process begins with the patient making an appointment and ends with the receipt of the payment. Think of a health center's revenue cycle as a wheel. The spokes are the critical functions of the billing and collection process. Each function has several key activities, often in the form of tasks that health center staff or clinicians must perform. Unless each function is performed effectively, the wheel will fail to turn. If the wheel fails to turn, the agency will not bill effectively and will fail to maximize revenue.

Figure 1 – The Revenue Cycle Process



Case Study Site Selection Methodology

To complete the case study, the *Life after 40* project staff created a case study team that included two consultants with revenue cycle experience, as well as experience within the family planning provider community. Potential case study participants with effective third-party billing and collection practices were identified through discussions with Title X service and training grantees, Title X program review consultants, and NFPRHA staff.

A preliminary list of 12 Title X programs throughout the country was identified through these discussions. Each of the identified agencies was contacted about participating in the case study; eight agencies responded with interest. The case study team conducted initial interviews with the identified programs to obtain general information about their billing and coding experiences. Based on the interviews, NFPRHA selected three sites with significant experience working with third-party insurance. The selected sites were chosen to represent the variety of health centers in the NFPRHA membership – freestanding health centers, Planned Parenthood affiliates, and family planning services provided in a community-based organization such as a community action agency. It is important to note that public health programs were not included since billing and collections in those settings were covered in the second case study. Federally qualified health centers were also not included given their unique program requirements.

After the sites were selected, each participating agency completed a pre-visit survey that included basic services utilization, financial, staffing, and revenue cycle metrics.

Site Visits

To document the revenue cycle processes in the selected sites, the case study team visited each of the three agencies and surveyed health center leadership and staff to document operations related to revenue cycle management. In addition, related health center flow and patient interactions were observed and documented. As part of the site visit, the case study team directly observed staff and patient interactions related to billing and collection as well as toured the health center to comprehend workflow. During the site visit, key materials, checklists, and job aids associated with the revenue cycle process were identified and collected for inclusion in the companion workbook. After the site visit, follow-up conversations were conducted with each of the sites to clarify information collected during the visit.

Case Study Sites

The following agencies participated in the case study:

- Planned Parenthood Arizona (PPAZ) operates 13 health centers throughout the state with a total agency budget of close to $13 million per year. Three of these sites receive funds from the Title X program. PPAZ provides approximately 60,000 comprehensive reproductive health services a year, of which more than 20,000 visits are funded by Title X. PPAZ employs approximately 175 staff members in a variety of programs and services, of which 15 are clinicians.
- Community Action Partnership of San Luis Obispo County, Inc. (CAPSLO) offers more than 20 programs in ten counties throughout central California. Family planning services are provided at two locations in San Luis Obispo County, both called The Center for Health & Prevention (THE CENTER). With an annual budget close to $850,000, THE CENTER employs twelve staff including three clinicians providing more than 9,000 visits per year.
- Bridgercare (BRIDGER) has provided comprehensive reproductive health services in Bozeman, Montana, for the past 40 years. With an approximately $1.5 million budget, BRIDGER provides close to 7,500 patient visits per year with a total staff of 19, of which seven are clinicians.

The following table is a summary of the key metrics and billing systems of the selected sites.

Table 1 – Summary of Sites

	Planned Parenthood Arizona	The Center for Health & Prevention	Bridgercare
Location	Phoenix, Arizona	San Luis Obispo, California	Bozeman, Montana
Number of Sites (Title X)	13 (3)	2 (2)	1 (1)
Total Third-Party Revenue and Patient Fees (2012)	8,964,601[1]	851,335	907,104
Annual Claims (2012)	34,990	9,938	7,959
Total Staff FTEs (Title X)	14.84	11.825	13.6
Electronic Patient Management System	NextGen	Centricity	NextGen
Electronic Health Record	None	None	NextGen
Billing Clearinghouse	Navicure	None	Navicure
Remittance Processing	Electronic	Electronic and Paper	Electronic

This figure is annualized from a nine-month reporting period due to a change in the fiscal year at PPAZ.

Organizational Revenue Cycle Process Design

Designing an effective revenue cycle process begins by examining each component of the cycle separately and the sub-processes within each of these steps. It is also necessary to understand the business model that drives decision-making and activities in the organization. The recognition of an agency's limitations and opportunities as a result of its business model will aid in decision-making on a variety of issues within the organization including: the staffing for billing-related activities, workflow associated with the revenue cycle, and choosing electronic systems to aid in this workflow. Further, it must be recognized that an organization may not have the necessary expertise on staff to implement new systems and processes, which is when external expertise becomes a useful option. Finally, it is important not to overlook the foundation of billing, the development of the fee schedule, which can markedly impact the success of the revenue cycle processes. Each of these areas of the revenue cycle holds the possibility for great change in organizational structure and process. It is essential for leadership to recognize the impact that change may have on staff members and employ strategies to effectively transition into new structures.

This section presents the practices of the three participating agencies in the following areas:

- Addressing change
- The agency business model
- Billing systems and staffing
- Systems needs and requirements
- Use of external expertise
- Fee schedule development

Addressing Change

All three of the agencies interviewed by the case study team have strong leadership – health center managers, department directors, or executive-level staff – that recognizes the importance of designing and implementing new business models to ensure financial survival in the changing health care environment. These leaders not only embraced change but demonstrated the importance of remaining flexible and the continuing need to reinvent their operations to respond to changing environments. They were able to admit when they made mistakes and understood when to bring in outside expertise to assist in their organizational transformations. In addition, all sites demonstrated an appreciation of the power that having well-suited and dedicated staff contributes to their agencies' fiscal sustainability. Leadership at these three agencies understands that not all tenured employees will be able to adjust to ever-changing business processes such as billing, and that they themselves need to demonstrate flexibility when managing a changing staff composition. Consequently, they all expressed – and actively worked to support – the continuing need for staff development and appreciation.

At these sites, leadership recognized the need for continuous communication with staff during periods of organizational change. Specifically during these times of change, leadership communicated to staff the need to expand billing and collections in order for the organization to remain fiscally sustainable. Each site has regularly scheduled staff meetings to discuss changes; the length and frequency vary but all occur in a consistent manner. Each agency has ad hoc trainings to introduce new procedures or strategies. Before the trainings occur, leadership makes a point to learn the new process, is able to do the function, and, subsequently, is able to address staff questions and concerns. Finally, the leadership at each location is willing to have one-on-one conversations with staff members who have problems with adapting to changes in processes. Members of the leadership proved to be fundamental in communicating the changes in strategy, as well as the associated rationale for the change.

Agency Business Model

The team found during the site visits that the agencies' overarching revenue cycle management strategies drove the design and implementation of processes for billing and collections. Paramount within that is the ability of an agency's leadership to design new strategies that address changes in the community as well as the changes in health care environment. The following describes the organizations' strategies, how they have shifted, and the new processes leadership utilized to achieve effective billing and collections.

PPAZ

PPAZ leadership recognized in 2008 that the current systems and billing processes were not sufficient to maximize the potential revenue for the organization. Several factors contributed to this realization including: the merger with another Planned Parenthood affiliate; changes in fiscal leadership; and a reliance on a homegrown patient management system that could not sustain the needs of a larger, post-merger agency. In the Phoenix area there was an increase of small businesses offering health insurance, which caused a shift in PPAZ's patient population from mostly self-paying to an increased number of patients with health insurance. Given the need for a new infrastructure, a new electronic patient management system was purchased in 2009. The new system had benefits beyond expectations: upon implementation, the agency found a large accounts receivable balance that was not managed by the previous billing electronic systems or work processes. Leadership realized that in order for this new system to be effective, the organization needed a fresh start and recreated all of the billing activities. To assist in this transformation – including the management of newly realized accounts receivable balance – leadership chose to contract its billing to a third-party consultant. The leadership's willingness to shift the billing process in multiple ways required flexibility and commitment. After one year of using the billing company, PPAZ found that it had acquired sufficient internal expertise and improved infrastructure to return billing to an in-house function.

Effective billing and collections is one way to ensure the sustainability of all the services that PPAZ provides, including clinical care, education, and advocacy. Leadership has invested in creating a data-driven organization by hiring a full-time data analyst. This position allows the agency to collect, analyze, and utilize key performance information for organizational decision-making purposes, such as adding a new service or health center. Weekly and monthly data dashboards (**see companion workbook**) are prepared for each site that include summaries of services delivered, charges, collections, and other metrics. Those data dashboards are on the agency's shared drive and are available for all staff to review.

THE CENTER

THE CENTER is part of the Health and Prevention division of a community action agency (CAA). CAAs were created by the federal Economic Opportunity Act of 1964 to provide services, assistance, and other activities to make progress toward the elimination of poverty or a cause or causes of poverty.[3] The mission of the Community Action Partnership of San Luis Obispo County, Inc. (CAPSLO) as a whole is to empower individuals and families to achieve economic self-sufficiency and self-determination through a comprehensive array of community-based programs and actions. The mission of THE CENTER, as a part of CAPSLO, is to foster personal health and empowerment through access, advocacy, and education[4]. To be successful in meeting the diverse needs of the community, THE

CENTER must piece together funding for programs from a variety of sources.

For THE CENTER, maximizing enrollment of patients in and billing for services to California's Medicaid Family Planning Expansion was key to sustainability. THE CENTER also bills for services to traditional Medicaid through the regional managed care plan. For the most part the health center has been fiscally sustainable, although there have been periods when the number of staff and hours had to be reduced to balance the budget. With the expansion of health care coverage through Medicaid and commercial insurance as a result of the ACA, THE CENTER leadership recognizes the need to expand billing to commercial insurance in the near future to ensure the continued sustainability of the family planning program.

BRIDGER

BRIDGER is a standalone health center that provides reproductive health services to meet its patients' needs. However, BRIDGER's business model is built on a solid understanding that those services have costs, and that the health center must have revenue to offset those costs. With government funding covering less than 25% of BRIDGER's costs, it is imperative that all staff members are involved with aspects of revenue collection. The health center's billing focus is on both billing insurance and using a sliding fee scale to collect patient fees from self-paying patients. In addition, staff members regularly ask patients for donations.

BRIDGER sees itself as a reproductive health program with diversified funding, rather than solely a Title X program. BRIDGER is both firmly committed to the needs of the patient and the agency's economic survival. Those dual commitments are not mutually exclusive, and BRIDGER has taken steps to meet both commitments. The agency has expanded services, including adding a part-time social worker and providing limited primary care. They also find ways to make the Title X program financially viable given its constraints. For example, BRIDGER has expanded the income verification process with a revised form and training staff to have a complete conversation with the patient about income without creating barriers to services.

BRIDGER also ensures that the services provided at the health center respond to the needs of the patients first and the needs of the agency second. For example, the agency does on-site enrollment into the Medicaid Family Planning Waiver. When discussing the Medicaid Family Planning Waiver with a patient, staff discusses the benefits the waiver provides to the patient and not the health center. A common strategy used by other organizations where family planning waivers are utilized is to discuss with the patient how waiver enrollment helps to economically sustain the health center. BRIDGER refocuses that message to discuss the benefits of enrollment for the patient even if that means alerting the patient to the fact that once she is on the waiver she may receive care at other locations.

