THIRD-PARTY BILLING FOR

Public Health STD Services

A Summary of Coordinated Needs Assessment Results

MARCH 2014

REGION I STD TAC
STD-RELATED REPRODUCTIVE HEALTH TRAINING AND TECHNICAL ASSISTANCE CENTER

JSI Research & Training Institute, Inc.

Third-Party Billing for Public Health STD Services:

A Summary of Coordinated Needs Assessment Results

STD-Certified 340B Clinics

State/Project Area STD Programs

State Public Health Laboratories

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REGION I STD TAC STD-RELATED REPRODUCTIVE HEALTH TRAINING AND TECHNICAL ASSISTANCE CENTER

JSI Research & Training Institute, Inc.

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ACRONYMS

340B	HRSA drug discount program for covered entities
ACA	Affordable Care Act
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center (Federally Qualified Health Center or “Look Alike”)
CPT	Current Procedural Terminology Codes
EHR	Electronic Health Record
EOB	Explanation of Benefits for insurance
FQHCs	Federally Qualified Health Centers
FP	Family Planning
HD	Health Department
HRSA	Health Resources and Services Administration
ICD	International Statistical Classification of Disease and Common Health Problems
IT	Information Technology
JSI	JSI Research & Training Institute, Inc.
LIMS	Laboratory Information Management System
PHLs	Public Health Laboratories
PMS	Practice Management System
PP	Planned Parenthood
QA	Quality Assurance
STD	Sexually Transmitted Disease (or Sexually Transmitted Infection)
STD RH TTACs	Full abbreviation for CDC-funded STD-related Reproductive Health Training and Technical Assistance Centers (Previously STDRHPTTACs)
STD TAC	Region I STD-related Reproductive Health Training and Technical Assistance Center
TA	Technical Assistance
TPP	Third-Party Payer
TTACs	Short abbreviation for STD-related Reproductive Health Training and Technical Assistance Centers (STD RH TTACs)

ACKNOWLEDGEMENTS

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Finally, we'd like to thank **each participant**. This report would not be possible without the nearly 500 respondents from clinics, agencies, public health laboratories and state programs who made time to answer the needs assessment questions.

EXECUTIVE SUMMARY

With the passage of the Patient Protection and Affordable Care Act (ACA), the environment in which health care is delivered is changing. Traditional safety net providers that have historically provided free or low-cost health care services through public financing face shifts in funding. Under the provisions of the ACA, the number of uninsured Americans is expected to drop, and future funding is uncertain. Federal and State funding agencies increasingly want to ensure that safety net services are utilized for the un-insured and under-insured. To sustain services, traditional safety net programs, including STD service providers, are diversifying their revenue streams by initiating or expanding billing of both public and private third-party payers.

The STD-related Reproductive Health Training and Technical Assistance Centers (STD RH TTACs) are funded regionally to provide training and technical assistance (TA) to support the implementation of third-party billing and reimbursement systems for clinics and public health laboratories providing publicly-funded STD services. This billing needs assessment is a compilation of ten coordinated regional needs assessments conducted by each of the ten STD RH TTACs. Each region assessed three different target audiences: STD-certified 340B clinics, state or project area STD programs, and state public health laboratories. The purpose of the assessment was to determine the current billing status, barriers to billing, and training and TA needs.

The results of the needs assessment showed that **a quarter of STD-certified 340B clinics (25%) and about a third (38%) of public health laboratories were not billing either Medicaid or private third-party payers.** About a third of STD-certified 340B clinics (30%) were billing Medicaid *only*; less than half of clinics (45%) were billing *both* Medicaid and other third-party payers for STD-related services. In fact, half of HD STD clinics (50%) do not collect fee-for-service payment from clients at all. Public Health Laboratories were less likely to bill than clinics: 38% do not bill any third-party payers, 41% bill Medicaid *only* for STD services, but only 21% of labs currently bill both Medicaid and other third-party payers.

SUMMARY OF COMMON THEMES

Findings from all three needs assessment target audiences had some similarities. The most commonly selected **barriers** to billing from all three assessments included: staffing constraints; confidentiality concerns; having a small percentage of patients that were insured; and to a lesser degree – that funds go into a general fund, and therefore do not support ongoing staffing and infrastructure needs.

All three of the needs assessment target audiences also indicated they have several of the same top training and technical assistance needs, including: assistance with contracting with third-party payers; development of a state-level coordinated effort for billing; and conducting cost analysis. Both clinics and project area respondents indicated a common need for training and technical assistance for coding, clinic flow, implementation of EHR, and use of claims data reports. Both project area and lab respondents indicated a common need for training and TA on contracting with third-party payers.

State public health laboratories and some clinics indicated that it would be helpful to have a coordinated state effort to assist with billing third-party payers for STD-related services. However, currently only around a third of STD program respondents reported there was already an effort to establish a state-level coordinated effort to bill Medicaid and other third-party payers for STD-related services (37%).

STD-CERTIFIED 340B CLINICS

According to the STD-certified 340B clinic needs assessment, 45% of clinics were billing *both* Medicaid and other third-party payers. **Smaller clinics, Health Department STD clinics, and STD-only service sites were less likely to bill third-party payers** than larger clinics, other site types, and those clinics providing integrated (STD and family planning) services. Health Department STD clinics made up 77% of those clinics *not* billing and small clinics (less than 2000 visits per year) made up 83% of those clinics *not* billing. When asked to rate internal capacity to carry out specific billing functions, Health Department STD clinics and small clinics had statistically less capacity to bill third-party payers than other site types. Overall, there was higher capacity among all clinic types to bill Medicaid than to bill private third-party payers.

In addition to current billing capacity, this needs assessment explored the potential for building billing capacity by identifying existing internal billing capacity in other programs. The potential for increased coordination or collaboration *within* agencies does seem to exist. Two thirds (60%) of respondents reported that other programs within their clinic or agency billed third-party payers, suggesting that those providing STD services may be able to benefit from the experience with billing that exists in other programs *within* their agency.

Clinics and agencies identified barriers to billing that included prohibitive billing policies, confidentiality concerns, and staff and infrastructure resource constraints. Respondents raised concerns about billing third-party payers for sensitive services and potentially violating client confidentiality. Several respondents expressed concern that some at-risk individuals might not seek care if insurance information was requested. Many pointed to the need for insurance reform for sensitive sexual health services. They sug¬gested that reforms should be made at the state or national level concerning the third-party payers' practice of sending explanation of benefits to the primary person insured. About 20% of respondents indicated that there were substantial organizational policies or legal barriers preventing them from billing, while infrastruc¬ture constraints were identified more broadly. Only 50% of needs assessment respondents had an electronic health record (EHR), and 37% of clinics report the lack of an EHR or Practice Management Software (PMS) is a barrier to their ability to begin billing. Health Department STD clinics and small clinics were also were also less likely than all other site types to report using an EHR. Because of the relatively **low number of insured patients** seeking services at publicly funded sites and the understanding that it is more expensive to bill per encounter with a lower volume, some clinics have not embraced billing third-party payers because of the anticipation of a low return on their investment. In addition to these barriers, several respondents mentioned that **scope of practice** and billing was a problem, as many clinics are staffed with RN's who can bill only for established patients, and only for a lower reimbursement rates.

Clinics and agencies reported substantial billing and reimbursement training/TA needs. **There were over 1,000 clinics represented in this needs assessment not currently billing private third-party payers. The top training needs for these clinics were identified as: ICD/CPT coding, cost analysis, and need for confidentiality protocols. Those not yet billing also identified a need for general billing information, or "Billing 101," and assistance finding partnerships to share resources and referrals.** Health Department STD clinics had consistently higher needs across response categories compared to other respondents. One exception is that assistance with ICD/CPT coding was requested by all site types, including 100% of PP/Free-Standing FP clinics.

Overall, the capacity to bill third-party payers varied, but the training/TA needs were consistently high. **Health Department STD clinics, STD services only clinics, and small sites had the least capacity to bill third-party payers and the most significant billing and reimbursement training/TA needs.**

STATE/PROJECT AREA STD PROGRAMS

Although state / project area STD programs are not expected to directly provide or bill for services, they are being asked to provide the technical and programmatic support for clinics and agencies around billing. Almost three-quarters **(70%) of respondents stated, however, they do not have the capacity to provide the needed services.** Project areas reported a wide range of levels of preparedness, but only 38% had conducted an assessment of billing and reimbursement capacity among clinics in their jurisdiction and even less (21%) had developed confidentiality protocols. Another 21% reported that the majority of the clinics in their jurisdiction already bill Medicaid and other third-party payers.

Among state/project area respondents, the identified barriers to billing included: the scope of license issues (clinics staffed by RNs), that the majority of their clients do not have third-party insurance (39%), and the lack of PMS or EHR (37%).

Revenue generation surfaced as a barrier to billing for several reasons, including the fact that in their system the funds will not come back to programs rather they will go to a state's general fund (28%), and a perception of inadequate revenue to justify billing (25%). Several (74%) of respondents reported that there were other programs in their Health Department that bill, which may represent an opportunity for sharing resources and protocols going forward.

The "top three" training / TA needs identified most commonly by respondents on behalf of 340B clinics in their jurisdiction were: contracting with third-party payers; setting up systems for a comprehensive cost analysis for STD services; and development of state-level coordinated efforts for billing third-party payers. State and project area STD programs reported limited ability to assist clinics in their transition to billing. **Only 20% of project area STD programs indicated they have capacity to assist clinics to initiate billing activities.** Asked to rate their readiness to assist clinics, 70% reported they needed TA in order to assist their funded clinics to bill third-party payers. Contracting with third-party payers and conducting cost analysis were identified by project areas as the most common TA needs for STD-certified 340B clinics in their jurisdiction.

STATE PUBLIC HEALTH LABORATORIES

Of the public health laboratories that participated in the needs assessment, **38% do not bill any third-party payers; 41% bill Medicaid *only* for STD services, and 21% currently bill *both* Medicaid and other third-party payers.** The majority of the public health laboratories are concerned about inadequate staffing to initiate billing and to follow-up on unpaid claims. A large number of the respondents (40%) cited confidentiality concerns (e.g. do not want Explanation of Benefits [EOB] to go to primary person insured) while 30% reported they did not know how to set up a contract or that the funds would not come back to their program (i.e. would go back to the general fund).

Nearly 80% of labs reported the need for some type of TA. **Over half of the labs identified contracting with third-party payers as one of their top TA needs, followed by developing a state-level coordinated effort for billing third-party payers.**

CONCLUSION

Across the needs assessments there were a significant number of clinics and public health laboratories not billing third-party payers. Very few state and project area STD programs reported an ability to provide the technical assistance STD-certified 340B clinics in their jurisdiction would need for billing. Across respondent types for the needs assessments there was a wide range across the entire continuum of capacity for billing. The common barri¬ers were identified as concerns about breaching confidentiality through billing, limited staff resources, limited infrastructure resources, organizational policies, and legal barriers.

The results of this assessment indicate that there were widespread unmet billing and reimbursement training and technical assistance needs. Across the respondent types, 74% of STD-certified 340B clinics, 70% of project area STD programs, and 88% of public health labs reported training/TA needs for billing and reimbursement. Overall, there was broad range of unmet need. Each potential training/TA need listed in the assessment was selected by 34-57% of clinics, 45% to 79% of STD programs (on behalf of clinics), and by 18%-71% of public health labs. To meet the extensive and diverse training/TA demands outlined in this report, a diverse group of TA providers will be needed. Coordination at the national level to address cross-cutting national issues like confidentiality concerns and infrastructure constraints should be continued.

BACKGROUND

With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, the environment in which health care is delivered is changing. Under the provisions of the ACA, enrollment in Medicaid and private insurance is expected to rise, and uninsured rates are expected to drop. Traditional safety net providers that have historically provided free or low-cost health care services through public financing may face shifts in funding for two main reasons. First, with lower uninsured rates, it is projected that fewer people will need safety net services because they will be able to obtain insurance coverage through Medicaid expansion and the health insurance marketplaces. Second, Federal and State funding agencies increasingly want to ensure that safety net services are available for uninsured and under-insured persons. To sustain services, traditional safety net programs are diversifying their revenue streams by initiating or expanding third-party billing of public (Medicaid and Medicare) and private third-party payers.

As cited in the recent report, **The Future of the Infertility Prevention Project: Policy Implications and Recommendations in Light of Passage of the Patient Protection and Affordable Care Act**, there are several implications of the changes in the health care environment.[1] While billing third-party payers promises a diversified revenue stream, in some project areas prohibitive policies, or local or state regulations and laws must be revised before third-party billing can be implemented. Changes in staffing and information technology infrastructure may also be required. Once the infrastructure is in place, staff will need to learn how to bill for services, including modifying the clinic flow, learning coding and documentation, and learning Medicaid and third-party payers contract obligations.

State, territorial, and local sexually transmitted disease (STD) prevention programs, family planning (FP) agencies, and public health laboratories (PHLs) need training and technical assistance (training/TA) to adapt to the changes, while maintaining or improving the quality of services provided. In 2012, the Centers for Disease Control and Prevention (CDC) Division of STD Prevention (DSTDP), in collaboration with the Office of Population Affairs (OPA) of the Department of Health and Human Services (HHS), funded a network of ten STD-related Reproductive Health Training and Technical Assistance Centers (STD RH TTACs) [http://www.cdc.gov/std/stdrhpttac/default.htm], one for each public health service region. These technical assistance centers (TTACs) were created to build capacity among STD and FP programs to improve sustainability of their programs. Specifically, the TTACs were asked to provide training/TA in billing and reimbursement, prevalence monitoring, and best practices using a range of modalities, including individualized technical assistance, training, and the development of online tools and other resources.

The goals of the STD RH TTACs addressed in this needs assessment are to build key stakeholder capacity to scale up billing, coding, and reimbursement systems and to promote STD-related operational billing best practices in STD-certified 340B clinics and public health labs.

1 The Future of the Infertility Prevention Project, 2011 is available for download from http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=13137&thisSection=Resources

INTRODUCTION

This report summarizes the findings of a coordinated needs assessment conducted between February and June 2013 to assess the billing and reimbursement training and technical assistance (training/TA) needs of the STD-related Reproductive Health Training and Technical Assistance Centers (STD RH TTACs) key stakeholders. The goal of this needs assessments was to compile local, state, regional, and national profiles of current capacity and training/TA needs related to billing, coding, and reimbursement among STD-certified 340B clinics and STD prevention programs, and the public health laboratories (PHLs) that support them.

The Heath Resources and Services Administration (HRSA) 340B program allows non-profit healthcare organizations that receive funding from specific federal programs and treat low-income and uninsured patients (covered entities) to register for 340B and purchase discounted outpatient drugs through the 340B program. These organizations include Federally Qualified Health Centers (FQHCs), Ryan White HIV/AIDS Program grantees, and certain types of hospitals and specialized clinics such as safety net family planning (FP) and STD clinics.[2] In this report, we refer to those 340B eligible clinics that were certified through STD programs as STD-certified 340B clinics. These clinics include Health Department STD clinics, Health Department Family Planning clinics, Community Health Centers or look-alikes, and Planned Parenthood or Free Standing Family Planning clinics (non-Title X-funded).

The needs assessment was designed to answer the following evaluation questions:

1. What is the current status of billing and reimbursement among STD-certified 340B clinics and state PHLs in each of the project areas?
2. What is the current capacity of state / project area STD programs to provide the needed support to family planning, STD clinics, and PHLs in order for them to bill Medicaid and other (private) third-party payers?
3. What types of billing and reimbursement training/TA needs do the states / project areas, clinics, and PHLs need in order for them to scale up to fully functioning billing and reimbursement systems?

This report presents a national picture of billing capacity among clinics and PHLs, as well as the capacity of STD programs to support billing among their funded clinics. There are three sections of this report which reflect the three different needs assessment tools that were employed to reach the different key stakeholders, defined for this assessment as:

1. STD-certified 340B service delivery sites including Health Department STD clinics, Health Department Family Planning clinics, Community Health Centers or look-alikes, and Planned Parenthood or Free Standing Family Planning clinics (non-Title X-funded).
2. State/project area STD Prevention programs, and
3. PHLs conducting STD testing.

2 Information available at: http://www.hrsa.gov/opa/eligibilityandregistration/.

The needs assessment was conducted by each of the ten STD-related Reproductive Health Training and Technical Assistance Centers (TTACs) and coordinated by JSI Research & Training Institute, Inc. (JSI). This report reflects the combined datasets from the three data collection tools implemented across ten regions. The needs assessment tools, evaluation questions, definitions of key stakeholders, and methodology were all determined through consensus with participation from the TTACs and guidance from CDC. Each needs assessment data collection tool was reviewed by the TTACs and CDC before implementation in the field. Needs assessment data collection was conducted by each of the ten TTACs through a web-based data collection tool (SurveyMonkey®). JSI compiled the data in Microsoft Excel and analyzed them in SAS. While these data are nationally representative of the defined target populations, they are not generalizable to other medical services or service providers. More information about methods and limitations is available in Appendix I: Methods.

This report is intended to be a national summary of the three combined billing needs assessments; results from each assessment are described separately. For each section the overarching evaluation questions are: 1) Who participated in this assessment? 2) What are respondents' capacity to bill? 3) What are barriers to billing? and 4) What are the training and technical assistance needs? Highlights of the assessment findings are found in the Results section of this report. Summary data for each needs assessment question are presented in Appendix II: Summary Data. Each STD RH TTAC will analyze and utilize the assessment data at the state and regional level to determine the training/TA needs for their region.

RESULTS

A. STD-CERTIFIED 340B CLINICS

I. Who participated in the needs assessment?

The STD-related Reproductive Health Training and Technical Assistance Centers' (STD RH TTAC) clinic billing needs assessment was an assessment of the non-Title X-funded STD-certified 340B clinics in the U.S. These clinics included Health Department STD Clinics, Health Department Family Planning clinics, Community Health Centers, Planned Parenthood clinics, Free Standing Family Planning clinics among others. The purpose of the assessment was to determine the billing status and current capacity to bill, as well as training and technical assistance (TA) needs of these clinics. The overall participation rate was 72%, ranging by region from a low of 36% to a high of 87% (Table 1 and Figure 1). The participation rates were determined by whether a representative of the "entity" as listed on the CDC-generated list of STD-certified 340B clinics participated in the needs assessment. Prior to requesting participation in the needs assessment, 279 entities were excluded because they were Title X-funded.[3] Of the 870 entities that responded, the majority (723) answered the assessment as an agency representing multiple clinics. Entities from 45 states (five states—Kansas, Minnesota, New Hampshire, South Dakota and Rhode Island—did not have STD-certified 340B clinics) the District of Columbia, and funded territories (Commonwealth of Puerto Rico and U.S. Virgin Islands) were asked to participate in the needs assessment. Clinics from 42 of these 45 states, the District of Columbia, and the territories participated in the needs assessment (see Appendix II: Summary Data). While participation rates varied by state and region there was broad participation from across all parts of the country.

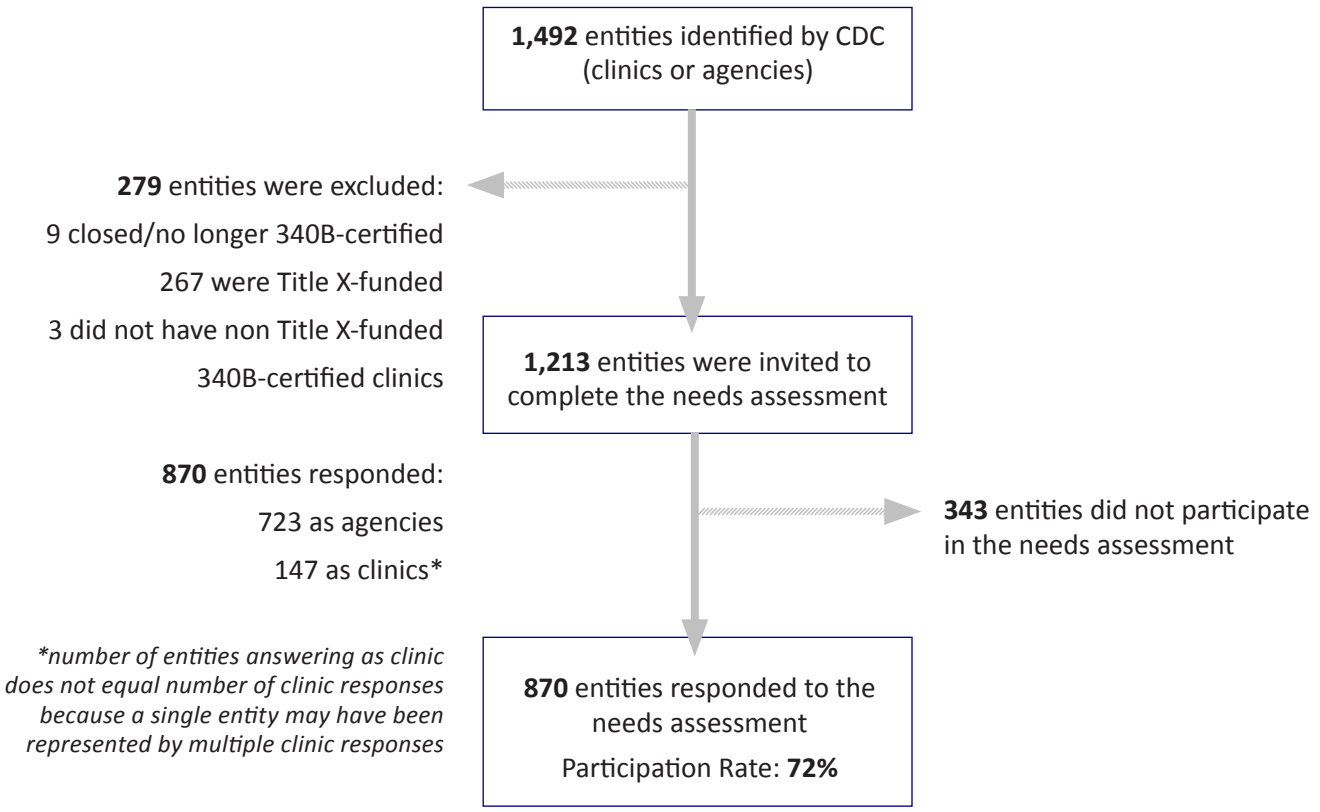
TABLE 1: PARTICIPATION RATE OF STD-CERTIFIED 340B CLINICS BY REGION

Region	# Eligible Entities	# Entities Responded	# of Entities Responding as Clinic*	# of Entities Responding as Agency*	Participation Rate
Region I	27	16	5	11	60%
Region II	75	33	25	8	44%
Region III	45	33	15	18	73%
Region IV	573	498	2	496	87%
Region V	111	42	18	24	38%
Region VI	17	12	9	3	71%
Region VII	36	26	7	19	72%
Region VIII	70	25	15	10	36%
Region IX	109	76	18	58	70%
Region X	150	109	33	76	73%
Total	**1,213**	**870**	**147**	**723**	**72%**

**Note: Total number of clinics and agencies are not equivalent to the number of assessment responses. For example, an agency may represent multiple entities. See Methods.*

3 *For example, a Health Department that funded only clinics that were Title X-funded or did not directly fund clinics was an "entity" with no clinics.

FIGURE 1: STD-CERTIFIED 340B CLINIC PARTICIPATION RATE



Needs assessment respondents could respond either as a single clinic or as an agency representing multiple clinics. Agency respondents were included only if billing decisions and protocols were executed centrally within the agency. There were 333 responses to the STD-certified 340B clinic needs assessment, 206 (62%) participated as single clinics and 127 (38%) participated as agencies. The 127 agencies represented 1,729 clinics. Overall, 1,935 clinics were represented. The number of clinics did not equal the number of entities from the master list of 340B entities because the entity type (clinic or agency) listed in the list of 340B clinics was not always the same as the respondent type.[4] Each entity listed as an STD-certified 340 B entity may have responded as: a single entity representing only one clinic, a single entity that responded for multiple clinics, a single entity that responded for multiple entities. See Methods for more information.

4 Common reasons for there being more clinics represented in the needs assessment than were accounted for in the master list of 340B clinics were: 1) an "entity" listed as a clinic in the 340B list answered the assessment as an agency that represented more than one clinic and 2) there was one agency listed in the master 340B list and it either answered on behalf of multiple clinics or forwarded the assessment to multiple clinics.

The two respondent types (clinic and agency) differed somewhat from each other. Respondents answering as a single clinic had on average 3,190 annual visits (1,100 median annual visits), while those responding as agencies were much larger and had on average 42,179 annual visits or an average of 5,212 annual visits per clinic (8,000 median annual visits). A few very large single clinics and agencies caused the average to be higher than the median number of visits. On average, each agency represented 14 clinics (median of 5 clinics). Single clinics were more likely to provide STD services only, compared to agencies that participated in the needs assessment (53% vs. 17%, respectively) (Table 2). Single clinics also represented a higher percentage of Health Department (HD) STD clinics compared to those responding as an agency (61% vs. 32%, respectively) (Table 3).

TABLE 2: SERVICES PROVIDED BY RESPONDENT TYPE (Q7)

	Clinic		Agency		Total Respondents	
	N	%	N	%	N	%
STD services only	105	53%	21	17%	126	39%
Integrated Services (including FP and STD services)	80	40%	97	76%	177	54%
Other (Such as primary care and HIV)	14	8%	9	7%	23	7%
Total	**199**	**100%**	**127**	**100%**	**326**	**100%**

Number of missing responses: *7* *0* *7*
Percentages may not add up to 100% due to rounding.

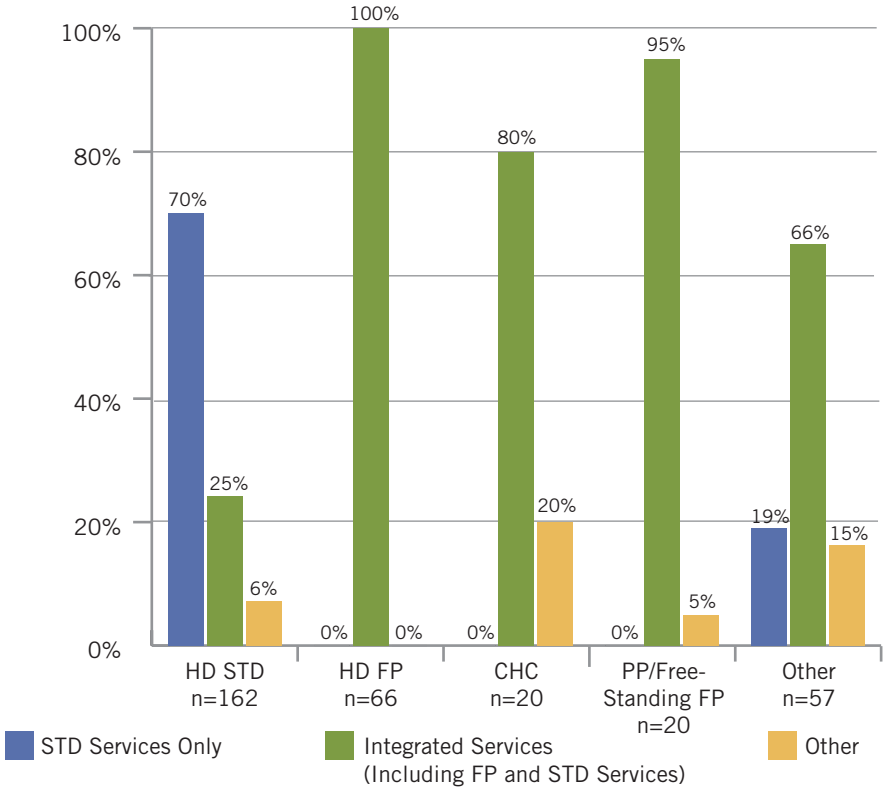
TABLE 3: SITE TYPE BY RESPONDENT TYPE (Q8)

	Clinic		Agency		Total Respondents	
	N	%	N	%	N	%
Health Department STD Clinics	121	61%	41	32%	162	50%
Health Department FP Clinics	33	17%	33	26%	66	20%
Community Health Center	5	3%	15	12%	20	6%
PP/Free-standing FP	3	2%	17	13%	20	6%
Other	36	18%	21	17%	57	18%
Total	**198**	**100%**	**127**	**100%**	**325**	**100%**

Number of missing responses: *8* *0* *8*

The majority of Health Department STD clinics provided STD services only (70%), while the majority of all other sites offered integrated clinic services (family planning (FP) and STD services) (Figure 2). All Health Department FP clinics reported integrated services, as well as 80% of Community Health Centers (CHCs), and 95% of Planned Parenthood (PP)/Free-Standing FP clinics.

FIGURE 2: SERVICES PROVIDED BY SITE TYPE (N=333) (Q7/Q8)



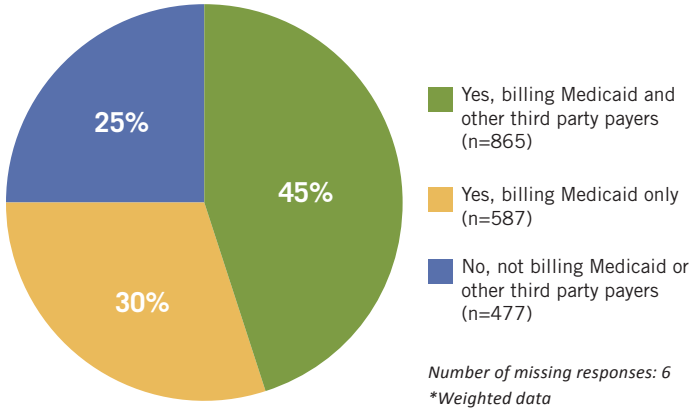
**Number of missing responses: 8*

II. What are STD-certified 340B clinics' billing status?

BILLING STATUS

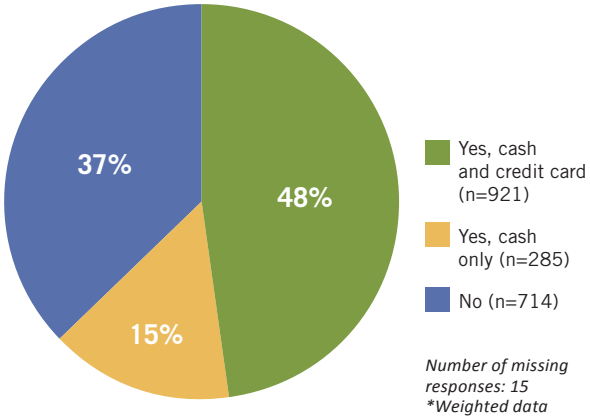
The billing status was assessed by combining clinics represented as agencies and single clinics. This section uses weighted data; the agency data were weighted by how many clinics they represented to demonstrate the magnitude of the number of clinics billing and not billing. Overall, less than one half (45%) of clinics (865) were billing both Medicaid and third-party payers; 30% (587) of clinics were billing Medicaid only, and one quarter (25%) of clinics were not billing Medicaid or other third-party payers at all (477) (Figure 3). There were over 1,000 clinics not billing private third-party payers, which is likely an underestimate given that 28% of 340B entities did not participate in the assessment. About a third of clinics (37%) do not collect payments from their clients for STD services. This is an important function for collecting co-pays associated with third-party billing (Figure 4). For those clinics collecting payment from clients (either cash or credit card payments), 68% (824) are using a sliding scale to assess fees (Figure 5).

FIGURE 3: STD-CERTIFIED 340B CLINICS' BILLING STATUS* (N=1,935) (Q13)



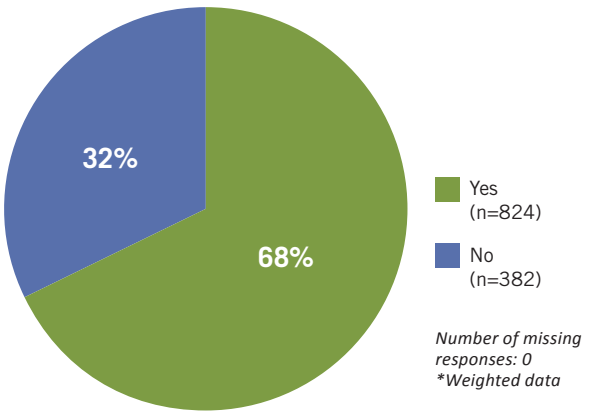
Number of missing responses: 6
**Weighted data*

FIGURE 4: STD-CERTIFIED 340B CLINICS COLLECTING FFS FROM CLIENTS * (N=1,935) (Q11)



Number of missing responses: 15
**Weighted data*

FIGURE 5: OF CLINICS CHARGING FFS, CLINICS USING SLIDING FEE SCALE TO ASSESS FEES* (N=1,206) (Q12)

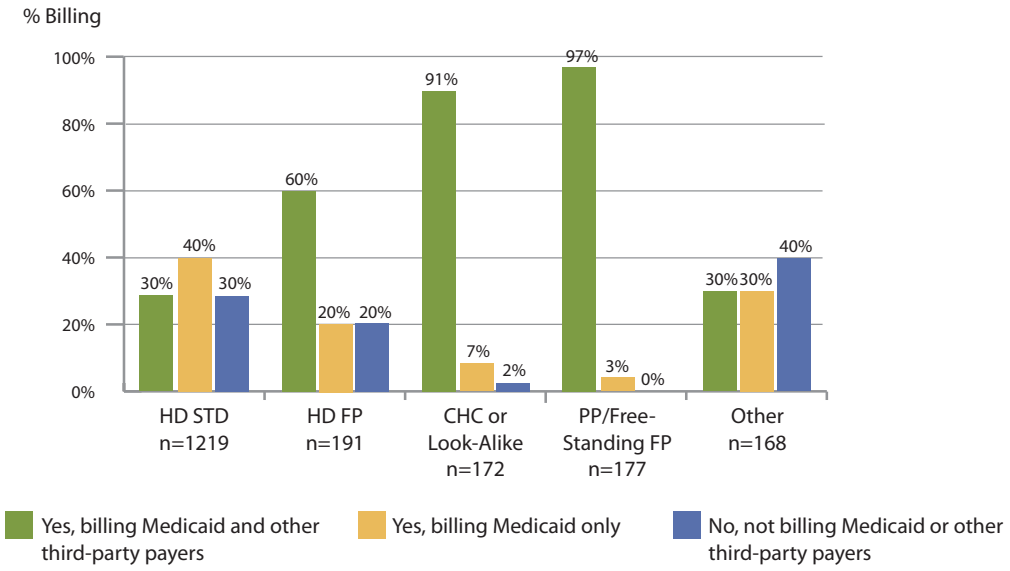


Number of missing responses: 0
**Weighted data*

BILLING STATUS STRATIFIED BY SITE TYPE

Some settings were less likely to bill for STD services than others. Nearly one-third (30%) of Health Department STD clinics did not bill Medicaid or other third-party payers compared to 20% of Health Department FP clinics, 2% of CHCs, and none (0%) of the PP / Free-Standing FP clinics (Figure 6). Health Department STD Clinics were more likely to bill Medicaid only compared to other site types that were more likely to bill both Medicaid and other third-party payers (Figure 6). Those clinics providing STD services only were also less likely to bill than those clinics providing integrated services (data not shown).[5]

FIGURE 6: PERCENT OF CLINICS BILLING THIRD-PARTY PAYERS FOR STD SERVICES BY SITE TYPE* (N=1,935) (Q8/Q13)

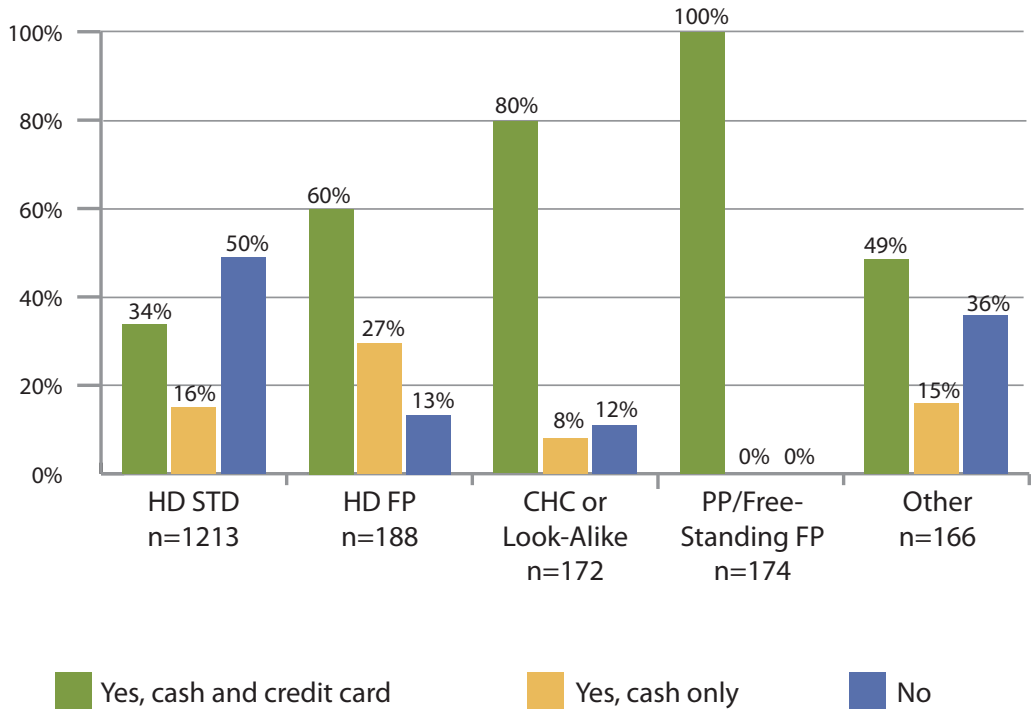


Number of missing responses: 8
**Weighted Data*

5 STD clinics were more likely than all other site types to provide STD services only. To simplify the presentation only site type data were presented.

