Ohio Department of Health
Immunization Program

American Recovery and Reinvestment Act - Immunization Billables
Demonstration Project

Ohio Billables Action Plan

December 28, 2011
Ohio Department of Health Immunization Billables Project
Immunization Billing Action Plan

BACKGROUND

Rationale behind the Billables Project

Strain on the vaccine financing system due to an increase in the number of routinely recommended vaccines and the rising costs of vaccines has challenged the provision of immunization services in Ohio. Moreover, stagnant funding through section 317 of the Public Health Services Act and state general revenue funding (GRF) contributed to Ohio becoming “two-tiered” for some vaccines in the public sector. Children who are not eligible for the Vaccines for Children (VFC) federal entitlement program have been unable to receive these two-tiered vaccines at local health departments (LHDs). At various times over the past few years, Ohio has been two-tiered and unable to provide rotavirus, hepatitis A, and human papillomavirus (HPV) vaccines for non-VFC eligible children.

In 2008, the Ohio Department of Health (ODH) implemented VFC deputization to increase the number of children who could be immunized in the public sector. Over time, VFC deputization enabled ODH to decrease the number of two-tiered vaccines; currently, HPV is the only remaining two-tiered vaccine, although additions to the recommended immunization schedule (e.g., booster dose of meningococcal vaccine) create significant uncertainty regarding the ability to provide vaccines to non-VFC eligible children in the future. Although VFC deputization enables children who are underinsured to receive VFC vaccine in local health departments, the underinsured category is narrowly defined. Only children whose insurance does not cover specific recommended vaccines, children whose coverage does not include vaccines, and
children whose insurance caps vaccine coverage are considered underinsured. Therefore, many children are left without access to routinely recommended vaccines because of high insurance co-payments or deductibles. These children are considered insured for the purposes of the VFC program.

Through the Billables project funded by the Centers for Disease Control and Prevention (CDC) through the American Recovery and Reinvestment Act, ODH seeks to increase reimbursement in the public sector by working with LHDs to implement billing systems for immunization services provided by public health clinics. By beginning to bill private insurance companies for immunizations administered to plan enrolled patients, LHDs will be able to increase operating funds and potentially offer more vaccines. This plan will cover billing for routinely recommended vaccines only (with the exception of seasonal influenza vaccine) and does not include billing for or provision of travel vaccines. According to responses from a local health department survey, 25.1% of Ohio’s LHDs currently bill private insurance companies for immunizations. This indicates a large window of opportunity for more LHDs to begin billing and collecting reimbursement for immunization services.

From additional data collected through the LHD survey, ODH found that 28.4% of LHDs bill private insurance companies for non-immunization services provided at LHD, including tuberculosis testing, women’s health services including prenatal care, sexual health services, dental services, refugee health services, primary care services, family planning, BCMH (Bureau for Children with Medical Handicaps) services, lead testing, and adolescent wellness.
Population Breakdown for Ohio

The 2010 U.S. census results specify that Ohio has a population of 11,536,504, which is a moderate increase from 11,353,140 from the 2000 census. There are 136 public health clinics that are operated by 125 local health districts in 88 Ohio counties.

In order to better define those Ohioans seeking immunization services in LHDs, ODH administered a patient survey to collect relevant information, including insurance status. From June 2010 to September 2010, twelve college interns were assigned to territories within Ohio, and the interns administered patient surveys within LHD clinics in their territories. The surveys collected the following information about a patient receiving an immunization: age of the patient, zip code, previous use of the LHD, reason for using the LHD clinic, and insurance status. If the patient was privately insured, the insurance company name, group number, contact information and co-payment information were collected. Survey collection ended on September 24, 2010 with a total of 9,563 surveys collected. Of these surveys, 87.6 % represented children (age 0-18 years) and 12.4 % represented adults. The following chart represents the breakdown of insurance status of patients presenting at LHD clinics:

<table>
<thead>
<tr>
<th>Insurance Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privately Insured</td>
<td>44.6 %</td>
</tr>
<tr>
<td>Medicaid</td>
<td>37.9 %</td>
</tr>
<tr>
<td>Medicare</td>
<td>1.1 %</td>
</tr>
<tr>
<td>Uninsured</td>
<td>15.4 %</td>
</tr>
<tr>
<td>Other</td>
<td>1.0 %</td>
</tr>
</tbody>
</table>
Regionally, the proportion of privately insured, publically insured (including Medicaid and Medicare), uninsured, and the “other” category varied slightly, with the following distribution:

<table>
<thead>
<tr>
<th>Total Surveys</th>
<th>Northwest</th>
<th>Northeast</th>
<th>Southeast</th>
<th>Southwest</th>
<th>Central</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collected</td>
<td>2577</td>
<td>2229</td>
<td>1100</td>
<td>2722</td>
<td>935</td>
</tr>
<tr>
<td>Privately Insured</td>
<td>53.9 %</td>
<td>48.4 %</td>
<td>43.5 %</td>
<td>36.5 %</td>
<td>34.7 %</td>
</tr>
<tr>
<td>Publically Insured</td>
<td>37.7 %</td>
<td>28.5 %</td>
<td>39.3 %</td>
<td>45.7 %</td>
<td>47.3 %</td>
</tr>
<tr>
<td>Uninsured</td>
<td>7.2 %</td>
<td>21.1 %</td>
<td>16.2 %</td>
<td>17.1 %</td>
<td>17.7 %</td>
</tr>
<tr>
<td>Other</td>
<td>7.0 %</td>
<td>2.0 %</td>
<td>1.1 %</td>
<td>0.7 %</td>
<td>0.4 %</td>
</tr>
</tbody>
</table>

Of the privately insured individuals, more than 70% of the patients were covered by four companies: Anthem Blue Cross and Blue Shield, Medical Mutual of Ohio, United Healthcare, and Aetna. The following provides the breakdown for privately insured patients:

<table>
<thead>
<tr>
<th>Insurance Company*</th>
<th>Number</th>
<th>% of Total Privately Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem</td>
<td>1279</td>
<td>30.0 %</td>
</tr>
<tr>
<td>Medical Mutual</td>
<td>1090</td>
<td>25.6 %</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>382</td>
<td>9.0 %</td>
</tr>
<tr>
<td>Aetna</td>
<td>293</td>
<td>6.9 %</td>
</tr>
<tr>
<td>Aultcare</td>
<td>108</td>
<td>2.5 %</td>
</tr>
<tr>
<td>Frontpath</td>
<td>74</td>
<td>1.7 %</td>
</tr>
<tr>
<td>Cigna</td>
<td>72</td>
<td>1.7 %</td>
</tr>
<tr>
<td>Humana</td>
<td>54</td>
<td>1.3 %</td>
</tr>
<tr>
<td>Allied</td>
<td>51</td>
<td>1.2 %</td>
</tr>
<tr>
<td>CoreSource</td>
<td>31</td>
<td>0.7 %</td>
</tr>
<tr>
<td>Tricare</td>
<td>30</td>
<td>0.7 %</td>
</tr>
<tr>
<td>MedBen</td>
<td>28</td>
<td>0.7 %</td>
</tr>
<tr>
<td>NGS</td>
<td>26</td>
<td>0.6 %</td>
</tr>
<tr>
<td>Paramount</td>
<td>26</td>
<td>0.6 %</td>
</tr>
</tbody>
</table>
Regarding the reason for visit to the LHD for immunization services, patients cited several common reasons, ranging from cost to issues involving lack of vaccine or appointment availability at their primary care provider (PCP) office. Following are the top six patient responses*:

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost (e.g., free vaccine available)</td>
<td>44.4%</td>
</tr>
<tr>
<td>Location</td>
<td>37.2%</td>
</tr>
<tr>
<td>Clinic hours</td>
<td>17.5%</td>
</tr>
<tr>
<td>Vaccine not available at PCP</td>
<td>12.8%</td>
</tr>
<tr>
<td>No appointment available at PCP</td>
<td>7.9%</td>
</tr>
<tr>
<td>High quality of care at LHD</td>
<td>5.2%</td>
</tr>
<tr>
<td>Patient does not have a PCP</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

*Patients were encouraged to check all reasons that applied

The patient survey was essential in building a case for local health departments to begin billing third-party payers for immunizations administered to covered patients in addition to elucidating the reasons for seeking immunization services from public health. An important reason to note is the number of patients who seek immunization services at LHDs because they have no PCP and because the vaccine was unavailable through the PCP. In some counties, the LHDs are the sole provider of childhood immunizations.
**Management of the Immunization Program**

The ODH Immunization Program manages the Vaccines for Children (VFC) program for Ohio, which includes over 1,200 public and private provider sites in 88 counties. LHD clinics comprise about 136 of the VFC providers in Ohio, all of which participate in VFC deputation and can provide VFC vaccine to children meeting the VFC definition of underinsured. Private VFC providers in Ohio are not able to serve underinsured children through VFC and do not receive other government-supplied vaccine for these children.

Ohio is a local (home) rule state, meaning that all LHDs operate autonomously from ODH and are each individually responsible for the health of their own residents. This contributes to the significant diversity in billing experience of LHDs across the state, as well as the type of immunization services provided, beyond vaccine that is currently supplied by ODH.

**PLANNING PROCESS**

**Stakeholder Group**

Stakeholders were selected to include a diverse group of LHD representatives, members of the pediatrician community, a member of the family practitioner community, a representative of community health centers, representation from the state Medicaid program, state agency representatives for insurance, representative billing experts from each organization mentioned, as well as from large private insurance companies in Ohio and Medicaid managed care. Also, several staff members from the Ohio Department of Health and the CDC serve on the Billables stakeholder committee. A list of stakeholders for the Billable Project follows:

- Billing Local Health Departments
  - Immunization Coordinator, Public Health – Dayton and Montgomery County
o Financial Services Office, Public Health – Dayton and Montgomery County
o Office Manager, Summit County Health District
o Management Analyst II- Billing Specialist, Columbus Public Health
o Director of Nursing, Putnam County Health Department

• Non-billing Local Health Departments
  o Director of Nursing, Delaware General Health District
  o Director of Nursing, Findlay City Health Department
  o Director of Nursing, Fulton County Health Department
  o Director of Nursing, Medina County Combined General Health District

• Private Insurers
  o Senior Network Account Manager, United Healthcare
  o Program Manager- Provider Contracting & Reimbursement, WellPoint
  o Program Manager - Provider Contracting & Reimbursement, Anthem Blue Cross
    & Blue Shield
  o Medical Mutual of Ohio

• Medicaid Managed Care
  o Manager - Provider Services, Molina Healthcare of Ohio, Inc.
  o Regulatory Clinical Performance Specialist, CareSource
  o Senior Quality Improvement Coordinator, Paramount
  o Director of Quality Improvement, United Healthcare Community Plan (formerly
    Unison)

• State Agencies
  o Assistant Director - Policy and Research, Ohio Department of Insurance
  o Regulatory Unit Supervisor - Managed Care, Ohio Department of Job and Family
    Services, Office of Ohio Health Plans

• Non-profit Organizations
  o Past Chapter President, Ohio Chapter-American Academy of Pediatrics
  o Director of Community Development, Ohio Association of Community Health
    Centers
  o President, Ohio Association of Health Plans
  o Executive Director, Ohio Academy of Family Physicians

Stakeholder group participants were solicited through their professional organizations, including
those who are represented on Ohio’s Immunization Advisory Committee. The stakeholder group
first met on July 15, 2010. The first meeting included an introduction of the Billables project
and perspectives from local health districts with billing experience.
The Billables project stakeholder group has been vital to the project, advising ODH staff and providing insight from their specific backgrounds that has been useful in planning. Stakeholders have helped develop the data collection methods for the Billables project, as well as helped to disseminate the data and provide direction for the next steps in the project.

Though the Billables stakeholder group represents a large variety of organizations, there were a few additional organizations that would have been beneficial to have serving as a stakeholder for the project. A greater number of private insurance company representatives would be ideal, especially from top insurers in Ohio such as Aetna.