Billing Systems and Staffing

Each of the participating sites employs different billing systems and models for staffing the billing and collections processes. Each system and model is different based on the needs of the organization, as well as the ability to fund needed positions. While each of the sites may benefit from increased staffing and infrastructure as a way to increase billing system effectiveness, their current structures still allow each to succeed in the management of revenue. It is important to note that each site lives within its current means as a way to achieve that success. The following describes each site's staffing as well as the selected billing systems.

PPAZ

PPAZ uses electronic systems to complete all of the revenue cycle processes. The agency currently bills more than 13 insurance carriers and plans to expand to more as the marketplace warrants. PPAZ has located the revenue cycle function in the Health Center Operations department rather than Finance department, which is common in many multi-site health care centers. Current staffing of this process includes a revenue cycle manager and the following: an insurance verification specialist; a medical billing specialist; and a medical reimbursement specialist **(see companion workbook for job descriptions)**.

The average amount of claims per billing staff member at PPAZ is 6,998. This is below the national recommendation for a medical practice, which is one billing staff full-time equivalent per 10,000 claims.[5]

The revenue cycle manager was hired with a background in accounting; she had no medical billing experience. Leadership believed that this individual had the key leadership and organizational skills necessary for success and that the billing-related specifics could be learned. The transferrable skill-set deemed important included being thorough, detail-oriented, and data focused. The rest of the staff has medical office experience. The medical billing specialist has recently become a certified coder. Though this credential is not crucial for the position, it has been useful in ensuring correct coding of patient visits and in the submission of clean claims.

THE CENTER

THE CENTER uses both electronic and paper processes to submit claims. THE CENTER utilizes electronic billing for its largest payer, California's Medicaid

Family Planning Expansion. Currently the remaining Medicaid billing is done with paper claims as the number of claims submitted is below the threshold for electronic claims submission set by this payer. As the volume of clients covered by Medicaid increases THE CENTER will convert to the electronic submission of claims. Although the claims submission process varies between electronic and paper based on the payer, all payments are posted to accounts manually. At present, THE CENTER submits claims directly to the two payers and does not use a clearinghouse.

Currently, one full-time billing staff member reviews all claims prior to submission; this staffing structure creates an average of 9,938 claims per billing staff full-time equivalent. This staff member started as the health center's receptionist. She came to THE CENTER with experience at a medical practice and was able to learn the billing and collections process from previous billing staff. THE CENTER recognized that although this verbal transfer of knowledge worked to train the current billing staff member, it was in the agency's best interest to create a written documentation of this process s**ee companion workbook**) rather than rely solely on the verbal instructions from one staff member to another. The existence of detailed documentation of the billing and collection process supports knowledge transfer and ensures process continuity.

Based on her comprehensive understanding of billing issues gained from the direct processing of all claims – as well as her participation in offsite and webinar trainings provided by the state and the regional Medicaid managed care provider – this staff member provides ad hoc training and technical assistance to the front office and clinical staff on billing-related procedures. Through her daily interaction with claims processing, the trainer is able to identify individual staff members who need help and the specific errors that need to be rectified. In preparation for the expansion of insured individuals and the consequent growth in billing, a medical assistant is being trained on the billing and collection processes.

BRIDGER

BRIDGER does all of its billing electronically and uses a clearinghouse to create and submit claims to a variety of payers. BRIDGER receives electronic remittances from many of its payers, which post directly into the clearinghouse. These remittances describe what services and payments are included in the payment sent by the payer to the provider. Most payments are received and posted electronically. Some payments are posted manually when a check is received.

The introduction of an electronic practice management system (PMS) and electronic health records (EHR) required all health center staff to develop an understanding that they were part of the revenue cycle team. This was instilled through continuous communication by both the executive director and associate director. From the clinicians who create the charges in the EHR to the front desk staff members who review and update charges to the billing staff who create the claims and submit them to the clearinghouse – all staff recognize the role they play in managing the revenue cycle. The evolution to electronic management of the revenue cycle also contributed to staff transitions into new positions at BRIDGER: two staff members who had experience working at the front desk moved into positions that focus on revenue cycle management. These two staff members do all of the claims processing. They estimate that they spend half of their time on billing functions and the other half on additional responsibilities to support center operations (**see companion workbook for job descriptions**).

System Needs and Requirements

With expanding third-party payer billing and collections, a PMS allows a health center to integrate scheduling, patient information, and visit documentation. Using this data, the PMS also allows for electronic claims submission to insurance carriers. In addition, with health providers increasing the number of insurance plans that they are billing, some health centers find that a clearinghouse is useful for ensuring claims meet the specific submission requirements for each plan. Both of these systems should also allow for reviewing claims data for standard errors, such as mismatches of demographics and services. While the ACA does not specifically mandate EHR use, many providers are implementing EHR to improve patient visit records. A fully integrated electronic system between the PMS, clearinghouse, and EHR simplifies the transfer of patient information and reduces the need for paper documents. Each of the three participating sites recognize the importance of implementing new technologies to improve their health center operations and are in different phases of assessing and implementing electronic health systems.

PPAZ

In 2009, PPAZ implemented a PMS system. Staff members at the health centers enter charge data during the patient check-out. An electronic data file is created in the PMS and uploaded electronically to the clearinghouse, Navicure, which creates and submit claims to various payers. PPAZ is planning to implement an EHR in 2013, which will require an update to the process.

THE CENTER

THE CENTER uses Centricity as a PMS system for scheduling, to store patient demographic information, and for the creation of electronic claims. While THE

CENTER's leadership expressed that they were pleased with Centricity and its capabilities, they have had challenges with the system support and are concerned that it has not been able to meet the agency's needs. Specifically, THE CENTER has had difficulty obtaining customized reports and ongoing technical support. The transition to HIPAA 5010 in January 2012 was a particularly trying experience for THE CENTER as the process for claims testing resulted in the inability to enter and submit electronic claims for nearly three weeks, which resulted in a delay of revenue. Because of the need to be able to bill commercial insurance carriers, THE CENTER is exploring a new PMS as well as an EHR. However, there is concern over how to cover the expense of these new systems.

BRIDGER

In October 2011, BRIDGER implemented an electronic PMS and EHR. BRIDGER chose NextGen for both the EHR and PMS after reviewing eight different systems. Key criteria for selecting a system included:

- ability to support sliding fee scales;
- strong interface with a clearinghouse; and
- experience with family planning programs and Title X reporting requirements.

Another factor in the selection of NextGen was the ability for BRIDGER to access an external consultant in an established family planning agency that had previously implemented NextGen at its own sites. Details of this working relationship are described in the next section.

Before implementing NextGen, BRIDGER used Ahlers for billing and family planning data collection and had a paper appointment scheduling system. One downside of this transition is that BRIDGER's new system is unable to submit electronic files to Ahlers to meet the Title X grantee requirement and must continue to do dual data entry into both systems at this time. BRIDGER continues to utilize a paper client visit record to capture the information necessary for that data entry (**see companion workbook for paper client visit record**).

It is well known that the implementation of new electronic data systems is a costly endeavor that requires thoughtful budgeting processes on the part of the implementers. To address the high cost of this implementation BRIDGER spread the costs of implementation over two different fiscal years; the software license and server was purchased at the end of one fiscal year and the hardware was purchased at the beginning of the next fiscal year. BRIDGER found additional cost savings by hiring an outside consultant to aid in the customization within the EHR rather than relying completely on NextGen for all technical assistance, which was markedly more expensive. Finally, BRIDGER leadership researched software and hardware products online to find those available for purchase at a lower price than BRIDGER would pay at a big box store or purchasing through a tech vendor.

Both the PMS and EHR were implemented almost simultaneously – two weeks apart. Leadership felt that lagging the EHR implementation by two weeks would give staff an opportunity to adjust to the systems. However, staggered implementation did create additional work documenting and entering the visit information. In hindsight, leadership recognized that implementing the two systems so close together worked, yet a few additional weeks of lag time would have been beneficial to staff.

The impact of the implementation of an EHR must not be underestimated. In addition to the changes to the staffing model described earlier, the implementation process of these systems at the BRIDGER clinic has resulted in:

- a reduced number of patient visits and longer patient visit times to allow staff to adjust to the new process; and
- the need to allow for a learning curve regarding new technology. Some staff members were able to adjust to the system faster while others experienced increased frustrations learning the new systems.

Critical to the success of the implementation was, once again, the hands-on leadership demonstrated by the executive director and the associate director at BRIDGER. This included learning the specific requirements of the system in order to support staff when questions arose in real time. Furthermore, leadership made a concerted effort to listen to staff concerns and issues at both staff meetings and individual meetings. A culture of "we are all in this together" characterized the transition.

In reviewing revenue and billing in the implementation of the electronic processing systems, the executive director noticed an increase in insurance revenue without a corresponding increase in visits. The executive director attributes this to the requirement in the system to attach an insurance plan to each record, thus creating more opportunity to bill insurance.

Use of External Expertise

Two of the sites used external expertise to assist with the implementation of effective billing and coding processes.

PPAZ

After selecting and implementing a new PMS, leadership was determined to expand the organization's billing capacity. In order to reach this goal, PPAZ opted to contract with a nationally recognized consulting firm with a great deal of sexual and reproductive health experience to do the billing and collections. The consultant identified the strengths and weaknesses in PPAZ's existing processes, assisted with the set-up of the PMS, and helped make the necessary changes and improvements to the billing procedures. Areas for improvement included: ensuring consistent data entry; coding to maximize revenue; and setting up the fee schedules in the PMS to allow for acceptance of electronic remittances and payments. After a year of using the external billing consultant and working to address the processes, the agency had developed sufficient internal expertise and staffing levels to bring the billing function back into the agency. Furthermore, given the structure of the consultant payment structure in the contract – percentage of billed revenue collected – it made financial sense to bring billing back in house.

BRIDGER

BRIDGER used a consultant to assist with the implementation of the PMS as well as the EHR. BRIDGER chose to contract with another sexual and reproductive health organization that had previously implemented the same PMS and EHR platform. The two agencies have had a collegial working relationship for some time and the idea for a consultant relationship evolved as BRIDGER identified its specific needs in EHR implementation. This work included: inputting CPT codes and sliding fee scales; developing templates and flow for data entry; and selecting the necessary hardware to complement the system. The ability of BRIDGER to have a consultant who understood its business was critical to successful implementation. BRIDGER found that the consultant was more responsive than an EHR vendor would have been to the specific needs of the agency given the consultant's own experience in a similar setting.

Fee Schedule Development

A requirement of the Title X program is to create a fee schedule for family planning services using data from a cost analysis. While each agency has been doing cost analyses to meet the requirement, THE CENTER recently utilized cost analysis to improve third-party revenue. THE CENTER completed a cost analysis (**see companion workbook**) after participating in a webinar sponsored by its Title X grantee. The first analysis was completed in 2010 and, while it was time consuming, leadership found the process and results extremely useful. Leadership was surprised by the actual cost-per-visit by visit type. Based on this analysis, THE CENTER made several changes to its fee schedule, including expanding its sliding fee scale.

