Transitioning to Billing Part 1: Assessing your Capacity to Successfully Manage Revenue as a Key Element of Agency Sustainability

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Alexia: Hi everyone. This is Alexia Eslan from JSI. Thank you so much everyone for joining us today for this Transitioning to Billing I, Assessing your Capacity to Successfully Manage Revenue as a Key Element of Agency Sustainability webinar. This webinar is going to last about 90 minutes. The main goal is as agencies, as agencies shift from relying on grants to billing payers for their services, they must assess and analyze their capacity, manage revenue through billing third party payers. So this webinar will introduce cultural shifts that agencies must consider prior to seeking reimbursements through third party payers in order to ensure success.

We will be talking about organizational culture and also about the required infrastructure to set up getting reimbursed from third party payers. This is the first webinar in a series of two webinars. This is Transitioning to Billing I and we will have Transitioning to Billing II which is a follow up for this webinar next Tuesday, December 17 and that will be at the same time at 1:00 p.m. Eastern Time, 11:00 a.m. Mountain Time. It will also be a 90 minute webinar. So before we get started on the actual, actual content, I wanted to do a few introductions so you know who we are.

From the JSI team, we have two members today myself and Yvonne Hamby. I have been with JSI now for a little bit over six years. And I am currently the Project Manager for the Capacity Building [00:02:00] Assistance Project funded through the CDC to provide capacity building assistance to community based organizations throughout the US to assist with a few different topics. I'll talk about that in just a minute. Just wanted to say hi and I'm from Argentina so if you notice an accent that where, that's where it's from. I'll now let Yvonne introduce herself.

Yvonne: Hi everyone. This is Yvonne Hamby. I'm also with JSI and I've been with JSI actually next month it will be my 15 year anniversary. And so I'm really excited to celebrate that. And I've actually worked with a lot of people that might be joining in on the webinar today through our Region I Infertility Prevention Project that's now shifted to the Sexual and Reproductive Health Prevention Training and TA Center. That's a long name. And that's funded through the Center for Disease Control STD prevention program. And one of our main areas of focus is to and I guess I should stop and we'll say a little bit more about that, but it's to help STD programs and public health lab shift towards a billing in reimbursement system. So it's nice to be with everybody.

Alexia: Great. Thank you so much, Yvonne. So Yvonne gave a little bit of an introduction about the, the project she's on as well. And so I switched the slide here to let you know a little bit also about the Capacity Building Assistance project. So as you can tell, this webinar is a partnership between two projects; the Capacity Building Assistance project funded by CDC for community based organizations who do HIV prevention work and by as Yvonne talked about the SHRPTTAC project [00:04:00] which is for region seven and eight STD related reproductive health training and TA center.

Under the capacity building assistance project, we provide technical assistance and training to community based organizations around the three topic areas that are listed on the slide; monitoring and evaluation, organizational infrastructure and program sustainability and then how to select, adopt, implement and evaluate effective behavioral intervention. And as obviously the, the shift with high impact prevention, now we're not only focusing on behavioral intervention. So we're also focusing on biomedical interventions and other interventions as well. Yvonne, did you want to say anything else about your project?

Yvonne: No. I think that, that's one of our primary areas of focus as well as continuing to work with our STD program partners to utilize data to plan and provide quality STD prevention and treatment services. And so those are our two main areas of focus with this project as we move forward.

Alexia: Wonderful. Thank you very much. So welcome everyone that is on this webinar. As part of the content and information we will be presenting, we're partnering with R.T Welter & Associates and both Lou Ann and Hilda Delgado are on the line and so they will take a, a minute each to introduce themselves. Lou Ann, Hilda?

Lou Ann: Thank you Alexia. Hi. This is Lou Anne and I am very pleased to be here with you all today. Just a brief introduction about us. R.T Welter & Associates is a consulting firm based in Denver, Colorado and we work with all types of healthcare providers and facilities. We have a billing service [00:06:00] in our organization that actually does full service billing for providers. We specialize in helping health care providers improve their business practices and sustain their business models long term.

And I work mostly with safety net providers myself, with rural and urban clinics and hospitals that serve underserved population. We've been working over the last year with the Colorado Department of Public Health & Environment, our

state health department here in Colorado to help Title 10 agencies learn how to code and bill and get reimbursed from third party payers. And now I'll turn it over to Hilda so she can introduce herself.

Hilda: Thank you, Lou Ann and thank you everyone for participating. Yes, my name is Hilda Delgado and I have, and I'm a part of this webinar being the billing perspective, the management perspective. I have ran our billing service, that rate that Lou Ann was talking about and would like to just bring to the table some of that billing knowledge to this webinar. Alexia?

Alexia: Wonderful. Thank you both for that introduction. And just so you know, I'm going to be moving between full screen and not full screen. So if participants want to view full screen, you can just click on the bottom left of your screen and you can click on the full screen view so then you can see the full screen even if I'm not showing it at the time. So a few other logistic things again before we get started with the content. We will have a couple of interactive activities throughout the webinar. One will be polled and that will appear on your screen when we activate the poll. And we ask everyone to please participate and give us answers because it helps us to get a sense of where your organization is at.

And then the other function is the chat function. [00:08:00] And so if you view this screen right here, the chat function should be on your right hand side right here and if it's not activated you have a little icon on the top right, right where I highlighted that you would click and then you get the chat function open. And then if you can make sure if we're asking a question for you to answer, if you could please answer to everyone and then just make sure that this box right down here on the bottom right says everyone and then chat your response to everyone so we can all see what everyone is answering and then it becomes a lot more participatory.

If you have any technical difficulties or issues, then please make sure that you actually select just the host from this dropdown menu versus everyone. Okay. So at the end of the … towards the end of the webinar we're going to have a Q&A section. And for that section we're actually going to unmute your line. So anyone can ask a question via the phone line. If you, if you could please make sure at that point to mute your actual lines so then there's not so much background noise. And then we do actually welcome questions throughout. We love it when people ask questions as we are presenting the information. So if you have any

question as we're going through the content please go ahead and send those questions via chat.

And as much we can we'll answer those during the webinar today. If we're not able to answer them today, we will definitely create a Q&A website for everyone to go to, to get information answers to their questions. I'll talk more about that at the end of the webinar as well. Okay [00:10:00] so let's get started here with the actual content of the webinar. So first we have the learning objective. There are four main learning objectives for our webinar today. And the first one is to understand the billing choices that are available to your organization. Second one is to identify three to four cultural shifts to becoming a billing organization. And so as I said at the beginning we'll be talking about what does it entail for your organization to shift to bill and get reimbursed for services you provide because it is a big culture shift from where we are currently or where many CBOs are currently so an STD clinic.