There were also differences in capacity to accept cash and credit cards for fee-for-service payment across site types. The Health Department STD clinics were the least likely to collect fee-for-service. Only one third (34%) of Health Department STD clinics accept both cash and credit cards, and half (50%) do not collect fee-for-service at all (Figure 7). The majority of all other sites billed fee-for-service.

FIGURE 7: PERCENT OF CLINICS THAT CHARGE FEE-FOR-SERVICE FROM CLIENTS FOR STD SERVICES BY SITE TYPE* (N=1,935) (Q12)

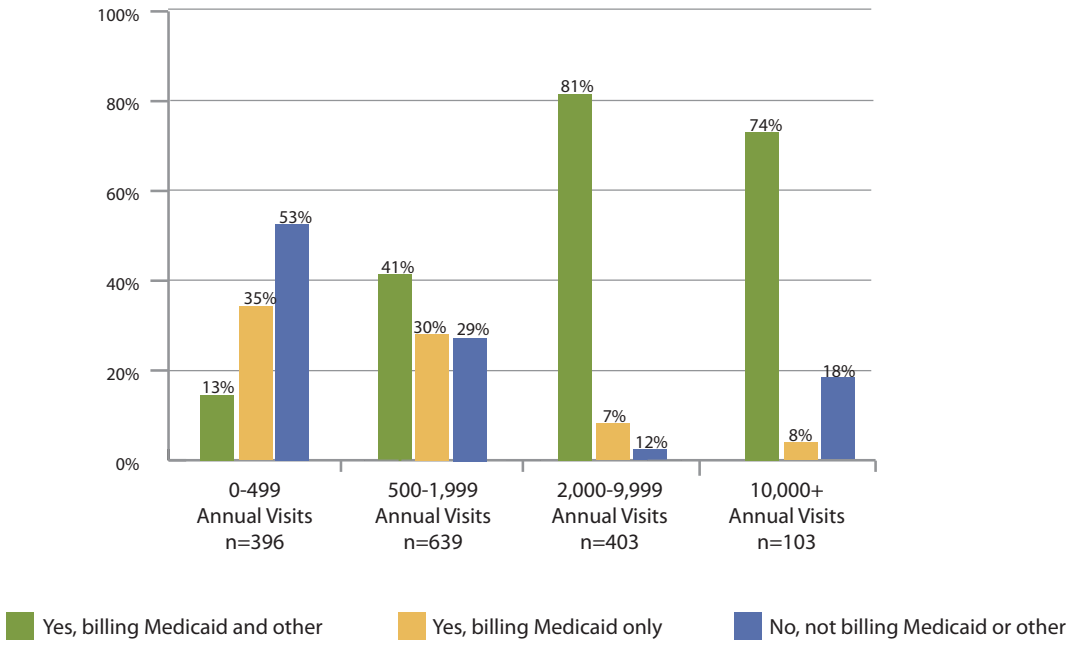


Number of missing responses: 22
**Weighted data*

BILLING STATUS STRATIFIED BY SIZE

Small clinics were less likely to bill both Medicaid and other third-party payers than large clinics. Among clinics with less than 500 annual visits, just over half (52%) were not billing. Among the medium sized clinics, or those with annual visits between 500 and 1,999, about a third (29%) were not billing, and among those with the largest number of annual visits (2,000-9,999 and 10,000+), only 12% and 18% were not billing (Figure 8). Small clinics, or those with fewer annual visits, were also less likely to collect fee-for-service (Less than 500: 42% and 500-1,999: 55%) than those with more annual visits (2,000-9,999: 86% and 10,000+: 74%).

FIGURE 8: BILLING STATUS BY CLINIC SIZE* (N=1935) (Q13/Q6)

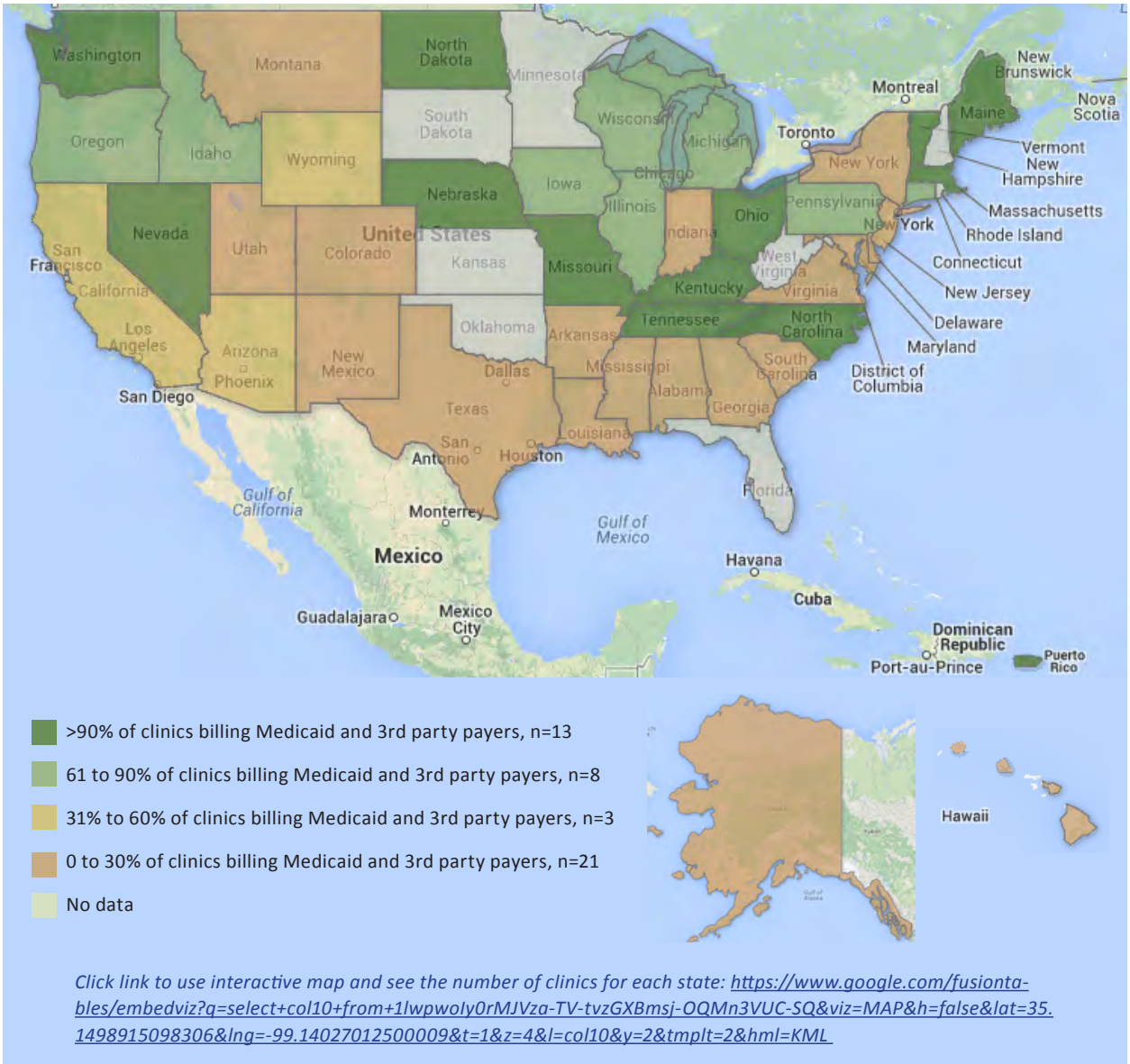


Number of missing responses: 394
**Weighted data*

GEOGRAPHIC DISTRIBUTION OF CLINICS BILLING AND COLLECTING PAYMENTS FROM CLIENTS

Respondents in 19 states and two territories (Guam and Virgin Islands not shown) had less than 30% of clinics billing Medicaid and other third-party payers (Figure 9). Of the 21 states and territories that had a low percentage of clinics billing insurance for STD services, three indicated they had a state or local law prohibiting billing for STD services. Three states had 31-60% of clinics billing Medicaid and other third-party payers. Eight states and the District of Columbia had 61-90% of clinics billing, but only twelve states and Puerto Rico, or around a third of participating states, had more than 90% of their clinics billing. No data were available in five states because they did not have non-Title X STD-certified 340B clinics. Clinics from three states did not participate in the needs assessment.

FIGURE 9: PERCENT OF CLINICS BILLING MEDICAID AND OTHER THIRD-PARTY PAYERS FOR STD SERVICES BY STATE* (N=1,935) (Q13/Q1)

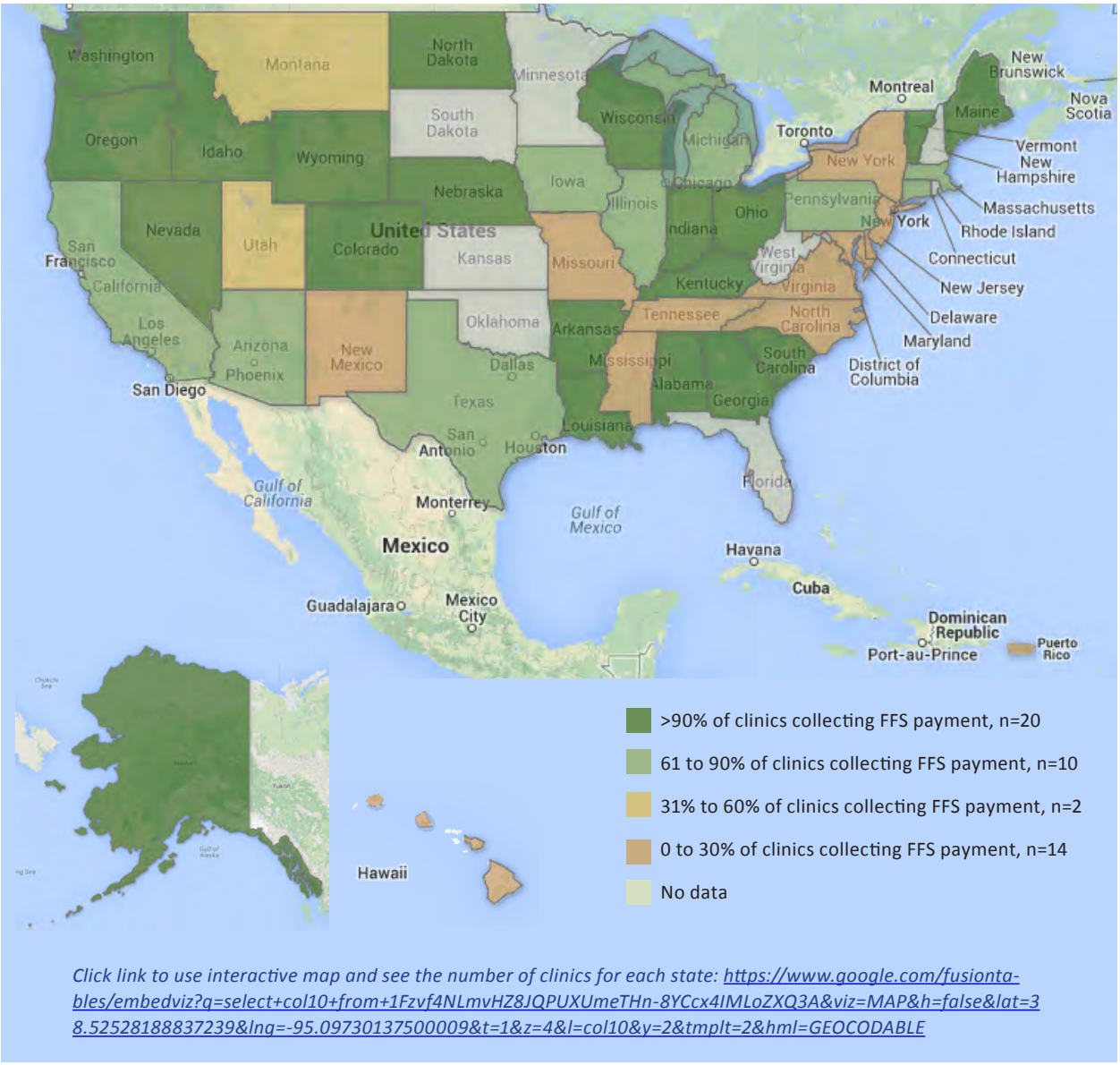


Click link to use interactive map and see the number of clinics for each state: https://www.google.com/fusiontables/embedviz?q=select+col10+from+1lwpwoIy0rMJVza-TV-tvzGXBmsj-OQMn3VUC-SQ&viz=MAP&h=false&lat=35.1498915098306&lng=-99.14027012500009&t=1&z=4&l=col10&y=2&tmplt=2&hml=KML

**Weighted data*

Needs assessment respondents in 12 states and two territories (Guam and Virgin Islands not shown) reported less than 30% of clinics collecting fee-for-service payment from clients for STD services (Figure 10). There were two states where 31-60% of clinics were collecting fee-for-service and nine states and the District of Columbia where 61-90% of clinics were collecting fee-for-service. In 20 states, however, greater than 90% of clinics were collecting payments from clients.

FIGURE 10: PERCENT OF CLINICS COLLECTING FEE-FOR-SERVICE PAYMENT FROM CLIENTS FOR STD SERVICES BY STATE (N=1,935) (Q11/Q1)



Click link to use interactive map and see the number of clinics for each state: https://www.google.com/fusiontables/embedviz?q=select+col10+from+1Fzvf4NLmvHZ8JQPUXUmeTHn-8YCcx4IMLoZXQ3A&viz=MAP&h=false&lat=38.52528188837239&lng=-95.09730137500009&t=1&z=4&l=col10&y=2&tmplt=2&hml=GEOCODABLE

**Weighted data*

CHARACTERISTICS OF CLINICS NOT BILLING

The clinics that were not billing were smaller; more likely to provide STD services only; and more likely to be Health Department STD clinics compared to those that were billing (Table 4). The median number of visits was significantly lower for clinics not billing (741) compared to those billing (1,370). Those clinics not billing were more likely to provide STD services only (52%) compared to those billing (20%). Those not billing were also more likely to represent a Health Department STD clinic (77%) compared to those billing (59%). All of these differences were statistically significant.

TABLE 4: COMPARISON OF CHARACTERISTICS OF CLINICS BILLING AND NOT BILLING* (Q13/Q7)

	Billing		**Not Billing**		
	N	Median	N	Median	*p-value***
Median Number of Annual Visits	1,065	1,370	435	741	<0.0001

Number missing: 435

	N	%	N	%	*p-value****
Service Type					
STD services only	288	20%	245	52%	
Integrated clinic (FP and STD services)	949	65%	200	43%	
Other	220	15%	25	5%	<0.0001
Total	**1,457**		**470**		

Number missing: 8

	N	%	N	%	*p-value****
Site Type					
Health Department STD clinics	859	59%	360	77%	
Health Department FP clinics	152	10%	39	8%	
PP/Free-standing FP clinics	177	12%	0	0%	
Other	269	18%	70	15%	<0.0001
Total	**1,457**		**469**		

Number missing: 9

**Weighted data*

***The Wilcoxon Rank Sum test was used for significance testing because the data are not normally distributed*

****p-values from Pearson chi-square test*

III. What capacity do clinics have to begin billing?

The previous discussion describing clinics' billing status used weighted data to describe the total number of clinics billing. For the remainder of the report, data are presented as total number and percent of respondents.

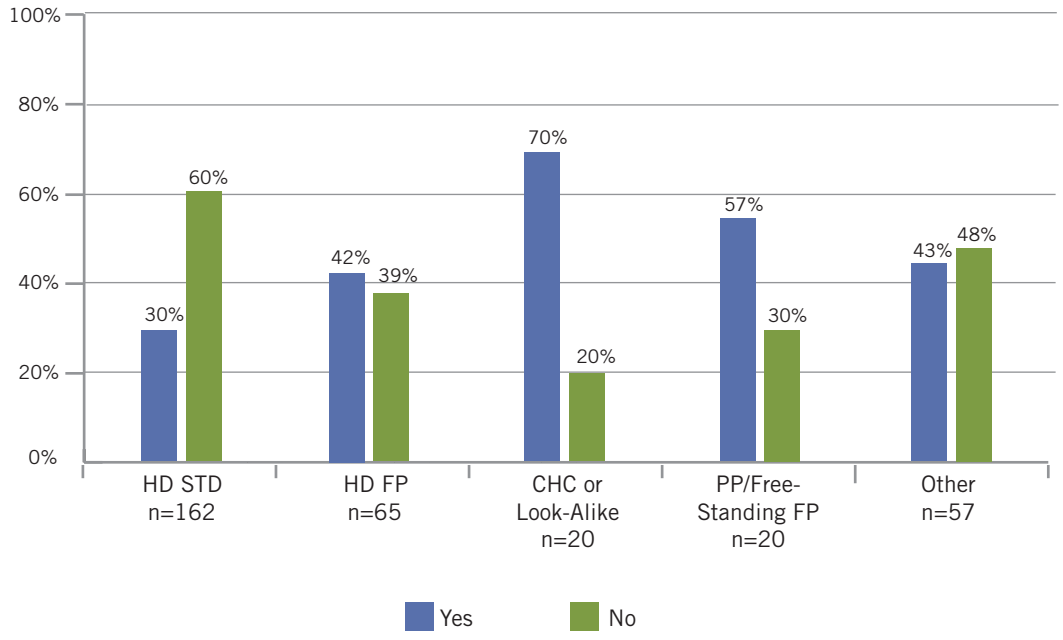
Health care billing is predominantly done electronically, and use of an electronic health record (EHR) and/or a practice management system (PMS) are commonly used tools to bill, albeit not required ones. The needs assessment asked whether clinics were using an EHR and/or a PMS. Over a third (38%) of respondents used an EHR (Table 5). Health Department STD clinics were less likely than all other site types to report using an EHR (Figure 11). Small clinics were also less likely than large clinics to report having an EHR (Figure 12). Among needs assessment respondents that reported using an EHR, considerable flexibility existed: 87% were able to customize reports, 81% collected insurance information, and 80% were able to customize data fields (see Appendix II: Summary Data).

TABLE 5: RESPONDENTS WITH ELECTRONIC HEALTH RECORD (Q9)

	Total Respondents	
	N	**%**
Yes	127	38%
No	166	50%
Implementing by end of 2014	38	11%
Total	**331**	**100%**

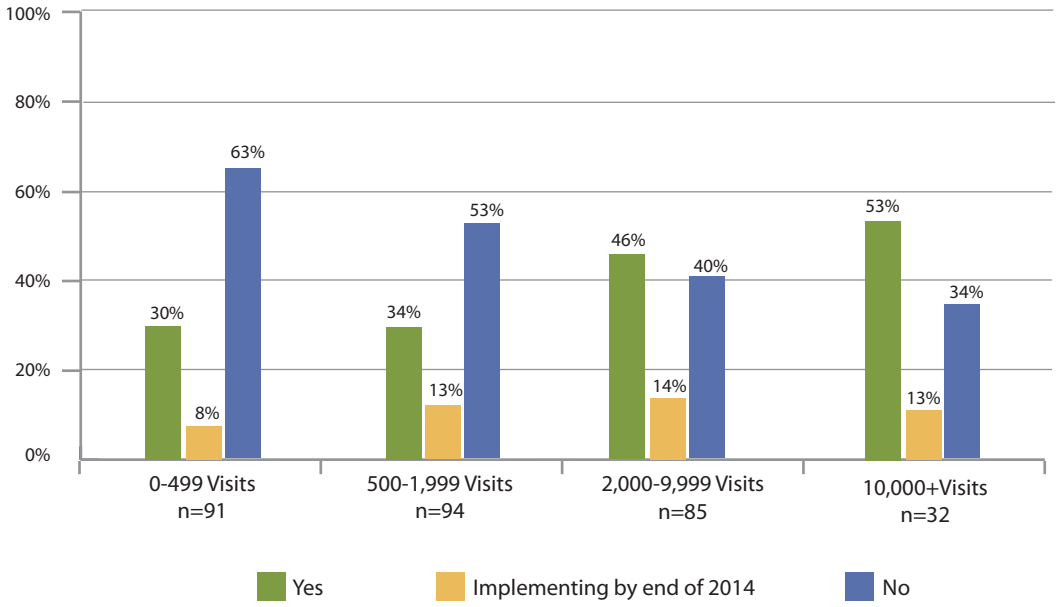
Number of missing responses: 2

FIGURE 11: PERCENT OF RESPONDENTS WITH ELECTRONIC HEALTH RECORD BY SITE TYPE (N=333) (Q9/Q8)



Number of missing responses: 2

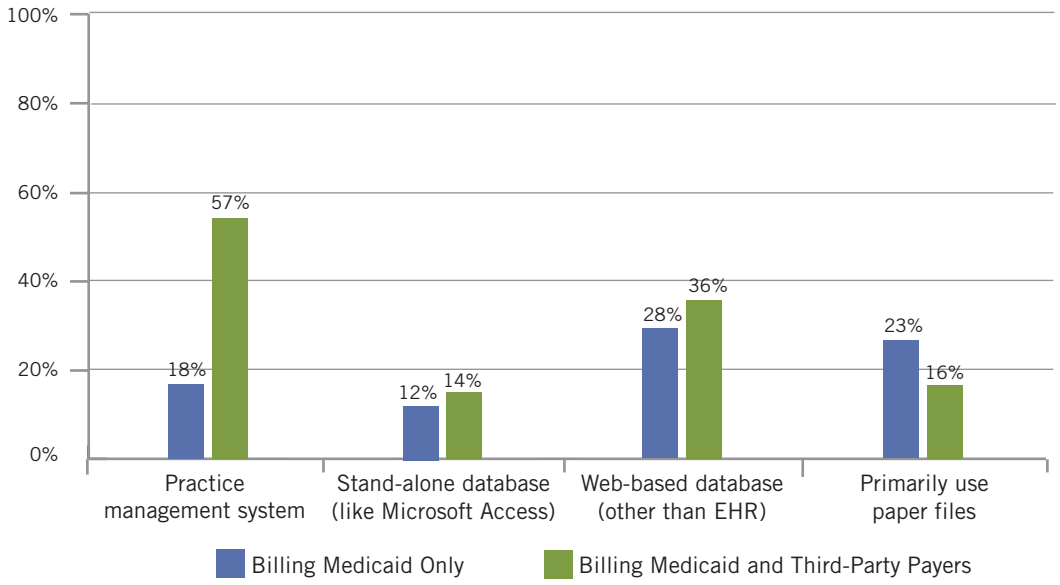
FIGURE 12: PERCENT OF RESPONDENTS WITH ELECTRONIC HEALTH RECORD BY CLINIC SIZE (N=333) (Q9/Q3)



Number of missing responses: 31

Those clinics and agencies billing only Medicaid were less likely to use a practice management system to collect insurance information (18% compared to 57%) and were more likely to primarily use paper files (23% compared to 16%) when compared to those billing both Medicaid and third-party payers (Figure 13).

FIGURE 13: TYPES OF INFORMATION SYSTEMS (OTHER THAN EHR) USED TO COLLECT INSURANCE INFORMATION BY BILLING STATUS (BILLING MEDICAID ONLY N=65; BILLING MEDICAID AND THIRD-PARTY PAYERS N=119) (Q16/Q22)



Number of missing responses: 6, 14

Percentages will not add to 100% because this question is check all that apply.

One strategy for scale-up of billing is for STD service providers to partner with other programs or agencies that already bill for services. In order to assess the overall feasibility of this strategy, respondents were asked about other programs' capacity to bill in their agency. Among organizations not currently billing for STD services, but billing for other services, there is potential for expanding billing to STD services within their agency. Two thirds (60%) of respondents reported that other programs within their clinic or agency billed third-party payers (Table 6). Clinics and agencies already billing may also be a potential resource to those not yet billing. Three-quarters (76%) of those billing Medicaid and third-party payers have developed protocols or guidance on how to ensure patient confidentiality when billing third-party payers for STD services (see Appendix II: Summary Data). Already existing tools and protocols could be used as samples for those clinics that do not yet bill. However, almost two thirds of respondents (67%) reported no plans to begin billing or they were "not sure" of billing plans, suggesting that for many organizations the decision to bill third-party payers has not been made.

TABLE 6: OF THOSE NOT BILLING, INTERNAL CAPACITY TO BILL FOR STD SERVICES (Q14/Q15)

	Any Program within Clinic or Agency Bills Private Third-Party Payers		Steps Underway to Begin Billing for STD-Related Services Within the Next Year	
	N	**%**	**N**	**%**
Yes	87	60%	45	32%
No	55	38%	56	40%
Not sure	4	3%	38	27%
Total	**146**	**100%**	**139**	**100%**
Number of missing responses:	*2*		*9*	

Having an accounts receivable staff is an important component of the capability to bill in-house as staff must bill third-party payers, post payments, and follow-up on denied claims. Among clinics or agencies who report billing Medicaid only, the majority (85%) reported having a department or staff assigned to manage and follow-up on accounts receivable; almost all (95%) of those billing Medicaid and third-party payers have these staff (Table 7). Some clinics or agencies used an outside billing agency rather than using in-house staff to manage accounts. Only a small percentage of those respondents billing Medicaid only used an outside billing agency (11%) compared to almost a quarter of those billing third-party payers (23%).

TABLE 7: INTERNAL AND EXTERNAL ACCOUNTS RECEIVABLE CAPACITY (Q13/Q17/Q18)

	Bill Medicaid Only				Bill Medicaid and Other Third-Party Payers			
	Have a Department or Staff Assigned to Manage Accounts Receivable		Use Outside Billing Agency		Have a Department or Staff Assigned to Manage Accounts Receivable		Use Outside Billing Agency	
	N	%	N	%	N	%	N	%
Yes	54	87%	7	11%	111	95%	27	23%
No	8	13%	54	89%	6	5%	88	77%
Total	62	100%	61	100%	117	100%	115	100%

Number of missing responses:
3 *4* *0* *2*

In order to remain financially viable, a cost analysis is recommended to assess the impact of billing and assess the cost of STD-related services. A little less than one-third of respondents (30%) had conducted a detailed cost analysis to identify the cost of STD-related services within the past two years (Table 8). Approximately the same percentage (32%) had also conducted an analysis of their payer mix. Those that were billing Medicaid and other third-party payers were more likely to have conducted the analysis (50%) compared to those billing Medicaid only (20%) and those not billing at all (20%) (see Appendix II: Summary Data).

TABLE 8: COST ANALYSIS AND CLIENT PAYER MIX ANALYSIS (Q28/Q29)

	Detailed Cost Analysis to Identify Cost of STD Services in Last Two Years		Client Payer Mix Analysis	
	N	%	N	%
Yes	93	30%	100	32%
No	173	55%	173	55%
Not sure	47	15%	41	13%
Total	**313**	**100%**	**314**	**100%**

Number of missing responses: *20* *19*

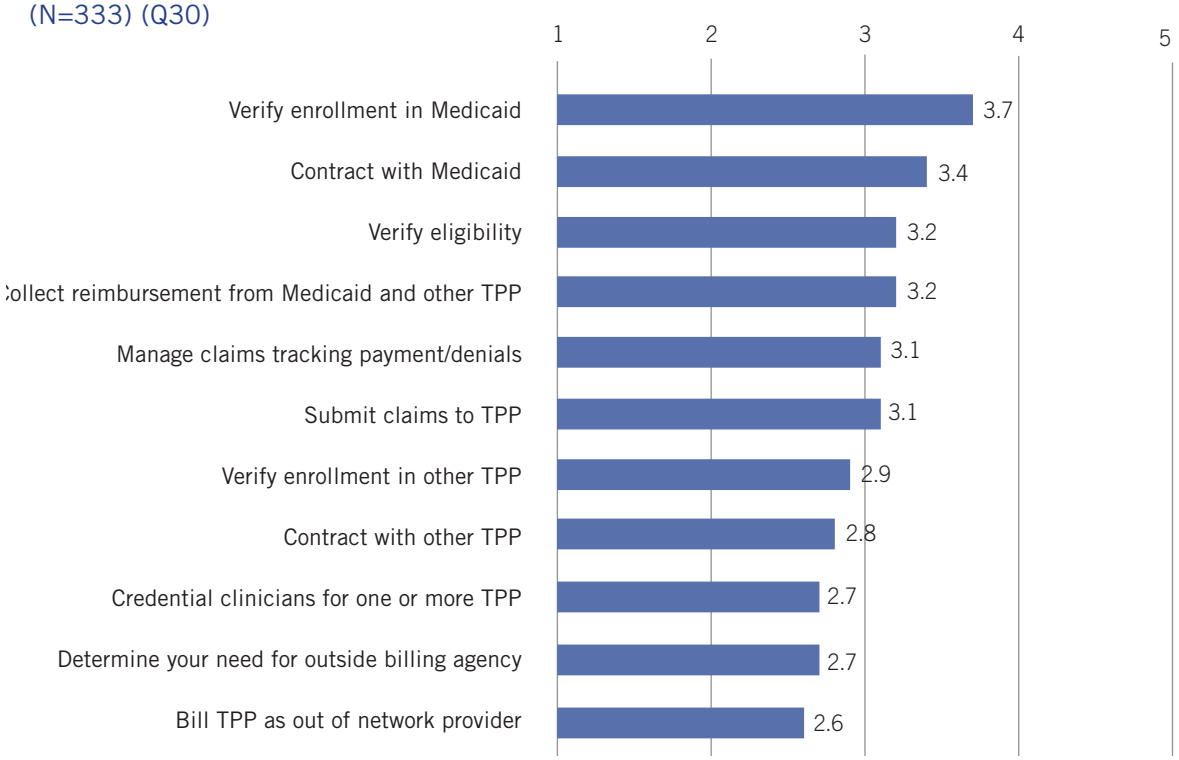
Finally, needs assessment respondents were asked to rate (on a scale of one to five) their respective program's capacity to bill Medicaid and other third-party payers for STD services across a number of billing activities. Respondents were asked to identify which of following response categories best represents their current capacity as shown below.

1	2	3	4	5	N/A
Don't know what this is, ***have not begun this activity;***	Just getting started, ***e.g. doing the activity for the first time;***	Able to do the activity, ***but may benefit from help;***	Able to do the activity ***and do not need help;***	Highly capable, ***i.e. could teach others;*** and	Not applicable

The majority of respondents, which included those already billing, reported a mean response for most categories somewhere between "just getting started (e.g. doing the activity for the first time)" to "being able to do the activity (but may benefit from help)" indicating that there was substantial need for training/TA to assist clinics with these activities.

Respondents had more capacity to bill Medicaid than other third-party payers. However, the average self-assessed score for doing a basic billing activity like verifying Medicaid enrollment still indicated that there was some need for training. The areas of lowest average capacity included: billing third-party payers as out of network provider (2.6); credentialing clinicians for one or more third-party payers (2.7); determining clinic needs for billing assistance such as a billing agency/clearing house (2.7); contracting with other third-party payers (2.8); and verifying enrollment in other third-party payer insurance (2.9) (Figure 14).

FIGURE 14: CLINIC CAPACITY TO BILL MEDICAID AND OTHER THIRD-PARTY PAYERS FOR STD SERVICES (N=333) (Q30)



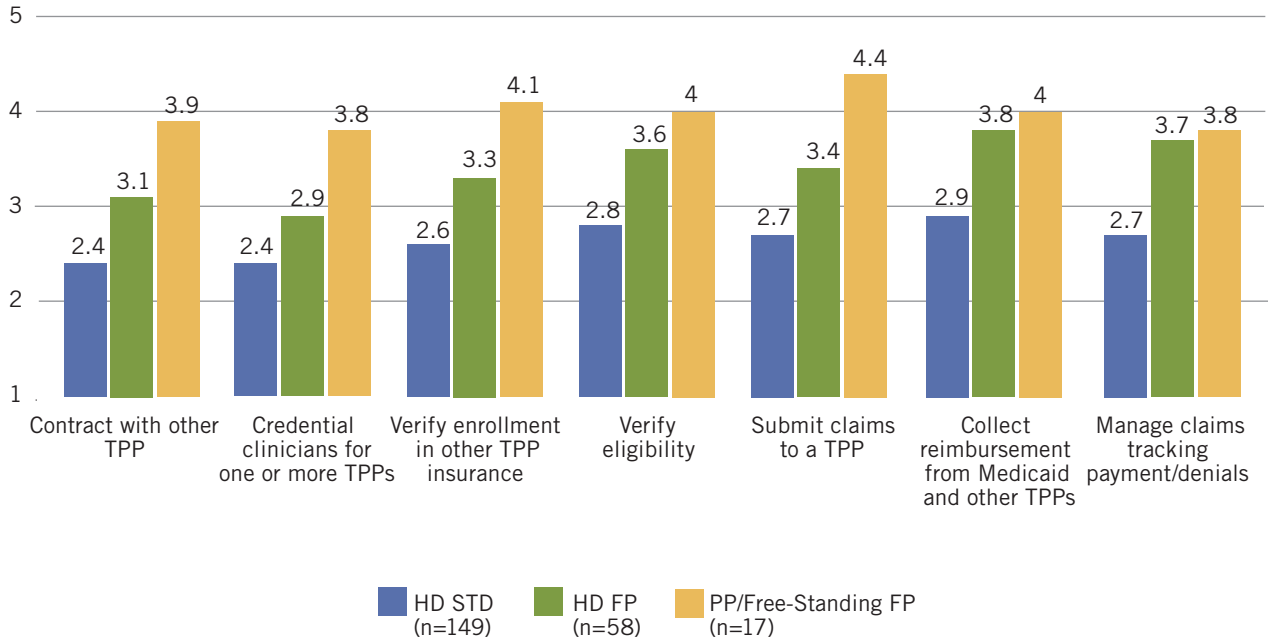
Number of missing responses: 30

In general, Health Department STD clinics had less capacity to bill third-party payers than other site types (Figure 15). The difference in capacity between STD clinics and PP/Stand-alone Family Planning clinics was statistically significant for all topics in the capacity scale except for: verify enrollment in Medicaid and verify eligibility (data not shown). Stratified by size, smaller clinics indicated less capacity to bill than larger ones (Figure 16)[6]. This relationship was also statistically significant for all topics except for the capacity to contract with Medicaid (data not shown).[6] The group of clinics starting at level one will likely need more resources to begin billing than those with some experience billing (either billing other services within their agency or billing Medicaid).

