



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

January 21, 2014

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

RE: 2013 Joint Chairmen's Report, Page 63, M00F02.07 – Local Health Department Billing Challenges

Dear Chair Kasemeyer and Chair Conway:

Pursuant to page 63 of the Joint Chairmen's Report of 2013, the Department of Health and Mental Hygiene (DHMH) respectfully submits this report on local health department billing challenges. Specifically it was requested that DHMH provide the Budget Committees with a report on efforts to address the challenges that local health departments face with regard to: 1) billing, generally, and 2) third-party contracting in particular. In addition, the report comments on whether statutory changes are necessary and/or feasible to remedy these challenges.

I hope this information is useful. If you have any questions regarding this report, please contact Ms. Christi Megna, Assistant Director of the Office of Governmental Affairs, at (410) 767-6509.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Laura Herrera, MD, MPH
Michelle Spencer, MS
Christi Megna, JD

**Report on Local Health
Department Billing Challenges**

Department of Health and Mental Hygiene

**2013 Joint Chairmen's Report,
Page 63, M00F02.07**

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Introduction

In 2012 the federal Centers for Disease Control and Prevention (CDC) announced funding opportunities aimed at “Immunization Capacity Building Assistance to Strengthen Public Health Immunization Infrastructure and Performance.” One of these opportunities was for health department clinics to develop strategic plans for immunization service billing. Difficulties billing for immunization services provided to insured individuals had been identified on the national level as problematic. The ability to efficiently bill insurers for these services would ultimately enable immunization programs to reach additional populations in need of vaccination services.

The Department of Health and Mental Hygiene (DHMH) applied for and was awarded a grant from the CDC to assess capabilities, and to develop and implement a Statewide process enabling Maryland’s local health departments (LHDs) to bill insurance companies for immunization services provided at LHD clinics by January 2014. Although this extensive assessment process focused specifically on billing for immunization services, the training and recommendations provided are applicable across the spectrum of LHD services. Adopting and implementing the recommended policies, procedures (with coding tailored to each clinical area), and processes creates the potential for increased revenue in all program areas.

DHMH entered into a grant agreement with the Maryland Partnership for Prevention (MPP) to administer parts of the program. MPP partnered with SHR Associates, Inc. (SHR), a Maryland-based practice management firm with experience in assisting healthcare organizations in strengthening internal operations and implementing medical billing processes, to conduct 24 LHD site assessments, and to develop implementation plans for each individual LHD.

SHR was engaged to:

- Evaluate, recommend, and assist LHDs in strengthening internal operations that will be impacted by implementation of an internal billing process;
- Recommend and help LHDs execute the changes in procedures and workflow processes necessary to support implementation of billing;
- Create appropriate forms and documents for accurate patient and third-party billing;
- Create policies and procedures for effective and compliant claims submission, tracking, and monitoring of billing activity;
- Provide educational training and support for LHD providers and staff on proper documentation, coding, and billing;
- Provide advice and training to LHDs regarding the appropriate use of technology and resources to successfully accomplish patient and third-party billing; and
- Provide advice and support related to the third-party contracting process being coordinated by the Office of the Attorney General (OAG).

Assessment Process

After completing a pre-visit survey, SHR conducted a site visit to each of Maryland's 24 LHDs between November 2012 and April 2013. As an integral part of the assessment process, SHR closely examined front office, billing, and financial processes at each LHD. The assessment focused in part on collection of patient demographics, insurance eligibility verification, patient and third-party billing, coding, charge calculation, fee schedules, claims submission, collections and reconciliation of payments, follow-up on accounts receivable, and adequacy and use of information technology.

Subsequent to each site visit, SHR prepared individualized assessment reports which included the site reviewer's findings and billing implementation recommendations. Follow-up conference calls were conducted with each local health officer and/or designated staff to review the findings, and recommendations, make report revisions, and discuss the billing implementation process. A final report was then prepared and distributed to each local health officer.

General Observations and Challenges

These general observations and challenges were recorded during the site visit process.

