NACCHO

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*The National Connection for Local Public Health*

**[ISSUE BRIEF]**

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# Billing for Clinical Services: Health Department Strategies for Overcoming Barriers

## Introduction

Implementation of the Patient Protection and Affordable Care Act (ACA) and federal and state budget cuts are driving dramatic changes in the local public health system. Discretionary funds previously designated to public health are being reallocated to other healthcare initiatives or are disappearing due to sequestration. Preliminary results from the National Association of County and City Health Officials' (NACCHO's) 2013 National Profile of Local Health Departments (Profile) study, a census of local health departments' (LHDs') workforce, funding, and activities, indicate that nearly half (48%) of all LHDs reduced or eliminated services in at least one program area in 2012. Immunization and other clinical health services were two areas frequently affected.[1]

In this new era of healthcare delivery, some LHDs have decreased direct preventive and clinical services to focus on population-based health activities, while others are exploring alternative ways to develop revenue to adapt and sustain these services. One model is to bill third-party payers (public insurance providers, such as Medicare and Medicaid, and private insurers) for services provided in LHD clinical settings. Revenue earned through third-party reimbursement helps ensure that LHDs continue to provide essential services, conduct core public health functions, and improve the health and well-being of their communities.

NACCHO has prepared this issue brief to help public health officials, state and local leaders, and policymakers understand the opportunities and challenges LHDs face when billing third-party payers for clinical services. This issue brief includes information about the public health billing landscape, how NACCHO is supporting LHDs, barriers to third-party reimbursement, and strategies LHDs have used to overcome these challenges. NACCHO prepared this document based on a literature review and key informant interviews.

## Background

Billing public and private insurance providers for reimbursable services, such as immunizations and HIV/STI testing, allows LHDs to sustain their services, ensures stewardship of public funds, and promotes equity. Health departments should be reimbursed the same as any other healthcare provider for the billable clinical services they perform. Providing these services to insured patients at federally and state-funded health departments, without reimbursement from insurers, diverts scarce public resources away from those in need. Billing can create a revenue stream for health departments and keep health department clinics viable in the face of decreasing state and federal funds.[2]

The Centers for Disease Control and Prevention (CDC) started the Billables Project for Health Department Immunization Services Reimbursement (Billables Project) in 2009 to help state and local health departments develop capacity to bill insurance companies for immunization services they provide to insured patients. Since the project began, the CDC has dispersed $27.5 million to 38 project grantees.[3] Project grantees have produced resources that share lessons learned and effective practices that can assist other health departments to establish billing infrastructure and ensure sustainable programs.

Recently, billing public and private insurance providers has become increasingly important for LHDs due to CDC guidance on the use of 317 vaccines for insured individuals. As of Oct. 1, 2012, CDC's guidance stated, "Grantees may not administer Section 317 vaccines to fully insured

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children or adults, except in limited circumstances."[4] The Billables Project has established a reimbursement model to prevent state and local health departments from missing opportunities to vaccinate insured individuals. Other CDC divisions, such as the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, want to expand health department billing capacity to additional clinical services.[5]

The Billables Project funded NACCHO to help LHDs in their billing efforts with third-party payers by collecting and sharing tools and resources. NACCHO offers a central database of more than 260 resources in the "Billing for Clinical Services Toolkit" to support LHDs through the billing process. The toolkit includes resources such as several CDC State Immunization Grantee's Billing Guides, recorded webinars, LHD templates, policies, procedures, job descriptions, and implementation strategies.

## Current Landscape

According to NACCHO's 2010 Profile study, 83.1 percent of the LHDs surveyed reported that they received revenue from Medicaid/Medicare. Almost 81 percent reported receiving some other form of revenue beyond local, state, or federal funds that included either reimbursement from private insurance providers or money collected from charging patients.[6] These data demonstrate that the majority of LHDs have some level of experience with receiving reimbursement beyond traditional grant and discretionary funding. Because the ACA is increasing the extent of insurance coverage, it will provide an opportunity for LHDs to increase these revenue streams.

Public health services have traditionally been viewed as free, and a move toward billing for these services requires a paradigm shift for both LHD staff and individuals seeking services. Scott Coley, an immunization billing coordinator from New York State, expressed the need for a change in public health culture. "Even in cases when health departments are contracted with insurers, periodically we hear of claims that are denied because public health equals free."