6 Annual visits was derived by dividing annual visits by number of clinics for respondents who answered on behalf of multiple clinics.

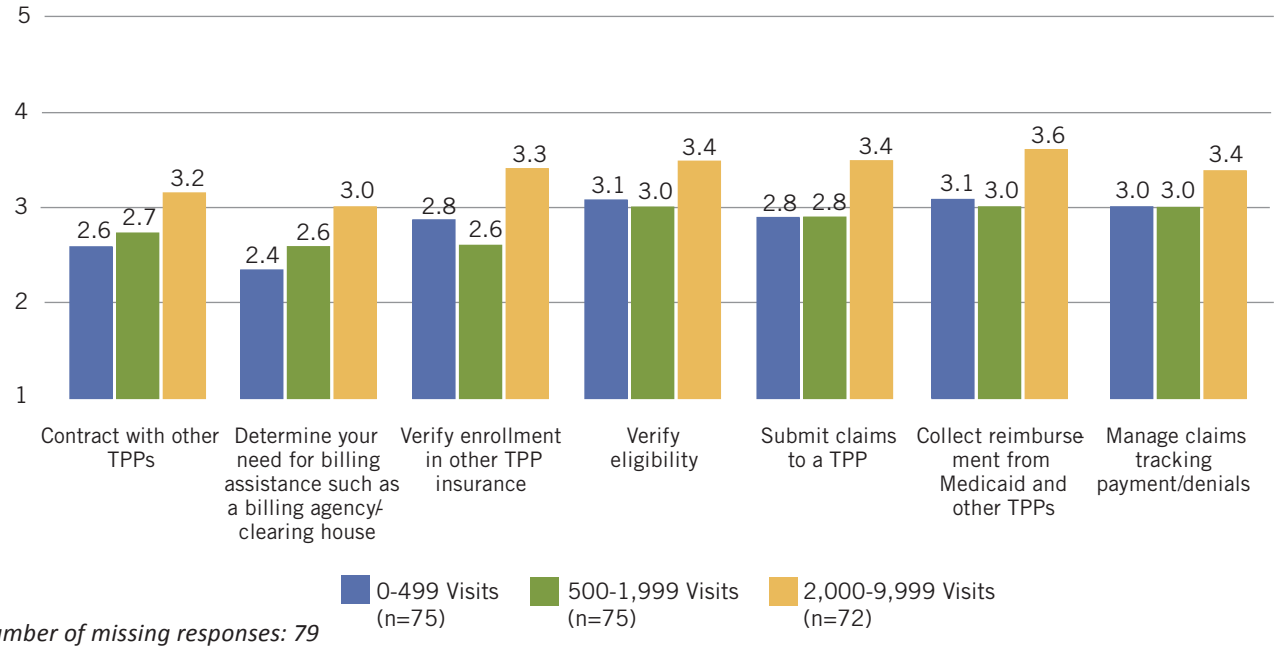
These resources may include information about why they may want to consider billing, resources to expand or improve information technology (IT) resources like PMS or EHR, and information about how to modify internal systems to include billing.

FIGURE 15: CLINIC CAPACITY TO BILL OTHER THIRD-PARTY PAYERS FOR STD SERVICES BY SITE TYPE (N=248) (Q30/Q8)



Number of missing responses: 24

FIGURE 16: CLINIC CAPACITY TO BILL OTHER THIRD-PARTY PAYERS FOR STD SERVICES BY CLINIC SIZE (N=301) (Q30/Q3)



Number of missing responses: 79

IV. What are the barriers to billing for STD services?

The barriers to billing identified most often by the respondents were: prohibitive policies, lack of staffing resources, and lack of infrastructure resources. These barriers present significant challenges. Policy changes require leadership and time to modify. Resource constraints may be difficult for small clinics and agencies to overcome on their own as they may have fewer internal resources than larger organizations. Hiring staff or modifying IT systems may be out of reach for some government agencies that suffered budget cuts as a result of the fiscal downturn in 2008. The top barriers to billing Medicaid included: Health Department policy (47%); not enough staff to initiate billing (31%); don't have PMS or EHR (28%); and confidentiality concerns (28%). Those not currently billing Medicaid and those not billing other third-party payers reported similar barriers to billing (Figure 17).

> "***Patients come to us because they want anonymity and do not want to use their insurance… Since all STDs are reported to the Health Department and 90% of all reported STDs come from the private sector, we are confident that patients who have insurance are for the most part using their health insurance appropriately. For 200 patients a year, we are not interested in pursuing insurance contracts."***

Confidentiality concerns were mentioned frequently in the open-ended responses. In particular, several comments described that, "some patients do not want primary provider or employer based insurance to have STD information." Respondents expressed concern about confidentiality and that billing could be a barrier to care with comments such as, "For confidentiality purposes, STD-related services are not billed, which removes this factor as a barrier to seeking care." Other respondents expressed specific concerns about confidentiality. Parents and employers access to information were listed as common concerns, but other confidentiality concerns were detailed in comments such as, "…fear of discrimination from insurance company (clinic serves gay men) or fear that information collected could be shared with third-party (immigration services)." Also, "lower socioeconomic clients who are more likely to not have insurance express concerns about mistrust of health care system due to previous or historic discrimination (i.e. - Tuskegee)." Billing successfully will require building trust among both providers and patients that their services can and will be kept confidential.

The idea that the STD clinics were filling a particular needed niche that respondents were hesitant to change was also expressed through the write-in comments. One respondent noted, for instance, that it was their belief that providing services to the uninsured was the role of the local Health Department, stating, "I do not understand why LHDs [Local Health Departments] should be competing with HCPs [Health Care Professionals]. If the client has insurance then they should be seen by a HCP. LHDs should be handling under insured and uninsured if any at all." This reluctance to change is in some locations a barrier to billing.

Additional barriers to billing included no staff or not enough staff available to follow-up on unpaid claims (24%). This current lack of staff resources is combined with the political and fiscal climate and a number of comments indicated that hiring staff was a challenge with comments such as, "there will be no more hiring of new staff due to County hiring freeze, which is indefinite" and "we do not have staff to do billing and will be unable to hire any now or in the near future."

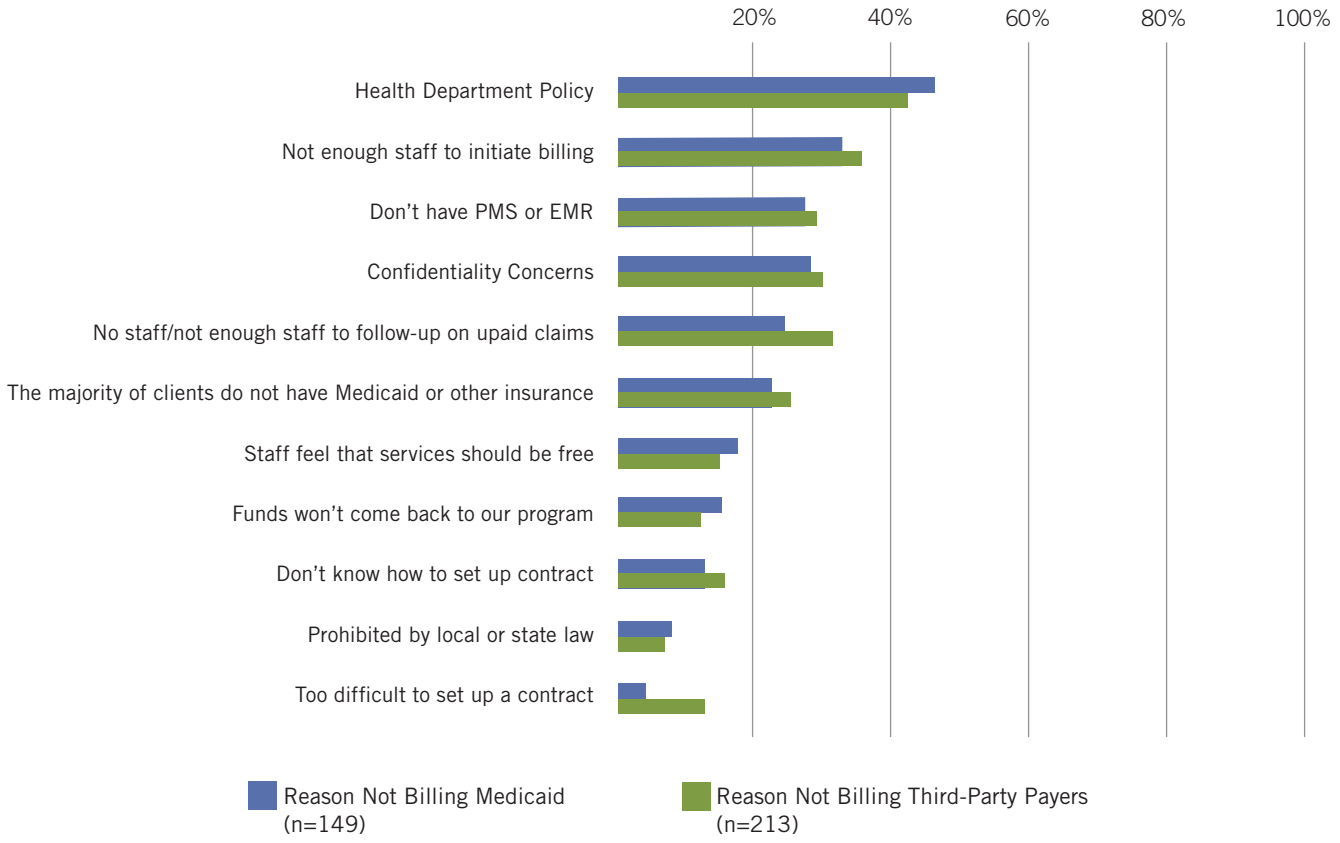
The relatively low number of insured patients seeking services at publicly funded sites and the understanding among many respondents that the majority of their clients do not have Medicaid or other third-party payers coverage (22%) was also cited as a barrier and for those clinics with few numbers of clients with insurance,

"There's a general commitment to having as few barriers to testing as possible."

billing will be more expensive per encounter. Respondents mentioned that, "It costs more to bill and follow-up than the cost of the visit, so has not been thought to be worthwhile." Another said, "We did a cost analysis and found it would cost more to bill than we would receive."

In addition to these barriers, several respondents mentioned that scope of practice and billing was a problem, as many clinics are staffed with RN's. As they explained, "Although the Health Departments use expanded role nurses, "private insurance" does not recognize them as a provider of services."

FIGURE 17: BARRIERS TO BILLING THIRD-PARTY PAYERS FOR STD SERVICES (Q19)



Number of missing responses: 5,31
Percentages will not add to 100% because this question is check all that apply.

Among respondents either not billing, or billing Medicaid-only, almost one-fifth (19% from 14 states and territories and the District of Columbia) reported state or local laws or regulations prevent their organization from billing for STD services (Table 9). Although overall a small percentage, for these clinics, regulations represent a significant barrier to billing because in order to bill for STD services, changes would have to be made to these prohibitive laws. Additionally, of those not billing, or billing Medicaid-only, 18% noted policies within their organization that prevented clinic(s) from billing for STD services (Table 9).

TABLE 9: STATE OR LOCAL LAWS OR POLICIES PREVENTING BILLING (Q20/Q21)

	State or Local Laws or Regulations that Prevent Billing for STD Services		Policies within Organization that Prevent Billing for STD Services	
	N	**%**	**N**	**%**
Yes	39	19%	36	18%
No	128	62%	121	59%
Not sure	38	19%	47	23%
Total	**205**	**100%**	**204**	**100%**

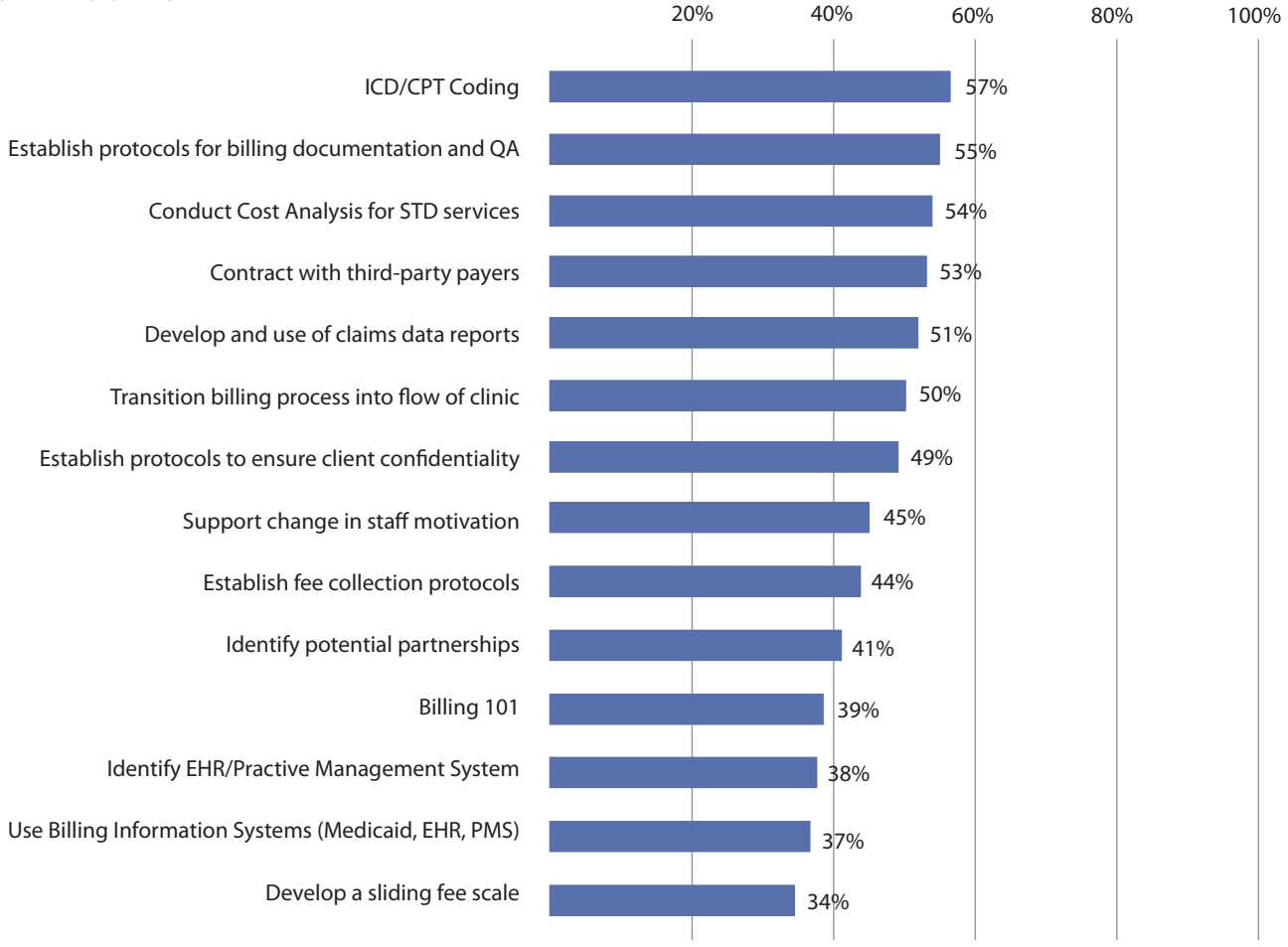
Number of missing responses: *9* *10*

V. What are STD-Certified 340B Clinics' Training and TA Needs?

The primary goal of this needs assessment was to determine the training/TA needs of STD-certified 340B sites. The needs assessment asked for selection of both the "Overall" (any) training/TA needs, and respondents' "Top Three" training/TA needs. The majority of respondents (75%) identified at least one training/TA need, suggesting that the training/TA needs are extensive. The majority of respondents selected the following overall training/TA need training/TA needs: ICD/CPT coding instruction (57%); establishing protocols for billing documentation and Quality Assurance (QA) (55%); conducting cost analysis for STD services (54%); contracting with third-party payers (53%); and, developing and use of claims data reports (51%). A quarter of respondents (counted as missing) did not select a TA need and included both billing and non-billing clinics (Figure 18).

ICD/CPT coding assistance was most commonly selected both for overall and the "Top Three" training/TA needs among both all respondents and those respondents not billing Medicaid or TTP. Coding represents a substantial need for all respondent types; responses from the billing capacity data show over one-third (37%) of those already billing have experienced reimbursement problems or auditing concerns as a result of inaccurate billing or coding (see Appendix II: Summary Data).

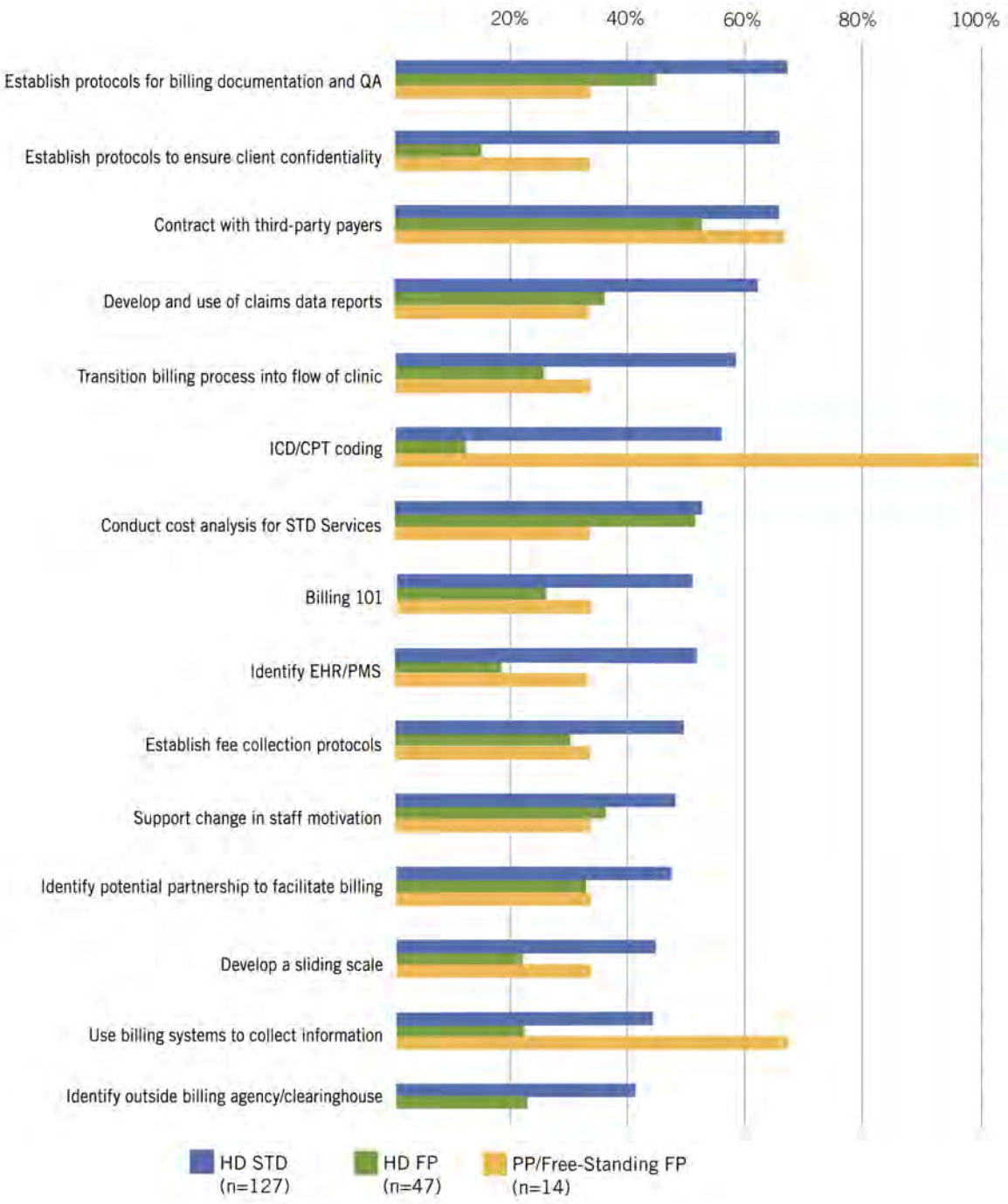
FIGURE 18: ANY TRAINING AND TECHNICAL ASSISTANCE NEEDS FOR STD-CERTIFIED 340B CLINICS (N=333) (Q31)



Number of missing responses: 85
Percentages will not add to 100% because this question is check all that apply.

Training and TA needs vary by site type. Health Department STD clinics had consistently higher needs across response categories compared to other respondents (Figure 18). One exception is that assistance with ICD/CPT coding was requested by all site types, including 100% of PP/Free-Standing FP clinics.

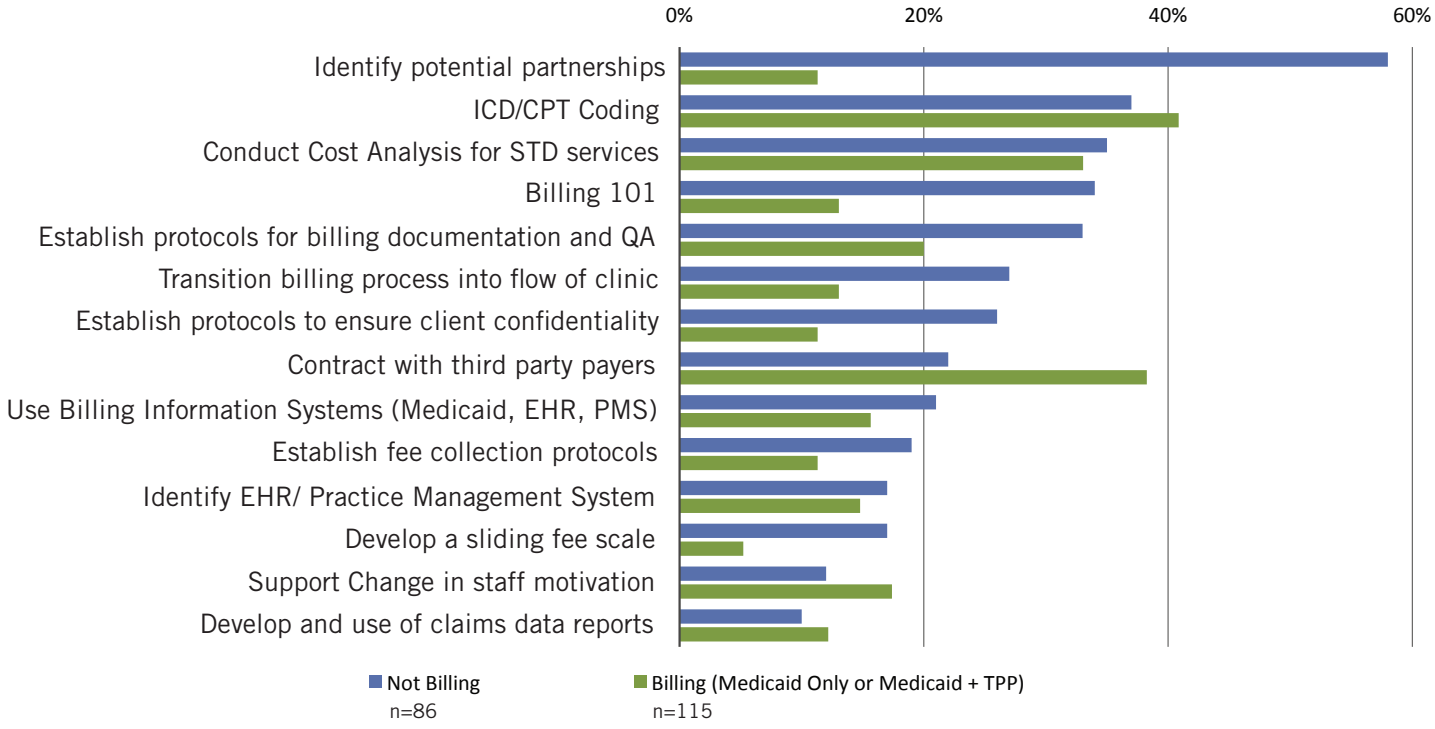
FIGURE 19: ANY TRAINING AND TECHNICAL ASSISTANCE NEEDS BY SITE TYPE (N=248) (Q30/Q8)



Number of missing responses: 60
Percentages will not add to 100% because this question is check all that apply.

The "Top Three" needs generally reflected a slightly different priority ranking from the overall training/TA needs between those billing and those not billing. The "Top Three" needs for those already billing included: ICD/CPT coding assistance (39%); conducting cost analysis for STD services (34%); contracting with third-party payers (31%); establishing protocols to ensure client confidentiality (25%); and establishing protocols for billing documentation and QA (24%) (Figure 20). The "Top Three" TA needs for clinics/agencies not billing are somewhat different from all respondents combined. Those not billing selected their "Top Three" TA needs as: identifying potential partnerships (58%), followed by ICD/CPT coding (37%), conducting cost analysis for STD services (35%), "Billing 101" (34%), and establishing protocols to ensure client confidentiality (33%). There is considerable unmet billing training/TA needs. Despite the fact that three quarters of respondents identified training/TA needs, only 17% of clinic or agencies are receiving or scheduled to receive training/TA on billing and reimbursement. Those not identifying TA needs included those billing and not billing.

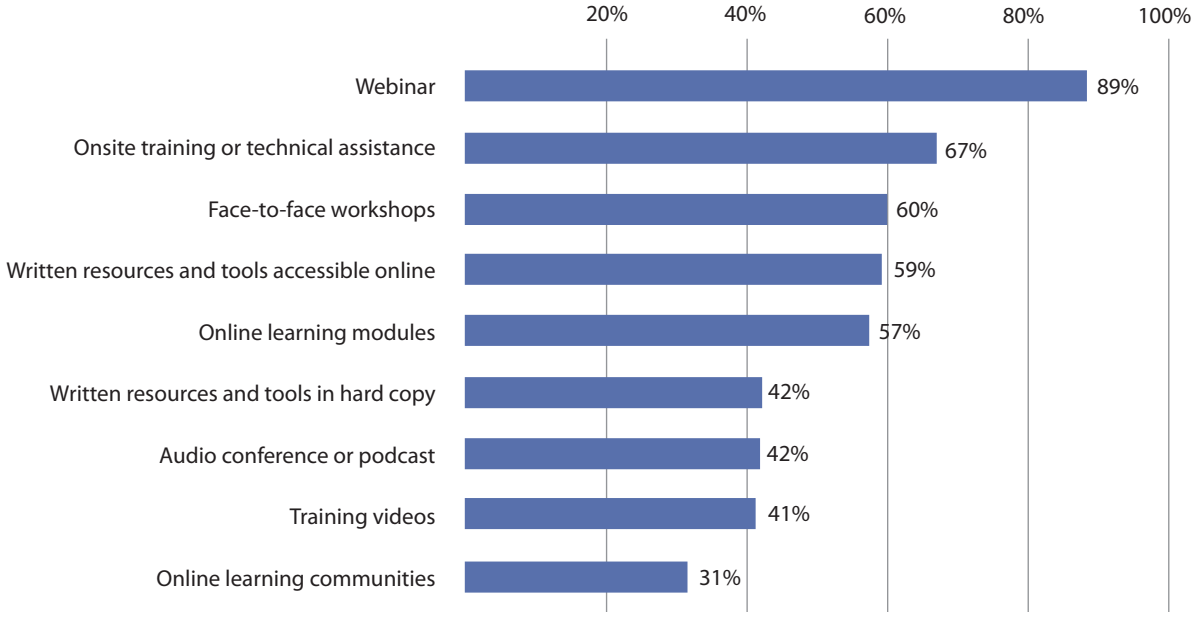
FIGURE 20: TOP THREE TRAINING AND TECHNICAL ASSISTANCE NEEDS BY BILLING STATUS (N=333) (Q31/Q13)



Number of missing: 132
Percentages will not add to 100% because this question is check all that apply.

Respondents were asked about the training modality they would be most likely to access if the content meets one of their training needs. The overwhelming majority of needs assessment respondents (89%) indicated that webinar training was preferred (Figure 21). Other popular options included other online modalities such as: written resources and tools accessible online (59%) and online learning modules (57%). In person training or TA via site visits or face-to-face workshops were also highly ranked by respondents, 67% and 60%, respectively. In fact, one respondent commented that, "For this, face to face, onsite technical assistance bringing the tools and resources would be extremely helpful. This is a paradigm shift in how we in public health do business. Intense, focused, onsite assistance would be of great help. We are not business people in STD and HIV public health. To change this perspective to "making money" from this work to help keep our program alive, we need help and technical assistance." Other comments, however, cited a lack of funding for and travel restrictions for travel to in-person training that were not "on site." Finally, other training modalities preferred by assessment respondents included: audio conferences or pod casts (42%); written resources and tools in hard-copy (42%); and training videos (41%) (Figure 21).

FIGURE 21: CLINICS' PREFERRED TRAINING AND TECHNICAL ASSISTANCE MODALITIES (N=333) (Q 33)



Number of missing responses: 45
Percentages will not add to 100% because this question is check all that apply.

B. STATE/PROJECT AREA STD PROGRAMS

I. Who participated in the assessment?

Sexually Transmitted Disease (STD) Prevention Programs in all 59 funded project areas were invited to participate in the billing and reimbursement needs assessment by each of the regional STD-related Reproductive Health Training and Technical Assistance Centers (STD RH TTACs). The funded project areas consist of the 50 U.S. states plus an additional nine funded cities and territories: Los Angeles, CA; San Francisco, CA; District of Columbia; Chicago, IL; Baltimore, MD; New York, NY; Philadelphia, PA; the Commonwealth of Puerto Rico; and the U.S. Virgin Islands. The overall response rate for the needs assessment was 90%, or a total of 53 respondents (Table 10). Six regions (Regions I, II, VII, VIII, IX, and X) had 100% participation in the needs assessment. All respondents represented state or project area STD prevention programs; one represented both STD and family planning (FP) programs.[7]

TABLE 10. STATE/PROJECT AREA STD PROGRAM RESPONDENTS BY REGION (Q1)

Region	Number of Participating STD Programs	Total Number of STD Programs	STD Program Participation Rate
Region I	6	6	100%
Region II	5	5	100%
Region III	7	8	88%
Region IV	7	8	88%
Region V	5	7	71%
Region VI	3	5	60%
Region VII	4	4	100%
Region VIII	6	6	100%
Region IX	6	6	100%
Region X	4	4	100%
Total	**53**	**59**	**90%**

7 The needs assessment tool asked if they represented STD/STI, Family Planning, or Both; only STD/STI and Both are included in this analysis, as this was the target for this assessment.

II. What capacity do project area STD programs have to assist clinics initiate or improve billing?

Project areas are largely administrative, and do not necessarily provide direct clinical services. Therefore this assessment does not attempt to determine whether or not they bill, but instead looks at if they have the capacity to provide support and technical assistance (TA) for the scale up of billing to the clinical service entities in their jurisdiction providing STD services.

In order to assess the capacity for providing support, respondents were asked about whether any other programs within the public Health Department or their organization (e.g. Immunization, WIC, HIV, etc.) already bill Medicaid and other third-party payers and thus represent a resource for potential partnerships, resources, and knowledge. Almost three quarters (74%) of respondents reported that there were other programs in their Health Department that bill and 9 project areas (17%) that do not. Of those that were aware of other programs that bill, and responded to the "please specify" – the most common responses were Immunization and FP programs, each with 8 responses, followed by the State Lab (7), HIV program (4) and local Health Department (3).

Several questions were asked about potential barriers to billing including whether or not county and local Health Department have the authority to contract with third-party payers. Although some states and project areas did not organize by county and local Health Departments ("not applicable" responses), the majority of project areas did provide services organized this way. The authority to contract with third-party payers was assumed to be a prerequisite to establishing billing systems through the Health Departments. The majority of respondents (62%) reported that county and local Health Departments do have the authority to contract with third-party payers, while only four respondents (8%) stated with certainty that county and local Health Departments do not have the authority (Table 11). Almost one quarter (23%) were "not sure" about the authority to contract for services.

TABLE 11. COUNTY AND LOCAL HEALTH DEPARTMENTS IN THE STATE HAVE AUTHORITY TO CONTRACT WITH THIRD-PARTY PAYERS (Q8)

	N	%
Yes	32	62%
No	4	8%
Not sure	12	23%
Not applicable	4	8%
Total	**52**	**100%**

Number of missing responses: 1

Respondents were asked about state or local laws or regulations that might prevent entities from billing. The majority of respondents (73%) were not aware of any state or local laws or regulations that would prevent their organizations from billing for STD-related services (Table 12). However, nine respondents (17%) noted that they were prohibited from billing for these services. For instance, one respondent commented that, "NYS

Public Health Law Article 23 requires that local Health Departments provide free STD diagnosis and treatment. Amendments to this legislation have been included in the Governor's budget and are awaiting action by the state legislature. If adopted, local Health Departments would have the authority to implement billing for STD clinical services but no patient can be denied access to services due to a lack of insurance or a request that insurance not be billed." Also included was a comment from a Virginia-based participant said, "Virginia Administrative Code (12VAC5-200-150), which states STD services are to be provided to Virginia residents at no charge when seen in STD clinics; however, it does not specifically state that third-party payers cannot be billed for STD services." Therefore, although only a small percentage (17%) are aware of legal or regulatory barriers; these laws and regulations represented a significant barrier for these particular project areas.

TABLE 12. STATE OR LOCAL LAWS OR REGULATIONS THAT PREVENT BILLING FOR STD SERVICES (Q7)

	N	**%**
Yes	9	17%
No	38	73%
Not sure	5	10%
Total	**52**	**100%**

Number of missing responses: 1

The capacity for state STD departments to assist clinics to initiate or improve billing practices was limited. One of the first anticipated steps toward scale up of billing would be to conduct an assessment of the billing and reimbursement capacity of clinics in their jurisdiction. About one third, (38%) had conducted an assessment of the billing and reimbursement capacity of clinics in their area, while 25 (47%) had not, and the remaining eight (15%) were not sure if such an assessment took place (Table 13).