Historically, the fee scale rates were based on the Medicaid Family Planning Waiver rates at the top of the fee scale. After the cost analysis, THE CENTER revamped the fee scale to reflect the actual costs of services. Once these fees were established THE CENTER applied a ten-level sliding fee scale (**see companion workbook**) that runs from 0% to 325% of the federal poverty level (FPL). The table below presents an example of the revised fee scale for one visit.

THE CENTER then increased the fees billed to the Medicaid Family Planning Waiver to reflect the new fee schedule. The agency also increased the price of laboratory and medications, including contraceptives, which had been set at cost plus a flat fee of 2 dollars.

When implementing the new fee schedule, leadership discussed the change with staff members to ensure buy-in. They explained how the cost analysis was used to redesign the fee schedule and also included a review of all of the incidental costs that are involved in the operation of the health center. The effort to explain the decision-making process behind the changes proved to be a successful strategy to gain staff support for the new fee schedule. The impact of this change to the fee schedule was significant. During the time of a site closure at THE CENTER due to renovation, the total billable visits declined by over 16%. However, the total amount billed declined by only 4% over the same time period because of the revision to THE CENTER's fee schedule.

Table 2 – THE CENTER Revised Fee Scale

Visit Type	Cost	<100% FPL	Level 1 101-125%	Level 7 251-275%	Level 10 >326%
99211	$15	$0	$1.50	$15	$30

Insurance Contracting

With an anticipated increase in third-party billing and collections, health care providers need to assess their role with insurance carriers. If insurance contracts are not already in place, securing contracts with both Medicaid and commercial insurance plans is an important first step. Two of the three sites are currently contracting with commercial insurance carriers. The following section highlights the practices used by PPAZ to improve revenue through managing the insurance contracting process.

PPAZ

When the new revenue cycle manager (RCM) was hired, her primary role was to improve the process of insurance contracting. Upon review, the RCM found that most of the agency's contracts with insurance had been on auto-renewal, or what is called "evergreen" in the industry. PPAZ had not been aware of the renewal process and the RCM's discovery identified an opportunity to possibly increase reimbursement rates. The RCM renegotiated all of PPAZ's contracts and was able to increase reimbursement rates for some of the contracts. In addition the RCM created structures and tools to monitor insurance contracts. For example, a spreadsheet (**see companion workbook**) was created with the names of each plan as well as the following information:

- Website
- Telephone number
- Login information
- Ability to use online insurance verification with the plan

The spreadsheet also lists the agency's tax identification number as well as the agency's National Provider Identifier (NPI) number. This spreadsheet ensures that the billing staff has easy access to regularly used data and improves efficiency when contacting plans.

The second tool used to manage contracts is a spreadsheet (**see companion workbook**) with the location of key items within the contract. This is done for each insurance plan and includes the following items:

- Payer name
- Effective date
- Payer contact
- Term of contract
- Termination clause
- Timely filing of claims
- Claims turn-around
- Claims appeal process and time frames
- Offset/refund
- Assignment successors
- Indemnification
- Amendment
- Rates
- Dispute resolution
- Coordination of benefit

This worksheet supports billing staff to ensure compliance with insurance contract requirements.

Billing Processes During a Visit

In order to submit a claim to an insurance carrier, the following must be included: the patient's name, recipient identification number, the health care provider's name, date of service, location of service, and diagnosis (ICD codes) and procedure (CPT and HCPCS) codes. To effectively bill and maximize third-party reimbursement, it is crucial to have strong processes for collection of the data needed to submit a claim. To minimize denial of claims from the insurance companies, it is useful to have processes that ensure the quality of the data collection during the visit. During a patient visit, there are three points of interaction where critical information is collected:

1. Pre-visit/Arrival/Check-in
2. Visit Documentation
3. Check-out

This section presents possible processes and mechanisms that can be used to ensure quality data collection throughout a patient visit (**see companion workbook for a sample visit workflow**).

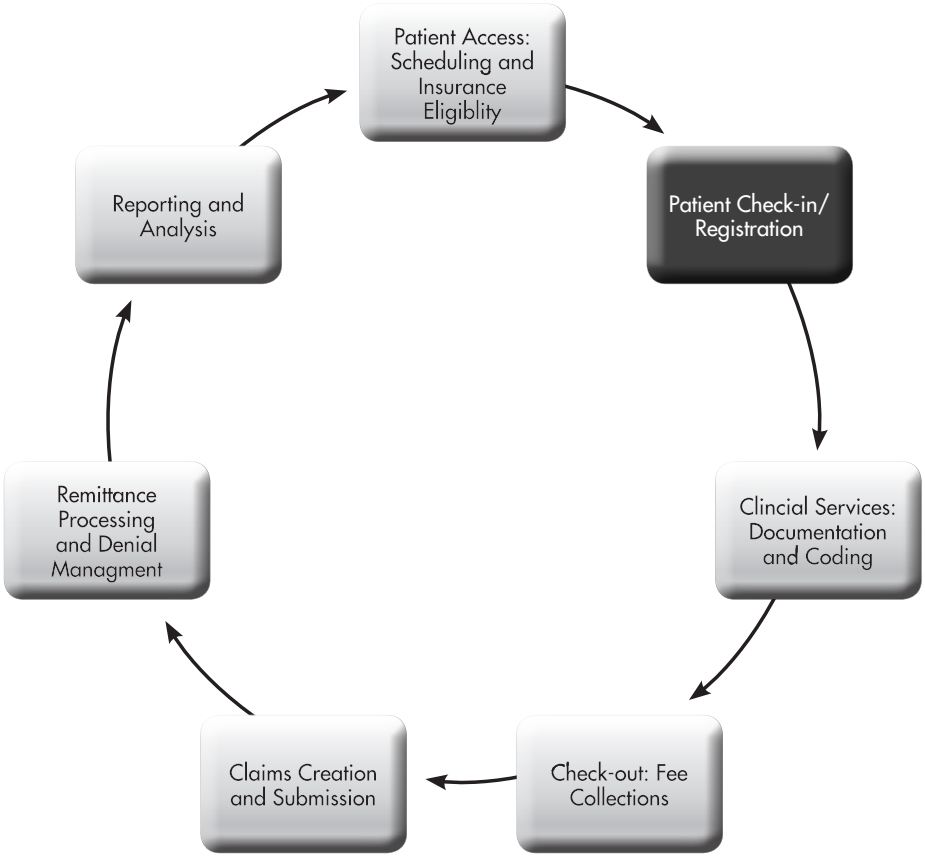
1. Pre-visit/Arrival/ Check-in

The revenue cycle process begins when a patient makes an appointment or walks into the health center. At this time, it is necessary to establish who will be responsible for visit fees; specifically, to determine whether the patient has insurance or will be self-pay. That first step also consists of collecting patient information. This includes authorization from the patient to do the following:

- Contact the patient
- Identify the patient
- Identify any insurance to cover costs of the visit
- Request income information to determine sliding fee scale rate for self-pay patients

All three agencies collect this data either when an appointment is scheduled or when the patient arrives at the health center. When a patient makes an appointment, all three sites verify (if an established patient) or collect (if a new patient) pertinent information in the PMS. That information includes the following:

- Patient name
- Patient date of birth
- Patient address
- Patient phone number



All three sites use a patient information form (**see companion workbook**) to verify and collect additional data from a patient when she arrives for her appointment. The following data are collected using that form:

- Demographic and ethnicity data
- Monthly income (as required by Title X)
- Medicaid or insurance information
- Emergency contact
- Consent or waiver to submit insurance claims

All three agencies have a paper document to capture billing and reporting data. Each site uses a different name for this form such as encounter form, fee ticket, or superbill (**see companion workbook**). In the case study, the form will be referred to as a superbill.

The following describes the unique elements involved with collection of data and fees during the appointment scheduling or arrival in the health center. Though many of these processes have the same end result, each agency has a slightly different model that works with its unique billing and coding staffing levels.

PPAZ

PPAZ has a centralized call center to make all patient appointments. When an appointment is scheduled, the patient's insurance information, including policy number, is collected and entered into the PMS. When a patient arrives, the staff collects a copy of the patient's insurance card. Front desk staff verify patient information at each visit and a patient information form is used to capture any changes. The front desk staff members collect all patient co-pays at the time of patient registration. A superbill is printed for each visit after all patient data is updated (**see companion workbook for sample policies and procedures for appointment scheduling and patient check-in**).

THE CENTER

At each of THE CENTER's sites, the front desk staff is responsible for entering basic information when scheduling appointments over the phone and collecting patient data upon the patient's arrival. The patient provides this material by filling out a patient information form. Data from the patient information form is then entered into the PMS by the front desk staff and a superbill is generated and printed from the PMS.

BRIDGER

The BRIDGER front desk staff is responsible for scheduling appointments and the collection of patient data upon arrival of the patient. All patients complete a patient information form, which has a comprehensive income data section that expands beyond the basic data on monthly income and family size. (This form will be discussed in more detail in a later section.) The front desk staff enters patient data from the completed document into the PMS and superbill form is generated. This form is used for collecting data needed to complete BRIDGER's Title X reporting requirements. During this time, a copy of the patient's insurance card is made and scanned into the PMS. Finally, the EHR generates an electronic superbill that is completed by the clinician during the visit.

Insurance Verification Process

The data collection process discussed above greatly assists in the verification of a patient's insurance eligibility. The eligibility verification process is a critical step to ensuring claims will be paid, as well as the ability of health center staff to collect co-pays and deductibles. Determining exactly what services will be covered and what costs are the patient's responsibility before or during a visit can help alleviate difficulties around fee collection. Verifying coverage prior to an appointment is considered a best practice. The verification process is becoming less time-intensive as more insurance carriers have moved to provide online verification services. This process allows real-time verification without the wait time often associated with phone verification, and some online options also include the ability to receive multiple patient verifications at one time.

PPAZ

PPAZ has developed a comprehensive electronic verification process that is effective at ensuring all patient insurance is verified before arrival at a health center. One staff member in the billing department is responsible for the insurance verification of all patients. The goal of this staff member is for a patient's insurance coverage to be verified two days before her appointment. The staff member runs a report from the PMS to identify the expected and pending appointments for each day. Using an electronic verification process that PPAZ purchased as an add-on to the PMS, the staff member verifies:

- Patient coverage
- The amount for co-pays and deductibles
- Referral and authorization requirements

While this insurance verification report is extremely useful for the staff member, the insurance verification report generated does not present the patient eligibility in a way that clearly states the patient's responsibilities for co-pays and deductibles. Thus, the billing staff translates the verification report into a Word document and attaches it to the patient record in the PMS. This allows the health center staff to quickly locate relevant information in an easy-to-read document. Finally, the verification staff member contacts the patient prior to her visit to relay any patient obligation information for deductible or co-pays.