The Stakeholder group met in July 2010, September 2010, November 2010, January 2011, March 2011, May 2011, July 2011, September 2011, October 2011, and December 2011. Meetings were well-attended and included strong representation from both billing and non-billing LHDs. The meetings included excellent discussion and sharing of experiences that were critical in the plan development.

**Determining capacity for local health departments to bill**

To determine the capacity for local health departments to bill for immunization services, an online LHD survey was conducted via SurveyMonkey from October 2010 to January 2011. The survey collected information about LHD experience with collecting patient information and submitting claims, knowledge of current billing codes and attitudes towards implementing a billing system. Upon conclusion of the collection period, a total of 116 surveys were collected,
representing a response rate of 87.9%. Aside from determining the number of LHDs that currently bill third-party payers for immunizations (25.1%), the survey indicated that 87.9% of LHDs currently bill Medicaid fee-for-service and Medicaid managed care plans, and 86% bill Medicare, though this number likely includes LHDs that roster bill for pneumococcal or influenza vaccination.

Responses from the local health department survey indicate that a large proportion (70.9%) of LHDs have reservations about implementing billing systems within their local health departments. Ranked concerns include:

1. No staff or not enough staff to undertake the task
2. Staff not trained
3. Too busy
4. It would take too much time to implement
5. No equipment or insufficient equipment

Although concerns were expressed, the LHDs also indicated that these could be alleviated through training internal staff to successfully bill, providing support for billing related questions, offering further information on the purpose of billing implementation and supplying financial support for equipment and personnel.

*State regulations that impact the Billables Project*

There are no regulations in Ohio that prohibit local health districts from billing insurance plans for immunization services. In fact, survey results indicated that approximately 25% of local health districts bill at least one third-party payer.
Collection of Survey Information

Two surveys were conducted as part of the Billables project - the patient survey administered by college interns and the LHD survey administered via SurveyMonkey. In addition, cost-benefit interviews were conducted with currently billing LHDs. As previously described, patient surveys from immunization clinics indicate that 44.6% of the population seeking immunization services from LHDs are privately insured. Additional breakdown of the data by region, as well as a listing of insurance companies most frequently represented at LHDs, is described in the background section. The patient information collected was extremely useful for the Billables project in identifying the landscape of payers in Ohio, quantifying the number of privately insured visiting LHDs for immunizations, and describing the reasons that patients visit public health clinics. The LHD survey also was useful in assessing the capacity of LHDs to bill.

An additional method of data collection involved conducting cost-benefit interviews with currently billing local health departments. As LHDs indicated that further information on the purpose and benefits of billing would be beneficial, ODH set out to determine the costs, benefits, and overall experience currently billing LHDs had throughout the billing process. Currently billing LHDs were identified and effort was made to select a range of demographically diverse LHDs in order to reflect experience billing from all perspectives. ODH staff composed a survey and conducted face-to-face and telephone conference interviews. Directors of nursing, billing clerks and managers were interviewed from Columbus Public Health, Summit County Health Department, Putnam County Health Department, Steubenville City Health Department, Public Health-Dayton Montgomery County, Erie County Health Department, Toledo-Lucas Health Department, and Ross County Health Department. Information collected included: training time
commitment, experience with credentialing and contracting, full time equivalents (FTEs) utilized for immunization billing, billing software used, and other costs or benefits associated with billing.

From health department surveys, the general consensus was that credentialing and contracting is the most difficult and time-intensive part of the process. Many private insurers, as well as Medicaid managed care plans, have different requirements or processes for credentialing and contracting; however, some do utilize the CAQH (Council for Affordable Quality Healthcare), a free service used to collect provider information. A few LHDs report using both web and server based electronic medical records (EMRs), though most LHDs in the state do not utilize any type of EMR or practice management software (PMS). In general, billing health departments utilize one FTE biller/clerk and utilize billing software. They also report postage, fees and the capital investment associated with their EMR or PMS to be an additional cost, as well as additional computers, printers, telephone lines, fax machines, and office supplies. In addition to these costs, determining eligibility was deemed to be time-intensive, yet vital, in the process of billing. Electronic data interchange (EDI) technology, eligibility resources provided by individual insurers, health information exchanges, and direct insurance company websites are tools utilized in order to determine patient eligibility. Despite the many costs and complications involved in billing, beginning to bill was seen as advantageous to all currently billing LHDs. Not only does it increase operating revenue, but it allows for other immunization programs and vaccines to be offered that otherwise would not have been available.
Process for Submitting Claims

In general, most large insurance companies require LHDs to be credentialed as a provider, thus becoming part of the network. This process can be lengthy, and it involves review of a provider’s education, experience, account information, as well as other information individual to the insurance plan. Credentialing an LHD as a facility, rather than credentialing each practitioner at the LHD individually, would be the most efficient option.

In some cases, LHDs were not able to credential as providers, but they were able to establish contracts and thus submit claims that will be paid according to the agreements specified in the contract. The primary importance of a contract is the establishment of reimbursement rates, and the assurance that a correct claim will be paid in full, with the exception of claims for which a patient may not have reached their deductible. According to a currently billing LHD, the process for billing smaller or regional third-party payers is much different than billing larger insurance companies. Becoming an “in-network” provider is not always necessary for smaller plans, and full reimbursement may be received by sending in a claim.

Of the billing LHDs interviewed, a few submitted paper claims while others submitted claims to payers electronically. One LHD utilized a program with which claims could be printed off and mailed using InstaClaim. Other LHDs utilize HDIS (Health District Information Software). LHDs that have significant experience with submitting large claims generally utilized EMRs and utilized a clearinghouse for eligibility support and to send billing claims to third-party payers. From a review of the major insurance companies in Ohio, claims can be submitted in a batch file in the ANSI (American National Standards Institute) 837 format. Currently, Anthem is the only
large payer that accepts direct submission of these claims. United Healthcare and Medical Mutual require batch files to be submitted through a clearinghouse. However, a select few insurance companies offer capabilities to submit claims one-by-one by entering individual claim data directly through a web portal. LHDs that currently bill submit claims as frequently as once per week to as infrequent as once per month.