TABLE 13. STATES THAT CONDUCTED AN ASSESSMENT OF BILLING AND REIMBURSEMENT CAPACITY OF CLINICS (Q5)

	N	%
Yes	20	38%
No	25	47%
Not sure	8	15%
Total	**53**	**100%**

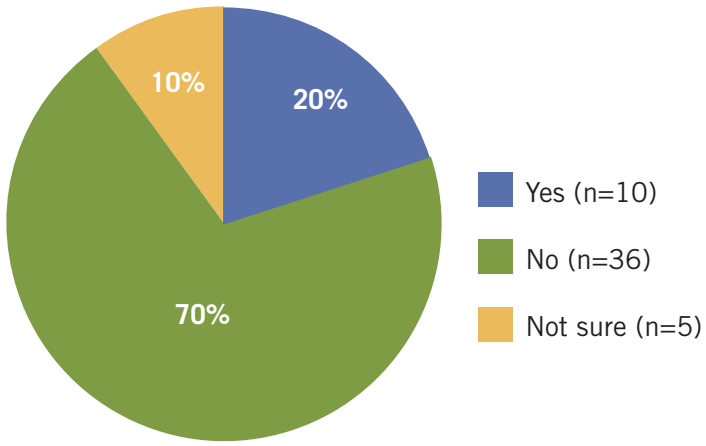
The ability to ensure patient confidentiality while billing third-party payers is a key component to widespread scale-up of billing for STD services. Only 11 respondents (21%) reported that their state had developed protocols or guidance on how to ensure patient confidentiality when billing third-party payers for STD services (Table 14).

TABLE 14. STATES THAT DEVELOPED CONFIDENTIALITY PROTOCOLS OR GUIDANCE FOR BILLING THIRD-PARTY PAYERS FOR STD SERVICES (Q4)

	N	%
Yes	11	21%
No	30	57%
Not sure	12	23%
Total	**53**	**100%**

Project areas reported that their capacity to provide billing and reimbursement support to jurisdictional clinics remains limited. Only 10 respondents (20%), reported they are currently able to provide billing and reimbursement support (Figure 22). In contrast, 36 respondents (70%) stated they do not have this capacity, and the remaining five were not sure.

FIGURE 22: STD PROGRAMS CURRENTLY ABLE TO PROVIDE BILLING SUPPORT TO CLINICS (N=53) (Q6)



Number of missing responses: 2

State public health laboratories and some clinics have indicated that it would be helpful to have a coordinated state effort to assist with billing third-party payers for STD-related services. However, currently only around a third of STD program respondents reported there was a state-level coordinated effort to bill Medicaid and other third-party payers for STD-related services (37%). The same number reported state-level coordinated efforts to establish EHRs at state-funded STD service clinic sites.

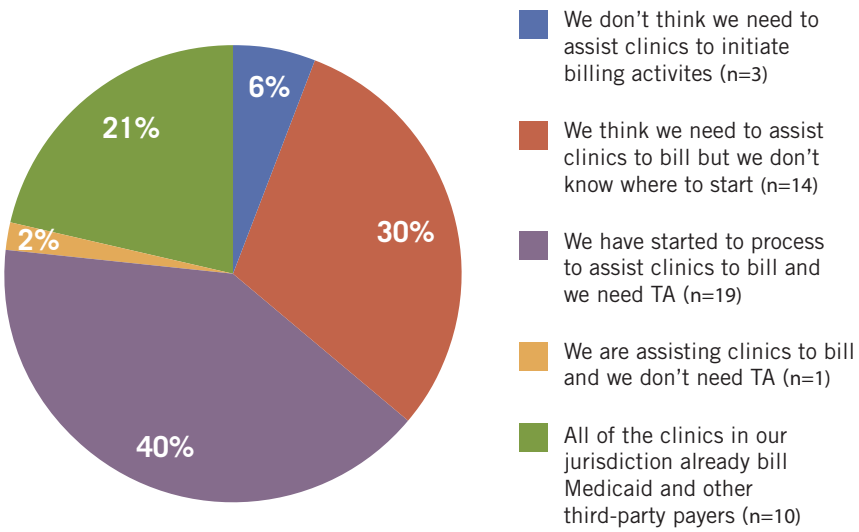
TABLE 15. STATE-LEVEL COORDINATED BILLING EFFORTS (Q9/Q10)

	State-Level Effort to Bill Medicaid and Other Third-Party Payers		State-Level Effort to Establish EHR for Sites	
	N	%	N	%
Yes	19	37%	19	37%
No	24	47%	23	44%
Not sure	8	16%	10	19 %
Total	**51**	**100%**	**52**	**100%**

Number of missing responses: *2* *1*

Over 70% of project area respondents were in need of TA to assist clinics in their jurisdiction to initiate billing activities (Figure 23). Of this group, 30% self-assessed they had no idea where to start the process and 40% stated they have started to assist clinics with billing, but need TA. Only one respondent reported that they were assisting clinics to bill and did not need TA (2%). The remaining 13 respondents (28%) noted no need for TA around these billing issues, including ten respondents (21%) that stated that all of the clinics in their jurisdictions already bill Medicaid and other third-party payers and three (6%) reported they did not need to assist clinics to initiate billing activities.

FIGURE 23: STD PROGRAM READINESS TO ASSIST FUNDED CLINICS TO INITIATE BILLING (N=53) (Q16)



Number of missing responses: 6

III. What are the barriers for funded clinics to bill for STD services?

The most widely recognized barrier to billing according to the state/project area respondents was confidentiality concerns (e.g. do not want Explanation of Benefits [EOB] to go to primary person insured) (59%)(Figure 24). Comments expressed both the concern, and the need to come up with solutions to address these challenges. One respondent stated, ""This will require a change in mind set and in the clinics skill set in STD clinics. But it is also reality that STD services should be seen as being available from providers that maintain confidentiality and are seen as experts in providing these services. It is a matter of public health to assure there is a safe place to go to be tested and treated." Other comments describe the desire for comprehensive reform at the state or national level, ""We feel that confidentiality of STD information, especially as it relates to minors, needs to be dealt with at the State level. Since there are no State Laws prohibiting billing for STD services, there needs to be a prohibition for sending the explanation of benefits statement to the primary insurance holder if STD testing for a minor is the service provided." Confidentiality was identified as a barrier by all respondent types.

"This will require a change in mind set and in the clinics skill set in STD clinics. But it is also reality that STD services should be seen as being available from providers that maintain confidentiality and are seen as experts in providing these services. It is a matter of public health to assure there is a safe place to go to be tested and treated."

Inadequate staffing was also considered a barrier; staffing was perceived to be a barrier both to initiate billing (49%) and follow-up on unpaid claims (57%). The other staffing issue noted several times in the comments was related to scope of practice. Some clinics are staffed by RNs only and do not have clinician staff that are licensed to bill. For instance, one respondent commented that, "Medicaid requires a NP or doc to do first visit to be able to bill and most of our STD clinics are nurse run based on standing orders so they cannot bill for the majority of their services."

"We feel that confidentiality of STD information, especially as it relates to minors, needs to be dealt with at the State level. Since there are no State Laws prohibiting billing for STD services, there needs to be a prohibition for sending the explanation of benefits statement to the primary insurance holder if STD testing for a minor is the service provided."

Over one-third of respondents (39%) reported that the majority of their clients do not have third-party insurance. Several sites (37%) noted a lack of a PMS or EHR as a barrier. Staff knowledge was also a perceived barrier. Specifically, not knowing how to set up a contract (31%) or believe that it is too difficult to set up a contract (12%)(Figure 24).

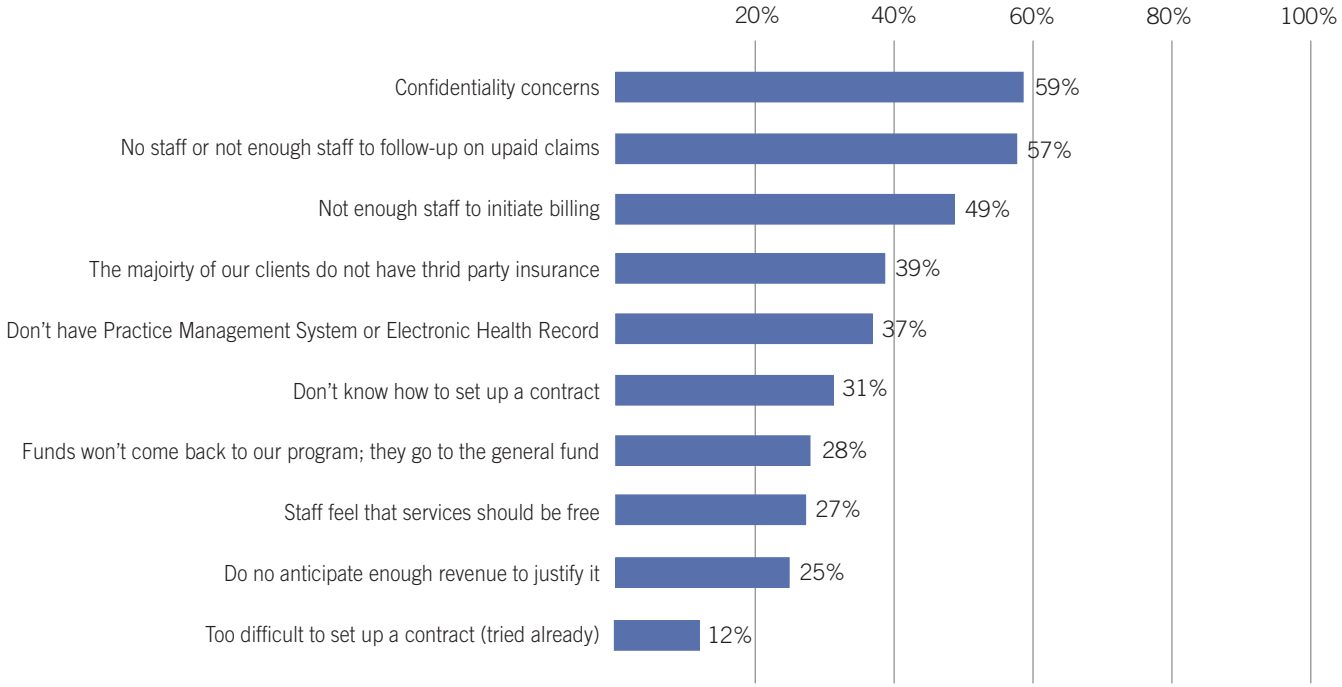
Revenue generation surfaced as a barrier to billing for several reasons including: the funds will not come back to programs rather they will go to a state's general fund (28%); and inadequate revenue to justify billing (25%). Several respondents comments such as, "The money goes into general Public Health infrastructure rather than into the clinic or STD program." Other programs were concerned about the cost effectiveness of billing with their particular program such as indicated in this comment, "We are told that given the rate of infection… that per the number of cases and investment of time, it ultimately would not be worth it for the department of health."

Finally, among some staff there is resistance to change. In one question, respondents noted that some believe services should be free and therefore no revenue should be generated (27%). In another question, eleven respondents (22%) noted some level of resistance in their project area toward billing for STD services with an equal number "not sure" of resistance (see Appendix II: Summary Data).

One respondent described that, "Some directors of Health Departments at the local level feel that it is not the role of public health to bill for STD services. Some have indicated they will not even begin the process until they no longer have any support for this from state or federal funding." It will be important for TA providers to address these concerns and provide real-world examples of how to maintain confidential services for everyone and low-cost or free services for those who cannot pay. On the other end of the spectrum, respondents stated that their clinics already billed for STD services, "Most of our clinics already bill for STD services."

"Most of our clinics already bill for STD services."

FIGURE 24: BARRIERS TO BILLING THIRD-PARTY PAYERS FOR STD SERVICES AMONG STD PROGRAM-FUNDED CLINICS (N=53) (Q15)

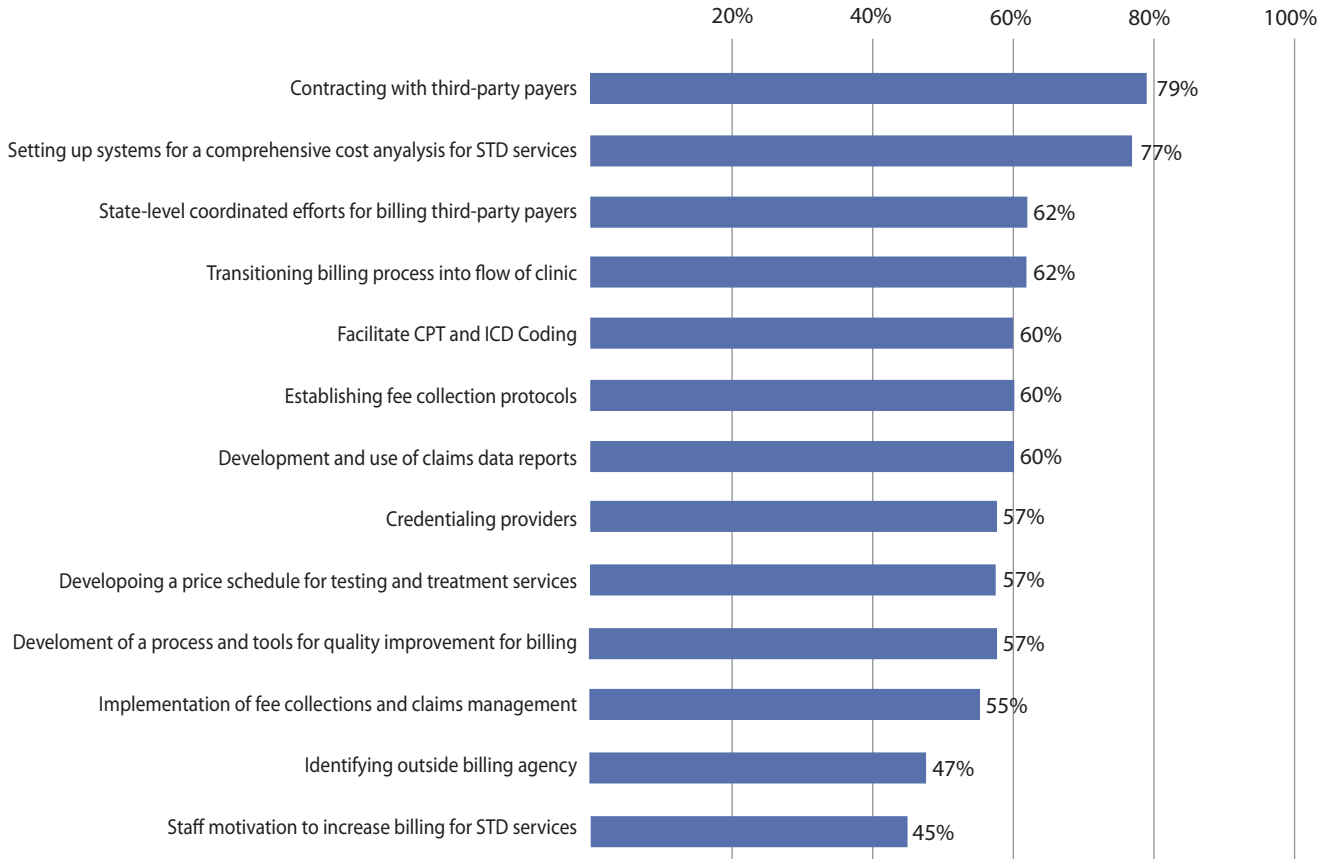


Number of missing responses: 2
Percentages will not add to 100% because this question is check all that apply.

IV. What are the State/Project Area STD Programs' training and technical assistance needs?

The needs assessment asked for selection of both the overall training and technical assistance (training/TA) needs and respondents' "top three" training/TA needs. The "top three" were consistent across both categories: contracting with third-party payers, setting up systems for a comprehensive cost analysis for STD services, and development of state-level coordinated efforts for billing third-party payers (Figure 25).

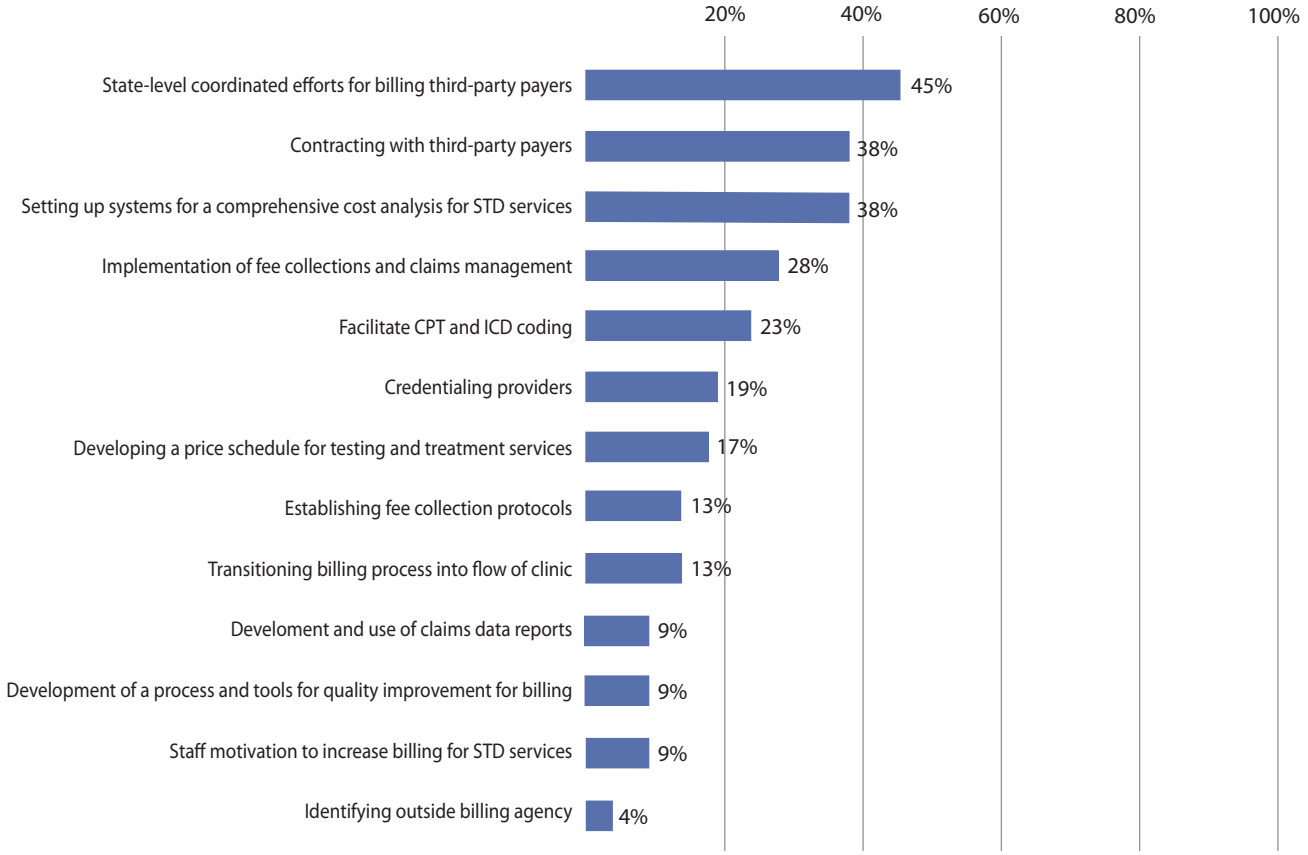
FIGURE 25: ANY TRAINING AND TECHNICAL ASSISTANCE NEEDS FOR STD PROGRAM-FUNDED CLINICS (PER STATE/PROJECT AREA RESPONDENTS) (N=53) (Q17)



Number of missing responses: 6
Percentages will not add to 100% because this question is check all that apply.

Additional training/TA needs identified as "top three" priorities were: implementation of fee collections and claims management systems (28%); facilitating CPT and ICD-9 coding (23%); credentialing providers (19%); and developing a price schedule for testing (17%) (Figure 26).

FIGURE 26: TOP THREE TRAINING AND TECHNICAL ASSISTANCE NEEDS FOR STD PROGRAM-FUNDED CLINICS (N=53) (Q17)

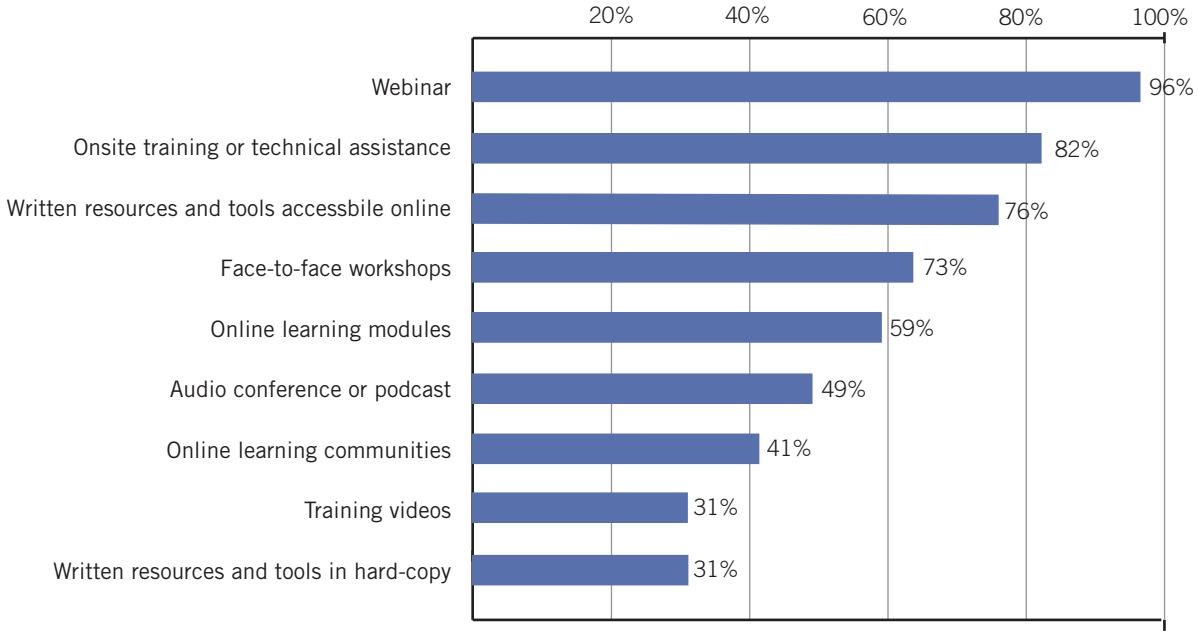


Number of missing responses: 6
Percentages will not add to 100% because this question is check all that apply.

"We prefer modalities that are tailored to specific needs, or where learners can work through issues or examine case studies.

Nearly all state/project area needs assessment respondents (96%) stated that a webinar would be the training modality most likely accessed if the content meets one of their indicated clinic training needs (Figure 27). Other popular online options included: written resources and tools accessible online (76%); online learning modules (59%); and online learning communities (e.g. chat or discussion forums with peers) (41%). In person training or technical assistance via site visits or face-to-face workshops are also highly ranked by respondents, 82% and 73%, respectively. One comment that described the need for a pragmatic approach stated that, "We prefer modalities that are tailored to specific needs, or where learners can work through issues or examine case studies."

FIGURE 27: STATE/PROJECT AREA STD PROGRAMS' PREFERRED TRAINING MODALITIES (N=53) (Q18)



Number of missing responses: 2
Percentages will not add to 100% because this question is check all that apply.

C. STATE PUBLIC HEALTH LABORATORIES

I. Who participated in the needs assessment?

The Lab Billing Needs Assessment was aimed at state public health labs (PHLs) conducting STD testing. The overall participant response rate across all regions was 75%, (43 respondents) (Table 16). Three regions had 100% participation in the needs assessment (I, VI, and X). Of the respondents, 93% (n=40) represented a state public health lab, while the remaining 7% (n=3) represented a local public health lab from a city designated as a project area funded for STD prevention.

TABLE 16. PUBLIC HEALTH LABORATORY PARTICIPATION RATES BY REGION (Q1)

Region	N	Total Number of Labs	%
Region I	6	6	100%
Region II*	2	5	40%
Region III**	5	7	71%
Region IV	6	8	75%
Region V	3	6	50%
Region VI	5	5	100%
Region VII	3	4	75%
Region VIII	5	6	83%
Region IX**	4	6	67%
Region X	4	4	100%
Total	**43**	**57**	**75%**

**Territories included*
***Local labs included*

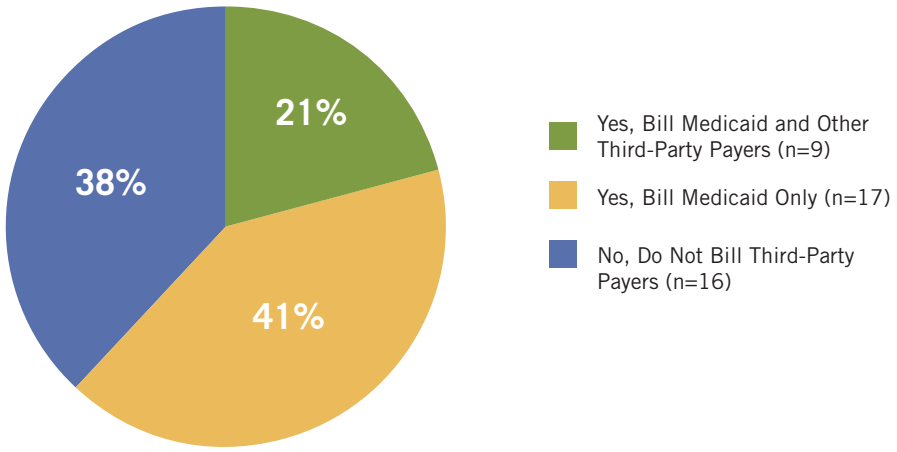
II. What capacity do state public health laboratories have to bill or begin billing?

In order to assess state PHL capacity for billing, PHLs were asked if they currently billed clinics directly for STD services. The majority of respondents (60%) reported they did not, while the remaining 40% reported that they did bill clinics directly (Table 17). This may be a low estimate, however, as some of the comments illustrated some respondents were referring to third-party billing, not direct clinic billing when answering this question. Respondents were also asked if they bill Medicaid and other third-party payers for STD services and 41% (n=17) responded that they bill Medicaid only for STD services, while only 21% (n=9) reported they bill Medicaid and other third-party payers for STD services (Figure 28).

TABLE 17. PUBLIC HEALTH LABORATORIES DIRECT BILLING STATUS (Q3)

	Bill Directly for Services	
	N	**%**
Yes	17	40%
No	26	60%
Total	**43**	**100%**

FIGURE 28: PUBLIC HEALTH LABORATORIES THIRD PARTY BILLING STATUS (N=43) (Q16/17)



Number of missing responses: *1*

In order to assess the overall capacity to bill third-party payers within the PHL, respondents were also asked if any program within their lab (e.g. Newborn Screening, HIV, etc.) billed Medicaid and other third-party payers. Of those labs not billing Medicaid, about half (56%) of the labs reported that there were other programs within their lab that were billing third-party payers (Table 18). The most common noted programs billing third-party payers were Newborn Screening, Tuberculosis, and HIV. While the internal billing capacity represented a potential opportunity for partnerships or internal resource sharing, about half of the respondents that had other programs that billed Medicaid (43%), reported that their STD program had not considered combining billing and reimbursement activities with another program in their lab.

TABLE 18. OF THOSE NOT BILLING OTHER THIRD PARTY PAYERS, POTENTIAL INTERNAL CAPACITY TO BILL FOR STD-SERVICES IN PUBLIC HEALTH LABORATORIES (Q4/Q5)

	Any Program in the Lab Bills Medicaid and Third-Party Payers		**Of those with Other Programs that Bill, Lab Considered Combining Billing STDs Testing with Another Program**	
	N	%	N	%
Yes	18	56%	8	47%
No	11	34%	9	43%
Not sure	3	9%		
Total	**33**	**100%**	**17**	**100%**
Number of missing responses:	*1*		*1*	

Confidentiality was recognized as a substantial barrier to expansion of billing for STD services across both the clinic and laboratory settings. Only 26% of the PHL respondents reported that their state had developed protocols or guidance on how to ensure patient confidentiality when billing third parties for STD services (Table 19). When asked for comments to describe these protocols, one participant commented, "Our requisition has a spot to select for confidential services. If confidential services are requested and the patient does not have Medicaid alone, the bill goes to the submitting clinic. If the patient has private insurance with or without Medicaid and confidential services are requested, no bill is generated and the lab writes off the cost of the test." The relatively low number of labs reporting state protocols on confidentiality illustrated the potential technical assistance (TA) need for the development of these types of protocols and guidance.

"Not resistant to the idea but making it happen in a confidential way is a concern."

TABLE 19. STATE DEVELOPED PROTOCOLS OR GUIDANCE TO ENSURE PATIENT CONFIDENTIALITY WHEN BILLING THIRD-PARTY PAYERS FOR STD SERVICES (Q 6)

	N	**%**
Yes	11	26%
No	19	44%
Not sure	13	30%
Total	**43**	**100%**

All respondents indicated that their lab had a Laboratory Information Management System (LIMS). This was significant because it represents the first step in readiness to submit claims for billing. The majority of respondents also reported broad functionality of their systems, although the functionality of their LIMS varied (Table 20): over three quarters of respondents reported their LIMS' ability to customize reports (79%) and data fields (76%); two thirds reported LIMS' capacity to collect insurance information (67%); and 64% reported LIMS' capability to electronically report results to clinics. Two respondents (5%) reported that their LIMS' had none of the capabilities listed above. A recently published paper about public health labs' billing capability reported that

"there is a lack of billing and tracking software that is compatible with the LIMS currently in use in SPHLs [State Public Health Labs].[8]"

TABLE 20. LABORATORY INFORMATION MANAGEMENT SYSTEM CAPABILITIES (Q8)

	N	%
Customize reports	33	79%
Customize data fields	32	76%
Collect insurance information	28	67%
Electronic reporting of results (to clinics)	27	64%
None of the above	2	5%
Total	**42**	

Number of missing responses: 1
Percentages will not add to 100% because this question is check all that apply.

Of those that billed either Medicaid or third-party payers for STD services (n=25), 88% reported that their LIMS had the capability to customize data fields and reports, 80% reported the ability to collect insurance information, and 72% had the ability to electronically report results to clinics, while only one site's LIMS did not have the capability to complete any of these functions (Table 21). Of those that did not bill for STD services, fewer reported having flexible LIMS than those that billed, however the differences were not statistically significant. Given that only 50% of labs that are not currently billing have the ability to collect insurance information, some labs may have challenges and may require resources to update or customize their LIMS to accommodate billing for individual services, or to purchase other LIMS compatible billing software.

TABLE 21. LABORATORY INFORMATION MANAGEMENT SYSTEM CAPABILITIES BY BILLING STATUS (Q9)

	Billing*		Not Billing		
	N	%	N	%	*p-value*
Customize reports	22	88%	11	69%	0.23
Customize data fields	22	88%	10	63%	0.12
Collect insurance information	20	80%	8	50%	0.08
Electronic reporting of results (to clinics)	18	72%	8	50%	0.19
None of the above	1	4%	1	6%	n/a
Total	**25**		**16**		

Number of missing responses: 2
Percentages will not add to 100% because this question is check all that apply.
p-values from Fisher's Exact Test
**Billing included those billing Medicaid only and those billing Medicaid and other third-party payers.*

8 Loring, C., et al. Using Fee-for-Service Testing to Generate Revenue for the 21st Century Public Health Laboratory. Public Health Reports, 2013 Supplement 2: Volume 128, 97-104.

Of those not currently billing for STD services (Figure 28), 80% reported the need for some type of TA. Equal numbers of respondents reported that they think they need to bill but do not know where to start (27%), have started the process of billing initiation and will need TA (27%), or have limited billing capacity and will need TA (27%). The remaining three sites reported either that they do not need to initiate billing (13%), and in one case, already bill Medicaid and third-party payers for other services (7%). In this particular case, regulations prevented the lab from billing for STD-related services.

"Readiness is not a one shot process. Guidelines and reimbursement changes are continually changing. And labs and clinics must be aware of these changes as early as possible."

III. What are the barriers to billing for STD services?

Barriers to billing are reported to be more structural and less a lack of motivation or support for billing. The vast majority of respondents (80%) indicated that there was not resistance within their program to bill for STD services (Table 22). Of the 20% that reported resistance, reasons ranged from leadership's belief that testing should be a free service, unwillingness to dedicate staff to conduct billing, and concern about the complexity of billing.

TABLE 22: RESISTANCE TO BILLING FOR STD SERVICES IN PUBLIC HEALTH LABORATORIES (Q 10)

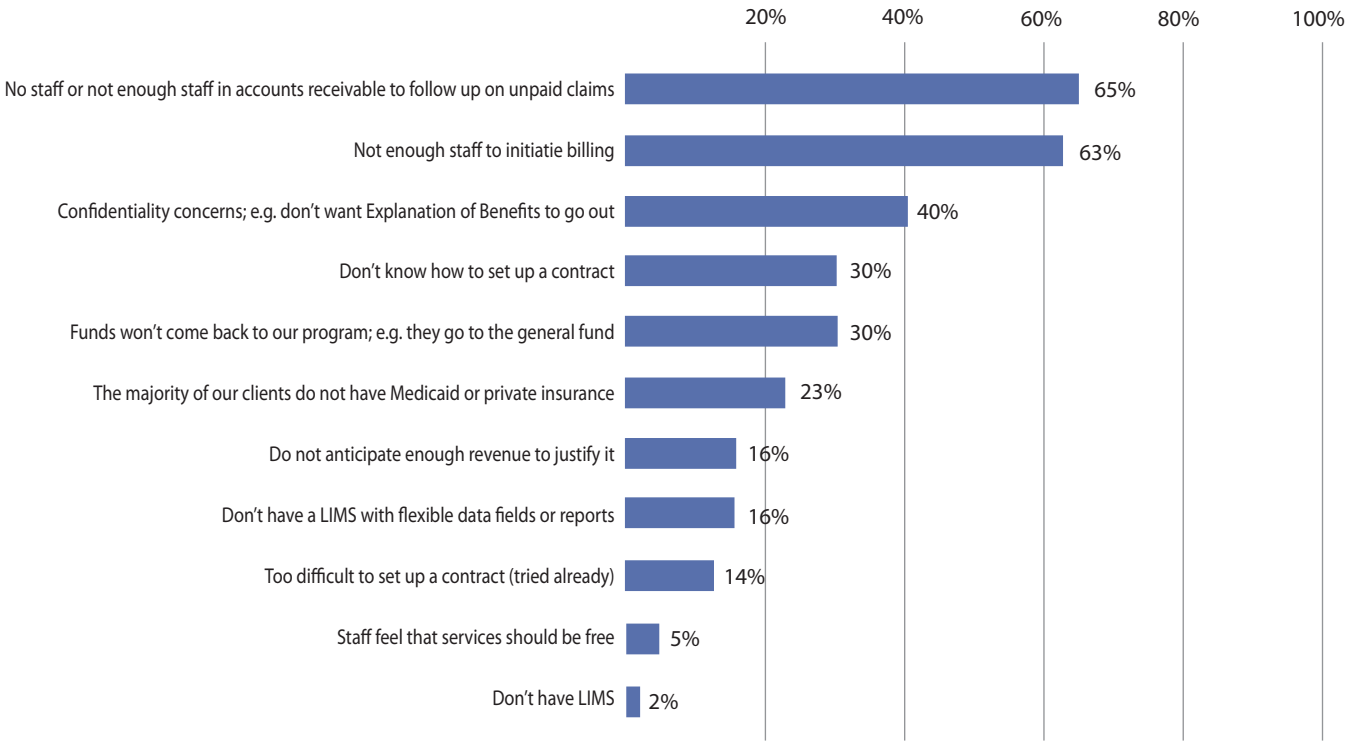
	N	%
Yes	8	20%
No	32	80%
Total	**40**	**100%**

Number of missing responses: 3

Several types of barriers to billing for STD services among labs were reported, including staff resources, confidentiality concerns, and knowledge gaps. A lack of staff resources was selected most often as a barrier. Almost two thirds (65%) of the respondents reported inadequate staffing as a barrier to follow-up on unpaid claims and 63% reported inadequate staffing to initiate billing. In addition, there were seven write-in responses of "not enough resources." One state lab had looked into billing and found that doing in-house billing was going to be cost prohibitive, "The Public Health Director requested we get a quote for a turnkey billing system; projected revenues couldn't justify upfront costs ($500,000) and percentage taken off by billing company. Other barriers are the challenge of contracting with multiple insurance companies and the lack of in-house coding expertise." Some labs may not be aware of options of doing billing in different ways, with less up-front investment, such as contracting with a billing company.