General Observations

- **Vaccination Clinic Observations** - LHD clinics follow appropriate industry standards for screening, patient education and consent, HIPAA privacy, inventory management, vaccine administration, and documentation policies and procedures. This is a strength of every LHD. Nearly all LHDs use ImmuNet (Maryland's immunization registry) for recording vaccinations, and a few utilize ImmuNet to track private and/or VFC (Vaccines for Children) vaccine inventory.
- **Vaccination Services Provided** - In general, LHDs provide a basic level of adult vaccinations, and a broader array of childrens' vaccinations, primarily to VFC-eligible children. Other services, such as travel, employee health, and pre- and post-exposure rabies vaccines may also be provided depending on the constituency and service delivery model unique to the community.

Additionally, some LHDs administer vaccinations in other service area settings, such as school-based health and wellness centers, and clinics for HIV, sexually transmitted infections, family planning, and maternal and child health.

- **Flu Vaccination Services** - Most LHDs are active in elementary school-based flu clinics, and some still conduct flu clinics at LHD facilities and/or various community sites. Currently, some LHDs bill Medicare for the flu vaccine, while others elect not to bill Medicare. Also,

some LHDs may charge a standard fee, not charge at all, or accept a donation for administering a flu vaccine.

Challenges

- Access to Payer Contracts - LHDs frequently cited limited access to third-party commercial and managed care organization contracts as a significant barrier to billing. Access was limited, in part, due to standard provisions in health plan contracts that conflict with State law regarding contracts with governmental agencies. The OAG is working to resolve contracting issues unique to LHDs; see the Contracting and Credentialing Initiatives section of this report for further details.
- Patient Volume - Some LHDs' vaccination volumes are so low that they believe implementing a process to bill third-party payers for these services is unlikely to be cost-effective. Some of these low-volume LHDs are either billing patients that do not pay at the time of service, or collecting fees from patients at the time of service and providing patients with the necessary information to submit reimbursement claims to their insurers.
- Coding Issues - Following Current Procedure Technology (CPT) guidelines for proper coding of vaccines and vaccine administration services is a challenge for most LHDs. Some LHDs either do not charge a vaccine administration fee, only charge a single fee for multiple vaccines administered during the same day, or charge a separate fee for each vaccine administered. To properly bill and maximize reimbursement from third-party payers, it is imperative to select and apply the appropriate CPT vaccine administration code and ICD-9 (International Classification of Diseases, Ninth Revision) diagnosis to each vaccine given.

Further, a review of the current schedule of charges for clinical services for each LHD identified some inaccurate billing codes which precluded third-party billing consistent with the CPT guidelines. Inaccurate billing codes compromise the ability of LHDs to recover funds from third-party payers. All LHDs were given opportunities to work with DHMH to correct coding problems, and to date most LHDs have made the necessary corrections to ensure accurate third-party billing. LHDs will need to be proactive to ensure that their billing codes remain up-to-date.

- Sliding Fee Scale - LHDs inconsistently apply the sliding fee scale to vaccination services. In some cases, the sliding fee scale, which takes into consideration gross annual income and family size in determining one's ability to pay, is applied either to the vaccine charge or the administration charge, when it should be applied to both charges.
- Fee Schedules – SHR observed that the current methodology used by the LHDs for fee-setting is highly complex and inconsistent with Current Procedure Terminology (CPT) guidelines for third-party billing. Those inconsistencies have impeded LHDs' ability to

maximize recoveries from third-party payers. See the section entitled “Statutory and Regulatory Changes” for more information on efforts to address this problem.

Billing Readiness Assessment

SHR assessed the overall readiness level of each LHD based on both current industry standards and onsite observations and discussions with LHD officials during and following each site visit. LHDs with readiness scores of 14 to 15 (out of 15) were ranked as having a “High Readiness” level; those with scores of 11 to 13 were ranked as having a “Moderate Readiness” level; and those with scores of 10 or below were ranked as having a “Low Readiness” level. Characteristics and next steps for each readiness level follow.

Characteristics of High Readiness LHDs:

- Perform billing for vaccination services;
- Perform billing for other services including behavioral health, family planning, and substance abuse;
- Use a practice management (PM) system for billing;
- Have written policies and procedures in place for billing;
- Have staff with billing experience; and
- Perform checks on insurance eligibility.

Next Steps for High Readiness LHDs:

- Review and revise as necessary immunization fee schedules to maximize reimbursement;
- Streamline and strengthen internal operations to enhance revenue cycle processes and collections;
- Provide coding (ICD-9 and CPT) and billing training;
- Continue contracting and credentialing support; and
- Improve PM functionality to maximize the overall billing process.