As part of the claims process, EMRs as well as clearinghouses are able to perform “scrubbing” of the claims, to ensure the cleanest claim and reduce the likelihood of claim rejection. This “scrubbing” component includes checking correct and current code data, as well as checking for the completion of patient demographic data. Through the cost-benefit interviews, most LHDs indicated that they experienced a low proportion of claim rejection, ranging from 2-8%. If claims are denied, LHDs are able to review the reason for rejection and the claim is re-billed, or the patient can be billed for the balance, if applicable.

For the 74.9% of LHDs that do not currently bill private insurance companies for immunizations administered to plan enrolled patients, they will need to establish relationships with their top area insurers, and determine if credentialing and contracting is necessary to receive consistent and adequate reimbursement. In addition, LHDs need to establish a system to compile claims through one of the following options:

- Purchase PMS or EMR to batch claims
- Use the CMS (Centers for Medicare and Medicaid) 1500 form to mail claims individually
- Work with a billing company to batch claims
• Utilize health information exchanges or insurance company website portals to directly enter and submit individual claims

To ensure that these claims are ultimately paid, LHDs will need to work with a clearinghouse, as mentioned previously, or they will need to format files to an insurance company’s specifications to directly submit claims. These options will need to be weighed carefully by the individual health department so that the maximum reimbursement can be received, while considering resources available and the efficiency of the process.

In addition to credentialing and contracting, one of the most important steps in the billing process is eligibility determination. As indicated through the cost-benefit interviews, there are many different ways to check patient eligibility for an immunization. In order to bill with maximum effectiveness, LHDs will need to choose a method of eligibility determination:

• using free technology and payer websites to view patient information
• using the capabilities from an EMR or PMS to check eligibility
• purchasing services through a clearinghouse to determine eligibility
• purchasing the use of EDI technology to determine eligibility

Identification of insurance coverage for vaccines is vital to determining the source of funding for vaccines (e.g., VFC, 317, private stock). Correct eligibility determination can also reduce time spent on billing, if a patient’s insurance coverage has lapsed and they are no longer billable.
**Barriers**

A number of barriers were identified through discussions in the stakeholder meetings. Stakeholders were able to offer some helpful suggestions for mitigating barriers. One potential barrier is that Ohio is a local rule state and that some LHDs might not want to participate. In fact, one LHD did not allow ODH interns to complete the patient survey in its immunization clinics. LHDs offered suggestions for forums to reach out to health commissioners, for example, through a poster session at an upcoming conference.

Lack of funding for the purchase of vaccine up-front was identified as a significant barrier. Several potential solutions were discussed, such as having some LHDs purchase vaccine themselves, starting the project with one or two vaccines that are already purchased with state GRF, or starting by encouraging LHDs to initially bill for an administration fee.

**ASSESSMENT OF READINESS FOR IMPLEMENTATION**

The surveys completed provide valuable insight about the readiness for implementation. For example, the patient survey demonstrated that a significant number of patients presenting at LHD clinics are privately insured. Another survey confirmed that several LHDs already have experience billing private insurance plans. The cost-benefit interviews provided valuable insight in regards to resources, barriers, and benefits related to billing private insurance plans for immunization services. Additionally, LHDs in Ohio clearly understand that there is a lack of adequate financing for vaccines, as evidenced by ODH’s inability to supply all vaccines for non-VFC eligible children. All of this information suggests that there is an ability to implement billing, to some degree.
ANALYSIS

Based on experience from LHDs who currently bill private insurance companies, as well as information shared from the Oregon Department of Human Services, Division of Public Health, it is assumed that something less than 100% of claims will be paid. An LHD who currently bills indicated that recommended immunizations are generally paid and estimates that 55% of filed claims are paid. Paid claims vary by plan, with common reasons for non-payment of claims involving co-insurance and deductibles. Travel vaccines are usually not covered. Some LHDs indicated that “take-backs” can be of concern, meaning that a payer takes back a payment, believing that the claim was paid in error. Some billing LHDs indicated that they do not generally check eligibility and collect copayments upfront. One LHD indicated that most of their patients do pay their copayments and deductibles and another indicated that they send a patient four statements and then write unpaid balances off as bad debt. Sixty to 75% pay and a payment plan can be worked out. Patients continue to present to the LHD for services, because they know that their unpaid bills will not be sent to a collections agency.

Revenue in the form of administration fees will be received by LHDs, which will assist in covering operating costs (e.g., nursing time for administering vaccine, administrative time dedicated to billing private insurance plans). Revenue in the form of reimbursement for vaccine cost can be reinvested towards the purchase of additional vaccine for non-VFC eligible patients. Anecdotally, LHDs who bill have indicated that revenue from billing for immunization services has enabled them to pay for nursing time, support clinics, and pay for services that are not levy-funded.
The patient survey completed in the summer of 2010 indicated that 44.6% of patients surveyed at LHD clinics were privately insured, ranging from 34.7% in the central region to 53.9% in the northwest region of Ohio. The high percentage of privately insured patients suggests that billing would be beneficial.

A study conducted by Gary L. Freed, MD, MPH addresses vaccine purchase prices and payer reimbursement (1). The study found that the purchase price per dose for private practices differed between practices from $4 to more than $30. Differences in reimbursement between practices ranged from $8 to more than $80. Net yield (reimbursement minus price paid) varied between payers across vaccines from $3 to more than $24. Administration fees varied from $0.00 to $26.55. So, predicting specifics regarding costs and reimbursements is a challenge. The experience for this project is likely to be different in that if ODH purchases all vaccine for LHDs, the vaccine cost will be consistent and should represent a competitive price.