Describe two of the key steps involved in the pre visit state of the revenue cycle, both Lou Ann and Hilda will be talking about the revenue cycle and in this webinar we're going to be talking about the pre visit stages. And then in the follow up webinars we're going to be talking more about what it entails and the visit and the post visit stages of the revenue cycle. And then our last learning objective for today is to differentiate between credentialing and contracting. So if some of these terms are not familiar with you don't worry. They will be by the end of this webinar.

So first a little bit about why we're doing this webinar. Why is it important? As you can see here the affordable care act so with the passage of the Patient Protection Affordable Care Act the traditional safety net providers that have historically provided free or low cost health care services to public financing may face shift in funding. Under the provisions of the Affordable Care Act the number of uninsured Americans is expected to drop. And so that we're expecting now to extend insurance coverage to about 30 million more people in 2014 [00:12:00]. In addition federal and state funding agencies increasingly want to ensure that definite services are utilized only as the payer of last resort. To sustain services, traditional safety net programs and that includes community based organizations, STD clinics.

They are diversifying their revenue streams by initiating or expanding third party billing of public and private third party payers. And so what I am guessing is that

probably many of the line are already transitioning towards billing. Some of you probably are right at the beginning just pondering about the idea of doing so. And then probably some of you already started. So we will be asking a poll question a little bit further along to see where you are in that continuum. So the primary priorities of the affordable primary Care Act are increasing the number of Americans with insurance coverage, decreasing healthcare costs and improving health status. So by ceasing opportunities for the advancement of community based care and prevention and working as partners with other providers.

Community based organizations and STD clinics can play an important role in the healthcare community. So this is very important that you are very crucial and important to the changes that are going on and to the community healthcare. So let's dive into a little bit more about some of the aspects of the global care action. This is the main reason why we are shifting towards looking, you know looking at billing. So one of the things of the Affordable Care Act is Medicaid expansion, currently there are about 26 states that will be implementing Medicaid expansion with assistance from federal funding through the Affordable Care Act. So it's you are in a state that is having Medicaid Expansion then that is really important to know and [00:14:00] especially of course if you're considering billing for your services.

So it's important to be aware where your state is at with the different pieces of affordable Care Act including the Medicaid expansion. Also on January 1st 2014 all states are required to operate health insurance market places. I'm sure everyone has heard a lot about this on the news lately since there has been a lot of talk about the electronic online market places. Either they can have their own … either states can have their own health insurance market places or they can participate in the federal market place. And this is where an individual or a small business can compare the cost with various health plans and different types of health coverage benefits and make decisions on what health plan they would like.

Two, if you're a health planner and you'd like to participate in the market place you need to make sure to be what they call a qualified health plan because there are certain requirements that you need to meet to be able to be part of this market. So this is very attractive for a health plan and so the Affordable Care Act requires qualified health plans participating in their places to include in their net worth a sufficient number and geographic distribution of providers that serve

predominantly low income medically underserved individuals. These are referred to as the Central Community Providers, CCP what you see there. So you should check to find out if you qualify as an ECP. Please, not that while in qualified health plans are required to include ECPs in their network they are not required to use all essential community providers.

So even if you are an essential community provider doesn't mean that a qualified health plan has to contract with you but [00:16:00] what is really important about this is if you are an essential community provider then you have an advantage to be able to contract with health plans. So there is a research here at the bottom of the, the slides. The Center for Medicare and Medicaid services list of essential community providers. So if … so I'll highlight that but if you go to this length right down here you can check if your organization is listed as an essential community provider. So designation as an essential community provider provides you with a valuable opportunity to serve your local population by participating in low cost competitive comprehensive qualified health plan option.

And as I said this will allow you to continue many of the uninsured clients you currently serve who will purchase coverage to the market place many of whom will be eligible for tax credits through the market places if they meet income criteria. So again it's, it's important for you to find out where your state is at if it is expanding Medicaid. It's important for you to look at if you are an essential, if you are an essential community provider. And all these pieces I think as you're moving towards conserving or as you're moving towards billing for services this is important to be aware of.

Yvonne: So as, as Alexia said the decision to bill or not to bill on the surface seems like a simple question but it's, its answer remains terribly complex. The desire to bring in a reliable and constant source of revenue is tempered by the energy and resources needed to create an effective infrastructure for such an endeavor. [00:18:00] so I think is at the point that we're trying to help everyone start at an important component when transitioning to being a billing organization as the culture will change. This livens some of the questions that are important to contemplate prior to making a decision about moving towards your billing system. Billing might not fit in with the culture of your organization. And if that's the case then a transition would not be successful even if all the systems are set in place to do so.

Alexia: So just quickly going through some of these questions with you as you look at this list it's very important for your organization to spend significant time looking at what is your current mission, what, what is your current purpose. What are you there to do? And figure out as Yvonne said, "Will the transition towards billing affect your mission?" will it enhance your mission? You know how, how will it work with what you stand for? And I think it's a very, very important step for all community based organization and STD clinics to go through as they're contemplating doing this. So for example some of the questions that you might want to look at or what are the needs of your community? So that's the primary one, what do they need? What do your clients and patients need? And then from that decide okay what are you going to provide?

What programs and services do you currently provide and then looking at do you want to expand those services. So for example if currently you're doing say HIV testing and you're looking at billing for your HIV testing services [00:20:00]. You might also want to look at who's the provide … who's providing this HIV test and if so can you bill for them? and if you need say a provider, a licensed provider to be providing this test who'll then be able to bill for it then you might actually want to add some other services that that provider could also, could also provide to the community. So when you're looking at transitioning to being a billing organization you're not only looking at what do we do currently do and how does that fit. But how can we transition entirely as an organization to become a billing organization.

What other services can we provide that meet the community needs? So just some examples, how can you adapt to meet community needs? What models are available to promote sustainability? You look at the rest of these questions but I think let me set upon these bottom two here and please Yvonne chime in. how do you have conversations with your clients about money? This is a really important question. I think many times when we think about transitioning towards billing or get reimbursed for services we look a lot at our programs and our processes. But we don't think sometimes of how will it affect our clients and patients? We'll be, be able to have a conversation with them about, you have a co pay. This is how much you owe or if they're not paying sending them a letter and saying you owe us this much.

I mean all, all those conversations and pieces will affect your staff and how they interact with clients. And it will affect how you, you manage your programs and will also obviously influence your, your patients and clients as well. So a very

important question there. And then how will you adopt best business practices for receiving third party reimbursement. We'll be touching up on that a lot more throughout this webinar.

Yvonne: Alexia I just wanted to go back [00:22:00] to the question about how to have conversations with your clients. And I think you touched on this as well. It's also before you shift to even having the conversations with your clients that you know organizational or clinic leadership having conversations with their staff that there is going to be this shift. Hopefully those conversations are happening all along this process of looking at culture with the whole staff. And I think with doing that I think our family planning partners have some good models and lessons learned that I think could be shared with our HIV CBOs and STD clinics as they move along and moving through these questions to, to kind of help guide that process.