Before it implemented this process of electronic verification, PPAZ did not offer same-day appointments. For some patients, this created a barrier to accessing care. The ability to check patient insurance status quickly through electronic verification has allowed PPAZ to now offer same-day appointments. In order to facilitate this, PPAZ had to create a new process (**see companion workbook**) to complete verification in a timely manner. The primary verification staff person who completes this work for regularly scheduled appointments does not complete the verification for same-day and walk-in appointments. Instead, health center or call center staff notify the billing department by phone or email of the need for insurance verification. The first available billing specialist completes the verification and sends an email to the inquirer once finished to notify them that the verification is complete and attached to the patient visit in the PMS.

THE CENTER

At the time of NFPRHA's site visit, THE CENTER only billed Medicaid (both Medicaid Family Planning Waiver and traditional Medicaid). For patients with traditional Medicaid, electronic verification of coverage occurs when the patient arrives at the agency for a visit. The front

desk staff completes the verification process by using a website provided by the state and attaches a copy of the verification to both the chart and superbill. THE CENTER verifies the eligibility of patients with waiver coverage at the start of each visit. (Further discussion of waiver eligibility is included in a later section.)

BRIDGER

BRIDGER does not do electronic insurance verification for most services. Information to bill insurance is collected directly from the patient's insurance card, which is presented at the time of visit. As mentioned previously, a copy of the insurance card is scanned into the PMS. This information is used to submit a claim to the payer, but BRIDGER does not verify the status of coverage before the claim is sent with the exception of LARC insertion visits. The insurance billing staff calls insurance companies to verify LARC coverage so that patients can be advised ahead of the scheduled appointment what insurance is expected to cover and what the patient's financial responsibility would be for the visit.

Self-pay – Income Verification Process

The collection of patient fees for self-pay patients is a critical process for Title X programs to expand revenue. One of the major challenges facing programs is the collection and verification of patient income. BRIDGER has been able to collect over 40% of its total revenue from patient fees and donations.

BRIDGER's executive director realized when she was hired that the agency had an opportunity to increase patient sliding fee scale revenue by improving the income verification process. That opportunity involved three steps:

1. Expanding the income information gathered through the patient information form.
2. Training staff to have income-related conversations with patients.
3. Providing patients with information on payment expectations.

The redesigned patient information form (**see companion workbook**) includes the ability for a patient to elect to be considered for the sliding fee scale. Specifically, a patient can check yes to the following statement: "I do not want to be considered for sliding fee scale. I understand that if I am insured I may be left with a balance or a co-pay. I also understand that I cannot retroactively be considered for sliding fees for this date of service." For those patients who elect to be considered for a sliding fee scale, the following items are included in the income verification process:

- Directions for how to complete the form, including a disclaimer that they may be asked for income documentation and to enter gross income before taxes.
- A statement that a spouse's or co-habiting partner's income is required by BRIDGER's federal grant, regardless of how expenses are shared.
- Specific information fields including:
  - number of household members;
  - patient current employment income – either by hourly wage and hours or annual salary. There are two lines to accommodate a patient who holds a second job;
  - partner's current income in the same format as for the patient;
  - secondary income including tips, parental support, grants/stipends/scholarships, trust accounts, unemployment/disability income, child support/alimony, rental income, and any other income; and
  - For females: age, currently pregnant or seeking pregnancy, ability to become pregnant, and United States and Montana residency status. (This information is used to assess if the patient may be eligible for the Montana Family Planning Waiver. Further documentation is required to complete the application process.)

The second step in BRIDGER's revenue collection improvement process was to normalize the aforementioned collection of this information as a routine health center process. Staff members were trained to ask the necessary questions of patients to ensure the income section was complete. Staff members were also taught how to explain to patients that this information is needed in order for the health center to meet federal grant requirements.

Leadership identified that it was also important to train the staff on how to find a middle ground with the patient. Specifically, BRIDGER found ways to ask the necessary follow-up questions in a way that was not too strict with the patient. The executive director stated that staff needed continued support and feedback in this area to find the best practice for each individual. Some staff members were initially uncomfortable asking patients for personal financial information; having a script with examples of how to ask for this information helped alleviate the discomfort (**see companion workbook for sample staff communication**). Further, the staff members' comfort level with asking such questions can also influence how a patient responds. If the questions are asked in a straightforward manner, BRIDGER staff finds that it is more likely that patients see sharing financial information as a routine part of care. Adequate training and consistent feedback can help ensure staff members feel confident in obtaining income information from patients.

The final step in the improvement process was to provide patients with information related to their fees responsibilities. The same messages were reiterated on the BRIDGER website and throughout the patient waiting room (**see companion workbook for sample materials**). With these improvements, overall patient sliding fee scale revenue at BRIDGER increased dramatically. In 2012, sliding fee revenue and donations were over 40% of the agency's revenues.

Enrollment into Medicaid Family Planning Expansion Programs

Another important source of revenue for family planning programs are Medicaid family planning expansions. Both THE CENTER and BRIDGER have access to their states' Medicaid family planning expansions. The following section highlights the practices used to maximize eligible patient enrollment into these programs.

THE CENTER

California's Family Planning, Access, Care, and Treatment Program (FPACT) began in 1997, and the program became a federally approved Medicaid family planning waiver demonstration in 1999. In 2011, California used state plan amendment (SPA) authority to implement a permanent Medicaid family planning expansion that serves individuals with incomes up to 200% of the FPL, regardless of age or gender. As the program is a major source of revenue, THE CENTER has designed a system to maximize enrollment into this program. Front desk staff members utilize the income verification section included on the previously mentioned patient information form to assess if a patient may be eligible for FPACT. If eligible, the patient is given a state eligibility form to complete. The front desk staff use this paper application completed by the patient to fill out an online approval process while the patient is onsite. With no requirements for documentation, most patients who apply are approved on the same day. Front desk staff place a copy of the approval in the chart and on the superbill. The state distributes pre-populated FPACT identification cards that all accepting providers, such as THE CENTER, can give to approved patients.

BRIDGER

The Montana Medicaid Family Planning Waiver began in July 2012. Given that the state provides an online application process, BRIDGER initially established a computer station for patients to complete the application. This process shifted from patient completion to a staff responsibility after a trial period showed that it was not conducive to patient flow for patients to use to the station set up in the back of the health center for self-enrollment. At the start of the process, staff members enrolled approximately six patients per week. Staff members were trained to discuss the benefits of the waiver with the patient by focusing on how it would benefit the individual. Staff members were encouraged not to discuss the benefits that enrollment provides to BRIDGER.

Health center leadership quickly recognized facilitating waiver enrollment was an excellent source of income. To help decrease the occurrence of missed enrollment opportunities, leadership initiated a five dollar bonus for each enrollment completed by a staff member. Staff completes the online form as well as attaching a scanned version of required documents. It is uncommon for a patient to have all the necessary documentation such as a Social Security card or birth certificate at the time of visit. As a result, the front desk staff created a system for storing incomplete applications; now the information is easily retrievable by staff when the patient provides necessary documentation on a subsequent visit. If more than one staff member assists with the application process, the incentive bonus is shared. This incentive program has led to an increase in the number of completed applications and approvals.

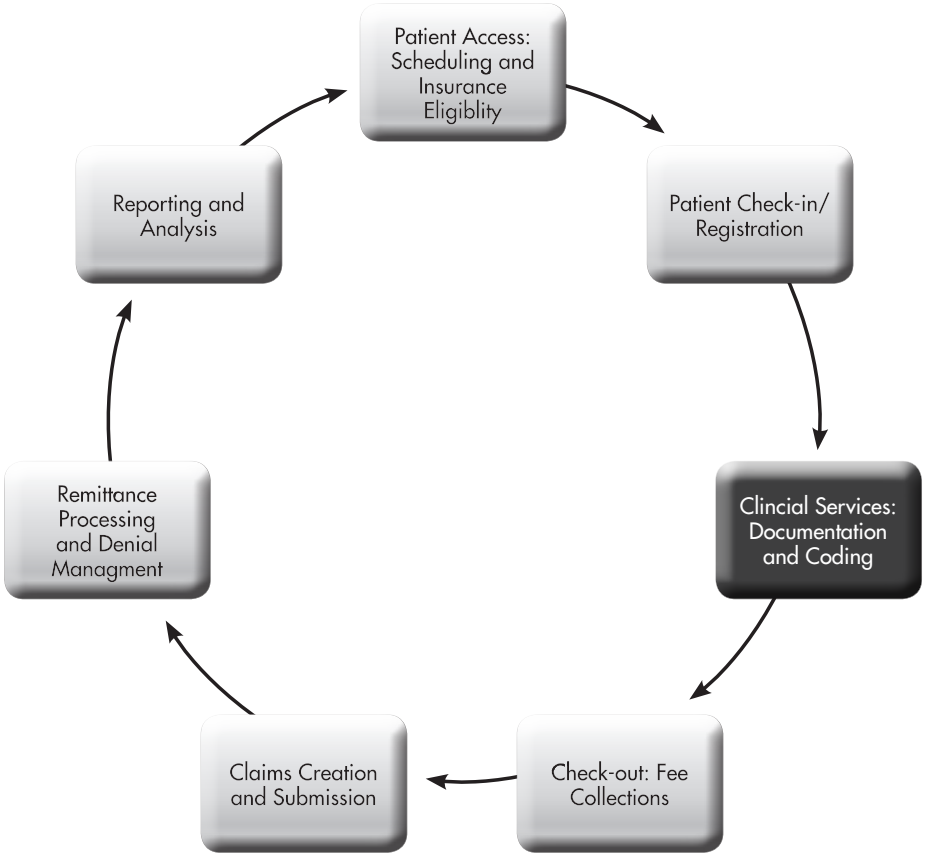
2. Visit Documentation

Coding is a numerical expression of what, why, and how care is delivered. It quantifies for billing purposes what is contained in the clinical chart. It is important to note that billing codes must reflect the same level of care noted in the chart or operative report. Procedure codes (CPT) and supply codes (HCPCS) are used to identify what the clinician has done during a patient encounter (**see companion workbook for coding guide**). There are numerous tools available to assist in fully documenting clinical services. Capturing billing codes can be done in several ways. One of the most widely accepted techniques is the use of a superbill. The following describes the process for documenting the services delivered during a visit and techniques for ensuring the quality of the data reports.

During the patient visit, it is the responsibility of the clinician or medical assistant to document the visit with the appropriate CPT and diagnosis codes. At both PPAZ and THE CENTER, a superbill is pre-populated with the most commonly used CPT and diagnosis codes, although the clinician is required to verify the provision of the actual services. The form includes codes for the following:

- The visit – evaluation and management codes
- Laboratory tests
- Medication dispensed
- Procedures performed

BRIDGER utilizes an electronic superbill for documenting the visit and reporting the CPT and diagnosis codes, which functions in the same way as the paper superbill described earlier. In addition, BRIDGER uses a paper superbill to collect required data for Title X reporting purposes. As a Title X provider, BRIDGER is required to submit user and visit data to its grantee – the Montana Department of Health. The grantee uses Ahlers for collection of patient-level data to complete the family planning annual report. At the present time, Ahlers is unable to accept electronic records from BRIDGER's EHR platform, NextGen. Therefore, BRIDGER staff members need to enter the superbill data into Ahlers from a paper record.