Characteristics of Moderate Readiness LHDs:

- Have very limited or no billing for vaccinations, but are currently billing for other services including behavioral health, family planning, and substance abuse;
- Have a PM system that can be used for immunization billing;
- Have in place front and back-end billing processes for the programs for which they bill;
- Have some written policies and procedures in place for billing;
- Have some staff with billing experience;
- Possess the capacity to check eligibility for Medicaid, but not other insurance coverage; and
- Have manual rather than automated billing processes.

Next Steps for Moderate Readiness LHDs:

- Establish immunization fee schedules;
- Establish front and back-end processes for immunization billing;
- Develop written policies and procedures for immunization billing;
- Conduct coding (ICD-9 and CPT) and billing training;
- Improve PM functionality to maximize the overall billing process; and

- Continue contracting and credentialing support in the coming years.

Characteristics of Low Readiness LHDs:

- Are not billing for vaccination services. May bill for other services including behavioral health, family planning, and substance abuse on occasion;
- Do not have a PM system that can be used for billing immunizations;
- Do not have front and back-end billing processes in place for billing;
- Do not have written policies and procedures in place for billing;
- Do not have staff with billing experience or adequate staff to support the billing process;
- Do not check eligibility for Medicaid or other insurance coverage; and
- Use only manual processes.

Next Steps for Low Readiness LHDs:

- Achieve a higher level of commitment from management to implement billing for immunizations;
- Establish immunization fee schedules;
- Establish front and back-end processes for immunization billing;
- Develop written policies and procedures for immunization billing;
- Conduct coding (ICD-9 and CPT) and billing training;
- Improve PM functionality to maximize the overall billing process; and
- Continue contracting and credentialing support in the coming years.

Of Maryland's 24 LHDs, eight were rated at a "high readiness" level, nine were rated at "moderate readiness" level, and seven were rated at "low readiness" level. These readiness assessments were conducted in May 2013, so any initiatives undertaken by LHDs to improve their billing readiness since that time are not reflected.

Immunization Services' Practice Management Systems

SHR strongly recommends that all LHDs use a robust, electronic PM system throughout their clinical services areas. This means that all of the key billing-related functions, including patient registration, appointment scheduling, billing and collections, reconciliation, and inventory tracking, would be supported through the PM system, thus eliminating a number of manual processes.

All 24 LHDs use one or more electronic PM systems. However, of the 20 LHDs that use a PM system for vaccination-related functions, only 10 bill for immunization services. The PM system most commonly used by the LHDs is PatTrac. PatTrac was initially created as a patient tracking program to address procedures and services that are unique to public health. This PM system has evolved to include a billing component but SHR believes PatTrac should be enhanced and better supported to be considered a more viable billing solution for the LHDs. As of November 2013, some of the system's limitations have been addressed by the sole owner/programmer of PatTrac and made available, but not yet downloaded or tested by the LHDs. The system remains limited

in functionality and support compared to most commercially available, state-of-the-art PM systems.

Table 1 summarizes the number of LHDs using PatTrac or another PM system to support vaccination-related activities.

Table 1. Local Health Departments Using PatTrac and Other Practice Management Systems for Vaccination-Related Functions

| VACCINATION-RELATED FUNCTION | PATTRAC USED FOR LISTED FUNCTION | OTHER PRACTICE MANAGEMENT SYSTEM USED | NO PRACTICE MANAGEMENT SYSTEM USED* |
|---------------------------------|----------------------------------|---------------------------------------|-------------------------------------|
| Patient Registration | 10 | 8 | 6 |
| Patient Scheduling | 5 | 4 | 15 |
| Care Documentation | 7 | 2 | 15 |
| Charge Entry | 10 | 2 | 12 |
| Time of Service Payment Posting | 11 | 5 | 8 |
| Patient Billing/Statements | 8 | 2 | 14 |
| Insurance Claims Submission | 9 | 3 | 12 |
| Insurance Claims Clearinghouse | 8 | 0 | 16 |
| Insurance Claims Follow-up | 8 | 2 | 14 |
| Insurance Payment Posting | 8 | 3 | 13 |
| Management Reporting | 8 | 4 | 12 |
| Inventory Management | 8 | 1 | 15 |

** Although this column indicates "No Practice Management System is Used" for vaccination services, LHDs may use a Practice Management System for services other than vaccinations.*

Contracting and Credentialing Initiatives

Entering into contracts with private insurers and Medicaid Managed Care Organizations (MCOs) will be critical to successful billing of third-party payers. Finalized contracts and completed credentialing are required in order for a LHD to bill a payer as an in-network provider, which generally allows for greater reimbursement.