Alexia: Great point, Yvonne. Thank you for sharing that. Okay so now we want a little bit of interactivity from all of you. So if you could please take a couple of minutes and chat your answer. So open your chat and make sure that you send your, your chat to everyone. So everyone's highlighted on there. And answer this question, "Do you think billing third party payers may or will fit the culture of your organization? If yes why? And if no, why not?" okay so we have a few answers coming in here. "Not at this time as we're not a Medicaid expansion state." Okay so we will talk a little bit further on about different models. Actually the next line we'll be talking about billable [00:24:00] models. So billing Medicaid is one but then there are other models that you can also look at if you're interested in billing or getting reimbursed for services.

I have another here yes we have already began. Great, no because if they have third party insurance they will go to primary care physician rather than a state clinic. Okay so I think for that one it's again in the billable models we'll talk about next. We can … we'll be talking about partnering with primary care physicians and others. So you can make sure that you are looking at some, those other models. Okay I see a few of you have currently begun that is great. And then here I see one that says, "No, the population that we work with don't usually have income."

So, just a thought on that is that you can look at partnering potentially with another organization and get reimbursed from them for your services versus billing your clients. So you don't always have to bill your clients directly. You can

also look at other models. And I felt it's great to say you know what, its billing does not fit with our mission. It doesn't fit with our, the population we serve so we will not do it. That's another great another good choice if that's the case.

Yvonne: There's one come through privately that said, "Yes they are in the DC area with strong models and have begun this planning in conjunction with their strategic planning.

Alexia: Great, great. So it sounds like people are I see a lot of us fans are the people that have already started [00:26:00] looking at this and getting started on it which is great. Right people we started the chat. We got a question about will we share links to the family planning models that we had talked about? And actually we do have in the resources at the end. We do have a link to some of those models and resources. And then of course we'll give you our contact information so you can always email us if you need more information. Thank you everyone for participating on this chat. It's really helpful to get your answers and see where you're at. As we were going through some of your responses I mentioned that we have this hand raised. Oh okay I see a hand raised.

Barbara: Barbara.

Alexia: Barbara, so Barbara we are un-muting since you raised your hand. Do you have a que, a question or comment at this time?

Barbara: No, I just had a frisky mouth, sorry.

Alexia: Oh okay, no problem great but we'll go ahead and mute you again. And just so you know that is an option. If you do if you cannot send a chat for any reason and you want to participate please do raise your hand and we can always un-mute your line. So let's go ahead and move forward to the billable model. So I mentioned this briefly previously in the discussion. So what I'm introducing here are just some examples of different models that you can look at. So, the first one includes establishing a contract with a federally qualified health center or other clinic or another partner.

The second one is billing the state directly for the Medicaid services. Then the third model talks about providing direct services that are billable by either Medicaid or other third party payers and other third party payers being health plans in this case. So what we've done here is list a few key steps [00:28:00] needed for each of these billable models. This is not an extensive or exhaustive

list so there are other steps that might need to take place but it's just a good framework to give you an idea of okay, what would it entail to follow one of these models. So for the first one and they go from less complicated to more complicated or more complex as you go through.

So the first one, establishing a contract with a fairly qualified health center or clinic or other partner, some of the key steps entailed in that is to establish a formal partnership with that fairly qualified health center or clinic, determine services that can be built through the FUHTR clinic. And so for example if you're providing say linkage to care services, if you are either an STD clinic or a community based organization providing HIV services and you provide currency linkage to care then you could look at an SQHC that you're linking those patients to getting … see if they could get … give you payment for that actual linking services that you're providing.

So it's really important to look at what services you provided and what services would an SQHC, a fairly qualified health center or clinic be willing to pay you for and so that of course entails having those conversations with the SQHC, establishing that partnership. Then it's important for you to establish value for each of your service. This is a component that many times … that is it's extremely important and it's hard to do, determining what is the value for that service?

So what should you be getting paid for providing that service? And [00:30:00] Lou Ann and Hilda from R.T. Welter & Associates will be talking more about that component as we move forward. Then keep track of services provided, very important. You need to document all services that you provide and make sure that you're keeping check of them, not only so you can get paid for them, but also because it's a good practice. Then you need to establish some kind of system to invoice to probably qualify, health center, the clinic, your partner for the services provided. This does not need to be a very robust system. It can be a pretty simple system. So this first model is definitely the easier model to get in place.

The second one, build the state for Medicaid services. So some of the key steps involved in that model are determine the providers and services that are reimbursable by state Medicaid, determine medical codes and establish systems to track services provided. One of the things that's really nice with Medicaid is that yearly state Medicaid establishes what, what are the rates that they're going to reimburse you with

and they're very clear about which providers and services they cover. So it makes it easy for you to determine okay, do I provide those services? Do I have those providers and how much am I going to get paid for that service?

So even if the paperwork might, there might be quite a bit of paperwork to become, to be able to build Medicaid. What's nice about it is that you don't have to worry about establishing that value or that rate that you'll get reimbursed by. So in a way it makes it slightly less complex. And then of course you would bill the state directly for services provided. And for doing that, you, you definitely need a rudimentary process in place, but it doesn't have to be as robust as when you are [00:32:00] billing to, other third party payers.

And the other point on here, establish systems to determine Medicaid eligibility for clients and patients. Medicaid has typically an online website you can go to and you can check people's eligibility. So obviously that's another step that you would have to look at and looking how you would establish that, how you would check eligibility for patients or clients coming in. And just keep in mind that this is just checking if they're eligible. It's not helping them get Medicaid. That's something that you can choose not to do and it's a lot more complex and typically you can refer them to like social services or refer them by a health center than can help them with that step. So just food for thought.

Okay, the last billable model on here is filling Medicaid and other third party payers. And I, I listed a small note in there that when, when we, when we look at all the systems you have to be, have in place to bill, one of the options you can consider is actually outsourcing your billing. So there are billing agencies that you can outsource your billing to that facilitate that whole infrastructure. So you don't need to have that infrastructure in place. You need to definitely keep track of the services you're providing and have the value for what you're providing and a few of these original steps that you don't need to have the whole infrastructure for billing in place in house. So that's an option to consider there.

But beside that, the key steps entailed in this third model are determine reimbursable providers and services, same as with Medicaid, but for ser, other third party payers you do need to determine what your rate is going to be and that's what makes it a lot more complicated because you need to make sure that you are establishing a value for each of your service [00:34:00] and, and you know that just adds extra planning of course. Then same as with billing Medicaid, you need to determine your medical codes and establish a system to track

services, establish a system to determine third party payer for clients and patients.