Clearinghouses offer a variety of services from instant eligibility verification to claim scrubbing and submission. If LHDs choose to use a service, a deciding factor is the costs associated. Also, some insurance companies such as United Healthcare and Medical Mutual will only accept claims submitted by a clearinghouse. ODH does not have the capability to contract with one company because of the variability among LHDs and the decisions made based on cost considerations and needs. The stakeholder group discussed the use of a billing company as an option. LHDs felt that, based on their experiences in billing, outsourcing billing was not a practical option, due to the importance of being involved in troubleshooting problem claims.
Some commented that if they are already verifying eligibility and entering billing data, it makes more sense to submit the claim themselves, rather than paying a company (generally a per claim rate) to submit claims that may later come back to them for troubleshooting. However, one LHD with billing experience indicated that they use a clearinghouse and find that the clearinghouse is well-versed on current requirements of insurance companies, that it serves as a second scrub of the claims, and that the electronic remittances received are useful.

Eligibility verification is a main area of need for all health departments. A service that can accurately provide that information cuts down on time wasted by personnel calling insurance companies or going to individual payer websites to check each patient’s insurance status. A few LHDs on the stakeholder group indicated that they use Availity®, which is a health information network that supports electronic data interchange. It offers an eligibility and benefits inquiry tool that is free of charge. This may be an option for LHDs with limited resources.

Billing for administration fees will result in an additional source of funds for LHDs who are not already billing public and/or private insurance plans for vaccine administration. Eventually, it is hoped that revenue collected for vaccine will enable Ohio to begin purchasing all vaccines (e.g., HPV) for all children who present at LHD clinics, regardless of ability to pay. This could lead to an increase in the number of children that can be fully vaccinated. Additionally, the potential to increase adult vaccine availability could result in the future.

While implementation of the Billables project will increase reimbursement in the public sector and ultimately increase the availability of vaccines to communities there are also some potential
barriers that will be faced upon implementation. They include:

A) Establishing LHD buy-in for the project: Due to the autonomous nature of LHDs in Ohio, vaccine resources may need to be allocated based on participation in billing. This barrier will be addressed by educating LHDs on the many benefits of billing and simplifying the process. Local health districts will be assured that 317 purchased vaccine will continue to be available for children who are insured, but cannot afford vaccines due to high co-payments and deductibles. Additionally, ODH staff will make direct contact with LHDs opposing billing to discuss their reasons for not wanting to implement billing and formulate strategies to address their concerns.

B) Lack of billing knowledge and experience: Many local health districts recognize the importance of billing, but are hesitant because of the lack of knowledge needed to begin billing. To address this barrier, ODH contracted with the Erie County General Health District, an experienced billing LHD, to provide training on the various aspects (e.g., contracting, credentialing, submitting claims) of billing.

C) Lack of LHD staff available for billing activities: Most LHDs do not currently have staff available to undertake billing activities and may have difficulty getting approval to create a new position to manage these duties. ODH can assist in addressing this barrier by continuing to communicate with various LHD staff through multiple venues about the importance and benefits of billing for immunization services. For example, ODH could reach out to health commissioners through the Association of Ohio Health Commissioners.

D) Funds to purchase billing software: ODH is addressing this barrier through the use of grant funds to create the capability within ImpactSIIS for LHDs to create batch files that
can be sent to clearinghouses or insurance companies; qualifying LHDs will be able to use these services free of charge.

E) Accurate reporting into ImpactSIIS: Reliable billing data will be dependent on accurate reporting, which could be problematic due to the use of other practice management systems or electronic medical records that are not HL7 compliant. ODH will overcome this barrier by only allowing LHDs that directly enter and report data into ImpactSIIS the ability to use the abovementioned batch file capabilities. Additionally, ODH may continue to work with electronic medical records to ensure interoperability with ImpactSIIS for all purposes. Insurance companies will likely support reporting to ImpactSIIS, as this is an important data source for HEDIS (Healthcare Effectiveness Data and Information Set) rates.

F) Lack of seed money for private vaccine purchasing for billable doses: ODH will work to overcome this barrier by implementing billing systems slowly, by first testing and utilizing pilots to explore the various options:

1) Use state funds to initially offer a limited number of state purchased vaccines, and thus build a reservoir of funding to gradually increase the number of vaccines that can be purchased with these funds;

2) Utilize private companies/organizations to complete the purchasing of and billing for vaccine

3) Billing for administration fees for 317 and GRF-purchased vaccine until enough revenue is gathered to purchase vaccine at the local level.

G) Shift in patient thinking: Beginning to bill insurance plans and collect payments (e.g., copayments, deductibles) from patients will likely cause a shift in thinking amongst
patients who are accustomed to receiving services at LHD clinics for low or no cost. While insurance companies realize the problems inherent in high-deductible plans, the plan design is chosen by the employer who purchases the plan. Patients do generally have to pay deductibles and copayments upon check-in at a private provider office; however, this has not traditionally occurred at LHD clinics. Health plans do prefer that patients receive care, including immunizations, in their medical home and do not want to see immunization rates decline. It is important to address this issue in a way that patients will continue to receive this preventative care, whether it be in their medical home or the LHD clinic. Patients will need to be educated about the change in process and the need to bring their insurance card and copayment to their visit. Collecting copayments from patients may cause some patients to return to their medical home for vaccination services. Furthermore, as the provisions of the Affordable Care Act begin to affect more health plans, patients will begin to have full coverage for preventable services and large deductibles will become a lesser concern.

H) Screening for patient eligibility determination prior to service: This barrier will be overcome by creating and implementing training modules for each pilot type. The training modules will cover the topics of screening for eligibility in detail. This process may vary slightly for each pilot type but will cover the general topics of screening and eligibility at the local level.

IMPLEMENTATION

Some progress towards implementation has been realized during the planning period. ARRA funding was used for two initiatives that will assist with implementation. The first initiative
involves the training of LHDs to bill. The second involves making enhancements to ImpactSIIS, Ohio’s statewide immunization information system, to better enable billing.