Quality Review of Superbill

One technique to minimize claim rejections and denials is to complete a quality check of the documentation on the superbill. All three of the sites do some type of quality check of the data on the encounter and superbill. Even though this process may occur after the visit, it is useful to discuss it here as it applies to the documentation process.

PPAZ

Before creating an electronic claim, the medical billing specialist reviews the CPT codes, diagnosis codes, and modifiers for a visit. This review ensures that there is consistency in coding and that all possible codes associated with the visit are included. For example, the billing specialist ensures that the code for the device is also included on the bill when the clinician includes an IUD insertion procedure in her documentation. Given that the billing staff is not located in a health center, real-time data entry minimizes the lag between the close of the visit and the ability of billing staff to access the superbill data.

THE CENTER

At the end of each day or during the morning of the next day, the billing staff member or the clinic director completes a comprehensive review of the chart and superbill for each patient seen on the day. Specifically, the following tasks are completed:

- a comparison between the appointment schedule and patient charts to ensure all charts and accompanying bills for that day are available for review;
- a comparison between the patient questionnaire and the FPACT application to ensure that all information matches. Examples of the reviewed data fields include Social Security number and family size;
- a review of the event problem list in the patient chart to ensure that the agency is not billing for services that do not qualify for FPACT (Example: Hepatitis C testing is not covered by FPACT);
- a comparison of services listed on the chart and the patient's superbill. The staff member ensures that all the services on the superbill are documented in the chart. In addition, she notes if any service that was provided and documented in the chart is not included on the superbill; and
- a review of the medication and laboratory logs to assist in reconciling the chart and the superbill.

If this process reveals any inconsistency between the chart and the superbill, the chart and superbill are returned to the clinician or medical assistant who filled out the document for review and correction.

THE CENTER staff state that approximately 10% of charts are clean upon first review. On average, it takes two to three minutes per chart to review, which averages to about one to two hours daily. However, leadership believes this time is worthwhile since completing these reviews produces cleaner claims and better family planning data reports. In addition, with estimates of additional costs of up to $35 to rework a denied claim, the additional review time reduces these costs.[6] While primarily for revenue collection, this process has also proved to be useful for ensuring that new processes are followed. For example, through these daily chart reviews THE CENTER discovered that male service requirements and activities were not being documented consistently in the patient's chart. Leadership was able to improve documentation by having follow-up discussions with staff about the requirements.

BRIDGER

During the patient check-out at BRIDGER, front desk staff compares the paper encounter form with the electronic superbill completed by the clinician in the EHR. A comparison of the two forms ensures that one is consistent with the other. If the two are inconsistent, the front desk staff follows up with the clinician to make the necessary corrections.

Charge Capture in Patient Management System

To create an electronic claim all of the documentation from the superbill needs to be entered into the PMS. This process should occur regardless of whether the electronic claim is eventually submitted to the payer electronically or printed onto a paper claim and then mailed. The staff position with responsibility for entering the charges into the PMS varies at each of the sites. This variety demonstrates that organizations have the flexibility to place this task in the part of the workflow that works best for its individual scenario.

PPAZ
Front desk staff members in the health centers enter the visit documentation from the superbill into the PMS when the patient checks out before leaving the site. This immediate check-out ensures electronic claims are created quickly.

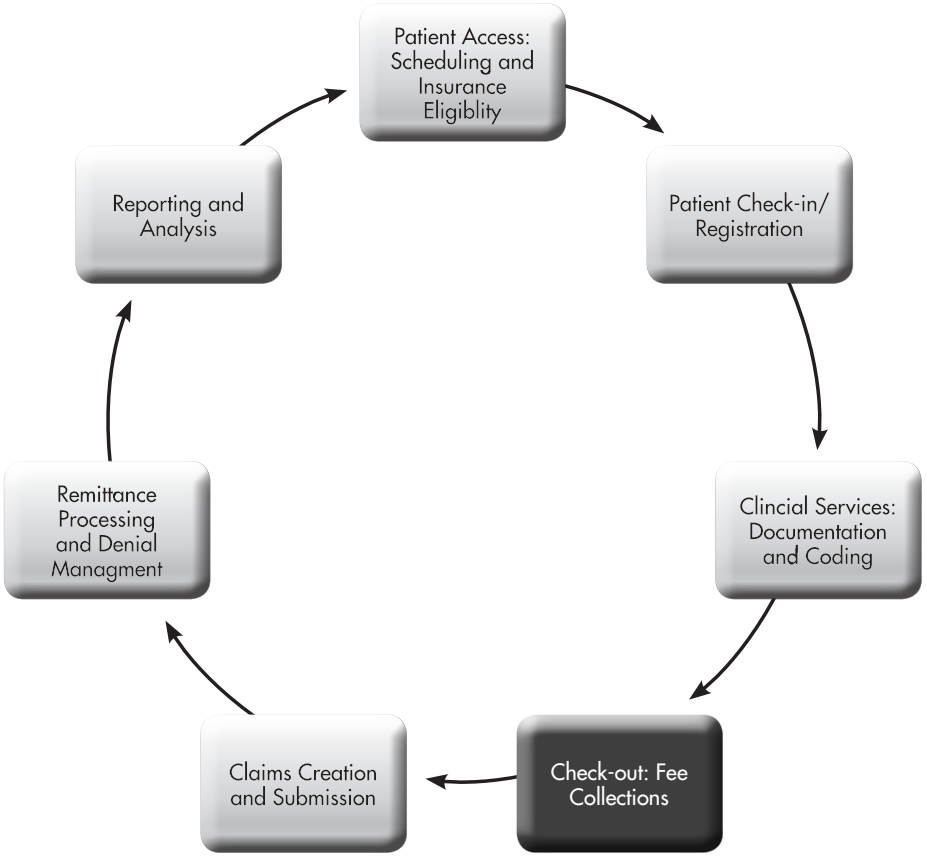
THE CENTER
The biller enters the visit documentation from the superbill after the quality review is completed. An initial quality check before creating the claim decreases the likelihood of the payer denying the claim.

BRIDGER
All visit documentation is entered directly into the electronic health record by the clinician during the visit; the data is then transferred into the PMS at check-out. Entering data during the visit ensures that the charges for services rendered are not overlooked.

3. Patient Check-out

Several activities that occur at check-out before the patient leaves are important to revenue cycle management. This includes fee collections and ensuring all charges are captured in preparation for creating a claim. Overall, all three sites have similar patient check-out procedures. This includes the review of the superbill with the patient and explanation of the fees for the visit. Staff asks for payment of fees and gives the patient a copy of the superbill.

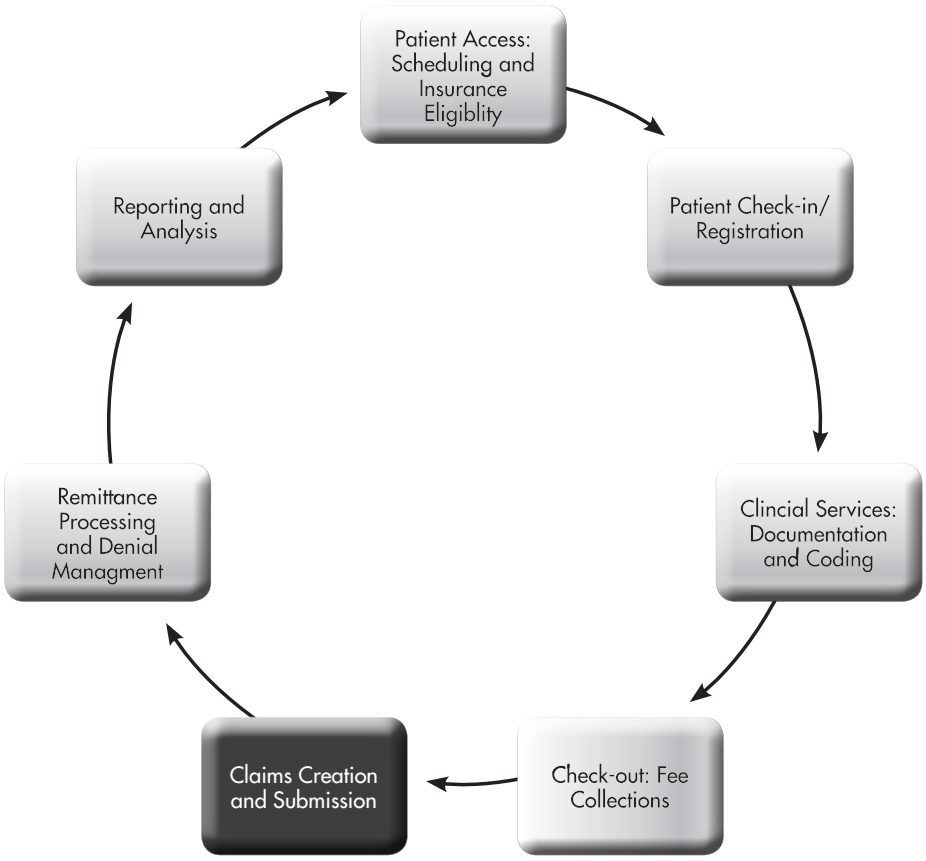
At PPAZ, part of the check-out process (**see companion workbook**) involves the staff member entering the superbill into the PMS before the patient leaves. The front desk staff member also prints a copy of the bill from the PMS to offer to the patient. Both THE CENTER and BRIDGER explicitly ask patients upon check-out if they are able to make a donation. Leadership at both sites identified the need for staff training in this area in order to foster acceptance among the staff. During a particularly difficult financial period for THE CENTER, leadership identified that there was potential to increase patient donation amounts as a way to increase revenue. THE CENTER includes a jar at the front desk for cash donations and also allows patients to add a donation to check and credit card payments.



Leadership at THE CENTER was already working the front desk at this time because of understaffing and used this as an opportunity to show staff members how to incorporate this request into their routines. While staff members state that it is sometimes challenging to ask a low-income patient for a donation, the support of THE CENTER leadership staff continues to help them find increased comfort in identifying the best practice to accomplish this task.

Creation and Submission of the Claim

Upon completion of the patient visit, the health center submits a claim to a third-party payer to receive payment for services provided. This claim includes demographic information about the patient, a summary of the services provided and their associated charges, as well as any other information required by the payer. Claims are submitted utilizing a standard form – the CMS 1500 – that can be populated either manually or electronically from charges entered into a patient's record in the PMS. If the agency does not have a PMS, claims are created from the data on the paper superbill. Claims are then printed and mailed or transmitted electronically to the payer. To ensure payment, the submission of a claim must occur within the payer's specific timeframe requirements or "timely filing" limits. The payer will not accept claims submitted after the timely filing deadlines, which may range from 90 to 180 days after the date of service.



