NACCHO
National Association of County & City Health Officials

[RESEARCH BRIEF]
May 2014

Billing for Clinical Services: Findings from the 2014 Forces of Change Survey

Background

The implementation of the Patient Protection and Affordable Care Act (ACA), along with shrinking federal, state, and local budgets, is driving change in the public health system. This time of transformation presents both new challenges and growing opportunities for local health departments (LHDs) as they look to adapt to these changes. Some LHDs are exploring ways to develop revenue to sustain essential public health services, including billing third-party payers (public insurance providers, such as Medicare and Medicaid, and private insurers) for services provided in LHD clinics.[1]

This research brief describes the extent to which LHDs are billing for clinical services, what third-party payers LHDs are billing, approaches they are using to bill third-party payers, and whether LHDs are engaged in efforts to increase the extent to which they bill for services.

Methods

The National Association of County and City Health Officials (NACCHO) distributed the Forces of Change Survey to a statistically representative sample of 957 LHDs in the United States from January to February 2014. A total of 648 LHDs completed the survey (response rate of 68%). NACCHO generated national statistics using estimation weights to account for sampling and non-response. All data were self-reported; NACCHO did not independently verify the data provided by LHDs. A detailed description of survey methodology is available on NACCHO's Forces of Change webpage at www.naccho.org/topics/research/forcesofchange.

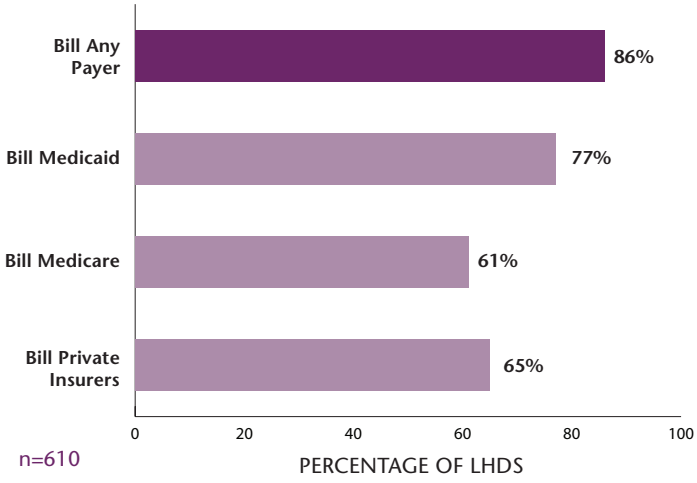
The survey included questions on the extent to which LHDs were billing third-party payers for clinical services. Respondents were first asked to select the types of clinical services provided by their LHD from a list of 10 services. The list was not exhaustive but did include a wide range of possible clinical services. Respondents were then asked whether they billed third-party payers for each of the clinical services they offered, and, if so, which third-party payers. In this research brief, percentages of LHDs that reported billing for a clinical service are out of those LHDs that provided that particular service (which ranged from 97 respondents for behavioral health/substance abuse to 596 respondents for immunization).

Results

Types of Third-Party Payers Billed

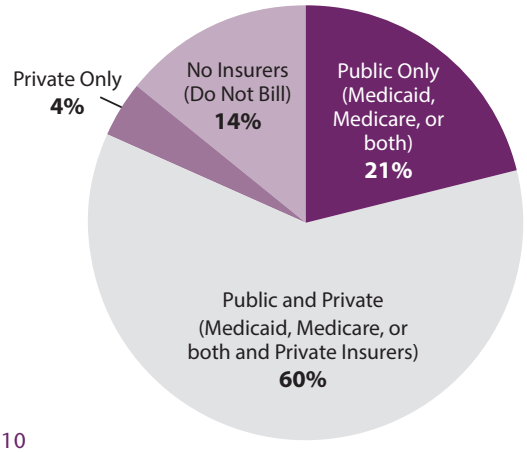
Most LHDs (86%) billed third-party payers for at least one clinical service they offered (Figure 1). LHDs were most likely to bill Medicaid (77%), followed by private insurers (65%), and Medicare (61%).