For LHDs, billing is a comprehensive approach and not isolated to just one clinical service. Most LHDs establish billing programs to include all of the clinical services that they provide. Once a health department has established a billing infrastructure, it can seek revenue across programs for reimbursable services such as immunizations and testing and counseling for HIV, STIs, and tuberculosis. Ultimately, state or local health departments should decide to bill after carefully assessing the communities they serve. For example, LHDs within the states that have declined Medicaid expansion and that serve predominately uninsured communities may not find revenue generation feasible. If billing is the right decision for the LHD, dwindling public funds could be used for the most vulnerable populations. Health departments would also be able to keep serving insured clients who continue to seek services after ACA implementation.

## General Barriers to Billing and Reimbursement

Although a majority of health departments have a long history of working with public insurance providers (e.g., Medicaid, Medicare, Children's Health Insurance Program), many have found the transition to working with private insurers difficult. Despite challenges, LHDs have remained persistent and have developed creative ways to establish successful billing programs.

The process of building billing infrastructure is time consuming and requires a high level of staff engagement and commitment. Health department staffs are already being tasked with more responsibilities as a result of shrinking budgets. Not all health departments have switched to electronic health records, which are helpful in establishing a billing program. Resources and training are greatly needed to support many health departments across the country.

Insurance companies have not traditionally contracted with health departments and may not understand what services health departments provide for insured individuals. Insurance companies have worked with LHDs through Medicaid, especially Managed Care, but LHDs have little history of being in-network providers in private insurance networks. Under the ACA, there is a push towards the "medical home" or using primary care providers with bundled payments for managed care. Due to this shift in service delivery, private insurance companies may not recognize health departments' clinical services as part of the medical home.

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## Tools and Resources

The following are toolkits and resources for LHD staff and others interested in billing third-party payers for clinical services:

- CDC Billables Project for Health Department Immunization Services Reimbursement: http://1.usa.gov/1hXvNfB
- NACCHO's Billing for Clinical Services Website: www.naccho.org/topics/hpdp/billing/
- NACCHO's Billing for Clinical Services Toolkit: http://bit.ly/19O7OHA
- NACCHO's Webinar: "Becoming an In-Network Provider: The Health Department Perspective": http://bit.ly/1dipdur
- NACCHO's Statements of Policy: (1) Local Health Department Capacity to Conduct Third-Party Billing for Immunization: http://bit.ly/1ejoeiy; (2) Provision of Clinical Services by Local Health Departments: http://bit.ly/1gCiIbe
- phConnect—Improving Reimbursement for Health Department Clinics: http://bit.ly/19tLp5S
- National Coalition of STD Directors—Shifting to Third-Party Billing Practices for Public Health STD Services: Policy Context and Cases: www.ncsddc.org/third-party-billing-practices
- National Alliance of State and Territorial AIDS Directors—Issue Brief: Billing and Reimbursement—Health Departments and Capacity for Third-Party Payers and Reimbursement: A Status Report and Resources for Capacity Building: http://bit.ly/1hf0zO5

## Health Department Examples of Successes and Challenges

Baca County (CO) Public Health Agency has demonstrated that billing private insurers is possible with a staff of only three. The county was able to contract with five private insurance companies despite limited resources and a paper-based health record system. The agency built billing capacity through the help of a state grant and by leveraging existing resources. Baca County encouraged staff to use existing knowledge from billing experts and develop peer mentorships. At first, the local health insurance companies were uninterested in contracting with the LHD, so the county encouraged patients to call their health insurance providers and request that the LHD be included as an in-network provider. They spread the work among all staff so no one was overburdened.

LHDs in Arizona also encountered health insurance companies that were unwilling to contract with them. The Arizona Partnership for Immunization (TAPI) met with leaders in the healthcare field to discuss what could be done to ease LHD billing burdens. TAPI established a centralized billing clearinghouse system that included the entire public health system instead of each LHD establishing its own billing program. With this group, TAPI was able to educate lawmakers about why health departments should bill for immunization services. In May 2013, the Arizona legislature passed HB 2430, which requires health insurance providers to reimburse LHDs as in-network providers regardless of contract status, thereby enabling LHDs to be fully reimbursed.[8]

Health departments function differently than private physician offices; they often operate under standing orders, have registered nurses rather than nurse practitioners, lack 24-hour access to clinicians, and lack hospital admittance privileges. New York LHDs have successfully worked with health insurance companies by inviting a contracting representative to come to the public health clinic to observe and understand how LHDs work under these management models.