A large number of the respondents (40%) cited confidentiality concerns (e.g. do not want Explanation of Benefits [EOB] to go to primary person insured) while 30% reported they did not know how to set up a contract or that the funds would not come back to their program (e.g. would go back to their organization's general fund) (Figure 29).

FIGURE 29: PUBLIC HEALTH LABORATORIES' BARRIERS TO BILLING THIRD-PARTY PAYERS FOR STD SERVICES (N=43) (Q 11)



Percentages will not add to 100% because this question is check all that apply.

When asked about legal barriers, a large majority of lab respondents (74%) reported that they were not aware of state or local laws or regulations that prevent them from billing for STD-related services, with only 16% saying there were such legal restrictions and 9% who were unsure (Table 23). For the 16% that have state or local regulations, this represents a significant barrier as getting the local laws and regulations changed takes a concerted effort from leaders and policy makers outside of the laboratory.

TABLE 23. STATE OR LOCAL LAWS OR REGULATIONS THAT PREVENT THE PUBLIC HEALTH LABORATORIES FROM BILLING FOR STD-RELATED SERVICES (Q 7)

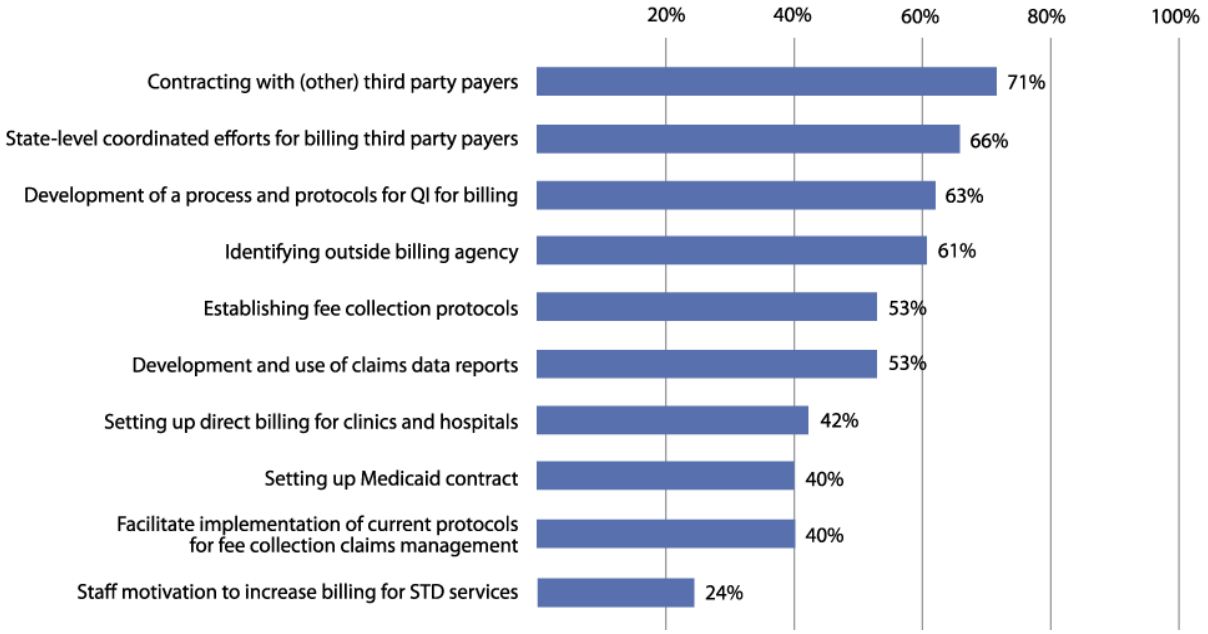
	N	%
Yes	7	16%
No	32	74%
Not sure	4	9%
Total	**43**	**100%**

IV. What are Public Health Laboratories' Training and Technical Assistance Needs?

> ***"If we were to do so (and we might want to revisit this after current legislative session) we would need training and technical assistance."***

Respondents reported a wide range of training and technical assistance (training/TA) needs as they relate to billing and reimbursement for STD services with 71% reporting the need for assistance with contracting with third-party payers, 66% needing assistance with State-level coordinated efforts for billing thirty-party payers, and 63% needing help with the development of a process and tools for quality improvement in billing. More than half of respondents also reported the need for TA to establish a fee collection protocol, to develop and use claims data reports, and to help identify an outside billing agency (Figure 29).

FIGURE 30: ANY TRAINING AND TECHNICAL ASSISTANCE NEEDS FOR PUBLIC HEALTH LABORATORIES (N=43) (Q13)

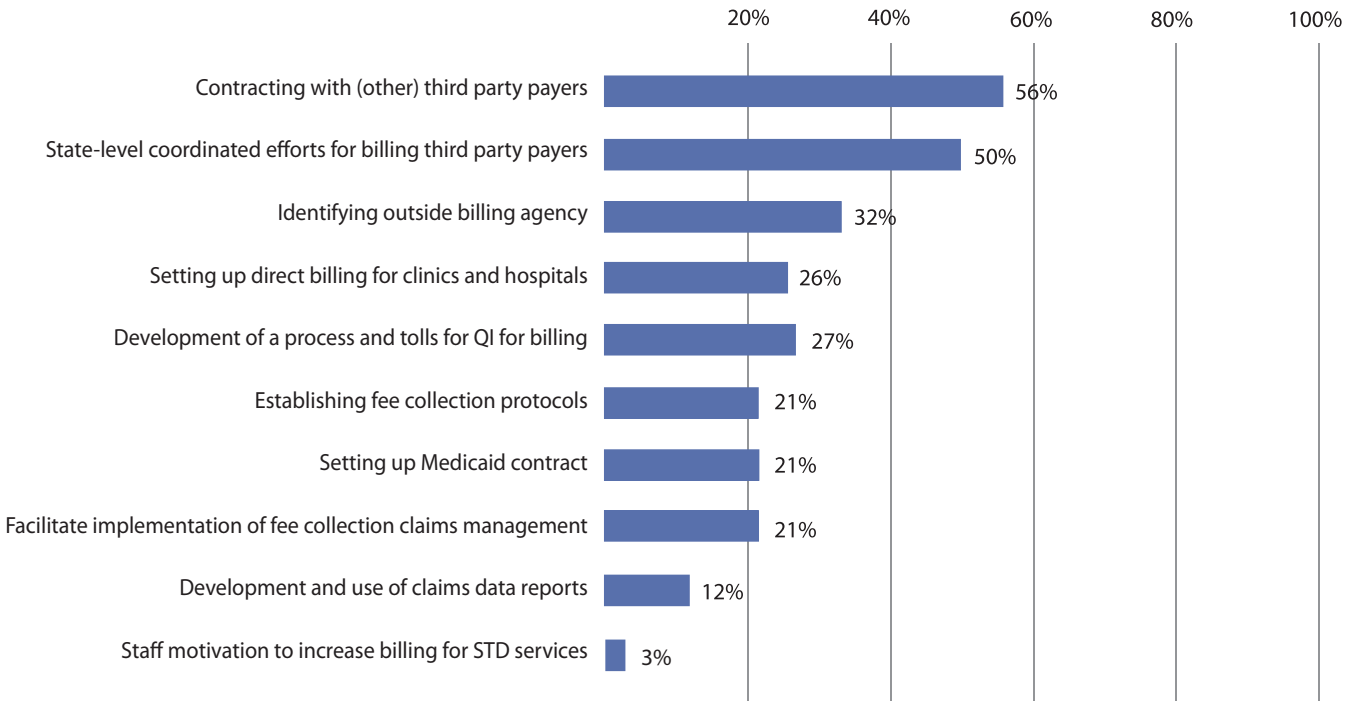


Number of missing responses: 5
Percentages will not add to 100% because this question is check all that apply.

Of the areas identified for training/TA, lab respondents reported their "top three" training/TA needs (Figure 30). The highest rated item, contracting with third-party payers, was selected by 56% of respondents as one of their top three needs. The next most commonly selected items identified as top three TA needs included state level coordinated efforts for billing third-party payers (50%); identifying an outside billing agency (32%); and setting up direct billing for clinics and hospitals (29%). Among those who selected: "Other: please specify" respondents listed, "lab-specific" billing and "IT/software updates." Six labs indicated that they do not need TA at this time. All 10 options, plus an "other" category were chosen as at least one respondent's top three categories of TA, illustrating the wide range of assistance needed to help PHL's bill and receive reimbursement for STD services.

FIGURE 31: TOP THREE TRAINING AND TECHNICAL ASSISTANCE NEEDS FOR PUBLIC HEALTH LABORATORIES (N=43) (Q13)

Number of missing responses: 9
Percentages will not add to 100% because this question is check all that apply.



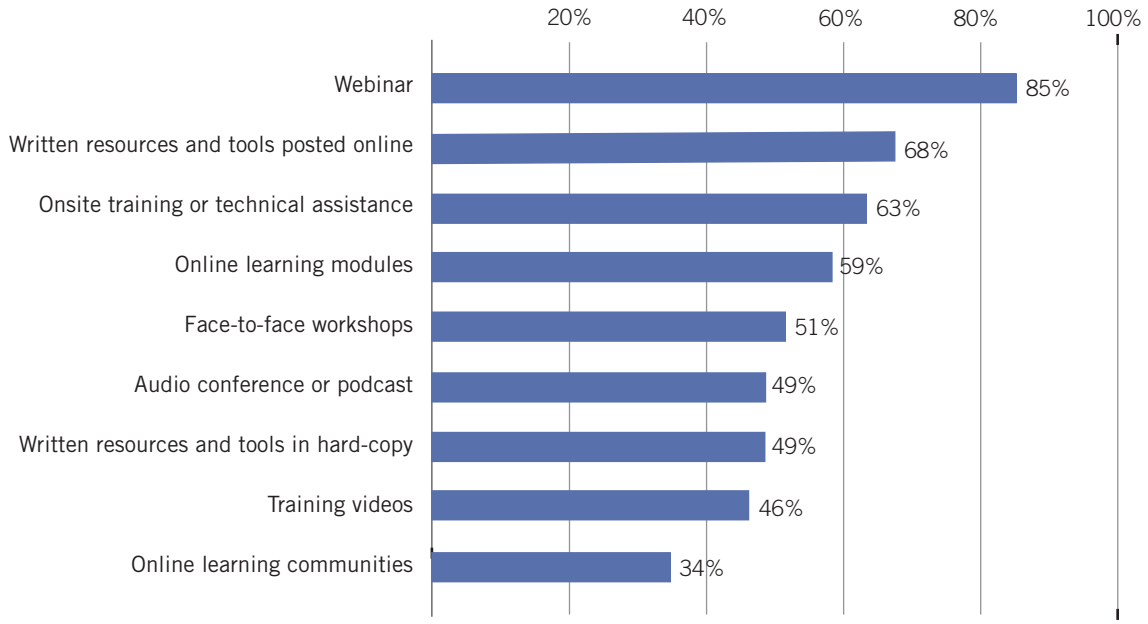
Respondents identified the modalities that they are likely to access for their training/TA needs if the training topic meets their needs (Figure 32). Online modes of learning were popular, with webinars selected by 85%,

written resources and tools available online by 68%, and online learning modules by 59%. In addition, in-person option such as onsite training or technical assistance (63%), and face-to-face workshops (51%) were also favored by more than half of the respondents.

"Until we get additional staffing and our new billing system, there is no need for TA to help us do third-party billing."

FIGURE 32: PUBLIC HEALTH LABORATORIES' PREFERRED TRAINING MODALITIES (N=43) (Q14)

Number of missing responses: 2
Percentages will not add to 100% because this question is check all that apply.



CONCLUSIONS

Despite the potential revenue that billing offers, less than half of STD-certified 340B clinics and less than one quarter of public health labs currently bill both public and private insurers. This needs assessment provides some understanding of which STD service providers have not moved forward with billing, what some of the barriers are to implementing billing, and how they might be able to be assisted to implement it.

Since World War II, confidential STD services have been provided at no cost or at drastically reduced rates by health departments and other types of federally funded clinics. Many health departments still have prohibitive billing policies, and it is not surprising that these policies were cited as the number one barrier to billing by STD-certified 340B clinics. From their inception, STD clinics were committed to providing confidential services to their clients, and one of the top barriers cited in this needs assessment by 340B clinics, public health labs (PHLs), and STD programs alike was confidentiality concerns. Publicly-funded STD service providers want to make sure that confidential services are not compromised through the billing practice of sending an "explanation of benefits" (EOB) to the primary person insured.

Other top barriers identified through the needs assessment included not enough staff to initiate or follow up on unpaid claims, and lack of PMS or EHR. Many state and local STD programs have experienced funding cuts as a result of the recession and other financial constraints, and continue to face staffing barriers. Updating or implementing IT systems is also expensive and the up-front costs may be prohibitively expensive even with the promise of future revenue increases. In addition to these barriers, clinics pointed out that clinics staffed with RNs are not always able to bill for services provided, because of limitations on billing by RNs (not a direct concern for PHLs). They also pointed out the relative low number of insured individuals in their service sites makes the unit cost of billing more expensive. The PHLs were consistent with clinics, listing staff limitations and confidentiality concerns among their top five barriers. However, they differed in that they were more concerned about funds not coming back to the lab and the difficulty of setting up contracts with third-party payers, which is understandable given that PHLs would be subject to state funding and contracting rules.

STD-Certified 340B Clinics

According to the needs assessment findings, only 45% of clinics were billing both Medicaid and other third-party payers (weighted data). Billing status and capacity varied based on geography, clinic size, site type and service type. Small clinics, Health Department STD clinics, and STD only service sites were less likely to bill compared to large clinics, other site types and clinics providing integrated STD and family planning (FP) services. STD services only clinics made up 77% of those clinics *not billing* and small clinics (less than 2000 visits per year) made up 83% of those clinics *not billing*.

Barriers to Billing Third-Party Payers for STD-Certified 340B Clinics

Health Department Policy prohibiting billing for STD services was identified by clinics and agencies as the most common barrier to billing both Medicaid and other third-party payers. About 20% of respondents indicated that there were **legal barriers** preventing them from billing, which varied by geography. For example, New York was one of the states with less than 30% of clinics billing, and until recently it had a law prohibiting billing for STD services.

The second most commonly identified barrier to billing is broadly described as **resource constraints**. Respondents indicated that they did not have the staff required to initiate billing or follow-up on unpaid claims. Around a fifth of respondents also noted that funds received from billing did not come back to the program (and instead went into the general fund), indicating that it may be difficult to financially support the increased staffing needs for billing. Texas, a state with a low percentage of billing clinics, has a law requiring Health Departments to place any funds it generates from third-party billing in a public health services fund.[9] Those funds would not necessarily be available to support STD program billing staff. There was a common concern that additional staff would be needed to initiate billing, negotiate and monitor contracts, process claims, and follow-up on unpaid claims.

After staffing, the next most commonly identified barrier to billing was **infrastructure constraints**. About half of respondents indicated they did not have the tools needed to bill electronically such as a practice management system (PMS) or billing software and/or electronic health record (EHR). Only about half have an EHR and 37% of clinics report the lack of an EHR or PMS as a barrier to billing. Both tools are helpful, but not required, for billing third-party payers. The Information Technology (IT) infrastructure capacity differs by clinic size, site type, and service type, with small clinics, Health Department STD clinics, and those providing STD services-only having the greatest infrastructure needs. For those with limited staff and infrastructure resources, or those anticipating limited revenue due to low rates of insured clients, the use of an outside billing agency could potentially facilitate the process of billing with less up-front investment than hiring staff and developing internal IT infrastructure. However, outside billing agencies sometimes require a certain minimum number of claims per year, which may necessitate small clinics to partner with others to be successful in hiring an outside billing company.

Concerns around **confidentiality** were also identified as a substantial barrier to billing by clinics and agencies. About 30% of those not currently billing third-party payers identified the potential for violating client confidentiality through billing as a barrier to initiating billing. Approximately half of all respondents and over 60% of Health Department STD clinics selected establishing confidentiality protocols as a technical assistance (TA) need. This concern was widespread. A provision of the ACA allows young people to stay on their parents' insurance until they are 26; thus, the number of people who may be concerned that they will receive confidential STD services when their insurance is billed has expanded. The most common concern about confidentiality was that an EOB will be sent to the primary person insured and that this may breach the confidential service for a dependent, including a minor or a spouse.

Finally, a lack of **internal capacity** and understanding about billing, reimbursement, and related activities was also identified as a barrier. Around 20% of *all* respondents (including those billing and not billing) said they did not know how to contract with private third-party payers and over a third of those *not billing*, selected "Billing 101" as one of their top five TA needs.

STD-Certified 340B Clinic Billing Capacity

When asked to self-assess level of capacity on a one to five scale for billing activities, such as contracting, credentialing, billing, verification, and managing claims, respondents rated themselves on average between "just getting started" (2) and "able to do the activity, but may benefit from help" (3). About 20% of respondents rated

9 D Kumar, D Hendrik. National Alliance of State & Territorial AIDS Directors' State Health Department Billing for HIV/AIDS and Viral Hepatitis Services: An Analysis of Legal Issues in Five States, 2013.

themselves at one (1), the lowest level of capacity for billing third-party payers, indicating they had no knowledge or experience with billing. For this 20% who have no knowledge of billing, substantial internal and external resources will be needed if they are to transition to billing third-party payers. These clinics with low capacity are more likely to be STD clinics and/or small clinics. The clinics or agencies will likely need internal leadership to first decide to bill and second, to devote staff and financial resources to developing billing policies, procedures, and systems. External resources for assisting with IT infrastructure upgrades and staff training about a variety of billing topics – from credentialing providers to revenue cycle management – will also be needed. Moving from not billing to billing Medicaid and other third-party payers will take time, commitment, and a variety of internal and external resources.

STD-Certified 340B Clinics' Training and Technical Assistance Needs

Clinics and agencies have substantial training/TA needs. Of those STD-certified 340B clinics that participated in this needs assessment, **there are over 1,000 clinics not billing third-party payers** (and the actual number is likely to be more since 28% of 340B entities did not participate). For each of the training/TA topics listed, between 34-57% of respondents said they would like TA on the topic. For all respondents, the top needs were: **coding, cost analysis, and need for confidentiality protocols**. Of those not yet billing, they also needed: **Billing 101** and assistance **identifying partnerships**. Of those already billing, they needed assistance with improving **quality assurance** activities and help with **expanding and monitoring contracts.** Small clinics and those providing STD services only are the least likely to bill and will need the most comprehensive training/TA.

State/Project Area STD Programs

Overall, the state and project area STD programs report limited ability to assist clinics in their transition to billing. **Only 20% said they have capacity to assist clinics to initiate billing activities.** In addition, only 21% have protocols or guidance on how to ensure patient confidentiality, and only about a third (37%) report a state-level coordinated effort to bill for STD services. Asked to rate their readiness to assist clinics, **70% said they need TA in order to be able to assist clinics to bill.** When STD Programs were asked whether STD-certified 340B clinics in their jurisdiction needed billing training/TA, 89% identified at least one training/TA need; for all TA topics listed, between 45% -79% of respondents selected them as a TA need.

State Public Health Laboratories

Approximately 40% of state public health laboratories (PHLs) that participated in this assessment bill clinics directly, 62% bill Medicaid, and **only 21% bill Medicaid and other third-party payers.** Over two thirds of the labs were concerned about inadequate staffing as a barrier to billing and follow-up on unpaid claims. Approximately 40% cited confidentiality concerns as a barrier to billing. A small number of labs (16%) reported that there were laws that expressly restrict their ability to bill for STD services through the lab, which will likely be a significant barrier for them.

Nearly 80% of labs reported the need for some type of TA. Almost three quarters of labs (71%) selected contracting with third-party payers as one of their top TA needs, which is not surprising given some of the

documented difficulties of obtaining state-approved contracts.[10] This was followed by developing a state-level coordinated efforts for billing third-party payers (50%); identifying an outside billing agency (32%); and setting up direct billing for clinics and hospitals (29%). The findings of this needs assessment were consistent with the findings in the recent paper, "Using Fee-for-Service Testing to Generate Revenue for the 21st Century Public Health Laboratory." The authors found that "restrictive legislation, staffing shortages, inadequate software for billing fee-for-service testing, and regulations on how PHLs use their generated revenue are impediments to implementing fee-for-service testing."[11]

Conclusion

Overall, the capacity to bill third-party payers was varied, but the training/TA needs were consistently high. Among STD-certified 340B clinic needs assessment respondents, Health Department STD clinics, STD services-only clinics, and small service sites have the least capacity to bill third-party payers and the most significant training/TA needs. More than half of state/project area STD programs and state public health labs also indicated needing billing training/TA.

Fortunately, there is a robust training/TA network already in existence. Advocacy organizations and partners such as the National Chlamydia Coalition (NCC), National Coalition of STD Directors (NCSD), the Title X National Training Centers (NTC), the National Family Planning and Reproductive Health Association (NFPRHA), the Association of Public Health Laboratories (APHL), and the National Association of County and City Health Officials (NACCHO) have already developed resources and training related to billing for STD services. In addition, the STD RH TTACs have begun to deliver billing training and TA to clinics, agencies, STD programs, and labs. To meet the extensive and diverse training/TA demands outlined in this report, a diverse group of TA providers will be needed. Coordination at the national level to address cross-cutting national issues like confidentiality concerns and infrastructure constraints should be continued.

10 Loring, C., et al. Using Fee-for-Service Testing to Generate Revenue for the 21st Century Public Health Laboratory. Public Health Reports, 2013 Supplement 2: Volume 128, 97-104.

11 Ibid.

APPENDIX I. METHODS

The goal of this needs assessment was to compile local, state, regional, and national profiles of current capacity and Training and Technical Assistance (T/TA) needs related to billing, coding, and reimbursement among STD-certified 340B eligible clinics and STD prevention programs, and the public health labs that support them.

The needs assessment was designed to answer the following evaluation questions:

1. What is the current status of billing and reimbursement among STD-certified 340B eligible clinics and public health labs in each of the project areas?
2. What is the current capacity of state / project area STD programs to provide the needed support to family planning, STD clinics, and public health labs in order for them to bill Medicaid and other (private) third-party payers?
3. What types of billing and reimbursement T/TA needs do the states / project areas, clinics, and labs need in order for them to scale up to fully functioning billing and reimbursement systems?

This report presents a national picture of billing capacity among clinics and public health labs, as well as the capacity of STD programs to support billing among their funded clinics.

APPROACH

Existing billing needs assessments were reviewed to inform the national billing needs assessment. Assessments for Public Health Labs, State/Project Area STD Programs, and Family Planning and STD clinics had all been conducted previously. However, because of low participation rates, differences in the definition of the target audience or a lack of data about training and TA needs, it was decided that a coordinated national needs assessment would be helpful to summarize the current billing capacity and training and TA needs for Public Health Labs, State STD Programs and STD-certified 340B clinics.

The needs assessment approach, tools, evaluation questions and definitions of target audience were all determined through consensus with participation from all 10 regional TTACs and guidance from CDC. The approach to the needs assessment was to contact a representative from each of the Labs, STD Programs and STD-certified 340B clinics that were among the defined target audience.

ASSESSMENT TOOL DEVELOPMENT

Three tools were developed, corresponding to each target audience: public health labs, STD Programs, and STD-certified 340B clinics. Tools were drafted by JSI and contained a combination of categorical and open-ended questions. The tools were reviewed several times by the regional TTACs and feedback was incorporated into a draft shared with CDC. Staff from CDC made additional changes and those changes were incorporated into the tools. One more round of edits were made and the tools were finalized.

ASSESSMENT ADMINISTRATION

Each of the three billing needs assessments were distributed by regional TTACs. An online assessment tool was utilized to gather data from respondents with the advantages that: 1) the technology was readily accessible to all of regional TTACs; 2) respondents were familiar with this technology from prior needs assessments; 3) participants could answer according to their own availability; 4) results from the needs assessment could be analyzed quickly within the online tool and utilized for T/TA plans; and 5) data was easy to extract and share with JSI for compiling into the national needs assessment.

The final needs assessment questions were entered into the online assessment tool by JSI and transferred to each of the regional accounts electronically to ensure consistency and accuracy. Regional TTACs were asked not to add additional questions within the body of the assessment to allow for data compilation at the national level. However, regions could ask region-specific questions at the end of the assessments.

Public Health Labs Billing Needs Assessment

Each regional TTAC distributed the billing needs assessment by email to state public health labs within their region, and several TTACs also sent the needs assessment to city-level public health labs that are represented as STD project area cities. Non-responders were monitored using each TTAC's web-based data collection tools (SurveyMonkey®); email and phone call follow-ups were made to non-responders. Data collection was conducted for 4 weeks. Regions extracted line-level data from the online assessment tool and uploaded them to JSI's secure website. Following a review of the data, JSI contacted all of the respondents by phone and/or email and asked them two additional questions that were not included in the needs assessment.

State/Project Area STD Programs Billing Needs Assessment

TTACs worked with their partner STD Programs to distribute both the state/project area and clinic-level needs assessments. Regional TTACs sent a request for participation to project area STD programs with an email that included a link to the needs assessment. Respondents were monitored at the Regional level and non-responders were contacted with emails and phone calls. Non-responders were identified and CDC made an additional request for non-responders to participate. Data collection was conducted for 4 weeks. Final data sets were extracted from each Region's SurveyMonkey® account and were uploaded to JSI's secure website.

Clinic-Level Billing Needs Assessment

With guidance from CDC, it was decided that only STD-certified 340B clinics would be included in the assessment. A list of STD-certified 340B clinics was obtained from CDC. The list was stratified by state and region and incorporated into a "Tracking spreadsheet" that tracked Title X funding status, entity type (clinic or agency) and participation. It was sent to each of the Regional TTACs. Regional TTACs were asked by CDC to coordinate with the state STD programs to confirm that the clinics listed were STD-certified 340B and that the clinics were not Title X-funded clinics. Once the final list of clinics was confirmed, regional TTACs emailed joint letters from the state/project area STD Programs and the TTACs to engage non-Title X, STD-certified 340B clinics in the billing needs assessment. Regional TTACs tracked exclusions and participation in the Tracking spreadsheet and sent it to JSI for compilation.

Many of the clinics included on the STD-certified 340B list were clinics that fell under the umbrella of a parent agency within which billing decisions were made at a central level. To reduce data collection burden by agencies with multiple clinics, and to ensure accurate answers, the TTACs requested, and CDC agreed, to allow agencies representing multiple clinics to answer the needs assessment on behalf of all their clinics. To participate in the needs assessment at the agency (multiple clinic) level, administrative decisions for billing had to be made at agency level, and not the clinic level. Any agency that reported that it had multiple clinics *and* that billing decisions were made at the clinic level did not receive any additional assessment questions. If respondents did not meet the inclusion requirements, they received a request to forward the assessment to their clinics. There were seven agencies who started the assessment and who were excluded. Of those seven agencies, six sent the assessment on to their clinics.

The list of STD-certified 340B "clinics" contained a list of entities that included clinics, agencies that represented multiple clinics, and agencies that funded clinics or other agencies but that did not provide direct STD services. To track participation, regional TTACs were asked to indicate whether the entity listed in the Tracking spreadsheet answered the needs assessment as a clinic or an agency and if it was an agency, how many clinics the agency represented. Since some agencies listed in the Tracking spreadsheet represented multiple clinics or multiple clinics and other agencies, there were more clinics represented in the needs assessment than were listed in the original STD-certified 340B list. However, participation rates were determined using the "entity" included in the list of STD-certified 340B clinics.

FIGURE 1. MAPPING 340B ENTITIES LIST TO NEEDS ASSESSMENT RESPONDENTS

DATA COLLECTION, CLEANING, AND ANALYSIS

Data for all three needs assessments were collected in SurveyMonkey® data by each of the ten regional TTACs. Line-level data extracts were downloaded from regional accounts and uploaded to a secure website provided by JSI. The ten data sets were combined in Excel and imported into SAS for data cleaning and data analysis. Duplicate records and records where respondents did not answer the required questions were deleted (Lab: 2; State: 9; and Clinic: 6). In the clinic needs assessment, six clinics and agencies that reported they conducted zero visits a year were reviewed in entirety and deleted when it was determined that they did not provide STD services. Two additional records were deleted because the respondents representing "multiple clinics" answered that they had zero clinics and did not provide STD services.

As described above, participation rates were tracked in the Tracking spreadsheet. To clean data in the Tracking spreadsheet, tests for logical relationships were done. If there was a record that had missing data or that did not follow logic rules, follow-up questions were sent to regional TTACs representatives for clarifications. The final Tracking spreadsheet from each region was compared to each region's assessment records and additional data cleaning was done to ensure that the data in the Tracking spreadsheets reflected the assessment data collected.

After the data were cleaned, the final data analysis process began. For continuous variables, JSI calculated the overall mean and median values; mean and median values were also calculated for specific groups of interest (stratified analysis). JSI tested differences between group medians using the Wilcoxon Rank Sum test, the non-parametric version of a t-test. A p-value of less than 0.05 was considered indicative of a significant difference. For categorical variables, JSI calculated proportions for the entire sample and for specific groups of interest (stratified analysis). JSI tested the association of service type and site type with billing status using a chi-square test. A p-value of less than 0.05 was considered indicative of a significant difference.

For the STD-certified 340B clinic data, descriptive statistics are displayed for single clinics and agencies (multiple clinics) and combined in the appendices. JSI also ran stratified analyses by number of visits (categorized), service type and site type. For agencies that responded on behalf of multiple clinics, a new variable was calculated for the average number of visits per clinic (question 5 divided by question 3).

In a supplemental analysis, agency responses were weighted to reflect the number of clinics that they had responded on behalf of. This data set was then combined with the responses from single clinics to create one clinic-level data set. Proportions were calculated for questions of interest and differences in the median number of visits per clinic were tested using the Wilcoxon Rank Sum test, the non-parametric version of a t-test. A p-value of less than 0.05 was considered indicative of a significant difference.

JSI used Google Fusion tables to map the clinic-level data set by state for questions of interest. The percentage of clinics in each state was categorized, with color coding corresponding to each category. Maps were created for question 11 (currently collecting fee-for-service payment for STD related services) and question 13 (currently billing Medicaid or other third-party payers for STD-related services).

PARTICIPATION

Public Health Labs

Among Public Health Labs, 40 state public health labs and three local public health labs participated in the needs assessment, a 75% participation rate (Tables 1 and 2). Not all Regions sent the lab needs assessment to local labs that are STD program project areas. (Instructions were to send them to state labs but some project areas do not utilize state labs). The local labs were only counted in the denominator if they received a request for participation. While the participation rate was not as high as the STD program participation rate, there were enough participants to provide a national picture for billing capacity among public health labs. Data were not stratified by local and state level labs because there were only three local labs that participated in the needs assessment. No private labs participated in the needs assessment.

TABLE 1. PUBLIC HEALTH LABORATORY PARTICIPATION RATES BY REGION

Region	Number of Labs Participated	Total Number of Labs	%
Region I	6	6	100%
Region II*	2	5	40%
Region III**	5	7	71%
Region IV	6	8	75%
Region V	3	6	50%
Region VI	5	5	100%
Region VII	3	4	75%
Region VIII	5	6	83%
Region IX**	4	6	67%
Region X	4	4	100%
Total	**43**	**57**	**75%**

**Territories included*
***Local labs included*

TABLE 2. TYPES OF LABS

	N	%
Local public health lab	3	7%
State public health lab	40	93%
Total	**43**	**100%**

State/Project Area STD Programs

There was an excellent participation rate among State/Project Area STD Programs: 90% of all programs assessed answered the required questions for the needs assessment (Table 3). Participants represented all 50 states, plus an additional nine funded cities and territories: Los Angeles, CA; San Francisco, CA; District of Columbia; Chicago, IL; Baltimore, MD; New York, NY; Philadelphia, PA; the Commonwealth of Puerto Rico; and the U.S. Virgin Islands.

TABLE 3. STATE/PROJECT AREA STD PROGRAM PARTICIPATION RATES BY REGION

Region	Number of Participating STD Programs	Total Number of STD Programs	STD Program Participation Rate
Region I	6	6	100%
Region II	5	5	100%
Region III	7	8	88%
Region IV	7	8	88%
Region V	5	7	71%
Region VI	3	5	60%
Region VII	4	4	100%
Region VIII	6	6	100%
Region IX	6	6	100%
Region X	4	4	100%
Total	**53**	**59**	**90%**

STD-Certified 340B Clinics

As explained above in *Assessment Administration*, the list of STD-certified 340B clinics was a list of "entities" that included clinics, agencies who represented multiple clinics, or agencies who funded clinics or other agencies. The participation rates were determined by tracking whether a representative of the "entity" listed in the list of STD-certified 340B clinics participated in the needs assessment. For example, there may be 20 clinics in the master list for which one agency responded. Conversely, one agency in the list may have forwarded the needs assessment to multiple clinics. For this reason, the number of records in the needs assessment does not equal the number of entities in the master list.