FIGURE 1: Percentage of LHDs that Billed for Any Clinical Service Provided, by Type of Payer



In combination, 60 percent of LHDs billed both public (Medicaid, Medicare, or both) and private insurers (Figure 2). Approximately one-fifth (21%) of LHDs billed only public insurers, while few (4%) billed only private insurers. Fourteen percent of LHDs did not bill for any clinical service they offered.

FIGURE 2: Percentage of LHDs that Billed Third-Party Payers for Any Service



n=610

Type of governance and size of population served revealed modest differences in the percentage of LHDs that billed for at least some clinical services (not shown). Slightly more LHDs governed by both state and local authorities (shared governance) billed for at least some clinical services offered (95%), compared to locally governed LHDs (86%) and units of the state health department (82%).

Types of Clinical Services Billed to Third-Party Payers

LHDs were most likely to bill for family planning (85%), immunizations (84%), and home health (77%) (Figure 3). Most LHDs billed both public and private insurers; few LHDs billed only private insurers for every clinical program area. Type of governance and size of population served revealed few differences in the percentage of LHDs that billed for various clinical program areas (not shown).

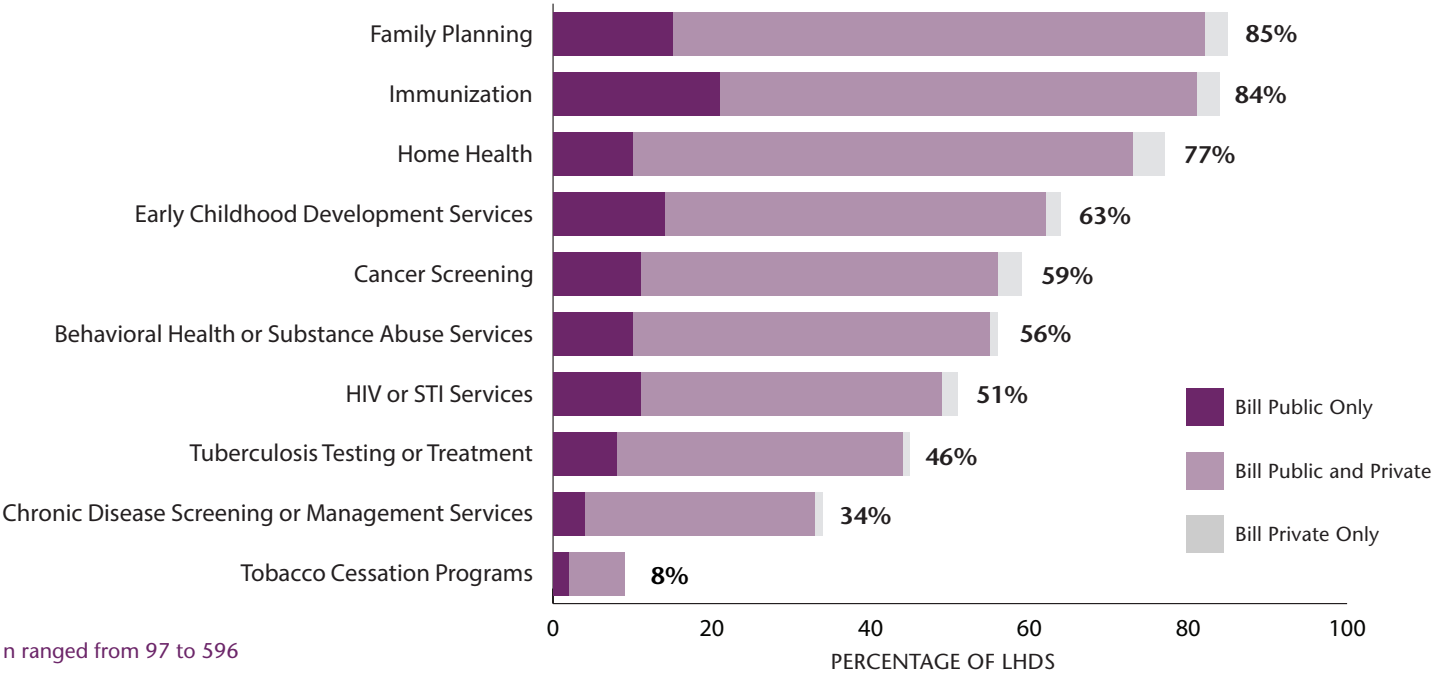
Government Authority of LHDs

LHDs vary in their relationships with their state health agency. Some LHDs are local or regional units of the state health agency (referred to as state-governed LHDs), others are agencies of local government (referred to as locally governed LHDs), and others are governed by both state and local authorities (called shared governance). Refer to the following figure online for more details on how LHD governance varies across the United States: http://bit.ly/1hHXHbd.

Approaches Used to Bill Third-Party Payers