So how are you going to determine what insurance they have and so forth? And then with other third party payers, many times there's actually a co-payer and a fee involved. So here is where there's a big culture change of asking people for money and this you might decide to do this or not. So definitely could be collecting co-pay involved, and then finally billing the actual Medicaid or other third party payer for the services provided. And again, having that infrastructure in place can be a decision of yours, but you could actually outsource it if it's easier.

So I briefly covered these models. what we're going to do is actually go into a lot more detail about mostly the model number three, what is the infrastructures and pieces you have to have in place to bill? Well, both two and three. So bill Medicaid and other third party payers. That's what we'll be talking about more in the rest of this webinar. So as you see these models, if you can take now just again a couple of minutes to answer the poll, I'm going to open the poll right now. And so what you'll see on your screen is on the right hand side you'll have the poll questions.

So which model do you think best fits the culture of your organization? So if you can click on the circle of the answer that best fits you. So shifting to billing for services does not fit with the culture of my organization. Model one, [00:36:00] establish a contract with FQHC, with a fed, federally qualified health center or clinic or other partner. Model two, bill the state for Medicaid services. Model three, bill Medicaid and other third party payers directly. The fifth option on there, E, is outsource billing. So it would be billing Medicaid and other third party payers, but actually outsourcing the billing for that. And then the last option, F, is another model that's not listed in these examples.

So please take a few minutes and select your choice. Okay. So the poll close. So we have about half of you that responded. So if we look at the responses here, we see that … let's see. A majority of you that answered are looking at model number three, billing Medicaid and other third party payers. Then a few of you are looking at maybe establishing a partnership within FQHC or just billing Medicaid itself. But it's great to see that the majority of you are looking at billing Medicaid and other third party payers. So that's what we're going to dive into more as, as we move forward.

Here's a quick overview of some of the question, some of the providers and services that community based organizations and/or STD clinics might provide that you can look at billing for. And these providers and services [00:38:00] and when I say billing, you can look at billing either through one of those models that I talked about. So either through a partnership with an FQHC or clinic, billing directly Medicaid or and other third party payers. So here when you look in the left provider, mental health providers, dental providers, licensed clinical social workers.

There's a list of medical providers on here and depending on your state, depending if some of these providers are covered as billable providers. So for example I know that some states LPNs are licensed practitioner nurse. Some states cover services that are provided directly by an LPN versus other states do not and the service actually has to be billed through either registered nurse or a nurse practitioner or someone else, and same with medical assistance. So it really depends on your state and what providers can bill and which providers cannot.

So it's very important for you to get that information. If you go to the … specific for Medicaid, if you go to the state, your state specific Medicaid page, you can look there at providers that are covered and what services could be reimbursed for. Hilda and Lou Ann will talk more about as far as other third party bay, payers' health plans. Yvonne, would you like to add anything about those services?

Yvonne: No. I think you covered them really well, Alexia.

Alexia: Okay, great. So now I am going to transition over to Lou Ann and Hilda and they are going to be talking more [00:40:00] in detail about the actual infrastructures and processes you need in place for billing for services.

Lou Ann: All right. Thank you, Alexia and Yvonne. So as we saw from the poll earlier, we have some organizations on the webinar today that have already started engaging in this process of billing third party payers and some who have not taken those steps yet. But regardless of where you are in the process, as you begin to engage in a start, strategic decision making process and decide to accept insurance and submit bills or claims to insurance companies for payment, if this is not something that you've historically done in your facility or maybe

you've engaged in this minimally, the revenue cycle management process brings about a significant change in your culture.

We've already talked about this a little bit, that you'll transition from being considered a free clinic so to speak to an organization that functions as a medical practice, collecting payments for services upfront at the time of the visit when the patient comes in and then billing insurance companies and receiving reimbursement from them. So as health reform is implemented and an increased number of your clients or your patients, and we'll use the word client and patient interchangeably on the webinar today, in order to sustain your business long term, you'll need to understand the business of healthcare.

Healthcare services are not free. It is not intended to be given away. Complete dependency on grants and other program funding are really not a sustainable manage for the future, even if you are a safety net facility that serves the underserved, especially now that the health reform law has been passed. Most healthcare providers charge for their services upfront like any other business, even retail. So think about your patients or your clients. They're your customers. Who are they? What do [00:42:00] they need? What are the products and services that you offer?

What is your pricing structure? How do you, how do you charge for your services? How do you figure out how much to charge? Are you being paid fair market value for the services you provide? What's your pricing structure? How do you document the services that you provide? In healthcare as you're going to hear about later, if it isn't documented in the medical records, technically it didn't happen. You provide the service and then you document the service, then you charge for the service and hopefully you get paid for the service. You want to obtain payment for your services and you do this by collecting from clients or billing insurance.

And you'll track your payments through an accounts receivable process by balancing payments to receivables. And carrying out this whole process is revenue cycle management. The graphic on this slide demonstrates the components of the revenue cycle management process. According to the field shown, the cycle is broken down into activities that happened before the client visits, during the client visits and then after the visits. During today's webinar, we're going to cover some of the basics of the components of the revenue cycle

management process that occurred before the visits and that's the blue section that you see on the wheel.

Alexia: Okay, great. So before we dive in more into this information, we wanted to run another poll and wanted to kind of get a sense of if your organization currently has contracts with Medicaid or with other third party payers. So give me a second. So I'm going to open a new poll here. [00:44:00] Oh actually Hilda and Lou Ann, could you pass me the ball again please? Thank you very much. Okay. So … okay, so here we go. I am going to open this poll and we are going to give you two minutes to answer the poll. Okay, so now you should all be seeing the poll in your right hand side.

So if you could choose an answer just to give us a sense of does your organization car, currently have contracts with Medicaid and/or other third party payers? Yes, no, not sure, not applicable. Okay, great. If we can take, let's see, one more minute. It shows we have about 70% of people answered. Let me give you a few more seconds. So does your organization currently has contracts with Medicaid and/or other third party payers? Okay, I'm going to go ahead and close the poll now and we'll be displaying the answers to everyone in just 10 seconds [00:46:00]. Okay.

So you should see the answers now in the right hand side. Okay, there we go. So most of you I think you were about, almost half and half, a little bit mo, a little bit higher on the yes's. So many of you are actually currently have contracts with Medicaid and/or other third party payers, which will make it a lot easier and then about half of you no and then a few of you are not sure. Okay, great. This is really helpful for us to know as we move forward with the rest of the information. Okay, I'll pass it back to Hilda and Lou Ann.