The overall participation rate was 72%, with participation by region ranging from a low of 36% to a high of 87% (Table 4 and Figure 1). Prior to sending the needs assessment to clinics, 279 entities were excluded because they were Title X-funded, closed or were an agency that did not have any clinics (e.g., a health department that funded clinics that were Title X funded). Of the 870 entities that responded, the majority (723) answered the assessment as an agency representing multiple clinics. Entities from 45 states (five states did not have STD-certified 340B clinics), District of Columbia and 3 territories (Guam, the Commonwealth of Puerto Rico and the

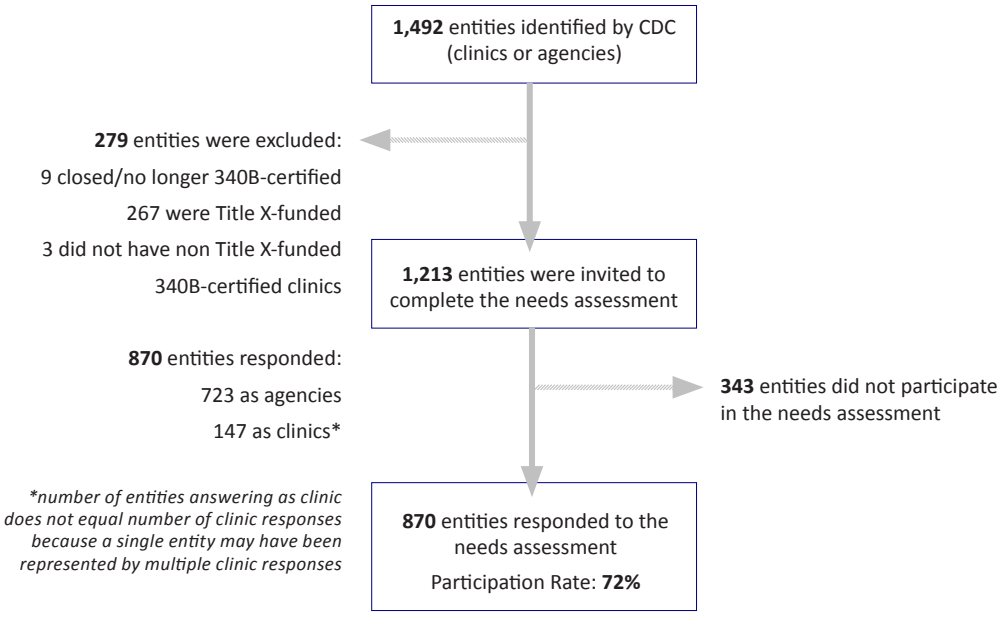
U.S. Virgin Islands) were asked to participate in the needs assessment. Clinics from 42 of the 45 states and all of the territories, participated in the needs assessment (data not shown). While participation rates varied by state and region, overall clinics from across the country participated, allowing for conclusions to be drawn at a national level.

TABLE 4: PARTICIPATION RATE OF STD-CERTIFIED 340B CLINICS BY REGION

Region	# of Entities	# Excluded Entities	# Eligible Entities	# Entities Responded	# of Entities Responding as Clinic*	# of Entities Responding as Agency*	Participation Rate
Region I	77	50	27	16	5	11	60%
Region II	75	0	75	33	25	8	44%
Region III	80	35	45	33	15	18	73%
Region IV	590	17	573	498	2	496	87%
Region V	164	53	111	42	18	24	38%
Region VI	17	0	17	12	9	3	71%
Region VII	39	3	36	26	7	19	72%
Region VIII	122	52	70	25	15	10	36%
Region IX	162	53	109	76	18	58	70%
Region X	166	16	150	109	33	76	73%
Total	**1492**	**279**	**1213**	**870**	**147**	**723**	**72%**

**Note: Total number of clinics and agencies are not equivalent to the number of assessment responses. For example, an agency may represent multiple entities. See discussion in Assessment Administration.*

FIGURE 2: STD-CERTIFIED 340B CLINIC PARTICIPATION RATE



LIMITATIONS

This was a needs assessment of three identified target populations: STD-certified 340B clinics, public health labs, and State/Project Area STD programs. The participation rates for the target populations were high, ranging from 75-90%. The data from this needs assessment were sufficiently representative of the STD RH TTACs to determine local, state and regional training and TA plans. However, the data are not generalizable to other services, clinics, state programs or other types of labs.

Caution ought to be used when interpreting the STD-certified 340B clinic weighted data results because the results do not reflect any differences between clinics that were a part of the same agency. The analysis assumes that all clinics who belong to the same agency would answer the assessment questions in the same way since they could only participate as an agency if billing policies and procedures were established at the agency level. Weighted data were used sparingly; they were used primarily to demonstrate the magnitude of the number of clinics billing and not billing.

While it was the aim of this assessment to exclude Title X-funded clinics, some were represented in the assessment. As described above, agencies representing multiple clinics were allowed to answer the assessment. The main way that Title X-funded clinics were included in the assessment was at the agency-level. For example, an agency would answer on behalf of its non-Title X, STD-certified 340B clinic from the master list, but it also answered on behalf of all its other clinics, many of which were Title X-funded. Because the assessment was done at the agency and clinic level to ensure maximum participation, agencies representing both Title X and non-Title X clinics could not be excluded. Since Title X clinics were more likely to bill than STD clinics (The Future of the Infertility Prevention Project, 2011)[1] billing capacity among non-Title X, STD-certified 340B clinics is over represented in the *Agency* data, and in the weighted clinic data. However, despite their unintended inclusion, regional TTACs can prioritize STD-certified 340B clinics without Title X funding in their training and TA plans.

1 The Future of the Infertility Prevention Project, 2011 is available for download from http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=13137&thisSection=Resources

APPENDIX II. SUMMARY DATA

A. STD-Certified 340B Clinics Billing Needs Assessment

TABLE 1. IN WHICH STATE/PROJECT AREA DO YOU WORK? (Q1)

STATE	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Alabama	0	0%	1	1%	1	0%
Alaska	3	1%	3	2%	6	2%
Arizona	4	2%	6	5%	10	3%
Arkansas	1	0%	1	1%	2	1%
California	18	9%	15	12%	33	10%
Colorado	1	0%	0	0%	1	0%
Connecticut	7	3%	1	1%	8	2%
Delaware	3	1%	0	0%	3	1%
District of Columbia	2	1%	1	1%	3	1%
Georgia	0	0%	12	9%	12	4%
Guam	1	0%	0	0%	1	0%
Hawaii	1	0%	0	0%	1	0%
Idaho	0	0%	4	3%	4	1%
Illinois	0	0%	2	2%	2	1%
Indiana	3	1%	0	0%	3	1%
Iowa	6	3%	1	1%	7	2%
Kentucky	0	0%	1	1%	1	0%
Louisiana	0	0%	1	1%	1	0%
Maine	2	1%	0	0%	2	1%
Maryland	14	7%	4	3%	18	5%
Massachusetts	0	0%	2	2%	2	1%

TABLE 1. CONTINUED

STATE	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Mississippi	0	0%	1	1%	1	0%
Missouri	0	0%	1	1%	1	0%
Montana	3	1%	1	1%	4	1%
Nebraska	1	0%	1	1%	2	1%
Nevada	1	0%	3	2%	4	1%
New Jersey	24	12%	7	6%	31	9%
New Mexico	0	0%	1	1%	1	0%
New York	26	13%	8	6%	34	10%
North Carolina	0	0%	1	1%	1	0%
North Dakota	3	1%	2	2%	5	2%
Ohio	3	1%	3	2%	6	2%
Oregon	14	7%	11	9%	25	8%
Pennsylvania	0	0%	2	2%	2	1%
Puerto Rico	0	0%	1	1%	1	0%
South Carolina	0	0%	1	1%	1	0%
Tennessee	2	1%	1	1%	3	1%
Texas	10	5%	0	0%	10	3%
Utah	2	1%	3	2%	5	2%
Vermont	0	0%	1	1%	1	0%
Virgin Islands	0	0%	1	1%	1	0%
Virginia	0	0%	3	2%	3	1%
Washington	14	7%	6	5%	20	6%
Wisconsin	10	5%	2	2%	12	4%
Wyoming	15	7%	1	1%	16	5%
Total	**206**	**100%**	**127**	**100%**	**333**	**100%**

TABLE 2. HOW MANY CLINICS ARE YOU REPRESENTING TODAY? (AGENCY ONLY) (Q3)

AGENCY				
	N	**Mean**	**Standard Deviation**	**Median**
Number of Clinics	127	13.6	24.8	5

TABLE 3. APPROXIMATELY HOW MANY VISITS DOES YOUR AGENCY SEE PER YEAR ACROSS ALL SITES? (AGENCY ONLY) (Q5)

AGENCY				
	N	**Mean**	**Standard Deviation**	**Median**
Number of visits per year	109	42179	92285	8000

Number of missing responses: 18

TABLE 4. APPROXIMATELY HOW MANY VISITS DOES YOUR CLINIC SEE PER YEAR? (CLINIC ONLY) (Q6)

CLINIC				
	N	**Mean**	**Standard Deviation**	**Median**
Number of visits per year	193	3191	5198	1100

Number of missing responses: 13

TABLE 5. WHICH OF THE FOLLOWING BEST DESCRIBES SERVICES PROVIDED AT YOUR CLINIC? (Q7)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
STD services only	105	53%	21	17%	126	39%
Integrated clinic (including FP and STD services)	80	40%	97	76%	177	54%
Other	14	8%	9	7%	23	7%
Total	199	100%	127	100%	326	100%
Number of missing responses:	*7*		*0*		*7*	

TABLE 6. WHICH OF THE FOLLOWING BEST DESCRIBES THE TYPE OF CLINIC(S) YOU ARE REPRESENTING? (Q8)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Health department STD Clinics	121	61%	41	32%	162	50%
Health department Family Planning Clinics	33	17%	33	26%	66	20%
Health Department	10	5%	11	9%	21	6%
Part of a Community Health Center (FQHC or look-alike)	5	3%	15	12%	20	6%
Planned Parenthood/ Free-standing	3	2%	17	13%	20	6%
Other	26	14%	10	8%	36	11%
Total	**198**	**100%**	**127**	**100%**	**325**	**100%**
Number of missing responses:	*8*		*0*		*8*	

TABLE 7. DOES YOUR CLINIC USE AN ELECTRONIC HEALTH RECORD? (Q9)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Yes	68	33%	59	47%	127	38%
No	121	59%	45	36%	166	50%
Implementing by end of 2014	16	8%	22	17%	38	11%
Total	**205**	**100%**	**126**	**100%**	**331**	**100%**
Number of missing responses:	*1*		*1*		*2*	

TABLE 8. WHICH OF THE FOLLOWING IS YOUR CLINIC(S) ABLE TO DO WITH YOUR ELECTRONIC HEALTH RECORD? (INCLUDED ONLY THOSE WHO RESPONDED YES FOR Q9) (Q10)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Collect insurance information	46	71%	54	93%	100	81%
Customize data fields	52	80%	47	81%	99	80%
Customize reports	55	85%	52	90%	107	87%
Total	**65**		**58**		**123**	

Number of missing responses: *3* *1* *4*

Percentages will not add to 100% because this question is check all that apply.

TABLE 9. IS YOUR CLINIC(S) CURRENTLY COLLECTING FEE-FOR-SERVICE PAYMENT FROM CLIENTS FOR STD SERVICES? (Q11)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Yes, cash only	36	18%	16	13%	52	16%
Yes, cash and credit card	77	38%	71	58%	148	45%
No	90	44%	36	29%	126	39%
Total	**203**	**100%**	**123**	**100%**	**326**	**100%**

Number of missing responses: *3* *4* *7*

TABLE 10. IS YOUR CLINIC(S) USING A SLIDING SCALE TO ASSESS FEES? (INCLUDED ONLY THOSE THAT RESPONDED YES TO Q11) (Q12)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Yes	67	59%	76	87%	143	72%
No	46	41%	11	13%	57	29%
Total	**113**	**100%**	**87**	**100%**	**200**	**100%**

TABLE 11. IS YOUR CLINIC(S) CURRENTLY BILLING MEDICAID OR OTHER THIRD-PARTY PAYERS FOR STD-RELATED SERVICES? (Q13)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Yes billing Medicaid only	39	19%	26	20%	65	20%
Yes billing (other) third party payers only	1	0%	0	0%	1	0%
Yes billing Medicaid and other third party payers	51	25%	68	54%	119	36%
No not billing Medicaid or other third party payers	115	56%	33	26%	148	44%
Total	**206**	**100%**	**127**	**100%**	**333**	**100%**

TABLE 12. DOES ANY PROGRAM WITHIN YOUR CLINIC OR AGENCY BILL PRIVATE THIRD PARTY PAYERS? (INCLUDED ONLY THOSE THAT RESPONDED NO FOR Q13) (Q14)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Yes	68	60%	19	59%	87	60%
No	44	39%	11	34%	55	38%
Not sure	2	2%	2	6%	4	3%
Total	**114**	**100%**	**32**	**100%**	**146**	**100%**
Number of missing responses:	*1*		*1*		*2*	

TABLE 13. ARE STEPS UNDERWAY TO BEGIN BILLING FOR STD-RELATED SERVICES WITHIN THE NEXT YEAR? (INCLUDED ONLY THOSE THAT RESPONDED NO TO Q13) (Q15)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Yes	28	26%	17	53%	45	32%
No	47	44%	9	28%	56	40%
Not sure	32	30%	6	19%	38	27%
Total	**107**	**100%**	**32**	**100%**	**139**	**100%**
Number of missing responses:	*8*		*1*		*9*	

The following questions 16-19 included only those that responded Yes Billing Medicaid or Yes Billing Other Third Party Payers Only to Q13.

TABLE 14. DO YOU USE ANY OF THE OTHER FOLLOWING DATABASES TO GATHER INSURANCE INFORMATION? (Q16)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Practice management system	7	19%	4	17%	11	18%
Stand-alone database (like Microsoft Access)	5	14%	2	9%	7	12%
Web-based database (other than EHR)	8	22%	9	39%	17	28%
Primarily use paper files	11	30%	3	13%	14	23%
Not Applicable	0	0%	0	0%	0	0%
Other	0	0%	0	0%	0	0%
Total	**37**		**23**		**60**	
Number of missing responses:	*3*		*3*		*6*	

Percentages will not add to 100% because this question is check all that apply.

TABLE 15. DO YOU HAVE A DEPARTMENT OR STAFF ASSIGNED TO MANAGE AND FOLLOW-UP ON ACCOUNTS RECEIVABLE? (Q17)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Yes	34	85%	20	83%	54	84%
No	5	13%	4	17%	9	14%
Not Applicable	1	3%	0	0%	1	2%
Total	**40**	**100%**	**24**	**100%**	**64**	**100%**
Number of missing responses:			*2*		*2*	

TABLE 16. DO YOU USE AN OUTSIDE BILLING/COLLECTIONS AGENCY? (Q18)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Yes	4	11%	3	12%	7	11%
No	33	87%	22	88%	55	87%
Not Applicable	1	3%	0	0%	1	2%
Total	**38**	**100%**	**25**	**100%**	**63**	**100%**
Number of missing responses:	*2*		*1*		*3*	

TABLE 17. WHY ARE YOU NOT CURRENTLY BILLING MEDICAID AND OTHER THIRD PARTY PAYERS? (Q19)

	CLINIC				AGENCY				TOTAL RESPONDENTS			
	Reason Not Billing Medicaid		**Reason Not Billing Third Party Payers**		**Reason Not Billing Medicaid**		**Reason Not Billing Third Party Payers**		**Reason Not Billing Medicaid**		**Reason Not Billing Third Party Payers**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Don't know how to set up contract	16	14%	20	15%	2	6%	9	18%	18	13%	29	16%
Health department Policy	51	46%	58	44%	16	50%	21	41%	67	47%	79	43%
Too difficult to set up a contract (tried already)	4	4%	15	11%	1	3%	9	18%	5	3%	24	13%
The majority of our clients do not have Medicaid or other third party payers	28	25%	33	25%	4	13%	13	25%	32	22%	46	25%
Not enough staff to initiate billing	36	32%	47	36%	9	28%	14	27%	45	31%	61	34%
Don't have practice Management System or Electronic Medical Records	35	31%	42	32%	6	19%	10	20%	41	28%	52	29%
Staff feel that services should be free	24	21%	22	17%	1	3%	6	12%	25	17%	28	15%
No Staff or not enough staff to follow-up on unpaid claims	28	25%	42	32%	7	22%	14	27%	35	24%	56	31%

Funds won't come back to our program	19	17%	21	16%	2	6%	2	4%	21	15%	23	13%
Confidentiality Concerns	33	29%	41	31%	7	22%	14	27%	40	28%	55	30%
Prohibited by local or state law	8	7%	9	7%	4	13%	4	8%	12	8%	13	7%
School-based services	2	2%	2	2%	1	3%	1	2%	3	2%	3	2%
Other	15	13%	15	11%	9	28%	9	18%	24	17%	24	13%
Total	**112**		**131**		**32**		**51**		**144**		**182**	
Number of missing responses:	*4*		*23*		*1*		*8*		*5*		*31*	

Percentages will not add to 100% because this question is check all that apply.

The following questions 20-21 included only those that responded No, Not Billing and Yes Billing Medicaid Only for Q13.

TABLE 18. ARE YOU AWARE OF ANY STATE OR LOCAL LAWS OR REGULATIONS THAT PREVENT YOUR ORGANIZATION FROM BILLING FOR STD-SERVICES? (Q20)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Yes	29	19%	10	18%	39	19%
No	93	62%	35	64%	128	62%
Not sure	28	19%	10	18%	38	19%
Total	**150**	**100%**	**55**	**100%**	**205**	**100%**
Number of missing responses:	*5*		*4*		*9*	

TABLE 19. ARE THERE ANY POLICIES WITHIN YOUR ORGANIZATION THAT PREVENT YOUR CLINIC(S) FROM BILLING FOR STD-SERVICES? (Q21)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Yes	28	19%	8	15%	36	18%
No	83	56%	38	69%	121	59%
Not sure	38	26%	9	16%	47	23%
Total	**149**	**100%**	**55**	**100%**	**204**	**100%**
Number of missing responses:	*6*		*4*		*10*	

The following questions 22-27 included only those that responded Yes billing Medicaid *and* other third party payers.

TABLE 20. DO YOU USE ANY OF THE FOLLOWING DATABASES TO GATHER INSURANCE INFORMATION? (Q22)

	CLINIC				AGENCY				TOTAL RESPONDENTS			
	Yes		No		Yes		No		Yes		No	
	N	%	N	%	N	%	N	%	N	%	N	%
Practice management system	20	47%	23	53%	40	65%	22	35%	60	57%	45	43%
Stand-alone database (like Access)	6	14%	37	86%	9	15%	53	85%	15	14%	90	86%
Web-based databases (other than EHR)	15	35%	28	65%	23	37%	39	63%	38	36%	67	64%
Primarily use paper files	11	26%	32	74%	6	10%	56	90%	17	16%	88	84%
Other	1	2%	42	98%	0	0%	62	100%	1	1%	104	99%
Total	**43**				**62**				**105**			
Number of missing responses:	*8*				*6*				*14*			

Percentages will not add to 100% because this question is check all that apply.

TABLE 21. DO YOU HAVE A DEPARTMENT OR STAFF ASSIGNED TO MANAGE AND FOLLOW-UP ON ACCOUNTS RECEIVABLE? (Q23)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Yes	47	92%	64	97%	111	95%
No	4	8%	2	3%	6	5%
Total	**51**	**100%**	**66**	**100%**	**117**	**100%**
Number of missing responses:			*2*		*2*	

TABLE 22. DO YOU USE AN OUTSIDE BILLING/COLLECTIONS AGENCY? (Q24)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	%	N	%	N	%
Yes	12	24%	15	23%	27	23%
No	38	76%	50	77%	88	77%
Total	**50**	**100%**	**65**	**100%**	**115**	**100%**
Number of missing responses: 1			*3*		*4*	

TABLE 23. HAS YOUR CLINICS DEVELOPED PROTOCOLS OR GUIDANCE ON HOW TO ENSURE PATIENT CONFIDENTIALITY WHEN BILLING THIRD PARTY PAYERS FOR STD SERVICES? (Q25)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Yes	37	73%	50	79%	87	76%
No	6	12%	2	3%	8	7%
Not Sure	8	16%	11	17%	19	17%
Total	**51**	**100%**	**63**	**100%**	**114**	**100%**

Number of missing responses: *5* *5*

TABLE 24. PLEASE INDICATE WHICH THIRD PARTY PAYER PLANS YOUR AGENCY CURRENTLY BILLS? (Q26)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Medicaid	51	100%	64	97%	115	98%
Aetna	29	57%	42	64%	71	61%
BlueCross BlueShield	42	82%	56	85%	98	84%
Coventry	8	16%	10	15%	18	15%
Humana	14	27%	25	38%	39	33%
Kaiser Permanente	3	6%	8	12%	11	9%
United Healthcare	30	59%	41	62%	71	61%
Tufts	3	6%	4	6%	7	6%
Other	14	27%	22	33%	36	31%
Total	**51**		**66**		**117**	

Number of missing responses: *2* *2*
Percentages will not add to 100% because this question is check all that apply.

TABLE 25. HAS YOUR CLINIC EXPERIENCED REIMBURSEMENT PROBLEMS OR AUDITING CONCERNS AS A RESULT OF INACCURATE BILLING OR CODING? (Q27)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Yes	16	31%	27	42%	43	37%
No	24	47%	28	44%	52	45%
Not sure	11	22%	9	14%	20	17%
Total	**51**	**100%**	**64**	**100%**	**115**	**100%**

Number of missing responses: *4* *4*

The following questions 28-33 included ALL respondents.

TABLE 26. IN THE LAST 2 YEARS HAS YOUR CLINIC SITE CONDUCTED A DETAILED COST ANALYSIS TO IDENTIFY THE COST OF STD-RELATED SERVICES? (Q28)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Yes	61	31%	32	27%	93	30%
No	105	54%	68	58%	173	55%
Not sure	30	15%	17	15%	47	15%
Total	**196**	**100%**	**117**	**100%**	**313**	**100%**
Number of missing responses: 10			*10*		*20*	

TABLE 27. HAVE YOU CONDUCTED AN ANALYSIS OR YOUR CLIENT PAYER MIX? (Q29)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Yes	51	26%	49	42%	100	32%
No	119	60%	54	46%	173	55%
Not sure	27	14%	14	12%	41	13%
Total	**197**	**100%**	**117**	**100%**	**314**	**100%**
Number of missing responses: 9			*10*		*19*	

TABLE 28. PLEASE RATE YOUR PROGRAM'S CAPACITY TO BILL MEDICAID AND OTHER THIRD PARTY PAYERS FOR STD-RELATED SERVICES AS OUTLINED IN THE QUESTIONS BELOW (Q30)

	CLINIC													AGENCY											
	N	1		2		3		4		5		N/A		mean	N	1		2		3		4		5		N/A		mean
		n	%	n	%	n	%	n	%	n	%	n	%			n	%	n	%	n	%	n	%	n	%	n	%	
Contract with Medicaid	191	40	21%	13	7%	33	17%	47	25%	35	18%	23	18%	3.1	111	5	5%	6	5%	25	23%	36	32%	27	24%	12	11%	3.7
Contract with other third party payers	187	50	27%	25	13%	35	19%	33	18%	14	7%	30	7%	2.6	110	14	13%	14	13%	21	19%	31	28%	13	12%	17	15%	3.2
Bill third party payers as out of network provider	188	60	32%	21	11%	34	18%	22	12%	13	7%	38	7%	2.4	112	19	17%	14	13%	24	21%	21	19%	12	11%	22	20%	2.9
Credential clinicians for one or more third party payers	187	52	28%	23	12%	30	16%	32	17%	14	7%	36	7%	2.6	111	18	16%	12	11%	22	20%	27	24%	13	12%	19	17%	3.1
Determine your need for billing assistance such as a billing agency/clearing house	188	49	26%	27	14%	27	14%	28	15%	14	7%	43	7%	2.5	111	16	14%	13	12%	19	17%	23	21%	12	11%	28	25%	3
Verify enrollment in Medicaid	188	32	17%	13	7%	24	13%	45	24%	52	28%	22	28%	3.4	112	4	4%	6	5%	13	12%	37	33%	42	38%	10	9%	4
Verify enrollment in other third party payer insurance	188	52	28%	24	13%	27	14%	30	16%	25	13%	30	13%	2.7	112	15	13%	11	10%	18	16%	31	28%	21	19%	16	14%	3.3
Verify eligibility	180	47	26%	17	9%	24	13%	38	21%	33	18%	21	18%	3	109	11	10%	10	9%	22	20%	26	24%	31	28%	9	8%	3.6
Submit claims to a third party payer	187	49	26%	21	11%	25	13%	38	20%	24	13%	30	13%	2.8	111	12	11%	10	9%	17	15%	32	29%	27	24%	13	12%	3.5
Collect reimbursement from Medicaid and other third party payers	187	41	22%	17	9%	36	19%	39	21%	30	16%	24	16%	3	112	7	6%	9	8%	21	19%	41	37%	26	23%	8	7%	3.7
Manage claims tracking payment/ denials	188	44	23%	19	10%	34	18%	40	21%	30	16%	21	16%	3	112	13	12%	11	10%	21	19%	32	29%	25	22%	10	9%	3.4

Number of missing responses: Clinic =15; Agency = 15;

TABLE 29. PLEASE RATE YOUR PROGRAM'S CAPACITY TO BILL MEDICAID AND OTHER THIRD PARTY PAYERS FOR STD-RELATED SERVICES AS OUTLINED IN THE QUESTIONS BELOW (Q30)

	TOTAL RESPONDENTS												
	N	1		2		3		4		5		NA		Mean
		n	%	n	%	n	%	n	%	n	%	n	%	
Contract with Medicaid	305	46	15%	19	6%	59	19%	84	28%	62	20%	35	11%	3.4
Contract with other third party payers	300	66	22%	40	13%	56	19%	64	21%	27	9%	47	16%	2.8
Bill third party payers as out of network provider	303	81	27%	36	12%	58	19%	43	14%	25	8%	60	20%	2.6
Credential clinicians for one or more third party payers	301	71	24%	36	12%	52	17%	59	20%	27	9%	56	19%	2.7
Determine your need for billing assistance such as a billing agency/clearing house	302	66	22%	42	14%	46	15%	51	17%	26	9%	71	24%	2.7
Verify enrollment in Medicaid	303	37	12%	19	6%	38	13%	83	27%	94	31%	32	11%	3.7
Verify enrollment in other third party payer insurance	303	69	23%	35	12%	46	15%	61	20%	26	15%	46	15%	2.9
Verify eligibility	292	59	20%	27	9%	47	16%	65	22%	64	22%	30	10%	3.2
Submit claims to a third party payer	301	63	21%	32	11%	42	14%	70	23%	51	17%	43	14%	3.1
Collect reimbursement from Medicaid and other third party payers	302	50	17%	27	9%	57	19%	80	26%	56	19%	32	11%	3.2
Manage claims tracking payment/denials	303	58	19%	32	11%	55	18%	72	24%	55	18%	31	10%	3.1

Number of missing responses: 30

TABLE 30. INDICATE ANY TRAINING AND TECHNICAL ASSISTANCE (T/TA) NEEDS AS THEY RELATE TO BILLING AND REIMBURSEMENT FOR STD AND RH SERVICES (Q31)

	CLINIC				AGENCY				TOTAL RESPONDENTS			
	We Need T/TA on this topic		Top 3 T/TA need		We Need T/TA on this topic		Top 3 T/TA need		We Need T/TA on this topic		Top 3 T/TA need	
	N	%	N	%	N	%	N	%	N	%	N	%
Billing 101	68	43%	33	26%	28	31%	12	16%	96	39%	45	22%
Use Billing Information Systems (Medicaid, EHR, PMS)	61	39%	28	22%	30	33%	8	11%	91	37%	36	18%
Identify EHR/ Practice Management System	66	42%	26	20%	27	30%	7	9%	93	38%	33	16%
Conduct Cost Analysis for STD services	80	51%	35	28%	55	61%	33	45%	135	54%	68	34%
Develop a sliding fee scale	61	39%	16	13%	23	26%	5	7%	84	34%	21	10%
Establish fee collection protocols	75	47%	24	19%	35	39%	5	7%	110	44%	29	14%
Establish protocols to ensure client confidentiality	83	53%	40	32%	38	42%	11	15%	121	49%	51	25%
ICD/CPT Coding	91	58%	46	36%	51	57%	33	45%	142	57%	79	39%
Support Change in staff motivation	70	44%	21	17%	41	46%	10	14%	111	45%	31	15%
Develop and use of claims data reports	87	55%	17	13%	39	43%	6	8%	126	51%	23	11%
Establish protocols for billing documentation and QA	94	59%	34	27%	42	47%	14	19%	136	55%	48	24%
Transition billing process into flow of clinic	83	53%	23	18%	40	44%	15	20%	123	50%	38	19%
Identify outside billing agency/ clearinghouse	56	35%	13	10%	21	23%	1	1%	77	31%	14	7%
Identify potential partnerships	69	44%	9	7%	33	37%	9	12%	102	41%	18	9%
Contract with third party payers	91	58%	39	31%	40	44%	24	32%	131	53%	63	31%
No TA needed	12	8%			7	8%			19	8%	0	0%
Total	**158**		**127**		**90**		**74**		**248**		**201**	
Number of missing responses:	*48*		*79*		*37*		*53*		*85*		*132*	

Percentages will not add to 100% because this question is check all that apply.

TABLE 31. IS YOUR CLINIC CURRENTLY RECEIVING OR SCHEDULED TO RECEIVE ANY TRAINING/ TECHNICAL ASSISTANCE ON BILLING AND REIMBURSEMENT? (Q32)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Yes	31	17%	19	17%	50	17%
No	126	67%	74	66%	200	67%
Not sure	30	16%	19	17%	49	16%
Total	187	100%	112	100%	299	100%

Number of missing responses: 9 *15* *34*

TABLE 32. PLEASE INDICATE WHICH TRAINING MODALITIES YOU ARE LIKELY TO ACCESS (Q33)

	CLINIC		AGENCY		TOTAL RESPONDENTS	
	N	**%**	**N**	**%**	**N**	**%**
Webinar	151	86%	96	93%	247	89%
Audio conference or podcast	70	40%	46	45%	116	42%
Online learning communities (e.g. chat or discussion forums with peers)	52	30%	35	34%	87	31%
Online learning modules	100	57%	60	58%	160	57%
Training videos	68	39%	47	46%	115	41%
Written resources and tools (e.g. sample policies, case studies, check-lists, etc) accessible online	99	56%	66	64%	165	59%
Written resources and tools in hard-copy	77	44%	40	39%	117	42%
Face-to-face workshops	105	60%	62	60%	167	60%
Onsite training or TA	124	70%	62	60%	186	67%
Other	3	2%	1	1%	4	1%
Total	**176**		**103**		**279**	

Number of missing responses: *30* *24* *54*

Percentages will not add to 100% because this question is check all that apply.

B. State/ Project Area STD Programs Billing Needs Assessment

TABLE 1. STATE/ PROJECT AREA STD PROGRAM PARTICIPATION BY REGION

Region	N	%
Region I	6	100%
Region II	5	100%
Region III	7	88%
Region IV	7	88%
Region V	5	72%
Region VI	3	60%
Region VII	4	100%
Region VIII	6	100%
Region IX	6	100%
Region X	4	100%
Total	**53**	**90%**

TABLE 2. WHICH OF THE FOLLOWING DO YOU REPRESENT? (Q2)

	N	%
STD / STI	52	98%
Both STD / STI and Family Planning	1	2%
Total	**53**	**100%**

TABLE 3. DOES ANY PROGRAM WITHIN YOUR PUBLIC HEALTH DEPARTMENT OR ORGANIZATION (E.G. IMMUNIZATION, WIC, HIV, ETC.) BILL MEDICAID AND OTHER THIRD PARTY PAYERS? (Q3)

	N	%
Yes	39	74%
No	9	17%
Not sure	5	9%
Total	**53**	**100%**

TABLE 4. HAS YOUR STATE DEVELOPED PROTOCOLS OR GUIDANCE ON HOW TO ENSURE PATIENT CONFIDENTIALITY WHEN BILLING THIRD PARTY PAYERS FOR STD SERVICES? (Q4)

	N	%
Yes	11	21%
No	30	57%
Not sure	12	23%
Total	**53**	**100%**

TABLE 5. HAVE YOU CONDUCTED AN ASSESSMENT OF THE BILLING AND REIMBURSEMENT CAPACITY OF CLINICS IN YOUR JURISDICTION? (Q5)

	N	%
Yes	20	38%
No	25	47%
Not sure	8	15%
Total	**53**	**100%**

TABLE 6. ARE YOU CURRENTLY ABLE TO PROVIDE BILLING AND REIMBURSEMENT SUPPORT TO CLINICS WITHIN YOUR JURISDICTION? (Q6)

	N	%
Yes	10	20%
No	36	70%
Not sure	5	10%
Total	**51**	**100%**

Number of missing responses: 2

TABLE 7. ARE YOU AWARE OF ANY STATE OR LOCAL LAWS OR REGULATIONS THAT PREVENT YOUR ORGANIZATION FROM BILLING FOR STD-RELATED SERVICES? (Q7)

	N	%
Yes	9	17%
No	38	73%
Not sure	5	10%
Total	**52**	**100%**

Number of missing responses: 1

TABLE 8. DO COUNTY AND LOCAL HEALTH DEPARTMENTS IN YOUR STATE HAVE THE AUTHORITY TO CONTRACT WITH THIRD PARTY PAYERS? (Q8)

	N	%
Yes	32	62%
No	4	8%
Not sure	12	23%
Not applicable	4	7%
Total	**52**	**100%**

Number of missing responses: 1

TABLE 9. IS THERE A STATE-LEVEL COORDINATED EFFORT UNDERWAY TO BILL MEDICAID AND OTHER THIRD PARTY PAYERS FOR STD-RELATED SERVICES? (Q9)

	N	%
Yes	19	37%
No	24	47%
Not sure	8	16%
Total	51	100%

Number of missing responses: 2

TABLE 10. IS THERE A STATE-LEVEL COORDINATED EFFORT TO ESTABLISH ELECTRONIC HEALTH RECORDS (EHR) AT CLINIC SITES IN YOUR STATE? (Q10)

	N	%
Yes	19	37%
No	23	44%
Not sure	10	19%
Total	**52**	**100%**

Number of missing responses: 1

TABLE 11. DO YOU HAVE CHALLENGES DIRECTING REVENUE COLLECTED TOWARD YOUR SPECIFIC PROGRAM? (Q11)

	N	%
Yes	19	39%
No	19	39%
Not sure	11	22%
Total	**49**	**100%**

Number of missing responses: 4

TABLE 12. WHAT DO YOU USE YOUR 2013 CSPS FUNDS FOR? (Q12)

	N	%
To fund health department staff	44	83%
To fund public health lab supplies (e.g. reagents, kits)	43	81%
To fund public health lab staff	23	43%
Other	19	36%
For medications	18	34%
For grants to clinics	18	34%
Total	**53**	

Percentages will not add to 100% because this question is check all that apply.

TABLE 13. IF YOU PROVIDE GRANTS TO CLINICS, WHAT DOES THIS SUPPORT? (Q13)

	N	%
Staff time	15	83%
CT/GC test kits	10	56%
Treatment	5	28%
I don't know	2	11%
I don't provide grants to clinics	1	6%
Total	**18**	

Percentages will not add to 100% because this question is check all that apply.