Among LHDs that billed one or more third-party payers, more than half (66%) reported in-house capability to bill third-party payers (Figure 4). LHDs that served a jurisdiction of more than 50,000 people were more likely to report in-house capability to bill third-party payers than those that served smaller populations. Almost all LHDs with shared governance (90%) reported in-house billing capabilities, compared to only 20 percent of state-governed LHDs. Approximately one-quarter of LHDs contracted with another entity (25%) or used a centralized billing function at the state health agency (24%) to bill third-party payers. Most state-governed LHDs (80%) reported that the state health agency had a centralized billing function.

FIGURE 3: Types of Clinical Services Billed to Third-Party Payers



n ranged from 97 to 596

FIGURE 4: Approaches Used to Bill Third-Party Payers

LHD Characteristics	In-House Capability	Contracts with Another Entity	State Health Agency has a Centralized Billing Function
All LHDs that Bill One or More Third-Party Payers	**66%**	**25%**	**24%**
Size of Population Served			
<50,000	59%	26%	25%
50,000–499,999	73%	23%	22%
500,000+	75%	27%	32%
Type of Governance			
State	20%	7%	80%
Local	76%	31%	7%
Shared	90%	17%	25%

n=509

LHD Engagement to Bill Third-Party Payers

Over 80 percent of LHDs were planning to increase the extent to which they bill third-party payers (77%) or planned to establish billing with third-party payers (4%) (Figure 5). Twelve percent of LHDs were billing without plans to increase billing efforts and seven percent were not billing and did not intend to establish billing capacity. LHDs that served larger populations were more likely to plan to establish billing with third-party payers than LHDs that served smaller populations. Among LHDs that served less than 50,000 people, a larger proportion of LHDs did not intend to change their billing efforts: 17 percent were billing but were not considering increasing their billing efforts, and 11 percent had no plans to establish billing.