Lou Ann: Okay, great. Thank you, Alexia and thanks to all of you for, answering the poll. So we'll ta, let's talk a little bit about contracting with health plans. If, if you're one of those agencies that answered the poll yes that you do contract with Medicaid or, or third party payer, other third party payers, then you've probably already discovered how complex this process is and it can be a little bit intimidating. We want to make sure that you have the basics about contracting with health plans, what this means and what some of the types of plans are.

There are several different types of health plans on the market. You've got your public plans which are Medicare and Medicaid that are administered by the, by

governmental agencies. And then we have private or commercial insurance and then we have a small percentage of other and other includes Tricare. You might have some kinds of, some kind of local coverage that are available in your state or in your community. There also quite are quite a few different types of products and each health plan itself may offer a myriad of different [00:48:00] products.

We'll walk through some of these more commonly known health insurance products quickly. An indemnity plan is the type of medical plan that reimburses the patient and/or the provider as expenses are incurred. This is the most flexible type of health plan. The services are reimbursed regardless of where they're provided or who the provider is. So there isn't really a set of provider networks that's set up that you have to utilize. Reimbursement under indemnity plans might be based on a percentage.

For example the plan might cover 80% of total charges and then or also might pay a total per diem amount per day. And then your Health Maintenance Organizations or more commonly known as HMOs are healthcare systems that assume both the financial risks associated with providing comprehensive medical services, the insurance and service risk and the responsibility for providing the delivery of healthcare services in a particular geographic area to the HMO members.

Usually this is in return for a fixed prepaid pee, fee, excuse me. And one of the most widely known HMOs that you're probably all familiar with is Kaiser Permanente. A Preferred Provider Organization or a PPO is actually an indemnity plan where coverage is provided to participants through a network of selected healthcare providers such as hospitals and physicians and ancillary services. The enrollees in a PPO may go outside the network, but if they do, they usually incur larger costs in the form of higher deductibles or higher copays or non-discounted charges from the providers.

So basically the provider with, that sees the patient outside of the PPO network would be paid based on a lower fee schedule. And then a Point of Service is an [00:50:00] HMO PPO hybrid. These are sometimes referred to as an open ended HMO when offered by an HMO. Point of Service plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a similar manner to a conventional indemnity plan. So the

provider is reimbursed based on a fee schedule that's based on usual customer reasonable charges.

And then through Private Fee for Service Plans, providers are reimbursed negotiated payment amounts based on volume. In addition, there are performance based Fee for Service Plans out there today through which payments are negotiated based on volume plus additional incentives for managing costs, quality and patient experience. The Medicare Pay for Performance Program is a great example of a performance based Fee for Service Plans.

In addition to different types of health plans and different types of health plan products, there are different types of contracts that health plans may wish to execute with you. Health plans vary greatly with regard to the options they offer for contracting. Some plans may offer one group contracts for your entire practice or clinic and all the services provided to the covered members would be billed under one contract and one provider number for your facility.

This can be of great benefit to a community based organization that is not staffed regularly by licensed providers because it makes it easier for you to bill for different levels of visits, like nursing visits. Many health plans will only agree to contract with licensed individual providers though and in this case, a physician or an advanced practice nurse would most likely be required to hold the contract with the health plan. Some health plans will sign one contract with [00:52:00] your agency and then will include a list of your licensed providers as an addendum or an attachment.

A good way to find out about the health plans that are available in your state is to check out your division of insurance or department of insurance. Every state has a department or division of insurance that is responsible for overseeing all the insurance companies and health plans that are licensed in your state. So now we'll talk a little bit about some of the nuts and bolts of health plan contracts and the key components that you'll see in a contract. There's usually a section at the beginning of the contract that provides definitions for terms that are going to be used throughout the agreement. You want to make sure that you watch for subtle hidden language distinctions. Here are a few examples on the slide; a clean claim.

A clean claim should be very basic and defined as a standardized claim form with required fields completed. Anything outside of that or in addition to this might be a red flag and might result in your claims getting rejected or your payment being delayed. The contracting payer; this definition should cover exactly who, which health plans, employer groups or third party administrators will have access to your negotiated discounts under the contract. Sometimes health plans will try to include other entities in the contract and you want to make sure that you don't allow that.

This is important and it prevents the health plan from being able to basically rent out the provider network which you're participating in to other entities without your knowledge. And then covered services; you want to review the definition of covered services carefully as well as the definition of healthcare services if they're both included. You want to make sure that you are required to accept a health plan discount only for covered services rather than all healthcare [00:54:00] services.

Notifications of policy changes; this definition would describe how the health plan is going to notify you of policy changes. And you want to make sure that in the contract, the health plan is required to provide you with advanced written notice of any policy changes. We would recommend 30 days as a reasonable timeframe for this. The contract also will outline the obligations of the health plan and it will also outline the obligations of the provider. And so you want to make sure you read those carefully. You want to make sure that any provider obligations are obligations that you can easily comply with.

Some of the typical health plan obligations that we see and that we want to make sure that you're watching for, you want to make sure that the health plans provides its members with an ID card. That's going to be important. You want to make sure that the health plan provides you with fee schedules and addresses how fee schedule changes are implemented. You want to make sure that the health plan is obligated to process payment in a timely manner. We would suggest that that happens at least within 30 days.

You want to look for an obligation on behalf of the health plan that they're going to give you electronic access to electronic claims submissions, referrals, eligibility and benefits verification. You want as much of that to be automated as possible. And also you want to make sure that the health plan agrees to a timely credentialing process, that they're going to get all your providers credentialed

and up and running with their health plans so that you can be paid promptly. And that timeframe should be 90 days or less. And we're going to talk a little bit more about credentialing in a moment.

And then when it comes to provider obligations, some of the things you want to look for are specific office req, hours required in the contract. Can you meet those requirements? Is on call coverage required? Not very many of our local public health [00:56:00] agencies, CBOs or STD clinics provide after hours on-call coverage. So you want to make sure that that's not an obligation, that it's in the contract. Claims sub, submission requirements should be standard. You want to make sure there aren't any special or non-standard requirements for submitting claims.

Check and see if there's anything in the contract about medical records. Ha, what does the health plan expect as far as accessing your medical records information? And make sure that you can comply with that. You want to always ask for a provider policy manual from the health plan and make sure you review that manual before you sign the contract. And also another thing to keep in mind, see if there are any minimum liability insurance requirements in the, in the health plan contract and make sure that you have the liability coverage to meet those requirements before you sign the contract.

This slide just provides you with a list of unacceptable contract provisions that you want to look for. We've already talked about a lot of these. But we're providing you with the slides. Maybe you can even print out this list, keep it with you as you're reviewing contracts. Make sure that you don't sign a contract that has any of this language in it. And like I said, we've covered a lot of this. A couple of things just to mention here. Number five, any reference to most favored nation. You want to make sure that you don't sign a contract with that language in it because that, that basically requires that you are going to give this insurance company the, the greatest discount over any other health plan that you contract with.

