safety net SOLUTIONS *A program of the DentaQuest Institute*

DentaQuest INSTITUTE

Safety Net Solutions Online Learning Modules Glossary

330 Grant Allocation – The funding that a Community Health Center designated as a Federally Qualified Health Center (FQHC) receives from the federal government to help subsidize the cost of providing care to uninsured and underinsured patients. A portion of the 330 grant funding is allocated to the dental program to offset dental program expenses.

Aging Report (AR) – Also referred to as "accounts receivable aging". The AR is a report that categorizes the amount of money owed to the practice according to the length of time an invoice or bill has been outstanding. It is used as a gauge to help determine the financial health of the dental program.

Baseline Data – Initial collection of dental program data utilized to establish a starting point of reference to assess the preliminary level of efficiency. This foundational dental practice data set is also used for comparison to subsequently acquired data.

Benchmark – A point of reference from which practice performance measurements may be compared; a starting point for comparison. Benchmarks are often developed from averages of national practice performance data.

Broken Appointment – Any time a patient misses or cancels a scheduled appointment, leaving insufficient time for the dental program to schedule another patient.

Broken Appointment Rate – Percentage of all scheduled appointments that failed, found by dividing the number of appointments that were not kept by the total number of scheduled appointments.

Capitation - A flat rate payment system in which programs are given a set amount of money to provide access and patient care. This amount is based on the number of patients within the practice and many other factors related to the cost of care to patients. The intention of capitation payment is to relieve providers of their need to bill for every patient service in order to earn income at each visit, and thus allowing them to focus more on patient health outcomes. However, capitation needs to be well thought out with specific oral health outcome measurements and guidelines for it to work for payers, dental programs, and patients.

Chief Executive Officer (CEO) - A chief executive officer is the highest ranking executive in a health center. His/her main responsibilities include the development and implementation of high-level strategies, making major organizational decisions, managing the overall operations and resources of a health center, and acting as the main point of communication.

Chief Financial Officer (CFO) - The CFO reports to the chief executive officer (CEO) but has significant input in the health centers investments, capital structure and how the health center manages its income

and expenses. The CFO works with other senior managers and plays a key role in a company's overall success, especially in the long run.

Community Health Center (CHC) – A healthcare organization/entity that targets an underserved community or population.

Contractual Adjustment – When dental programs contract with dental insurance companies, they agree to charge each dental insurance company's "contracted fees" to said company's members. This means that they will write off (or adjust off) the difference between their full fee schedule rates for the dental services they provide to patients with all contracted dental insurance companies to what their insurance company has defined as rates for these services. For example, if the insurance company is willing to pay say 80% of restorative services, they will reimburse the dental program 80% of their contracted rates. On a profit and loss statement, the contractual adjustment line reflects the difference between gross charges for all services and the potential amount they will be able to collect from patients and third party payers for all services. Note: if the dental program chooses not to participate with the insurance company (ie: does not enter into a contract with them) they do not need to write off the difference between their fees and what the dental program charges.

Cost Per Visit – The average cost to provide care per visit, found by dividing the total direct and indirect expenses by the total number of visits during a specific reporting period.

Daily Revenue Goal – The amount of patient revenue a dental program sets as a target to generate each day to meet daily operational expenses.

Daily Maximum Capacity – The maximum number of patient visits a dental program can provide each day based dental program factors such as the number of providers and support staff, hours of operation, and the number of operatories.

Dental Procedures/Transactions – The number of ADA-coded (or CDT-coded) procedures provided over the course of the reporting period.

Direct Expenses – Costs associated with the provision of dental services. These are usually broken out as salary, benefits, dental supplies and equipment and all those costs directly related to dental. This does not include administrative or support allocation, which are indirect expenses unique to health centers.

Electronic Dental Record (EDR) – A paperless electronic record of dental practice data including patient charts, patient information, treatment plans, dental schedule, billing and collections information, fee schedules, etc. This includes all related information on a patient that is used by dentists, providers and dental staff, for purposes of documenting clinical facts, diagnoses, treatment plans, and services provided.

Electronic Health Record (EHR) – Electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and is created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

Electronical Medical Record (EMR) – Electronic medical record is a digital version of the traditional paper-based medical record for an individual. The EMR represents a medical record within a single facility.

Eligibility Documentation – Patient information required to determine whether or not the patient is eligible for services covered by third party dental insurers. Eligibility documentation can also refer to the documentation of a patient's financial/family size status in order to determine their eligibility for the sliding fee discount schedule as determined by the federal poverty guidelines.

Encounter Form – Document used to collect data on services received at a dental visit; this may either be a documented in a digital or a paper version.

Encounter Rate – The term encounter is defined as a face to face visit between the patient and provider. Medicaid dental visits are sometimes reimbursed by means of an all-inclusive cost-based reimbursement rate for each Medicaid covered patient visit. As long as the dental program provides one Medicaid covered service they will be able to receive the cost based reimbursement for the encounter; however it is highly recommended that gross charges are greater than the encounter rate reimbursement to avoid any charges of churning or fraudulent Medicaid billing.

Fee-For-Service (FFS) – Payment model in which a provider is paid for each individual service rendered to a patient. Most commercial/private insurance companies reimburse providers this way.

Federal Poverty Guidelines (FPG) or **Federal Poverty Level (FPL)** – A set of poverty guidelines, updated at least annually by the Department of Health and Human Services, are the based on poverty thresholds determined by the Census Bureau to estimate of the number of individuals and families living in poverty. The guidelines are rounded and adjusted to standardize the differences between family sizes.

Federally-Qualified Health Center (FQHC) – An organization that meets specific criteria of the Medicare and Medicaid statute and receives grants under the Health Center Program as authorized under section 330 of the Public Health Service Act. FQHCs must comply with HRSA program regulations including practice information such as: serve an underserved area or population, offer a sliding fee discount schedule, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

FQHC Look-alike – Health centers that operate in compliance with the requirements of the FQHC program but do not receive grant funding under section 330 of the Public Health Services Act.

Full-Time Employee (FTE) – A standardized method of quantifying the total number of personnel who contribute to the operations of the health center at approved locations and within the scope of the project. This includes: employees, contracted staff, residents, locums, and volunteers. The definition of full-time equivalent (FTE) should be measured by hours of clinical patient care divided by the standard

number of hours worked per week. Therefore, if a provider has 20 clinical hours per week, and most health center staff work 40 hour weeks, that provider's full-time equivalent is 0.5 FTE. (20 hours divided by 40 possible hours = 0.5 FTE)

Gross Charges - The total full fee amount (non-discounted) charged for all services provided during a time period. Gross charges represent the value of the dental services provided to patients and the community it serves.

Health Resources and Services Administration (HRSA) - Agency within the Bureau of Primary Health Care charged with increasing access to health care for those who are medically underserved. HRSA's programmatic portfolio includes a range of programs or initiatives designed to increase access to care, improve quality, and safeguard the health and well-being of the nation's most vulnerable populations.

Indirect expenses - Costs that are allocated to the dental program for administrative and/or agency (support) overhead.

Indian Health Service (IHS) – IHS is the agency within the Department of Health and Human Services, responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for Indian people and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for American Indians and Alaska Natives.

Late Arrival: Any time a patient does not arrive by 10 minutes after the start of their appointment.

Late Cancellation: Any time a patient cancels their appointment with less than 24 hours' notice, prior to the start of their appointment time.

National Network for Oral Health Access (NNOHA) – A national oral health focused organization consisting of a membership network of Health Center oral health providers committed to improving the oral health of underserved populations and contribute to overall health through leadership, advocacy, and support to oral health providers in safety-net systems.

Net Expenses – Both the direct and indirect costs incurred by the dental practice for the reporting period.

Net Revenue – The amount that is actually collected for all dental services within the reporting period plus any grant revenue. (Net revenue is equal to the gross charges minus contractual allowances and sliding fee discounts, plus grant revenue.)

No-Show – Any time a patient is scheduled for an appointment and they do not show up for that appointment.

Nominal Fee or Nominal Charge – FQHC dental programs are required to provide full discounts for individuals or families with annual incomes at or below 100% of the FPG. However, programs are permitted to establish nominal charges to prevent the overutilization of services. If a nominal fee is

used, it must be a fixed fee, that doesn't not reflect the true value of the service and is seen as nominal by the view of the patient.

Phase 1 Treatment – Prevention, maintenance and/or elimination of oral pathology that results from dental caries or periodontal disease. This includes: oral cancer prevention and early diagnosis; prevention education and services; emergency treatment; diagnostic services and treatment planning; restorative treatment; basic periodontal therapy (non-surgical); basic oral surgery that includes simple extractions and biopsy; non-surgical endodontic therapy; and space maintenance and tooth eruption guidance for transitional dentition.

Phase 2 Treatment – Rehabilitative services, such as dentures, partials, crown and bridge, elective oral surgical procedures, periodontal surgery, and orthodontics (Elective dental procedures.)

Prior Authorization - Process to determine eligibility, benefit coverage, and medical necessity of services before service is received for private and public dental insurances.

Profit and Loss Statement (P&L) - A financial statement that summarizes the revenues, and expenses incurred during a specific period of time, usually a fiscal quarter or year. The P&L statement provides information about a dental program's ability – or lack thereof – to generate enough revenue to cover the cost of providing patient care and operating a dental clinic. A profit occurs when total revenues are higher than total expenses. A loss occurs when total expenses are higher than total revenue. This report is considered essential to financially responsible management of a dental program.

Revenue Per Visit – The average revenue received for every patient visit, found by dividing the total revenue by the total number of visits during a specific reporting period.

Safety Net Provider - Hospital, clinic or health system committed to providing health care to low-income, uninsured and vulnerable populations (regardless of ability to pay.)

Sliding Fee Discount Schedule (SFDS) – a schedule of discounts for eligible patients that is adjusted based on the patient's ability to pay as defined by income and household size.

Sliding Fee Discount Schedule Adjustments/Write Offs – This dollar amount represents the amount of discount provided to self-pay patients based on income level and household size. This amount reflects the difference between gross charges to self-pay patients and what the patient actually pays out of pocket after the discounts are applied.

Transactions/Encounters – The number of ADA-coded procedures provided over the course of the reporting period.

Usual and Customary Fees – This is the average full fee amount charged for dental services per ADA code based on the average fees of all other providers in the same geographic area for the same or similar services. Safety Net Dental Programs are encouraged to set their full fees to be consistent with usual and customary fees in their location to avoid competition for private practice patients, to ensure

maximum revenue from 3rd party insurers, and to dissuade patients with higher incomes so that the access to care is reserved for lower income patients.

Uniform Data System (UDS)- A federal system used to track a core set of information appropriate for reviewing the operation and performance of Health Centers, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs and revenues. UDS data is collected annually and required by HRSA for all FQHCs.