Billing at the Milwaukee Health Department Clinics: An Analysis of Potential Revenue Gains

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List of Acronyms

AIDS: Acquired Immunodeficiency Syndrome

BMD-DOA: The City of Milwaukee Budget and Management Division, Department of Administration

CDBG: Community Development Block Grant

CF: Consent Form

HIV: Human Immunodeficiency Virus

HMOs: Health Management Organizations

KHC: Keenan Health Center

MAOP: Medical Assistance Outreach Program

MHD: The City of Milwaukee Health Department

MOU: Memorandum of Understanding

OA: Office Assistant

PCP: Primary Care Provider

PHN: Public Health Nurse

STD: Sexually Transmitted Disease

TB: Tuberculosis

UCR: Usual and Customary Rate

UHC: United Health Care

WIC: Women, Infants, and Children

WIR: Wisconsin Immunization Registry

Foreword

This report, which analyzes potential revenue streams for Milwaukee Health Department clinics, is the product of a collaboration between the Robert M. La Follette School of Public Affairs at the University of Wisconsin–Madison, the City of Milwaukee Budget and Management Division, Department of Administration and City of Milwaukee Health Department. Our objective is to provide graduate students at La Follette the opportunity to improve their policy analysis skills while contributing to the capacity of the City of Milwaukee to effectively provide public services.

The La Follette School offers a two-year graduate program leading to a master's degree in public affairs. Students study policy analysis and public management, and pursue a concentration in a public policy area of their choice. They spend the first year and a half taking courses that provide them with the tools needed to analyze public policies. The authors of this report are all enrolled in Public Affairs 869, Workshop in Public Affairs, Domestic Issues. Although acquiring a set of policy analysis skills is important, there is no substitute for doing policy analysis as a means of learning policy analysis. Public Affairs 869 provides graduate students that opportunity.

The students were assigned to one of six project teams. Two teams, including the one that authored this report, worked with the City of Milwaukee Budget and Management Division. Other teams worked for the Wisconsin Department of Natural Resources, the Wisconsin Department of Revenue, the Wisconsin Department of Administration, and the Joint Legislative Council. The topic of this report—identifying possible revenue sources to fund public clinic services—was chosen by Mark Nicolini, the budget director of the City of Milwaukee, in consultation with his staff.

This report does not provide the final word on the complex issues the authors address. The graduate student authors are, after all, generally new to policy analysis, and the topic they have addressed is large and complex. Nevertheless, much has been accomplished, and I trust that the students have learned a great deal, and that Mayor Barrett and the staff of the City's Budget and Management Division will profit from the evaluation of possible revenue sources.

Like many large cities, Milwaukee is facing an environment where there is consistent demand for health services, but there are limited local resources to provide such services. Milwaukee Health Department clinics provide a range of health services intended for uninsured or underinsured citizens. Many clients have Medicaid, but some clinics do not always appear to bill Medicaid for services received, and Medicaid does not cover all services provided. Other clients have private insurance, but the City does not have reimbursement agreements with

private insurers. The authors examined insurance billing data and survey data to assess the range of possible revenue loss, visited clinics to understand management procedures in place, and looked to other city health departments for different revenue practices that could be applied in Milwaukee. The authors recommend putting in place procedures where all uninsured clients are checked for Medicaid eligibility and all clinics are audited to ensure they are billing Medicaid for eligible services. Based on the experience of other cities, the authors also recommend extending current Medicaid reimbursement agreements to cover services that the clinics provide but which are not currently supported by Medicaid, and to develop new reimbursement agreements with private providers. All of these recommendations seek to increase revenue provided to the Health Department and maintain current service levels, without imposing new fees on the clients.

This report would not have been possible without the support and encouragement of Budget Director Mark Nicolini, and Eric Pearson, who served as the project coordinator for the Budget and Management Division and solicited ideas for policy analysis from the Budget Office staff and coordinated the efforts of staff in support of the project. Budget Office staff Jennifer Meyer-Stearns and Renee Joos provided project advice, and Michele Le Bourgeois of the Milwaukee Health Department provided practical guidance in helping the authors understand how the clinics worked.

The report also benefited greatly from the active support of the staff of the La Follette School. Terry Shelton, the La Follette outreach director, along with Kari Reynolds, Mary Mead, and Gregory Lynch, contributed logistic and practical support for the project. Karen Faster, La Follette publications director, edited the report and shouldered the task of producing the final bound document.

I am very grateful to Wilbur R. Voigt whose generous gift to the La Follette School supports the La Follette School public affairs workshop projects. With his support, we are able to finance the production of the final reports, plus other expenses associated with the projects.

By involving La Follette students in one of the tough issues faced by the City of Milwaukee, I hope the students not only have learned a great deal about doing policy analysis but have gained an appreciation of the complexities and challenges facing city government in Wisconsin and elsewhere. I also hope that this report will contribute to the work of the Division of Budget and Management and the Health Department in their efforts to provide health care to the citizens of Milwaukee.

Donald Moynihan
May 1, 2006

Acknowledgments

We would like to thank all those who contributed significant time and effort to our analysis of billing practices at the Milwaukee Health Department, including Jennifer Meyer-Stearns and Renee Joos of the City of Milwaukee's Budget and Management Division, Department of Administration; Michele Le Bourgeois of the Milwaukee Health Department; and Professor Donald Moynihan of the Robert M. La Follette School of Public Affairs at the University of Wisconsin-Madison.

We greatly appreciate the help and assistance provided by the Milwaukee Health Department's health and administrative professionals, who are too numerous to list by name. Specifically, we would like to thank all of the clinic staff at Keenan, Northwest, and Southside health centers who took time out of their busy day to meet with us. Without their expertise and knowledge, this report would not have been possible. Further, we would like to thank the health and policy professionals in the cities we reviewed who greatly contributed to this analysis.

The contributions provided by La Follette faculty and staff throughout the development of this analysis have been remarkably helpful. We would specifically like to thank Professor David Weimer for the mentorship he has provided to the members of this group over the past two years. We are also greatly appreciative for the assistance of our editor, Karen Faster, publications director at the La Follette School of Public Affairs.

Executive Summary

The City of Milwaukee Budget and Management Division, Department of Administration asked the La Follette School of Public Affairs to investigate current billing processes at the City of Milwaukee Health Department (MHD) clinics and to make recommendations on how these practices could be changed to increase clinic revenue. The MHD clinics are intended to provide health services to uninsured and underinsured people, but frequently they serve people who have public or private insurance. Currently, the MHD bills Medicaid for a limited set of services provided to publicly insured clients, permitted by memoranda of understanding between the MHD and Medicaid health management organizations. However, data indicates that the MHD does not bill for all Medicaid clients served. In addition, the MHD does not bill privately insured clients because the MHD lacks memoranda of understanding with private insurance companies. Services provided to uninsured clients and those without Medicaid insurance are free of charge. By failing to bill for all services provided to all insured clients, the MHD is not maximizing its revenue. The goal of this report is to make recommendations regarding billing practices at the MHD clinics with the purpose of increasing revenues.

In this analysis, we consider seven policy alternatives:

(1) maintain the status quo,
(2) change the billing process,
(3) increase billing for services by implementing monthly audits,
(4) increase billing for services by implementing incentives,
(5) expand existing Medicaid memoranda of understanding to cover additional services,
(6) sign memoranda of understanding with private insurance providers operating in the area, and
(7) charge uninsured and privately insured clients fees for services.

We evaluate these policies by their relative progress toward the achievement of the following three policy evaluation criteria: maintain level of service to uninsured and underinsured people, increase revenue, and have implementation feasibility. (For a schematic representation of the policy evaluation criteria and alternatives, please see Appendix A.)

Based on our analysis, we recommend that the Milwaukee Health Department

(1) change the billing process to refer all uninsured clients to the Medical Assistance Outreach Program, implement a process checklist, and change the intake form,

(2) implement monthly clinic billing audits,

(3) investigate the possibility of extending the memoranda of understanding the MHD has with Medicaid HMOs to permit reimbursement for additional services such as testing and treatment for sexually transmitted diseases, and

(4) investigate the feasibility of entering into similar agreements with private insurance companies.

Of all the policy alternatives that we considered, we believe that these options will best fulfill the goal of increasing revenue while maintaining the level of services provided to the uninsured and underinsured people of Milwaukee.

Introduction

The City of Milwaukee Budget and Management Division asked the Robert M. La Follette School of Public Affairs at the University of Wisconsin-Madison to investigate the current billing processes at the City of Milwaukee Health Department (MHD) clinics and to make recommendations on how these practices could be changed to increase clinic revenue. The purpose of the MHD clinics is to provide health services to uninsured and underinsured clients. The clinics serve many people who have public or private insurance. While the MHD has memoranda of understanding with Medicaid health maintenance organizations (HMOs) that allow the MHD to bill for specified services, the clinics do not bill for all services provided to all publicly insured clients. Additionally, the MHD does not have memoranda of understanding with private insurers and does not bill private insurance companies. Unless a client has public insurance, services are provided free of charge.

The MHD clinics bill at a very low rate. According to our data, the MHD is billing for roughly 19 percent of its client population. This is far below the estimated 34 percent who have Medicaid insurance. In addition, an estimated 13 percent of clients with private insurance are not billed. Clinic revenue could be increased by billing all Medicaid clients, expanding the set of billable services, and billing privately insured clients. By failing to bill for all services provided to all insured clients, the MHD is not maximizing revenue. The goal of this report is to make recommendations to the MHD in regard to billing practices at its clinics with the purpose of increasing revenues.

We first provide background information on the MHD and its clinics. Second, we describe the current billing processes at the clinics. Third, we discuss potential sources of revenue gains. Fourth, we identify differences between Milwaukee's billing practices and those found in the health departments of other large cities. Fifth, we lay out a set of criteria and outline multiple policy alternatives. Finally, we state our policy recommendations based on our evaluation of our policy alternatives.

Background:
The City of Milwaukee Health Department

The MHD was established in 1867 to provide for the health needs of the residents of Milwaukee. The MHD's mission is to "ensure that services are available to enhance the health of individuals and families, promote healthy neighborhoods, and safeguard the health of the Milwaukee community" (CMHD 2006). MHD's budget for 2006 is approximately $31 million. Of this sum, roughly $13 million is from city funds, and the remaining $18 million comes from state, federal, and private grants. The MHD employs 326 individuals in five divisions: Maternal and Child Health, Healthy Behaviors and Health Care Access, Consumer Environmental Health, Home Environment Health, and Disease Control and Prevention. To deliver many of its services to the public, the MHD operates from five health centers throughout the city[1] (City of Milwaukee 2006a).