TABLE 14. IS THERE RESISTANCE IN YOUR PROJECT AREA TO BILLING FOR STD SERVICES? (Q14)

	N	%
Yes	11	22%
No	29	57%
Not sure	11	22%
Total	**51**	**100%**

Number of missing responses: 2

TABLE 15. FROM YOUR PERSPECTIVE WHAT ARE THE MAIN BARRIERS TO BILLING FOR STDS AMONG YOUR FUNDED CLINICS? (Q15)

	N	%
Confidentiality concerns - e.g. Don't want Explanation of Benefits (EOB) to go to primary person insured.	30	59%
No staff or not enough staff to follow-up on unpaid claims	29	57%
Not enough staff to initiate billing	25	49%
The majority of our clients do not have third party insurance	20	39%
Don't have Practice Management System or Electronic Health Record	19	37%
Don't know how to set up a contract	16	31%
Funds won't come back to our program; they go to the general fund	14	27%
Staff feel that services should be free	13	25%
Do not anticipate enough revenue to justify it	12	24%
Other	8	16%
Too difficult to set up a contract (tried already)	6	12%
Total	**51**	

Number of missing responses: 2

Percentages will not add to 100% because this question is check all that apply.

TABLE 16. HOW WOULD YOU DESCRIBE YOUR READINESS AS A STATE TO ASSIST STD CLINICS AND FAMILY PLANNING CLINICS IN YOUR JURISDICTION TO INITIATE BILLING ACTIVITIES? (Q16)

	N	%
1. We don't think we need to assist clinics to initiate billing activities	3	6%
2. We think we need to assist clinics to bill but we don't know where to start	14	30%
3. We have started the process to assist clinics to bill but we need TA	19	40%
4. We are assisting clinics to bill and we don't need TA	1	2%
5. All of the clinics in our jurisdiction already bill Medicaid and other third party payers	10	21%
Total	**47**	**100%**

Number of missing responses: 6

TABLE 17. PLEASE INDICATE ANY TRAINING AND TECHNICAL ASSISTANCE (T/TA) NEEDS AS THEY RELATE TO BILLING AND REIMBURSEMENT FOR STD AND RH SERVICES (Q17)

	This is a **T/TA Need**		This is one of our **Top 3 T/TA Needs**	
	N	**%**	**N**	**%**
Contracting with third party payers	37	79%	18	38%
Setting up systems for a comprehensive cost analysis for STD services	36	77%	18	38%
State-level coordinated efforts for billing third party payers	29	62%	21	45%
Transitioning billing process into flow of clinic	29	62%	6	13%
Facilitate CPT and ICD coding	28	60%	11	23%
Establishing fee collection protocols	28	60%	6	13%
Development and use of claims data reports	28	60%	4	9%
Credentialing providers	27	57%	9	19%
Developing a price schedule for testing and treatment services	27	57%	8	17%
Development of a process and tools for quality improvement for billing	27	57%	4	9%
Implementation of fee collections and claims management	26	55%	13	28%
Identifying outside billing agency	22	47%	2	4%
Staff motivation to increase billing for STD services	21	45%	4	9%
Total	**47**		**47**	

Number of missing responses: 6

Percentages will not add to 100% because this question is check all that apply.

TABLE 18. PLEASE INDICATE WHICH TRAINING MODALITIES YOU ARE LIKELY TO ACCESS IF THE CONTENT MEETS ONE OF YOUR TRAINING NEEDS. (Q18)

	N	%
Webinar	49	96%
Onsite training or technical assistance	42	82%
Written resources and tools (e.g. sample policies, case studies, check-lists, etc) accessible online	39	76%
Face-to-face workshops	37	73%
Online learning modules	30	59%
Audio conference or podcast	25	49%
Online learning communities (e.g. chat or discussion forums with peers)	21	41%
Training videos	16	31%
Written resources and tools in hard-copy	16	31%
Total	**51**	

Number of missing responses: 2

Percentages will not add to 100% because this question is check all that apply.

C. Public Health Laboratory Billing Needs Assessment

TABLE 1. PROJECT AREA LAB PARTICIPANTS BY REGION

Region	N	%
Region I	6	100
Region II	2	40
Region III	5	71
Region IV	6	75
Region V	3	50
Region VI	5	100
Region VII	3	75
Region VIII	5	83
Region IX	4	67
Region X	4	100
Total	**43**	**75%**

TABLE 2. WHICH OF THE FOLLOWING TYPES OF LABS DO YOU REPRESENT? (Q2)

	N	%
Local public health lab	3	7%
State public health lab	40	93%
Privately operated lab	0	0%
Other	0	0%
Total	**43**	**100%**

TABLE 3. DOES YOUR LAB CURRENTLY BILL CLINICS DIRECTLY FOR SERVICES? (Q3)

	N	%
Yes	17	39.5%
No	26	60.5%
Total	**43**	**100%**

TABLE 4. DOES ANY PROGRAM WITHIN YOUR LAB (E.G. NEWBORN SCREENING, HIV, ETC.) BILL MEDICAID AND OTHER THIRD PARTY PAYERS? (Q4)

	N	%
Yes	26	62%
No	12	29%
Not sure	4	9%
Total	**42**	**100%**

Number of missing responses: 1

TABLE 5. HAS YOUR STD PROGRAM CONSIDERED COMBINING BILLING AND REIMBURSEMENT ACTIVITIES WITH ANOTHER PROGRAM WITHIN THE LAB? (Q5)

	N	%
Yes	16	40%
No	24	60%
Total	**40**	**100%**

Number of missing responses: 2

TABLE 6. HAS YOUR STATE DEVELOPED PROTOCOLS OR GUIDANCE ON HOW TO ENSURE PATIENT CONFIDENTIALITY WHEN BILLING THIRD PARTY PAYERS FOR STD SERVICES? (Q6)

	N	%
Yes	11	26%
No	19	44%
Not sure	13	30%
Total	**43**	**100%**

TABLE 7. ARE YOU AWARE OF ANY STATE OR LOCAL LAWS OR REGULATIONS THAT PREVENT YOUR LAB FROM BILLING FOR STD-RELATED SERVICES? (Q7)

	N	%
Yes	7	16%
No	32	75%
Not sure	4	9%
Total	**43**	**100%**

TABLE 8. DOES YOUR LAB HAVE A LABORATORY INFORMATION MANAGEMENT SYSTEM (LIMS)? (Q8)

	N	%
LIMS	43	100%
No LIMS	0	0%
Total	**43**	**100%**

TABLE 9. WHICH OF THE FOLLOWING CAN YOU DO WITH YOUR LIMS? (Q9)

	N	%
Collect insurance information	28	67%
Customize data fields	32	76%
Customize reports	33	79%
Electronic reporting of results *(to clinics)*	27	64%
None of the above	2	5%
Total	**42**	

Number of missing responses: 1

Percentages will not add to 100% because this question is check all that apply.

TABLE 10. IS THERE RESISTANCE IN YOUR PROGRAM TO BILLING FOR STD SERVICES? (Q10)

	N	%
Yes	8	20.0%
No	32	80.0%
Total	**40**	**100%**

Number of missing responses: 3

TABLE 11. FROM YOUR PERSPECTIVE, WHAT ARE THE MAIN BARRIERS TO BILLING FOR STDS AT YOUR LAB? (Q11)

	N	%
No staff or not enough staff in accounts receivable to follow-up on unpaid claims	28	65%
Not enough staff to initiate billing	27	63%
Confidentiality concerns; e.g. don't want Explanation of Benefits to go out	17	40%
Don't know how to set up a contract	13	30%
Funds won't come back to our program; e.g. they go to the general fund	13	30%
The majority of our clients do not have Medicaid or private insurance	10	23%
Other	8	19%
Do not anticipate enough revenue to justify it	7	16%
Don't have a LIMS with flexible data fields or reports (e.g. Can't add fields needed to bill or Can't extract billing information)	7	16%
Too difficult to set up a contract (tried already)	6	14%
Staff feel that services should be free	2	5%
Don't have Laboratory Information Management System (LIMS)	1	2%
Total	**43**	

Percentages will not add to 100% because this question is check all that apply.

TABLE 12. HOW WOULD YOU RANK YOUR READINESS AS THE STATE PUBLIC HEALTH LAB TO INITIATE BILLING ACTIVITIES? (Q12)

	N	%
We bill Medicaid and other third party payers	13	35%
We have limited billing but we need TA	8	22%
We have started process of billing initiation but we need TA	7	19%
We think we need to bill but we don't know where to start	6	16%
We don't think we need to initiate billing	3	8%
Total	**37**	**100%**

Number of missing responses: 6

TABLE 13. PLEASE INDICATE ANY TRAINING AND TECHNICAL ASSISTANCE (T/TA) NEEDS AS THEY RELATE TO BILLING AND REIMBURSEMENT FOR STD AND RH SERVICES (Q13)

	This is a **T/TA Need**		This is one of our **Top 3 T/TA Needs**	
	N	**%**	**N**	**%**
Setting up Medicaid contract	15	40%	7	21%
Contracting with (other) third party payers	27	71%	19	56%
Setting up direct billing for clinics and hospitals	16	42%	10	26%
State-level coordinated efforts for billing third party payers	25	66%	17	50%
Establishing fee collection protocols	20	53%	7	21%
Facilitate implementation of current protocols for fee collection claims management	15	40%	7	21%
Staff motivation to increase billing for STD services	9	24%	1	3%
Development and use of claims data reports	20	53%	4	12%
Development of a process and tools for quality improvement for billing	24	63%	9	27%
Identifying outside billing agency	23	61%	11	32%
Other	7	18%	n/a	n/a
Total	**38**		**34**	
Number of missing responses:	*5*		*9*	

Percentages will not add to 100% because this question is check all that apply.

TABLE 14. PLEASE INDICATE WHICH TRAINING MODALITIES YOU ARE LIKELY TO ACCESS IF THE CONTENT MEETS ONE OF YOUR TRAINING NEEDS (Q14)

	N	**%**
Webinar	35	85%
Audio conference or podcast	20	49%
Online learning communities (e.g. chat or discussion forums with peers)	14	34%
Online learning modules	24	59%
Training videos	19	46%
Written resources and tools (e.g. sample policies, case studies, check-lists, etc) accessible online	28	68%
Written resources and tools in hard-copy	20	49%
Face-to-face workshops	21	51%

TABLE 14. CONTINUED

	N	%
Onsite training or technical assistance	26	63%
Other	5	12%
Total	**41**	

Number of missing responses: 2

Percentages will not add to 100% because this question is check all that apply.

TABLE 15. DOES YOUR LAB BILL MEDICAID FOR STD SERVICES?

	N	%
Yes	26	62%
No	16	38%
Total	**42**	**100%**

Number of missing responses: 1

TABLE 16. DOES YOUR LAB BILL OTHER THIRD PARTY PAYER FOR STD SERVICES?

	N	%
Yes	9	21%
No	33	79%
Total	**42**	**100%**

APPENDIX III. CLINIC NEEDS ASSESSMENT—ADDITIONAL TABLES

A. Selected Questions Stratified by Site Type- Responding as Single Clinic

TABLE 1. WHICH OF THE FOLLOWING BEST DESCRIBES SERVICES PROVIDED AT YOUR CLINIC? (Q7)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
STD services only	93	77%	0	0%	0	0%	0	0%	12	33%	105	53%
Integrated clinic (including FP and STD services)	21	17%	33	100%	4	80%	3	100%	18	50%	79	40%
Other	7	6%	0	0%	1	20%	0	0%	6	17%	14	7%
Total	**121**	**100%**	**33**	**100%**	**5**	**100%**	**3**	**100%**	**36**	**100%**	**198**	**100%**

Number of missing responses: 8

TABLE 2. DOES YOUR CLINIC(S) USE AN ELECTRONIC HEALTH RECORD? (Q9)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	35	29%	12	36%	5	100%	1	33%	12	33%	65	33%
No	76	63%	16	48%	0	0%	2	67%	23	64%	117	59%
Implementing by ends of 2014	10	8%	5	15%	0	0%	0	0%	1	3%	16	8%
Total	**121**	**100%**	**33**	**100%**	**5**	**100%**	**3**	**100%**	**36**	**100%**	**198**	**100%**

Number of missing responses: 8

TABLE 3. IS YOUR CLINIC(S) CURRENTLY COLLECTING FEE-FOR-SERVICE PAYMENT FROM CLIENTS FOR STD SERVICES? (Q11)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes, cash and credit card	36	30%	24	75%	5	100%	3	100%	7	19%	75	38%
Yes, cash only	23	19%	7	22%	0	0%	0	0%	6	17%	36	18%
No	61	51%	1	3%	0	0%	0	0%	23	64%	85	43%
Total	**120**	**100%**	**32**	**100%**	**5**	**100%**	**3**	**100%**	**36**	**100%**	**196**	100%

Number of missing responses: 10

TABLE 4. IS YOUR CLINIC(S) USING A SLIDING SCALE TO ASSESS FEES? (INCLUDED ONLY THOSE WHO RESPONDED YES TO Q11) (Q12)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	26	44%	28	90%	5	100%	3	100%	5	38%	67	60%
No	33	56%	3	10%	0	0%	0	0%	8	62%	44	40%
Total	**59**	**100%**	**31**	**100%**	**5**	**100%**	**3**	**100%**	**13**	**100%**	**111**	**100%**

Number of missing responses: 2

TABLE 5. IS YOUR CLINIC(S) CURRENTLY BILLING MEDICAID OR OTHER THIRD-PARTY PAYERS FOR STD-RELATED SERVICES? (Q13)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes billing Medicaid and other third-party payers	16	13%	21	64%	2	40%	3	100%	9	25%	51	26%
Yes billing Medicaid only	23	19%	10	30%	3	60%	0	0%	3	8%	39	20%
Yes billing (other) third-party payers only	0	0%	0	0%	0	0%	0	0%	1	3%	1	1%
No not billing Medicaid or other third-party payers	82	68%	2	6%	0	0%	0	0%	23	64%	107	54%
Total	**121**	**100%**	**33**	**100%**	**5**	**100%**	**3**	**100%**	**36**	**100%**	**198**	**100%**

Number of missing responses: 8

TABLE 6. ARE THERE ANY POLICIES WITHIN YOUR ORGANIZATION THAT PREVENT YOUR CLINIC(S) FROM BILLING FOR STD-RELATED SERVICES? (INCLUDED ONLY THOSE WHO RESPONDED NO NOT BILLING MEDICAID OR YES BILLING MEDICAID ONLY FOR Q13) (Q21)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	21	21%	1	9%	0	0%	0	0%	6	23%	28	10%
No	58	57%	8	73%	1	33%	0	0%	10	38%	77	27%
Not sure	23	23%	2	18%	2	67%	0	0%	10	38%	37	13%
Total	**102**	**100%**	**11**	**100%**	**3**	**100%**	**0**	**0%**	**26**	**100%**	**142**	**50%**

Number of missing responses: 13

TABLE 7. IN THE LAST 2 YEARS, HAS YOUR CLINIC SITE CONDUCTED A DETAILED COST ANALYSIS TO IDENTIFY THE COST OF STD RELATED SERVICES? (Q28)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	33	28%	17	57%	0	0%	2	67%	9	26%	61	32%
No	65	56%	10	33%	2	40%	0	0%	24	69%	101	53%
Not sure	18	16%	3	10%	3	60%	1	33%	2	6%	27	14%
Total	**116**	**100%**	**30**	**100%**	**5**	**100%**	**3**	**100%**	**35**	**100%**	**189**	**100%**

Number of missing responses: 17

TABLE 8. PLEASE INDICATE ANY TRAINING AND TECHNICAL ASSISTANCE (T/TA) NEEDS AS THEY RELATE TO BILLING AND REIMBURSEMENT FOR STD AND RH SERVICES (Q31)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Billing 101	48	51%	7	26%	1	33%	1	33%	11	46%	68	45%
Use billing data systems (e.g., Medicaid, EHR, PMS) to collect billing information	41	44%	6	22%	1	33%	2	67%	11	46%	61	40%
Identify EHR/Practice Management System	48	51%	5	19%	0	0%	1	33%	12	50%	66	44%
Conduct cost analysis for STD Services	50	53%	14	52%	2	67%	1	33%	13	54%	80	53%
Develop a sliding scale for testing and treatment services	42	45%	6	22%	1	33%	1	33%	11	46%	61	40%

TABLE 8. CONTINUED

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Establish fee collection protocols	47	50%	8	30%	1	33%	1	33%	12	50%	69	46%
Establish protocols to ensure client confidentiality for billed services	62	66%	5	19%	1	33%	1	33%	14	58%	83	55%
ICD/CPT coding	53	56%	16	59%	1	33%	3	100%	13	54%	86	57%
Support change in staff motivation to increase billing for STD services	46	49%	10	37%	0	0%	1	33%	13	54%	70	46%
Develop and use of claims data reports	58	62%	10	37%	1	33%	1	33%	12	50%	82	54%
Establish protocols for billing documentation and quality assurance	64	68%	12	44%	1	33%	2	67%	15	63%	94	62%
Transition billing process into flow of clinic	55	59%	7	26%	1	33%	1	33%	15	63%	79	52%
Identify outside billing agency/ clearinghouse	39	41%	6	22%	1	33%	0	0%	10	42%	56	37%
Identify potential partnership to facilitate billing	45	48%	9	33%	1	33%	1	33%	13	54%	69	46%
Contract with third-party payers	62	66%	14	52%	1	33%	2	67%	12	50%	91	60%
Total	**94**		**27**		**3**		**3**		**24**		**151**	

Number of missing responses: 55

Percentages will not add to 100% because this question is check all that apply.

TABLE 9. PLEASE INDICATE TOP THREE TRAINING AND TECHNICAL ASSISTANCE (T/TA) NEEDS AS THEY RELATE TO BILLING AND REIMBURSEMENT FOR STD AND RH SERVICES (Q31)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Billing 101	21	28%	6	24%	1	100%	0	0%	5	26%	33	27%
Use billing data systems (e.g., Medicaid, EHR, PMS) to collect billing information	17	22%	6	24%	0	0%	1	50%	4	21%	28	23%
Identify EHR/Practice Management System	18	24%	6	24%	0	0%	0	0%	2	11%	26	21%
Conduct cost analysis for STD Services	24	32%	6	24%	0	0%	0	0%	5	26%	35	28%
Develop a sliding scale for testing and treatment services	14	18%	1	4%	0	0%	0	0%	1	5%	16	13%
Establish fee collection protocols	12	16%	6	24%	0	0%	0	0%	5	26%	23	19%
Establish protocols to ensure client confidentiality for billed services	25	33%	5	20%	1	100%	0	0%	9	47%	40	33%
ICD/CPT coding	28	37%	9	36%	0	0%	1	50%	6	32%	44	36%
Support change in staff motivation to increase billing for STD services	13	17%	5	20%	0	0%	0	0%	3	16%	21	17%
Develop and use of claims data reports	9	12%	7	28%	0	0%	0	0%	1	5%	17	14%
Establish protocols for billing documentation and quality assurance	21	28%	5	20%	0	0%	0	0%	8	42%	34	28%
Transition billing process into flow of clinic	16	21%	2	8%	0	0%	0	0%	4	21%	22	18%
Identify outside billing agency/ clearinghouse	6	8%	2	8%	0	0%	1	50%	4	21%	13	11%
Identify potential partnership to facilitate billing	5	7%	3	12%	0	0%	1	50%	0	0%	9	7%
Contract with third-party payers	22	29%	12	48%	1	100%	1	50%	3	16%	39	32%
Total	**76**		**25**		**1**		**2**		**19**		**123**	

Number of missing responses: 83

Percentages will not add to 100% because this question is check all that apply.

B. Selected Questions Stratified by Site Type- Responding as an Agency

TABLE 1. WHICH OF THE FOLLOWING BEST DESCRIBES SERVICES PROVIDED AT YOUR CLINIC? (Q7)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
STD services only	20	49%	0	0%	0	0%	0	0%	1	3%	21	17%
Integrated clinic (including FP and STD services)	19	46%	33	100%	12	80%	16	94%	17	84%	97	76%
Other	2	5%	0	0%	3	20%	1	6%	3	13%	9	7%
Total	**41**	**100%**	**33**	**100%**	**15**	**100%**	**17**	**100%**	**21**	**100%**	**127**	**100%**

TABLE 2. DOES YOUR CLINIC(S) USE AN ELECTRONIC HEALTH RECORD? (Q9)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	13	32%	16	48%	9	60%	9	59%	12	50%	59	47%
No	22	54%	10	30%	4	27%	5	26%	4	20%	45	36%
Implementing by ends of 2014	6	15%	7	21%	2	13%	3	15%	4	30%	22	17%
Total	**41**	**100%**	**33**	**100%**	**15**	**100%**	**17**	**100%**	**20**	**100%**	**126**	**100%**

Number of missing responses: 1

TABLE 3. IS YOUR CLINIC(S) CURRENTLY COLLECTING FEE-FOR-SERVICE PAYMENT FROM CLIENTS FOR STD SERVICES? (Q11)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes, cash and credit card	19	48%	18	56%	7	47%	16	100%	11	55%	71	58%
Yes, cash only	3	8%	8	25%	2	13%	0	0%	3	15%	16	13%
No	18	45%	6	19%	6	40%	0	0%	6	30%	36	29%
Total	**40**	**100%**	**32**	**100%**	**15**	**100%**	**16**	**100%**	**20**	**100%**	**123**	**100%**

Number of missing responses: 4

TABLE 4. IS YOUR CLINIC(S) USING A SLIDING SCALE TO ASSESS FEES? (INCLUDED ONLY THOSE WHO RESPONDED YES TO Q11) (Q12)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	16	73%	25	96%	9	100%	14	88%	12	86%	76	87%
No	6	27%	1	4%	0	0%	2	13%	2	14%	11	13%
Total	**22**	**100%**	**26**	**100%**	**9**	**100%**	**16**	**100%**	**14**	**100%**	**87**	**100%**

TABLE 5. IS YOUR CLINIC(S) CURRENTLY BILLING MEDICAID OR OTHER THIRD-PARTY PAYERS FOR STD-RELATED SERVICES? (Q13)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes billing Medicaid and other third-party payers	11	27%	20	61%	12	80%	16	94%	9	43%	68	54%
Yes billing Medicaid only	14	34%	4	12%	2	13%	1	6%	5	24%	26	20%
No not billing Medicaid or other third-party payers	16	39%	9	27%	1	7%	0	0%	7	33%	33	26%
Total	**41**	**100%**	**33**	**100%**	**15**	**100%**	**17**	**100%**	**21**	**100%**	**127**	**100%**

TABLE 6. ARE THERE ANY POLICIES WITHIN YOUR ORGANIZATION THAT PREVENT YOUR CLINIC(S) FROM BILLING FOR STD-RELATED SERVICES? (INCLUDED ONLY THOSE WHO RESPONDED NO NOT BILLING MEDICAID OR YES BILLING MEDICAID ONLY FOR Q13)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	3	10%	1	9%	0	0%	0	0%	4	33%	8	15%
No	22	76%	8	73%	2	100%	1	100%	5	42%	38	69%
Not sure	4	14%	2	18%	0	0%	0	0%	3	25%	9	16%
Total	**29**	**100%**	**11**	**100%**	**2**	**100%**	**1**	**100%**	**12**	**100%**	**55**	**100%**

Number of missing responses: 4

TABLE 7. IN THE LAST 2 YEARS, HAS YOUR CLINIC SITE CONDUCTED A DETAILED COST ANALYSIS TO IDENTIFY THE COST OF STD RELATED SERVICES? (Q28)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	7	18%	10	34%	2	15%	6	40%	7	33%	32	27%
No	28	72%	16	55%	6	46%	6	40%	12	57%	68	58%
Not sure	4	10%	3	10%	5	38%	3	20%	2	10%	17	15%
Total	**39**	**100%**	**29**	**100%**	**13**	**100%**	**15**	**100%**	**21**	**100%**	**117**	**100%**

Number of missing responses: 10

TABLE 8. PLEASE INDICATE ANY TRAINING AND TECHNICAL ASSISTANCE (T/TA) NEEDS AS THEY RELATE TO BILLING AND REIMBURSEMENT FOR STD AND RH SERVICES (Q31)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Billing 101	14	42%	6	27%	1	10%	2	18%	5	36%	28	31%
Use billing data systems (e.g., Medicaid, EHR, PMS) to collect billing information	14	42%	7	32%	2	20%	2	18%	5	36%	30	33%
Identify EHR/Practice Management System	14	42%	7	32%	1	10%	1	9%	4	29%	27	30%
Conduct cost analysis for STD Services	23	70%	11	50%	5	50%	7	64%	9	64%	55	61%
Develop a sliding scale for testing and treatment services	15	45%	2	9%	2	20%	1	9%	3	21%	23	26%

TABLE 8. CONTINUED

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Establish fee collection protocols	17	52%	11	50%	1	10%	3	27%	3	21%	35	39%
Establish protocols to ensure client confidentiality for billed services	18	55%	7	32%	5	50%	4	36%	4	29%	38	42%
ICD/CPT coding	18	55%	15	68%	7	70%	5	45%	6	43%	51	57%
Support change in staff motivation to increase billing for STD services	18	55%	9	41%	6	60%	3	27%	5	36%	41	46%
Develop and use of claims data reports	15	45%	11	50%	4	40%	2	18%	7	50%	39	43%
Establish protocols for billing documentation and quality assurance	18	55%	12	55%	3	30%	3	27%	6	43%	42	47%
Transition billing process into flow of clinic	16	48%	13	59%	2	20%	5	45%	4	29%	40	44%
Identify outside billing agency/ clearinghouse	9	27%	6	27%	2	20%	2	18%	2	14%	21	23%
Identify potential partnership to facilitate billing	12	36%	12	55%	4	40%	1	9%	4	29%	33	37%
Contract with third-party payers	16	48%	12	55%	3	30%	3	27%	6	43%	40	44%
Total	**33**		**22**		**10**		**11**		**14**		**90**	

Number of missing responses: 37

Percentages will not add to 100% because this question is check all that apply.

TABLE 9. PLEASE INDICATE TOP THREE TRAINING AND TECHNICAL ASSISTANCE NEEDS AS THEY RELATE TO BILLING AND REIMBURSEMENT FOR STD AND RH SERVICES (Q31)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Billing 101	8	30%	2	10%	0	0%	0	0%	2	18%	12	16%
Use billing data systems (e.g., Medicaid, EHR, PMS) to collect billing information	5	19%	1	5%	0	0%	0	0%	2	18%	8	11%
Identify EHR/Practice Management System	5	19%	1	5%	0	0%	0	0%	1	9%	7	9%
Conduct cost analysis for STD Services	16	59%	7	35%	2	33%	4	40%	4	36%	33	45%
Develop a sliding scale for testing and treatment services	4	15%	0	0%	1	17%	0	0%	0	0%	5	7%
Establish fee collection protocols	2	7%	1	5%	0	0%	1	10%	1	9%	5	7%
Establish protocols to ensure client confidentiality for billed services	6	22%	1	5%	1	17%	2	20%	1	9%	11	15%
ICD/CPT coding	7	26%	13	65%	5	83%	3	30%	5	45%	33	45%
Support change in staff motivation to increase billing for STD services	4	15%	3	15%	2	33%	0	0%	1	9%	10	14%
Develop and use of claims data reports	1	4%	1	5%	2	33%	0	0%	2	18%	6	8%
Establish protocols for billing documentation and quality assurance	4	15%	4	20%	2	33%	2	20%	2	18%	14	19%
Transition billing process into flow of clinic	3	11%	7	35%	0	0%	3	30%	2	18%	15	20%
Identify outside billing agency/ clearinghouse	0	0%	1	5%	0	0%	0	0%	0	0%	1	1%
Identify potential partnership to facilitate billing	2	7%	3	15%	0	0%	2	20%	2	18%	9	12%
Contract with third-party payers	8	30%	8	40%	1	17%	3	30%	4	36%	24	32%
Total	**27**		**20**		**6**		**10**		**11**		**74**	

Number of missing responses: 53. Percentages will not add to 100% because this question is check all that apply.

C. Selected Billing Capacity Questions with Combined (Weighted) Data

TABLE 1. DOES YOUR CLINIC(S) USE AN ELECTRONIC HEALTH RECORD? (Q9)

	Agencies		Clinics Represented by Agencies		Clinics		Clinics Combined (Weighted data)	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	59	47%	617	36%	68	33%	685	35%
No	45	36%	809	47%	121	59%	930	48%
Implementing by end of 2014	22	17%	301	17%	16	8%	317	16%
Total	**126**	**100%**	**1727**	**100%**	**205**	**100%**	**1932**	**100%**
Number of missing responses:	*1*				*1*			

TABLE 2. IS YOUR CLINIC(S) CURRENTLY COLLECTING FEE-FOR-SERVICE PAYMENT FROM CLIENTS FOR STD SERVICES? (Q11)

	Agencies		Clinics Represented by Agencies		Clinics		Clinics Combined (Weighted data)	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes, cash and credit card	71	58%	844	49%	77	38%	921	48%
Yes, cash only	16	13%	249	14%	36	18%	285	15%
No	36	29%	624	36%	90	44%	714	37%
Total	**123**	**100%**	**1717**	**100%**	**203**	**100%**	**1920**	**100%**
Number of missing responses:	*4*				*3*			

TABLE 3. IS YOUR CLINIC USING A SLIDING SCALE TO ASSESS FEES? (Q12)

	Agencies		Clinics Represented by Agencies		Clinics		Clinics Combined (Weighted data)	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes	76	87%	757	69%	67	59%	824	68%
No	11	13%	336	31%	46	41%	382	32%
Total	**87**	**100%**	**1093**	**100%**	**113**	**100%**	**1206**	**100%**

TABLE 4. IS YOUR CLINIC(S) CURRENTLY BILLING MEDICAID OR OTHER THIRD-PARTY PAYERS FOR STD-RELATED SERVICES? (Q13)

	Agencies		Clinics Represented by Agencies		Clinics		Clinics Combined (Weighted data)	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Yes billing Medicaid and other third-party payers	68	54%	814	47%	51	25%	865	45%
Yes billing Medicaid only*	26	20%	553	32%	40	19%	593	31%
No not billing Medicaid or other third-party payers	33	26%	362	21%	115	56%	477	25%
Total	**127**	**100%**	**1729**	**100%**	**206**	**100%**	**1935**	**100%**

**One clinic billing other third-party payers only is included in this category.*

TABLE 5. IS YOUR CLINIC(S) CURRENTLY COLLECTING FEE-FOR-SERVICE PAYMENT FROM CLIENTS FOR STD SERVICES? (Q11)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No	603	50%	25	13%	21	12%	0	0%	60	36%	709	37%
Yes, cash and credit card	415	34%	112	60%	137	80%	174	100%	81	49%	919	48%
Yes, cash only	195	16%	51	27%	14	8%	0	0%	25	15%	285	15%
Total	**1213**	**100%**	**188**	**100%**	**172**	**100%**	**174**	**100%**	**166**	**100%**	**1913**	**100%**

Number of missing responses: 8

TABLE 6. IS YOUR CLINIC(S) CURRENTLY BILLING MEDICAID OR OTHER THIRD-PARTY PAYERS FOR STD-RELATED SERVICES? (Q13)

	Health Department STD Clinics		Health Department FP Clinics		Part of a CHC (FQHC or look-alike)		Planned Parenthood/ Free-Standing FP		Other		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No not billing Medicaid or other third-party payers	360	30%	39	20%	3	2%	0	0%	67	40%	469	24%
Yes billing (other) third-party payers only	0	0%	0	0%	0	0%	0	0%	1	1%	1	0%
Yes billing Medicaid and other third-party payers	371	30%	114	60%	157	91%	172	97%	51	30%	865	45%
Yes billing Medicaid only	488	40%	38	20%	12	7%	5	3%	49	29%	592	31%
Total	**1219**	**100%**	**191**	**100%**	**172**	**100%**	**177**	**100%**	**168**	**100%**	**1927**	**100%**

Number of missing responses: 8

APPENDIX IV. BILLING NEEDS ASSESSMENT TOOLS

A. Clinics

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Introduction

The goal of the needs assessment is to compile local, state, regional, and national profiles of current capacity and Training and Technical Assistance (T/TA) needs related to billing, coding, and reimbursement among STD-certified 340b eligible clinics.

Thank you so much for taking the time to respond.

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Respondent Description

***1. In which state / project area do you work?**

***2. Are you answering this as a representative of a single clinic or multiple clinics?**

- ◯ Single Clinic
- ◯ Multiple Clinics

Comments:

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

For multiple clinics

***3. How many clinics are you representing today?**

Number of clinics

***4. We are trying to determine if administrative decisions for billing are centralized at the agency level (made across all clinic sites by one agency) or are decentralized (made on a clinic-by-clinic basis). Are billing / reimbursement policies and procedures established at the clinic level, or at the agency / umbrella organization level?**

- ◯ Clinic level
- ◯ Agency level

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

For multiple clinics (2)

5. Approximately how many visits does your agency see per year across all sites?

Number of visits per year

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

For single clinics

6. Approximately how many visits does your clinic see per year?

Number of visits per year

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Site descriptions

***7. Which of the following best describes services provided at your clinic(s)?**

- ◯ STD services only
- ◯ Integrated clinic (including FP and STD services)
- ◯ Family Planning services only
- ◯ Other (please specify)

8. Which of the following best describes the type of clinic(s) you are representing?

- ◯ Health department STD Clinics
- ◯ Health department Family Planning Clinics
- ◯ Hospital-based
- ◯ Planned Parenthood
- ◯ Free-standing family planning
- ◯ Part of a Community Health Center (FQHC or look-alike)
- ◯ Tribal health clinic
- ◯ University-based
- ◯ School-based
- ◯ Faith-based
- ◯ Correctional facility
- ◯ Other, private non-profit
- ◯ Other (Please specify):

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

EHR

9. Does your clinic(s) use an Electronic Health Record?

- ◯ Yes
- ◯ No

Comments

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

10. Which of the following is your clinic(s) able to do with your Electronic Health Record (EHR)? ***(select all that apply)***

- ☐ Collect insurance information
- ☐ Customize data fields
- ☐ Customize reports

Comments

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Current Fee Capacity

11. Is your clinic(s) currently collecting fee-for-service payment from clients for STD services?

- ◯ Yes, cash only
- ◯ Yes, cash and credit card
- ◯ No

Comments

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

12. Is your clinic(s) using a sliding scale to assess fees?

- ◯ Yes
- ◯ No

Comments:

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Currently billing

***13. Is your clinic(s) currently billing Medicaid or other third party payers for STD-related services?**

- ◯ No not billing Medicaid or other third party payers
- ◯ Yes billing Medicaid only
- ◯ Yes billing (other) third party payers only
- ◯ Yes billing Medicaid and other third party payers

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Not billing

14. Does any program within your clinic or agency (Immunization, HIV, WIC, etc.) bill private third party payers (including Medicaid)?