The OAG and LHDs have identified legal barriers to contracting with health insurance plans. One of these barriers is standard language, commonly found in health plan contracts, that conflicts with provisions of State law related to governmental entities. Examples of these provisions include requirements that LHDs:

- Unconditionally indemnify the payer;
- Purchase private professional liability insurance;
- Waive or limit defenses;
- Agree to certain confidentiality provisions;
- Interpret a contract according to the laws of a foreign jurisdiction; and
- Agree to resolve disputes in a tribunal other than a Maryland court (i.e., in arbitration proceedings or in another state).

Such requirements conflict with State law that, for example, (i) provides that the State of Maryland is self-insured, which precludes the rationale for purchasing professional liability

insurance, or (ii) prohibits State officers from contracting to bind the State to pay any amount, including indemnification, unless money has been appropriated for that purpose and remains unspent. In the past, LHDs have had difficulty with identifying problematic contractual provisions and with engaging private payers in contractual negotiations.

In response, DHMH has engaged the OAG to conduct outreach to health insurance plans to identify contacts for negotiation, and to obtain a copy of each insurance plan's standard contract for review. DHMH and the LHDs, in conjunction with the OAG, are in the process of negotiating contracts with several insurance plans, which must comply with legal contracting requirements applicable to State of Maryland governmental agencies. Negotiations have included discussions of credentialing and quality assurance requirements. These contracts are intended to cover the full range of clinical services provided by the LHDs, not solely immunizations.

In some cases, the OAG is assisting DHMH and LHDs with negotiating master Statewide contracts with commercial insurance plans. Once a master umbrella contract is finalized and approved by DHMH, each LHD would have the opportunity to "sign-on" to the contract. A Statewide contract is currently being negotiated with one private insurance plan, and two other private insurance plans are considering entering into a Statewide contractual arrangement.

In other cases, insurance plans have indicated a preference to contract with each LHD individually. In those cases, the OAG and DHMH are assisting the LHDs with negotiating form addenda that are specific to and pre-approved by each payer. These form addenda are intended to address any legal barriers in a particular payer's contract, and would allow an individual LHD to negotiate and enter into a contract with an individual payer, without having to engage in additional negotiation of legal terms. The OAG and the LHDs have finalized and agreed upon a form addendum with one payer. Also, there is a separate addendum that the OAG has developed for use with various MCO contracts.

In addition to entering into contracts with third-party payers, LHD providers with a license that would allow their services to be billed directly (not under another provider's license) will need to be credentialed with the payers before the LHD can bill as an in-network provider. The OAG is providing credentialing process assistance to the LHDs with one commercial health insurer, and many LHD providers are in the process of completing credentialing applications with that insurer. In Maryland insurers are required by COMAR 31.10.26.03 to accept a uniform credentialing application. Accordingly, applications completed in connection with credentialing under one health plan can also be used for credentialing purposes with other third-party payers.

The OAG has generally acted as a central point of contact for contract negotiation and credentialing. Also, the OAG is assisting the LHDs in developing forms and procedures to obtain local approval for health plan contracts, as required by Health-General Article §3-306(d), and for approval of certain MCO contracts, as required by COMAR 10.09.72.02.

Table 2 illustrates the current status of the contracting process with several key third-party payers in Maryland, including MCOs that have engaged in discussions with the OAG.

**Table 2. Status of Contracting Process with Key Payers
(as of October 18, 2013)**

| PAYER | IN DISCUSSION | CONTRACT IN NEGOTIATION | CONTRACTS FINALIZED | CREDENTIALING PROCESS INITIATED |
|--------------------------|---------------|-------------------------|---------------------|---------------------------------|
| AETNA | X | X | | |
| CAREFIRST BCBS | | X | X | |
| CIGNA | X | X | | |
| UNITED | X | X | | X |
| MCOs | | | | |
| AMERIGROUP | X | | | |
| MARYLAND PHYSICIANS CARE | | X | | |
| RIVERSIDE HEALTH | X | X | | |
| UNITED COMMUNITY PLAN | | X | | X |