Health Department Clinics

The MHD operates five clinics to provide services to the city's underinsured and uninsured residents. These clinics are Walk-In; Family Health; Women, Infants, and Children; HIV/AIDS and STD; Tuberculosis (TB) Control and Refugee Health[2]; and Well Woman Program. (CMHD 2004) The clinics offer a wide range of services including immunizations, prenatal and reproductive care, pregnancy testing, TB testing and therapy, HIV/AIDS and STD testing and treatment, general health assessments, and counseling. In addition to providing health services, the clinics serve as gateways to more permanent health care providers through their referral services (City of Milwaukee 2006a).

In addition to offering different services, the clinics have different operating schemes. For example, some are by appointment only while others welcome walk-ins. The different clinics also have different sources of funding. For example, the WIC clinic is federally funded (U.S. Department of Agriculture 2005) and the Well Woman Program is state-funded (Leigh-Gold 2006). As neither of these two clinics receives funding from the City of Milwaukee, they are not included in our analysis.

The clinics are housed in three health centers located throughout the city: Northwest, Southside, and Keenan. Some of these specific clinics are offered only

[1] Although the MHD operates five public health centers, the Issac Coggs Health Center and the Johnston Community Health Center are contracted and administered by private actors, and are not discussed or examined as part of this report. From here forward, any reference to the MHD's health centers will specifically refer to the three publicly staffed, run, and managed centers: Keenan, Southside, and Northwest.

[2] From here on, the Tuberculosis Control and Refugee Health clinic will be referred to as the TB clinic.

at one health center while others are offered at more than one (CMHD 2005a). Table 1 shows the clinics located at each of the three health centers.

Table 1: Location of Clinics within Health Centers

	Health Centers		
Clinics	**Keenan**	**Northwest**	**Southside**
Walk-In	X	X	X
Family Health	X	X	X
WIC	X	X	
TB	X		
HIV/AIDS and STD	X		
STD			X
Well Woman Program			X

Source: City of Milwaukee Health Department's 2005 clinic schedules

Existing Memoranda of Understanding

The MHD has memoranda of understanding with the three Medicaid HMOs operating in the Milwaukee area (LeBourgeois 2006). These memoranda allow the MHD to bill Medicaid HMOs for some services. The services covered by these agreements include health checks, vision screening, hearing screening, hemoglobin testing, TB skin testing and therapy, lead screening, specified immunizations, pregnancy testing, and prenatal care (CMHD undated). Under these memoranda of understanding, the HMOs reimburse for services at the state Medicaid maximum fee. Reimbursements do not go to the clinics or the MHD but rather to the City of Milwaukee (Wisconsin Department of Health and Family Services 2006).

For the MHD to bill Medicaid HMOs, the client must complete and sign a billing form while at the clinic. Clinic staff use web-based third-party software called Passport to verify a client's insurance status. Passport quickly verifies plan names, co-payments, co-insurance, deductibles, and primary care provider information. Each Passport query costs the MHD 25 cents. The MHD only uses Passport to verify Title XIX, public insurance. However, Passport can verify private insurance coverage. If Passport is used to determine private insurance status, queries must include a specified insurance provider (Passport Health Communications 2006).

Clinic Visits and Billing Processes

To learn more about the clinics and their intake and billing processes, our team visited each of the three health centers: Northwest, Southside, and Keenan. During our visits, we were able to observe clinic intake procedures at the Southside Walk-In, Northwest Family Health, Keenan Walk-In and Keenan Family Health. We did not observe any intakes at the TB clinic but were able to learn about their process by interviewing a member of their staff. We did not observe intake processes at either of the HIV/AIDS and STD clinics.

Family Health Clinic and Walk-In Clinic

The intakes observed at the Northwest Family Health clinic and the Keenan and Southside Walk-In clinics involved children in need of immunizations. (For a map of current intake and billing procedures in the clinics, see Appendix B) At all three clinics, the intake began with clinic staff asking for the client's immunization records. At Keenan, the staff person then asked whether the client had insurance. If so, the staff person asked for the client's insurance cards, which were then photocopied. We did not observe clinic staff inquiring about insurance at Southside. At all three clinics, staff searched for the child in the Wisconsin Immunization Registry, a web-based database. Then, at all three clinics the client was given a packet of paperwork to fill out. The first question on the first form asked about insurance status. Notably, there is not a box for "private insurance" on this form. In addition, instead of listing Medicaid and Medicare, the form has a box for "medical assistance," a term with which many clients might be unfamiliar. At the Southside and Northwest clinics, a billing form, which the MHD must have to bill the Medicaid HMOs, was completed for all clients. It is unclear, based on our observations, if this is the case at Keenan.

The billing form then goes with the client to the nurse, who must indicate on the form which services have been provided. After the client leaves, the nurse returns the form to the clinic office assistants, who look up the client in Passport. We did not observe staff at any of the clinics accessing Passport during our visits; staff at all of the clinics said that Passport is accessed after the client left. We noted that Passport was available on the staff computer in the intake area at Keenan and Northwest but not at Southside. After the billing form is complete and the staff has searched for the client in Passport, the form is sent to the main office of MHD for processing.

TB Clinic

Although we were unable to observe any intakes at the TB clinic, we spoke with an office assistant about their processes. The office assistant determines the billing status of clients before they arrive by checking Passport. If the client is uninsured, the office assistant determines if the client is eligible for TB dispensary funds, state funding for TB health services for people who are suspected of having

or who have TB. If a client has been to the clinic before, but it has been more than two weeks since the client's last visit, the office assistant rechecks Passport. After checking a client's insurance and eligibility, the office assistant attaches the appropriate billing sheet to the client's file: the Medicaid billing sheet, dispensary billing sheet, or writes NB for not billable.

Billing Forms

A major problem with the MHD's billing process is that it is not uniform across all clinics. This is largely because there is no MHD standard billing procedure. Instead, each clinic determines its own procedure. In early 2006, the MHD attempted to standardize some parts of the billing process. For example, the MHD now requires that all clients complete and sign a billing form. However, there seems to be some confusion about this policy. From our discussions with clinic personnel and MHD administrators, and from our observations of clinic operations, there seems to be some disagreement as to when a client should be required to complete a billing form. At the Southside clinic, we were told that, starting March 1, 2006, the policy of the MHD is that all clients, regardless of whether they say they have insurance, are required to sign a billing form (Carroll 2006). This will allow the MHD to bill for services provided to clients who are Medicaid HMO subscribers and who indicate to clinic staff that they do not have insurance. Based on our observations at the Southside clinic in late February 2006, this policy seems to be in effect. At the other clinics, it is not clear whether all clients are signing the billing forms. In addition, we learned from the MHD clinic operations manager that having clients sign billing forms is not a new policy but rather has been a standard procedure at all clinics for some time, even though our observations show that this policy is not uniformly followed. This example illustrates the challenges that the MHD might face in making changes to the billing process.

Sources of Revenue Loss

One of the concerns of the City of Milwaukee Budget and Management Division and the MHD is that not all services provided to clients who have Medicaid insurance are being billed. Indeed, the data show that while 34 percent of all clients have Medicaid insurance, only 19 percent are billed (see Appendix C for information on data sources). In some cases, the clients fail to accurately report their insurance status. We assume that this is because clients are unaware that they have Medicaid insurance or are confused by the question on the intake form, which asks if the client has "medical assistance," but not if the client has Medicaid or Medicare. A MHD analysis of administrative data showed that while 34 percent of the client population has Medicaid, only 25 percent report it. This means 9 percent fail to report Medicaid accurately and therefore are not billed (CMHD 2005b).

In addition, data show that MHD does not bill some clients who indicate Medicaid insurance status. While 25 percent of all clinic clients report having Medicaid, only 19 percent are billed. This means that 6 percent of all clients report having Medicaid but are not billed (see Appendix D for data calculation). The reasons for this are unclear. This could result from problems at the clinic, the MHD main office, or Medicaid HMOs. At the clinic level, staff might be failing to have clients complete billing forms or to search for client eligibility in Passport. We propose policies that should eliminate these problems at the clinic level.

However, billing staff at the MHD headquarters may be failing to submit complete and correct information to the insurance companies for all Medicaid clients. In addition, the Medicaid HMOs may not be reimbursing the city for all services billed. Individual clients' Medicaid insurance may not cover the services the clinics provide. In that case, the percentage of services reimbursed would also be smaller than the percentage of clients reporting Medicaid. We were unable to pinpoint steps in the process at the MHD main office or at the Medicaid HMOs that might contribute to this problem. As a result, our proposed policies do not address the potential problems at those locations.

Table 2 shows the estimated percentage of each insurance status by health center from the Immunization Consent Analysis. The Medicaid percentages are verified numbers from Passport. All other percentages are self-reported, but adjusted for people who did not report their Medicaid coverage. Most of the clients who were found to have Medicaid but had not reported it self-reported as uninsured. Table 3 shows the percentage of clients who reported having Medicaid insurance versus the percentage found by querying clients in Passport.[3]

Table 2: Insurance Status by Health Center

	Health Center			
Insurance Status	**Keenan**	**Northwest**	**Southside**	**All**
Private	9%	21%	10%	13%
Medicaid	39%	43%	26%	34%
Not Insured	37%	28%	55%	43%
Unknown	15%	8%	9%	10%

Source: City of Milwaukee Health Department Immunization Consent Analysis

[3] Tables 2 and 3 indicate a great deal of variance in insurance coverage by health center. One possible explanation for this points to differences between the populations served by the different health centers. From our observations, the majority of clients at the Southside Health Center are Spanish-speakers, presumably recent immigrants. On the other hand, most of the clients at Northwest and Keenan are native born. For more information on demographic information by health center, see Appendix E.

Table 3: Clients Underreport Medicaid Insurance			
	Health Center		
	Keenan	Northwest	Southside
Medicaid Verified	39%	43%	26%
Medicaid Self-Reported	31%	31%	20%

Source: City of Milwaukee Health Department Immunization Consent Analysis

Estimates of Revenue Loss[4]

We estimate that the loss of revenue from not billing all Medicaid insured clients was $24,400 in 2005. This figure was calculated using the MHD's Analysis of Services, clinic flow-sheets, the MHD's Immunization Consent Analysis, and the MHD billing summary. (for more detail as to how calculations were made, see Appendix D). Table 4 shows annualized 2005 billing, billing if 100 percent of Medicaid clients were billed, the loss of revenue from not billing 100 percent, and the percent lost. Table 4 shows that by failing to bill all Medicaid clients, the MHD is losing 43 percent of potential reimbursements.