So you don't want to sign a contract that has that language. Also you want to make sure that the health plan is not able to amend the contract without your signature. Any amendments or changes should be in writing and that should be described in this contract and that's number nine on the list.

Alexia: And Lou Ann, just to add, in case anyone had a question, [00:58:00] we will be sharing the slides with everyone. We'll send them to you via email after the webinar so you will be able to, to have access and print out this, this list if you need to.

Lou Ann: Oh great. Thank you, Alexia. Okay, so moving on, we're going to talk a little bit about negotiating fees. So when you're contracting with a health plan, and this, this applies to Medicare and Medicaid as well, our public health plans. You know, in addition to the private commercial plans, what you're doing when you agree to participate in a health plan or you contract with a health plan, if you're getting, you're basically getting free marketing from that health plan. They're going to put you on their provider list.

You are going to be considered an enrolled provider in Medicare or Medicare or you're going to be considered a contracted provider, part of the network of the health plans that you contract with. And in return, when members that are covered under those health plans are looking for a provider, your, the name of your facility, your clinic or your providers are going to come up. So you're basically getting free marketing from that health plan. In return for that, the health plan expects you to agree to a certain fee schedule or a certain reimbursement rate that you're going to receive for, from them that's going to be set.

And you're going to know what you're going to, what payment you're going to get from the health plan. So one of the most important components of moving into this process of accepting insurance is figuring out how much it costs you to provide services. You have to have a fee schedule that you understand and you have to be really aware of what your costs are in order to be able to go to the health plans and negotiate a fee schedule that makes sense. The first step in negotiating fees is conduct a cost analysis internally so that you can understand your costs.

And we have some great resources for you related to how to conduct a cost analysis. JSI conducted a three part webinar series this summer on how to conduct a cost [01:00:00] analysis. And Alexia is going to provide you with the link to the website so that you can access those resources. There are three webinars. There's a transcript and a recording for the webinars and there's also a cost analysis manual that you can download. The training was designed

specifically for title 10 for family planning agencies, but it is applicable actually to any provider who's interested in doing cost analysis.

So once you've analyzed your cost and you know what it's costing you to provide services, then you set up a fee schedule for your services. And you can do this simply by using an Excel spreadsheet and lifting all of your CPT codes on an Excel spreadsheet and then the costs, the, the average cost that's associated with those services. And then when you go to the health plan to negotiate, you're going to keep that fee schedule in mind that that really reflects your actual costs and you're going to start high.

If you've ever bought a new car or negotiated for anything that you've purchased in life, it's the same concept. You always want to start high. You want to give yourself some negotiating room because the health plan will come back to you and they will try to negotiate and try to talk you down from where you start. So you want to always start high. A couple of tips. You can share with the health plans that the fees that they're offering you are a lot lower than other plans based on your fee schedule analysis. Let the health plan know that you've conducted a cost analysis and that you know what your costs are and that you're not willing to take a loss by participating in their plan.

You can communicate that to the health plan. And then make sure that you're prepared to wait and wait and wait, because those of you who have been participating in this process already, you know how this works. If there is a provider relations representative who's in the field working with providers and working through this contracting process, but that provider relations representative is not the decision maker. The decision makers are back at the health plan.

And so you sort of have a liaison that goes between [01:02:00] the provider and the health plan and there's a lot of back and forth. And sometimes it might take three or four weeks, maybe more for the health plan to get back with you. So just be prepared for that timeframe. Sometimes they can take up to six months or more to get to a place that you're satisfied with, with the fee schedule and get that contract signed. You want to be prepared to negotiate as I mentioned earlier and always remember that you're not obligated to sign a contract with the health plan.

If you're not satisfied with the final fee offer from the health plan, just consider discontinuing the contracting process, especially if this contract with the particular health plan is going to bring you a fairly low volume. If you're anticipating that it won't be a really high volume of patients, you might consider just dis, discontinuing the contracting process and you would be considered an out of network provider which Hilda is going to talk about in a few minutes.

So now we'll talk a little bit about credentialing. There are two different components to working with health plans; the contracting process and the credentialing process. And these are two totally separate things. That you want to make sure that as you're engaging in the contracting and fee schedule negotiations, that you're also thinking about credentialing and getting that process rolling. It's not too early to start the credentialing process, even if you don't have a contract to execute with the health plan yet.

In fact, we recommend that you start the credentialing process as soon as possible because it can take some time as well. Credentialing is the process of verifying and validating the background and qualifications for providers. So the health plan is responsible for making sure that you as a facility or a clinic and the providers who work with you are who you say you are. So they have to go … they have to go behind the scenes and verify primary source, with primary source [01:04:00] verification, the licensure and training, a practice coverage, to confirm all the information that you provide to them as a provider.

It takes about three to six months in, and that's sort of optimistic to complete this process. One of the things that is of great benefit to providers today is the Council for Affordable Quality Healthcare, CAQH. Through CAQH there's a universal provider database that is used by most commercial health plans. And we've provided you with the website here. It's free of charge to providers. Basically how it works is an individual provider goes on the CAQH website and you sign in, get a login and password.

You can go into CAQH and you can enter the credentialing information about yourself that is going to be necessary to complete the credentialing process. And then the major health plans across the country can actually go to CAQH to download your information and use that information to complete the credentialing process. If you don't use CAQH, then you have to submit your information to each of the health plans individually over and over again. And so this, this process just makes it a little bit more efficient.

Then with Medicare and Medicaid, credentialing is a little bit different. It's direct enrolment, which means that you do have to fill out a provider application form and make sure all your T's are crossed and your I's are dotted and get that into Medicare and Medicaid so that they can process it. So remember that credentialing and contracting are ongoing process. This is not … processes. This is not something that you do one time as you're getting started with ace, accepting payment from health plans and accepting clients that are insured.

You go through this process of course to get it started and get contracted and get credentialed, [01:06:00] but then you don't just file all the paperwork away and never look at it again. Credentialing and contracting are something that you have to pay attention to on an ongoing basis. You need to be reviewing your contracts with health plans and fee schedules at least every two to three years, making sure that you repeat that cost analysis and check and see if anything has changed with the cost that you're incurring and providing services. Check and see what's happening with your fee schedules.

If you feel like there's still a fair market value. If not, you can go back to the health plan to renegotiate. CAQH actually requires quarterly attestation for credentialing. So providers have to go on to the CAQH website every quarter and attest that nothing's changed related to the information that's loaded into the CAQH system about credentialing. You have to make sure that all of your new providers that are joining your practice are credentialed and affiliated with health plans. You have to get those enrolled and up and running and then you also have to make sure that re- credentialing requirements are met.