It is important to note that many insurance plans will pay electronic claims quicker than paper claims. A survey by America's Health Insurance Plans (AHIP) found that in 2011, 93% of electronic claims are paid within 14 days, while only 79% of paper claims are processed within 14 days.[7]

Electronic Claims

As discussed earlier, all three agencies create charges from a PMS. Once created, the agencies use those charges to populate claims, the majority of which are submitted electronically. The billing staff members at the sites generate claims for each of the visits by creating an electronic file with the necessary data including patient demographics, services, codes, and charges. The billing staff member who is responsible for creating the claims "batches" all the visits from a single day into one electronic data file. A batch ideally consists of all the claims from a specific time frame so as to have them processed by the payer in one fell swoop. Each agency creates claims and batches on a regular basis with the goal of doing it daily.

The PMS populates the charges for the specific service codes from the visit through the use of a fee schedule uploaded into the PMS. At this stage, the billing staff members run a program in the PMS called "claims editing" to review the accuracy of the coding, as well as identify any possible discrepancies in the coding. Depending on the nature of the errors found, staff members refer to the health record for additional information or review the

claim with the appropriate clinician to determine the necessary correction. For electronic claims submission, the file containing the claims data is known as the Electronic Data Interchange (EDI) file. Once the EDI file is created, both PPAZ and BRIDGER save this file.

PPAZ saves it as an Excel spreadsheet while BRIDGER saves it as both a Word document and Excel spreadsheet (**see companion workbook for PPAZ process manual**). THE CENTER does not keep a separate EDI file outside of the PMS. Since EDI files contain protected health information, they are subject to the rules and requirements of the HIPAA[8] Security Rule and HITECH ACT of 1996, which includes specific transactional and coding requirements.

Paper Claims

While the majority of payers have made the transition to electronic claims submission, most still allow providers to submit paper claims. For some payers the health center is required to meet an annual or monthly level of claims to be able to submit claims electronically. THE CENTER submits paper claims for its regional Medicaid managed care plan, CenCal, because they do not meet the claims threshold requirement. However, staff hopes to switch to electronic submissions in the near future as its CenCal claims increase.

To bill for CenCal, paper claims are created using the PMS paper claims creation program. A separate batch is created for paper claims once all the data is entered into the PMS and the quality review is completed. The billing staff member prints out the claims through the PMS print function and then mails the paper claim to the payer.

Claims Submission

Once the claim is created, the next step is to submit either the EDI file or the paper claim to the clearinghouse or the insurance company. Electronic claims can be submitted directly to the payer or through a clearinghouse. A clearinghouse is an intermediary between the health center and the third-party payer. The advantage of using a clearinghouse is that the health center only needs to produce claims in one format – the format of the clearinghouse. It is the responsibility of the clearinghouse to produce and send the claims in a variety of formats acceptable to the individual payers. Health centers are more likely to utilize a clearinghouse when billing to numerous different insurance payers. Two of the participating agencies, PPAZ and BRIDGER, use a clearinghouse to submit most claims.

PPAZ and BRIDGER

PPAZ and BRIDGER use the same clearinghouse – Navicure – to submit claims to the different payers they bill. Both chose Navicure due to the company's relationship with their PMS vendor, NextGen, as well as cost considerations. A benefit of the clearinghouse is access to a tool called a scrubber that will evaluate, or "scrub," claims for either missing or inconsistent data items. A report within the clearinghouse identifies potentially rejected claims and the items that require correction. Once the billing staff corrects the claims in the PMS, a new EDI file is uploaded and the claims are submitted to the clearinghouse (**see companion workbook for upload process for PPAZ**). PPAZ creates the Electronic Send Report, which is a standard report template in the clearinghouse, to document the submission of claims.

Table 3 presents the percent of claims that are returned by the clearinghouse before they are sent to the insurance company for the participating agencies. The ability to catch errors in the claim before submission to the payer increases the number of clean claims submitted and increases the number of claims paid correctly with the initial submission. Given the level of quality review checks of the superbill, the low percentage of claims returned was to be expected.

In order for BRIDGER to ensure all the claims in the PMS for a selected time frame are uploaded into the clearinghouse system, the billing staff compares the files uploaded to the clearinghouse with the EDI file created in the PMS. Specifically, a billing staff member runs an Electronic Send Report on the clearinghouse website, copies and pastes the report into a Word document, and then compares it to the EDI file in the PMS for the same date. Each encounter in the PMS is verified against the Electronic Send Report. When a claim is missing from the clearinghouse Electronic Send Report, the billing staff investigates the claim and resends the data to the clearinghouse when necessary (**see companion workbook for a copy of this report**).

Table 3 – Percent of Claims Returned by Clearinghouse

Site	Percent of Claims Returned
PPAZ	5%
BRIDGER	4%

THE CENTER

THE CENTER submits electronic claims to Medicaid FPACT, which is the payer for approximately 95% of all of the agency's claims. The billing staff member uploads an EDI file created in the PMS directly to the FPACT website. For all other Medicaid billing, THE CENTER prints and mails paper claims to the regional provider, CenCal.

To ensure all encounters are billed in a timely fashion, the billing staff member runs a monthly report in the PMS to identify any encounters that do not have a claim attached to it. If unbilled encounters are found through this report, the staff member will take several actions to determine the reasons for the lack of claims. Those actions include reviewing the patient medical chart to check that a visit actually occurred and reviewing the copy of the superbill in the medical chart. If no documentation of the visit is found in the medical record, the biller may review the hard copy of the patient appointment book to see if the appointment was canceled. If there was a patient visit and superbill, the staff member enters information from the superbill into the PMS and a claim is generated and submitted (**see companion workbook for payment processing procedure**).

Another useful indicator to manage timely filing of claims that optimizes the revenue cycle is measuring the number of days from date of service to claims submission. A goal of 3 business days from service to submission is recommended to optimize cash flow.[9] Table 4 presents the average number of business days it takes each site to create and submit a claim. Given the level of manual processes done by the single billing staff member, it is not surprising that THE CENTER's time to submit a claim is longer than the other participating agencies. However, their focus on quality and the submission of clean claims leads to a rejection rate of less than 1%.

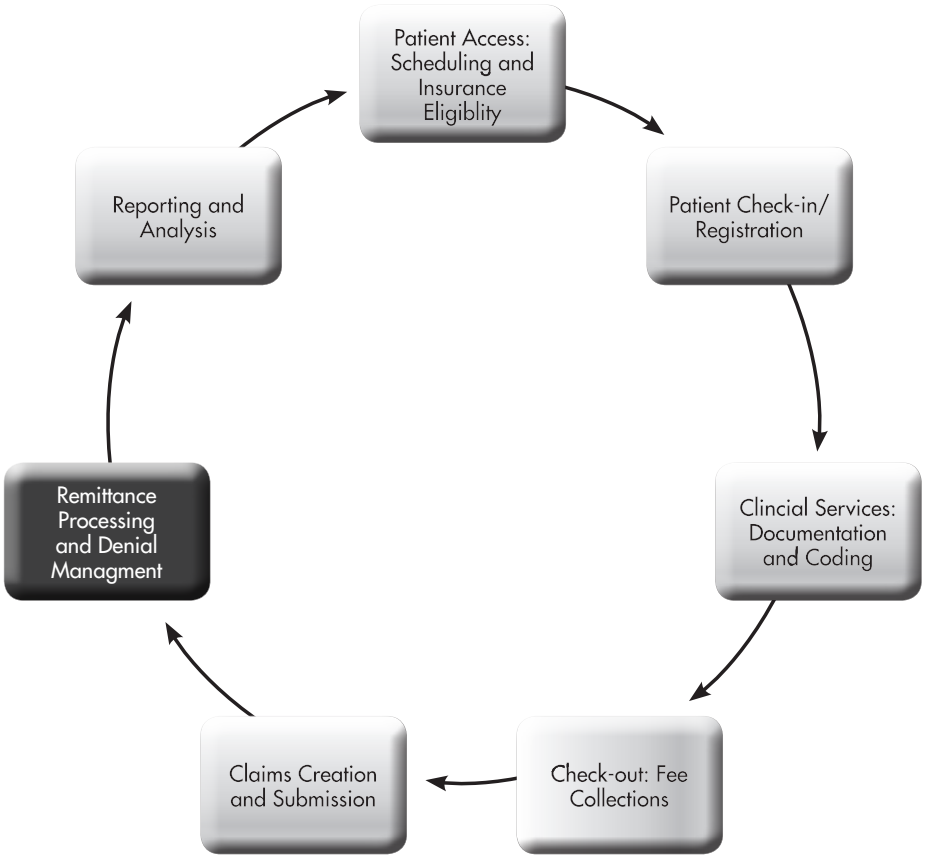
Table 4 – Average Days to Send Claim to Payer

Site	Business Days
PPAZ	1
BRIDGER	2
THE CENTER	10

Remittance Processing and Denial Management

Payment Processing

Payments are received from third-party payers through either an electronic funds transfer (EFT) or a check. For EFTs, the agency will receive a receipt that includes confirmation of the transfer as well as the specific patient payment information. This receipt is called an electronic remittance advice. For check payments, the insurance company may send an electronic remittance or attach a paper remittance with the check payment. No matter how the remittance is received, all payments should be documented in or "posted to" the patient's account. When an electronic remittance is received, the payment posting process is completed either manually by a staff member entering data into the PMS or automatically by the PMS. From time to time even with an electronic payment posting, manual adjustments for contractual or other allowances may need to be completed. Payment posting can be done manually when there is not an electronic remittance sent to the health center.



PPAZ

PPAZ's electronic remittances and EFT reports are downloaded from the website of its clearinghouse, Navicure. At PPAZ the billing staff manually posts the amount of the EFT in a monthly report that is used to document all insurance payments received. This report is on the organization's shared drive. The billing staff will confirm that the payment amount in the remittance is the same as the payment in the EFT. After the payments are confirmed, the remittance is imported into the PMS for posting of the payments to the patients' accounts. A report is printed to document the importing of the remittance into the PMS. In processing the remittance, all contractual adjustments with reason codes are automatically posted to the patients' accounts. A billing specialist will review those postings periodically for accuracy. Any other patient account balance adjustments are posted manually, as this action is decided on a case-by-case basis.

THE CENTER

THE CENTER receives a check weekly from FPACT, its dominant payer. FPACT, as with other payers, includes with the check an explanation of benefits – most commonly referred to as an EOB. When the EOB is received, the billing staff member sends the check to the agency's administrative office with a copy of the EOB, while retaining a copy of the check for the health center's record. Payments are posted in the patients' accounts in the PMS by the biller. For each service, the amount paid is manually entered into the patient's account. Each patient visit may have multiple services including the exam, contraceptive method, labs, and other services. THE CENTER has chosen to accept payments from the insurer as full payment even if it is less than the charges for the service delivered. Thus, when the payment does not equal the charge for the service, the biller manually adjusts the charge so that the difference is written off of the patient's account. The biller completes all adjustments until the balance on the patient account is zero. These write-off adjustments are due to contractual allowances and are summarized on the agency's financial statements (**see companion workbook for a copy of this process**).