Table 4: Revenue Increase from Billing All Medicaid Insured Clients				
Medicaid	**2005 Annualized Billing**	**100% Medicaid Billing for 2005**	**Loss**	**Percent Lost**
Immunizations	$29,900	$52,700	$22,800	43%
Health Check Exams	$1,400	$2,000	$600	30%
Pregnancy Tests	$400	$1,400	$1,000	71%
	$31,700	$56,100	$24,400	43%

Source: Calculations based on data from City of Milwaukee Health Department's flow sheets, Analysis of Service, Immunization Consent Analysis, Billing Summary; and Wisconsin Department of Health and Family Services Medicaid maximum fee rates.

Further, the data show that the percentage of clients who have private insurance is 13 percent. The MHD currently is not billing for any of these services. If the MHD were also able to bill private insurance for services, they could similarly increase revenue.

[4] Figures are rounded to the nearest hundredth.

Billing and Reimbursement in Comparison Cities

We surveyed the health departments of a number of cities with demographic similarities to Milwaukee to seek innovations in billing practices. These cities were Boston; Baltimore; Cleveland; Columbus, Ohio; King County (Seattle); Madison, Wisconsin; Maricopa County (Phoenix); Marion County (Indianapolis); Minneapolis; Nashville; and San Francisco. Through our research, we identified three practices employed by other health departments that, if implemented, could increase revenues at the Milwaukee health centers.

First, some health departments bill Medicaid for a wider range of services. For example, the Columbus Health Department bills for STD testing and the Maricopa County Health Department bills for HIV/AIDS and STD testing in addition to billing for all the services currently billed by MHD (Clark 2006). Billing Medicaid HMOs for these services would increase MHD revenues.

Second, many of these health departments charge clients without public insurance a fee for services. The amount of the fee is fixed or determined using a sliding scale based on income. The Baltimore, Minneapolis, Columbus, Cleveland, Marion County, and Maricopa County health departments all charge clients without public insurance for some services (Clark 2006, Rowley 2006).

Finally, some health departments bill private insurance companies. The Columbus Health Department has a contract with United Health Care (UHC) and is in the process of entering into a contract with another private insurance company. The Columbus Health Department bills UHC for sexual health services, TB testing, perinatal care, and immunizations. Under the contract, the billing rates are slightly higher than the Medicaid rates.[5] This contract was implemented in August 2005 and so far the health department has received little revenue from the agreement, due to administrative errors and limited client enrollment with UHC (Clark 2006).

In addition, both the King County (Seattle) and Marion County (Indianapolis) Health Departments bill private insurance for some services without having contracts with private insurers. In Marion County, billing is limited to dental and mental health services (Rowley 2006). In King County, the health department bills private insurance for all services with the exception of immunizations. The King County Health Department does not bill private insurance for immunizations because many insurers do not cover these services. Instead, individual clients are billed for immunizations. King County bills private insurers the Medicaid

[5] Although the reimbursement rates are higher than the Medicaid rates, these rates often do not cover the costs of providing these services. For example, the cost of providing immunizations at the health department clinics is much higher than it is at UHC provider clinics. Because the cost of immunizations is higher at the clinics, clinic staff encourages clients with private insurance to go to the primary care provider for immunizations.

maximum fee, however, they implemented a new higher fee schedule on May 1, 2006. Yet King County is also considering no longer billing private insurance. The percent of KCHD clinic clients who have private insurance, estimated to be about 3 percent of all clients, is very low. When weighed against the difficulty of billing private insurance companies, the benefit the KCHD receives from doing so is small (Anderson 2006).

The experience of the Columbus Health Department shows that private insurance companies may be willing to enter into contracts with health departments. Indeed, the King County fiscal specialist stated that she believed private insurance companies would want their subscribers to use health department clinics as the clinics charge a lower rate for services (Anderson 2006). However, in Columbus's case, significant procedural barriers blocked the health department from becoming an UHC approved provider. To do so, the health department had to go through "credentialing," a lengthy process prescribed by Ohio law that requires a great deal of administrative paperwork (Clark 2006). Under Wisconsin law, managed-care organizations individually develop processes for selecting participating providers, including written policies and procedures that they use for review and approval of providers. Discretion in these matters, pending criterion approval by the Wisconsin Office of the Commissioner of Insurance, is left to private insurance companies (Wisconsin State Statutes 2006).

Policy Evaluation Criteria

We evaluated our policy alternatives using three criteria. The first was the extent to which the policy would maintain the MHD's ability to serve uninsured and underinsured clients. This is one of the central goals of the health centers; the recommended policy alternative should not inhibit the health centers' ability to realize this goal. The second evaluation criterion is the extent to which the policy alternative will increase clinic revenue. The City of Milwaukee Budget and Management Division requested this study to find ways to increase revenue from MHD clinics; this is the primary goal of our analysis. The third evaluation criterion is implementation feasibility. A policy cannot be successful if it cannot be fully implemented. Therefore we weighed the ease of implementation and anticipated level stakeholder support for each of the policy alternatives. (For a schematic representation of the policy evaluation criteria and alternatives, please see Appendix A.)

Policy Alternatives

This section provides descriptions of the status quo and policy alternatives and then evaluates each using our policy evaluation criteria.

Status Quo

The MHD has memoranda of understanding with the three Medicaid HMOs (LeBourgeois 2006). These allow the MHD to bill these HMOs for specific services provided to HMO subscribers at the state Medicaid maximum fee (CMHD undated). The City of Milwaukee Budget and Management Division is concerned that under the current system they are losing potential revenue. The two perceived sources of this loss of revenue are the failure of health center staff to bill for all services covered by the memoranda of understanding and the use of health-center services by clients with private insurance.

There appears to be variation in billing practices and procedures across the clinics and health centers. Some clinics use a billing form for all clients as standard practice, while others appear to use it on an ad hoc basis. Referring uninsured clients to Medical Assistance Outreach Program is not the norm. (See Appendix F for an explanation of the program.)

Implementation of Changes to the Billing Process

To achieve greater efficiency in the billing process and to assist with increasing revenue, we have developed a number of process changes and enhancements. We suggest that the process be changed so that all uninsured clients are referred to the Medical Assistance Outreach Program, that billing processes are tracked and documented using a checklist (see Appendix G for a sample checklist), and that intake forms be made clearer. By not referring clients to Medical Assistance Outreach Program, the MHD bears the financial burden of potentially Medicaid eligible clients. Although not every MHD client is Medicaid eligible, in the long run, this process change should result in more Medicaid billable clients and revenue. (See Appendix H for a schematic representation of the process changes).

Employing a billing checklist would ensure that all staff are familiar with the standard billing procedures. The checklist would have the added benefit of creating an audit trail that could be used to verify implementation of the standard billing processes if problems continue.

Another change in the billing process concerns one particular intake form, the "Vaccine(s) Administration Record & Questionnaire," which is confusing and may result in misreported insurance status. On this form, the question about insurance status does not provide Medicaid or Medicare as options but rather the potentially unfamiliar term "medical assistance." By simply changing the

response options to this question, the MHD could potentially increase the number of clients self-reporting Medicaid.

When weighed against our three policy evaluation criteria, the policy alternative of changing the billing process is likely to have mixed success. In terms of maintaining the level of service to the clinics' target population, by increasing referrals to Medical Assistance Outreach Program we believe that a greater number of MHD clients will be enrolled in Medicaid, which in turn will make them eligible for more health services. This should not decrease the use of the clinics by the target population but rather increase access to health services. In regard to the second policy evaluation criteria, to increase revenue, changing the billing process will help the clinics move toward complete billing of Medicaid clients. By increasing the number of Medicaid clients billed, this alternative will increase revenue. In regard to the final evaluation criteria, this alternative has moderate implementation feasibility. This alternative imposes an additional burden on MHD clinic and administrative staff. As such, it might be resisted or not fully implemented by clinic staff. In addition, the MAOP is already targeting and enrolling Medicaid eligible residents in Milwaukee County. At current staffing levels, MAOP may not be able to handle the increase in referrals from the adoption of this policy.

Increase Billing for Services by Implementing Monthly Audits

Existing memoranda of understanding between the MHD and the Medicaid HMOs allow billing for a specific set of services. Data suggest that more Medicaid insured clients receive services than are billed (CMHD 2005b). By raising its billing level, the MHD would increase revenue. The health department has taken steps to try to increase the number of services billed by requiring that a billing form be completed for all clients and that all clients are queried in Passport. However, site visits suggest that these policies are not always followed.

The MHD could ensure the full implementation of these policies via monthly audits. To conduct audits, all billing forms and checklists (for a sample checklist, see Appendix G) would need to be sent to the MHD clinic operations administrative staff, who would compare them to the total number of services provided. However, to make such audits possible, the clinics would have to keep accurate records of services provided. Although clinic flow sheets exist as Excel spreadsheets, we have noticed sufficient inaccuracies to warrant a better auditing standard. For example, a 2005 Northwest Family Clinic flow sheet indicated that during a seven-month period, only one client was served. However, the same flow sheet showed 97 services administered. Additionally, a 2005 Keenan Family Clinic flow sheet indicated that no clients were served, yet 71 services were administered (CMHD 2005c). These examples call into question the accuracy of the information on the clinic flow sheets. The MHD should explore alternative methods of tracking and reporting clinic activities. For example, the clinics could

track services using Microsoft Access or SPHERE, a web-based Wisconsin health data repository in use at some MHD clinics. Currently, SPHERE only includes information for Family Health clients (Rach 2006). For auditing purposes, all clients would have to be entered in SPHERE. From this, the MHD could accurately quantify the number of services provided.

Through our conversations with staff at other health departments we learned that other health departments conduct audits. The Marion County health department, for example, does not perform formal clinic audits, but rather checks new client information against existing information (Rowley 2006). One the other hand, King County Health Department has an established audit procedure. There, each encounter is recorded in Signature, a computer software program offered by Siemens. Client eligibility is then queried using WaMed, a web-based software maintained by the Washington Medicaid program. The billing forms for all clients who have stated that they do not have Medicaid coverage or whose coverage was not verified by WaMed are sent to the health department's main office. Once every three months, main office staff re-check Medicaid eligibility of all non-Medicaid clients using a web-based software called Megabatch that allows verification in bulk. The KCHD estimates that Medicaid eligibility is determined for 70 percent of all clients queried in Megabatch. It is important to note that while the KCHD has up to a year to bill Medicaid, the MHD must bill within 90 days. This means that the MHD would have to perform audits more often than the KCHD (Anderson 2006).

We estimate that the audit should not take more than eight hours a month to complete, because the audit involves counting forms and then comparing these to the numbers from improved clinic flow sheets. This includes time to follow up with the clinics about proper procedures in cases of discrepancies. To estimate the cost from having the audit performed, we used staffing costs from the 2006 budget. We suggest that tabulation of the audit be performed by an accounting assistant and the enforcement of policies by the clinic operations manager; by allocating half of the audit task to each the audit would cost $2,100 annually (City of Milwaukee 2006b). These estimates are only for the basic audit and do not include an estimate for a more in-depth audit using the checklists as an audit trail. In addition, there would be some costs associated with the improvement of flow sheets at the clinic level, including software and training costs.