Most health plans will require that you go through a re- credentialing process about every two years where you have to actually update all of your information and get yourself re- credentialed so you can continue to get paid. So I'm going to turn it over to Hilda now and Hilda is going to talk to us a little bit about what it means to be an in network or out of network provider. But before we do that, are there any questions that we may be able to answer at this point?

Alexia: So if you have any questions you can send them via chat to everyone or you can raise your hand and we can unmute your phone. [01:08:00] I don't see anything at this time.

Hilda: Great. Then I will just keep going. Let me just change this to full screen. So thus far we've talked about some of the cultural changes that, that will take place in

your organization. We've talked about some of the business models if you will or some of the billing models that, that you may be able to implement. Lou Anne has talked about the contracting and crede --credentialing component. I want to dive in a little bit more into the in-network and out of network and what those terms mean both to you as an organization and to your clients or your patients.

So first, what, what does it mean to be in network? Lou Ann has already talked about this and explained that in network is one of, one, the term that's used when you have a contract to acc, accept a specific payment, a set rate for the services that you provide to the insurance or the plan member, your clients, your patients. That, that being in network as Lou Ann already mentioned has some benefits. You get added to their list of in network providers. To the patient, what that means is the services are less expensive than being out of network. If, if you've experienced this in your own, in your own health insurance plan, you're familiar with that.

Oftentimes for the clients or the co-insurance is higher if the provider in this case you are out of network. The co-insurance or copayment could be lower if you are in network. So I've already said this, but just for clarity's sake, out of network means you do not have a contract with them and you could choose to not have a contract like Lou Ann would say if you are not satisfied with [01:10:00] with the rate that is being offered to you or if that rate isn't enough to cover for your costs or for whatever other strategic reason that, that may be necessary for your organization.

So now I want a little bit … we've been talking about your relationship with the payers and how this is go … billing is going to impact your organization's culture, but now I want to talk a little bit and build a bridge to how billing and being in or out of network impacts your relationship with your clients.

Alexia: And Hilda, could I quickly add, just as an FYI, you can also be out of network provider with Medicaid health maintenance organization. So, with Medicaid HMOs it kind of works similarly to an actual commercial insurance where you could be in or out of network. Just as an FYI. Thanks.

Hilda: Okay. Thank you, Alexia. So I gave you example that if, if one of your clients comes to you and you are an out of network provider, the co-insurance or the copayments may be higher. And this is important for you to be aware of when you make that decision to not be in network. And it's also important for you to

be aware of while you're in the process of, of executing that contract and/or being credentialed. And it's important for you to communicate that to the client as well because you don't want your clients, none of us want their clients to be surprised by a higher copayment when they think that you may be [01:12:00] in network.

So some of the, some of the important things to consider are outlined in this slide. First of all you have to discuss payment or the higher charge with your client. So if you know that you do not accept that insurance and that insurance card that the client has that has been provided to them by the plan will outline what that copayment is. So you can notify the client at that time. You can also notify them over the phone or when they come in to make, make that appointment. Another thing to keep in mind is that some plans do not reimburse out of network providers.

Plans like an HMO is, is an example of they may not have out of network coverage. So if a client comes in that does not have out of network benefits, those services will not be covered even at a discounted rate by their insurance plan and the client will be responsible for the full amount of the, the charge. Another consideration is assignment. To receive assignment means you will be as a provider in or out of network, able to receive payment directly from a health plan. Whether you're in network or out of network, you must accept or the patient must give you authority to receive payment directly from the insurance company.

If assignments is not accepted, if you don't mark on that claim form which we'll talk about more during our next webinar, if you do not indicate there that you accept the assignment, that health plan will actually send reimbursement for your services to the patient, to your [01:14:00] client. Then your client has to give or, or turn around and make a payment to you. This is some language that ought to be included in your registration forms. And again we'll talk about some of these steps at our webinar next week, but make sure that you are accepting assignments when you send that claim information out to the payer.

This graph is familiar if you you've been a part of the webinar since the beginning. What we've covered thus far is some components of the pre-visit, that blue section. Primarily we focus, we have focused thus far on the administrative functions, the managed care contracting. We talked about credentialing and we're going to talk more about the actual patient scheduling,

registration and everything else during our next webinar. But what I'd like to talk about right now is … Lou Ann talked about the obligation that the plan has to provide an identifying card to the member.

That card has information for you to know, but a lot, a number of things and one of them is whether you're in network or not based on your contract. The other thing is that the pa patient or your client's coverage, what services are covered by their health plans? So I'm going to jump and talk a little bit about eligibility and benefits. And this next slide is a grid that provides information that you ought to obtain from that insurance card that is given to your, your client by the insurance. Some of the information you can gather is your client's name as the insurance has it listed; date of birth; address.

Oftentimes social security number is listed [01:16:00] on there and then the insurance carrier and phone number. We talked about the different plans and the different types of, of coverage that plans offer. So you may be contracted under let's say a PPO preferred network, but you may not be contracted with an HMO for example for the same carrier. So having that carrier phone number will give you the ability to know whether you are in network or out of network and therefore communicate that information to your client.

The ID number and group number for your client is necessary to determine what type of service they have and what type of coverage they have. Also understanding what type of information ought to be verified with the carrier before you, you treat and provide services to the client is outlined on the right side of this grid. Some of those items include whether authorization is required for the services you provide or a referral, any deductible that may apply. And we've already talked about being in network or out of network which will impact copayment as well.

Those cards are also helpful because it tells you where that claim form needs to be sent and how, whether you can mail it, or you can fax it or it could be sent electronically or not. Again we'll talk more, in more detail in the practical steps collecting this information during our next webinar, but I just wanted to give you just a brief list of items to, to keep in mind. Now, while we haven't discussed all [01:18:00] of the components on this slide, we have heard from you that you … that at least 40% of you are currently billing for services or interested in billing Medicaid and third party carriers.

And if this process is overwhelming in any way or, or it's completely new and, and challenging, please know that any, most components, any one of these components on this slide can be outsourced to third parties. There are third party billing services that, that can do this or clearing houses that can check eligibility or send claims to payers for you and, and interact directly with payers. There are other services that can print statements for your clients and also, consultants that can help you with the contracting and credentialing piece if this is unfamiliar territory for you.

Alexia: Great. Well, thank you so much Lou Ann and Hilda for presenting that information. I think it's great to start putting the bricks or laying the bricks for, for the rest of the information that we're going to be presenting next Tuesday which will really hone in more into a lot of the infrastructure that you need to have in place for, part of it for the pre-visit, most of it for the visit and the post visit. So at this time before we share resources, we would like to see if there's any observations from those of you on the line or any questions.

And so if you have a question that you would like to do via phone, if you could please raise your hand and we can go ahead and unmute your line or if you have a question or observation you would like to share via the chat, if you could please do that at this time as well. [01:20:00]. Okay, I see Barbara.