Denial Management

When a claim is not paid, the third-party payer will notify the agency. This notification usually is included in the EOB as a set of codes that describes the reason for the denial. That code will be used to determine the correction necessary to have the claim paid. Part of the revenue cycle process is to correct and resubmit denied claims consistent with insurance company filing timeframes. With estimates of additional costs of up to $35 to rework a denied claim, it is beneficial in terms of maximizing revenue for agencies to have the capacity to minimize the number of claims that are not initially paid by the insurance company for specific errors.[10] A benchmark for a high-performing health center is a denial rate of 7% or less.[11] Table 5 presents the denial rates for the participating agencies.

Table 5 – Percent of Claims Denied by Payer

Site	Percent of Claims Denied
PPAZ	10%
BRIDGER	24%
THE CENTER	7%

PPAZ

PPAZ processes denied claims through a daily process they call "working the accounts receivable." This process is described in the accounts receivable section of the case study. When denied claims are identified, the medical reimbursement specialist will make the necessary adjustments or corrections to the claim and resubmit to the insurance provider for payment.

BRIDGER

BRIDGER's denied claims are identified upon receipt of the remittance from the insurance company. For denied claims that can be rebilled, the billing staff make the necessary corrections after reviewing the EHR or, when necessary, contacting the clinician. If the claim cannot be rebilled, the biller will check to see if the patient pre-paid for the service. If there is no payment, a bill is sent to the patient explaining that insurance did not pay for the service and the amount is now owed by the patient. For patients who were eligible for reduced payments on the day of the visit as a result of their placement on the sliding fee scale, the patient bill will reflect the sliding fee scale amount for the service.

BRIDGER recognizes that its claims denial rate may be higher given the philosophy to bill commercial insurance even when the there is no verification of coverage. Leadership believes the additional work to bill insurance and increase revenue whenever possible outweighs the impact of processing denied claims. During the site visit, the billing staff stated that most denials were for contraceptives and other medications that were not covered by the patient's plan.

THE CENTER

On the weekly remittance sent to THE CENTER, FPACT lists the claims that were denied with the reasons for the denial. The biller reviews the patient's account, makes any of the necessary corrections, and then resubmits the claim. Some claims cannot be rebilled, for example, when a patient was not eligible at time of visit or the service is not a covered benefit. For those claims, the biller writes off the charge on the patient's account and enters the reason that the service was not paid. During the site visit, THE CENTER leadership shared that the last remittance from CenCal had only one denied claim. This was the only denial that THE CENTER had received since they started billing CenCal in 2012.

Appeals Process

All three of the participating agencies take several actions to rebill claims that have been denied. One of the actions is to appeal the denial with the third-party payer. The common reasons for appeals include not filing the claim within the agreed-upon time frame, coding errors such as secondary visits missing the appropriate modifier, the provider not participating in the payer's network, and high-cost items such as IUD insertions. Both BRIDGER and PPAZ appeal denials for payment when there is sufficient documentation to support the claim. For example, documentation for a timely filing of a claim would be the transmission history report from the clearinghouse. Other documentation examples include copies of referrals and authorizations, provider network approval confirmation, and copies of the medical chart documenting the services delivered. Billing staff at both BRIDGER and PPAZ gather all documentation and file appeals with the insurance company according the specific requirements of the payer. The steps taken in the appeals process are not a function of the clearinghouse.

Accounts Receivable Management

Accounts receivable management involves follow-up on third-party payer claims that have not been paid and self-paying patient accounts with outstanding balances. There are two possible reasons why a third-party claim has not been paid – it has been denied based on the information on the claim or it was lost in translation on the way to the payer and has not been processed in their system. Either of those reasons requires the agency to take action to resolve the status of the claim. Thus, it is important to identify unpaid claims and follow up with the payer when appropriate. The use of electronic remittance and standard reports from the PMS are tools to manage this process.

"Days in Accounts Receivable" is a metric to assess the status of accounts receivable. It measures the time from date of service to claim payment. A goal of 35-40 days in accounts receivable is recommended to ensure sufficient cash flow in a medical practice.[12] Table 6 presents the average days claims spend in accounts receivable for the participating agencies.

BRIDGER and THE CENTER do not monitor accounts receivable on an ongoing basis. Both use the payment remittance to identify and monitor unpaid submitted claims. At present, both believe this method manages accounts receivable to an acceptable level. Indeed, both agencies' average days in accounts receivable are below the best practice recommendation provided above.

Table 6 – Days in Accounts Receivable

Site	Business Days
PPAZ	20
BRIDGER	32
THE CENTER	10

PPAZ

With close to 35,000 annual claims and more than 13 insurance payers, PPAZ recognized the need to develop a comprehensive process to monitor the accounts receivable. The revenue cycle manager developed a process to manage accounts receivable that involves working closely with the billing specialists on staff. Each billing specialist is assigned a set of third-party payers and is responsible for managing the reimbursements associated with these payers. To manage outstanding claims that have not been paid, PPAZ utilized two standard reports in its PMS, NextGen:

- "Billed Encounters" with a filter set to reflect all positive open balances that are over 30 days from the date of service. This report identifies each of the unpaid claims for a specific insurance provider including the claim number and amount owed.
- "Aging Categories by Encounter" that summarizes the number as well as the amount of unpaid claims by provider and category of days from date of service (e.g., 0-30, 31-60, 61-90, 91-120…).

The billing specialist downloads the reports in an Excel file and uses them daily to manage the outstanding accounts. The first step is to identify the accounts with the highest balances. The second step is to access the payer website to determine the status of the claim, as this is the easiest and quickest way to collect data from the third-party payer. The billing specialist makes notes in the Excel file to explain the follow-up necessary to resolve the claim's issue. When data cannot be retrieved electronically or more specific information is needed, the billing specialist will call the payer. Given that reaching a representative at the payer can be time consuming, PPAZ staff members have found that having multiple claims ready maximizes the efficiency and effectiveness of the call. To monitor the status of the accounts receivable, the revenue cycle manager meets weekly with each billing specialist to review the status of the receivables. Finally, the billing specialist will rebill any denied or rejected claims from the payer when appropriate.

THE CENTER

As with many family planning programs located within larger agencies, the agency's finance department oversees patient accounts and is responsible for adjusting claims with remaining balances. Leadership at THE CENTER has started to work with the agency's finance department to create a process for writing off patient balances in accounts receivable in a systematic way, rather than having all discretion left with the finance department.

Self-pay Collections

In many health centers, self-pay patients may have outstanding balances. Following up on outstanding balances can produce additional revenue for the agency. However, as is common with other health care providers in the safety net, THE CENTER does not do any follow-up to patients with balances beyond a verbal request to collect a payment at the time of service.

To assist with collection of outstanding patient accounts, PPAZ uses an alert that is set to go off when a patient with an outstanding balance has a visit scheduled in the PMS. The staff will make every attempt to collect the balance when the patient returns to the center for a visit. Statements are sent once a month for all patients with an outstanding balance.

One possible technique to manage outstanding patient balances is the use of a collection agency. BRIDGER collects over 40% of all revenue from patient fees. Even though the staff makes every effort to collect patient fees at the time of the visit, many patients are unable to pay at that time. Thus, the agency has developed a comprehensive process for the collection of patient accounts. Account balance statements are issued at the beginning of each month to all patients with a balance over seven dollars.

BRIDGER does not send statements to patients with balances under seven dollars, as it is not worth the cost of creating and sending the statement. The agency requests that the patient pay a minimum of ten dollars per month when there is a balance over ten dollars. To ensure confidentially for patients, a filter is used in the PMS to ensure statements are not sent to the homes of patients who are minors with parents unaware of the services rendered, or patients who cannot receive mail for safety reasons. When insurance does not pay all of the charges for the encounter, the staff will print an insurance balance letter through the PMS during the payment processing process (**see companion workbook for sample letter**).

In most cases, the agency writes off any balance under thirty dollars when no payment has been received for more than 3 months. If the patient returns for care, an attempt to collect the balance is made and, if successful, the account is adjusted accordingly. When a patient has a balance over thirty dollars and has not made a payment in three months, the agency will prepare the account to be sent to a local collection agency. First, billing staff will call or email the patient to encourage payment on the outstanding balance. The following is the general script used:

"*We are calling/emailing to let you know that you have a balance which is now past due and eligible for pre-collection. We wanted to give you an opportunity to make a payment to avoid starting the collection process. As a reminder, our payment policy requires $10/month minimum (on top of any new balances acquired) to stay ahead and out of collection activity. If you ever have trouble making your monthly payment, please talk to our billing department – we are always willing to work with you but communication is required. Once your account is sent to pre-collection with our agency, they will process you into straight collection if you do not make a payment here within 30 days.*"

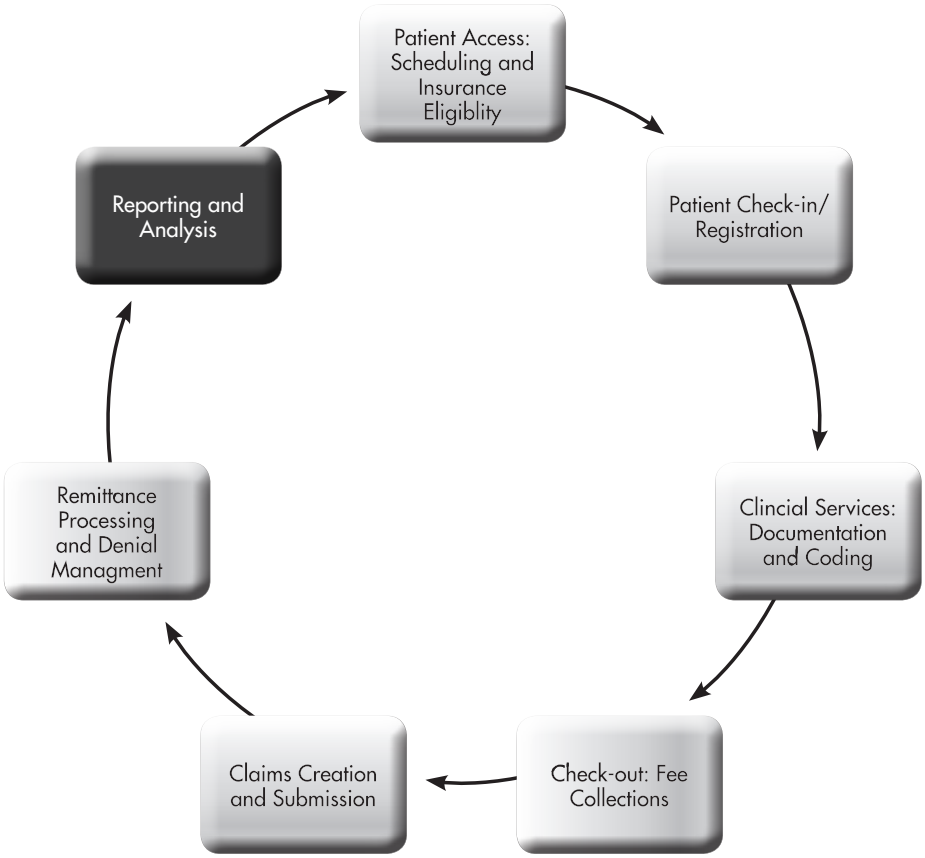
If the patient does not make a payment or payment arrangements, the account goes to the collection agency. The collection agency will send a letter to the patient and if payment is made within 30 days, BRIDGER gets to keep the full payment. After thirty days, the collection agency does all the follow up with the patient. BRIDGER receives a percentage of the patient payments received by the collection agency. During the site visit, leadership reflected that using the collection agency is cost effective given the level of staff and other resources needed to collect outstanding balances (**see companion workbook for collections policy**).