To prepare LHDs for billing, ODH released a Request for Proposals (RFP) called, “Training Local Health Departments to Institute the Billing of Third-party Health Insurers for Immunization Services.” The grant was awarded to the Erie County General Health District. As outlined in the RFP, Erie County completed the following prior to December 31, 2011:

- Develop a training module and training schedule that includes procedures, steps, mechanisms and logistics necessary to begin billing third-party health insurers
- Conduct seven live regional training sessions
- Develop and provide information for a web-based training seminar for local health departments to use as a reference to facilitate implementation of a billing system
- Produce educational modules for training local health departments on pertinent topics, including vaccine financing and funding sources, credentialing, contracting, bill submission, troubleshooting of unpaid claims, and other relevant topics
- Develop a comprehensive question and answer document local health departments can use as a reference
- Serve as a resource for local health departments until the grant period ends

With modifications funded through the Billables Project, ImpactSIIS will have the capacity to increase accountability for VFC and section 317 purchased vaccines, as well as allow LHDs to utilize ImpactSIIS for billing purposes through increasing the functionality. This will increase the capacity of LHDs to bill who do not utilize other practice management or billing software.
Payers on the stakeholder group indicated that insurance companies want to be billed for services, as this is typically the only method for them to know if a patient has received needed services.

The staff resources needed for an LHD to bill can vary, depending on the number of payers billed and the volume of privately insured immunization patients. For example, one LHD who bills only one common private insurance company employs a half time position to complete this billing. Billing health departments have at least one clerk and depending on the size of the clinic, duties of personnel are divided between intake and billing. The possibility of collaboration of multiple smaller LHDs or of LHDs with a local Federally Qualified Health Center was mentioned as a possibility.

The stakeholder group discussed that it may be most practical for LHDs to contract with only the top three or four payers in their area. Top payers in each county were identified through the patient survey. It was indicated that most physician offices contract with their top five or six payers. Other payers could still be billed without a contract, but reimbursement would be uncertain. LHDs should be able to be credentialed or contracted, regardless of whether the medical director is part-time or full-time.

It is likely that it will take some time for the billables project to cash flow its existence completely, and to accomplish an expansion of vaccines offered to non-VFC eligible patients. The credentialing process may take as much as six to nine months to complete. Additional time may be necessary for contracting. However, once LHDs begin to bill, some revenue may
become available quickly. Payers have timeliness requirements that should result in receipt of payments, or a claim denial, within 30 to 45 days if filing paper claims, less so with electronic claims. It will likely take up to 90 days following the beginning of the pilot period to get an accurate picture of total reimbursements.

Billing will be implemented incrementally, initially using pilots and a small number of vaccines. Lack of money for purchasing an initial inventory of all recommended vaccines and lack of implementation funding are challenges that necessitate this approach. The implementation plan builds on information obtained during the planning grant. Input on the plan was received from members of the stakeholder group.

The ultimate goal of the Billables planning grant was the creation of a plan outlining how Ohio LHDs will implement billing, with the outcome being to provide vaccines for which Ohio is currently two-tiered (i.e., HPV as of December 2011). As the planning process moved along, it became clear that the implementation plan must be flexible in order to allow for testing several available options for local health departments to bill private insurance.

Ohio proposes to implement billing by initiating and evaluating three different methodologies for billing private insurance. This will be accomplished by establishing one year pilot programs with two to three volunteer LHDs for each methodology (six to nine pilot clinics in total). Training, support, and evaluation will be provided by the Ohio Department of Health through the use of Immunization Program staff (in-kind), given the lack of funding available for implementation. Upon completion of the pilot projects, an evaluation of each will be undertaken to ascertain cost-
effectiveness, barriers, and implementation and operational issues associated with each strategy. A decision can then be made on how the Billables project will operate going forward.

The rationale for utilizing the piloting strategy stems from a variety of reasons, one of which is the realization that new possibilities for billing private insurance at the local level have surfaced; namely, the ability for LHDs to work with a private company that has the ability to supply vaccine, bill insurance, and provide some remuneration to the LHD for vaccine administration. It is important that this, and more traditional billing methods, be fully explored to bring the most benefit to the LHDs, ODH, and ultimately the patient. The reason for multiple pilots is due to the variability of demographics for each LHD, along with the fact that LHDs are self-governing in Ohio.

The three methodologies proposed for the pilot include:

1. Utilizing the statewide immunization information system, ImpactSIIS, to prepare billing. Development has begun to create enhancements to ImpactSIIS to enable dose-level (rather than visit-level) accountability and to batch individual patient insurance and vaccination services information from LHDs, which could then be transmitted to a billing clearinghouse for processing. This will be especially important for small LHDs that have no experience with billing private insurance and little or no capacity to increase staff. Under this plan, ODH will purchase and supply the vaccine, will use billing data to determine the number of privately insured patients that received ODH-supplied vaccines, and will invoice LHDs for the replacement cost of the vaccine. LHDs would still need to complete contracting and
credentialing processes with applicable payers. See appendix 2 for a more detailed description of this pilot.

2. LHD contracting with a company that will provide all vaccine, supplies, and insurance billing services (credentialing, contracting, billing, troubleshooting of denied claims, etc.) and in return provide the LHD with a set administration fee. This will negate the need for the state or LHD to purchase vaccines and address the many complex aspects of billing. Under this plan, ODH would not be responsible for supplying vaccines to the LHD for privately-insured patients. However, ODH will continue to supply VFC, 317, and state GRF vaccines, for patients eligible to receive them. See appendix 3 for a more detailed description of this pilot.

3. A more traditional approach whereby LHDs are responsible for all contracting, credentialing, billing, form completion, direct submission to the third-party insurer, and claim rejection troubleshooting. Under this system, ODH will purchase vaccine, identify the amount of vaccine administered to privately insured patients, and invoice LHDs for the replacement cost of vaccine.

Upon completion of the pilots, ODH will evaluate all three methodologies to ascertain the most cost-effective and beneficial method(s) to implement, on a statewide basis, for those LHDs not currently billing private insurance for non-VFC immunizations.
As indicated, one significant barrier to overcome is the lack of funding to purchase vaccines for this project. Although ODH receives GRF vaccine funds, the amount is not sufficient to supply all vaccines on the Advisory Committee on Immunization Practices (ACIP) schedule. During proposed pilots 1 and 3, vaccines supplied to LHDs will likely be limited to a few vaccines until an adequate pool of funds can be established. ODH will explore opportunities to purchase vaccines at the most inexpensive cost to maximize limited resources.