Yvonne: It's the same one.

Alexia: It's the same one from before. Okay. Anyone else? Let's see. We'll go ahead and unmute the lines for everyone.

Yvonne: We do have a question from, from Nick. He asked, could you elaborate on the implications of being a classified ECP?

Alexia: Oh, okay, great. So we have a question from Nick talking about what are the implications of being a classified Essential Community Provider. And I'll chime in and Lou Ann if you want to chime in as well. Basically if you're an Essential Community Provider and you're on that list, because to be a qualified health plan that's part of a marketplace, you need to contract with, with at least a specific amount of essential community providers. So by being on that list, your chances of contracting with a health plan are a lot higher. Lou Ann, did you want to chime in?

Lou Ann: Sure. Yes and the list that Alexia is referring to the Centers for Medicare and Medicaid Services, CMS at the federal level actually came up with a list of what they would consider to be Essential Community Providers. And that list includes safety net providers like clinics who participate in Ryan White HIV/AIDS Programs Title 10, all the federally qualified health centers, certified rural health clinics are on the list. And you can go on the CMS website and check the list to see if your agency is listed on there and we can provide you with that website.

That list is not exhaustive however. That's [01:22:00] just … it's a list that CMS that came up with to try to help classify what EC, how ECPs would … what agencies would be considered ECPs. Each state actually has the authority if they so choose to develop their own definition for an Essential Community Provider. And for example here in Colorado where where we are, our state has its own definition of an Essential Community Provider that's being used for the purposes of our health insurance marketplace.

And if an agency would like to become an Essential Community Provider, there's a very simple, straightforward application process. So simply being on the list you are automatically considered an ECP, but there are a couple of steps that you have to go through. So I would encourage you all to check in your specific states. If your state is using the federal marketplace and has not developed its own state specific marketplace, then if you're listed on that federal list on the CMS website you should be fine.

If your state has its own marketplace that it's administering, you might want to double check and see if there are any additional steps you need to take to become considered as an Essential Community Provider. And as Alexia shared, each health plan has to contract with Essential Community Providers and it's sort of, it's sort of a way to ensure that low income and underserved populations are going to be served by the marketplace. So these … we don't have an exact number or percentage that's been set for how many Essential Community Providers the health plans have to contract with, but they do have to have some Essential Community Providers in their networks.

Alexia: Thank you so much, Lou Ann. Thank you Nick. We have another question from Jessica. Can you collect copay from a patient with insurance if you're an out of network [01:24:00] provider? Hilda, Lou Ann, would you like to answer that?

Hilda: Yeah. I would, I would love to. This is Hilda. Jessica, you can and you should. If you have the ability and know what the, your patients, your clients coinsurance is, regardless of whether you're in network or out of network, go ahead and collect it if you are able to. And we'll talk a lot more about collecting copays during the next webinar. But the short answer is yes.

Alexia: Great. Thank you.

Yvonne: And Alexia, this is Yvonne. I just wanted to do a little bit of a follow up around examples of services that would be covered or could be covered as we move forward with the Affordable Care Act and getting credentialed as a m provider with various insurance payers. And I just wanted to share that the Affordable Care Act requires group and individual private insurance plans to cover certain preventative health services either with or without copays or cost to the patient. And these include all services that receive an A or B rating by the U.S Preventative Taskforce.

So some examples specifically related to our STD program partners and, and potentially our HIV CBOs that are on, on the webinar are STD screenings for high risk populations and high intensity behavioral counseling to prevent STDs as well as HPV vaccine. So and that's not an exhaustive list. That's just … that was just some examples to kind of give you a sense of what they mean when they're looking at an A or B rating by the U.S Preventative Taskforce [01:26:00] and what that would mean for, providing a reimbursable service.

Alexia: That's a great point, Yvonne. Thank you. And HIV testing actually has an A rating. So that's definitely applicable as well as some of the others on this list. So that's very helpful. As we see if there's any other last minute questions that come up, I would like to also share with you another way in which you can submit your questions, because we know that this is a topic that might actually have a lot of more individual type questions versus general questions. We have created on our, on the capacity building assistance at JSI website, we have created a specific Q&A form.

And basically if you go to the link that is listed right here and you click on transitioning to building webinar Q&A, it will give you the opportunity to enter your name and enter a question that you have and we will be answering, monitoring this for the month of December and January and we will be providing answers to those questions. And those will be posted on that website. So you

can easily look at other questions that people have asked and answers to those questions. You can submit your own and of course you can always email us as well if you prefer to use that method.

I will be providing the email in just a second. And before that, let me just make sure to stress the importance of everyone filling out the evaluation form. We will be sending you the link via chat right now. So you can click directly on that link and it will take you to the evaluation form. If everyone could please spend … it just takes a couple of minutes and it really provides us important information for us for [01:28:00] future webinars. So if you could spend just a couple of minutes and fill that … that evaluation out it would be great.

So Morgan, just send the link to everyone via chat. So you can click on that. Also I have another question that came from Nick. It says, if you credential and then expand services before the next quarter, can you simply re-credential at that point after service expansion or wait until the following quarter? So Hilda and Lou Ann, would you like to answer that?

Hilda: Yes. Thank you. This is Hilda. The credentialing process is typically for the specific provider and their credentials. So if the provider is qualified to provide more services than what are currently provided within an organization and the provider itself has been credentialed, then you don't have to re-credential for additional services since that provider has already credentialed to provide services within their scope. Does that make sense?

Alexia: It made sense to me. We can … and Nick, it made sense to Nick as well. Great. Thank you. So last before we are at the hour. So again if you have other questions we'll be sending you the slides out. So please go ahead and either go to our website or you can email us at this, this link right here, cba@jsi.com or you can also go to the SHRPTTAC … if you're on that project you can go to the SHRPTTAC website and email them directly as well. The other resources listed on here are resources that we talked about during the webinar. It's a link to the Council for Affordable Quality Healthcare.

Then the following link, the cost analysis resources [01:30:00] is the resource that Lou Ann talked about that was put together for family planning Title 10 clinics, but it's very transferable and applicable to CBOs that are doing HIV prevention and STD clinics as well. So that's the link to that cost analysis work.

And then the last one is the National Association of Insurance Commissioners, the website that I think Lou Ann or Hilda mentioned.

So we will be emailing everyone that participated in the webinar today the, the slides and again the follow up webinar to this one will be next Tuesday. It will be December 17th at 1:00 p.m. Eastern Standard Time. And if you have not already registered for that, please go ahead and register and we will be sending out email with, with that registration to those who have not registered already. Thank you and thanks again for participating in this webinar and thank you so much for the presenters to Lou Ann, to Hilda and Yvonne. Bye now.