Patient Refund

From time to time, agencies will need to send a patient a refund. This situation arises when a patient pays for a service and then the health center receives payment from an insurance provider for the service. At PPAZ, the medical reimbursement specialist identifies patients in need of a refund by running a "Billed Encounter" report for accounts with credit balances that are over thirty days beyond the date of service. The medical reimbursement specialist completes a check request form. The revenue cycle manager then approves the request and sends it to the finance department. When a patient at BRIDGER has a credit on her patient account, front desk staff typically alerts her during the visit and gives her the option to use it, donate it, or request a refund check. If a refund is requested, a note is sent to the billing staff through the PMS. Billing staff then completes a refund adjustment in the PMS. The billing staff will issue refund checks on a regular basis through the accounting system. No letter accompanies the check, just a note on the check indicating a payment refund.

Management Analysis of Reports

Health center leadership access a number of reports to assess financial health, including those that summarize key indicators and identify trends. Management reports on revenue collected or service utilization can be used to assess possible revenue trends. Each of the agencies has a set of reports that is used to review the status of the revenue cycle process as well as the overall operation of the health center.



PPAZ

The revenue cycle manager prepares a monthly insurance performance report. This report tracks the following items:

- Transactions – the number of encounters or visits.
- Relative Value Units (RVU) Trends – relative values are units that indicate the resources used during a specific service provided by the clinician. Tracking trends with this metric measures the complexity of the visits.
- Charges – the cost for the services delivered.
- Adjustment – changes made to patient accounts based on insurance payments.
- Payments – the amount insurance paid for claims submitted.
- A/R Ending Balance – the amount of patient/insurance payments due at the end of the month.
- Days In Accounts Receivable – average days since submission of claims for payment.
- Percent of Accounts Receivable over 90 days – the percentage of claims that have not been paid in more than 90 days.
- Net Collection Rate – the percent of charges that have been collected.

The report compiles data on all claims within the agency, as well as separating data out by payer (**see companion workbook**). Data are presented in tables and graphs. The chief operating officer reviews this report monthly.

Weekly and monthly data dashboards (**see companion workbook**) are prepared for each site that include summaries of services delivered, charges, collections, and other metrics. These data dashboards are on the agency's shared drive and are available for all staff to review. Health center managers review the data with their staff as well as using the data to set monthly and weekly service goals.

THE CENTER

The agency's division director reviews a monthly report that tracks the visits and charges for each site (**see companion workbook**). This report compares the metrics for the current year and the previous five years. The division director uses this data when she meets separately with the agency CFO and representatives from the third-party payers monthly to review division financial status.

BRIDGER

The executive director uses many reports to monitor service utilization and the financial status of the agency. During the site visit, the executive director shared her viewpoint that giving staff as much information as possible assists with staff members' understanding of the rationale for their job activities. For example, reviewing financials helps the front desk staff to understand the rationale for verifying income and collecting accurate insurance information. A variety of hard copy reports are posted in a centrally located area in the health center. Data reports are also reviewed periodically with staff during staff meetings. Samples of reports shared with staff include:

- Patients by county
- Financial reports – budget-to-actual for current and previous year
    - Revenues
    - Expenses
- Differences in revenues and expenses for previous years

During the site visits, leadership at all three agencies stated that sharing the status of the agency through a variety of reports helps staff to better understand the agency, including successes and challenges.

Summary of Key Findings

With the full implementation of the ACA approaching, family planning providers must assess the potential impact the law will have on their organizations' operations. Foremost in this assessment is examining the opportunity to increase revenue streams by serving an increased number of newly insured patients. Specifically, many providers are exploring options to either initiate or expand the number of insurance payers they are billing. Furthermore, to ensure effective and efficient billing, agencies are reviewing the current billing processing systems and determining ways to leverage electronic systems. This case study examined the strategies and processes implemented by three family planning agencies to increase the collection of third-party revenue.

It is important to note that while the specific approaches used to design and implement the revenue cycle processes and systems varied among the three sites, common traits exist among the factors that contributed to their successes. All three of the agencies studied have strong leadership that embraced the need to implement new billing and collection strategies to remain fiscally viable. The following are essential leadership traits found at all three sites:

- **Communication** – Continuous communication with staff to explain the rationale for expanding billing. This was done by using a variety of strategies including training, staff meetings, and one-on-one communication.
- **Flexibility** – The willingness to adjust and readjust new systems and processes.
- **Being Realistic** – As unfamiliar processes are introduced, staff composition may need to change to meet the need for new skill-sets. Leadership must acknowledge that some staff may not adjust to the changes.
- **Solidarity** – Having a "we are all in this together" approach for achieving staff buy-in. Leadership made it a point to understand how staff members were impacted by the changes and were committed to working with staff to make adjustments to support them.

As described throughout this document, the revenue cycle process involves multiple activities that need to be performed for health centers to efficiently and effectively collect third-party reimbursement. At each of the sites, staff and technology were vital to the collection of information and data at each step of the cycle. With the expected growth in insured patients, the case study participants are preparing to leverage technology to adjust to an increase in billing workload. While all three sites have some level of technology for billing and collection, all three are in different phases of the process:

- one site used both a PMS and EHR for a year;
- one site had a PMS for several years and is preparing to implement an EHR; and
- one site has recognized the need to upgrade its current PMS and implement an EHR. This site is exploring a new PMS and EHR, as well as considering options for financing these systems.

All three sites acknowledged that the ability to automate numerous steps in the revenue cycle process improves the efficiency and effectiveness of billing and collection activities.

Each of the locations studied has dedicated billing staff. The specific skill-sets across the staff vary from having extensive experience in health center operation to no direct health center operation experience. Yet, the billing staff members across the sites possess important skills – detail-oriented, thorough, and data focused. In addition, at each site, billing staff work directly with clinicians and other staff to ensure effective and accurate data collection. It is important to note that some of the agencies recognized that despite having dedicated billing staff, additional support through an external consultant was necessary for billing implementation. Two sites that utilized external support identified the knowledge transfer from the external support to the agency staff as the most beneficial outcome.

During the site visits, the case study team observed that revenue cycle processes occur at every step of the patient's interaction with the health center staff. This begins with appointment scheduling and continues through check-out when the visit is completed. All three sites collect the data needed to submit a claim to the insurance company during the patient visit. Yet, there are slight variations in the model used for data collection including:

- collection and verification of insurance information done before the visit or upon arrival at the health center;
- the use of a paper superbill or an electronic superbill;

- the timing of when to enter a paper superbill into a PMS – either before or after a patient leaves the health center; and
- when to collect a patient's fee or donation. One site collects co-pays during the patient registration while the others collect at the time of check-out. At one site, staff asks each patient at check-out if they wish to make a donation and another site uses a donation jar to facilitate donating.

Because of the additional costs associated with resubmitting rejected or denied claims, all three sites complete a quality review of the documentation of the data on the superbill prior to submission – this step goes beyond the quality check that electronic systems can complete when creating a claim. These reviews help ensure that there is consistency in coding and that all possible codes associated with the visits are included on the bill. One agency goes further, with a more comprehensive quality review for each visit to ensure consistency in coding and that the patient chart and superbill are consistent.

The participating sites make every attempt to maximize the use of technology for the creation and submission of claims for services delivered at the health center. All three sites create electronic claim files from the charges entered into the PMS. In addition, the participating agencies use a claims review process in the PMS to ensure the creation of accurate claims and minimize rebilling of denied claims. The sites submit the majority of claims electronically to the insurance provider. From time to time, each agency will submit paper version of claims to the insurance company. This is due, in part, to the agency not meeting the threshold of claims required by the insurance company to submit electronically. Two out the three participating agencies submit claims to the insurers through a clearinghouse. One agency submits claims directly to insurers.

Two of the three participating agencies receive payments from insurers through electronic fund transfer as well as traditional checks. The third agency receives only checks for insurance reimbursement. Two of the three participating agencies receive and process the majority of payments electronically through the clearinghouse. This includes notice of electronic funds transfer and a summary of the claims paid. Payments are posted electronically into patients' accounts and adjusted for contractual allowances. The third agency manually posts all payment into patients' accounts from the paper summary received.

A key to maximizing reimbursement is the resubmission of denied claims. All three agencies have processes to monitor claims that are not paid and make the necessary corrections for resubmission of the claim. One of the participating agencies created a process to manage outstanding claims using a series of standard reports from the PMS that the billing staff review to identify claims that have not been paid. This process has been critical to each agency minimizing accounts receivable.

Another area that increases agency revenue is billing and collecting for services by self-paying patients. Two agencies send self-paying patients with balances monthly statements requesting payment. The third agency did not consider sending statements to be cost-effective. To further expand collections, one agency uses a collection agency to collect balances over thirty dollars that have been inactive for over 30 days.

The final step in the revenue cycle process is the use of reports to manage and monitor the level of revenue that is collected. Leadership at all three sites relied on management reports to oversee and maximize potential revenue. In addition, information on financial standing and service utilization is shared with staff on an ongoing basis. The leadership stated that sharing reports is a critical step to ensure staff members understand and acknowledge the importance of all aspects of the revenue cycle process.

As evidenced by the participants in this study, agencies are beginning to assess the opportunity to collect third-party revenue from newly insured patients. It is imperative for agencies to have innovative leadership willing to invest in additional technology, staff, training, and processes to maximize the potential revenue from these patients. These participants recognized that the techniques used at their sites met their specific needs and each family planning program will need to determine what will work best given their individual circumstances. There is no one-size-fits-all approach. However, the variety of options that have been used by these sites can be applied to other family planning programs. The common requirement among all family planning agencies is the presence of determination and leadership to make the necessary changes to access new revenue sources.

Endnotes

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About NFPRHA

The National Family Planning & Reproductive Health Association (NFPRHA) represents the broad spectrum of family planning administrators and clinicians serving the nation's low-income and uninsured.

NFPRHA serves its members by providing advocacy, education and training to those in the family planning and reproductive health care fields.

For more than 40 years, NFPRHA members have shared a commitment to providing high-quality, federally funded family planning care – making them a critical component of the nation's public health safety net. Every day NFPRHA members help people act responsibly, stay healthy, and plan for strong families.

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Tell Us What You Think

NFPRHA surveys its membership to inform its advocacy, assess member priorities, and gain valuable perspective on service delivery in the safety-net setting.

Please consider taking a moment to **complete a brief survey** related to this case study, as well as the *Life After 40: The Family Planning Network and the ACA* project.

The survey will be used to help produce more useful and relevant *Life After 40* resources for the membership.

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