Contracting and Credentialing Next Steps

The continued engagement of LHDs and third-party payers will be required to ensure that contracts are finalized. Specifically, these items must be completed:

- OAG negotiation of legal terms with several third-party payers. This will likely continue into FY 2015;
- LHD or OAG identification of private insurer reimbursement rates; uncertainty about this is a reason LHDs have hesitated to contract to date;
- Completion of credentialing applications and fulfillment of any additional credentialing requirements by LHD providers;
- Finalization of forms and procedures for approval of contracts by LHDs and OAG;
- Review of vaccine purchasing procedures and fee waiver policies by LHDs, with assistance from the OAG and DHMH; and
- LHDs and DHMH identification of staff to monitor and ensure compliance with contracts.

General Implementation Plans

SHR has developed individualized implementation plans for each LHD based upon its needs, level of interest in third-party billing, internal resources, and system and staffing capabilities. In

addition, SHR has created standardized but customizable billing-related forms, materials, and policy and procedure recommendations.

Additionally, staff in all 24 LHDs have received training in the implementation of billing for immunization and other clinical services. Webinars were conducted in fall 2013 to address issues related to immunization coding and third-party billing:

- Coding and Billing for Influenza Immunizations – Influenza-specific coding and billing of various payers for individual patient services as well as Medicare roster billing;
- Immunization Coding and Billing Basics – Coding for vaccines and vaccine administration, front-end operations, and patient and third-party billing;
- Insurance Carrier Basics – Third-party payers including Medicare, Medicaid, commercial insurance plans, and MCOs; and
- Payer Contracting and Revenue Cycle Management – Payer contracting, practice management system set-up, revenue cycle management, claims denial reduction, and introduction to the LHD Immunization Billing Guide.

LHDs will require continued support in order to achieve a higher level of billing readiness. This support will require collaboration among DHMH, MPP, and SHR.

Future Support – LHD Billing and Implementation Grants

SHR's assessments found that LHDs in Maryland possess varying levels of readiness and interest in billing insurers. Even with the detailed assessment reports and implementation plans prepared by SHR for each LHD, the nature, scope, and financial assistance that each LHD may need to implement billing is still unclear. Each LHD must decide whether it will continue to utilize their existing PM system(s), or invest in a new, more robust PM system, as recommended by SHR. A new system would provide each LHD with fully integrated billing capability, including improved potential for recoveries from patients and third-party payers for immunization and other clinical services.

Future Support – Technical Billing Support

DHMH will continue offering technical support and training in calendar year 2014 to facilitate third-party billing by the LHDs. This support may include: staff education on vaccine coding, entering charges, and time of service payments; creation of standardized registration and charge capture forms; and establishing policies and/or procedures for front-end billing processes, generating billing reports, pre-edit claim review and processing, identifying and processing denials and appeals, and accounts receivable follow-up.

Statutory and Regulatory Changes

Both statutory and regulatory changes are needed to help address LHD billing challenges. DHMH has developed proposed legislation for introduction during the 2014 General Assembly session that would complement the efforts described in this report to improve overall LHD

readiness to bill for clinical services. This proposal would clarify, with certain exceptions established by law, LHD authority to expend funds collected from fees or charges, as well as carry over any unspent balances for use in subsequent fiscal years.

In addition, DHMH and the LHDs have agreed on changes to COMAR 10.02.01 concerning the setting of charges for LHD clinical services. Proposed changes would simplify the methodology for the setting of charges, and eliminate disparities in charges set by LHDs for similar services.

Upon implementation, both changes should benefit LHD billing and collection efforts. If LHDs are assured that they are able to retain these collections, they would have more incentive to make the changes necessary to successfully implement or improve upon existing third-party billing processes.

Conclusion

SHR has developed for each LHD an implementation plan which can be customized based upon its needs, internal resources, and system and staffing capabilities. SHR has also created and provided standardized but customizable billing-related forms, materials, and policy and procedures recommendations. The adoption of proposed legislative and regulatory changes, the correction of bill coding problems to enable third-party billing in accordance with CPT guidelines, and entering into contractual arrangements with health insurance plans and MCOs will help LHDs with the recovery and retention of third-party payments and other collections. Finally, each LHD must assess the benefits and costs of installing a new, robust PM system in determining its future course of action.