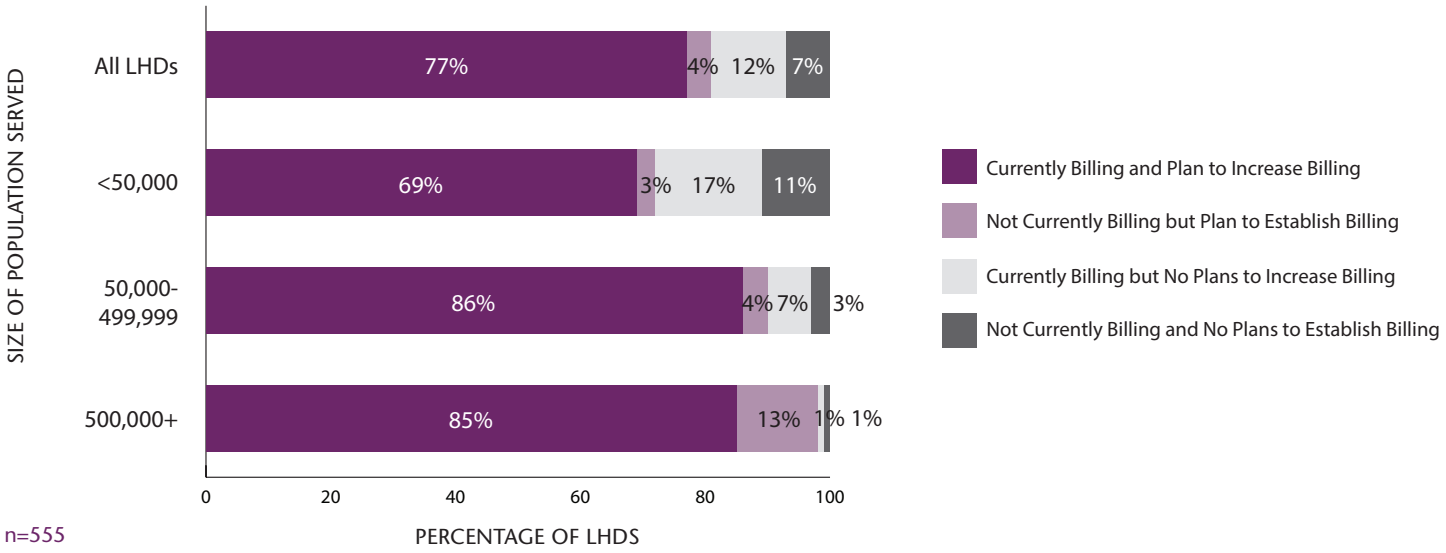
Among LHDs that did not bill any third-party payers for clinical services, 30 percent were working to establish billing with Medicaid, 16 percent with Medicare, and 20 percent with private insurers (Figure 6). LHDs that served jurisdictions of more than 500,000 people were much more likely to be working to establish billing with Medicaid (92%), Medicare (44%), or private insurers (77%) than LHDs serving smaller jurisdictions.

FIGURE 6: Percentage of LHDs Not Billing but Working to Establish Billing with Third-Party Payers

Third-Party Payer	LHDs that do Not Bill any Third-Party Payers	Size of Population Served		
		<50,000	50,000–499,999	500,000+
Medicaid	30%	20%	38%	92%
Medicare	16%	13%	14%	44%
Private Insurers	20%	13%	21%	77%

n=62

FIGURE 5: LHD Level of Engagement to Increase or Establish Billing with Third-Party Payers



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[RESEARCH BRIEF]

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Discussion

Most LHDs (86%) bill third-party payers for clinical services they provide, including Medicaid, Medicare, and private insurers. Out of the clinical services they offer, LHDs are most likely to bill for family planning, immunizations, and home health and report in-house capability to bill. Most LHDs are billing or considering increasing efforts to increase billing (77%); among LHDs that are not billing, 30 percent are working to establish billing with Medicaid, 16 percent with Medicare, and 20 percent with private insurers.

The implementation of the ACA and shrinking budgets are driving change in the public health system. Some LHDs are exploring new revenue sources to sustain essential public health services, including billing third-party payers for services provided in LHD clinics.[2] While LHDs have traditionally provided services without regard to insurance status, findings from the Forces of Change Survey show that LHDs are adapting to the changing public health system and billing for their clinical services. Nevertheless, LHDs will also continue to serve uninsured patients despite the implementation of the ACA and the uneven uptake of expanding the Medicaid Program across states. Further research will be needed to identify whether it remains cost-effective for LHDs that serve large populations of uninsured patients to bill for clinical services.

References

1. National Association of County and City Health Officials (NACCHO). (January 2014). Billing for clinical services: Health department strategies for overcoming barriers. Retrieved April 1, 2014, from www.naccho.org/topics/hpdp/billing/upload/issuebrief_billing_jan2014.pdf

2. Ibid.

Acknowledgments

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For more information, please contact the Research & Evaluation Team at research@naccho.org.

Tools and Resources

Refer to the following toolkits for more information and resources on billing third-party payers for clinical services:

- NACCHO's Billing for Clinical Services Website: www.naccho.org/topics/hpdp/billing
- NACCHO's Billing Task Analysis Resources: www.naccho.org/topics/hpdp/billing/billing-task-analysis.cfm
- 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/1gCilbe
- Centers for Disease Control and Prevention's Billables Project for Health Department Immunization Services Reimbursement: www.cdc.gov/vaccines/programs/billables-project

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