- ◯ Yes
- ◯ No
- ◯ Not sure

Comments:

15. Are steps underway to begin billing for STD-related services within the next year?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please explain:

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Billing Medicaid or TPP only

16. Do you use any of the other following databases to gather insurance information? (select all that apply)

- ☐ Practice management system
- ☐ Stand-alone database (like Microsoft Access)
- ☐ Web-based database (other than EHR)
- ☐ Primarily use paper files
- ☐ Not Applicable
- ☐ Other (please specify)

17. Do you have a department or staff assigned to manage and follow-up on accounts receivable?

- ◯ Yes
- ◯ No
- ◯ Not Applicable

Comments:

18. Do you use an outside billing/collections agency?

- ◯ Yes
- ◯ No
- ◯ Not Applicable

Comments:

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Reasons not billing

19. Why are you not currently billing Medicaid and other third party payers?** ***(Select all that apply)

	Reason not billing Medicaid	Reason not billing other third party payers (including Medicaid Managed Care)
Don't know how to set up a contract	☐	☐
Health Department Policy	☐	☐
Too difficult to set up a contract (tried already)	☐	☐
The majority of the clients do not have Medicaid or other third party payers	☐	☐
Not enough staff to initiate billing	☐	☐
Don't have Practice Management System or Electronic medical record	☐	☐
Staff feel that services should be free	☐	☐
No staff or not enough staff to follow-up on unpaid claims	☐	☐
Funds won't come back to our program; e.g. they go to a general fund	☐	☐
Confidentiality concerns: e.g. don't want EOB to go to primary person insured	☐	☐

Other (please specify)

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Billing Policy

20. Are you aware of any state or local laws or regulations that prevent your organization from billing for STD-services?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe:

21. Are there any policies within your organization that prevent your clinic(s) from billing for STD-services?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe:

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Yes Billing

22. Do you use any of the other following databases to gather insurance information? (select all that apply)

- [ ] Practice management system
- [ ] Stand-alone database (like Access)
- [ ] Web-based databases (other than EHR)
- [ ] Primarily use paper files
- [ ] Other (please specify)

23. Do you have a department or staff assigned to manage and follow-up on accounts receivable?

- ◯ Yes
- ◯ No

Comments:

24. Do you use an outside billing/collections agency?

- ◯ Yes
- ◯ No

Comments:

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Yes Billing (2)

25. Has your clinic(s) developed protocols or guidance on how to ensure patient confidentiality when billing third party payers for STD services?

- ◯ Yes
- ◯ No
- ◯ Not Sure

Please describe:

***26. Please indicate which third party payer plans your agency currently bills (Medicaid Managed Care, HMO, or PPO): (Select all that apply)**

- ☐ Medicaid
- ☐ Aetna
- ☐ BlueCross BlueShield
- ☐ Coventry
- ☐ Humana
- ☐ Kaiser Permanente
- ☐ United Healthcare
- ☐ Tufts
- ☐ Other (please list):

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

27. Has your clinic experienced reimbursement problems or auditing concerns as a result of inaccurate billing or coding?

- ◯ Yes
- ◯ No
- ◯ Not sure

Comments:

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Cost Analysis

28. In the last 2 years, has your clinic site conducted a detailed cost analysis to identify the cost of STD related services?

- ◯ Yes
- ◯ No
- ◯ Not sure

Comments:

29. Have you conducted an analysis of your client payer mix?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe any relevant findings:

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Capacity Challenges

30. Please rate your program's capacity to bill Medicaid and other third party payers for STD-related services as outlined in the questions below– please check one:

(1) Don't know what this is, ***have not begun this activity***
(2) Just getting started, ***e.g. doing the activity for the first time***
(3) Able to do the activity, ***but may benefit from help***
(4) Able to do the activity ***and do not need help***
(5) Highly capable, ***i.e. could teach others)***
(N/A) = Not Applicable

	1	2	3	4	5	Not Applicable
Contract with Medicaid	○	○	○	○	○	○
Contract with other third party payers (including Medicaid Managed Care)	○	○	○	○	○	○
Bill third party payers as out of network provider	○	○	○	○	○	○
Credential clinicians for one or more third party payers	○	○	○	○	○	○
Determine your need for billing assistance such as a billing agency / clearinghouse	○	○	○	○	○	○
Verify enrollment in Medicaid	○	○	○	○	○	○
Verify enrollment in other third party insurance	○	○	○	○	○	○
Verify eligibility	○	○	○	○	○	○
Submit claims to a third party payer	○	○	○	○	○	○
Collect reimbursement from Medicaid and other third party payers	○	○	○	○	○	○
Manage claims tracking payment/denials	○	○	○	○	○	○

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

31. Please indicate any training and technical assistance (T/TA) needs as they relate to Billing and Reimbursement for STD and RH services.

Check all that apply. Then, identify your top 3 T/TA needs among those selected.

	We need T/TA on this topic	This is one of our **top 3 T/TA needs** related to billing and reimbursement
Billing 101	☐	☐
Use billing data systems (e.g. Medicaid, EHR, PMS) to collect billing information	☐	☐
Identify EHR / Practice Management System	☐	☐
Conduct cost analysis for STD services	☐	☐
Develop a sliding scale for testing and treatment services	☐	☐
Establish fee collection protocols	☐	☐
Establish protocols to ensure client confidentiality for billed services	☐	☐
ICD / CPT coding	☐	☐
Support change in staff motivation to increase billing for STD services	☐	☐
Develop and use of claims data reports	☐	☐
Establish protocols for billing documentation and quality assurance	☐	☐
Transition billing process into flow of clinic	☐	☐
	☐	☐

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

Identify outside billing agency / clearinghouse	☐	☐
Identify potential partnerships to facilitate billing	☐	☐
Contract with third party payers	☐	☐

Other (please specify)

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

32. Is your clinic currently receiving or scheduled to receive any training / technical assistance on billing and reimbursement?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please specify:

33. Please indicate which training modalities you are likely to access (select all that apply):

- ☐ Webinar
- ☐ Audio conference or podcast
- ☐ Online learning communities (e.g. chat or discussion forums with peers)
- ☐ Online learning modules
- ☐ Training videos
- ☐ Written resources and tools (e.g. sample policies, case studies, check-lists, etc) accessible online
- ☐ Written resources and tools in hard-copy
- ☐ Face-to-face workshops
- ☐ Onsite training or technical assistance
- ☐ Other (please specify)

Region I STDR RH TTAC 340b Clinic Billing Needs Assessment

34. Who can we list as the point of contact for coordinating training / technical assistance?

Name:	
Job Title:	
Phone:	
Email:	

B. State/Project Area STD Programs

STDR RH TTAC State / Project Area Billing Needs Assessment

Respondent Identification

The goal of this needs assessment is to compile local, state, regional, and national profiles of current capacity and Training and Technical Assistance (T/TA) needs related to billing, coding, and reimbursement for STD services.

***1. Which project area do you represent?**

***2. Which of the following do you represent :**

- ◯ STD / STI
- ◯ Family Planning
- ◯ Both

None of the above (please specify):

STDR RH TTAC State / Project Area Billing Needs Assessment

Billing Capacity

3. Does any program within your public health department or organization (e.g. Immunization, WIC, HIV, etc.) bill Medicaid and other third party payers?

- ◯ Yes
- ◯ No
- ◯ Not Sure

Please specify:

4. Has your state developed protocols or guidance on how to ensure patient confidentiality when billing third party payers for STD services?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe:

5. Have you conducted an assessment of the billing and reimbursement capacity of clinics in your jurisdiction?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe:

STDR RH TTAC State / Project Area Billing Needs Assessment

TA Capacity

6. Are you currently able to provide billing and reimbursement support to clinics within your jurisdiction? ***(i.e. you have the skills and knowledge or access to the skills and knowledge needed to support billing scale up activities in your jurisdiction)***

- ◯ Yes
- ◯ No
- ◯ Not sure

7. Are you aware of any state or local laws or regulations that prevent your organization from billing for STD-related services?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe:

8. Do county and local health departments in your state have the authority to con third party payers?

- ◯ Yes
- ◯ No
- ◯ Not sure
- ◯ Not Applicable

STDR RH TTAC State / Project Area Billing Needs Assessment

Systems Challenges

9. Is there a state-level coordinated effort underway to bill Medicaid and other third party payers for STD-related services?

- ◯ Yes
- ◯ No
- ◯ Not sure

Comments:

10. Is there a state-level coordinated effort to establish Electronic Health Records (EHR) at clinic sites in your state?

- ◯ Yes
- ◯ No
- ◯ Not sure

Comments:

11. Do you have challenges directing revenue collected toward your specific program? ***(For example, does it go to the state general fund)?***

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe:

STDR RH TTAC State / Project Area Billing Needs Assessment

Funding

12. What do you use your 2013 CSPS funds for? (Check all that apply)

- [ ] To fund public health lab staff
- [ ] To fund public health lab supplies (e.g. reagents, kits)
- [ ] To fund health department staff
- [ ] For medications
- [ ] For grants to clinics
- [ ] Other (Please specify):

13. If you provide grants to clinics, what does this support?

- [ ] Treatment
- [ ] CT/GC test kits
- [ ] Staff time
- [ ] I don't know
- [ ] I don't provide grants to clinics

Comments:

14. Is there resistance in your project area to billing for STD services?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe:

STDR RH TTAC State / Project Area Billing Needs Assessment

Barriers

15. From your perspective what are the main barriers to billing for STDs among your funded clinics? (Check all that apply)

- ☐ Don't know how to set up a contract
- ☐ Too difficult to set up a contract (tried already)
- ☐ The majority of our clients do not have third party insurance
- ☐ Do not anticipate enough revenue to justify it
- ☐ Not enough staff to initiate billing
- ☐ Don't have Practice Management System or Electronic Health Record
- ☐ Staff feel that services should be free
- ☐ No staff or not enough staff to follow-up on unpaid claims
- ☐ Funds won't come back to our program; they go to the general fund
- ☐ Confidentiality concerns – e.g. don't want Explanation of Benefits to go to primary person insured.
- ☐ Other (please specify)

16. How would you describe your readiness as a state to assist STD clinics and family planning clinics in your jurisdiction to initiate billing activities?

- ○ We don't think we need to assist clinics to initiate billing activities
- ○ We think we need to assist clinics to bill but we don't know where to start
- ○ We have started the process to assist clinics to bill but we need TA
- ○ We are assisting clinics to bill and we don't need TA
- ○ All of the clinics in our jurisdiction already bill Medicaid and other third party payers

STDR RH TTAC State / Project Area Billing Needs Assessment

T/TA Needs

17. Please indicate any training and technical assistance (T/TA) needs as they relate to Billing and Reimbursement for STD and RH services.

Check all that apply. Then, identify your top 3 T/TA needs among those selected.

	We **need T/TA** on this topic	This is one of our **top 3 T/TA needs** related to billing and reimbursement
Setting up systems for a comprehensive cost analysis for STD services	☐	☐
Contracting with third party payers	☐	☐
Credentialing providers	☐	☐
State-level coordinated efforts for billing third party payers	☐	☐
Developing a price schedule for testing and treatment services	☐	☐
Establishing fee collection protocols	☐	☐
Implementation of fee collections and claims management	☐	☐
Facilitate CPT and ICD coding	☐	☐
Staff motivation to increase billing for STD services	☐	☐
Development and use of claims data reports	☐	☐
Development of a process and tools for quality improvement for billing	☐	☐
Transitioning billing process into flow of clinic	☐	☐
Identifying outside billing agency	☐	☐

STDR RH TTAC State / Project Area Billing Needs Assessment

Training & Technical Assistance

18. Please indicate which training modalities you are likely to access if the content meets one of your training needs (select all that apply):

- ☐ Webinar
- ☐ Audio conference or podcast
- ☐ Online learning communities (e.g. chat or discussion forums with peers)
- ☐ Online learning modules
- ☐ Training videos
- ☐ Written resources and tools (e.g. sample policies, case studies, check-lists, etc) accessible online
- ☐ Written resources and tools in hard-copy
- ☐ Face-to-face workshops
- ☐ Onsite training or technical assistance

Other (please specify)

19. Who is the main point of contact for coordinating T/ TA?

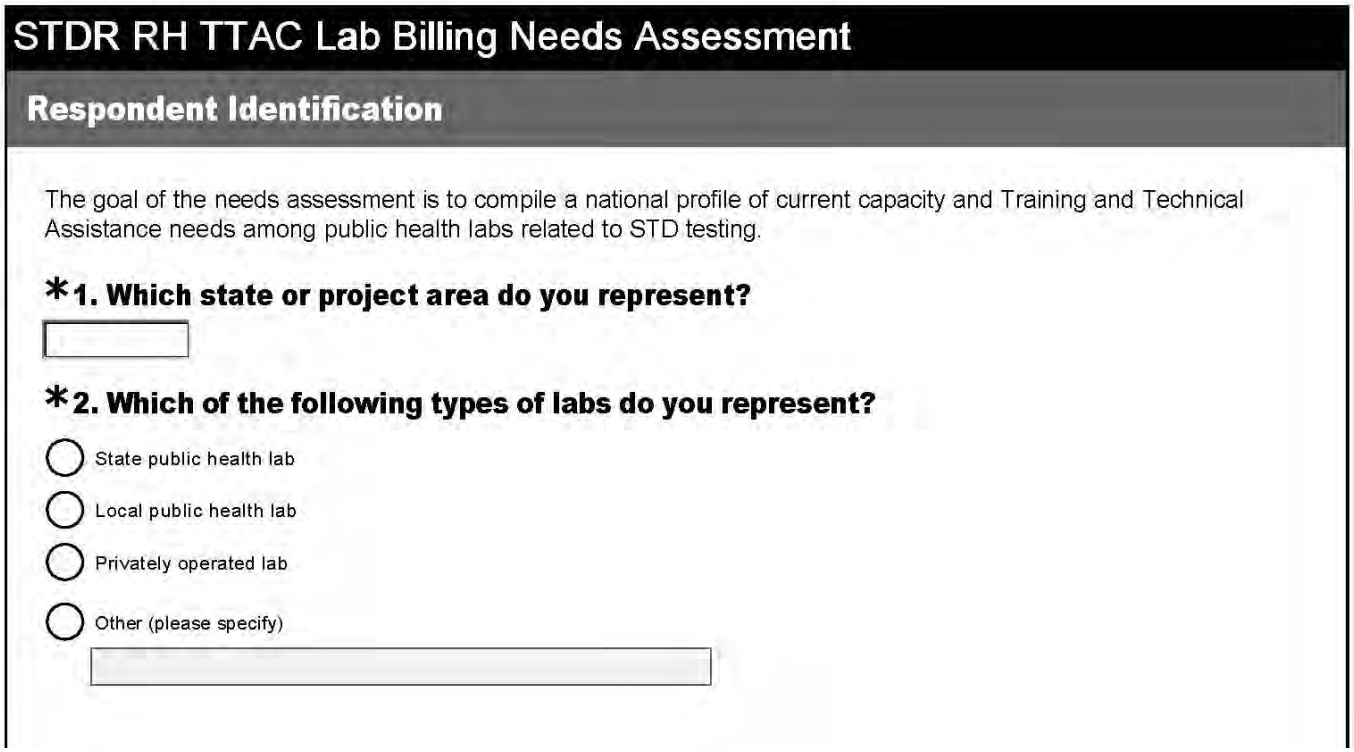
Name:

Job Title:

Phone:

Email:

C. Public Health Laboratories



STDR RH TTAC Lab Billing Needs Assessment

Respondent Identification

The goal of the needs assessment is to compile a national profile of current capacity and Training and Technical Assistance needs among public health labs related to STD testing.

***1. Which state or project area do you represent?**

***2. Which of the following types of labs do you represent?**

- ◯ State public health lab
- ◯ Local public health lab
- ◯ Privately operated lab
- ◯ Other (please specify)

STDR RH TTAC Lab Billing Needs Assessment

Currently Capacity

3. Does your lab currently bill clinics directly for services?

- ◯ Yes
- ◯ No

Comments:

4. Does any program within your lab (e.g. Newborn Screening, HIV, etc.) bill Medicaid and other third party payers?

- ◯ Yes
- ◯ No
- ◯ Not Sure

Please specify:

5. Has your STD program considered combining billing and reimbursement activities with another program within your lab?

- ◯ Yes
- ◯ No

Please describe. Indicate any barriers encountered.

STDR RH TTAC Lab Billing Needs Assessment

Capacity

6. Because of the high number of minors who receive STD testing services through the Public Health Laboratory System, and the need to maintain confidentiality of testing services from the primary insurance holder, many laboratories are adopting special practices to protect these patients' privacy.

Has your state developed protocols or guidance on how to ensure patient confidentiality when billing third party payers for STD services?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe:

7. Are you aware of any state or local laws or regulations that prevent your lab from billing for STD-related services?

- ◯ Yes
- ◯ No
- ◯ Not sure

Please describe:

8. Does your lab have a Laboratory Information Management System (LIMS)?

- ◯ Yes
- ◯ No

STDR RH TTAC Lab Billing Needs Assessment

Capacity

9. Which of the following can you do with your Laboratory Information System (LIMS)?
(Select all that apply)

- ☐ Collect insurance information
- ☐ Customize data fields
- ☐ Customize reports
- ☐ Electronic reporting of results *(to clinics)*
- ☐ None of the above

Comments:

10. Is there resistance in your program to billing for STD services?

- ◯ Yes
- ◯ No

Please describe:

STDR RH TTAC Lab Billing Needs Assessment

Barriers

***11. From your perspective what are the main barriers to billing for STDs at your lab? (Check all that apply)**

- [ ] Don't know how to set up a contract
- [ ] Too difficult to set up a contract (tried already)
- [ ] The majority of our clients do not have Medicaid or private insurance
- [ ] Do not anticipate enough revenue to justify it
- [ ] Not enough staff to initiate billing
- [ ] Don't have Laboratory Information Management System (LIMS)
- [ ] Don't have a LIMS with flexible data fields or reports (e.g. Can't add fields needed to bill or can't extract billing information)
- [ ] Staff feel that services should be free
- [ ] No staff or not enough staff in accounts receivable to follow-up on unpaid claims
- [ ] Funds won't come back to our program; e.g. they go to the general fund
- [ ] Confidentiality concerns; e.g. don't want Explanation of Benefits to go out
- [ ] Other (please specify)

STDR RH TTAC Lab Billing Needs Assessment

Readiness

12. How would you rank your readiness as the state public health lab to initiate billing activities?

- ◯ We don't think we need to initiate billing
- ◯ We think we need to bill but we don't know where to start
- ◯ We have started process of billing initiation but we need TA
- ◯ We have limited billing but we need TA
- ◯ We bill Medicaid and other third party payers

Comment:

STDR RH TTAC Lab Billing Needs Assessment

Training & Technical Assistance Needs

13. Please indicate any training and technical assistance (T/TA) needs as they relate to Billing and Reimbursement for STD and RH services.

Check all that apply. Then, identify your top 3 T/TA needs among those selected.

	This is a **T/TA Need**	This is one of our **Top 3 T/TA Needs**
Setting up Medicaid contract	☐	☐
Contracting with (other) third party payers	☐	☐
Setting up direct billing for clinics and hospitals	☐	☐
State-level coordinated efforts for billing third party payers	☐	☐
Establishing fee collection protocols	☐	☐
Facilitate implementation of current protocols for fee collections claims management	☐	☐
Staff motivation to increase billing for STD services	☐	☐
Development and use of claims data reports	☐	☐
Development of a process and tools for quality improvement for billing	☐	☐
Identifying outside billing agency	☐	☐

Other (please specify)

STDR RH TTAC Lab Billing Needs Assessment

Training & Technical Assistance

14. Please indicate which training modalities you are likely to access if the content meets one of your training needs (select all that apply):

- ☐ Webinar
- ☐ Audio conference or podcast
- ☐ Online learning communities (e.g. chat or discussion forums with peers)
- ☐ Online learning modules
- ☐ Training videos
- ☐ Written resources and tools (e.g. sample policies, case studies, check-lists, etc) accessible online
- ☐ Written resources and tools in hard-copy
- ☐ Face-to-face workshops
- ☐ Onsite training or technical assistance

Other (please specify)

***15. Who is the main point of contact for coordinating training and technical assistance?**

Name:	
Job Title:	
Phone:	
Email:	

APPENDIX V. Excerpt from: The Future of the Infertility Prevention Project: Policy Implications and Recommendations in Light of Passage of the Patient Protection and Affordable Care Act (Hamby, et al. 2011)

Third-Party Billing Capacity Development

With the advent of health care reform, both national and regional key informant interviewees agreed that FP and STI clinics will need to operate differently in the future. There was almost universal agreement that as the number of individuals with insurance increases, one of the primary challenges for FP and STI clinics will be engaging in third-party billing for services. Clinics will no longer be able to provide only "free" or "donation-only" services. Interviewees recognized that setting up the internal and external systems for billing is a time consuming and energy intensive process; however, establishing these systems will be necessary in order for the clinics to survive. Interviewees talked at length about supporting the workforce of FP and STI clinics as they transition to an environment that includes contracting with insurance companies and engaging in third-party billing.

> ***"…billing is a critical step for all IPP partners toward achieving financial stability."***

Challenges

While the benefits of developing third-party billing capacity were largely undisputed by regional interviewees, their perspectives on the challenges of doing so varied substantially. Legal barriers to third-party billing implementation are typically related to politics and statutory language. Elected officials may believe states should not run private enterprises, and state regulations in some project areas mandate certain tests to be free, which may become an outdated concept post reform. For those states with legislative policies that prohibit their ability to implement third-party billing, this challenge primarily impacts public health laboratories, categorical STI clinics, and FP title X clinics housed in city/county health departments.

The more consistently identified challenges to third-party billing capacity development included the following:

* Lack of uniformity in billing processes across clinics in a program area
* Limits in experience and comfort developing memoranda of agreements with insurers
* Costly changes related to IT infrastructure

Other general challenges noted in primary data collection included:

1. **Capacity.** It was noted that greater capacity-building challenges would be experienced by STI clinics and public health laboratories, which may lack key infrastructural components as a result of historically not billing for services.
2. **Resource and infrastructure constraints.** Lack of funding, staff, or a sizeable client base present additional challenges. Several interviewees noted that staff shortages due to budget cuts greatly reduce clinical capacity to devote resources to third-party billing. In addition, the cost per transaction required to bill a single visit or service could be too high to be cost-effective in low-volume facilities.
3. **Monitoring development.** This barrier was noted in two regional interviews. Lacking a system to monitor either success or failure creates challenges associated with determining the extent to which individual facilities are billing and where to target resources accordingly.
4. **Public health mindset.** Some interviewees cannot compete with the private sector and avoid taking their business. In addition, some believe that the mission of public facilities is to serve uninsured individuals or vulnerable populations regardless of insurance status.
5. **Incentives.** Revenue generated by agencies may go into a local or state general fund, to no benefit to a specific laboratory or STI program. In addition, some interviewees did not see the need to bill third parties because their current client base is largely uninsured, and billing third parties would not add value to the clinic or its clients.
6. **Contract development.** Interviewees noted challenges associated with managing multiple managed care organizations with which agencies may have to contract, ensuring reasonable reimbursement rates, being able to bill for services provided by nurses, and the complexity associated with managing a high volume of contractual agreements.
7. **Confidentiality.** This was noted as a barrier to even considering billing third parties. As one interviewee noted, "we are liked for confidentiality, if we do bill insurance we can't control their reporting and explanation of benefits, which will make it more difficult to provide confidential testing."
8. **Systems interface.** Lack of system interface capacity was a concern particularly for public health laboratories. Extracting information from

outside agencies or providing test results across systems that cannot interface is a challenge and could make providers hesitant to utilize or enter into agreements with state public health laboratories.

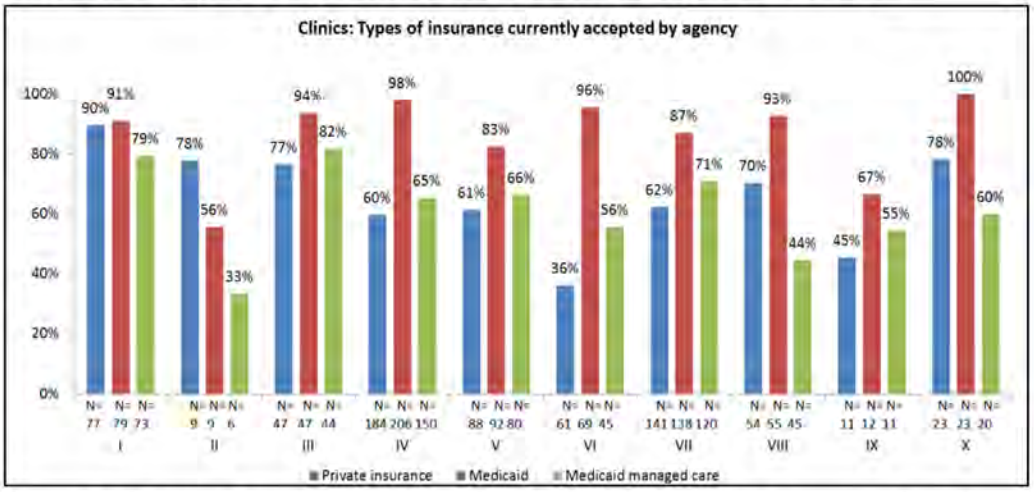
9. **Efficiency and proper coding.** Without appropriate procedures in place or qualified staff, billing inefficiently could increase staff time or delay reimbursements.
10. **Price breaks.** Currently, some family planning and STI clinics receive price breaks for laboratory testing, which would no longer be available if the clinic began to bill third parties.

In addition, public health laboratories may face some unique challenges associated with collecting the necessary billing information from the clients themselves. To that end, inability to interface Laboratory Information Management Systems (LIMS) in order to retrieve or send data with either providers or health departments is an inhibitive and costly barrier.

Opportunities to Leverage the Strengths of the IPP

With regard to the barriers and capacity-building needs, regional interviewees mentioned a number of strengths that could be leveraged in order to help build third-party billing capacity, the foremost being experience. Regional interviewees noted that while many IPP-funded agencies currently bill third parties, capacity varies on both the state and county levels. Family planning agencies were noted to have more experience with billing, and it was suggested that FP agencies might help other FP or STI clinics develop capacity. Planned Parenthood facilities in particular were noted to be more advanced than either traditional FP facilities or STI clinics, and have developed skills in billing and coding procedures along with successfully contracting with insurance companies and other health care providers, which could be leveraged.

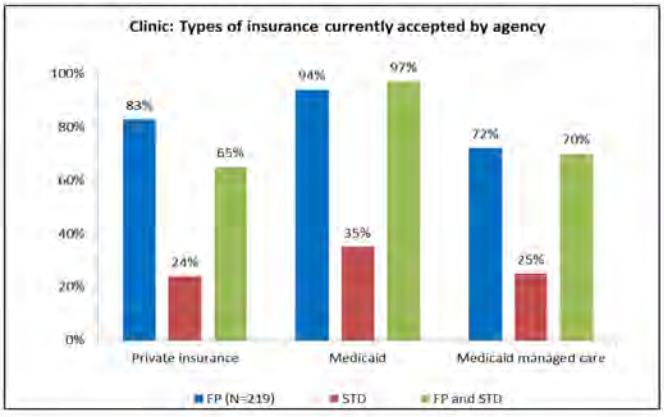
Graph 15: Does your agency currently accept the following types of insurance?*



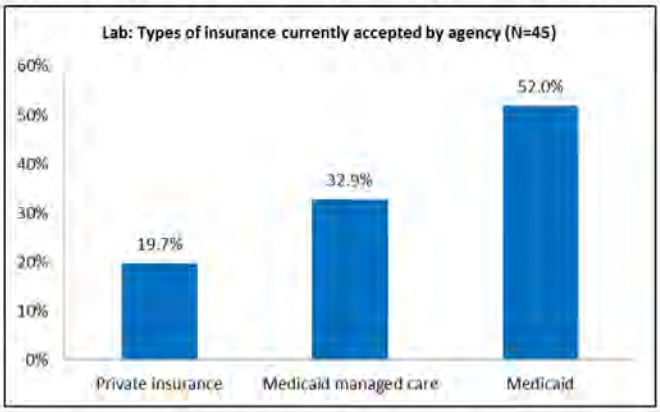
** Please note: Regional percentages presented in this graph are unweighted and represent the true frequency with which clinics reported billing capacity.*

To better understand clinical capacity to bill third-party insurance carriers at the local level, clinics were asked to indicate whether they accepted either: a) private insurance: b) Medicaid; or c) Medicaid managed care. As Graph 15 shows, individual clinics were more likely to accept Medicaid than they were to accept private insurance, with the exception of Region II, an anomaly likely explained by a low respondent frequency. In addition, survey findings confirm regional interviewee perspectives that FP clinics are more likely to have third-party billing capacities than are either STI clinics or public health laboratories, as can be seen from Graphs 16, below and 17 on the next page

Graph 16: Does your agency currently accept the following types of insurance?



Graph 17: Does your lab currently bill the following types of insurance for chlamydia and gonorrhea related



Some regional interviewees also noted that third-party billing capacities have allowed their agencies to both increase and diversify their funding stream. One interviewee, in fact, offered to make available reports showing the amount of revenue generated from third-party billing. In addition, outsourcing billing practices was mentioned as a way to develop capacity in cases in which resources may be scarce. From the laboratory perspective, for example, turning billing back over to the clinics could be a cost saving strategy. For smaller agencies with less or no infrastructural capacity, it was suggested to connect to a larger entity such as an FQHC with the appropriate knowledge/resources could bill for them. In fact, one project area noted attempts to increase their partnerships with several FQHCs for exactly that purpose. Another project area noted attempts to identify an outside contractor to conduct all billings.

Considering these capacities and the benefits of third party billing, several implementation and training efforts were noted across the regional interviews. Implementation efforts involved participating in billing advisory groups to standardize billing services and pricing; meeting with health plans and engaging in discussions as to how to better coordinate the provision of public health care in the reformed environment; and passing legislation ensuring that insurance plans recognize "public health" as a provider. Training efforts have involved workshops, IPP advisory committee meeting presentations, webinars, maintaining listservs to communicate with providers, and technical staff trainings. Some interviewees noted using local experts to develop content for trainings on a variety of common billing issues.

Agencies that had developed these capacities or partnerships mentioned common facilitators to successful billing practices, including:

* Ability to directly communicate with and train clinic staff
* Development of systematic procedures and trainings
* Technical assistance and training on billing and coding
* Guidelines and model procedures
* Development or purchase of off-the-shelf software
* Standardized coding and billing, procedures and the development of efficient coding practices
* Staff participation in trainings
* Implementation of EHRs
* Resources, such as experienced staff and funding
* Hiring practices: for example, it was noted that sites "should hire people who know how to do third-party billing." One interviewee noted that the director of finance at his/her agency had a private-sector background, and that this type of experience was necessary to develop capacity and leadership in this area.

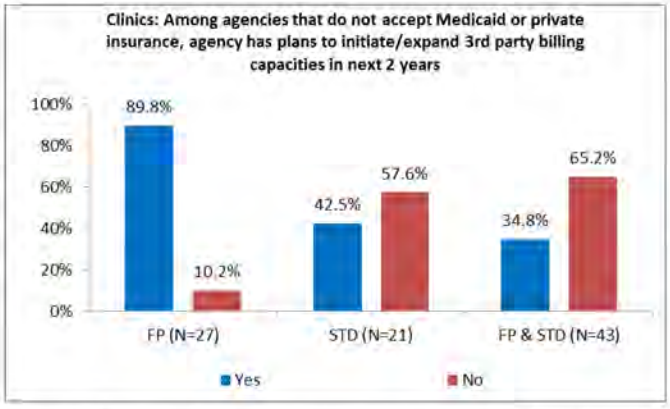
Regional interviewees also identified a number of potential roles for the IPP under health care reform that could help partner clinics take advantage of their experience. These included the development of training materials and the identification and dissemination of best practices. Suggestions for training opportunities included hosting workshops, creating presentations and providing opportunities to capitalize on the expertise of billing experts. It was also suggested that the IPP infrastructure could provide information about other agencies' best practices. In this sense, the IPP could identify states that could demonstrate the benefits of billing in order to facilitate the translation of such efforts into other states. Other suggestions included the development of standardized guidelines and protocols, as well as devoting specific funding to capacity-building efforts for billing and workforce development.

In contrast, two interviewees felt that the IPP is not suited to provide third-party billing assistance, stating that billing may be outside the scope of the IPP, which is generally more involved with surveillance and screening. One interviewee felt that the IPP could only contribute if the program could actually arrange funding for third-party billing initiatives and another stated that it was simply difficult to determine the IPP's role moving forward. In light of "bureaucratic resistance to change," however, one interviewee felt that there was a particular need for advocates to continue to encourage providers to both screen and provide

sexual and reproductive health services despite either HCR or third-party billing capacity. This person also stated, that, however, "It will be disastrous for jurisdictions that won't or can't develop systems for billing."

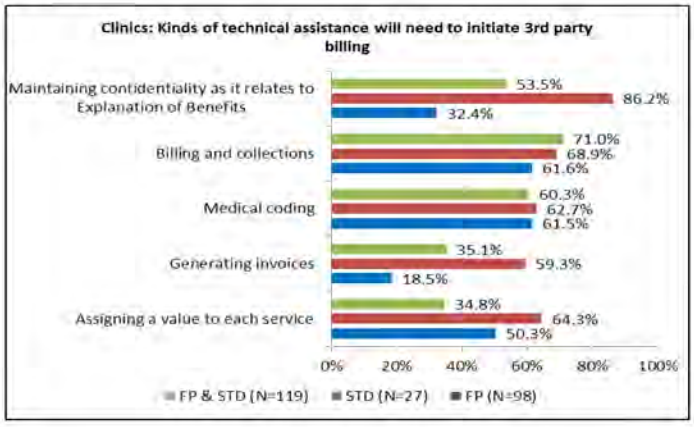
Accordingly, survey analysis demonstrates that among the 138 respondents representing clinics that do not have third-party billing capacity, approximately half have plans to initiate or expand that capacity within the next two years, a rate which varies depending upon clinic type. As shown in Graph 18 below, individuals representing family planning clinics alone were much more likely to respond that their clinic had plans to initiate third-party billing capacity within the next two years.

Graph 18: If your agency does not accept Medicaid or private insurance, does your agency have plans to initiate or expand 3rd party billing capacities in the next 2 years?



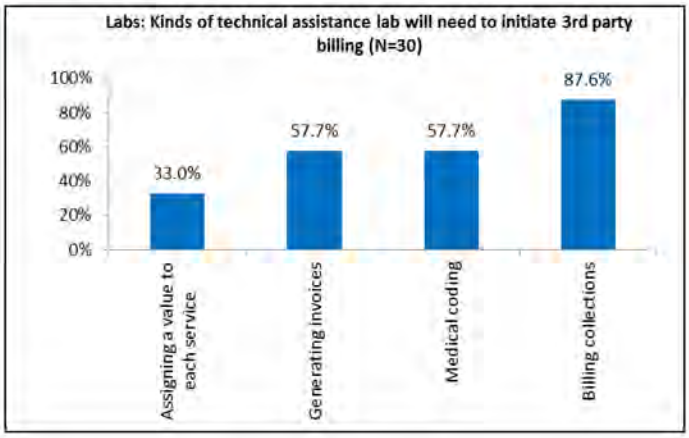
Survey findings also provide insight on the local clinics' and laboratories' specific technical assistance needs to initiate or expand billing capacities. As seen in Graph 19, among the 119 respondents representing FP and STI clinics who answered this specific question, the most commonly -cited technical assistance need was about billing and collections. This was also the case among respondents representing FP clinics alone. Among respondents representing STI clinics alone, however, confidentiality concerns pertaining to explanations of benefits were the most commonly-cited technical assistance need.

Graph 19: What kinds of technical assistance does your agency need in order to initiate or expand 3rd party billing?



Laboratory partners were also asked to indicate the types of technical assistance they would need in order to initiate third-party billing, and, as can be seen in Graph 20 below, technical assistance for billing and collections were again the most commonly cited.

Graph 20: What kinds of technical assistance do you feel your lab will need in order to initiate 3rd party billing?



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