The downside of this policy alternative is that it would increase the administrative burden on MHD clinic and main office staff. In addition, even if the MHD finds through its audits that the clinics are not fully implementing these policies, there may be little that they can do to penalize the clinics, which could lead to enforcement problems. For these reasons, this alternative has only moderate feasibility for improvement. In terms of the second policy evaluation criteria, monthly audits would increase the number of services billed, thereby raising

revenue. Finally, the level of service provided to MHD's target population would be unchanged, satisfying our first evaluation criteria.

Increase Billing for Services by Implementing Incentives

While the previous alternative increases billing through monitoring, this alternative does so through an incentive program. Under the status quo, insurance reimbursements go directly to the City of Milwaukee. The MHD does not directly receive any benefit from billing (Reed 2006). To encourage health center employees to fully implement billing procedures, we propose that some portion of the reimbursements go to the clinics themselves. This money could be placed in a discretionary fund, to be used by the clinics to purchase equipment, improve infrastructure, or conduct trainings. These funds should not be treated as part of the clinics' budgets; clinics should not be penalized, via decreased annual city funding, for increasing reimbursements. By remitting some portion of the reimbursements to the clinics, clinic staff would be motivated to increase billing. The increase in revenue resulting for this policy alternative would be the same as under the previous policy minus the percent remitted to the clinics.

Through our conversations with staff at health departments in other cities, we learned that some receive a portion, if not all, of the revenue from their clinics. Both the King County and the Marion County health departments reported that they receive 100 percent of their reimbursements (Allen 2006, Rowley 2006). However, these are both countywide health departments.

In terms of the first two policy evaluation criteria, this policy alternative fares well. As with the previous alternative, it should not affect the number of clients served and it should increase revenue. However, this policy alternative might be difficult to implement. Currently, reimbursements for services provided by the clinics go into the City of Milwaukee general fund, which is controlled by the City of Milwaukee Common Council. A vote by the Common Council would be required for any of portion of the reimbursements to be passed through to the clinics themselves. We do not know enough about the Common Council or the general fund to determine whether such a change is likely to be approved. However, we suspect that the MHD is just one of many city agencies whose revenues go directly into the general fund. In that case, the Common Council might be hesitant to approve a pass through of funds to the MHD in that it might set a dangerous precedent (Reed 2006). In addition, we lack strong evidence that doing so will lead to significant revenue increase. For these reasons, we believe that this policy alternative has low implementation feasibility.

Expand Existing Memoranda of Understanding to Cover Additional Services

Another way that the MHD could increase the level of reimbursements would be to expand the list of services billable to Medicaid HMOs. Currently, the MHD is

only able to bill for health checks, vision screening, hearing screening, hemoglobin testing, TB skin tests and therapy, lead screening, immunizations, family care coordination, pregnancy testing, and prenatal care services. However, other health departments bill for additional services, including HIV/AIDS and STD testing. The MHD could increase its reimbursements by billing for these services. To do so, the MHD would have to enter into memoranda of understanding with the Medicaid HMOs.

The MHD does not bill for services provided at the Keenan HIV/AIDS and STD clinic or the Southside STD clinic. The Southside STD clinic provides anonymous services, which would prevent billing. In contrast, the Keenan HIV/AIDS and STD clinic is not anonymous, making billing a possibility. We suggest that the Keenan HIV/AIDS and STD clinic bill for all services except HIV/AIDS testing, which is not offered at the anonymous Southside clinic. Table 5 shows the potential revenue gains from billing Medicaid HMOs for services provided at the Keenan HIV/AIDS and STD clinic.

Table 5:
Potential Revenue from Billing Medicaid

Eleven to 14 percent of the clients at the Keenan Health Center HIV/AIDS and STD clinic are estimated to have Medicaid insurance, but the clinic does not bill Medicaid for these services. This table shows potential revenue the clinics could collect by billing Medicaid.

	11%	14%	Amount billed 2005
Testing	$ 88,800	$ 113,100	$ 0
Hepatitis A and B Immunizations	600	800	0
Treatment	6,000	7,700	0
Total	$ 95,400	$ 121,600	$ 0

Note: Figures are rounded to the nearest hundred.
Source: City of Milwaukee Health Department Clinic Visit Report and Wisconsin Department of Health and Human Services Medicaid maximum fee rates

We estimate that between 11 and 14 percent of the clients at the Keenan HIV/AIDS and STD clinic are Medicaid insured. Administrative data shows that 11 percent of clients self-report Medicaid insurance (CMHD 2005d). However, data from the MHD Immunization Consent Analysis show that Keenan Walk-In clients underreport Medicaid status by 20 percent. Assuming that HIV/AIDS and STD clinic clients underreport at the same rate, the true percentage of clients with Medicaid insurance is 14 percent. Using Medicaid maximum fees and information from the MHD Analysis of Services, billing for these services could increase revenue by $106,600 to $136,100 annually (CMHD 2005e, Wisconsin

Department of Health and Family Services 2006). Between $600 and $800 of this amount is for billing for Hepatitis A and B vaccinations, a service already covered by the Medicaid memoranda of understanding.

To receive reimbursements for most treatments, the MHD would have to be certified as a dispensing physician for pharmaceuticals by Wisconsin Medicaid, which should not be a serious barrier. (Wisconsin Department of Health and Family Services 2006).[6] Billing for treatment may also place an additional burden on clinic and administrative staff if the reimbursement process is different from that for medical services. However, the majority of new reimbursements would come from tests, not treatment. Also, implementation of this policy alternative would require the Keenan HIV/AIDS and STD clinic to obtain access to Passport, which it does not have.

This policy alternative has several weaknesses in terms of feasibility of implementation. The major problem associated with this alternative is that the Medicaid HMOs may be unwilling to expand their lists of billable services. As the Medicaid HMOs must certainly provide these services with their own networks, they do not want to encourage their subscribers to seek care elsewhere and have no incentive to agree to reimburse MHD for services received by straying subscribers. The Medicaid HMOs only entered into the existing memoranda of understanding with the MHD after a measles outbreak exposed the weakness of the immunization program (Mays 1998). Another potential problem with this alternative is that there may be contractual stipulations in grant awards that limit billable services. The grants that are most likely to interfere with billing are the Sexually Transmitted Diseases Prevention Program grant from the (Wisconsin Department of Health and Family Services, Division of Public Health), and the AIDS Initiative which is part of a Community Development Block Grant. The terms for grants at the HIV/AIDS and STD clinic need to be examined prior to increasing billable services.

In addition, there is some concern that billing Medicaid for HIV/AIDS and STD testing might reduce use. Billing staff at the Marion County health department said that they do not bill Medicaid for these services because they fear it would deter clients. When Medicaid is charged for a service, it appears on the client's billing statement that is sent to the client's home. In many cases, married clients do not want their spouses to know that they are being tested for HIV/AIDS and STDs and therefore might be reluctant to seek services if they know the services will appear on the billing statement. However, while this may deter clients from using the Keenan clinic, the Southside clinic would be available for anonymous testing (Rowley 2006). Because the Southside clinic does not offer anonymous HIV/AIDS testing, we do not suggest billing for these tests at the Keenan clinic.

[6] A dispensing physician must be currently licensed to practice medicine and surgery according to sections 448.05 and 448.07, Wis. Stats., and chapters Med 1, 2, 3, 4, 5, and 14, Wis. Admin. Code.

As all HIV/AIDS and STD clinic services will still be available on a confidential basis either at Keenan or at Southside, the policy should not decrease the level of use of these services.

At first glance, of all of our policy alternatives, this one offers the greatest increase in revenue. However, these initial figures may be deceiving. As a result of this policy, the number of clients seen at the Keenan clinic would decrease while the number at Southside would increase; however, we have no way to estimate the increase in clients seeking testing at the Southside STD clinic that would result. As a result, revenues from the implementation of this policy may be lower than predicted as Keenan clients move to the Southside clinic. The impact of the diversion of these clients on revenues may be significant; at the time we cannot make any reliable estimates of its size.

Sign Memoranda of Understanding with Private Insurance Providers

The MHD is only able to bill Medicaid HMOs. While an estimated 13 percent of MHD health-center clients have private insurance, the MHD does not bill private insurance companies (CMHD 2005b). For the MHD to begin billing for services provided to individuals with private insurance, the MHD would need to enter into memoranda of understanding with private insurance companies. Like the understanding the MHD has with Medicaid HMOs, similar agreements with private insurance companies would include a list of billable services and applicable rates. Clinic implementation of this policy alternative would not be difficult as it would only require clinic staff to ask about private insurance coverage and use Passport to verify eligibility. Passport can be used to verify private insurance eligibility provided that the client has specified his or her private insurance provider. Table 6 shows the increase in revenue that would result from billing privately insured clients for three specific services.

Table 6: Revenue Gains from Billing Private Insurance

Private Insurance	Predicted Revenue	2005 Estimated Annual Revenue	Increase in Revenue
Immunizations	$ 19,900	$ 0	$ 19,900
Health Check Exams	700	0	700
Pregnancy Tests	700	0	700
Total	$ 21,000	$ 0	$ 20,700

Figures are rounded to the nearest hundred.
Source: City of Milwaukee Health Department clinic flow sheets, Analysis of Services, Immunization Consent Analysis, Billing Summary; and Wisconsin Department of Health and Human Services Medicaid maximum fee rates

Using the percentage of clinic clients with private insurance from the Immunization Consent Analysis, we found that this policy could increase clinic

revenue by $21,000 for three services (see Appendix D for details on calculation methods). Our estimate assumes reimbursement at the Medicaid maximum fee, but if the private insurance companies reimbursed at the usual, customary, and reasonable rate, which is higher than the Medicaid rate, revenue would be greater.

This policy should not affect the MHD clinics' ability to serve its target population. In terms of revenue gains, the experience of other cities suggests that revenues may be less than we have predicted. In Columbus, contracts are too new to draw any meaningful conclusions. However, the King County Health Department has been billing private insurance companies for quite some time and does not receive significant revenue from this source. In fact, revenue from billing private insurance companies is so low that KCHD is considering not billing private insurance in the future (Anderson 2006).

While billing private insurance may not make sense for King County, differences between that department and Milwaukee's may make billing private insurance more beneficial to the MHD. First, the KCHD estimates that only 3 percent of its clients have private insurance. The estimated percentage of MHD clients with insurance is much higher at 13 percent. Second, if the KCHD were to stop billing private insurance, it would instead directly charge clients for services who could then file claims with their insurers themselves. Whatever is lost by not billing private insurance would then be made up by an increase in cash payments by clients. The MHD does not charge clients for services; therefore it does not have an alternate method of collecting payment for these services. For these reasons, we believe that billing private insurance would significantly increase revenue, satisfying our second evaluation criteria.

In terms of feasibility of implementation, private insurance companies have a disincentive to sign memoranda of understanding with the MHD as this might decrease their revenue. However, if the reimbursement rates negotiated between the MHD and private insurance companies were lower than the current cost of services to the private insurer, such an agreement may be mutually beneficial. Certainly this has been the experience of the Columbus and King County health departments. Another possible problem with this alternative is that private insurance companies may not cover these services at all. In this case, a memorandum of understanding would be moot. For these reasons, the feasibility of implementation of this alternative is moderate.

Charge Uninsured and Privately Insured People Flat Fees for Services

Currently, services that are provided to clients who are not Medicaid HMO subscribers are provided free of charge. To increase revenue, the MHD could charge a fee for services provided to these clients. This is done in many areas, including Cleveland, Columbus, Detroit, Maricopa County and Marion County. Fees charged by the MHD could be fixed or based on a sliding scale. To implement

this alternative, the MHD would have to determine the fees and for which services it will charge. There would be some new administrative costs involved in charging a cash fee, in terms of the creation of cash handling procedures, as well as new equipment to accommodate cash transactions. The MHD has many options in terms of the fees it charges. For the purpose of this analysis, we examine a fixed $5 fee for all Family Health and Walk-In clinics. This would increase clinic revenue by $20,300 to $37,300. This estimate includes the likely decrease in the number of clients using the clinics, which we estimated to be between 8 and 50 percent.

When weighed against its cost, this alternative would still bring in significant additional revenue. Purchasing cash registers for all three health centers would cost between $300 and $900. In addition, the MHD would have to pay for cash register supplies and receipts, deposit slips, and other banking materials. (See Appendix I for further cost estimates) We have assumed that courier service can be secured free of charge based on discussion with a local bank.

While this policy alternative would certainly increase revenue, it would likely decrease the MHD's ability to serve uninsured and underinsured people. Staff at the Marion County and Columbus health departments stated that their departments' policies of charging a flat fee for services had not decreased the amount of clients using its clinics. However, research shows that charging for medical services decreases the use of these services. For example, when the state of Utah increased its Medicaid copayments from $2 to $3 per visit, the number of physician visits dropped from roughly 600 per 1,000 enrollees to fewer than 500 visits per 1,000 enrollees. Similarly, enrollment in Medicaid in Oregon dropped by nearly 50 percent when the state raised its monthly Medicaid premium (Ku and Wachino 2005). In addition, a study of the California Medicaid program conducted almost 30 years ago found that requiring a $1 co-payment for doctor visits reduced demand by 8 percent (Helms, Newhouse, and Phelps 1978). Given the results of these studies, it seems likely that if the MHD implements a fee for service policy, the number of clients using the clinics' services will decrease. This would compromise the MHD's mission to serve the underinsured and uninsured and provide preventative care.

As a result, this policy will certainly meet with resistance from health center staffs. From our conversations with these individuals, they clearly believe their job is to help those in need, regardless of expense. Given this, health-center staff are unlikely to implement this policy, making its feasibility low.

In Appendix J, we offer an alternative to address the overall problems involved with increasing revenue, a proposal to centralize client intake. Even though this alternative would not increase revenue, it would decrease health-center costs, and thus achieve the same underlying goal. Because this alternative is not within the scope of increasing revenue, we do not include it in the body of the report.

Recommendations

Of all the policy alternatives that we consider, we believe that following options will best fulfill the goal of increasing revenue while maintaining the level of services provided to uninsured and underinsured people. Based on our analysis, we recommend that the MHD:

- **Standardize and Enhance Clinic Processes:** The MHD should refer all uninsured clients to Medical Assistance Outreach, employ a billing checklist, and change potentially confusing intake forms.
- **Monitor Billing Processes:** The MHD should increase billing by implementing monthly audit procedures, performed by MHD clinic operations staff.
- **Increase Existing Revenue Streams:** The MHD should investigate the possibility of extending the memoranda of understanding it has with the three Medicaid HMOs operating in the area to permit reimbursement for additional services such as STD testing and treatment.
- **Identify and Establish New Revenue Streams:** The MHD should investigate the feasibility of entering into similar agreements with the private insurance companies in the area.

Sources

Anderson, Vanessa. 2006. King County Health Department, Fiscal Specialist. Telephone interview by Emily Pope. April 19, 2006. Notes in possession of Emily Pope.

City of Milwaukee. 2006a. City of Milwaukee 2006 Plan and Budget Summary: Health Department Executive Summary. Accessed February 23, 2006, from http://isdweb1.ci.mil.wi.us/citygov/doa/bmd/adoptedbook.pdf.

City of Milwaukee. 2006b. City of Milwaukee 2006 Health Department Budget and Personnel Allocation. Provided by Jennifer Meyer-Stearns, January 27, 2006.

City of Milwaukee Department of City Development. 2000. 2000 Census Data: Milwaukee Urban Atlas. Accessed February 11, 2006, from http://www.mkedcd.org/planning/data/pdfs/UrbanAtlasMilwaukeeComparison.pdf.

City of Milwaukee Health Department. 2006. About Us. Accessed February 17, 2006, from http://www.ci.mil.wi.us/display/router.asp?docid=404.

City of Milwaukee Health Department. 2005a. Clinic Schedules.

City of Milwaukee Health Department. 2005b. Immunization Consent Analysis.

City of Milwaukee Health Department. 2005c. Clinic Flow Sheets.

City of Milwaukee Health Department. 2005d. Analysis of Services.

City of Milwaukee Health Department. 2005e. Clinic Visit Report. January 1, 2006.

City of Milwaukee Health Department. 2005f. Clinic Billing Summary. July 2005.

City of Milwaukee Health Department. 2005g. Walk-In Survey.

City of Milwaukee Health Department. 2004. City of Milwaukee Health Department Annual Report 2004: Family and Community Health Services. Accessed February 20, 2006, from http://www.city.milwaukee.gov/display/displayFile.asp?docid=404&filename=/Groups/healthAuthors/ADMIN/PDFs/MHD_2004_Annual_Report.pdf.

City of Milwaukee Health Department. Undated. Memorandum of Understanding between the City of Milwaukee Health Department and a public insurance provider.

Clark, Anita. 2006. Columbus, Ohio Health Department. Telephone interview by Emily Pope. April 6, 2006. Notes in possession of Emily Pope.

Helms, L. Jay, Joseph P. Newhouse, and Charles E. Phelps. 1978. Copayments and the Demand for Medical Care: The California Medicaid Experience. The Rand Corporation: February 1978. Accessed April 1, 2006, from http://www.rand.org/pubs/reports/2005/R2167.pdf.

Ku, Leighton, and Victoria Wachino. 2005. The Effects of Increased Cost-Sharing in Medicaid: A Summary of Research Findings. Center for Budget and Policy Priorities: July 7, 2005. Accessed April 1, 2006, from http://www.cbpp.org/5-31-05health2.pdf.

LeBourgeois, Michele. 2006. Phone interview with MHD Clinic Operations Manager by Victoria Deitch. February 27, 2006. Notes in possession of Victoria Deitch.

Leigh-Gold, Mildred. 2006. In-person interview with Well Woman Program Manager from the Milwaukee Health Department by Victoria Deitch. February 24, 2006. Notes in possession of Victoria Deitch.

Mays, Glen. 1998. Case Study: The Local Health Department's Role in Milwaukee's Managed Care Market. In Halverson, Paul and Arnold Kaluzny, Curtis McLaughlin, Glen Mays (Eds.), Managed Care and Public Health, Gaithersburg, MD: Aspen Publishers.

Medical Assistance Outreach Program. 2006. Outreach and Referral Data for 2005. Provided by Nora Deberry.

Passport Health Communications, Inc. 2006. Passport OneSource Solutions. Accessed March 4, 2006, from http://www.Passporthealth.com.

Rach, Jan. 2006. E-mail interview with Nursing Supervisor from Southside Health Center by Eric Thomasgard. April 21, 2006. E-mail in possession of Eric Thomasgard.

Reed, Ali. 2006. In-person interview Policy Compliance Analyst, City of Milwaukee Health Department by Victoria Deitch. March 10, 2006. Notes in possession of Victoria Deitch.

Roberts, Paula, Nora Deberry, and Rodney Wilson. 2006. In-person interview with Medical Assistance Outreach Program by Victoria Deitch. February 24, 2006. Notes in possession of Victoria Deitch.

U.S. Department of Agriculture, Food and Nutrition Service. 2005. WIC at a Glance. Accessed April 21, 2006, from http://www.fns.usda.gov/wic/aboutwic/wicataglance.htm.

Wisconsin Department of Health and Family Services. 2001. Pharmacy Covered Services and Reimbursement. Accessed February 27, 2006, from http://dhfs.wisconsin.gov/medicaid2/handbooks/pharmacy/covered/pdfs/covered-services.pdf.

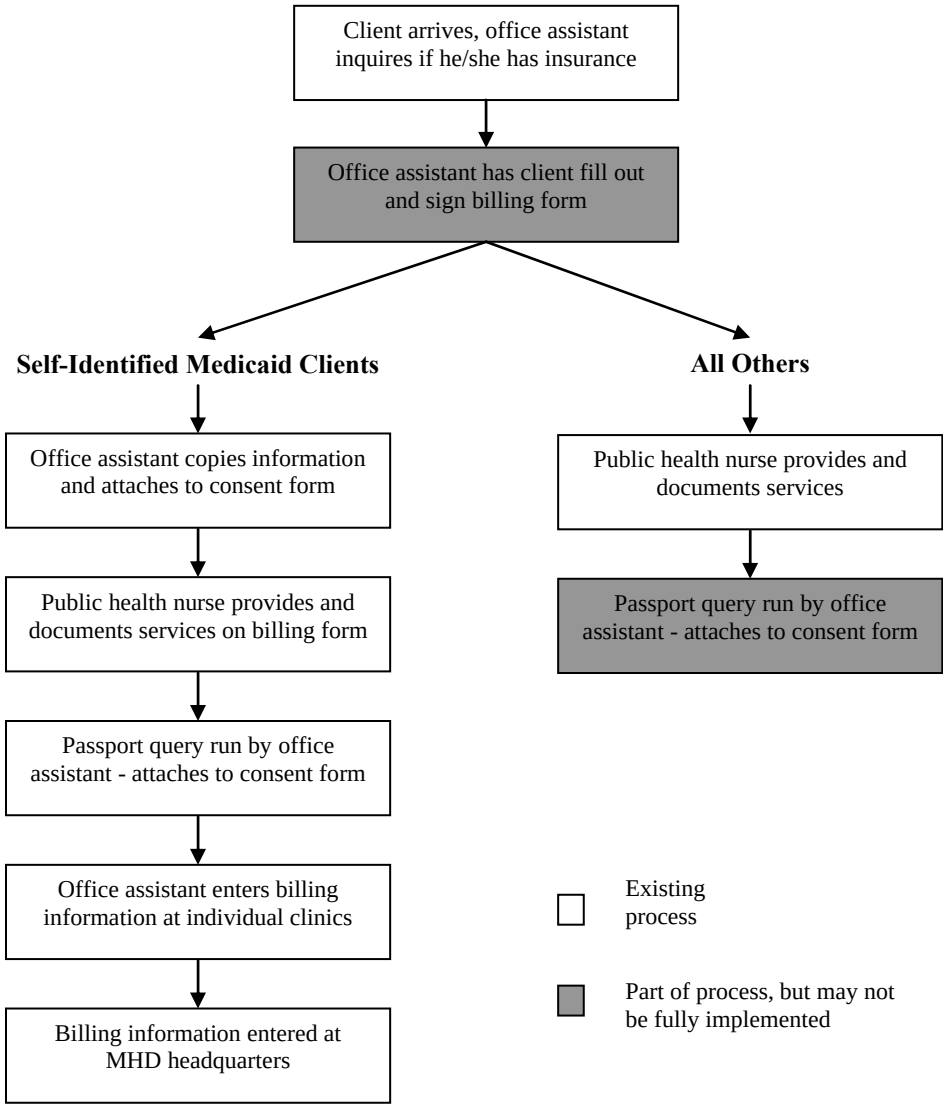
Wisconsin Department of Health and Family Services. 2006. List of Medicaid Fee Schedules for Downloading. Accessed February 25, 2006, from http://dhfs.wisconsin.gov/medicaid4/maxfees/maxfee.htm.

Wisconsin State Statutes. 2006. Statute §609.32(2). Accessed April 21, 2006, from http://www.legis.state.wi.us/statutes/Stat0609.pdf.

Appendix A: Policy Evaluation Criteria/Alternatives Matrix

Evaluation Criteria	Definition of Success	Status Quo	Process Changes	Increase Billing for Services by Implementing Monthly Audits	Increase Billing for Services by Implementing Incentives	Expand Existing Memoranda of Understanding to Cover Additional Services	Sign Memoranda of Understanding with Private Insurance Providers Operating in the Area	Charge Uninsured and Privately Insured Clients Flat Fees ($5) for Services
Serve Target Population	Serve uninsured and underinsured clients	High: Serves large number of uninsured and underinsured clients	High: Client service increased through more referrals to Medical Assistance Outreach Program	High: Client pool would be unaffected	High: Client pool would be unaffected, with potential increased quality of care from reinvestment	Medium: Would serve clients but may deter clients from seeking some services	High: Client pool would be unaffected	Low: May discourage uninsured and underinsured from coming to public health centers
Efficiency	Increase revenue	Low: Not maximizing revenue	High: Would increase revenue by making billing process consistent	High: Would increase revenue by billing for more services	Medium: Depends on change in reimbursements	High: Would increase revenue by billing for more services	High: Would increase revenue by having more billable clients	High: Would increase revenue by charging clients who are not billable
Implementation Feasibility	Acceptable to stakeholders	High: Easy to keep current practices	Medium: Imposes greater burden on MHD clinic staff	Medium: Requires additional staff work to perform audits and may require capital investment to improve clinic flow sheets	Low: Common Council reluctant to approve incentives High: Clinic staff has motivation to increase billing	Medium: May be more work to bill additional services and will require renegotiated contracts	Medium: Private insurance companies may be reluctant to reimburse for services already provided Medium: Requires MHD to craft and negotiate private memoranda of understanding and may involve additional administration	Medium: May require greater administrative oversight, increased staff workload, and cash handling controls

Appendix B: Current Billing Processes at MHD Walk-In Clinics



Appendix C: Data Sources Used for Estimating Insurance Coverage Rates and Potential Increases in Revenue

The MHD provided us with several sources of data to help us conduct our analysis. In some cases, the data in one source contradicted the data in another. Our estimates were made using the data sources that we believed to be the most accurate. This was usually the data source with the best explanation of methodology. As we are not completely confident in the data provided, we cannot be wholly confident in our estimates. The data sources we used are discussed in the paragraphs below.

(1) Immunization Consent Analysis

This analysis used administrative data to determine the true percentage of clinic clients with Medicaid insurance. For January, May, and June 2005, MHD summer interns ran a query in Passport for each client to determine the true percentage of clients with Medicaid. Clients of the walk-in clinics must identify their status as one of the following: no health insurance, health insurance does not pay for the vaccine, medical assistance, Native American, or unknown. For our analysis we assumed "health insurance does not pay for the vaccine" indicates private insurance.

We used this data source to estimate the percentage of clinic clients by insurance status. Of the available data sources, we believe that the Immunization Consent Analysis is the most accurate because it is the only data we have that is not based solely on self-reporting. The limitations of the Immunization Consent Analysis are that we do not have complete information about how the analysis was conducted, we think that it may be possible that clients' insurance statuses may have changed between when they accessed the clinic and when they were queried in Passport, and we have no way to verify the accuracy of the data. In addition, there are many different Medicaid plans and some may not cover the services that clients receive at the clinics. As a result, the percent of clients who have Medicaid may be higher than the percentage of services that can be billed.

(2) Clinic Flow Sheets

Clinic flow sheets serve the purpose of tracking general services provided at the clinics. Clinic flow sheets state the number of visits, number of Medicaid clients, and number of Medicaid clients billed. We used data from clinic flow sheets for June 2005 to December 2005 from the Walk-In and Family Health clinics. We used the clinic flow sheets to establish the number of services provided. Clinic flow sheets were the only data source available to us that had number of services.

Although we used the data from these flow sheets for many of our calculations, we have reason to believe that they may not be entirely accurate. For example, a 2005 Northwest Family Clinic flow sheet indicated that during a seven-month period only one client was served. However, the same flow sheet showed 97

services administered. Additionally, a 2005 Keenan Family Clinic flow sheet indicated that no clients were served, yet 71 services were administered. These examples call into question the accuracy of the information on the clinic flow sheets. Even though we doubt the accuracy of the flow sheets, we used them in our estimates because they were the only source of total services provided.

(3) Analysis of Services

The Analysis of Services provides billing information by procedure code for billable services provided in the TB clinic for 2005 and for other billable services from June 2005 to December 2005. Detailed billing information on pregnancy tests was not provided. We used this data to estimate annual billing by the MHD under various policy alternatives and to determine the average immunization fee. The MHD billing summary provided similar information, however, we decided against using its information because in some cases it could not be linked back to the Medicaid maximum fee rates. The limitations of the analysis of services are that the rates are sometimes above what the Medicaid HMOs will reimburse and information provided does not always correspond with information found on the billing summary.

(4) Walk-In Clinic Survey

We used data from the MHD Walk-In Clinic Survey to derive demographic statistics about the client population. The Walk-In Clinic Survey was conducted in the summer of 2005 and the beginning of fall 2005 at the Walk-In Clinic at Northwest and Southside Health Center. The survey collected information on access to care, satisfaction with the health department clinic, insurance status, and demographic information. The survey was voluntary and available to all Walk-In clinic clients. We chose not to use data from this survey in our revenue estimates because we thought it might be unreliable. First, the number of clients surveyed was very low when compared to the number of clients who accessed the clinics during that time. Second, those clients who chose to fill out the survey may have had different characteristics and backgrounds from those who chose not to answer, which would skew the results of the survey. Finally, only Walk-In clinic clients were surveyed and they may not be representative of all clinic clients. Although we did not use data from this survey in our revenue estimates, we did use it to determine the demographics of the clinic population as it was the only source of such information.

(5) Clinic Visit Report for STD and HIV/AIDS Clinic at Keenan Health Center

The Clinic Visit Report shows self-reported demographic and insurance information by clients for 2005. It also gives details of testing and treatments administered by the clinic. There are no obvious errors in the report.

(6) Billing Summary

The billing summary is a summary of billing activity from 2003 to July 2005. It shows the number of claims submitted, amount billed, and amount received by broad service categories.

Appendix D: Data Calculations

Our analysis attempts to calculate the amount of potential revenue that could be captured by implementing our policy alternatives. To estimate revenue increases, we used data from the Immunization Consent Analysis to estimate the fraction of clients in each insurance status, data from the clinic flow sheets to estimate number of services provided, and data from the Analysis of Services, the MHD billing summary, and Wisconsin Medicaid maximum fee rates to estimate reimbursement rates.

It is important to note that while it is possible to increase clinic revenue, this will not make them profitable. This is because the clinics can bill only at the Medicaid rate, which is often lower than the cost of providing the service, which is captured in the usual, customary, and reasonable rate (UCR). For instance, the Medicaid maximum fee for pregnancy testing is $8.74 while the UCR is $54.85. This means that the MHD loses $46.11 for each pregnancy test provided (Wisconsin Department of Health and Family Services 2006).

Share of Services by Insurance Status of Clients

Based on the Immunization Consent Analysis, 34 percent of all clinic clients have Medicaid insurance and 13 percent have private insurance. Our estimates show that the clinics are losing 43 percent of the potential revenue by not billing for all Medicaid insured clients. Based on this information, we estimate that 57 percent of all Medicaid insured client, or 19 percent of the total client population, are billed.

For the purpose of our analysis, we assumed that clients used the clinics at the same rate, regardless of their insurance status. This means that since Medicaid insured clients made up 34 percent of the clinic population, we assumed that they received 34 percent of clinic services. Likewise, clients with private insurance were assumed to receive 13 percent of clinic services. For our estimates we use the insurance status and number of services at each health center.

To estimate the fraction of clients with Medicaid insurance at the Keenan HIV/AIDS and STD clinic, we used clinic administrative data and information from the Immunization Consent Analysis. According to clinic data, 11.5 percent of clients self-report Medicaid insurance. However, from the Immunization Consent Analysis, we know that clients underreport Medicaid insurance. At Keenan, the Immunization Consent Analysis showed that Medicaid insured clients underreport Medicaid by 20 percent. That suggests that the true fraction of clinic clients with Medicaid insurance is 14 percent. In our analysis, we assume that the percentage of Keenan HIV/AIDS and STD clinic clients falls in the range of 11 to 14 percent and present revenue estimates accordingly.

Services

Our analysis focuses on immunizations, pregnancy tests, and health check exams. We focus on these three services because we have the most information on them. Clinic flow sheets from the Walk-In and Family Health clinics were used to estimate annual numbers of services provided. For estimates pertaining to STD testing and treatment, the Clinic Visit Report from the HIV/AIDS and STD Clinic at Keenan Health Center was used.

The majority of reimbursements are from immunizations. From June to December 2005, an average of 1,350 immunizations was administered each month. During the same period, on average 39 pregnancy tests and nine health checks were administered each month.

Table 7: Specified Services June 2005 – December 2005

	Health Center			Total for	Monthly
Service	Keenan	Northwest	Southside	Health Centers	Average
Immunizations	1,364	1,665	6,454	9,483	1,355
Health Check Exams	14	14	37	65	9
Pregnancy Tests	113	40	118	271	39

Source: City of Milwaukee Health Department clinic flow sheets

Data from the clinic flow sheets were not on an annual basis. To annualize the information, we converted it to a monthly average and then to an estimate of services that would be provided annually. Table 8 below shows the annualized number of services using information from the clinic flow sheets.

Table 8: Estimate of Annual Number of Specified Services

	Health Center			
Service	Keenan	Service	Keenan	Total
Immunizations	2,338	2,854	11,064	16,256
Health Check Exams	24	24	63	111
Pregnancy Tests	194	69	202	465

Source: City of Milwaukee Health Department clinic flow sheets

Reimbursement Rates

To determine reimbursement rates, data from the Analysis of Services, the MHD billing summary, and Medicaid maximum fee rates were used. Table 9 shows the reimbursement rate used from immunizations, pregnancy tests, and health check exams.

Table 9: Reimbursement Rates Used in Estimates		
Service	**Rate**	**Source**
Immunizations	$10.53	Average from the Analysis of Services
Health Check Exams	$55.31	Medicaid maximum fee
Pregnancy Tests	$8.74	Medicaid maximum fee

Source: City of Milwaukee Health Department clinic flow sheets; and
Wisconsin Department of Health and Human Services Medicaid maximum fee rates

In our analysis, we used $8.74, which is the Medicaid maximum fee, as the reimbursement rate for pregnancy (Wisconsin Department of Health and Family Services 2006). In addition, the existing MHD revenue numbers from the 2005 billing summary were adjusted down to reflect this rate of $8.74. In 2005, the MHD billed pregnancy tests at the UCR, which is $54.85. Pregnancy tests are a new billable service and the MHD is billing at the UCR in the hopes that the Medicaid HMOs will pay the higher rate. However, the HMOs likely will just pay the Medicaid maximum fee. The adjustment was needed to put the numbers on the same reimbursement rate and to avoid overstating the potential revenue from pregnancy tests.

The fee used for immunizations was $10.53, which is the average fee from the MHD Analysis of Services. Immunizations are billed by type; reimbursement rates from immunizations range from $3.28 to $41.13. However, immunizations with a reimbursement rate of $3.28 are administered most frequently; data showed that of the immunizations billed, 82 percent were charged at $3.28. In addition to the fee for the immunization itself, an administrative fee of $10.85 is charged for the visit. However, clients often receive more than one immunization per visit and so the average administrative fee per immunization is much lower than $10.85. For a health check exam, the average from the billing summary and the maximum fee are both $55.31 (CMHD 2005f, Wisconsin Department of Health and Family Services 2006).

The reimbursement rates used for the testing services provided at the HIV/AIDS and STD Clinic was from the Medicaid maximum fee table (Wisconsin Department of Health and Family Services 2006.). In many cases, several tests are available for each type of STD. The clinic confirmed the test most frequently used for chlamydia, gonorrhea, and genital herpes. In all other cases, the test with the lowest reimbursement rate was used for estimates. Rates for hepatitis A and B immunizations reflect the current billing rates from the Analysis of Services. Rates for treatments are from the Wisconsin Medicaid Pharmacy Data Tables, Legend Drug Maximum Allowed Cost List. Specific reimbursement rate information for services in the Keenan Health Center's HIV/AIDS and STD clinic estimates are given in Table 10.

Fee for Service Revenue Calculation

According to the clinic flow sheets from the Family Health and Walk-In clinics, 661 clients were billed out of 5,397 clients in a seven-month period. On an annual basis this would be 1,133 clients billed out of a total of 9,252 clients. So, if utilization does not decrease, the number of fees collected would decline to 8,119. However, our research suggests that utilization would decrease between 8 and 50 percent if a fee were imposed. In that case, the number of fees collected from clients would be between 4,060 and 7,470 at the Family Health and Walk-In clinics. By charging a $5 fee to uninsured and underinsured people at the Walk-In and Family Health clinics, the MHD would increase revenue by $20,300 to $37,350 annually.

Table 10: Detailed Estimate of Revenue from Billing Medicaid Clients for Services at the KHC HIV/AIDS and STD Clinic				
	Service	**Number of Services***	**Reimbursement Rate**	**Total Reimbursement (if all clients were billable)**
Testing	Bacterial Vaginosis	1,992	$ 27.71	$ 55,198
	Candidiasis	1,996	8.03	16,028
	Chlamydia	5,664	48.50	274,704
	Genital Herpes	281	16.58	4,659
	Gonorrhea	12,577	27.71	348,509
	NGU (non-gonoccocal urethritis)	1,774	-	-
	Syphilis	6,618	5.90	39,046
	Trichomoniasis	2,476	28.22	69,873
	HEP A Vac Adult 1.0ml IM (#1)	1	30.00	30
Treatment	HEP B Vac Adult 1.0ml IM	397	14.13	5,610
	HEP B Vac Ped .5ml IM	2	14.13	28
	HEP B Vac Teen .5ml IM (#3)	2	14.13	28
	Acyclovir 400mg	162	0.12	19
	Amoxicillin 500mg	21	0.07	1
	Azithromycin (Zithromax) 500mg	5,284	10.00	52,840
	Bicillin 2.4MU IM	146	-	-
	Ceftriaxone (Rocephin) 250mg IM	156	4.69	732
	Ciprofloxacin 500mg PO	1,500	0.12	180
	Clindamycin 150mg (2) BID x 7	28	0.20	6
	Diflucan 150mg	26	0.32	8
	Doxycycline 100mg PO	1,276	0.09	109
	Erythromycin 500mg PO QID x 7	56	0.17	10
	Metro-Gel .75%	34	1.10	37
	Metrondidazole 500mg POBID x 7	6,472	0.11	692
	Ofloxacin 400mg BID x 14 D	28	3.50	98
	Permethrin (Elimite) 5% cream	15	-	-
	Pyrethrine RID 1%	48	-	-
	Spectinomycin 2GM IM	10	-	-
	OTC Treatment Recommended	261	-	-
			Total	$ 868,445
		Medicaid Revenue (11%)		**$ 95,529**

*Treatment is in number of pills administered

Source: City of Milwaukee Health Department Clinic Visit Report; Wisconsin Medicaid Pharmacy Data Tables; and Wisconsin Department of Health and Human Services Medicaid maximum fee rates

Appendix E: Client Demographic Information

Limited sources of demographic data for MHD clinic clientele exist. One of the few is from the MHD Walk-In Clinic Survey, conducted in the summer of 2005 and the beginning of fall 2005 at the Walk-In Clinics of Northwest and Southside Health Centers. The survey collected information on access to care, satisfaction with the health department clinic, insurance status, and demographic information. The survey was voluntarily available to all walk-in clinic patients (CMHD 2005g).

The survey may have selection bias: people who chose to complete the survey may have different backgrounds than those who chose not to participate. The survey was conducted during three months and had 454 participants. Comparatively, based upon clinic flow sheet data, Northwest Walk-In Clinic serves 100 clients a month and Southside Walk-In Clinic serves 500 clients a month. This indicates that survey participation was relatively low.

All clinics may not serve the same clientele; the walk-in clinic population may be different than that of other clinic segments. The survey cannot be generalized to other clinic populations with great confidence. However, based on our observations, Keenan Health Center clients are relatively similar to clients at Northwest Health Center, so if generalization is required, clients at Keenan are the same as the clients at Northwest.

Client Demographic Information - Walk-In Clinics[7]

Surveys were completed primarily by adults, but most survey respondents were seeking services for their children at Walk-In Clinic. The survey data show variation in clientele by health center. Southside Health Center has a high percentage of Latino clientele whereas Northwest Health Center has a high percentage of African American clients. The survey results show that both health centers are serving primarily low-income families with children. The following series of tables shows the demographics of the people using the clinics and who answered the survey.

Table 11: Most People are at Walk-In Clinic for their Children

Most services administered at Walk-In Clinic were to children. The majority of clients at Walk-In Clinic have children. Most clients have one or two children, however one-third have three or more.

		Northwest	Southside	Total
Are you here today for yourself, your children, or both?	Yourself	30%	37%	34%
	Your Children	54%	52%	53%
	Both	17%	11%	13%

Source: City of Milwaukee Health Department Walk-In Survey

[7] Percentages are of respondents only.

Table 12: Most People at Walk-In Clinic have Children

Most services administered at Walk-In Clinic were to children. The majority of clients at Walk-In Clinic have children. Most clients have one or two children, however one-third have three or more.

		Northwest	Southside	Total
How many children younger than 18 live in your household?	None	22%	16%	18%
	1 – 2	46%	51%	50%
	3 – 4	21%	21%	21%
	More than 4	11%	11%	11%

Source: City of Milwaukee Health Department Walk-In Survey

Table 13: Southside has a High Percentage of Latino Clients

The clientele at the health centers vary by ethnicity. Southside Health Center generally serves the Latino community, whereas Northwest serves primarily non-Latino clients.

		Northwest	Southside	Total
What is your ethnicity?	Hispanic or Latino	6%	52%	36%
	Non-Hispanic or Latino	85%	41%	56%
	Don't Know	10%	7%	8%

Source: City of Milwaukee Health Department Walk-In Survey

Table 14: Client Race Varies by Health Center

Northwest Health Center serves more African-American clients than Southside Health Center.

		Northwest	Southside	Total
What is your race?	American Indian or Alaska Native	5%	1%	3%
	Asian	7%	8%	7%
	Black or African American	53%	11%	27%
	Native Hawaiian or Other Pacific Islander	3%	1%	2%
	White	25%	32%	30%
	Other	7%	43%	30%
	Don't Know	0%	4%	2%

Source: City of Milwaukee Health Department Walk-In Survey

Table 15: Client Age Varies by Health Center

The health centers primarily serve people younger than 64.
Northwest Health Center generally serves people ages 18-25.
Southside mainly serves people age 35 to 64.

		Northwest	Southside	Total
What is your age?	12-17	6%	2%	4%
	18-25	40%	25%	31%
	26-34	24%	28%	26%
	35-64	26%	44%	38%
	65-older	4%	1%	2%

Source: City of Milwaukee Health Department Walk-In Survey

Table 16: Client Education Varies by Health Center

Health-center clients have a variety of levels of education. Approximately one-third of clients have not completed high school, one-third has completed high school, and one-third have some higher education.

		Northwest	Southside	Total
What is your education level?	Less than high school	13%	18%	16%
	Some high school	16%	18%	17%
	Completed high school or GED	34%	31%	32%
	Associate degree	3%	7%	6%
	Some college	24%	15%	19%
	Completed college	8%	7%	7%
	Professional degree	1%	4%	2%

Source: City of Milwaukee Health Department Walk-In Survey

Table 17: Health Centers Primarily Serve Low-Income Households

The health centers are primarily serving low-income households. The majority of households have less than $15,000 of annual income. There are a small percentage of households with more than $50,000 of annual income utilizing the health centers.

		Northwest	Southside	Total
How much does your household make in a year?	Less than $10,000	51%	40%	44%
	$10,000 - 14,999	12%	20%	17%
	$15,000 - 19,999	11%	10%	10%
	20,000 - 29,999	11%	11%	11%
	$30,000 - 39,999	7%	8%	7%
	40,0000 - 49,999	6%	4%	5%
	50,000 - 59,999	0%	3%	2%
	60,000 or more	3%	4%	4%

Source: City of Milwaukee Health Department Walk-In Survey

Appendix F: Medical Assistance Referral Process

Medical Assistance Outreach Program (MAOP) educates and provisionally enrolls individuals in Medicaid, as well as other programs for which they may be eligible. The county makes final eligibility and enrollment decisions. In addition to assisting in the Medicaid application, MAOP acts as an intermediary, helping the client communicate with the county and medical providers. MAOP follows up with clients to ensure that clients are able to access medical services after enrollment in Medicaid (Roberts, et al. 2006).

MAOP offers services in the MHD health centers, as well as throughout the community. MAOP staff is always available at Southside Health Center where they have their main office. MAOP staff is also available at Keenan Health Center on Wednesdays and Fridays, and at Northwest Health Center on Mondays and Thursdays. The clinics can refer clients to MAOP when MAOP staff is not on the premises by giving client Passport printouts to MAOP staff at a later date (Roberts, et al. 2006). In 2005 the three public health centers referred 519 people to MAOP: 69 from Keenan, 166 from Northwest, and 284 from Southside (MAOP 2006). The majority of MAOP clients are not a result of referrals from the clinics (Roberts, et al. 2006).

The Medicaid application process with MAOP takes approximately 30 minutes if an interpreter is not needed and about 45 minutes if an interpreter is needed. Then it is about 30 days before the county notifies applicants whether they qualified for Medicaid. The process takes longer for BadgerCare because a verification form needs to be filled out by an individual's employer about the amount of health insurance that is paid by the employer. Pregnant women have presumptive eligibility that allows them to receive care under Medicaid while their application is being processed. A recent change in Medicaid allows pregnant women who have been in the United States for less than five years to qualify for presumptive eligibility. Other Medicaid services are not available to people who have not been in the United States for five years (Roberts, et al. 2006).

Appendix G: MHD Billing Process Checklist

Sample checklist for a hypothetical walk-in immunization client.

Intake

Office Assistant: **Date:**

___ Client's insurance status (circle one)

None Private Medicaid Medicare Other (specify) _____

___ Passport printout attached

___ Signed billing form attached

If uninsured:

___ Refer uninsured to Medical Outreach Assistance Program

MAOP staffer referred to: _____

Service Provision

Public Health Nurse: **Date:**

___ Billing form completed for services provided

Clinic Billing

Office Assistant: **Date:**

___ Billing and insurance information entered

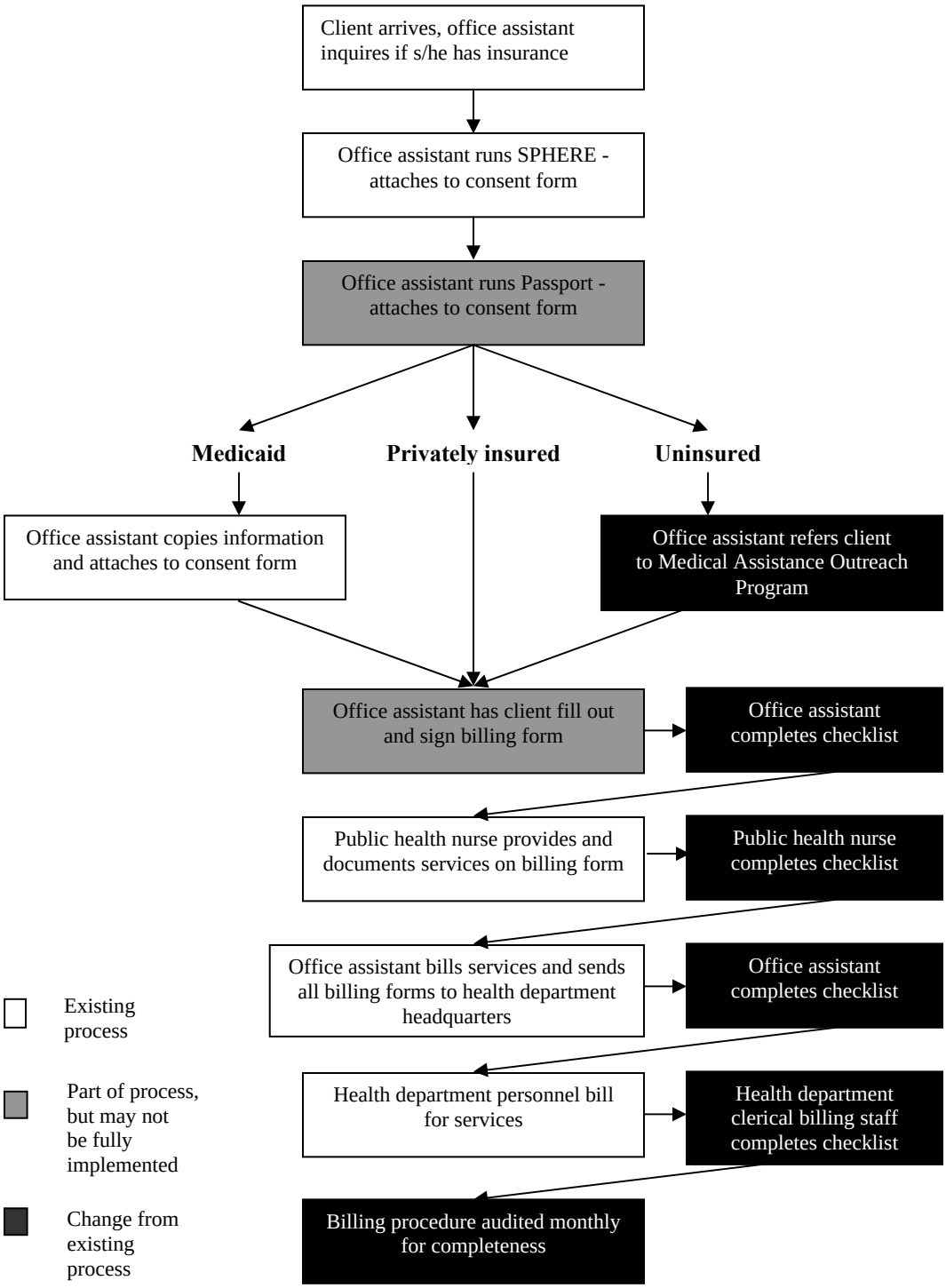
___ Billing and records information forwarded to MHD administration

Headquarters Billing:

Clerical Assistant: **Date:**

___ Billing and insurance information entered

Appendix H: Map of Billing Processes with Policy Alternative to Increase Billing For Services by Implementing Monthly Audits (Walk-In Clinic Example)



Appendix I: Cost of Implementing a Cash Fee

To implement a cash fee for health department services, cash-handling procedures will need to be in place, as well as new equipment to accommodate cash transactions. A secure cash register or cash box will need to be in each of the health centers. The cash register would keep cash more secure than a cash box and would keep track of transactions for balancing the register. However, cash registers are more costly than cash boxes. On the other hand, a cash box would require a secure location to store the cash box (e.g. a locked drawer).

The register will need to be balanced by one staff person and then verified by another staff person. Deposit forms should be signed and verified by two people. The health department can have two people go to a nearby bank to make a daily deposit or arrange to have a courier pick up the deposit. This outlines some general cash handling procedures, but the health department will want to devise specific cash handling procedures prior to implementing this alternative.

The cost of implementing a cash fee varies based on the cash handling procedures implemented by the health department. According to Office Depot, a cash register would cost between $100 and $300 depending on what features the health department wants. For all three health centers to have cash registers, the cost would be between $300 and $900, whereas a cash box costs $10 to $25 ($30 to $75 for all three health centers). Based on information from Milwaukee Western Bank, we assume that courier service can be secured free of charge.

Appendix J: Reduce Health-Center Costs By Centralizing Intake Operations

This option is not being offered as a policy alternative because we feel that it outside of the scope of our project goal of increasing clinic revenue. Though centralizing intake would not increase revenue, it would decrease health-center costs, and thus achieve the same underlying goal. Northwest Health Center has recently implemented a centralized intake system, so this suggestion is only for Southside and Keenan health centers.

Centralizing intake operations has two potential benefits. First, it would raise the productivity level of the staff within each health center. We noticed after several health center visits that some clinics were busy at certain times of the day and others were not. Currently, a rigid personnel system prevents staff from moving from slow areas to busier areas when necessary. Greater flexibility in allowing employees to switch roles to meet client demand would solve this problem. This may also have the added benefit of increasing staff satisfaction by adding more variety to their work and by relieving overburdened individuals of some of their work. A centralized intake system may also make more efficient use of health-center space. For example, in Keenan, there are four clinics with four intake areas; a centralized intake protocol can make some of these rooms available for other purposes. A centralized intake system may also have the additional benefit of reducing the potential stigma associated with specific services, such as HIV/AIDS and STD testing.

To facilitate centralized intake operations, the software used for each clinic would need to be on all computers in the centralized intake area. Currently, not all of the computers in the health centers have access to all of the software used by the various clinics. The software used by health centers consists of online databases and Windows operating systems and thus does not require dedicated terminals. Therefore, computer software does not present a significant barrier.

Centralizing intake may require costly infrastructure changes to the health centers. We do not have an estimate for the cost of infrastructure changes, but greater changes would probably be required at Keenan Health Center and thus the cost at Keenan would likely be greater than at Southside Health Center. The cost of infrastructure changes may pose a barrier to centralizing intake.