REFERENCES


ADDENDICES

1. Erie County Training Overview
2. ImpactSIIS Billing Module Description
3. Vendor Pilot Description
4. Guide to Credentialing
Appendix 1

**Erie County Health Department Training Description**

In June 2011, ODH released a Request for Proposals (RFP) called, “Training Local Health Departments to Institute the Billing of Third-party Health Insurers for Immunization Services.” Erie County General Health District’s proposal was approved and development of a training program consisting of seven regional demonstrations and web-based support resources began in August 2011. The last training session occurred on November 1, 2011. The goal of the training sessions was to increase the number of LHDs who bill third party insurers for immunization services.

A key part of the planning phase of the Billables project was to review current billing practices of LHDs and make appropriate recommendations to audiences on the most efficient method of constructing a billing process. Billing experts from Erie County gathered information on current resources for developing the training materials and outlined clear parameters for the training objectives. Plans for tracking participants and gaining feedback were also designed. The content of the training materials included an information binder with resources on how to contract and credential with third party insurers, guidelines on following CPT coding and ICD-9 coding, and the patient registration and denial management process.

The credentialing process is a time consuming process in which licensure of a provider is verified and validated. LHDs have to decide which insurance companies to contract with or credential, and whether to credential as a facility or under a medical director. During the training
sessions, guidance was provided to give LHDs the right tools to make an informed decision on how to proceed.

Accurate coding is important for proper reimbursement and compliance with insurance and government regulations. To detail this process, examples of billing scenarios and the correct coding rules were explained step-by-step in the training sessions for each type of third party insurer. Also, LHDs were shown the proper way to build an encounter slip using the CPT and ICD-9 codes that third party insurance require for claim submission. Included in the training budget was the purchase of reference tools given to all LHDs which have descriptions of 2011 CPT and ICD-9 codes and a book titled: “Working with Insured and Managed Care Plans.”

Registration is the first point of contact for patients and the best time for providers to collect information needed for billing and to properly screen for VFC eligibility. Denial management includes suggestions on how to identify and determine why a claim was rejected, plans for deciding who should correct it and how to do so, and also follow up procedures consisting of resubmitting and documenting in order to prevent future denials.

The objective of the billables training sessions and follow up activities was to increase the number of non-billing LHDs who take steps to establish a third-party billing system for patients who receive immunization services. ODH will monitor long-term activities of health departments and progress towards this goal.
Appendix 2

**Impact SIIS Modifications for Billing**

The billing module in ImpactSIIS will assist LHDs without access to billing software with the capability to input patient and insurance information and use the information to generate a billing extract that is sent directly by the LHDs to a clearinghouse or third party insurer by mail. This eases the burden of LHDs who do not have the resources to bill third party and want to begin billing by utilizing a free billing module which creates claim forms with populated data.

The enhancements to ImpactSIIS began with input from local health departments during stakeholder meetings and conversations with experienced billers which allowed for an exchange of information on what functions are most important for immunization clinics. Using these suggestions to tailor functionality, the system will be able to generate practice level and state level reports associated with billing.

A first step in beginning the process of modifying ImpactSIIS was to gather information on how LHDs currently bill insurance providers and to gain an understanding of ANSI-837 file format used for electronic billing (CMS-1500 form). Health departments who currently bill have indicated the efficiency of batch filing claims based on volume. Improvements have been made to ensure that the editing of claims can be processed quickly and with safeguards for user error. Another step is to specify the reporting of VFC eligibility in order to define the status of patients who are VFC eligible versus fully insured patients whose insurance can be billed for services.
The practice management section of ImpactSIIS will have the ability to create and maintain clinic setup, insurance contracts and insurance plan information and fee schedules. A common theme repeated by LHDs is the importance of being able to verify and edit data. Extra time was spent on taking suggestions into account and building a user-friendly tool whose ease of use is comparable to other established billing systems. By contacting a few insurance providers for information on direct submissions, further additions were made to the module.

In designing the billing management section, users will be able to search patient information already entered into ImpactSIIS and generate claims including the CMS-1500 forms with the ability to edit, extract for ASCII print image or ANSI-837 file format, and track reimbursements for the practice. Payment status is also available to view including records for settled, re-bill primary, re-bill secondary and re-bill patient options. Outstanding balances will be managed using these choices with a drop-down menu format.

Following completion of the billing module in ImpactSIIS, a test of the extract will occur during a pilot phase anticipated in March 2012. By correctly identifying patient insurance status, ImpactSIIS will be able to generate a report which calculates the amount of GRF funded vaccine used for insured patients. Once the claim forms are submitted and a reimbursement is collected for vaccine cost and administration fee, LHDs will be able to keep the administration fee and ODH will collect the vaccine cost in a special account to be used for the purchase of more vaccine. This process will occur in arrears (approximately 90 days) to allow for a concise accounting of patient VFC eligibility. If a patient is deemed to be underinsured following a denial of payment from the insurance company, the health department can shift the patient to
VFC eligible in ImpactSIIS and will not be billed for vaccine cost by ODH. During the pilot, health departments will use ImpactSIIS to enter patient information and create the CMS-1500 form to seek reimbursement. ODH will then assess the strength of the program and decide whether to expand the option to other local health departments who are interested in billing.
Appendix 3

**Immunization Vendors for Billables Pilot**

Ohio is a home (local) rule state with local health districts managed autonomously. Because of this, LHDs have the ability to choose the methods to proceed with billing third-party health insurers. One initiative that the Ohio Department of Health is considering is to pursue a partnership with a vendor specializing in vaccination services. The biggest barrier of the billing process is the cost of the initial purchase of vaccine and the risk of wasting vaccine. By using a vendor, LHDs can take advantage of the built-in network of payers and also the ability to return unused vaccine. This will allow a way for LHDs to benefit from the credentials the vendor has with third-party insurers and negotiate a vendor fee – usually a percentage of funds reimbursed - meaning no out of pocket expenses for the health department.

