Obtaining Third-Party Reimbursements: Issues for a Safety-Net Clinic to Consider

Many safety-net clinics that are *not* community health centers/federally qualified health centers (CHCs/FQHCs) are now considering the desirability – of financial necessity – of obtaining third-party reimbursements from Medicaid, Medicare, other public sources, or private insurance companies. There are many philosophical and practical, technical and operational questions and issues to consider. All can be addressed, but it is best to consider them early in the process. Following are some of them.

Financial Needs and Expectations

1. **What are your financial needs through third-party reimbursements? Is there a minimum amount or perhaps a percentage of costs you need to generate?** Sometimes Medicaid or even private insurance reimbursements do not cover actual costs. So if you serve 500 new patients, you have an *additional* deficit on each patient. However, if your clinic uses a lot of volunteer clinicians, then you may be most concerned with obtaining a specific minimum amount that covers costs like rent, equipment, and supplies.

2. **Have you done financial and client analysis and projections?** Do you have a sense of what level of reimbursements is likely or feasible? Have you done patient analysis or projections to determine what proportion of current and potential patients are likely to be eligible for Medicaid or other third-party reimbursements? Have you projected and analyzed expenses and linked them to the patient analysis?

Types of Third Party Reimbursements

3. **Are you planning to seek only Medicaid reimbursements, or also other types of public payments –** State Children's Health Insurance Plan (SCHIP), state/federal Pre-existing Condition Insurance Plan (PCIP, MCIP), Medicare? Which of these make sense, given your patient characteristics?

4. **Are you considering negotiating agreements with private insurance companies that are a part of the health insurance exchanges?** If the Supreme Court allows mandatory health insurance exchanges to go forward, it is likely that a considerable number of people will move from Medicaid to private insurance and back again fairly frequently, especially if they have hourly wage jobs that are heavily influenced by economic conditions, weather, etc. Your patients presumably want to remain with you even if their insurance situation changes, so you may want to contract with one or more insurance providers under the exchange in each state.

5. **Where do your clients live?** Do you have clients from neighboring states as well as the state(s) in which you have facilities? Will you be exploring third party payment sources in those states?

Required Relationships

6. **Are you planning to contract with one or more Medicaid Managed Care Organizations (MCOs)?** Except for special situations (like HIV/AIDS services in DC), most people on Medicaid in the region are now put into MCOs. This means that in addition to being certified for Medicaid, you will need to negotiate agreements with one or more MCOs.

7. **Are you considering relationships with specific private insurers?** This process can be very similar to the MCO negotiations.

8. **Can you get help to negotiate the best rates?** A safety net clinic that is not a CHC/FQHC does not get the "enhanced reimbursement" rate from Medicaid or Medicare. But if you negotiate with an MCO or a private insurer, there is no set reimbursement rate. If you provide outreach or primary care to hard-to-reach clients, you may be able to negotiate extra funds because of the language and cultural competence skills you bring and your ability to reach and service important populations.

9. **Do you have relationships with community health centers and/or federally qualified health centers (CHCs/FQHCs) in your state that might lead them to assist you in negotiating with MCOs or private insurers?** Might these other safety-net clinics want to partner with you and have you do some specific tasks for them, like outreach or navigation? What special relationships or skills can you offer?

Recordkeeping and Billing Capacity

10. **Do you have the electronic medical records (EMR) system needed for documenting services, sharing data, and evaluating outcomes?**

11. **Do you have the capacity to do billing, not just to Medicaid, but to MCOs that may have individualized requirements and forms?**

12. **If you have to develop that capacity, have you determined the cost both for development and for maintaining the necessary billing systems?** Do you have reason to believe that the amount of reimbursements will justify these costs?

13. **To what extent is your primary care association (if any) able to provide some or all the assistance you need in these areas?**

Board Readiness

14. **What will be the role of the Board in decision making and action around third party payments?** Is there agreement about the Board's roles? Are there individual Board members who have special expertise or relevant contacts?

15. **Has your Board discussed third party payment issues and options?** Does the Board have the information needed for decision making? Are there any philosophical issues that need to be resolved? What are the next steps for the Board?

Philosophical and Staff Preparation Issues

15. **Are your staff, particularly clinicians, comfortable with the concept of third party reimbursements?** Do they have any philosophical concerns (other than with regard to reproductive health), or only practical ones? If some of your contracts require charging copayments or using a sliding fee scales, will that be feasible?

16. **Have you thought about staff training to prepare clinicians for learning about billing codes and keeping track of the services they provide?** Are they already accustomed to this because of the DC Alliance? Northern Virginia Health Foundation has provided consultant assistance to several of its grantees to enhance Medicaid billing, and one provider was able to increase reimbursements by 40% by better understanding things like how to bill multiple services provided during the same visit.

Medical Home/Health Home

17. **Are you exploring the feasibility of seeking recognition as a patient-centered medical home?** If so, do you have funding for this effort? Are you looking at other, less demanding models that are a part of health care reform?