Kern County (CA) Public Health Services encountered budget cuts and was faced with scaling back or eliminating its clinic. Instead of closing its doors, the LHD established a billing program that increased revenue tenfold. Tracking denied claims and resubmitting them to insurers was an opportunity to increase reimbursement. The LHD was able to recoup $491,000 by fixing and resubmitting denied claims.[2]

Kern County Public Health Services shares a tax ID with the county hospital. Insurance companies reimburse by tax ID, and LHDs that share a tax ID with another county agency may not directly receive reimbursement for claims; instead, the reimbursement is often put into a general funds account, leaving many health departments wondering why they should bill insurers if they will not receive the funds to reinvest back into their programs. In Kern County's case, the LHD and hospital reimbursements were sent to the hospital with no way to delineate what money belonged to the LHD. As a result, the LHD created a system through which it would sort reimbursements by service provided (e.g., inpatient surgery or STI screening) and send the correct reimbursement to the hospital. This streamlined process has allowed the LHD to recoup the full amount of its reimbursement.

Some states have faced challenges due to the public health system's governance structure. Maryland has a mixed system in which the governance is split between the state and LHDs. This structure has made it difficult for county LHDs to negotiate or enter into contracts with health insurers on their own. Maryland has taken a unified approach, and Maryland Department of Health and Mental Hygiene is working to establish umbrella contracts that include LHDs. When negotiating contracts with insurers, LHDs should emphasize the Essential Community Provider requirement under the ACA, which requires all health insurance plans sold in the marketplace to include approximately 20 percent safety net providers as in-network providers to increase network adequacy for their members.

One challenge for LHDs in decentralized states is the lack of knowledge, staff time, technology, or financial resources. To overcome this challenge, the Washington State Department of Health formed a workgroup to leverage existing knowledge and infrastructure to reduce the burden for local health jurisdictions. This workgroup designated mentors for different parts of the billing process and offers training to staff at other LHDs. According to Carri Comer, the Public Health Reimbursement Coordinator, "Since January of 2013, 33 percent more LHDs (17 LHDs) are billing private insurance for the clinical services provided."[9]

When establishing a billing program, Calhoun County (MI) Health Department encouraged staff to innovate. Calhoun County was able to contract with the largest insurer in its area and billed other insurance companies as an out-of-network provider and received limited reimbursement. With a lower reimbursement rate, the LHD decided it was not worth the effort to contract with insurance companies that did not represent the majority of clients.

Another LHD concern is billing for confidential services. Most private insurance companies send an explanation of benefits (EOB) to the insured policy holder, which may breach the confidentiality of adolescents or spouses for services such as STI testing and treatment. Calhoun County protects confidentiality by asking clients upfront if they will let the LHD bill their private insurance. This small change ensured that clients were aware of their privacy rights and that EOBs were sent by insurance plans. Those adult clients that do not want the EOB sent are asked to pay for the services on a sliding scale.

Additionally, some states consider certain public health services such as HIV or STI testing and treatment core public health services and do not allow health departments to charge for them. For example, West Virginia's State Legislature decided that it would be illegal for the LHDs to bill for HIV and STI services because they have traditionally been free.[10] By contrast, Maryland was able to change this policy. Previously in Maryland, both HIV and STI services were on their non-chargeable list but health officers recently removed STI services with certain provisions. One provision prohibits any billing for adolescents. This change has allowed Maryland LHDs a large opportunity for reimbursement while protecting confidentiality.

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## Conclusion

The changing healthcare environment is making it imperative that LHDs examine whether they should be billing for clinical services. The ultimate decision to bill is up to each state and local health department and will depend upon the population the departments serve. Health departments will need to weigh expected revenue against the costs of developing and sustaining a billing infrastructure. No one approach to billing will fit all health departments, and various obstacles will arise. When an LHD decides to bill, the process will be much easier if it seeks assistance from its state billing coordinator, similar health departments, and others familiar with billing processes. With persistence and creativity, LHDs have been able to overcome obstacles to build successful billing programs. NACCHO has established a toolkit and guide for others to do the same.

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## Insights from LHD Staff

LHD staff offered the following insights about billing for clinical services:

- **Help change the perception that public health services are free.** Explained Scott Coley from the New York State Department of Health: “We have to change [that] paradigm. Public health is there as a safety net…it is not the same thing as free.”
- **Leverage time and resources by partnering with fellow LHDs.** “It was important to have the leverage of the entire public health community instead of each county health department trying to bill on its own,” noted Jennifer Tinney of The Arizona Partnership for Immunization.
- **Start with small steps.** Michelle Thorne of the Calhoun County Health Department explained: “If you are not billing [insurers] yet, you don’t necessarily have to have a contract and you can bill and get money. If you want to stick your foot into the water and give it a try, that’s a really good way to do that.”

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