Once a pilot has begun, the vendor will be able to bill and receive reimbursement for immunization services and provide local health departments with an administration fee. In August 2011, a Request for Interest (RFI) was released by ODH. Two companies submitted letters of interest and were then issued a Request for Proposal (RFP). The deadline for the RFP was November 18, 2011 and no vendors responded. This pilot will now be approached in a less formal manner.

The Ohio Department of Health will continue to provide vaccines for VFC eligible children served in the pilot LHD clinics.
GUIDE TO CREDENTIALING
OHIO DEPARTMENT OF HEALTH

BILLABLES PROJECT
December 2011
Guide to Credentialing

Background:

Credentialing is the process of reviewing and verifying the information of health care providers who provide services to the subscribers of health insurance plans. In order to begin billing insurance companies for services performed and realizing positive financial outcomes, the health department must be credentialed with the insurance company. This process is often time consuming due to the amount of information that needs to be exchanged between the two parties. It is important to gather the necessary information prior to beginning this process. Relevant documents include:

- Professional licensure (Ohio Board Certification)
- Educational background of practitioners
- Internship, Residency and Fellowship Training
- Malpractice insurance information and history of practitioners
- Form W-9
- Tax ID number
- NPI number of individual
- NPI number of facility (if applicable)
- CAQH username and password
- Drug License Certificate (DEA)

Each commercial health plan follows unique policies regarding credentialing and contracting with providers. Other documentation not listed may be required. Keeping track of all documents is important. To eliminate duplication of paperwork, health departments can utilize CAQH UPD (Council for Affordable Quality Healthcare Universal Provider Datasource) for the insurers who participate in the service. CAQH UPD is a free online database which stores provider information necessary for credentialing to reduce the time and resources expended when credentialing with multiple insurance companies. The electronic database reduces paperwork during the initial process and when it comes time to re-credential. LHDs who become a member may find credentialing easier. In order to utilize CAQH UPD, an organization
must be invited by a participating commercial insurer. After the initial invitation, the local health department will receive a registration kit in the mail within two weeks that includes a CAQH Provider ID number. Provider representatives at commercial insurers are the best resource for guidance during this step in the process. In some cases, a medical director or rendering provider will already have an existing CAQH number which can be used to process the application.

Estimates have ranged from six to nine months from initial contact to finalization. It is possible that an on-site visit is required by the insurance company to ensure quality assurance standards are being followed. In some cases, once the health department is credentialed, reimbursement for services can be backdated to the date the process began.

The decision of whether to credential as a facility or by rendering provider/supervisor depends on the organizational structure of the clinic and the policies of the insurance company regarding health departments. If the clinic has nurses performing the medical services but are overseen by a supervising physician or medical director, it is likely more efficient to credential the individual in the supervisory role. If the health department has multiple practicing physicians, then the choice becomes whether to credential each physician or to credential the facility for liability reasons. For traditional Medicaid and Medicaid Advantage plans, an on-site visit is required.

To assist in making the best choice on which route is best, health departments can take steps within the organization to learn whether another service area has already credentialed and contracted with a third party payer. All third party insurers are experienced in contracting and credentialing with providers. There is variability on their policies with public health agencies, and the best way to understand the process is to contact provider representatives in the most common commercial insurance plans in the region.

Council for Affordable Quality Healthcare Homepage:

- Resources such as a list of participating health plans and PPOs, FAQs, etc. – [http://www.caqh.org/ucd.php](http://www.caqh.org/ucd.php)

**United Healthcare:**

1. Call regional office or United Healthcare’s contracting department – (877) 842-3210.
2. To join network, credentialing specialist will ask questions for information in your Universal Provider DataSource. If provider does not have a CAQH number, ask for invitation to CAQH.

Cleveland, Ohio
Address: North Point Tower, 1001 Lakeside Avenue, Suite 1000, Cleveland, OH 44114
Main Phone: (216) 694-4080
Toll Free Phone: (800) 468-5001

Dayton & Cincinnati, Ohio
Address: 9050 Centre Pointe Drive, Suite 400, West Chester, OH 45069
Main Phone: (513) 603-6200
Toll Free Phone: (800) 861-4037

Columbus, Ohio
Address: 9200 Worthington Road, Westerville, OH 43082
Main Phone: (614) 410-7000
Toll Free Phone: (800) 328-8835

**Anthem Blue Cross / Blue Shield:**

1. Anthem Contracting Department – (866) 760-7550 (Anthem contracts with health departments - does not credential).
2. Anthem Ohio Provider Network Orientation Manual – Regional map and contact list on pages 11 and 12:
Aetna:

1. Aetna Contracting Department – 1-800-353-1232.

Medical Mutual of Ohio:

1. Medical Mutual Contracting Department – Sandra Keller (216) 687-2673 (Medical Mutual contracts with health departments - does not credential).

Ohio Medicaid Enrollment:

2. After saving and submitting provider enrollment application online, print form along with complete W-9 form and mail to Provider Enrollment Unit in Columbus, Ohio.
3. After four to six weeks, will receive approval and a Medicaid provider number.
4. Checklist of required documents for providers – [https://portal.ohmits.com/Public/Portals/0/StaticContent/Providers/CheckList.pdf](https://portal.ohmits.com/Public/Portals/0/StaticContent/Providers/CheckList.pdf)

Columbus, Ohio
Address: P.O. Box 1461 Columbus, Ohio 43216-1461
Provider Enrollment Unit phone number toll free: 1-800-686-1516 → select option 3 → then option 1 → then option 1 again → then option 4.

Medicare Provider Enrollment:

1. Provider Enrollment Application Forms: CMS 855I (for individual practitioners) and CMS 855B (for organizations) –
2. Internet based Provider Enrollment and Chain Organization System (PECOS)

3. Send to local “Medicare Administrative Contractor” (MAC)

4. Medicaid enrollment overview –

https://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage